Wirral University Teaching Hospital NHS
NHS Foundation Trust

Board of Directors

Public Board

25 May 2016

MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 25 MAY 2016
COMMENCING AT 9.00AM IN THE
BOARD ROOM
EDUCATION CENTRE, ARROWE PARK HOSPITAL

AGENDA

1.	**Apologies for Absence** Chairman	0900	v
2.	**Declarations of Interest** Chairman		v
3.	**Patient's Story** Director of Nursing and Midwifery		v
4.	**Chairman's Business** Chairman		v
5.	**Chief Executive's Report** Chief Executive	0930	d
6. Strategy and Development			
6.1	**Vanguard Programme Update** Director of Strategy		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 1 Finance and Cost Improvement Programme Report Acting Director of Finance		d
8. Quality			
8.1	**Francis Hard Truths – Nurse Staffing Report** Director of Nursing and Midwifery		d
8.2	**Workforce Annual Report** Director of Workforce		d
8.3	**CQC Compliance Progress Update** Medical Director		d
9. Governance			
9.1	**Annual Report and Accounts 2015/16**		
	• **Annual Accounts 2015-16 and Audit Opinions** Acting Director of Finance		d

- **Quality Report and Audit Opinion**
  Medical Director d
- **Annual Report and Annual Governance Statement** d
  Director of Corporate Affairs

9.2 Chair of the Audit Committee Report: d
- **19 May 2016**

Chair of the Audit Committee

9.3 External Assurance: d
- **Board declaration – General Licence condition G6**

Director of Corporate Affairs

9.4 Report of the Quality and Safety Committee: d
- **18 May 2016**

Chair of the Quality and Safety Committee

9.5 Board of Directors

d

9.5.1 Minutes of the Previous Meeting
- **27 April 2016**

9.5.2 Board Action Log
Director of Corporate Affairs

10. Standing Items

10.1 Items for BAF/Risk Register v
Chairman

10.2 Items to be considered by Assurance Committees v
Chairman

10.3 Any Other Business v
Chairman

10.4 Date and Time of Next Meeting v
Wednesday 29 June 2016 at 9am

Board of Directors	
Agenda Item	5.0
Title of Report	Chief Executive's Report
Date of Meeting	25 May 2016
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.

Partnership/Collaborative Working

It is recognised that success moving forward will require whole system change in addition to internally driven improvements. This wider system change is being progressed at several different levels: Cheshire and Merseyside; South Mersey and Wirral.

At a Cheshire and Merseyside level the draft Sustainability and Transformation Plan (STP) has been submitted and a review was held with Simon Stevens, Chief Executive of NHS England (NHSE) and senior NHS Improvement (NHSI) and NHSE personnel on the 11th May 2016. The feedback was encouraging of a more radical reconfiguration of acute services and that Cheshire in particular should seek to build on the good progress made by this Trust and the Countess of Chester (CoCH) on the Acute Care Alliance. A further submission is required by the end of June 2016 which we are fully involved in shaping.

On a South Mersey basis, further positive progress is being made with the Acute Care Alliance. A "dragons den" for support service reconfiguration has been arranged for late June and plans are being progressed to meet this deadline. An initial clinical meeting has been held on maternity, neonatal and paediatrics and early discussions with Cerner have been held regarding the potential roll out of Wirral Millennium. Of particular note is the joint process, supported by Bevan Brittan, to identify a partner that will accelerate our strategic transformation building on the strategic estates partnership model. A "soft marketing" day was held on the 10th May 2016 with five potential partners meeting with both Trusts to discuss their relative merits. A road map on how this could be progressed at pace is currently under development.

As part of gaining support for a South Mersey footprint and building on our current strategy eg increased emphasis on Clatterbridge, common support services, enabling technology and increased clinical alignment a series of meetings have been undertaken and arranged. Of note would be a meeting with Lord Carter on 6th June 2016; the joint Local Authority/Acute Care Alliance/CCG Meeting held on the 18th May and a meeting with Matthew Swindells, NHSE's new Director of Commissioning Operations on the 10th June 2016.

From a Wirral perspective the last month has been challenging having been dominated by extensive contract negotiations and the move from Vanguard to "Healthy Wirral". The latter has involved unpicking existing PMO resources and attempting to understand and agree key priorities to establish resourcing requirements going forward. This is very much a work in progress. It is worth noting that the latest Better Care Fund (BCF) submission was shared by the Local Authority and the CCG at very late notice affording little time for constructive debate, and given the significant disinvestment in intermediate care with no clear mitigating strategy, the submission was not supported by the Trust at this point. The impact is that the BCF will not be assured and further external validation is therefore likely.

The work with Cerner continues with two workshops having been held in the Trust to review the future roadmap for this work. The first workshop focused on a review of the current position with regard to medicines management and clinical and operational processes and the second was a more strategic view of what could be achieved over the next 5 - 10 years as we increasingly move toward a fully digital hospital and health economy. I am pleased to report that there was good engagement from both senior clinicians and managers in both events.

The agreed next steps were to develop a strategy based on:

- completing the digital clinical record, particularly with regard to doctors noting
- the use of clinical pathways to help embed best practice reduce un warranted clinical variation.
- improved clerical processes to embed best practice and reduce un warranted process variation.
- best practice medicines management.

- advanced analytics; using the data at an organisation and health economy level to improve clinical and organisational performance.
- patient engagement, involvement and ownership.
- revised governance structures that recognise the opportunities and complexities of operating in a digital environment.

Maternity Cultural Review

It has been a difficult few weeks since the maternity cultural review was undertaken and shared with our maternity and midwifery colleagues. The review on the whole was very positive although inevitably it highlighted areas where the Trust would want to make improvements. A full action plan has been developed as a result of the review and this has been shared with CQC, NHS Improvement and our commissioners, all of whom have been extremely supportive.

The Board will continue to monitor progress with the action plan to ensure that improvements are made where identified.

Junior Doctors

The Advisory, Conciliation and Arbitration Service announced on 18th May 2016 that a deal had been reached after more than a week of negotiations in relation to the Junior Doctors Contract. It is acknowledged that this deal will still need to be agreed by the British Medical Association's junior doctor membership.

And Finally

I am delighted to advise the Board that James Mawrey, Director of Workforce has been shortlisted for the HR Director of the Year by Heathcare People Management Association (HPMA), the results of which will be announced on the 30th June 2016. This is well deserved and of course we wish him the very best luck

David Allison
Chief Executive

May2016

BOARD OF DIRECTORS	
Agenda Item	6.1
Title of Report	Vanguard Programme Update
Date of Meeting	25 May 2016
Author	Mike Coupe Director of Strategy
Accountable Executive	David Allison Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Strategic objectives: To prioritise the development of new models of care in cooperation with our acute/secondary, primary, community and social care partners To build on joint working with partner organisations to deliver the maximum operational and financial benefits To guarantee the sustainability of the Trust through the transformation of service provision and system performance Key measure: n/a Principal risk: n/a
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To note
Data Quality Rating	Bronze – qualitative data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

1. Executive Summary

At its April meeting, the Board received a report which provided a briefing on the decision by NHS England to withdraw funding for the Vanguard programme, it highlighted the commitment of Wirral Partners to delivering the wider Healthy Wirral programme (of which Vanguard was a subset) and confirmed that discussions between Partners to understand the implications of the loss of Vanguard funding were taking place.

This further report describes the outcome of these discussions as they affect the projects in which WUTH has a direct interest.

The IT enabled population health management project proceeds as planned.

At the time of writing, an offer has been made by the Council's Director of Public Health to fund the respiratory medicine (COPD/ asthma) and diabetes projects for 2016/17. An oral update will be provided at the meeting of the Board.

It is proposed that the care of older people project forms part of a wider 'end to end' redesign of services for older people to be managed by the three NHS providers in Wirral.

It is also proposed that the Single Front Door (A&E) project forms part of a wider 'end to end' redesign of the unscheduled care system to be managed by the three NHS providers in Wirral.

The CEOs of the three NHS providers in Wirral have asked their planning leads to produce Project Initiation Documents for these two redesign exercises by the end of June.

Over and above the future of these five projects, the attention of the Board is drawn to the following points:

- The Vanguard PMO is being disestablished. Individuals seconded to the programme will return to their previous organisations. Where possible, individuals on fixed term contracts will be redeployed with Partner organisations to mitigate the risk of redundancy. At the time of writing it was not possible to confirm the actual extent of WUTH's liabilities in this regard.
- A smaller Healthy Wirral PMO will be established within Wirral CCG to support delivery of the Local Delivery System Plan. The Vanguard programme was best understood as a sub-set of Healthy Wirral. Healthy Wirral is now best understood as a 'badge' for the LDSP.

2. Recommendation

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

Board of Directors	
Agenda Item	**7.1.1**
Title of Report	**Integrated Performance Dashboard**
Date of Meeting	**25th May 2016**
Author	**John Halliday** **Assistant Director of Information**
Accountable Executive	**Mark Blakeman** **Director of Infrastructure and Informatics**
FOI status	**Document may be disclosed in full**
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	**All Strategic Objectives (1 through 7)** **All Key Measures (1A through 7D)** **All Principal Risks**
Level of Assurance • **Positive** • **Gap(s)**	**Partial with gaps**
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	**Discussion**
Data Quality Rating	**Silver – quantitative data that has not been externally validated**
FOI status	**Document may be disclosed in full**
Equality Impact Assessment Undertaken • **Yes** • **No**	**No**

1. Executive Summary

This report provides a summary of the Trust's performance against agreed key quality and performance indicators. The Board of Directors is asked to note the performance to the end of April 2016.

2. Summary of Performance Issues

The Trust continues to make good progress in delivering its strategic performance targets (Meeting our Vision and A Healthy Organisation domains).

Whilst there has been some significant improvement in a number of areas, operationally the Trust continues to struggle to achieve against its operational objectives (Operational Excellence and External Validation domains).

The month 1 financial position is a deficit of £1.3m against a plan of £1.1m. NHS Clinical income reflects the agreed financial 'envelope' with the CCG and operating expenses are £0.2m higher than plan reflecting operational pressures within the organisation with the escalation areas and the challenges on cost control and reduction.

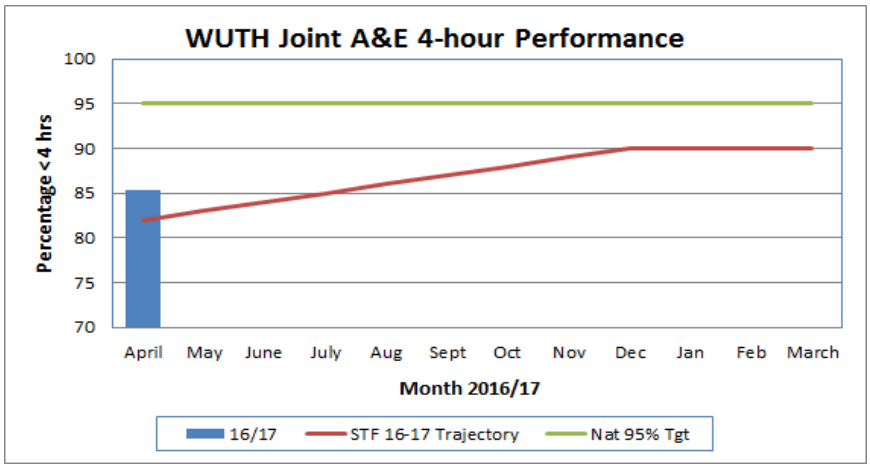
The key issues relating to external validation is achievement of the A&E and RTT targets, with detailed comments against each area below.

3. Detailed Explanation of Performance and Actions

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

Against the national emergency access standard of a minimum 95% to be treated within four hours, performance for April was 85.38% as measured across a combined ED and All Day Health Centre performance at the Arrowe Park site. ED alone was 80.17%.

April's 85.38% was above the Sustainability and Transformation Fund (STF) trajectory WUTH has submitted for the year, illustrated below.



The key initiatives to improve performance in the health economy & internal patient flow management action plan are continuing. The internal Task & Finish Group is meeting regularly to ensure there is both coordination & pace to delivery of the agreed improvements.

b. Advancing quality indicators

Detail on the three areas not achieving:

- **Community Acquired Pneumonia:** the main issue remains antibiotics: the visual prompt for stat drugs has been reintroduced and improvement is expected from May. Further education is being arranged to remind staff to document a CURB score as this determines the antibiotic choice.
- **AKI:** one of the nurses is now on long term sickness absence, which is having a big impact on the specialist review timing. Focus has been on delivering the CQUIN rather than service improvement on the wards. There is more ward engagement now but Informatics are being approached to see if there could be further improvement in the way patients with an AKI could be identified and also if a care plan could be built into the system. This work would need to be prioritised against other developments in line with the agreed criteria.
- **AMI:** the population was 18 for the month, therefore there was a big impact from a small number of missing measures. Cardiac rehabilitation referrals are the main concern. The auditor is moving to be more of a case manager from June.

c. Elective Performance

In April 2016 the Trust cancelled 298 elective procedures due to industrial action. However the Trust mitigated this loss and delivered an elective overperformance of 57 elective procedures above plan.

Despite the industrial action removing 19% of planned elective capacity the Trust mitigation meant that only 8% of inpatient elective & 11% of outpatient elective activity was cancelled in April.

The move from a cost per case contract towards a financial envelope in 2016/17 and the agreement of a year-end deal with Wirral CCG has mitigated this risk of underperformance from a contract performance point of view, though clearly it is essential that activity levels moving forward are capable of meeting the 18 week RTT target.

d. 18 Weeks RTT

Ongoing achievement of the RTT standard is directly linked to demand & capacity. It is clear that there is a mismatch between the demand for some services and their underlying capacity. Whilst this remains the case, it will be difficult to achieve the national RTT standard of a minimum 92% of patients waiting for treatment to be at 18 weeks or less, for all specialties and for the Trust's combined position.

The Trust did not achieve the standard at the end of April, with the final position being 91.08%. This is an improvement from the 90.46% at the end of March, and also above the Trust's STF trajectory for April. The specialties that are not achieving and contribute to the Trust's overall failure continue to be General Surgery (with the failing areas in colorectal, upper gastrointestinal surgery, and vascular), Trauma & Orthopaedics and "Other" which includes numerous specialties but notably Community Paediatrics.

Of general note is the impact on performance of the loss of four working days through the junior doctor's strike in April. The four days represents 19% of the possible elective capacity in the month. With minimising the impact as much as possible, an estimated 8% of elective capacity was lost.

As previously reported the RTT Task and Finish group has commenced and has established new reporting systems, including revised patient tracking lists, which all specialities are reporting against at weekly performance meetings chaired by the Director of Operations.

The Trust has started to rollout the NHS Intensive Support Team's capacity and demand model, initially within colorectal and endoscopy

with an expectation that this is used in all specialities by the end of quarter 2.

The Trust is scoping the requirement to validate all current open pathways, which currently stands at 22,000 patients. An audit at speciality level has commenced and discussions have taken place with external organisations regarding the ability to source trained validators to cleanse the full waiting list.

e. Infection Control

For C.difficile, there was one reported 1 C.difficile toxin with the Post Infection review identifying this to be unavoidable and therefore not cunting against the annual trajectory (subject to final approval).

The HPV programme has continued with the IPC Team prioritising the wards at greatest risk of C.difficile acquisition.

Ongoing monitoring of side room usage, documentation and the management of patients with diarrhoea continues to ensure all mitigating actions are consistently in place to prevent C.difficile infection against a trajectory of no more than 29 cases by the end of 2016/17.

There was a single reported MRSA bacteraemia during April which has since been assigned to the Community Trust, therefore zero cases against WUTH's trajectory.

f. Non Core Spend

Please see following finance report.

g. Summary Financial Position

Please see following finance report.

h. Delayed Transfers of Care

The historic numbers reported against this metric are under review, to ensure the process for identifying delays reflects all patients affected.

Governance Arrangements – Operational Management

A revised governance framework has been proposed by the Chief Operating Officer to strengthen the reporting arrangements for managing operational performance within the organisation. This details the establishment of weekly Access and Performance meetings, to ensure reliable delivery of access

standards. In addition the existing monthly Divisional Performance Reviews are to be replaced with a monthly Operational Performance Committee with divisional triumvirates and corporate services, with enhanced quarterly individual Divisional reviews.

4. Recommendation

The Board of Directors are asked to;

Note the Trust's current performance to the end of April 2016, with particular regard to;

- The risks associated with the delivery of the emergency access target where performance remains challenging despite a range of actions taken.

- 18 week RTT where improved performance is dependent on delivery of at least the activity volumes identified in the plan.

- Task and finish groups are underway to bring renewed emphasis to the improvements required in these areas.

WUTH Integrated Performance Dashboard - Report on April for May 2016 BoD

Area	Indicator / BAF	Feb	Mar	April	Trend / Future Concern	*Target (for 'Green')*	Latest Period	Exec Lead
Meeting Our Vision	**Satisfaction Rates**							
	Patient - F&F "Recommend" Rate	98%	97%	98%		>=95%	April 2016	GW
	Patient - F&F "Not Recommend" Rate	1%	2%	1%		<=2%	April 2016	GW
	Staff Satisfaction (engagement)	3.79	3.79	3.78		>=3.69	Q4 2015/16	JM
	First Choice Locally & Regionally							
	Market Share Wirral	85.7%	86.0%	85.2%		>= 85%	Nov 2015 to Jan 2016	MC
	Demand Referral Rates	0.8%	-1.1%	-6.8%		>= 3% YoY variance	Fin Yr-on-Yr to April 2016	MC
	Market Share Non-Wirral	9.5%	9.4%	9.4%		>=8%	Nov 2015 to Jan 2016	MC
	Strategic Objectives							
	Harm Free Care	96%	95%	95%		>= 95%	April 2016	GW
	HIMMs Level	5	5	5		5	April 2016	MB
Operational Excellence	**Key Performance Indicators**							
	A&E 4 Hour Standard *	80.85%	80.22%	85.38%		>=95%	April 2016	CO
	RTT 18 Weeks Incomplete Position *	90.3%	90.5%	91.1%		>=92%	April 2016	CO
	Cancer Waiting Time Standards *	On track	On track	On track		All met at Trust level	Q1 to April 2016	CO
	Infection Control *	0 MRSA; 35 C diff	0 MRSA; 35 C diff	0 MRSA; 0 C diff		0 MRSA Bacteraemia in month, and cdiff less than cumulative trajectory	April 2016	GW
	Productivity							
	Delayed Transfers of Care	4.2	3.4	Under review		<= 4	April 2016	CO
	Delayed Complex Care Packages	63	51	58		<= 45	April 2016	CO
	Bed Occupancy	93.4%	97.6%	91.8%		<=85%	April 2016	CO
	Bed Occupancy Medicine	91.4%	93.3%	89.5%		<=85%	April 2016	CO
	Theatre Utilisation	66.8%	69.8%	68.5%		>=85%	April 2016	CO
	Outpatient DNA Rate	7.7%	7.9%	8.3%		<=6.5%	April 2016	CO
	Outpatient Utilisation	80.3%	81.6%	81.3%		>90%	April 2016	CO
	Length of Stay - Non Elective Medicine	5.5	5.3	5.5		<= 5.0	April 2016	CO
	Length of Stay - Non-elective Trust	4.8	4.7	4.9		<=4.2	April 2016	CO
	Contract Performance (activity)	-2.1%	-2.0%	-5.3%		0% or greater	April 2016	CO
	Finance							
	Contract Performance (finance)	-1.3%	-1.7%	0.0%		On Plan or Above YTD	April 2016	GL
	Expenditure Performance	0.6%	0.4%	-0.7%		On Plan or Above YTD	April 2016	GL
	CIP Performance	-9.2%	-8.8%	-23.2%		On Plan or Above	April 2016	GL
	Capital Programme	-12.5%	10.5%	61.5%		On Plan	April 2016	GL
	Non-Core Spend	9.8%	9.9%	10.4%		<5%	April 2016	GL
	Cash Position	245%	215%	209%		On plan or above YTD	April 2016	GL
	Cash - liquidity days	-22.5	-24.9	-28.4		> 0 days	April 2016	GL
A Healthy Organisation	**Clinical Outcomes**							
	Never Events	1	0	0		0 per month	April 2016	EM
	Complaints	37.1	36.7	35.8		<30 per month	12-mth ave to April 2016	GW
	Workforce							
	Attendance	95.8%	95.9%	95.8%		>= 96%	April 2016	JM
	Qualified Nurse Vacancies	5.5%	5.7%	3.5%		<=6.5%	April 2016	GW
	Mandatory Training	89.8%	90.5%	89.7%		>= 95%	April 2016	JM
	Appraisal	84.70%	88.05%	87.81%		>= 85%	April 2016	JM
	Turnover	9.4%	9.3%	9.2%		<10%	April 2016	JM
	Agency Spend	New metric	New metric	-9.2%		On plan	April 2016	GW
	Agency Cap	199	113	185		0	April 2016	JM
External Validation	**National Comparators**							
	Advancing Quality (not achieving)	5	3	3		All areas above target	February 2016	EM
	Mortality: HSMR	89.23	90.8	89.35		Lower CI < 0.90	April 2015 to Jan 2016	EM
	Mortality: SHMI	0.980	0.988	0.988		Lower CI < 90	Oct 2014 to Sept 2015	EM
	Regulatory Bodies							
	Monitor Risk Rating - Finance CoS	2	2	2		4	April 2016	GL
	Monitor Risk Rating - Governance	Red	Red	Red		Green	April 2016	CO
	CQC	Amber	Amber	Amber		Overall CQC rating Outstanding or Good	April 2016	EM
	Local View							
	Commissioning - Contract KPIs	6	7	4		<=2	April 2016	CO
	Monitor enhanced monitoring							
	A&E 4 Hour Standard *	80.85%	80.22%	85.38%		>=95%	April 2016	CO
	Medical Outliers	10.1	8.76	3		<=5	April 2016	CO
	Bed occupancy	93.4%	97.6%	91.8%		<=85%	April 2016	CO
	Staff Friends and Family	58%	58%	58%		>= 75%	Q4 2015/16	CO

Note: * Indicators of governance concern under Monitor Risk Assessment Framework

Quarter	1
Period	01/04/2016 - 30/06/2016

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 1 - Total

Division	Tumour Group	Breaches Actual	Breaches Predicted	Breaches Total	Treatments Actual	Treatments Predicted	Treatments Total	Compliance Actual	Compliance Predicted
Medicine	Haematology	0	0	0	2	0	2	100.00%	100.00%
	Lung	0	0	0	5	0	5	100.00%	100.00%
	Other	0	0	0	0	0	0	N/A	N/A
Med & Surg	Upper GI	4	0	4	6	0	6	33.33%	33.33%
Surgery	Breast	0	0	0	18	0	18	100.00%	100.00%
	Colorectal	1	0	1	6.5	0	6.5	84.62%	84.62%
	Head & Neck	1	0	1	2.5	0	2.5	60.00%	60.00%
	Skin	0	0	0	30	0	30	100.00%	100.00%
	Urology	8	0	8	23	0	23	65.22%	65.22%
Women's	Gynaecology	0	0	0	2.5	0	2.5	100.00%	100.00%
	Total	**14**	**0**	**14**	**95.5**	**0**	**95.5**	85.34%	85.34%

Quarter 1 - April

Division	Tumour Group	Breaches Actual	Breaches Predicted	Breaches Total	Treatments Actual	Treatments Predicted	Treatments Total	Compliance Actual	Compliance Predicted
Medicine	Haematology	0	0	0	1	0	1	100.00%	100.00%
	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	4	0	4	5	0	5	20.00%	20.00%
Surgery	Breast	0	0	0	12	0	12	100.00%	100.00%
	Colorectal	1	0	1	6	0	6	83.33%	83.33%
	Head & Neck	1	0	1	2	0	2	50.00%	50.00%
	Skin	0	0	0	27	0	27	100.00%	100.00%
	Urology	8	0	8	19	0	19	57.89%	57.89%
Women's	Gynaecology	0	0	0	2.5	0	2.5	100.00%	100.00%
	Total	**14**	**0**	**14**	**78.5**	**0**	**78.5**	82.17%	82.17%

Quarter 1 - May

Division	Tumour Group	Breaches Actual	Breaches Predicted	Breaches Total	Treatments Actual	Treatments Predicted	Treatments Total	Compliance Actual	Compliance Predicted
Medicine	Haematology	0	0	0	1	0	1	100.00%	100.00%
	Lung	0	0	0	1	0	1	100.00%	100.00%
	Other	0	0	0	0	0	0	N/A	N/A
Med & Surg	Upper GI	0	0	0	1	0	1	100.00%	100.00%
Surgery	Breast	0	0	0	6	0	6	100.00%	100.00%
	Colorectal	0	0	0	0.5	0	0.5	100.00%	100.00%
	Head & Neck	0	0	0	0.5	0	0.5	100.00%	100.00%
	Skin	0	0	0	3	0	3	100.00%	100.00%
	Urology	0	0	0	4	0	4	100.00%	100.00%
Women's	Gynaecology	0	0	0	0	0	0	N/A	N/A
	Total	**0**	**0**	**0**	**17**	**0**	**17**	100.00%	100.00%

Quarter 1 - June

Division	Tumour Group	Breaches Actual	Breaches Predicted	Breaches Total	Treatments Actual	Treatments Predicted	Treatments Total	Compliance Actual	Compliance Predicted
Medicine	Haematology			0			0	N/A	N/A
	Lung			0			0	N/A	N/A
	Other			0			0	N/A	N/A
Med & Surg	Upper GI			0			0	N/A	N/A
Surgery	Breast			0			0	N/A	N/A
	Colorectal			0			0	N/A	N/A
	Head & Neck			0			0	N/A	N/A
	Skin			0			0	N/A	N/A
	Urology			0			0	N/A	N/A
Women's	Gynaecology			0			0	N/A	N/A
	Total	**0**	**0**	**0**	**0**	**0**	**0**	N/A	N/A

integrated Performance Dashboard - Metric Thresholds

Meeting Our Vision

Indicator	Definition	Green	Amber	Red
Satisfaction Rates				
Patient Satisfaction - F&F "Recommend" Rate	Patient Satisfaction - Friends & Family "Recommend" Rate for Trust	>=95%	n/a	<95%
Patient Satisfaction - F&F "Not Recommend" Rate	Patient Satisfaction - Friends & Family "Not Recommend" Rate for Trust	<=2%	n/a	>2%
Staff Satisfaction (engagement)	Results from staff satisfaction survey	>=3.69	>=3.59 to <3.69	<3.59
First Choice Locally & Regionally				
Market share : Wirral	WUTH share of Wirral CCG GP Referred New OP Activity (rolling 3 months)	>= 85%	>= 80% to <85%	< 80%
Demand : Referral Rates	Outpatient referrals received from all GP/GDPs - G&A specialties	>= 3% YoY variance	0% to <3% YoY	<0% YoY
Market share : Non-Wirral	WUTH share of West Cheshire GP Referred New OP activity	>=8%	>=6% to <8%	<6%
Strategic Objectives				
Harm Free Care	Compliance with Safety Thermometer definition of Harm Free Care	>= 95%	>= 93% to <95%	<93%
HIMMS Level	Current HIMMs level under Electronic Medical Record Adoption Model	5	n/a	<5

Operational Excellence

Indicator	Definition	Green	Amber	Red
Key Performance Indicators				
A&E 4-hour Standard	% of patients attending ED & ADHC treated within 4 hours	>=95%	n/a	<95%
RTT '18' Week' Standard	RTT "Incompletes" standard met for the Trust as a whole	>=92%	n/a	<92%
Cancer Waiting Time Standards	All Cancer Waiting standards met for the Trust per quarter	All met at Trust level	n/a	Not all met at Trust level
Infection Control	MRSA Bacteremia CDIFF	0 MRSA Bacteraemia in month, and cdiff less than cumulative trajectory	0 MRSA Bacteraemia in month, and cdiff equal to cumulative trajectory	>= 1 MRSA Bacteraemia in month or cdiff cases above cumulative trajectory
Productivity				
Delayed transfers of care	Average No of patients with a delayed transfer of care during the month	<= 4	> 4 and < 6	>= 7
Delayed complex care packages	Average No of patients on the complex discharge list in the month	<= 45	>= 46 and <= 70	>= 71
Readmissions	% of patients readmitted non-electively within 30 days of discharge	<= 7.5%	>7.5% and <= 10%	> 10%
Bed occupancy	Average % of General & Acute Beds occupied at midday	<=85%	>85% to <95%	>=95%
Bed occupancy - Medicine	Average % of Medical & Acute beds occupied at midday	<=85%	>85% to <95%	>=95%
Theatre utilisation	Average % of scheduled operating minutes utilised	>=85%	>=65% to <85%	<65%
Outpatient DNA Rate	Percentage of booked OP appointments that DNA (Med, Surg and W&C)	<= 6.5%	>6.5% and <= 9%	> 9%
Outpatient Utilisation	Percentage of OP appointments that DNA (Med, Surg and W&C)	>90%	>=80% to <90%	<80%
Length of stay - Non-elective Medical Division	Average length of stay per finished admitted spell (Medical Division)	<= 5.0	> 5.0 to 6.5	> 6.5
Length of stay - Non-elective Trust total	Average length of stay per finished admitted spell (Trust total)	<= 4.2	> 4.2 to 5.5	> 5.5
Contract performance (Activity)	Cumulative activity % variance against plan for all PODs combined	0% or greater	-2.0% to <0%	< -2.0%
Finance				
Contract Performance (Finance)	Delivering both contracted volumes and values	On Plan or Above YTD	1% below plan YTD	>1% below plan YTD
Expenditure performance	Delivering planned levels of expenditure	On Plan or Above YTD	1% below plan YTD	>1% below plan YTD

CIP Performance	Delivering against the in-year CIP forecast.	On Plan or Above	10% below plan	>10% below plan
Capital Programme	A sound investment programme maintained & resourced appropriately	On Plan	+/- 15% against plan	+/- 25% against plan
Non-Core Spend	Non core as a % of total pay spend	<5%	>=5.0% to 6.5%	>=6.6%
Cash Position	Delivering against cash plan	On plan or above YTD	n/a	Below plan
Cash - liquidity days	Liquidity Days: The number of days the Trust could support it's pre EBITDA expenditure with it's liquid assets i.e.((Current Assets - Inventories - Current liabilites) / Pre EBITDA expenditure)) x number of days elapsed in financial year	> 0 days	>= -14 days and < = 0 days	< -14 days

A Healthy Organisation

Indicator	Definition	Green	Amber	Red
Clinical Outcomes				
Never Events	Number of occurences of "Never Events"	0 per month	n/a	>= 1 per month
Complaints	Number of occurences of formal complaints	<30 per month	30 to 50 per month	> 50 per month
Workforce				
Attendance	Monthly staff attendance rate	>= 96%	>=95.3% to <96.0%	< 95.3%
Qualified Nurse Vacancies	% vacant posts	<=6.5%	>6.5% to 9.5%	>9.5%
Mandatory Training	Rolling 12-month staff mandatory training rate	>= 95%	>= 85% to <95%	< 84.9%
Appraisal	Rolling 12-month staff appraisal rate	>= 85%	>= 80% to <85%	<80%
Turnover	Rolling 12-month staff turnover rate	<10%	>= 10% to <12%	>=12%
Agency spend	Agency spend YTD compared to the ceiling in the plan	On Plan	>=5.0% to < 10%	>=10%
Agency cap	Monthly average of agency cap breaches	0	>0 and <= 80	>80

External Validation

Indicator	Definition	Green	Amber	Red
National Comparators				
Advancing Quality (not achieving)	Number of areas not achieving	All areas above target	1 area below target	> 1 area below target
Mortality : SHMI	SHMI	Lower CI < 0.90	Lower CI 0.90 to 0.99	Lower CI >= 1.0
Mortality : HSMR	HSMR	Lower CI < 90	Lower CI 90 to 99	Lower CI >= 100
Regulatory Bodies				
Monitor Risk Rating - Finance	Monitor Risk Assessment Framework - Continuity of Service rating	4	3 or 2*	2 or 1
Monitor Risk Rating - Governance	Monitor Risk Assessment Framework - Governance rating	Green	n/a	Red
CQC	Inspection area ratings	Overall CQC rating Outstanding or Good	Overall CQC rating Requires Improvement	Overall CQC rating Inadequate
Local View				
Commissioning - Contract KPIs	Number of Quality KPIs in the contract not being achieved	<=2	3 to 4	>=5
Monitor Enhanced Monitoring				
A&E 4-hour Standard	% of patients attending ED & ADHC treated within 4 hours	>=95%	n/a	<95%
Medical Outliers	Average daily medical outliers in non-medical beds	<=5	>5 to 10	>10
Bed occupancy	Average % of General & Acute Beds occupied at midday	<=85%	>85% to <95%	>=95%
Staff Friends and Family	Recommend Trust to work	>= 75%	>= 50% to <75%	<50%

Board of Directors	
Agenda Item	7.1.2
Title of Report	Month 1 Finance Report
Date of Meeting	25th May 2016
Author	Julie Clarke, Assistant Director of Finance
Accountable Executive	Gareth Lawrence, Acting Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	7
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To note
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

Overview

This paper provides an update to the Board of Directors on the financial position of the Trust at Month 1 of the 2016/17 financial year.
During the month of April the Trust has delivered a £1.3m deficit compared to the plan of £1.1m, with expenditure being above plan by £0.2m. The Trust delivered £0.5m of efficiencies in month against the target of £0.6m. This delivery includes non-recurrent slippage allocated by divisions.
The cash position is positive with a cash balance at the end of April of £5.7m which is some £2.9m above plan.
The overall Month 1 financial position delivers a financial sustainability risk rating of 2 which is in line with plan.

Income and Expenditure Performance

In March 2016 the Trust Board agreed to the control total set by NHS improvement that enabled access to the sustainability and transformation. The table below shows the current performance against the submitted plan.

SUMMARY FINANCIAL STATEMENT

		MONTH 1		
	Full Year Plan	Plan	Actual	Variance
	£k	£k	£k	£k
NHS Clinical Income	294,936	24,109	24,097	(12)
Other Income	29,987	2,430	2,452	22
Employee Expenses	(213,301)	(18,357)	(18,623)	(265)
All Other Operational Expenses	(97,768)	(8,199)	(8,129)	70
EBITDA	13,854	(17)	(203)	(185)
Post EBITDA Items	(13,673)	(1,099)	(1,105)	(7)
Net Surplus/(Deficit)	181	(1,116)	(1,308)	(192)
EBITDA %	4.3%	(0.1%)	(0.8%)	(0.7%)

An agreement has been reached with Wirral CCG for an envelope contract value for 2016/17 which covers c80% of the Trusts clinical income. The envelope will allow the Trust and wider health economy to look at innovative new ways of dealing with increased demand over the coming year while having the security of an agreed income value. Without the 'envelope' the income position would have been c£0.4m lower than plan reflecting the junior doctor industrial action in April.

Expenditure is currently above plan for the month of April with pay costs contributing to the current overspend. Additional escalation areas were still open during the month which has resulted in increased nursing and medical costs over and above plan. Operational plans are being worked through to enable the safe closure of the escalation areas through May.

Non pay costs are £(0.1)m lower than plan in-month partly due to the impact of the industrial action which has resulted in lower clinical supplies for the reduced day case activity together with small variances across a range of cost categories.

During 2016/17 the Trust will be measured on a capped agency and locum value. During April the Trust has exceed the cap value by £0.07m. Speciality reviews are currently being

undertaken led by the Chief Operating Officer and Director of HR to assist in reducing the current levels of spend within the Trust. The conclusions of these reviews will be reported back through FSPG in June. The Trust continues to work with all agencies and Trusts within the STP footprint on reducing the unit price of agency in line with NHS Improvement targets. Compliance against this measure continues to be reported through the Senior Management Team with exceptions signed off by the Executive Team.

Cost Improvement Programme (CIP)

The CIP for 2016/17 is £11.2m that is split as a target both by workstream and by division At the end of the Month 1 the Trust is marginally behind the year to date target of £0.6m. The position has been supported by non-recurrent savings (0.2m) identified within the divisions as they continue to develop and deliver the various work streams.

The table below details the month 1 position for CIP by Division and by work-stream.

	YTD		
Theme	**Monitor Plan**	**Actual**	**Variance**
Productivity & Efficiency	205	75	(130)
Workforce	183	62	(121)
Cost Control & Management	63	34	(29)
Estate Management	65	25	(41)
Income	92	87	(5)
Other Schemes	37	283	246
	645	**565**	**(80)**
Division			
Medicine & Acute	210	134	(76)
Surgery, Women & Children	193	172	(21)
Clinical Support Services	108	34	(74)
Corporate	120	141	21
Central	14	83	69
	645	**565**	**(80)**

As at 25th April 2016 £6.2m of plans had been fully developed and approved at the Transformation Steering Group. The Trust is currently forecasting delivery of c£8.8m of CIP compared to the £11.2m year-end target. The CIP delivery at Month 1 and profile is shown alongside the MONITOR plan in appendix 1.

Work continues within the respective work stream and divisional leads to bridge the gap and to ensure delivery of the schemes currently identified. A CIP networking event held in May has identified further opportunities. Workstream and divisional plans to bridge the gap will be reported back through the Transformation Steering Group (TSG) at the end of May.

These figures are **not** inclusive of the health economy challenge of £5m that has been included within the submitted plans. The Trust has yet to receive a date from NHS Improvement regarding the health economy meeting where the health economy challenge will be discussed. The Trust understands that this will be arranged in the coming months.

The PMO are continuing to develop the various governance measures to support and manage the programme, such as the development of key performance indicators, a reporting suite and workbooks to track and manage the projects. These activities take time to develop, but good progress is being made and robust processes are being developed which will be key in the reporting and management of CIP in future months and years.

In addition, a review of the PMO function has been undertaken during April 2016 and a paper has been approved by the Senior Management Team which describes a move from the provision of a solely assurance function to one of transformation which includes enhanced improvement and delivery capabilities that will augment the existing assurance arm. It is designed to provide work streams and divisions with additional support in the development and delivery of transformation and improvement opportunities across the organisation.

Cash position and Financial Sustainability Risk Rating (FSRR)

The April cash position was £5.7m , which is £2.9m higher than plan and is a result of a higher opening cash balance of £1.2m, lower capital spend of £1m and the positive impact of lower operating cash outflows.

Capital expenditure is £0.2m under plan during April as a result of delayed start to some capital projects.

The overall position returns a FSRR of 2, which is in line with plan.

Conclusion

The Trust has delivered an in month deficit of £1.3m some £0.2m above planned deficit of £1.1m as a result of higher than planned pay costs.

The cash position is positive and the April financial position delivers a financial sustainability risk rating of 2 which is in line with plan.

As a result of the financial envelope agreed with Wirral CCG the Trust will be exploring all opportunities to deliver new pathways of care that will increase patient experience, capacity and reduce Trust expenditure within the safety of a secured income position.

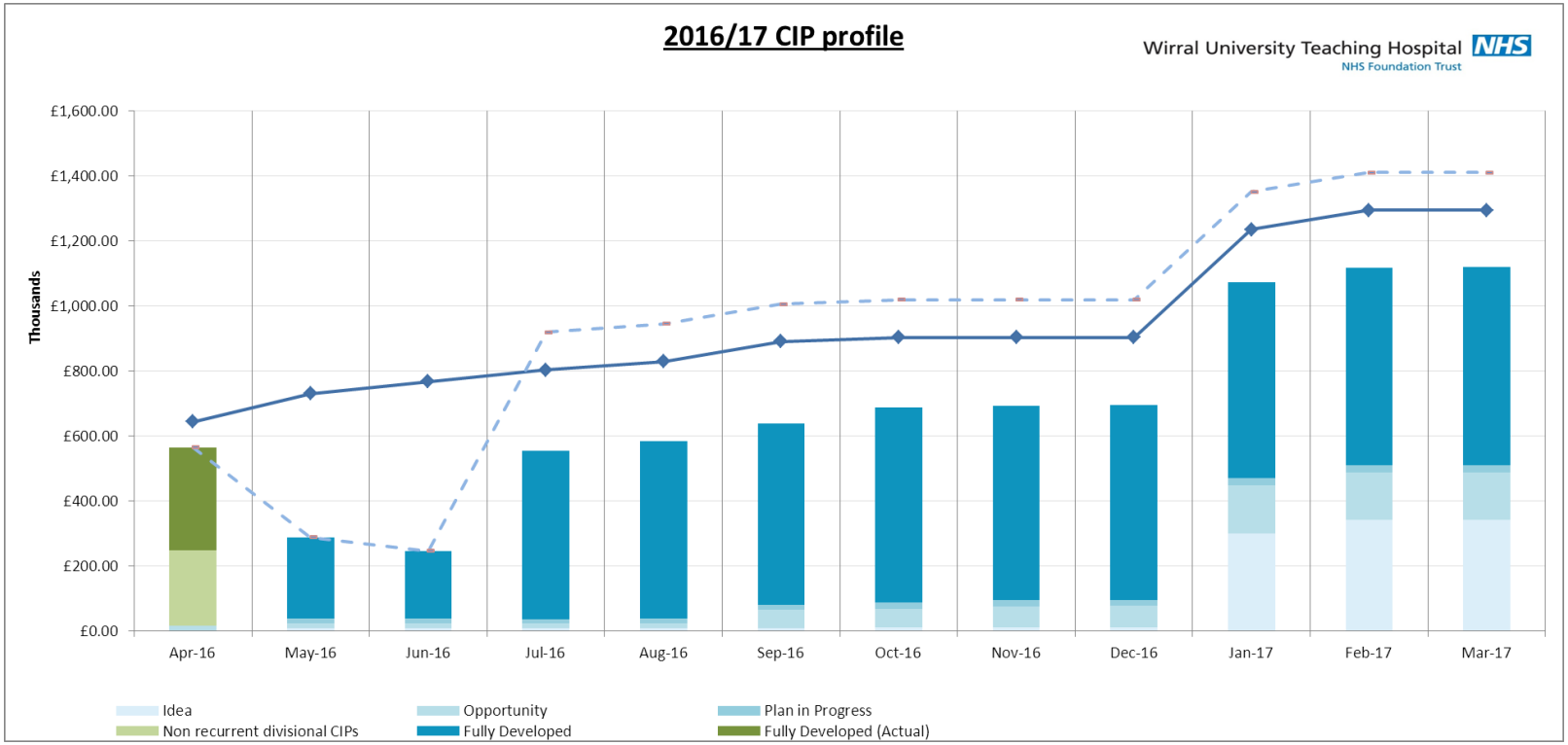
Recommendations

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

Gareth Lawrence
Acting Director of Finance
May 2016

Appendix 1: CIP Monthly Profile

The following chart highlights the CIP trajectory for the year, as at M1.



BOARD OF DIRECTORS	
Agenda Item	8.1
Title of Report	Francis Report: Hard Truths Commitment: Publishing of Nurse Staffing Data: March/April 2016
Date of Meeting	25th May 2016
Author	Gaynor Westray, Director of Nursing and Midwifery Clare Pratt, Deputy Director of Nursing
Accountable Executive	Gaynor Westray, Director of Nursing and Midwifery
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Strategic objectives: To be the top NHS Hospital in the North West; Delivering consistently high quality secondary care services; Supported by financial, commercial and operational excellence. 1A Risks 2799 & 2798 1B Risks 1908 & 1909 3A Risks 2837 & 2611 3B Risks 2799, 2837 & 2798 7A Risks 2798
Level of Assurance • **Positive** • **Gap(s)**	Positive: The Trust is well prepared to commence reporting on Care Hours Per Patient Day. All Registered Nurses due for revalidation in April 2016 have successfully achieved this status The Trust's recruitment plan continues to have a positive impact on staffing levels and the Trust's fill rates with overall 97% for March and April 2016 Gaps: The requirement for additional beds within Medicine and Acute past the planned closure date of April 2016 has an impact on the number of vacancies evident.
Purpose of the Paper	Discussion
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment	No

1 Executive Summary

This report provides the Board of Directors with information on Registered Nurse / Midwives and Clinical Support Workers staffing data including vacancy rates, age profile of nursing workforce and breakdown of years of experience in the workforce. The report also includes the details of the actual hours of Registered Nurses / Midwives and Clinical Support Workers time on ward day shifts and night shifts versus planned staffing levels for March 2016 and April 2016 as reported to NHS England each month.

2 Recruitment Strategy

Maintaining safe staffing levels remain a key priority. The investment in nurse staffing as well as a robust recruitment plan had ensured that the Trust had a stable nursing and midwifery workforce.

April 2016 electronic staff records (ESR) data shows an improvement in the vacancy rate now at 6.04% which equates to 42.74 WTE for band 5 inpatient and Emergency Department Registered Nurses. Although this is an improving position, and the Trust vacancy rate for Registered Nurses is below the national average of 10%.

Table 1 Band 5 Nursing Vacancies

Division	Area		February 2016	March 2016	April 2016
Trust	All Areas	Establishment	707.66	707.66	707.66
		Actual Numbers	658.9	661.82	664.92
		Vacancies	48.76	45.84	42.74
		Vacancies %	6.89%	6.48%	6.04%

Current vacancy position by division:

Surgery, Women and Children's is 2.07% equating to 4.83 WTE Registered Nurses.

Medicine and Acute is 8% equating to 37.91 WTE registered Nurses.

The majority of the vacancies within Medicine and Acute are within specialist areas; hence the corporate recruitment approach was not sufficient therefore the Division now holds monthly recruitment events to allow focus on the specialist areas as well as general in-patient wards. HR/OD have updated the recruitment strategy to maximise recruitment of newly qualified graduates and return to practice nurses.

The requirement for additional beds within Medicine and Acute past the planned closure date of April 2016 has also had an impact on the number of vacancies evident.

2.1 Preceptorship and support

The successful recruitment strategy has led to additional NMC registrants who require support during their preceptorship period.

WUTH has supported 57 registrants through an in house preceptor training programme plus 605 of our NMC registrants have successfully completed the mentorship module (Multi Professional learning and support in practice) and have the skills and experience to support our new recruits. We secured 12 months funding for our recruitment and retention facilitator

from Health Education England. The postholder is currently providing support to all areas and focusing on the implementation on the new Northwest recommended preceptorship standards due to be published June 2016.

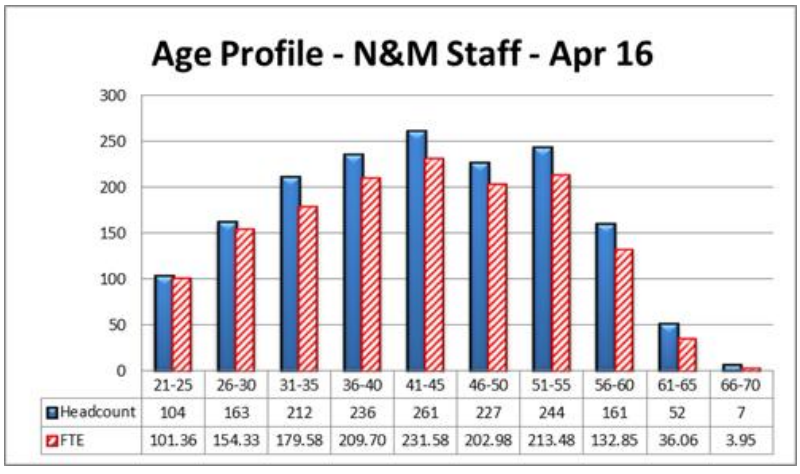
Table 2 Length of Service NMC Registrants

A workforce review has been undertaken that demonstrates the Trust has an experienced nursing and midwifery workforce with 561 registrants having more than 5 years' experience in NHS service

Length of Service Band	Headcount
<1 Year	167
1<5 Years	238
5<10 Years	157
10<15 Years	221
15<20 Years	93
20<25 Years	37
25<30 Years	15
30+ Years	38
	966

3 Age Profile

The table below demonstrates the age demographics of the nursing workforce. This review highlights that 15% of the current nursing workforce fall in the 51-55 years age group and as such may choose to retire in the next five years. This workforce data is considered as part of our recruitment strategy to mitigate against risks.



4 Monthly Safe Staffing Report

The report (Appendix 1) shows the actual hours of nursing cover (both Registered Nurse and Care Support Worker) compared to the expected hours for both day and night shifts for March and April 2016. It also presents data per ward. The information for average staff fill rates is triangulated with key quality indicators and sickness at ward level.

Trust Indicators:

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

These parameters provide information for the Board of Directors on how the Trust is progressing towards safe staffing. The overall fill rate for March and April 2016 is maintained at 97%. The table below shows compliance for fill rate for both RN and CSW shifts, both for day and night shifts for the month of March and April 2016.

	March 2016			April 2016		
Day Shift	**Green**	**Amber**	**Red**	**Green**	**Amber**	**Red**
Number of wards compliant with RN fill rate	29	7	0	27	8	0
Number of wards compliant with CSW fill rate	31	4	0	34	0	0
Night Shift						
Number of wards compliant with RN fill rate	27	7	2	29	6	0
Number of wards compliant with CSW fill rate	30	2	0	30	1	0

RN Day shift: Although there was a slight reduction in the number of wards with fill rate of above 95% in April 2016 compared to March 2016, there were no wards reported as 'red' i.e. with a fill rate of below 80% and ten ward achieved 100% fill rate.

CSW Day shift: An increased compliance in a fill rate of above 95% has been achieved

RN Night shift: This indicator have remained static with 18 wards achieving with a 100% fill rate and no wards in red for April.

The two areas reported for March 2016 with a fill rate of below 80% were:

Ward 30 (haematology) with a fill rate of 77.8% but assessed as safe by matron.

Maternity ward reported a fill rate of 66% due to sickness however processes were in place for escalation which was initiated as required. The staffing acuity is reviewed 4hourly as a minimum and if required the escalation process leads to community midwives being called into the unit ensuring safe staffing levels are maintained. There was no requirement to divert maternity services due to unsafe staffing levels.

CSW Night shift: an increased compliance in a fill rate of over 95%, with 27 wards reporting a fill rate of 100%.

The table below displays the lowest fill rate for each shift for each month. Maternity fill rates for January, February, and March were escalated to the Associate Director of Nursing for

Surgery, Women and Childrens Division and the Head of Midwifery. On review the escalation policy including the role of the Advanced Midwifery Practitioner has been implemented where appropriate for Maternity and community midwives staff have supported the in patient service. Maternity fill rates for April 2016 have improved. During April the lowest fill rate for CSW Days was 96.3% which is rated as "Green" as it is above the 95% threshold.

	January 2016	February 2016	March 2016	April 2016
RN Days Lowest Fill Rate	Ward 30 88.8%	Neonatal 93.4%	Ward 33/HAC 88.8%	Ward 38/37 85.4%
CSW Days Lowest Fill Rate	Maternity 91.9%	Maternity 94.8%	Ward 33/HAC 86.5%	CRC 96.3%
RN Nights Lowest Fill Rate	Maternity 81.8%	Maternity 86.5%	Maternity 66.%	EDRU 87.3%
CSW Nights Lowest Fill Rate	Maternity 83.3%	Maternity 94.4%	Delivery Suite 93%	Ward 21 89.6%

5 Reported Staffing Incidents

The number of reported staffing incidents has continued to reduce over the past four months The introduction of the ward profile dashboard will include this data to enable comparison between ward areas and clear actions required.

January 2016	February 2016	March 2016	April 2016
76	73	54	36

6 Care Hours Per Patient Day (CHPPD)

As set out In Lord Carter's final report, *operational productivity and performance in acute hospitals*; better planning of staff resources is crucial to improving quality of care, staff productivity and financial control. Working closely with Trusts, the Carter Team found there was not a consistent way to record and report staff deployment, meaning that Trusts could not measure and then improve on staff productivity.

One of the obstacles to eliminating unwarranted variation in nursing and clinical support staff deployment across the NHS provider sector has been the absence of a single means of recording and reporting deployment. Conventional units of measurement that have been developed previously, have informed the evidence base for staffing models, – such as using WTEs, skill-mix or patient to staff ratios at a point in time, but it is recognised by Nurse leaders this may not reflect varying staff allocation across the day or include the wider multidisciplinary team. Also, because of the different ways of recording this data, no consistent way of interpreting productivity and efficiency is straightforward or comparable between organisations.

The report recommended that all Trusts start recording Care Hours per Patient Day (CHPPD) – a single, consistent metric of nursing and clinical support workers deployment on inpatient wards. This metric will enable Trusts to have the right staff mix in the right place at the right time, delivering the right care for patients.

From 1 May 2016, all Trusts are required to report back monthly CHPPD data to NHS Improvement so that we can start to build a national picture of how nursing staff are deployed. This will allow Trusts to see how their CHPPD relates to other Trusts, within a specialty, and by ward in order to identify how they can improve their staff deployment and productivity.

CHPPD is calculated by adding the hours of Registered Nurses and Clinical Support Workers time and dividing the total by every 24hrs of inpatient admissions (or approximating 24 patient hours by counts of patients at midnight) From May 2016, CHPPD will become the principle measure of nursing and clinical support workers. The Senior Analyst within the Corporate Nursing team has been working with the Informatics team and the senior nurse team to ensure that data collection has commenced in time for the first uplift report to Unify in June 2016

6 Next steps

- Implement CPPHD reporting in line with NHSI requirements
- Continue with the programme of Monthly Trust wide recruitment for Registered Nurses, including overseas recruitment
- Continue to update the Board of Directors on a bi-monthly basis
- Conclude the Phase 2 work on midwifery staffing and skill mix for 2016/17

7 Conclusion

All mitigating actions are in place to ensure that safe and appropriate nurse staffing levels are in place.

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

8 Recommendations

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

Monthly Safe Staffing Report - March 2016

			RNs				CSW's				RNs				CSW's				Quality indicators						
			Days								Nights														
Specialty	Ward	Beds	Total monthly planned staff hours	Total monthly actual staff hours	Variance	% RN	Total monthly planned staff hours	Total monthly actual staff hours	Variance	% CSW	Total monthly planned staff hours	Total monthly actual staff hours	Variance	% RN	Total monthly planned staff hours	Total monthly actual staff hours	Variance	% CSW	Falls (moderate and above)	Pressure ulcers (Grade 2 and above)	Cdiff (Reportable to PHE)	MRSA (Reportable to PHE)	Sickness & Absence	RN Vacancies (WTE)	CSW Vacancies (WTE)
Orthopaedics	10	28	1725	1706.25	18.75	98.9%	1230	1211.25	18.75	98.5%	1080	1080	0	100.0%	690	824	-134	119.4%	0	0	0	0	2.91	-3	-2
Orthopaedics	11	25	1725	1712.5	12.5	99.3%	1230	1223.75	6.25	99.5%	1080	1080	0	100.0%	690	690	0	100.0%	0	1	0	0	7.58	0	1
Orthopaedics	12	16	1173	1166.75	6.25	99.5%	1035	1022.5	12.5	98.8%	690	690	0	100.0%	345	345	0	100.0%	0	3	0	0	4.9	0	0
DME	16 / OPAU	23	2342.5	2330.2	12.3	99.5%	1550	1550	0	100.0%	1069.5	1057.5	12	98.9%	713	713	0	100.0%	0	1	0	0	6.86	4	-1
Colorectal	17	30	1875	1825	50	97.3%	1230	1217.5	12.5	99.0%	1080	1080	0	100.0%	690	694.7	-4.7	100.7%	0	0	0	0	0.37	-1	0
General Surgery	18	29	1725	1725	0	100.0%	1230	1217.5	12.5	99.0%	1230	1230	0	100.0%	690	689	1	99.9%	0	1	0	0	1.59	-2	1
Urology	20	30	1725	1718.75	6.25	99.6%	1263.25	1244.5	18.75	98.5%	1230	1230	0	100.0%	690	702	-12	101.7%	0	0	0	0	2.08	0	0
DME	21	31	1572	1554	18	98.9%	1530	1530	0	100.0%	1215	1035	180	85.2%	1035	1035	0	100.0%	0	1	0	0	0.37	2	-1
DME	22	30	1722.5	1710.2	12.3	99.3%	1356.25	1350	6.25	99.5%	1263.25	1200.25	63	95.0%	713	725	-12	101.7%	0	1	0	0	3.36	0	1
Stroke	23	26	2110	1995.1	114.9	94.6%	1162.5	1150.2	12.3	98.9%	1069.5	1051.5	18	98.3%	713	713	0	100.0%	0	0	0	0	2.81	0	-1
DME	24 & Isolation	38	2098.52	1928.31	170.21	91.9%	1619.73	1673.48	-53.75	103.3%	1426	1330	96	93.3%	1426	1426	0	100.0%	0	1	0	0	7.65	5	0
General Medicine	26	29	2110	2054.75	55.25	97.4%	1937.5	1906.25	31.25	98.4%	1069.5	1069.5	0	100.0%	1069.5	1069.5	0	100.0%	0	0	0	0	4.64	2	0
Winter Contingency	27		1744	1715	29	98.3%	1550	1550	0	100.0%	1070	978	92	91.4%	1070	1070	0	100.0%	0	1	0	0		7	-2
Haematology	30	22	1722.5	1722.5	0	100.0%	1162.5	1151.5	11	99.1%	906.75	705.25	201.5	77.8%	1069.5	1069.5	0	100.0%	0	0	0	0	8.33	2	1
Cardiology	32 & CCU	31	3078.75	3026.75	52	98.3%	1550	1465	85	94.5%	1426	1403	23	98.4%	1069.5	1069.5	0	100.0%	0	1	0	0	6.03	-1	1
Cardiology	33 & HAC	29	1722.5	1528.8	193.7	88.8%	1162.5	1006	156.5	86.5%	1069.5	1010	59.5	94.4%	1069.5	1023	46.5	95.7%	0	0	0	1*	1.97	1	2
Gastro	36	32	2253.75	2253.75	0	100.0%	1550	1550	0	100.0%	1069.5	1069.5	0	100.0%	1069.5	1069.5	0	100.0%	0	3	0	0	2.04	4	1
Respiratory	38	45	2497.5	2376	121.5	95.1%	1743.75	1628.65	115.1	93.4%	1426	1403	23	98.4%	1069.5	1057.5	12	98.9%	1	1	0	0	2.05	-1	-1
Maternity	53	38	1598.5	1496.5	102	93.6%	744	726	18	97.6%	1426	940.5	485.5	66.0%	356.5	332.5	24	93.3%	0	0	0	0	10.07	4	7
Gynaecology	54	16	885.5	885.5	0	100.0%	713	713	0	100.0%	713	713	0	100.0%	0	0	0	-	0	0	0	0	6.01	1	-1
General Medicine	AMU	24	1955	1889.5	65.5	96.6%	1426	1433	-7	100.5%	1069.5	1064.5	5	99.5%	1069.5	1069.5	0	100.0%	0	0	0	0	3.26	4	-1
General Medicine	MSSW	21	2311.5	1962.5	349	84.9%	1782.5	1759.5	23	98.7%	1635.25	1437.2	198.05	87.9%	1635.25	1635.25	0	100.0%	0	1	0	0	3.26	4	-1
Emergency	EDRU	10	885.5	874	11.5	98.7%	356.5	356.5	0	100.0%	550.25	530.75	19.5	96.5%	356.5	356.5	0	100.0%	0	0	0	0	0.44	0	0
	Parksuite	8	840	840	0	100.0%	345	332.5	12.5	96.4%	690	690	0	100.0%	0	0	0	-	0	0	0	0	0.21	-1	1
Surgical Assessment	ESAU	12	1185	1160	25	97.9%	690	690	0	100.0%	1035	1006.7	28.3	97.3%	690	678	12	98.3%	0	0	0	0	10.13	2	-3
Critical Care	ITU	11	4822.5	4822.5	0	100.0%	212.5	212.5	0	100.0%	4278	4278	0	100.0%	0	0	0	-	0	0	0	0	4.84	5	-1
Critical Care	HDU	6	1722.5	1722.5	0	100.0%	387.5	387.5	0	100.0%	1426	1426	0	100.0%	356.5	356.5	0	100.0%	0	0	0	0	4.84	5	-1
Maternity	Delivery Suite	10	3381	3315	66	98.0%	690	690	0	100.0%	3208.5	2938.5	270	91.6%	690	642	48	93.0%	0	1	0	0	15.86	4	7
Neo Natal	Neonatal	24	3381	3207.5	173.5	94.9%	0	0	0	-	3208.5	3028.5	0	94.4%	0	0	0	-	0	0	0	0	3.33	5	1
Children's	Children's	27	2186	2079	107	95.1%	356.5	344.5	12	96.6%	1782.5	1735.5	47	97.4%	356.5	344.5	12	96.6%	0	0	0	0	1.82	1	0
Orthopaedics	M1	20	1530	1530	0	100.0%	1035	1035	0	100.0%	690	690	0	100.0%	345	345	0	100.0%	0	0	0	0	3.88	3	1
General Surgery	M2	26	345	345	0	100.0%	345	345	0	100.0%	138	138	0	100.0%	138	138	0	100.0%	0	0	0	0			
DME	CRC	20	1328.75	1231.25	97.5	92.7%	1550	1452.5	97.5	93.7%	713	713	0	100.0%	906.75	906.75	0	100.0%	0	0	0	0	0.88	0	2
Neuro & Rehabilitation	Ward 36 CBH	20	1335	1335	0	100.0%	968.75	968.75	0	100.0%	713	713	0	100.0%	356.5	356.5	0	100.0%	0	0	0	0	1.51	0	-2
Dermatology	Dermatology	12	602.25	602.25	0	100.0%	143.75	143.75	0	100.0%	264.5	264.5	0	100.0%	264.5	264.5	0	100.0%	0	0	0	0	5.98	0	0
Geriatric Medicine	25	30	750	750	0	100.0%	750	750	0	100.0%	690	690	0	100.0%	690	690	0	100.0%	0	1	0	0	0	2	1
Totals		829	65967.52	64097.61	1869.91		37588.98	36988.08	600.9		44701.5	42700.15	1821.35		24093.5	24100.7	-7.2								

Overall Staffing Hour totals (Rounded to the nearest hour)	Fill Rate	97%	Total Planned Hours	172351.5	Total Actual Hours	167886.54	Variance	4284.96

NB: RAG rating has been applied as 95% or above as "green" for % RN & % CSW and for sickness & absences equal to or below the Trust's target of 4% this is "Green" and Red if above Trust target of 4%.
Please note the Pressure ulcer data is sourced from clinical incident reporting and have not all been validated by the Tissue Viability team at the time of this report.
*Ward 33 MRSA under investigation if occurred in hospital

Wirral University Teaching Hospital NHS
NHS Foundation Trust

#PROUD TO CARE FOR YOU

Monthly Safe Staffing Report - April 2016

				RNs				CSW's				RNs				CSW's				Quality indicators						
				Days								Nights														
Specialty		Ward	Beds	Total monthly planned staff hours	Total monthly actual staff hours	Variance	% RN	Total monthly planned staff hours	Total monthly actual staff hours	Variance	% CSW	Total monthly planned staff hours	Total monthly actual staff hours	Variance	% RN	Total monthly planned staff hours	Total monthly actual staff hours	Variance	% CSW	Falls (moderate and above)	Pressure ulcers (Grade 2 and above)	Cdiff (Reportable to PHE)	MRSA (Reportable to PHE)	Sickness & Absence	RN Vacancies (WTE)	CSW Vacancies (WTE)
Orthopaedics	10	10	28	1725	1712.5	12.5	99.3%	1230	1305	-75	106.1%	1080	1080	0	106.1%	690	757.8	-67.8	106.1%	0	0	0	0	6.48	-3.72	-2
Orthopaedics	11	11	25	1725	1718.75	6.25	99.6%	1230	1230	0	100.0%	1080	1068	12	100.0%	690	690	0	100.0%	0	3	0	0	11	-0.57	2
Orthopaedics	12	12	16	1173	1160.5	12.5	98.9%	1035	1035	0	100.0%	690	690	0	100.0%	345	345	0	100.0%	0	0	0	0	3.95	0.16	0
DME	OPAU	16 / OPAU	23	2342.5	2342.5	0	100.0%	1550	1550	0	100.0%	1069.5	1069.5	0	100.0%	713	713	0	100.0%	0	1	0	0	7.55	0.00	-1
Colorectal	17	17	30	1875	1825	50	97.3%	1230	1217.5	12.5	99.0%	1080	1080	0	99.0%	690	690	0	99.0%	0	0	0	0	0	-0.01	0
General Surgery	18	18	29	1725	1662.5	62.5	96.4%	1230	1217.5	12.5	99.0%	1230	1230	0	99.0%	690	690	0	99.0%	0	0	0	0	2.73	-1.77	1
Urology	20	20	30	1725	1718.75	6.25	99.6%	1263.25	1263.25	0	100.0%	1230	1230	0	100.0%	690	690	0	100.0%	0	0	0	0	2.8	-0.28	0
DME	21	21	31	1572	1535.1	36.9	97.7%	1530	1493.1	36.9	97.6%	1215	1107	108	97.6%	1035	927	108	97.6%	0	1	0	0	0.22	1.59	-1
DME	22	22	30	1722.5	1691.5	31	98.2%	1356.25	1356.25	0	100.0%	1263.25	1251.25	12	100.0%	713	711	2	100.0%	0	1	1	0	2.58	0.00	0
Stroke	23	23	26	2110	2017.75	92.25	95.6%	1162.5	1162.5	0	100.0%	1069.5	1057	12.5	100.0%	713	713	0	100.0%	1	0	0	0	2.49	1.12	0
DME	24 & C Diff Cohort	24 & C diff Cohort	38	2098.52	1918.02	180.5	91.4%	1619.73	1607.43	12.3	99.2%	1426	1378.5	47.5	99.2%	1426	1432.25	-6.25	99.2%	0	1	0	0	5.23	3.04	0
General Medicine	26	26	29	2110	1878.5	231.5	89.0%	1937.5	1914.5	23	98.8%	1069.5	1069.5	0	98.8%	1069.5	1069.5	0	98.8%	1	0	0	0	3.31	1.72	-1
Haematology	30	30	22	1722.5	1722.5	0	100.0%	1162.5	1162.5	0	100.0%	906.75	906.75	0	100.0%	1069.5	1069.5	0	100.0%	0	0	0	0	3.37	1.68	1
Cardiology	32 & CCU	32 & CCU	31	3078.75	2852	226.75	92.6%	1550	1532	18	98.8%	1426	1414	12	98.8%	1069.5	1045.5	24	98.8%	1	1	0	0	4.22	-1.15	1
Cardiology	33 & HAC	33 & HAC	29	1722.5	1501	221.5	87.1%	1162.5	1151	11.5	99.0%	1069.5	1038	31.5	99.0%	1069.5	1069.5	0	99.0%	0	0	0	0	2.83	1.09	2
Gastro	36	36	32	2253.75	2132.75	121	94.6%	1550	1504	46	97.0%	1069.5	1069.5	0	97.0%	1069.5	1069.5	0	97.0%	0	0	0	0	2.25	4.53	1
Respiratory	38 & 37	38 & 37	45	2497.5	2132.75	364.75	85.4%	1743.75	1683.25	60.5	96.5%	1426	1414	12	96.5%	1069.5	1069.5	0	96.5%	0	2	0	0	3.14	-1.30	-1
Maternity	53	53	38	1598.5	1525.5	73	95.4%	744	726	18	97.6%	1426	1306	120	97.6%	356.5	368.5	-12	97.6%	0	0	0	0	6.12	5.04	7
Gynaecology	54	54	16	885.5	885.5	0	100.0%	713	713	0	100.0%	713	713	0	100.0%	0	0	0	100.0%	0	0	0	0	0.28	0.00	-3
General Medicine	AMU	AMU	24	1955	1896	59	97.0%	1426	1389.85	36.15	97.5%	1069.5	1063.5	6	97.5%	1069.5	1069.5	0	97.5%	0	0	0	0	4.42	3.49	-1
General Medicine	MSSW	MSSW	21	2311.5	2075	236.5	89.8%	1782.5	1759	23.5	98.7%	1635.25	1491.35	143.9	98.7%	1635.25	1611.25	24	98.7%	0	0	0	0	4.42	3.49	-1
Emergency	EDRU	EDRU	10	885.5	879.35	6.15	99.3%	356.5	356.5	0	100.0%	550.25	480.25	70	100.0%	356.5	356.5	0	100.0%	0	0	0	0	0.74	-1.67	0
	Parksuite	Parksuite	8	840	828	12	98.6%	345	345	0	100.0%	690	690	0	100.0%	0	0	0	100.0%	0	0	0	0	6	-2.60	1
Surgical Assessment	ESAU	ESAU	12	1185	1147.5	37.5	96.8%	690	665.2	24.8	96.4%	1035	1023	12	96.4%	690	690	0	96.4%	1	0	0	0	10.06	1.54	-3
Critical Care	ITU	ITU	11	4822.5	4822.5	0	100.0%	212.5	200.5	12	94.4%	4278	4271.8	6.2	94.4%	0	0	0	94.4%	0	0	0	0	4.71		
Critical Care	HDU	HDU	6	1722.5	1722.5	0	100.0%	387.5	387.5	0	100.0%	1426	1426	0	100.0%	356.5	356.5	0	100.0%	0	0	0	0	4.71	8.65	-1
Maternity	Delivery Suite	Delivery Suite	10	3381	3369	12	99.6%	690	690	0	100.0%	3208.5	2964	244.5	100.0%	690	690	0	100.0%	0	0	0	0	6.45	5.04	7
Neo Natal	Neonatal	Neonatal	24	3381	3111	270	92.0%	0	0	0	-	3208.5	3042.5	166	-	0	0	0	-	0	0	0	0	2.05	5.01	1
Children's	Children's	Children's	27	2186	2064.2	121.8	94.4%	356.5	356.5	0	100.0%	1782.5	1675.5	107	100.0%	356.5	356.5	0	100.0%	0	0	0	0	1.2	-0.53	0
Orthopaedics	M1	M1	20	1530	1530	0	100.0%	1035	1035	0	100.0%	690	690	0	100.0%	345	345	0	100.0%	0	0	0	0	0.85	2.26	1
General Surgery	M2	M2	26	345	345	0	100.0%	345	345	0	100.0%	138	138	0	100.0%	138	138	0	100.0%	0	0	0	0			
DME	CRC	CRC	20	1328.75	1245.75	83	93.8%	1550	1492.5	57.5	96.3%	713	713	0	96.3%	906.75	906.75	0	96.3%	0	0	0	0	1.05	0.11	2
Neuro & Rehabilitation	M2 Rehab	M2 Rehab	20	1335	1335	0	100.0%	968.75	955.75	13	98.7%	713	713	0	98.7%	356.5	356.5	0	98.7%	0	0	0	0	4.45	0.39	-1
Dermatology	Dermatology	Dermatology	12	602.25	602.25	0	100.0%	143.75	143.75	0	100.0%	264.5	264.5	0	100.0%	264.5	264.5	0	100.0%	0	0	0	0	4.89	0.30	0
Geriatric Medicine	25	25	30	750	750	0	100.0%	750	750	0	100.0%	690	690	0	100.0%	690	690	0	100.0%	0	2	0	0	0	1.90	1
Totals			829	64223.52	61656.42	2567.1		36038.98	35695.83	343.15		43631.5	42508.4	1123.1		23023.5	22951.55	71.95								

Overall Staffing Hour totals (Rounded to the nearest hour)	Fill Rate	98%	Total Planned Hours	166917.5	Total Actual Hours	162812.2	Variance	4105.3

NB: RAG rating has been applied as 95% or above as "green" for % RN & % CSW and for sickness & absences equal to or below the Trust's target of 4% this is "Green" and Red if above Trust target of 4%.
Please note the Pressure ulcer data is sourced from clinical incident reporting and have not all been validated by the Tissue Viability team at the time of this report.
*Awaiting confirmation of Band 5 Vacancy for Medicine and Acute Care

BOARD OF DIRECTORS	
Agenda Item	8.2
Title of Report	Workforce & OD Annual Report
Date of Meeting	25th May 2016
Author	James Mawrey, Director of Workforce Lynn Benstead, Deputy Director of OD Lawrence Osgood, Assistant Director of HR
Accountable Executive	James Mawrey, Director of Workforce
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	1, 1A, 2799, 2798, 4, 4A, 1909, 1, 1B, 1908, 2836, 1909 7, 7A, 2798 3, 3B, 2799, 2798
Level of Assurance **Positive** **Gap(s)**	Full
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

HR&OD Workforce Information

Annual Report

2015/16

April 2016

Executive Summary

1. This report provides a Workforce Annual Report for the year ending 31st March 2016.

2. The report shows that the Trust made progress towards achieving some of its Workforce targets as well as working towards embedding the values that underpin our patient experience.

3. The Workforce Strategy 2015-2018 has been developed and continues to be enacted; further targets have been set for the coming year(s) as we continue to strive to be the top NHS Hospital Trust in the North West for Patient, customer and staff satisfaction and an organisation that is Locally Focused and Regionally Significant.

4. Key points show that:

   - Trust values continue to be embedded in HR processes including recruitment, appraisal, remuneration and training.

   - Staff Satisfaction – Over the last three quarters there has been significant improvement in the staff engagement score which is now above the national average. National Staff Survey now includes the questions that make up the staff engagement score. The National Staff Survey 2015 which was undertaken in quarter 3 shows great improvement with an increase in the overall staff engagement score to 3.79 (equal to the national average) from 3.48 (bottom 20% of Acute Trusts). LiA Actions - 169 departments took part in the 100 Day Challenge to identify what staff were most proud of and what needed to be done to improve staff satisfaction for them. Over 1000 improvement actions were identified and are being completed by department managers.

   - 2015/16 saw the Trust achieve national recognition for staff engagement as winners of the Healthcare People Management Award and the Patient Experience National Network Award, recognising excellent achievements made through Listening into Action and staff engagement culture. WUTH Staff Guardians were included as one of the top 100 NHS stories as part of the #NHS100 Stories campaign. James Mawrey was shortlisted by the Healthcare People Management Association for the award of HR director of the year. Given our challenges around finance, quality, safety and performance, we are clear that we need further culture change to transform our services and meet these important agendas. We are committed to continuing working closely with our staff to improve year on year in staff satisfaction so that we achieve top 20% of Trusts nationally as measured in the national staff survey by 2017.

   - Trust Attendance Rates remain high. The Health and Wellbeing Strategy is in place, Trust sickness absence rates have dramatically reduced throughout 2015/16. This has delivered 16,251 additional working days in 2015/16 compared to 2014/15. Flu vaccination plan reached 79.2% of staff and positioned the Trust as third highest in England. Occupational Health department achieved SEQOHS accreditation.

   - Overall staffing numbers increased by 290 whole time equivalent (wte). Included in this :-
     a. 89 wte increase in Nursing and Midwifery in year and 97 WTE Additional Clinical Services, which includes Clinical Support Workers.
     b. Continued increase of Medical Workforce with 13 consultants more since 2015.

Given the continued need for prudent fiscal management, the strict controls remain in place with all recruitment being challenged whilst ensuring quality and safety are paramount. Non-patient facing roles in particular continue be subject to close scrutiny. A&C staff group has significantly reduced from the level 2 years ago. Benchmarking shows that there are higher percentages of lower banded staff at WUTH reflecting successful skill mix changes introduced as part of CIP activity. Vacancy rates in key staff groups such as N&M and Senior Medical staff remain low.

- HR&OD department continue to monitor the key characteristics of the workforce such as proportions in different staff groups, pay band, age, length of service, turnover etc. in order to inform the workforce strategy and departmental planning.

- There has been a general increase in the number of formal employee relations cases in 2015/16 compared with 2014/15 linked to increased raising of concerns and increased action in relation to sickness absence management.

- WUTH achieved better than National average results in respect Bullying & Harassment in the national survey.

- Since the introduction of the Guardians on 01/05/15 to March 2016, 92 concerns have been raised and responded to, which highlights an open culture. National Staff survey results 2015 have shown a 4% increase in the number of staff who know how to report concerns and 6% increase in the number of staff who would feel secure raising concerns.

- The Trust achieved its Appraisal compliance target of 88% at March 2016.

- The Mandatory Training Block A compliance rate at the 31 March 2016 was 90.49 % which falls below the 95% target rate, divisional action plans are being enacted to address this.

- Trust staff completed over 14,226 training episodes within the Leadership & Development Centre. This is a 27% (3,003) increase from the previous year which is due to the Centre leading on the coordination and monitoring of Safeguarding level 2 & 3 training. In addition the Clinical Excellence Department completed 8650 training episodes in Clinical Skills training. This is a 5% (430) increase from the previous year and is due to maximizing access to all programmes.

- A Cultural Engagement plan 2015 – 2018 has been developed and associated actions are being implemented.

- The Wirral University Teaching Hospital Library and Knowledge Service was one of the top scoring services in the North West in the Libraries Qualities Assurance Framework (LQAF) accreditation 96% assessment. The Trust has been consistent in achieving the highest standard of accreditation for the last 5 Years.

5. The Board is asked to:
   a. Note the details of the Annual Workforce Report.
   b. Note the actions which are being taken to maximise the effectiveness of the workforce.
   c. Highlight any specific additional assurance / workforce information required.

Trust values

1. The Trust aims to ensure our people are aligned with our vision. This means ensuring we have engaged, committed colleagues at every point of the healthcare journey that provide the best possible patient experience from staff on reception through to specialist consultants. Research tells us that there is a positive relationship between staff motivation and wellbeing and patient experience, outcomes and organisational performance.

   Our vision and objectives are underpinned by our PROUD core values and behaviours which define the standards of the organisation and individuals within it. Our PROUD core values are woven into our HR processes including recruitment, induction, appraisal, remuneration and training.

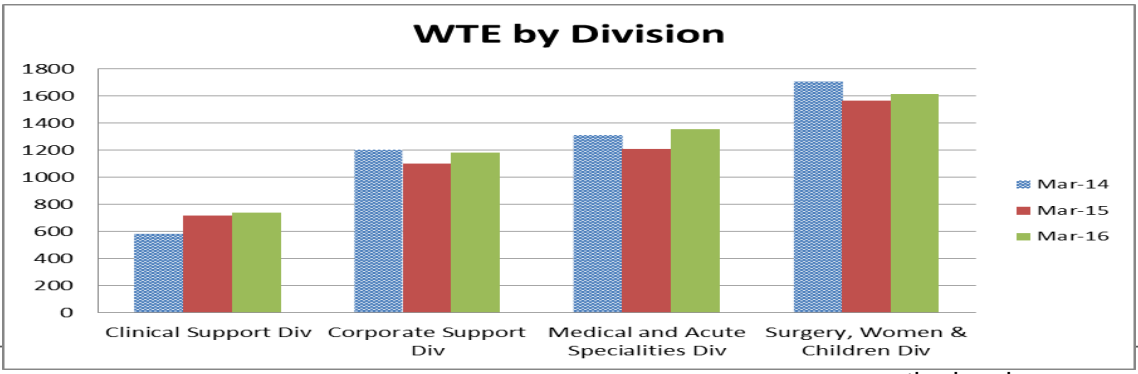
   In 2015/16 we have further embedded our PROUD core values by:

   - Developing and implementing a Staff Charter that sets out expectations values and behaviours for all staff
   - Producing and distributing a guide for leaders on staff engagement "The PROUD Way"
   - Implementing 360 degree feedback for our executives and operational management teams
   - Refining the appraisal process to give added prominence to values and behaviours.
   - Launching "Hello my name is …" campaign, including an event at the Trust attended by Dr Kate Grainger, campaign founder and NHS Doctor
   - Introducing PROUD wall boards
   - Developing a PROUD section of website
   - Producing a PROUD magazine
   - Following the cultural barometer exercise held feedback sessions for senior leaders and managers with opportunity for self-reflection and personal commitment pledges
   - Implementing Trust Board partner scheme to enhance senior visibility and staff support
   - Further developing PROUD communications, including teams and leaders in the spotlight, and refreshed Team Brief
   - Recognising our staff through annual PROUD awards and regional and national awards

Trust Workforce Profile

1. The Trust employs 5871 staff, (4885.83 Whole Time Equivalent March 2016). The number of whole time equivalent staff has increased by 290.19wte during 2015/16 (4595.64 wte March 2015). The following provides a breakdown of this:-

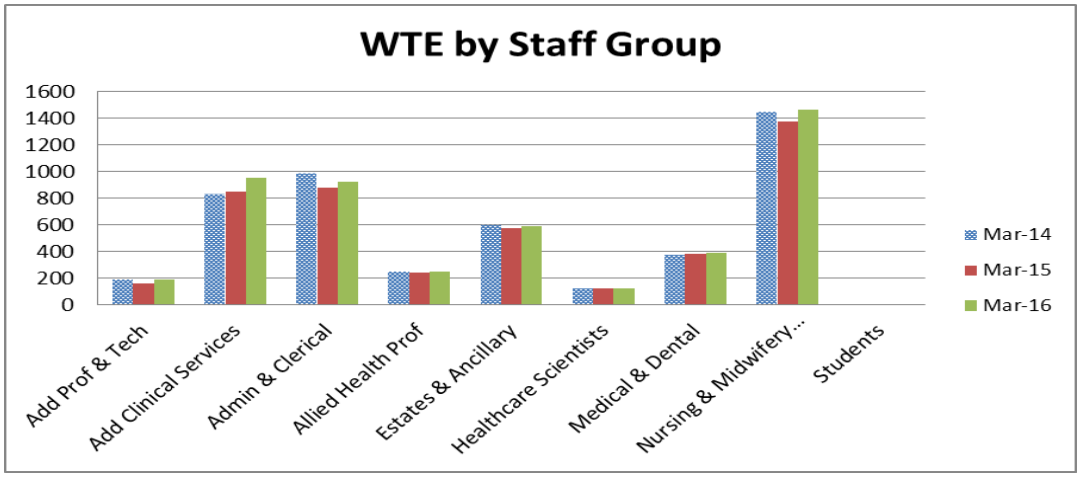
   Division –Headcount and WTE



Comparing 2016 to 2015 all divisions have seen an increase in staff numbers. Clinical Support have seen the smallest increase in staff, Medicine & Acute have seen the greatest.

During 2015/16 the strict vacancy control system has continued, which involves signoff of any recruitment or increases in staff hours by a panel consisting of Executive Directors and the Director of Workforce. Very senior divisional managers present their cases to this panel and are challenged on the need for the increase and whether alternatives have been sufficiently explored. In particular recruitment of non-clinical staff is very tightly controlled.

Staffing Group –Headcount and WTE



Consultants	WTE	Headcount
Mar-14	221.16	234
Mar-15	227.39	243
Mar-16	235.39	256

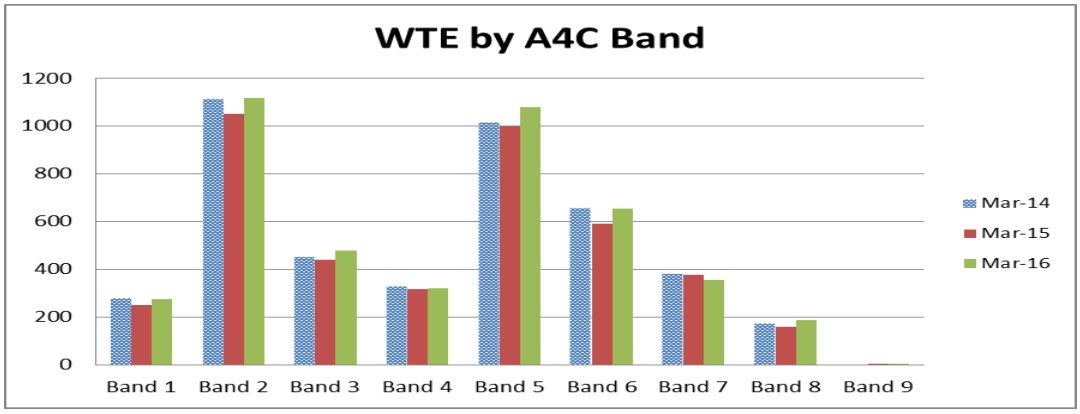
Workforce Changes:- There has been an overall increase in wte staff numbers this year (290wte) owing to continued investment in front line staff. Additional Clinical Services and Nursing and Midwifery have seen by far the largest increases (97.21wte and 89.07wte respectively). In order to ensure qualified nurse vacancies are quickly recruited to and in line with increased investment in Nursing, the Trust has been holding monthly Nurse Recruitment campaigns organised corporately to recruit for all Divisions. In addition the Trust has been proactive in overseas recruitment resulting in 37 qualified nurses recruited from the EU in 2015/16. Skill mix changes have resulted in considerably more staff in the additional clinical services staff group (this grouping includes clinical support workers).

The numbers of medical and dental staff have increased and the trend of increasing numbers of consultants continues with 22 more consultants than in March 2014. (Please note in addition to the Medical & Dental numbers above there are 147 junior doctors hosted by Whiston but working in this Trust).

The numbers of Administrative and Clerical staff have increased by 42.08 wte in 2015/16, although A&C staff group is the only staff group with a significant reduction in numbers compared to 2013/14. One of the main reasons for the increase this year is due to the transfer back in house of

some previously outsourced services, for example Informatics. Other reasons would include various skill mix reviews undertaken as part of the Trust cost efficiency programme.

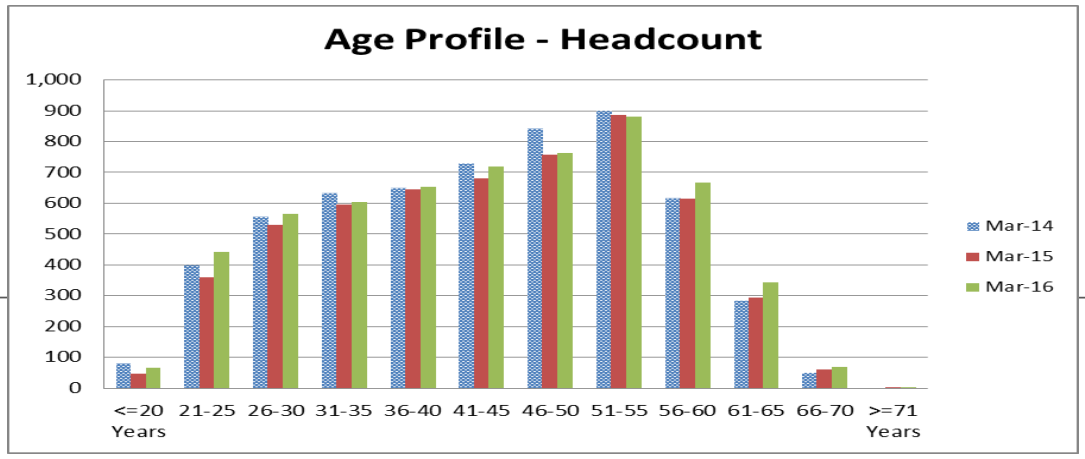
Agenda for Change Whole Time Equivalent staffing (WTE)



	Bands 1-3	Bands 4-7	Bands 8-9	Non A4C	Total
Wirral University Teaching Hospital NHS Foundation Trust	38%	49%	4%	9%	100%
Lancashire Teaching Hospitals NHS Foundation Trust	35%	52%	3%	9%	100%
University Hospital of South Manchester NHS Foundation Trust	28%	56%	6%	11%	100%
Countess of Chester Hospital NHS Foundation Trust	38%	49%	3%	9%	100%
Blackpool Teaching Hospitals NHS Foundation Trust	30%	59%	4%	7%	100%
Central Manchester University Hospitals NHS Foundation Trust	24%	59%	7%	10%	100%
Salford Royal NHS Foundation Trust	29%	54%	6%	11%	100%
Stockport NHS Foundation Trust	33%	55%	4%	7%	100%
University Hospitals of Morecambe Bay NHS Trust	35%	52%	5%	8%	100%
Wrightington, Wigan and Leigh NHS Foundation Trust	38%	49%	4%	9%	100%
Aintree University Hospitals NHS Foundation Trust	34%	51%	5%	11%	100%
East Lancashire Hospitals NHS Trust	35%	53%	4%	8%	100%

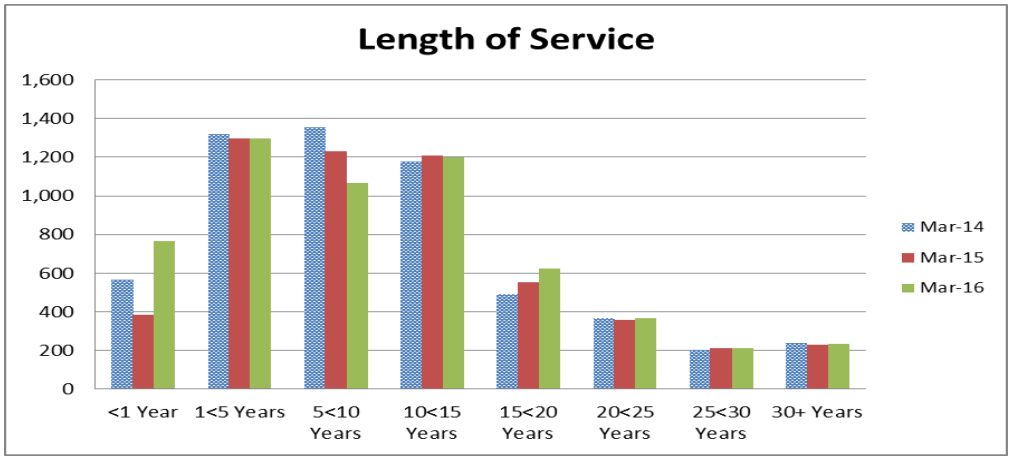
The table above of comparable Acute Trusts shows that relative to these other Trusts WUTH has a high percentage of staff at Bands 1 – 3, a lower percentage of staff at Bands 4 – 7, a lower percentage of staff at Bands 8 – 9 and a median percentage of non-A4C staff. The higher percentages of lower banded staff at WUTH reflects successful skill mix changes introduced as part of CIP activity.

Age Profile



It can be seen that the age profile of the Trust remains relatively stable with numbers in most categories increasing in proportion to the overall increase in staff numbers between 2015 and 2016, and the largest numbers of employees being aged between 41 and 55. However there has been an increase in young workers (under 31) as a result of the recruitment of more apprentices and more newly qualified and EU nurses. In line with the national trend towards an ageing workforce the Trust is also seeing rapidly growing numbers of older workers (56+). Increasingly, staff are remaining in work up to and beyond their pensionable age which in terms of risk, lowers the risk of the staff taking their skills away from the organisation – however this introduces a significant risk in terms of existing staff working beyond their pensionable age who may be more likely to leave at any time than younger staff. Divisional managers and HR monitor key staff in this category such as consultants and ensure succession planning is considered for these staff. Currently the Trust has 32 consultants aged over 60.

Length of NHS Service.



The biggest increases between 2015 and 2016 have occurred in category of less than 1 years NHS service' which reflects the recruitment of more apprentices and more newly qualified nurses.

Flexible Working

A significant proportion of Trust staff chose to work on a part time basis (47%), having a substantial proportion of staff working on other than a full time basis is beneficial to staff trying to balance work and life and is beneficial to the Trust. The potential benefits of part time working to the Trust include:

- Increasing recruitment and retention of staff by offering family-friendly working options.
- Staff satisfaction and reduced absence amongst staff who can more effectively get work life balance correct and who can attend appointments etc. more easily on non-working days.
- Providing cost-effective flexibility to meet peaks in demand (hours up to 37.5 are at flat rates).
- Reduction in the workloads of other workers and non-core spend, e.g. recruiting a part time worker when not enough work for a full-time position but regular use of non-core staffing.

There are some disadvantages in that having headcount high in relation to whole time equivalent (wte) does increase staff recruitment and development costs, however on balance the advantages above make part time staff an attractive proposition.

Joiners and Leavers, Turnover and Vacancies

1. A total of 600.07 wte staff (excluding rotational training doctors and honorary staff) joined the Trust in 2015/16, indicating that the Trust remains attractive to new employees. The number of joiners peaked in September and November 2015; this was mainly due to new nursing and midwifery staff and Clinical Support Workers. Reasons for leaving are broadly attributed to natural turnover e.g. 'Voluntary Resignation/Other', 'Retirement – age' or 'Flexi retirement'.

2. Turnover has decreased in 2015/16 when compared to 2014/15.

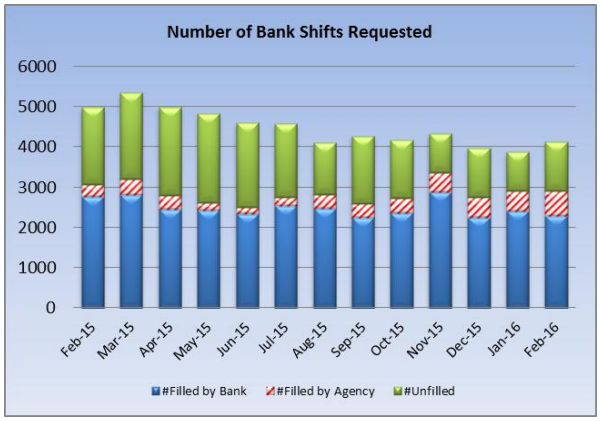
3. Vacancies.

Mar-16	Trust	Corporate	Clinical Support	Medicine & Acute	Surgery, W&C
Staff In Post	5034.57	1178.83	748.36	1413.53	1693.74
Vacancy %	5.34%	7.48%	5.83%	3.37%	4.93%
Vacancy #	253.33	94.12	43.64	41.83	73.75
N&M Vacancy %	5.73%	0.03%	1.21%	5.78%	6.26%
N&M Vacancy #	88.89	0.01	0.52	41.69	46.66
N&M Band 5 (Inpatient Areas & ED) %	6.48%	N/A	N/A	7.94%	3.52%
N&M Band 5 (Inpatient Areas & ED) #	45.84	N/A	N/A	37.61	8.23
Consultants Vacancy %	1.14%	0.00%	4.78%	3.40%	-1.61%
Consultants Vacancy #	2.69	0.00	1.60	2.94	-1.85

* Note a negative vacancy figure may indicate that an area is temporarily over-established

A significant proportion of the Corporate vacancies are in Facilities, there has been recent recruitment in this area. Consultant recruitment remains a priority and HR&OD are working with Medicine and Acute in particular to address some hard to fill posts. The Nursing Band 5 vacancies are reviewed each month by the Senior Nursing Team. Generic Nurse recruitment took place several times throughout the year and also 32 nurses were successfully recruited from overseas.

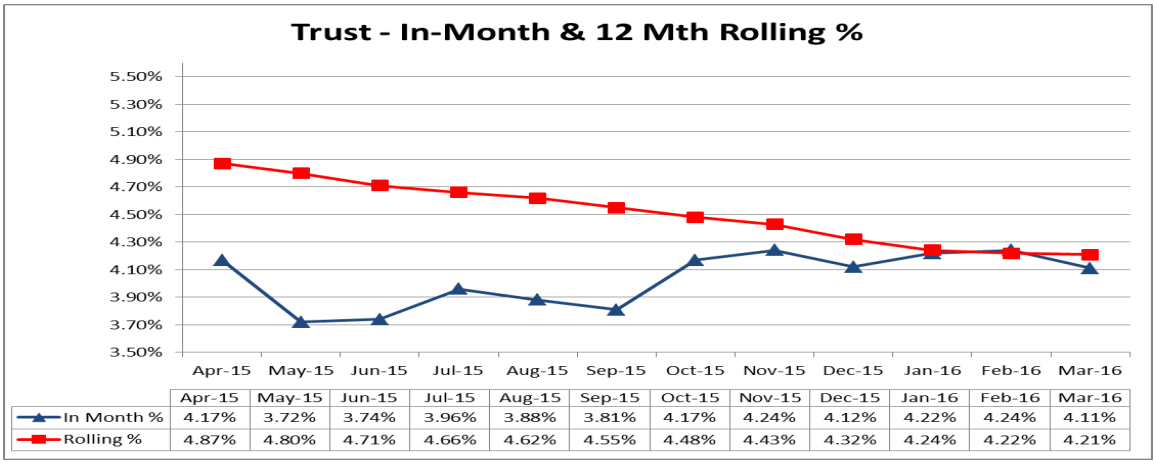
Bank Usage



The number of Bank shifts being requested has generally decreased greatly throughout 2015/16 as a result of successful recruitment of substantive staff and careful control of non-core expenditure. With effect from November 2015 the temporary staffing bank service was transferred from HR Wellbeing Services to NHS Professionals.

Attendance

1. Trust sickness absence rates have dramatically reduced throughout 2015/16. The average for 2015/16 was 4.21% which represents a very significant reduction on the previous year (2014/15 = 4.93%). This has delivered 16,251 additional working days in 2015/16 compared to 2014/15.



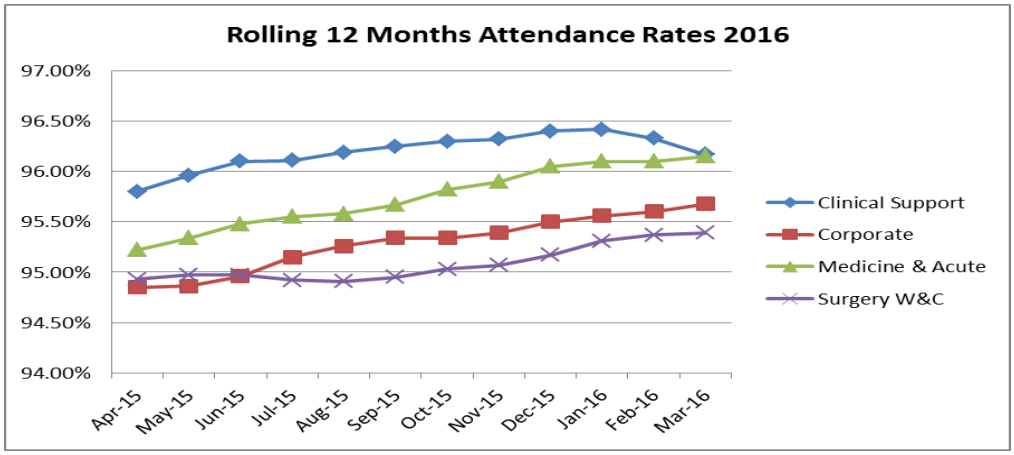
	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
In Month %	4.17%	3.72%	3.74%	3.96%	3.88%	3.81%	4.17%	4.24%	4.12%	4.22%	4.24%	4.11%
Rolling %	4.87%	4.80%	4.71%	4.66%	4.62%	4.55%	4.48%	4.43%	4.32%	4.24%	4.22%	4.21%

2. Reasons for sickness are continually monitored by HR&OD in order to target actions to improve attendance. The top five reasons for 2015/16 are in the table below, with the figures for the previous year.

Absence Reason	2014/15	2015/16
S10 Anxiety/stress/depression/other psychiatric illnesses	23.43%	25.30%
S12 Other musculoskeletal problems	13.18%	11.37%
S11 Back Problems	7.59%	8.77%
S25 Gastrointestinal problems	7.72%	8.63%
S28 Injury, fracture	8.37%	7.81%

In response to these a Health and Wellbeing Strategy and associated wellbeing plan has been developed to be delivered over 3 years, supported by the wellbeing group which monitors progress of the action plan on a monthly basis. The plan brings together a variety of initiatives providing a comprehensive approach to Health & Wellbeing based on DoH and NICE guidance of best practice. An intensive flu vaccination campaign has seen the highest percentage of Trust staff vaccinated this winter (79.2%). Anxiety/Stress/Depression remains a major factor in absence and a number of targeted actions are being taken to address this including stress audits, review of stress policy, departmental and individual stress risk assessments, training on stress awareness, self-help guides and a 'Mind Matters' day. The introduction of Mindfulness sessions that are being provided to staff out of hours has been particularly well received with 45 staff members attending each week.

3. Attendance performance has improved greatly across all divisions this year, with Clinical Support division achieving better than Trust target of 96% for the majority of the year, Medicine & Acute have been achieving the target for the most recent 4 months. Corporate and Surgery, W&C are both improving, but are still below the target. The chart below shows the rolling 12 months attendance by division. HR&OD are supporting Divisional / Corporate Managers to address worsening areas.



4. Senior Divisional and corporate managers receive a monthly detailed drill-down report on hotspot areas. The Quality & Safety Committee and Operational Management Team regularly receive reports detailing the approaches being taken to positively impact Attendance. This includes a range of pro-active measures being taken and reflects a more stringent focus on the effective management of sickness absence backed up by the revised Attendance Capability policy.

Staff Engagement including Listening into Action

1. In 2015/16, we continued to implement Listening into Action (LiA) as a way of working, embedding this further and deeper, aiming to achieve a fundamental shift in the way we work and lead, putting clinicians and staff at the centre of change for the benefit of our patients, our staff and the Trust as a whole.

2. Key Actions Taken to Deliver Improvement

The 100 Day Challenge - Four key components:

- **LiA Huddles -** 169 departments took part with over 1000 improvement actions identified
- **100 Senior Leaders and Managers -** developing a culture of engagement with our most senior leaders and managers
- **PROUD and Improved Communications**
- **Rewards and Recognition –** awards, Team of the Quarter, 100% attendance recognition

Other Actions Taken in 2015/16

- Improved process for Raising Concerns
- Introduced Staff Guardians
- Focus on health and wellbeing and introduced Schwartz Rounds
- Reviewed frequency of mandatory training
- Awareness raising regarding web based incident reporting
- Used LiA methodology to support key challenges e.g. Winter Plan and Communications.
- Held LiA Pass it On events for teams to share what they have achieved. Examples of LiA Team achievements include:
    - *Surgical Assessment Unit* – Standard operating procedures, reduction in waiting times, improved use of trolley and triage supported by emergency consultant.
    - *Winter planning*: Improved planning for opening winter wards, introduction of 29 step down beds in Charlotte House, introduced 'Single Front Door' initiative to triage

appropriate patients attending ED to the Walk In Centre. Introduced weekend discharge team and now regularly discharge 53% more patients over the weekend. Implemented the SAFER Patient Flow Bundle to improve patient flow resulting in 10%-15% improvement in patients discharge before midday. Nurse recruitment - 63 more nurses in March 2016 than in May 2015

- *5 pathways of care for older people* – electronic referral, simplified discharge process, early notification of assessment, named Integrated Discharge Team representative
- Improved *communications* cascaded through refreshed Team Brief and audit
- *End of Life Care* - Improved ward availability of anticipatory care drugs, new & improved patient information, more staff and volunteer training, Z beds to enable loved ones to stay with patient
- *Maternity scans* - increased ultrasound clinics to run until 7pm and made the 1st Trimester booking slot compliant with Foetal Anomaly Screening Programme.
- *Improving long term outcomes for acute brain injury* - Set up a Cheshire and Merseyside Acute Brain Injury Network, established funded beds for the most serious cases requiring long term rehabilitation, identified neuro-psychology clinics.
- *Staff Guardians* - 83 concerns raised between May 2015 and February 2016 and responded to. National Staff survey results 2015 have shown a 4% increase in the number of staff who know how to report concerns and 6% increase in the number of staff who would feel secure raising concerns.
- *Dermatology services*, standardisation of processes, psychological support, podcasts to support training.
- Staff social Group held children's Christmas party, Pantomime and staff discounts

3. Other outcomes for the Trust from the staff engagement agenda
   - Improvement in 2015 National Staff Survey Staff Engagement Score from 3.48 to 3.79 (equal to national average)
   - 14% more staff recommend the Trust to family and friends for care
   - 17% more staff recommend the Trust to family and friends as a place to work
   - 13% more staff feel that patient care is the Trusts top priority
   - More staff feel supported by their managers (3.48-3.76)
   - 12% more staff feel communication between senior management and staff is effective
   - 7% more staff feel able to contribute towards improvements at work

4. 2015/16 saw the Trust achieve national recognition for staff engagement as winners of the Healthcare People Management Award and the Patient Experience National Network Award, recognising excellent achievements made through Listening into Action and staff engagement culture. We are committed to continuing working closely with our staff to improve year on year in staff satisfaction so that we achieve top 20% of Trusts nationally as measured in the national staff survey by 2017.

5. The Trust Board agreed that the Staff Friends and Family Test (Staff FFT) would be used to monitor whether the required improvements were being made on an incremental basis in advance of the Annual NHS Staff Survey, with additional questions added that make up the staff engagement score in line with the Annual NHS Staff Survey. This aimed to give us a greater sense of how we were progressing and that the actions put in place were effective. The table below provides an overview of the measurable improvements during 2015/16 along with the results from the National Staff Survey 2015, from these it can be seen that 2015/16 ended with significantly better scores than it had begun with and this reflected the much improved Staff Survey results in 2015.

Staff Friends and Family Test Questions	Q1 2015/16 Staff FFT	Q2 2015/16 Staff FFT	Q3 2015/16 (from QH staff survey)	Q4 2015/16 Staff FFT
Question 1 Recommend Trust for Care	75%	81%	66%	82%
Question 2 Recommend Trust to work	47%	62%	58%	58%
Staff Engagement Score	**3.74**	**3.83**	**3.79**	**3.78**

Staff Development

Compliance

1. The Trust continued to improve on appraisal levels achieving its compliance target of 88% (88.05% at March 2016).

2. The Mandatory Training Block A compliance rate at the 31 March 2016 was 90.49 % which falls below the 95% target rate and is a fall from 97.48% at March 2015. Divisional action plans have been developed and are being enacted to address this.

3. Trust staff completed over 14,226 training episodes within the Leadership & Development Centre. This is a 27% (3,003) increase from the previous year which is due to the Centre leading on the coordination and monitoring of Safeguarding level 2 & 3 training. In addition the Clinical Excellence Department completed 8650 training episodes in Clinical Skills training. This is a 5% (430) increase from the previous year and is due to maximizing access to all programmes.

4. In addition to the internal training provided the Trust utilised external training via organisations such as the University of Liverpool, University of Chester, North West Leadership Academy, and Wirral Metropolitan College.

Coaching

1. The Trust has developed a Cultural Engagement plan 2015 – 2018 that is underpinned by building a coaching culture. This plan is part of the Workforce and Organisational Development Strategy 2015 to 2018. The Trust is actively building Coaching techniques within in house programmes to enable the Trust to further develop Coaching skills as a resource within the Organisation and to support transformational leadership styles.

2. The Trust now has 24 trained in house Coaches, 11 of which are medical Consultants who are supporting the Remediation process to develop Consultant Colleagues. In March 2016 the Trust received support from the NW Leadership Academy to train sub board level staff in developing Coaching Conversation styles. Dr Debra King is working with the Countess of Chester and Liverpool Heart and Chest on a pilot to support coaching for Junior Doctors. The work is being funded by HEE and will be evaluated by Chester University.

Consultant Development Programme

1. The second new Consultant Development Programme finished in March 2016. The Trust developed the programme in order to support Consultants during their first 12 months with the Trust.

   The aim of the programme was:
   - To raise awareness of the role of the Consultant and the importance of personal impact in interacting with and leading and influencing their team, locally, corporately and externally.
   - To understand the strategic and financial issues and the roles that they play as Clinical Leaders in the delivery of service improvement and quality of care.
   - To understand how to deliver and develop safe and effective clinical practice set against managing targets, finance and systems.

   The initial feedback has been excellent and positive comments on future programme content have been received.

Clinical Leadership Programme

2. The Clinical Leaders Development Programme 2014 - 2016 has been established in collaboration with Mid Cheshire Hospitals and the Countess of Chester Hospital. The Trust currently has 14 Consultant participants on the programme with an overall total of 44 Consultants attending the programme from across the three organisations.

3. The programme aims to provide a supportive environment in which clinicians can develop and expand their leadership knowledge and skills, reflect on their capabilities and explore new ways of behaving. This programme will support the process of talent management and succession planning for clinical leadership roles.

LQAF Accreditation

The Library & Knowledge Service is assessed annually by the NW Health Care Libraries Unit against criteria laid out in the national Library Quality Assurance Framework (LQAF). In 2015 the WUTH Library & Knowledge Service received a compliance score of 96% against the national criteria. This is a further increase from 94% in 2014.The Trust has been consistent in achieving the highest standards of accreditation for the last 5 Years.

Employee Relations

Employee Relations Formal Cases		
	2014/15	**2015/16**
Disciplinaries in year.	34	33
Disciplinaries – Bullying & Harassment	4	10
Formal Capabilities in year	7	8
Grievances in year	43	59
Concerns raised in Year	9 (PIDA recordable)	90 (22 PIDA recordable
Trust Board Appeals in year	4	3
Employment Tribunals in year	1	5

1. There has been a general increase in employee relations cases this year, much of this can be linked to increased raising concerns and increased action in relation to sickness absence management. There has been an increase in formal B&H cases, which again may be partly attributed to the increase in concerns raised, a proportion of which have resulted in formal processes. There has been an increase in the number of employment tribunals which is attributable to increased action under Attendance Capability policy, however the Trust has been successful in defending these claims.

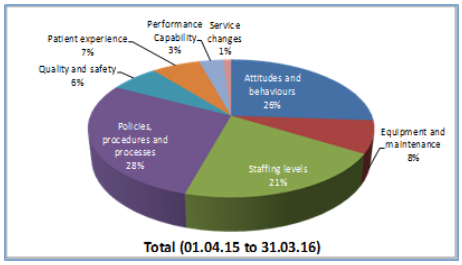
2. Raising Concerns and Staff Guardians - Following a Listening into Action work stream and recommendations made by Sir Robert Francis' Freedom to Speak Up review, a variety of changes occurred to the raising concerns (formerly whistleblowing) policy and process. The Trust introduced a Cultural Ambassador and three Staff Guardians as part of our Culture and Engagement Plan 2015-18. This supports the delivery of the Workforce and OD Strategy. A variety of Trust-wide communications were launched to highlight the importance of speaking up and the support mechanisms available, including the Staff Guardian service.

   The Guardians activity to date has been extremely successful, with positive feedback from both the National Staff Survey and other organisations. 92 concerns have been raised by staff in 2015/16 which have been acted upon as appropriate and activity is monitored on a monthly basis by the Director of Workforce and assured by the Workforce and Communications Group. Of the 92 concerns raised, 22 have been recordable under PIDA (Public Interest Disclosure Act) e.g. any disclosure of information which is in the public interest and, in the reasonable belief of the worker making the disclosure, tends to show one or more of the following:
   a) that a criminal offence has been committed, is being committed or is likely to be committed
   b) that a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject,
   c) that a miscarriage of justice has occurred, is occurring or is likely to occur
   d) that the health or safety of any individual has been, is being or is likely to be endangered
   e) that the environment has been, is being or is likely to be damaged
   f) or that information tending to show any matter falling within any one of the preceding paragraphs has been, is being or is likely to be deliberately concealed

Prior to the introduction of the Staff Guardian role; recording only focussed on those "whistleblowing" cases that fell under these categories. Therefore, a direct comparison identifies that only 9 PIDA recordable concerns were raised in the 2014/15 reporting period as a whole.. This therefore highlights an increase in the number of cases reported since the introduction of the Staff Guardian role.

Although this is a new service for the Trust and still in its infancy, we appear to be at the forefront of other NHS organisations in implementation. The main themes arising from concerns raised include: procedures and processes, attitudes and behaviours and staffing.

Themes	Total (01.04.15 to 31.03.16)
Attitudes and behaviours	24
Equipment and maintenance	7
Staffing levels	19
Policies, procedures and processes	26
Quality and safety	6
Patient experience	6
Performance Capability	3
Service changes	1
Total	92



Our Staff Guardians have:

- Presented our work at WUTH at an NHS Employers Event in London and had this published in their newsletter
- Taken part in the consultation to support the development of a National Whistleblowing Policy, which was published by NHS Improvement and NHS England on 1st April 2016.
- The Staff Guardians have been invited to join the "Freedom to Speak Up" National Workstream with Health Education England (Carol Skillen acting as representative)
- Been shortlisted for the HSJ Value in Healthcare Awards 2016
- Been invited to present at the "Changing Culture & Improving Whistleblowing Procedures in Healthcare" Conference hosted by Westminster Briefing on 8th June.

3. The Trust recognises the importance of providing a working environment and culture in which bullying and harassment is unacceptable. To support this, the Bullying and Harassment Policy provides a framework for raising concerns about harassment and / or bullying both informally or formally via the grievance policy. The Bullying and Harassment policy details the processes for dealing quickly, effectively and consistently with concerns and outlines the support available for individuals involved.

   The Bullying and Harassment policy is subject to audit on an annual basis. The objectives of the annual audit are:

   a. To ensure there is a process by which staff may raise grievances in relation to bullying and harassment.

   b. To ensure that on receipt of grievances in relation to bullying and harassment, that the correct process is followed in addressing the grievance.

   c. To ensure that staff who have raised a grievance relating to bullying and harassment are advised of the appropriate support available.

   d. To identify areas of non-compliance in relation to these objectives and policy KPI's.

   e. To develop an action plan to implement any relevant recommendations for changes in practice in order to improve compliance with the processes detailed within the Policy.

   The results from the audit for 2015-16 demonstrated that the Trust compliance with the policy was as follows:

   • Trust policy states that bullying and harassment is unacceptable

   • No grievances received as a result of the informal processes failing because of inadequate action.

   • An audit of formal cases demonstrated that the Trust was compliant with the process for addressing concerns and offering support.

   • WUTH achieved better than National average results in respect B&H in the national survey.

   These results will be reported in detail at Workforce and Communication Group, communicated at Divisional Management Team / Divisional Partnership Group meetings, in TIE and on the Intranet.

Although the audit did not identify any areas of non-compliance, as good practice, and to support the ongoing application of the policy in addressing bullying and harassment recommendations for action will be made and supported by regular reporting to Workforce and Communications Group.

The following recommendations will be taken forward:

- Promoting awareness of the Bullying & Harassment policy in dealing professionally and effectively with workplace issues.
- Reporting of audit outcomes and recommendations widely throughout the Trust.
- Trust-wide communications specific to reporting, support and options of addressing bulling and harassment issues including further promotion of staff guardians.
- Promotion of the in-house mediation services.

Delivering a safe workforce

1. In order ensure the safest possible patient care the Trust maintains a rigourous process for the checking of employee professional registrations, and full pre-employment screening. These processes are subject to regular audit. Audit results and any action plans associated with this are scrutinised by the Workforce & Communication Group.

2. The Trust undertakes regular skill mix and grading reviews ensuring staffing levels, particularly in clinical areas, remain safe and appropriate. A robust development plan for Advanced Nurse Practitioners is being enacted throughout the Trust to ensure ANPs can support the medical rota out of hours. The Trust closely monitors and has a supportive programme for those nurses due to revalidate, all those due are on target to achieve revalidation.

Equality and Diversity

1. The equality agenda is extremely important to the Trust and it is recognised that a diverse staff which reflects the population we serve is desirable. Every effort is made to ensure that all our policies and processes are developed in a way which fully considers protected characteristics (age, sexuality, gender, belief, ethnicity etc.) and ensures no impediment based on this.

2. The table below shows how WUTH compares to the Wirral population as a whole for different ethnic groups. The Trust broadly reflects the population it serves. Overall WUTH employs slightly less people from White and Mixed ethnicity groups than the local population, but slightly more from Asian and Black ethnicity groups.

Ethnicity	Total Number of WUTH Staff	% of WUTH Staff	% Wirral Population (2011 Census)	Wirral Population (2011 Census)
White: British	5,297	89.76%	94.70%	303,682
White: Irish	39	0.66%	0.88%	2,667
White: Gypsy or Irish Traveller	1	0.02%	0.03%	77
White: Other White	83	1.41%	1.23%	3,730
Mixed: White and Black Caribbean	1	0.02%	0.32%	964

Ethnicity	Total Number of WUTH Staff	% of WUTH Staff	% Wirral Population (2011 Census)	Wirral Population (2011 Census)
Mixed: White and Black African	7	0.12%	0.18%	558
Mixed: White and Asian	6	0.10%	0.31%	949
Mixed: Other Mixed	12	0.20%	0.27%	815
Asian or Asian British: Indian	180	3.05%	0.44%	1,344
Asian or Asian British: Pakistani	21	0.36%	0.07%	226
Asian or Asian British: Bangladeshi	6	0.10%	0.28%	851
Asian or Asian British: Chinese	16	0.27%	0.54%	1,653
Asian or Asian British: Other Asian	35	0.59%	0.34%	1,042
Black or Black British: African	30	0.51%	0.13%	389
Black or Black British: Black Caribbean	4	0.07%	0.06%	189
Black or Black British: Other Black	3	0.05%	0.04%	117
Other Ethnic Group/Not Specified	160	2.71%	0.18%	530
All Groups	**5,901**	**100%**	**100%**	**319,783**

3. The Trust 's gender split, disability, and sexual orientation groupings are as shown in the tables below:

Disabled	Total
No	2028
Not Declared	394
Undefined	3414
Yes	65
Grand Total	**5901**

Gender	Total
Female	4629
Male	1272
Grand Total	**5901**

Sexual Orientation	Total
Bisexual	16
Gay	29
Heterosexual	2549
I do not wish to disclose my sexual orientation	522
Lesbian	14
Undefined	2771
Grand Total	**5901**

The gender split reflects the largely female nursing workforce, age bandings are detailed in the section above and reflect the overall high retention rates for staff and the disabled and sexual orientation groupings showing a large number of undefined or not declared/ disclosed preferences. There is evidence that people are more reluctant to share information about disabilities and sexual orientation with their employer, this is not restricted to the NHS but is an issue across employment in general.

4. The Trust has an established Equality and Diversity Action Plan which is monitored at the Patient and Family Experience Group and reported to the Clinical Commissioning Group as part of the Quality Contract Schedule.

Next Steps

1. Key objectives (as outlined in the Workforce Strategy) for the HR / OD function have been agreed which include addressing issues raised in this report. Specifically actions emanating from this report include:

   a. Continuing to work towards meeting our key staffing metrics (metrics agreed at Quality & Safety Committee), this will support the Trust in managing our activity, improve patient care and work within staffing budgets.

   b. We will further develop the evidential behaviors that underpin the Trust values.

   c. Implementing the Trust's Staff Engagement plan in light of the findings of the NHS Staff Survey 2015.

   d. We will continue to identify strategies to improve compliance in Mandatory Training and to deliver further increases in attendance rates.

   e. The Trust will further develop our training of senior managers and clinicians.

Conclusions

1. As a result of this workforce analyses, the Trust can be satisfied that there are no significant areas of concern which are unique to this organisation, although there are a number of issues which continue to be raised which require further understanding and investigation and/ or specific action to address.

Recommendation

The Board is asked to:

1. Note the details of the Annual Workforce Report.
2. Note the actions which are being taken to maximise the effectiveness of the workforce.
3. Highlight any specific additional assurance / workforce information required.

Wirral University Teaching Hospital

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Board of Directors	
Agenda Item	8.3
Title of Report	CQC – Trust-wide Action Plan update
Date of Meeting	25.5.16
Author	Joe Roberts, Head of Assurance
Accountable Executive	Dr Evan Moore, Medical Director
BAF References	Strategic Objective 7 - Supported by financial, commercial and operational expertise Key Measure 7a - Fully comply with our registration with the Care Quality Commission
Level of Assurance	Positive
Purpose of the Paper	To note
Data Quality Rating	Bronze
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken	Not applicable

1. Executive Summary

This is an updated version of the CQC Action Plan, to show progress at mid-May 2016.

2. Background

In April 2016 the Senior Management Team approved the action plan, based on the results of the September inspection, to be submitted to the Care Quality Commission. The action plan is designed to address those issues which made us non-compliant with the CQC Regulations in the Health and Social Care Act (also known as the 'Fundamental Standards'). Therefore it does not cover every issue which was mentioned in the report, just those which are of the highest priority. Other issues are covered by divisional action plans.

A routine engagement meeting was held on Thursday 19th May involving representatives of CQC and of our Trust, and the progress of the action plan was one of the main issues for discussion.

3. Key Issues

The action plan has been RAG-rated according to the status completion of the actions. It includes 82 actions in total, of which 31 are not yet due (these are shown as 'grey' in the

attached document). This means that there are 50 actions which should be complete by now. Of these, 42 have been completed and are shown as green.

The remaining actions are shown as amber. These actions are progressing although they were not complete by their original deadlines, which were mainly the beginning of May. It is expected that these actions will be done by the end of May, or June at the latest. Commentary is provided within the action plan for these items. No actions are shown in red in the action plan as there has been progress with all of them.

For completed actions, the attached document also states what evidence we have that we have done the actions, for example copies of revised policies, meeting minutes etc. These documents are held in a portfolio on our shared network drive so that they are ready for inspection by CQC. We are still in the process of obtaining evidence documents for a small number of actions. Some actions relate, for example, to meetings which do not have formal agendas or minutes; in these cases we have had to obtain e-mail confirmation from the department concerned that the issue was discussed.

CQC made clear at the engagement meeting that they expected us to make more rapid progress in respect of End of Life Care – particularly individual care plans, which are being implemented on a pilot basis before going Trust-wide in November. In response to this feedback we will be accelerating this programme and a meeting is scheduled on Monday 23rd May involving senior nurses and Palliative Care Consultants in order to make this happen.

4. Next Steps

The next steps is to ensure that all the remaining actions are implemented and maintained in full. We will need to be ready to provide CQC with documentary evidence that we have done what we said we would do. Where actions have been delayed, these should be completed by late June at the latest.

Some actions involve awareness raising or changes to policy – it is important that this results in changes to practice and improvements in service quality. This will be monitored through audit and the Care Quality Inspection programme.

We also intend to merge this action plan (which includes 'must do' and 'should do' actions) with the more aspirational divisional action plans which are aimed at moving us from 'requires improvement' to a 'good' rating.

5. Conclusion

Although some deadlines have not been met, we are making progress with the action plan and envisage that we should be able to implement all the actions in full.

6. Recommendation

The Board is asked to note progress with the action plan.

Issue	Action	Responsible Person	Due Date	Completed Date	Comments	Status	Evidence
REGULATION 11 - CONSENT							
Mental Capacity Act Training The section of the CQC inspection report relating to the 'Medical Care' core service	Implement plan to improve compliance with Mental Capacity Act training across all clinical staff groups in the division from 27.5% to 90% for Level 2, and from 16.8% to 90% for Level 3 within 12 months, prioritising high risk areas.	Dr Ranjeev Mehra – Divisional Medical Director, Acute and Medical Specialties; Julie Reid – Associate Director of Nursing; Amanda Farrell – Divisional Director of Operations	30.9.16 (50% compliance) 30.4.17 (90% compliance)		*The most recent performance statistics (April) show that this is improving and current compliance is as follows:* *Level 1 – 93.01%* *Level 2 – 49.91%* *Level 3 – 20.69%*	*Grey*	*Statistics provided by Learning and Development from OLM Database*
Bed Rails Assessments In their inspection report, CQC observed that the bed rails assessment did not include the recording of consent to the use of bedrails or best interest decisions for patients who lacked capacity to consent. There is a risk that patients and/or their loved ones might not be fully aware of the need for bed rails and this could cause distress. Bed rails may be used inappropriately so possibly depriving an individual of their liberty or increasing the risk of falls from height.	Amend electronic bed rails assessment to ensure capture consent/best interest decisions consistently	Margaret Davies – Dementia Matron	13.4.16	13.4.16		*Green*	*Screen shots from Millennium system*
	Update Falls Prevention Policy to reflect changes to electronic bed rails assessment	Margaret Davies	30.4.16	13.5.16	*The policy has been updated and has gone live on the intranet.*	*Green*	*Revised policy on intranet*
REGULATION 12 – SAFE CARE & TREATMENT							

Issue	Action	Responsible Person	Due Date	Completed Date	Comments	Status	Evidence
Emergency Department – Call Bells CQC judged that the emergency department did not include arrangements to respond appropriately and in good time to people's changing needs. This is because they found that call bells were either out of reach of patients, or not installed at the bed side of patients in the 'trolleys' area of the emergency department.	Install call bells in every area and check as part of patient rounding 2 hourly each day	Helen Morris – Emergency Department Matron	30.9.15	30.9.15	*These actions have been completed although when the department was recently visited two buzzers had been removed for valid clinical reasons but could not be immediately reconnected.*	*Green*	*Observation by Q&S staff; Emergency Department Matron's Audit results; Copy of Patient Rounding pro forma*
Resuscitation Trolleys – Paediatrics CQC judged that we were not doing all that was reasonably practicable to mitigate the risks to service users. This is because a resuscitation trolley on a paediatric ward was not checked regularly and it contained out of date equipment and there was no defibrillator present.	Immediate communication to all staff regarding mandatory obligation to check resuscitation trollies	Pauline Riding – Children's Services Matron	30.9.15	30.9.15	*This was disseminated through handover and care improvement meetings*	*Green*	*E-mail confirmation provided; these meetings are not minuted*
	Replace the respiratory arrest trolley with emergency grab bags at each nurse base. These will have with clear signage to the defibrillator. These will have a seal in place; the seal will be broken on these monthly and equipment checked within, then they will be resealed.		1.5.16	1.5.16	*The grab bags are now in situ and signage regarding location of the defibrillator in place; support from the Resus Team.*	*Green*	*Observation by Quality and Safety staff*
	Develop a Standard Operating Procedure for the use and checking of the grab bags		1.5.16		*This is currently in draft – advice is being obtained from the Resuscitation Team.*	*Amber*	*Copy of draft guidance*
	Communicate new arrangements as follows: cascade at the ward meeting, the weekly care improvement meeting (it will be message of the week); and handovers (medical & nursing). Also, post information on the staff notice board and at each of the nurse bases.		1.5.16	1.5.16	*Staff awareness has been raised*	*Green*	*No documentary evidence for handover / care improvement meetings as these do not have formal minutes and agendas*
Diagnostic Test Results CQC found that there were lengthy delays in the reporting of urgent diagnostic test	Undertake an analysis of capacity and demand for the service	Dr Nitin Rao – Consultant Radiologist;	31.3.16	31.3.16		*Green*	*Copy of report and supporting data*

Issue	Action	Responsible Person	Due Date	Completed Date	Comments	Status	Evidence
results.	Implement mitigating measures in the meantime, including: contract out scans and plain imaging examinations; use an external agency to report plain films on site; Consultants to undertake extra sessions to meet reporting demand.	Pam Black – Radiology Services Manager	31.3.16	31.3.16		*Green*	*Spreadsheets showing number of additional Consultant sessions by month; number and cost of outsourced scans*
	Undertake review of MR reporting and develop action plan based on the findings; develop work plan for Consultant Radiologists		30.6.16	30.6.16		*Grey*	
	Develop and expand Radiology reporting and activity dashboard, covering, for example: access times; turnaround times for all referrals broken down into inpatients / outpatients / direct access / cancer referrals / urgent examinations; Do Not Attends, cancellations; equipment downtime; sickness; maternity leave; and vacancies.		30.6.16	30.6.16		*Grey*	
	Implement action plan based on capacity and demand review		31.3.17	31.3.17		*Grey*	
Infection Prevention and Control CQC found that care and treatment was not always carried out assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated. This is because not all staff in critical care were washing their hands or using antiseptic hand gel as appropriate when delivering patient care or moving from one patient or their bed space to the next.	Increased visibility of the Infection Prevention and Control Team (IPCT) in Critical Care – a member of the team to visit the unit daily to observe practices and to provide 'on the spot' education sessions	Andrea Ledgerton – Associate Director of Infection Prevention and Control	31.12.15	31.12.15		*Green*	*Verbal confirmation that members of IPCT have visited*
	Introduce monthly infection control walkabouts with the Critical Care Team, including the unit manager, matron, IPC Ambassador, and medical IPC lead		3.2.16	3.2.16		*Green*	*Verbal and e-mail confirmation of walkarounds taking place – *awaiting documentation**

Issue	Action	Responsible Person	Due Date	Completed Date	Comments	Status	Evidence
	Facilitate IPC education sessions for Clinical Support Workers in Critical Care		1.2.16		*Two sessions held in January and February. A third and final session will be held in June.*	*Green*	*Programmes for training days and attendance records*
	Support the Clinical Educators for Critical Care to develop and introduce an induction pack for new starters (nursing and medical) relating to IPC to include hand hygiene		30.4.16	30.4.16	*The IPCT have contributed content to the induction pack. However, the induction pack as a whole is still under development in Critical Care.*	*Amber*	*Draft new starter checklist*
	Support the Clinical Educators for Critical Care to lead the introduction of a programme to ensure all staff have had an annual hand hygiene competency assessment		30.4.16		*This commenced in late April. 30 members of staff have taken part during the last three weeks.*	*Green*	*Attendance records held by Critical Care Department*
	Recruit a Matron solely to manage Critical Care - this will support local ownership and closer supervision of infection control in Critical Care		30.4.16		*This has been slightly delayed – interviews took place two weeks later than planned, on 13.5.16*	*Amber*	*E-mail update from Divisional ADN*
Emergency Transfers from Clatterbridge to APH CQC judged that we did not have arrangements to take appropriate action if there was a clinical or medical emergency. This is because there wasn't a standard process or procedure in place in the event that a patient deteriorated and required transfer from Clatterbridge Hospital to an Acute hospital.	Establish group to review process for transfers, including the staff involved in transferring patients from Clatterbridge and Arrowe Park	Dr Melanie Maxwell – Associate Medical Director	30.9.15	30.9.15		*Green*	*Action notes from meetings and subsequent e-mail correspondence*
	Draft and approve a Standard Operating Procedure for such transfers		14.4.16	14.4.16	*This has been added to the Trust intranet. It covers deteriorating patients, the critically ill, and failed day cases.*	*Green*	*Guideline available on intranet*
	Implement and monitor the SOP		30.5.16		*Work is in progress at present. The number of patients transferred from CBH to APH in an emergency is low, which makes it difficult to identify common issues and trends.*	*Grey*	
	Audit the Standard Operating Procedure		30.11.16			*Grey*	

Issue	Action	Responsible Person	Due Date	Completed Date	Comments	Status	Evidence
REGULATION 13 - SAFEGUARDING							
Safeguarding Training CQC judged that safeguarding children's training was not provided in line with best practice guidance. This is because children's safeguarding training did not meet Royal College of Paediatric & Child Health (RCPCH) guidelines 2014.	Complete gap analysis for existing draft training strategy against Safeguarding children and young people: roles and competencies for Staff (PRCH 2014)	Sue Fogarty – Head of Safeguarding	29.2.16	29.2.16		*Green*	*Copy of gap analysis*
	Hold initial meeting with Learning & Development Department to amend draft training strategy and further develop training needs analysis to scope various methods of delivering training, i.e. blended/face to face/e-learning		29.2.16	29.2.16		*Green*	*Notes from meetings*
	Introduce "PREVENT" module into the current training (additional one hour)		30.4.16	14.4.16	*We use a standard presentation devised by the Home Office for use by the NHS*	*Green*	*Copy of training presentation*
	Complete further gap analysis against the Safeguarding Adults: Roles and competences for health care staff – Intercollegiate Document published by NHS England 2016		31.5.16	31.5.16	*We have reviewed the intercollegiate document and identified that we need to reinforce Level 1 and Level 2 Safeguarding training.*	*Grey*	
	Complete training needs analysis and implement new training strategy to ensure staff attain the competencies relevant to each role and follow subsequent guidance.		31.5.16	31.5.16	*The Safeguarding Team have been meeting regularly with the Learning and Development Team to develop a plan which includes training days and blended learning (a mix of e-learning and face-to-face teaching).*	*Grey*	*Notes from meetings*
	Through training plan, prioritise training in high risk areas such as care of the elderly		1.12.16			*Grey*	

Issue	Action	Responsible Person	Due Date	Completed Date	Comments	Status	Evidence
	Scope with Electronic Staff Record (ESR2) developing e-learning for both Level 1 and Level 2 training, following consultation with the Designated Nurses been on the use of NHS England e-Learning safeguarding level 1 & 2 for use with in WUTH, to ensure requirements met for competencies as specific in both intercollegiate documents		1.12.16			*Grey*	
	Implement E-Learning pathway		1.12.16			*Grey*	
REGULATION 15 – PREMISES & EQUIPMENT							
Ward Security CQC were concerned that access to, and exits from, a ward (M1 Clatterbridge) were not appropriately secure. This is because the security arrangements presented a risk that patients may leave and visitors may enter unnoticed.	Fit an electromechanical lock and link to fire alarm system	Gary Lewis, Associate Director of Estates	22.4.16	19.4.16		*Green*	*E-mail update from Maintenance Manager*
	Sister of the ward concerned to check security as part of her daily checks, and ensure that the door is not left open.	Helen Donaldson, Ward Sister	22.4.16	19.4.16	*This should not be necessary now that a lock is in place*	*Green*	*Action now superseded*
REGULATION 16 - COMPLAINTS							
End of Life Care Complaints CQC judged that we did not operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to end of life care	Introduce a category into the Safeguard system to highlight "end of life" complaints and incidents	Risk Information Team	31.12.15	31.12.15		*Green*	*Screen shot from Safeguard database*
	Review the terms of reference of the Palliative Care & End of Life Team meeting to include standing agenda items relating to: incidents reported within WUTH; incidents reported in Wirral Community NHS Trust relevant to WUTH; and complaints reported within WUTH, for review	Dr Melanie Maxwell – Associate Medical Director	29.2.16	29.2.16		*Green*	*Copy of Terms of Reference - *document awaited**
	Bereavement Office team to meet with Coroner; Coroner to address a meeting of Trust staff for a Q&A session	Marsha Parton-Murphy – Bereavement Office Manager	14.4.16	14.4.16		*Green*	*Copy of 'Start the Week' newsletter including item about the Coroner's visit*

Issue	Action	Responsible Person	Due Date	Completed Date	Comments	Status	Evidence
	All complaints and incidents relating to end of life care to be reviewed by the Clinical Lead for Palliative & End of Life Care (alongside standard complaints procedure and governance processes within the clinical divisions), allowing the generation of key themes to inform future training and service development across the organisation	Dr Catherine Hayle – Clinical Lead for Palliative and End of Life Care	31.5.16		*The Risk Information Team are collating this information. However, there has only been one case relating to end of life care in the first two months of the financial year so there has been little to review so far.*	*Grey*	
Death Certification CQC were concerned that complaints were raised in relation to the timely completion of death certificates but the trust had not taken any action to address this at the time of the inspection.	Review and update Trust policy on Death Certification	Jan Eccleston – Associate Director of Risk	31.10.15	31.10.15		*Green*	*Revised policy on intranet*
	Complete a survey of junior doctors to understand their perspective on why death certificates are not completed in a timely fashion	Dr Melanie Maxwell	31.3.16	31.3.16	*This was completed online using 'Survey Monkey'.*	*Green*	*Report from Survey Monkey showing results*
	Undertake a quality improvement project based on the findings of this survey, including a further amendment to the policy.		30.9.16			*Grey*	
REGULATION 17 – GOOD GOVERNANCE							
Risk Registers CQC were concerned that, although all departments had a risk register, the risks were not always managed and mitigated in a timely way.	Hold Patient Safety Week events to highlight the following areas to staff and visitors: incident Reporting; serious incidents and never events; Duty of Candour; safe clinical handover; record keeping and documentation	Jan Eccleston – Associate Director of Risk	18.3.16	18.3.16		*Green*	*Copy of programme for Patient Safety Week and information materials used*
	Review and propose new draft version of the Risk Management Strategy		31.3.16	1.4.16		*Green*	*Copy of draft strategy*
	Deliver focussed training to the staff in Critical Care, to ensure they fully understand the risk processes.		31.5.16		*One of these sessions has taken place so far with a further two booked in.*	*Grey*	*Diary entries for member of staff delivering the training*
	Approve revised Risk Management Strategy and go live		31.7.16			*Grey*	
	Complete full risk register review to 'cleanse' the register of old, mitigated or inappropriate risks		30.9.16			*Grey*	

Issue	Action	Responsible Person	Due Date	Completed Date	Comments	Status	Evidence
Critical Care Transfer Equipment CQC were concerned that the patient transfer equipment in Critical Care did not meet the current Intensive Care Society standards for the transport of critically ill adults.	Seek clarification from the regional Critical Care network with regard to transfer equipment (we have been advised that by having equipment positioned next to the baulk head is in line with current guidance).	Dr Tom Williams – Consultant Anaesthetist	31.3.16	31.3.16	*We are also in discussion with North West Ambulance Service. We have undertaken the actions which we can do and are dependent on their agreement.*	*Green*	*Minutes of meeting of Critical Care Joint Transfer Group, May 2016*
Records Storage CQC were concerned that records were not always secure, accurate or completed fully. This is because record trolleys were left unlocked on some of the medical wards which they visited.	Complete an information governance risk assessment of case notes storage on the wards and an option appraisal for consideration by the Information Governance Group	Mark Blakeman – Director of Infrastructure and Informatics	30.6.16		*We have identified a suitable type of trolley, costing approximately £400 each. We are establishing how many will be needed and are discussing a proposed Standard Operating Procedure for case note storage with Ward Sisters.*	*Grey*	
	Finalise plans to move to fully electronic case notes (i.e. including medical notes)		31.3.17			*Grey*	
Record-keeping in the Emergency Department CQC reviewed a sample of 23 patient records in the emergency department and found that 19 were not fully completed. For example, pain scores were missing in six records, initial observations were missing in three records and information relating to safeguarding and social circumstances was not recorded in five records.	Complete regular casenote and CAS card audits and report to divisional and specialty governance meetings	Dr Tim Bentham – Clinical Governance Lead, Acute Care	31.3.16	31.3.16		*Green*	*Audit plan showing record keeping audits scheduled for this year* **Copies of audit reports awaited**
Maternity – Completeness of Records CQC judged that the electronic record keeping system in maternity did not ensure records were always complete and contemporaneous in respect of each service user	Local mandatory training to include a session on documentation	Mr Mike Ellard – Consultant Donna Lloyd Jones – Divisional Quality and	30.4.16	30.4.16	*This has been slightly delayed but is included in the programme for the mandatory training day on 27th May.*	*Amber*	*Agenda for the training day is not yet available – will be circulated closer to the date*

Issue	Action	Responsible Person	Due Date	Completed Date	Comments	Status	Evidence
	Supervisors of Midwives are to plan to audit notes monthly with summary of findings to Clinical Governance team	Safety Manager, Women's and Children's Services			*It has been agreed that we will use the trust medical record keeping audit tool – 5 cases will be done at the mandatory training day. These tools are in a scannable format so once completed will be submitted to Trust and the results will be shown in the monthly trust audit report that is presented at Trustwide Clinical Governance Team.*	*Amber*	*Copy of audit tool which is being used*
End of Life Care – Assessing and Monitoring CQC judged that we did not collect and analyse all available information in end of life care to support improvements in clinical and operational practice.	Develop an EoL dashboard to monitor the service	Dr Catherine Hayle – Clinical Lead for End of Life Care Dr Melanie Maxwell – Associate Medical Director Claire Pratt – Deputy Chief Nurse	31.3.16	31.3.16		*Green*	*Examples of dashboard reports*
	Participate in the Care of the Dying Evaluation (CODE) project: Quality Assurance for Care of the Dying, Cheshire & Merseyside Strategic Clinical Network (a questionnaire survey of bereaved caregivers regarding their experiences of care and support provided in the Trust during the last days of their relative's life)		30.11.15	30.11.15		*Green*	*Report summarising the Trust's results in the project*
	Analyse the CODE report and generate an action plan, to be implemented by members of the WUTH Palliative & End of Life Team (PEOLT) during April 2016		1.5.16		*This has been slightly delayed – the team have reviewed the report and are meeting during the week commencing 16.5.16 to draft and agree actions. The actions are being incorporated into the CQC Action Plan for End of Life Care.*	*Amber*	

Issue	Action	Responsible Person	Due Date	Completed Date	Comments	Status	Evidence
	Introduce a bereavement survey to capture ongoing experience		1.5.16		*This has been delayed as we needed to identify a suitable survey to use. We now intend to use the West Hertfordshire questionnaire after this has been formally agreed by PEOLT in June.*	*Amber*	
	Analyse the report of the National Care of the Dying Audit for 2016; develop an action plan and disseminate across the Trust		1.5.16		*Because of the large number of detailed recommendations in the report, this has taken longer than expected but should be complete by the end of May*	*Amber*	
Medical Care – Assessing and Monitoring CQC judged that we did not collect and analyse all available information in medical care to support improvements in clinical and operational practice.	Refresh ward dashboards after consulting with ward staff	Dr Ranjeev Mehra – Divisional Medical Director Amanda Farrell – Divisional Director of Operations Julie Reid – Associate Director of Nursing	31.1.16	31.1.16		*Green*	*Example of revised dashboards (Microsoft Excel workbook)*
	Develop individual governance / quality dashboards for each ward		31.5.16	31.5.16		*Grey*	
	Introduce a structured approach to capturing actions agreed within the Divisional Governance meetings to provide assurance that these are implemented					*Grey*	
Maternity – Staffing CQC were concerned that there were insufficient systems or processes established and operated in maternity to effectively ensure a robust response by staff to the guidance provided and action required to mitigate risks. This was because of ineffective staff rostering, staffing escalation process.	Template roster to be reviewed by E-roster team	Debbie Edwards – Head of Midwifery	31.3.16	31.3.16		*Green*	*E-mail confirmation that team have reviewed reports*
	Template report to be rebuilt in the E-roster system		31.5.16		*The rosters are being rebuilt although there is a risk that this work could be delayed due to staffing pressures in the E-Roster team*	*Grey*	
	Update maternity staffing policy		30.11.15	30.11.15		*Green*	*Copy of policy*

Issue	Action	Responsible Person	Due Date	Completed Date	Comments	Status	Evidence
	Review and update maternity escalation policy		30.11.15	30.11.15		*Green*	*Copy of policy*
	Train senior midwives to support them in the implementation of escalation plans		31.5.16	30.3.16	*This has taken the form of one to one meetings with the Head of Midwifery rather than a formal training programme*	*Green*	*Not documented as not a formal training programme, but Head of Midwifery's diary entries available to confirm meetings*
Women's and Children's – Learning from Incidents CQC were concerned that there was insufficient implementation of changes in best practice guidance from lessons learnt from incidents or root cause analysis.	Complete Cultural Review of the maternity service and draft action plan	Mr Mike Ellard – Clinical Service Lead, Obstetrics and Gynaecology Dr Adrian Hughes – Consultant Paediatrician and Governance Lead for Children's Services Donna Lloyd-Jones –Quality and Safety Manager for Women's and Children's Services	1.4.16	1.4.16	*Actions in the plan are due by the end of June at the latest*	*Green*	*Copy of action plan showing current status of actions*
	Review the current Clinical Governance structure in the Women's and Children's division		31.5.16	31.5.16		*Grey*	

Issue	Action	Responsible Person	Due Date	Completed Date	Comments	Status	Evidence
Community Midwives' Equipment CQC were concerned that community midwives did not have easy access to emergency medication and equipment detailed in best practice guidance. The equipment must be checked and items provided within the use by date.	Benchmark current practice against best practice	Debbie Edwards Cathie Kelly – Matron	30.4.16	30.4.16	*We have reviewed the equipment in use and decided that all Midwives will be allocated standardised delivery equipment and medication*	*Green*	
	Develop Standard Operating Procedure for checking and maintenance of equipment – this should ensure community Midwives use only the "Born Before Arrival" (BBA) bags provided and this will include agreed medication (under discussion with pharmacy)		30.4.16		*A programme of assurance checks is being developed but this will not be fully implemented until late June.*	*Amber*	
REGULATION 18 – STAFFING							
Staffing Levels – Trustwide Actions CQC were concerned that there was not a systematic approach to determining the staff and range of skills required. There were not always sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet the needs of the patients. There were shortages of nurses, midwives and medical staff in several areas throughout both hospitals, particularly in the emergency department, maternity, medical care services, children and young people services, surgical services and radiology.	Deliver Year 2 of Workforce & Organisational Development Strategy	James Mawrey – Director of Workforce	31.3.17			*Grey*	
	Make further refinements to the dashboard to include Medical Workforce metrics in addition to Nurse metrics		31.5.16	11.5.16	*The workforce dashboard as reported to various committees, including the Quality and Safety committee, has now been amended to include detailed Medical Workforce metrics including month by month establishment data, consultant vacancy rates and the status of on-going senior medical staff recruitment.*	*Green*	*Recent example of Workforce Dashboard*

Issue	Action	Responsible Person	Due Date	Completed Date	Comments	Status	Evidence
	Continue to monitor Nursing & AHP key metrics on monthly basis to ensure all actions being taken (local, regional, national, return to practice, grow your own, new ways of working e.g. Associate Physician role), and with support from Health Education North West, appoint a recruitment and retention facilitator to focus upon nursing workforce		31.5.16	11.5.16		*Grey*	
	Agree enhanced key performance indicators with NHS Professionals via the Service level agreement meetings		31.5.16		*There has been discussion with NHSP and we have informally agreed a set of indicators; these will be finalised at the next meeting before the end of May.*	*Grey*	
	Develop a Medical Workforce Strategy to complement the Workforce & Operational Development Strategy		31.5.16			*Grey*	
	Deliver the Nurse Revalidation programme (the work programme of the Clinical Excellence Team has been re-prioritised to place more focus on revalidation).		31.5.16	11.5.16	*The programme was delivered and a plan is in place for 2016/17. In April we achieved 100% compliance for those registered and required to revalidate.*	*Green*	*Copy of performance report to Workforce & Communication Group (most recent report not yet available)*
Children's Services CQC were concerned that the systems to determine staffing levels in children's and young people's services were not robust.	Make contact with Children's Network regional leads regarding the acuity tools which they use to determine staffing levels; attend national workshop on staffing for children's inpatient areas	Pauline Riding – Children's Services Matron	31.3.16	31.3.16		*Grey*	
	Commence an acuity audit, using the SCAMPS audit tool		30.4.16	30.4.16	*The audit has commenced and is still underway in mid-May*	*Green*	*Copy of audit questionnaire being used*

Issue	Action	Responsible Person	Due Date	Completed Date	Comments	Status	Evidence
	Develop an action plan based on the results of the SCAMPS audit, when it is complete		31.7.16	31.7.16		*Grey*	
Theatre Recovery CQC found that there was an insufficient number of staff in theatre recovery with training in paediatric life support despite regularly caring for children.	Scope training availability of Paediatric Life Support (PLS) for recovery staff	Lilian Rimmington – Theatres Matron Jan Poynton – Recovery Co-ordinator	1.4.16	1.4.16		*Green*	*Division confirmed that they had identified suitable training*
	Review of recovery nursing establishment versus demand		31.12.16	31.12.16		*Grey*	
	Review recovery practitioner job descriptions					*Grey*	
	Establish an escalation policy for recovery staffing					*Grey*	
	Train all band 6 recovery nurses to ensure at least one PILs trained nurse on each shift					*Grey*	

Trust Board	
Agenda Item	9.1
Title of Report	Financial Accounts and Letter of Representation 2015/16
Date of Meeting	25 May 2016
Author	Deborah Harman Assistant Director of Finance – Financial Services
Accountable Executive	Gareth Lawrence Acting Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	7
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Approval
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

The Trust is required under the National Health Service Act 2006 to prepare, in respect of each financial year, annual accounts which comply with any directions given by the regulator (Monitor for 2015/16), with the approval of HM Treasury.

The Trust is also required annually to present a letter of management representation to the external auditor. In this letter, management state that the financial statements are, to its knowledge, correct and compliant, and the letter can be relied upon by the auditor in any areas where other types of audit evidence were not available or sufficient.

The purpose of this paper is to present the 2015/16 letter of representation and annual accounts to the Trust Board for approval.

2. Letter of representation

The draft letter of representation on the financial statements is included in Appendix 1. The composition of the letter follows a set format, and the required content is guided by Grant Thornton UK LLP, as it needs to satisfy the external auditor's requirement. The Chief Executive Officer and the Acting Director of Finance are the signatories required by the auditor.

3. Annual accounts

Draft annual accounts and foundation trust consolidation (FTC) schedules were submitted to Monitor / NHS Improvement on 22 April 2016. Copies were provided to the Trust's external auditor, Grant Thornton UK LLP.

The accounts are prepared under international financial reporting standards (IFRSs) and specific financial accounting guidance relevant to foundation trusts. For these reasons, the accounts and FTCs are presented differently from the Trust's month 12 financial return to Monitor / NHS Improvement, which is a budget monitoring return.

The draft accounts have been sent to members under separate cover.

4. 2015/16 accounts headlines

The Acting Director of Finance will present key messages from the Trust's annual accounts.

5. Conclusion

The draft annual accounts have been prepared in accordance with IFRSs and sector-specific accounting guidance. Grant Thornton UK LLP is currently in the process of completing audit processes and is presenting an ISA 260 report of summary findings to this Board.

The Audit Committee meeting of 19 May 2016 has recommended to the Board approval of the letter of representation and the accounts.

Subject to anticipated minor adjustments for Agreement of Balances, the final accounts will be submitted to Monitor / NHS Improvement on 27 May 2016 within the Trust's Annual Report and Accounts 2015/16.

5. Recommendation

The Trust Board is asked to accept and approve the 2015/16 letter of representation and annual accounts.

Deborah Harman

Assistant Director of Finance – Financial Services
April 2016

Grant Thornton UK LLP
Royal Liver Building

Liverpool

L3 1PS

25 May 2016

Dear Sirs

Wirral University Teaching Hospital NHS Foundation Trust

Financial Statements for the year ended 31 March 2016

This representation letter is provided in connection with the audit of the financial statements of **Wirral University Teaching Hospital NHS Foundation Trust** for the year ended 31 March 2016 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view in accordance with International Financial Reporting Standards and the NHS Foundation Trust Annual Reporting Manual (the ARM) issued by Monitor, the Independent Regulator of NHS Foundation Trusts.

We confirm that to the best of our knowledge and belief having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

Financial Statements

i As Trust Board members we have fulfilled our responsibilities under the National Health Services Act 2006 for the preparation of the financial statements in accordance with the ARM and International Financial Reporting Standards which give a true and fair view in accordance therewith.

ii We have complied with the requirements of all statutory directions affecting the Trust and these matters have been appropriately reflected and disclosed in the financial statements.

iii The Trust has complied with all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance. There has been no non-

compliance with requirements of the Care Quality Commission or other regulatory authorities that could have a material effect on the financial statements in the event of non-compliance.

iv We acknowledge our responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud.

v Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.

vi We are satisfied that the material judgements used in the preparation of the financial statements are soundly based, in accordance with International Financial Reporting Standards and the ARM, and adequately disclosed in the financial statements. There are no other material judgements that need to be disclosed.

vii Except as disclosed in the financial statements:

a there are no unrecorded liabilities, actual or contingent
b none of the assets of the Trust has been assigned, pledged or mortgaged
c there are no material prior year charges or credits, nor exceptional or non-recurring items requiring separate disclosure.

viii Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of International Financial Reporting Standards and the ARM.

ix All events subsequent to the date of the financial statements and for which International Financial Reporting Standards and the ARM requires adjustment or disclosure have been adjusted or disclosed.

x The financial statements are free of material misstatements, including omissions.

xi In calculating the amount of income to be recognised in the accounts from other NHS organisations we have applied judgement, where appropriate, to reflect the appropriate amount of income expected to be received by the Trust in accordance with the International Financial Reporting Standards and the ARM.

xii Actual or possible litigation and claims have been accounted for and disclosed in accordance with the requirements of International Financial Reporting Standards and the ARM.

xiii We acknowledge our responsibility to participate in the Department of Health's agreement of balances exercise and have followed the requisite guidance and directions to do so. We are satisfied that the balances calculated for the Trust ensure the financial statements and consolidation schedules are free from material misstatement, including the impact of any disagreements.

xiv We have no plans or intentions that may materially alter the carrying value or classification of assets and liabilities reflected in the financial statements.

Information Provided

xv We have provided you with:

a. access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;
b. additional information that you have requested from us for the purpose of your audit; and
c. unrestricted access to persons within the Trust from whom you determined it necessary to obtain audit evidence.

xvi We have communicated to you all deficiencies in internal control of which management is aware.

xvii All transactions have been recorded in the accounting records and are reflected in the financial statements.

xviii We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

xix We have disclosed to you all our knowledge of fraud or suspected fraud affecting the Trust and involving:

a. management;
b. employees who have significant roles in internal control; or
c. others where the fraud could have a material effect on the financial statements.

xx We have disclosed to you all our knowledge of any allegations of fraud, or suspected fraud, affecting the Trust's financial statements communicated by employees, former employees, regulators or others.

xxi We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing financial statements.

xxii We have disclosed to you the identity of all of the Trust's related parties and all the related party relationships and transactions of which we are aware.

xxiii We have disclosed to you all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

Annual Report

xxiv The disclosures within the Annual Report fairly reflect our understanding of the Trust's financial and operating performance over the period covered by the financial statements.

Annual Governance Statement

xxv We are satisfied that the Annual Governance Statement (AGS) fairly reflects the Trust's risk assurance framework and we confirm that we are not aware of any significant risks that are not disclosed within the AGS.

Approval

The approval of this letter of representation was minuted by the Trust's Board at its meeting on 25 May 2016.

Yours faithfully

Name……

Position…….

Date……..

Name……

Position…….

Date……..

Signed on behalf of the Board

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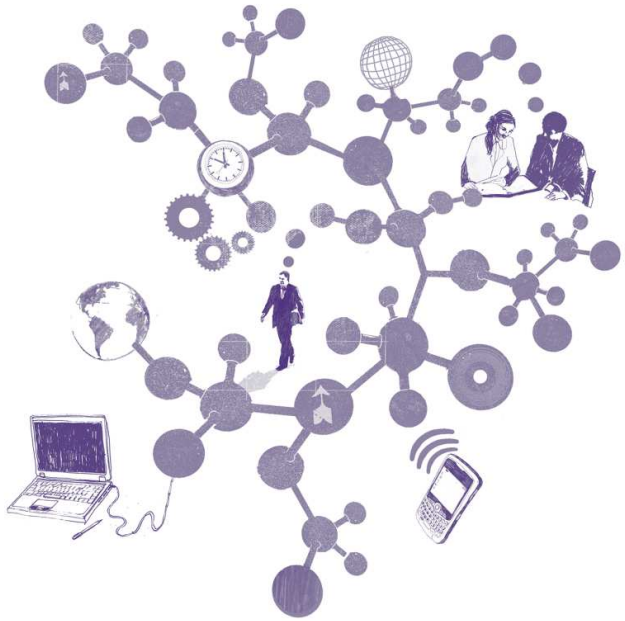
This version of the report is a draft. Its contents and subject matter remain under review and its contents may change and be expanded as part of the finalisation of the report.

The Audit Findings for Wirral University Teaching Hospital NHS Foundation Trust

Year ended 31 March 2016

13 May 2016



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13th May 2016

Dear Members of the Audit Committee

Audit Findings for Wirral University Teaching Hospital NHS Foundation Trust for the year ending 31 March 2016

This Audit Findings report highlights the significant findings arising from the audit for the benefit of those charged with governance, as required by International Standard on Auditing (UK & Ireland) 260, the National Health Service (NHS) Act 2006 and the National Audit Office Code of Audit Practice. Its contents have been discussed with management.

As auditors we are responsible for performing the audit, in accordance with International Standards on Auditing (UK & Ireland), which is directed towards forming and expressing an opinion on the financial statements that have been prepared by management with the oversight of those charged with governance. The audit of the financial statements does not relieve management or those charged with governance of their responsibilities for the preparation of the financial statements.

The contents of this report relate only to those matters which came to our attention during the conduct of our normal audit procedures which are designed primarily for the purpose of expressing our opinion on the financial statements. Our audit is not designed to test all internal controls or identify all areas of control weakness. However, where, as part of our testing, we identify any control weaknesses, we will report these to you. In consequence, our work cannot be relied upon to disclose defalcations or other irregularities, or to include all possible improvements in internal control that a more extensive special examination might identify. We do not accept any responsibility for any loss occasioned to any third party acting, or refraining from acting on the basis of the content of this report, as this report was not prepared for, nor intended for, any other purpose.

We would like to take this opportunity to record our appreciation for the kind assistance provided by the finance team and other staff during our audit.

Yours sincerely

Karen Murray

Engagement Lead

Contents

Section 1: Executive summary

Purpose of this report

This report highlights the key issues affecting the results of Wirral University Teaching Hospital NHS Foundation Trust ('the Trust') and the preparation of the Trust's financial statements for the year ended 31 March 2016. It is also used to report our audit findings to management and those charged with governance in accordance with the requirements of International Standard on Auditing (UK & Ireland) 260, and the National Health Service Act 2006 ('the Act').

Under legislation the Comptroller and Auditor General (C&AG) has a duty to prepare a code of audit practice prescribing the way in which auditors of public authorities are to required to carry out their audit functions. This Code of Audit Practice ('the Code') is prepared by the National Audit Office (NAO) on behalf of the C&AG. Section 10 of Schedule 6 of the Local Audit and Accountability Act 2014 mandates the application of this Code to Foundation Trust audits from 2015/16 onwards.

Under the Code we are required to report whether, in our opinion, the Trust's financial statements give a true and fair view of the financial position of the Trust and its income and expenditure. We are also required to give an opinion on some elements of the Remuneration report and some elements of the Staff Report. We are required to consider other information published together with the audited financial statements, whether it is consistent with the financial statements, apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit; or otherwise misleading and in line with required guidance.

We are required to carry out sufficient work to satisfy ourselves on whether the Trust has made proper arrangements to secure economy, efficiency and effectiveness in its use of resources ('the value for money (VFM) conclusion'). Auditor Guidance Note 7 (AGN07) clarifies our reporting requirements in the Code and the Act so that if we are not satisfied then we are required to report by exception.

The Act also details the following powers and duties for Foundation Trust auditors, which we are required to report to you if applied:

- a referral to the regulator if we have reason to believe that the Trust or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure. (section 7 of schedule 10 of the Act);
- a public interest report if we identify any matter that comes to our attention in the course of the audit that in our opinion should be considered by the Trust or brought to the public's attention (section 3 of schedule 10 of the Act).

In addition to our responsibilities under the Code we are also required to carry out a limited assurance engagement on the Trust's Quality Report in accordance with the requirements of ISAE 3000 (Revised), Assurance Engagements Other than Audits or Reviews of Historical Financial Information.

Introduction

In the conduct of our audit we have not had to alter or change our audit approach, which we communicated to you in our Audit Plan dated 22 March 2016.

Our audit is substantially complete and we expect to sign our opinion once the Board approve the accounts on 25 May 2016. We are finalising our procedures in the following areas:

- completion of a small amount of audit testing including journals and gathering some outstanding audit evidence such as invoices;
- completion of our audit of a few non material notes to the accounts;
- review of the final version of the financial statements, Annual Report and Annual Governance Statement;
- obtaining and reviewing the management letter of representation;

.

- updating our post balance sheet events review, to the date of signing the opinion;
- completion of the NAO Whole of Government Accounts review; and
- agreeing the audited accounts to the final version of the FTC forms

We received draft financial statements and accompanying working papers at the commencement of our work, and in accordance with the national deadline

Key audit and financial reporting issues

Financial statements opinion

We have not identified any adjustments affecting the Trust's retained deficit position which was reported at £15.425m. Adjustments arising from the audit were limited to improvements to presentation and disclosure within the notes to the accounts.

The key messages arising from our audit of the Trust's financial statements are:

- management produced a set of good quality financial statements, supported by most of the working papers
- there were no material errors in the draft accounts
- the audit adjustments arising from our work relate to disclosure and classification issues only and do not affected the reported financial position of the Trust.

Further details are set out in section two of this report.

We anticipate providing a unqualified audit opinion in respect of the financial statements (see Appendix B).

Other Financial Statement responsibilities

As well as an opinion on the financial statements, we are required to consider the consistency of other information published with the financial statements.

Based on our review of the Trust's Annual Report, which includes the Annual Governance Statement (AGS), we are satisfied that it meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual and is consistent with the audited financial statements.

Controls

Roles and responsibilities

The Trust's management is responsible for the identification, assessment, management and monitoring of risk, and for developing, operating and monitoring the system of internal control.

Our audit is not designed to test all internal controls or identify all areas of control weakness. However, where, as part of our testing, we identify any control weaknesses, we report these to the Trust.

Findings

Our work has not identified any control weaknesses which we wish to highlight for your attention.

Further details of the audit work performed are provided within section two of this report.

Value for Money

Based on our review, we are satisfied that, in all significant respects, the Trust had proper arrangements in place to secure economy, efficiency and effectiveness in its use of resources.

The Trust delivered a deficit of £15.4m against a planned deficit of £13.5m. This was in line with revised budget and largely due to increased pressures arising from the junior doctors industrial action.

The Trust has agreed a financial plan with NHS Improvement (NHSI), formerly Monitor to achieve a £200k surplus in 2016/17, including receipt of £9.9m Sustainability and Transformation Funding.

Achieving financial sustainability in the longer term is dependent upon future service re-configuration and partnership work. The Trust's position as a key player in the "Healthy Wirral" programme is set to bring this about, although progress so far has been limited due to competing priorities in the region.

The Trust received a "Requires Improvement" CQC inspection rating in March 2016. This reflected mixed performance across the Trust's sites and services. However, the Trust has responded positively to the report and action plans are in place to address the weaknesses.

Further detail of our work on Value for Money are set out in section three of this report.

Other statutory powers and duties

We have not identified any issues that have required us to apply our other statutory powers and duties under the Act. This is set out in section four of this report.

Quality Report

We have completed our limited assurance procedures on the Trust's Quality Report, based on Monitor's 'Detailed guidance for external assurance on quality reports 2015/16'. We have provided a separate report to the Trust's Council of Governors setting out our results and conclusions and planned limited assurance opinion.

The way forward

Matters arising from the financial statements audit and our review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources have been discussed with the Acting Director of Finance.

Acknowledgement

We would like to take this opportunity to record our appreciation for the assistance provided by the finance team and other staff during our audit.

Grant Thornton UK LLP
13 May 2016

Section 2: Audit findings

Materiality

In performing our audit, we apply the concept of materiality, following the requirements of International Standard on Auditing (UK & Ireland) (ISA) 320: Materiality in planning and performing an audit. The standard states that 'misstatements, including omissions, are considered to be material if they, individually or in the aggregate, could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements'.

As we reported in our audit plan, we determined overall materiality to be £4,605,000 (being 1.5% of gross revenue expenditure). We have considered whether this level remained appropriate during the course of the audit and have made no changes to our overall materiality.

We also set an amount below which misstatements would be clearly trivial and would not need to be accumulated or reported to those charged with governance because we would not expect that the accumulated effect of such amounts would have a material impact on the financial statements. We have defined the amount below which misstatements would be clearly trivial to be £250,000. This remains the same as reported in our audit plan.

As we reported in our audit plan, we identified the following items where we decided that a lower level of materiality was appropriate:

Balance/transaction/disclosure	Explanation
Cash and cash equivalents	This balance is sensitive by nature. Cash and Cash Equivalents is also one of the few balances in the statements that can be directly agreed to third party confirmation which we receive directly from the Trust's bank. Additionally, agreeing the cash and cash equivalents balance to the reconciled bank statements is a key source of assurance over the integrity of the Trust's ledger.
Disclosures of senior manager salaries and allowances in the remuneration report	A lower materiality level is appropriate because of the public interest in these disclosures and the statutory requirement for them to be made.
Disclosure of auditor's remuneration	This is a statutory disclosure requirement. It is also a requirement of ethical and auditing standards that the external auditor's fee for undertaking the audit of the accounts, together with the amount charged for the provision of other services, is accurately disclosed.
Related Parties	Users of the statements will have an interest in the Trust's transactions with related parties. Misstatements affecting the value of the transactions disclosed may alter reader's perception of the Trust's relationship with its related parties.

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Audit findings against significant risks

"Significant risks often relate to significant non-routine transactions and judgmental matters. Non-routine transactions are transactions that are unusual, either due to size or nature, and that therefore occur infrequently. Judgmental matters may include the development of accounting estimates for which there is significant measurement uncertainty" (ISA (UK&I) 315).

In this section we detail our response to the significant risks of material misstatement which we identified in the Audit Plan. As we noted in our plan, there are two presumed significant risks which are applicable to all audits under auditing standards.

	Risks identified in our audit plan	Work completed	Assurance gained and issues arising
1.	**Income from Patient Care Activities and other operating income include fraudulent transactions** Under ISA (UK&I) 240 there is a presumed risk that revenue may be misstated due to the improper recognition of revenue. For this Trust, we have concluded that the greatest risk of material misstatement relates to the occurrence/ existence of revenue from patient care activities and other operating revenue. We have also considered the risk of fraudulent expenditure recognition and rebutted this risk.	As part of our audit work we have: • tested the material revenue streams, including a review of unusual significant transactions • reviewed the documentation relating to year-end settlements and contract variations agreed with commissioners and confirmed these agreements are properly reflected in the accounts • reviewed the output from the Agreement of Balances exercise and discussed any significant variances • agreed information from the SLAM system to the general ledger and outputs from PAS system	Our audit work has not identified any issues in respect of fraudulent revenue recognition.
2.	**Management override of controls** Under ISA (UK&I) 240 there is a presumed risk that management will over-ride controls. This risk is present in all entities.	As part of our audit work we have: • reviewed the entity level controls • tested a sample of journal entries • reviewed the accounting estimates, judgements and decisions made by management • reviewed unusual significant transactions	Our audit work has not identified any evidence of management over-ride of controls. In particular the findings of our review of journal controls and testing of journal entries has not identified any significant issues. At the time of writing we have yet to complete our journal sample testing. We set out later in this section of the report our work and findings on key accounting estimates and judgements.

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Audit findings against significant risks continued

"Significant risks often relate to significant non-routine transactions and judgmental matters. Non-routine transactions are transactions that are unusual, either due to size or nature, and that therefore occur infrequently. Judgmental matters may include the development of accounting estimates for which there is significant measurement uncertainty" (ISA (UK&I) 315).

In this section we detail our response to the significant risks of material misstatement which we identified in the Audit Plan. As we noted in our plan, there are two presumed significant risks which are applicable to all audits under auditing standards.

	Risks identified in our audit plan	Work completed	Assurance gained and issues arising
3.	**Valuation of property, plant and equipment** The Trust re-values its land and buildings on a rolling 5 yearly basis to ensure that carrying value is not materially different from fair value. The last full revaluation by the external valuer was at 31 March 2014. The reported valuation at 31 Mach 2016 represents a significant estimate by management in the financial statements.	As part of our audit work we have: • enquired of management the processes and assumptions applied in calculating the estimate • reviewed the competence, expertise and objectivity of the Trust's external valuer to ensure we could rely on management's expert • reviewed the instructions and scope of the work of the Trust's valuer for year end revaluation • reviewed and challenged the information used by the valuer to ensure it is robust and consistent with our understanding • agreed the revaluations made during the year to ensure they are input correctly into the Trust's asset register • agreed the year end reconciliation between the fixed asset register and general ledger • agreed a sample of assets by physical verification and to title deeds	Our audit work has not identified any issues in respect of valuation of property, plant and equipment. The desk top revaluation at 31 March 2016 resulted in a net impairment of £2.2m which was charged £0.3m to expenditure and £2.5m credited to the available revaluation reserve. Our review of the competency of the external valuer and the Trust's method for obtaining and processing appropriate Modern Equivalent Asset (MEA) updated indices is considered reliable. The fixed asset register was reconciled to the general ledger in total at 31 March 2016.

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Audit findings against other risks

In this section we detail our response to the other risks of material misstatement which we identified in the Audit Plan.

	Risks identified in our audit plan	Work completed	Assurance gained and issues arising
1.	**Income from Patient Care Activities** Accounting for contract arrangements with commissioning bodies not consistent with terms. (Contractual adjustments with commissioning bodies not adequate)	As part of our work we have: • documented our understanding of management's controls over revenue recognition • reviewed and tested the revenue recognition policies • tested the material revenue streams, including a review of unusual significant transactions • reviewed the documentation relating to year-end settlements and contract variations agreed with commissioners and confirmed these agreements are properly reflected in the accounts • reviewed the output from the Agreement of Balances exercise and discussed any significant variances • agreed information from the SLAM system to the general ledger and outputs from PAS system	Our audit work has not identified any issues in respect of revenue from patient care activities.
2.	**Other operating income** Recorded revenues and debtors not valid	As part of our audit work we have: • agreed a sample of debtors balances at year end to subsequent receipts • agreed material income streams, including for education and training, to invoices and contracts	Our audit work has not identified any issues in respect of other operating revenues
3.	**Employee remuneration** Employee remuneration and benefit obligations and expenses understated Remuneration expenses not correct	As part of our audit work we have: • documented the processes and controls in place for recording employee remuneration (payroll costs) • walked through the controls established by management to ensure the Trust pays its staff the right amount based on hours worked and their contract of employment • sample tested salaries and wages payments to Trust staff • reviewed the Trust's reconciliation between the General Ledger and the Payroll system • completed a trend analysis and a predictive analytical review comparing actual payroll to expectation and seeking explanations for any variances • reviewed employee remuneration disclosures including senior officers remuneration and pensions to ensure they are in compliance with the Annual Reporting Manual	Our audit work has not identified any issues in respect of employee remuneration

DRAFT

Audit findings against other risks

In this section we detail our response to the other risks of material misstatement which we identified in the Audit Plan.

	Risks identified in our audit plan	Work completed	Assurance gained and issues arising
4.	**Operating expenses** Creditors understated or not recorded in the correct period Operating expenses understated or not recorded in the correct period	As part of our audit work we have: • documented the processes and controls around operating expenses and walked through them to confirm they work in line with our knowledge • sample tested operating expenses to ensure they have been accurately accounted for and are in the correct period • agreed clinical negligence expenditure to invoices from NHSLA (£11.3m) • tested the completeness of the purchase ledger interfaces with the ledger • documented the processes in place for month and year end accruals • tested a sample of creditor balances including accruals • reviewed post year end payments to identify unrecorded liabilities • tested a sample of goods received but not yet invoiced to identify any items which have not been accrued correctly. • performed cut-off testing to confirm payments made in March 2016 and April 2016 have been accounted for in the correct financial year	Our audit work has not identified any issues in respect of operating expenses

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Accounting policies, estimates & judgements

In this section we report on our consideration of accounting policies, in particular revenue recognition policies, and key estimates and judgements made and included with the Trust's financial statements.

Accounting area	Summary of policy	Comments	Assessment
Revenue recognition	Income in respect of services provided is recognised when and to the extent that performance occurs, and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.	The Trust's revenue recognition policies are consistent with standard accounting policies and with guidance issued by Monitor. Monitor's Annual Reporting Manual requires the Trust's revenue recognition to be congruent with the principles of IAS 18. Policies are adequately disclosed within the accounts and we have not been made aware of any new material revenue streams which would require additional policies to be put in place. The Trust exercises judgement in arriving at the income for part complete spells. Income for part complete spells have been agreed to the third party confirmation using the intra-NHS agreement of balances exercise.	
Judgements and estimates	Key estimates and judgements include: – Useful life of PPE – Revaluations – Impairments – Provisions – Accruals – Partially completed spells	For each of these estimates and judgements we have considered the: • appropriateness of the policy under the relevant accounting framework • extent of judgement involved • adequacy of disclosure of accounting policy We are satisfied that the Trust's use of estimates and judgements is reliable and properly disclosed.	

Assessment
● Marginal accounting policy which could potentially attract attention from regulators ● Accounting policy appropriate but scope for improved disclosure ● Accounting policy appropriate and disclosures sufficient

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Accounting policies, Estimates & Judgements continued

Accounting area	Summary of policy	Comments	Assessment
Going concern	The Directors have a reasonable expectation that the services provided by the Trust will continue for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the financial statements.	We have reviewed the Directors' assessment of going concern and are satisfied with the assessment that the going concern basis is appropriate for the 2015/16 financial statements. Due to the 2015/16 deficit position, and challenging financial position going forwards, we requested the accounts and Annual Report contained more disclosure supporting the Director's assessment. This has been included. The Trust requires a working capital (cash) loan of £8m during quarter one on 2015/16. The Directors have assurance that this will be received.	●
Land and Buildings Valuation	All land and buildings are revalued by professional valuers every 5 years. A three yearly interim valuation is also carried out. Valuations are carried out by Cushman and Wakefield , who is external to the Trust, and in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. In between these valuations the Trust considers whether assets are subject to significant volatility and, where this is the case, undertakes an annual valuation.	A full desktop revaluation has been undertaken during 2015/16 and applied at 31 March 2016. This resulted in an impairment of £2.5 million credited to the revaluation reserve and £0.312 million charged to operating expenditure. We have challenged the basis for the revaluation, including Modern Equivalent Asset (MEA) basis with Management. We are satisfied the Trust's accounting policy and accounting treatment of the land and buildings valuation comply with the requirements of the Annual Reporting Manual.	●
Financial reporting	In January 2016 a letter was sent from the Department of Health to all NHS Trusts and Foundation Trusts advising them to consider 'removing prudence' from key balance sheet areas.	We have had regard to this requirement when undertaking our procedures. We are satisfied the Trust has taken an appropriate approach that ensures the financial statements reflect appropriate levels of prudence. Specifically, we are satisfied that accruals and provisions are sufficient and robust, and that critical judgements (such as the choice of the alternate site, modern equivalent asset basis for the revaluation of property, plant and equipment) have been appropriately considered and disclosed.	●

Assessment

● Marginal accounting policy which could potentially attract attention from regulators ● Accounting policy appropriate but scope for improved disclosure ● Accounting policy appropriate and disclosures sufficient

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Other communication requirements

We set out below details of other matters which we, as auditors, are required by auditing standards and the Code to communicate to those charged with governance.

	Issue	Commentary
1.	**Matters in relation to fraud**	• We have not been made aware of any incidents in the period. • No issues have been identified during the course of our audit procedures.
2.	**Matters in relation to related parties**	• We are not aware of any related party transactions which have not been disclosed.
3.	**Matters in relation to laws and regulations**	• You have not made us aware of any significant incidences of non-compliance with relevant laws and regulations. • We have not identified any incidences from our audit work.
4.	**Written representations**	• A standard letter of representation has been requested from the Trust.
5.	**Confirmation requests from third parties**	• We obtained direct confirmations from NHSI for bank balances and loans. • We requested from management permission to send confirmation requests to other third party bankers. This permission was granted and the requests were sent. We are awaiting responses from a number of bankers. We anticipate will be available prior to the signing of the Annual Accounts. We will undertake alternative procedures if these are not received as expected.
6.	**Disclosures**	• Our review found no material omissions in the financial statements.
7.	**Auditable elements of Remuneration and Staff Report**	• We are required to give an opinion on whether the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements directed by the Secretary of State with the consent of the Treasury. • We have audited the elements of the Remuneration report , as required by the Code and found no issues. • We propose to issue an unqualified opinion.

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Other communication requirements continued

	Issue	Commentary
8.	**Matters on which we report by exception**	We are required to report on a number of matters by exception in a number of areas: We have not identified any issues we would be required to report by exception in the following areas • if the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual or is misleading or inconsistent with the information of which we are aware from our audit • the information in the annual report is materially inconsistent with the information in the audited financial statements or apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit, or otherwise misleading. • we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider that the Annual Report is fair, balanced and understandable • the annual report does not appropriately disclose matters that were communicated to the Audit Committee which we consider should have been disclosed.
9.	**Review of accounts consolidation schedules and specified procedures on behalf of the DH group auditor**	• We are required to give a separate audit opinion on the Trust's accounts consolidation schedules and to carry out specified procedures (on behalf of the NAO) on these statements under the group audit instructions . In the group audit instructions the Trust was selected as a non-sampled component. • At the time of writing we are following up some intra-NHS mis-matches with the finance team.

Internal controls

The purpose of an audit is to express an opinion on the financial statements.

Our audit included consideration of internal controls relevant to the preparation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of internal control. We have no deficiencies to report.

If we had performed more extensive procedures on internal control, we might have identified more deficiencies to be reported.

During the course of our audit, we noted the Trust does not have signed leases in place to support its use of the accommodation at St Catherine's Hospital and Victoria Community Hospital. From our discussion with management, we accept this does not expose the Trust to a significant financial risk because there is a history of rental payments to confirm the values agreed. However, management accepts the absence of a formal signed lease could give rise to an operational risk if the lessor wished to the end the agreement.

Misclassifications and disclosure changes

The table below provides details of misclassification and disclosure changes identified during the audit which have been made in the final set of financial statements.

	Adjustment type	Value £'000	Account balance	Impact on the financial statements
1	Disclosure	N/A	Going Concern	Management have agreed to expand the disclosure in respect of the going concern assertion in the accounts and Annual Report. The disclosure now provides more detailed explanation of the Director's assessment and reflects the paper considered by the Trust Board.

NAO Whole of Government Accounts (WGA)

Our work on the WGA submission is substantially complete.

We are required to report to the NAO all mis-matches with a value of £250k or above in the Trust's agreement of balances with other NHS bodies. There are 20 such mis-matches. A list is provided at Appendix A for your information.

Section 3: Value for Money

Background

We are required by Schedule 10 to the National Health Service Act 2006 ('the Act') and the NAO Code of Audit Practice ('the Code) to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. This is known as the Value for Money (VFM) conclusion.

The Act and the Code only require us to report by exception where we are not satisfied that Foundation Trusts have proper arrangements in place to secure value for money. However, we are required to carry out sufficient work to satisfy ourselves that proper arrangements are in place at the Trust.

In carrying out this work, we are required to follow the NAO's Auditor Guidance Note 3 (AGN 03) issued in November 2015. AGN 03 identifies one single criterion for auditors to evaluate:

> *In all significant respects, the audited body had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people.*

AGN03 provides examples of proper arrangements against three sub-criteria but specifically states that these are not separate criteria for assessment purposes and auditors are not required to reach a distinct judgement against each of these.

Risk assessment

We identified risks in respect of specific areas of proper arrangements using the guidance contained in AGN03 and updated the Audit Committee on 8th April 2016 of progress. We carried out an initial risk assessment in March 2016 and identified the following significant risks for follow up:

- the 2015/16 Financial deficit position may escalate without effective controls and the additional license conditions imposed by Monitor may not be met
- governance arrangements may not be robust in the new Vanguard structure which could de-stabilise the project
- service delivery may be compromised if the FT does not respond promptly and effectively to CQC recommendations

We have continued our review of relevant documents up to the date of giving our report, and have not identified any further significant risks where we need to perform further work.

We carried out further work only in respect of the significant risks we identified from our initial and on-going risk assessment. Where our consideration of the significant risks determined that arrangements were not operating effectively, we have used the examples of proper arrangements from AGN 03 to explain the gaps in proper arrangements that we have reported in our VFM conclusion.

Significant qualitative aspects

AGN 03 requires us to disclose our views on significant qualitative aspects of the Trust's arrangements for delivering economy, efficiency and effectiveness.

We have focused our work on the significant risks that we identified in the Trust's arrangements. In arriving at our conclusion, our main considerations were:

- despite a challenging financial year, the Trust has contained its expenditure and delivered planned cost savings such that the deficit exceeded the planned deficit by a relatively small margin
- the Trust has a financial plan and agreed control total in place for 2016/17
- the Trust has responded well to the planned reconfiguration of services across the Wirral and the wider footprint. It has responded flexibly as the situation changed and has engaged well with partners
- although the outcome of the CQC inspection in March 2016 was disappointing, the Trust has responded positively to the findings. Action plans are in place o deliver the improvements required We have set out more detail on the risks we identified, the results of the work we performed and the conclusions we drew from this work later in this section.

Overall conclusion

Based on the work we performed to address the significant risks, we concluded that:

- the Trust had proper arrangements in all significant respects to ensure it delivered value for money in its use of resources. We only report by exception in our auditors' report where we give a qualified conclusion. The text of our report, which confirms this under the 'matters on which we report by exception' section, can be found at Appendix B.

Key findings

We set out below our key findings against the significant risks we identified through our initial risk assessment and further risks identified through our on-going review of documents.

Significant risk	Work to address	Findings and conclusions
Financial Outturn 2015/16 Financial deficit position may escalate without effective controls and the additional license conditions imposed by Monitor may not be met. The Trust reported a deficit of £15.4m at 31 March 2016. This was £1.9m worse than plan largely due to lost income and pressures caused by the junior doctors strike. The Trust delivered £13.4m CIP savings in 2015/16 of which £11.5m was recurrent. The recurrent CIP plan agreed with Monitor was £16.4m	We reviewed the Trust's budget and outturn position, together with explanations for variances. We have reviewed the additional licence conditions imposed by Monitor and the Trust's arrangements for tracking and reporting progress.	We found the Trust had set a realistic budget for 2015/16, including achievable cost improvement plan savings. Financial performance was closely monitored and reported throughout the year to the Finance, Business and Assurance Committee and the Board. The licence conditions imposed by Monitor are closely monitored by management and reported to Audit Committee. Looking ahead, the Trust has agreed a financial plan for 2016/17 with NHSI which includes a £0.2m surplus control total. This plan provides for £9.9m Sustainability and Transformation Funding. The Trust has also agreed the 2016/17 commissioning contract with Wirral CCG securing £229 million of income. This provides a firm basis for exploring new pathways of care. **We concluded the Trust managed to contain its financial position throughout 2015/16 as closely as possible. It remained within the additional licence conditions imposed by Monitor.**
Vanguard Governance Arrangements Governance arrangements may not be robust in the new Vanguard structure which could de-stabilise the success of the project.	We reviewed the Trust's arrangements for working with other Vanguard parties as supported by the Memorandum of Understanding, including how it communicates progress to the Board.	We found that progress in establishing the "Healthy Wirral" structure is still developing. Efforts are being made to ensure a clear link through to the Sustainability and Transformation Plan that will drive greater service integration across a wider footprint. There is an overarching Memorandum of Understanding signed by all partners to the Vanguard arrangement setting out the structure. There is appropriate reporting of progress through the Trust. The Trust is exploring options for closer integration with Countess of Chester Hospital and the creation of a local delivery system as part of the Cheshire and Mersey Sustainability and Transformation Plan. **We are satisfied the Trust is putting in place an appropriate governance framework to support the on-going work exploring the best options to ensure sustainable patient care. However, this is at an early stage of development reflecting the changing plans around future models of care. The Trust is using its position to provide leadership in the debate on the future of health and social care provision for the region.**

Significant risk	Work to address	Findings and conclusions
CQC Report There is a risk that service delivery may be compromised if the Trust does not respond promptly and effectively to CQC inspection report of March 2016.	We reviewed how the Trust is implementing and monitoring delivery of the action plan agreed to address the findings of the CQC inspection.	The Trust was assessed as "requiring improvement" when the CQC report was published in March 2016. This report reflected a mix of judgements across the Trust's services and sites. The Trust is rightly proud that CQC assessed the Trust as good in providing caring and effective services. It can also reflect positively on the improvements it has made in response to previous CQC findings, for example, the actions taken by the Trust to address CQC's previous concerns about safe nurse staffing levels. Although the overall outcome of the inspection is disappointing, the Trust has again responded in a positive and open way. An action plan has agreed with CQC and implementation is underway. Progress is reported to the Quality and Safety Committee and also to the Board. This ensures service managers are held to account for delivery of the action plan. **We concluded the Trust has engaged appropriately in responding to the CQC report. An improvement plan has been put in place and there are sound arrangements to monitor its delivery.**

Significant difficulties in undertaking our work

We did not identify any significant difficulties in undertaking our work on your arrangements which we wish to draw to your attention.

Significant matters discussed with management

There were no matters where no other evidence was available or matters of such significance to our conclusion or that we required written representation from management or those charged with governance.

Any other matters

There were no other matters from our work which were significant to our consideration of your arrangements to secure value for money in your use of resources.

Section 4: Other statutory powers and duties

Other statutory powers and duties

We set out below details of other matters which we, as auditors, are required by the Act and the Code to communicate to those charged with governance.

	Issue	Commentary
1.	**Referral to the regulator**	• We have not identified any issues which we need to report to the regulator.
2.	**Public interest report**	• We have not identified any matters that would require a public interest report to be issued.

Section 5: Fees, non-audit services and independence

We confirm below our final fees charged for the audit and confirm there were no fees for the provision of non audit services

Fees

	£
Trust audit	38,400
Charitable fund audit	2,600
Total audit fees (excluding VAT)	**41,000**

Fees for other services

Service	Fees £
Audit related services	
Assurance on your quality report	6,000

Independence and ethics

We confirm that there are no significant facts or matters that impact on our independence as auditors that we are required or wish to draw to your attention. We have complied with the Auditing Practices Board's Ethical Standards and therefore we confirm that we are independent and are able to express an objective opinion on the financial statements.

We confirm that we have implemented policies and procedures to meet the requirements of the Auditing Practices Board's Ethical Standards.

Section 6: Communication of audit matters

Communication to those charged with governance

International Standards on Auditing ISA (UK&I) 260, as well as other ISAs, prescribe matters which we are required to communicate with those charged with governance, and which we set out in the table opposite.

The Audit Plan outlined our audit strategy and plan to deliver the audit, while this Audit Findings report presents the key issues and other matters arising from the audit, together with an explanation as to how these have been resolved.

Respective responsibilities

The Audit Findings Report has been prepared in the context of the document on the Roles and Responsibilities of the National Audit Office (NAO) and local auditors issued by the NAO (https://www.nao.org.uk/code-audit-practice/wp-content/uploads/sites/29/2015/03/Role-of-NAO-and-local-auditors.pdf)

Our annual work programme is set in accordance with the Code of Audit Practice ('the Code') issued by the NAO (https://www.nao.org.uk/code-audit-practice/about-code/). Our work considers the Trust's key risks when reaching our conclusions under the Code.

It is the responsibility of the Trust to ensure that proper arrangements are in place for the conduct of its business, and that public money is safeguarded and properly accounted for. We have considered how the Trust is fulfilling these responsibilities.

Our communication plan	Audit Plan	Audit Findings
Respective responsibilities of auditor and management/those charged with governance	✓	
Overview of the planned scope and timing of the audit. Form, timing and expected general content of communications	✓	
Views about the qualitative aspects of the entity's accounting and financial reporting practices, significant matters and issues arising during the audit and written representations that have been sought		✓
Confirmation of independence and objectivity	✓	✓
A statement that we have complied with relevant ethical requirements regarding independence, relationships and other matters which might be thought to bear on independence. Details of non-audit work performed by Grant Thornton UK LLP and network firms, together with fees charged Details of safeguards applied to threats to independence	✓	✓
Material weaknesses in internal control identified during the audit		✓
Identification or suspicion of fraud involving management and/or others which results in material misstatement of the financial statements		✓
Compliance with laws and regulations		✓
Expected unmodified auditor's report		✓
Uncorrected misstatements		✓
Significant matters arising in connection with related parties		✓
Significant matters in relation to going concern		✓

Appendices

Appendix A: Schedule of WGA mismatches over £250k

Name of Organisation	Balance	Trust	Third Party	Difference
NHS England	Expenditure	696k	nil	(696k)
Countess of Chester Hospital NHS FT	Expenditure	5,270k	6,130k	860k
East Cheshire NHST	Expenditure	nil	380k	380k
Royal Liverpool & Broadgreen UHNHST	Expenditure	521k	901k	380k
Wirral Community NHST	Expenditure	703k	1,513k	810k
Royal Liverpool & Broadgreen UHNHST	Income	65k	522k	(457k)
NHS Wirral CCG	Income	225,261k	226,200k	(939k)
Cheshire & Merseyside Local Office	Income	4,761k	5,248k	(487k)
Health Education England	Income	9,572k	9,831k	(259k)
Cheshire & Merseyside Local office	Payable	629k	Nil	629k
Wirral Community NHS Trust	Payable	103k	471k	(368k)
NHS Wirral CCG	Receivable	1,550k	2,166k	616k
NHS England	Receivable	37k	427k	390k

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Appendix B: Audit opinion

We anticipate we will provide the Trust with an unmodified audit report

Independent auditor's report to the Council of Governors of Wirral University Teaching Hospital NHS Foundation Trust

Our opinion on the financial statements is unmodified

In our opinion the financial statements of Wirral University Teaching Hospital NHS Foundation Trust (the Trust):

- give a true and fair view of the state of the financial position of the Trust's affairs as at 31 March 2016 and of the Trust's income and expenditure for the year then ended; and
- have been properly prepared in accordance with applicable law, the NHS Foundation Trust Annual Reporting Manual and the Directions under paragraph 25(2) of Schedule 7 of the National Health Service Act 2006.

Who we are reporting to

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors as a body, for our audit work, for this report, or for the opinions we have formed.

What we have audited

We have audited the financial statements of Wirral University Teaching Hospital NHS Foundation Trust for the year ended 31 March 2016 which comprise the Trust statement of comprehensive income, the Trust statement of financial position, the Trust statement of cash flows, the Trust statement of changes in taxpayers' equity and the related notes.

The financial reporting framework that has been applied in their preparation is applicable law and the NHS Foundation Trust Annual Reporting Manual (ARM) and the Directions under paragraph 25(2) of Schedule 7 of the National Health Service Act 2006 issued by Monitor, the Independent Regulator of NHS Foundation Trusts.

Overview of our audit approach

- Overall materiality: £4,605,000, which represents 1.5% of the Trust's gross operating costs;
- Key audit risks were identified as:
  - Occurrence, existence and valuation of healthcare income
  - Occurrence and existence of other operating income
  - Valuation of property, plant and equipment
  - Completeness of expenditure on goods and services
  - Completeness of expenditure on employees remuneration

Our assessment of risk

In arriving at our opinions set out in this report, we highlight the following risks that, in our judgement, had the greatest effect on our audit:

Audit risk	How we responded to the risk
Occurrence, existence and valuation of healthcare income Over 90% of the Trust's income is from contracts with NHS commissioners of healthcare services. The Trust invoices its commissioners throughout the year for services provided, and at the year end estimates and accrues for activity not yet invoiced. Invoices for the final quarter of the year are not finalised and agreed until after the year end and after the deadline for the production of the financial statements. This will involve an element of estimation and contractual adjustments. We therefore identified occurrence, existence and valuation of healthcare income as a risk requiring particular audit attention.	Our audit work included, but was not restricted to: • evaluating the Trust's accounting policy for recognising healthcare income for appropriateness and consistency with the prior year; • gaining an understanding of the Trust's system for accounting for health care income and evaluating the associated controls; • using a summary of expenditure with the Trust accounted for by other NHS bodies provided by the Department of Health to identify any significant differences in income and debtor balances with contracting bodies; • Agreeing, on a sample basis, amounts recognised in income in the financial statements to signed contracts; agreeing, on a sample basis, contract variations and non-contractual income adjustments made to year-end balances to supporting documentation; and • agreeing, on a sample basis, debtor balances at the year end to subsequent receipt. The Trust's accounting policy for recognising healthcare income is shown in note 1.4 to the financial statements and related disclosures are included in note 2.
Occurrence and existence of other operating income The Trust receives a significant amount of income which is not directly related to core patient activity such as training and income from other bodies. Income is recognised when due and at the year-end income is accrued for services that have been performed but for which an invoice has not been issued. We therefore identified occurrence and existence of non-healthcare revenues as a risk requiring particular audit attention.	Our audit work included, but was not restricted to: • evaluating the Trust's accounting policy for non-healthcare revenue recognition for appropriateness and consistency with the prior year; • gaining an understanding of the Trust's system for accounting for other operating revenue and evaluating the associated controls; • agreeing, on a sample basis, non-healthcare income recognised in the financial statements to signed contractsand invocies; and • agreeing, on a sample basis, accrued income and other revenue transactions to supporting documentations.. The Trust's accounting policy for recognising income is shown in note 1.4 to the financial statements and related disclosures are included in note 3.
Valuation of property, plant and equipment The valuation of property, plant and equipment requires significant judgements and estimation and also represents 81% of the total asset value on the Trust's balance sheet.	Our audit work included, but was not restricted to: • obtaining management's assessment of the valuation of property, plant and equipment and understanding the valuation process including assessment of key controls and significant assumptions; • evaluation of management's assessment of any assets

Audit risk	How we responded to the risk
The Trust's last full external valuation was as at 31 March 2014 and the policy is for an interim valuation every 3 years and full revaluation every 5 years. This leads to significant estimation uncertainty in the intervening period. We therefore identified the valuation of property, plant and equipment as a significant risk requiring special audit attention.	not re-valued during the year and how management are satisfied these are not materially different to current value; • challenging the assumptions made by management in relation to: o the valuation of property, plant and equipment, in particular the modern equivalent asset basis; o the useful lives of property, plant and equipment; and o the amount of depreciation charged in the year. The Trust's accounting policy for property, plant and equipment is shown in note 1.8 to the financial statements and related disclosures are included in note 11.
Completeness of expenditure on goods and services Expenditure on goods and services represent 31% of the Trust's total expenditure. Management uses judgement to estimate accruals of expenditure for amounts that have not been invoiced at the year end. We therefore identified completeness of expenditure on goods and services as a risk requiring particular audit attention.	Our audit work included, but was not restricted to: • gaining an understanding of the systems used to recognise expenditure on goods and services and year-end accruals, and evaluating the associated controls; • testing on a sample basis payments made after the year end to confirm the completeness of accruals; and • testing on a sample basis the treatment of goods received not invoiced to confirm completeness of accruals. • cut-off testing? The Trust's accounting policy for expenditure on goods and services is shown in note 1.5 to the financial statements and related disclosures are included in note 4.
Completeness of expenditure on employees Expenditure on employees represents the largest single area of expense for the Trust, at 67% of total expenditure. The Trust accrues at year end using estimates for employee related services. We therefore identified completeness of expenditure on employees as a risk requiring particular audit attention.	Our audit work included, but was not restricted to: • gaining an understanding of the systems used to recognise payroll expenditure and evaluating the associated controls; • reconciling expenditure on employees recorded in the general ledger to the payroll system reports for each month; • and • performing a trend analysis of payroll costs and investigating unusual variations. The Trust's accounting policy for employee benefits is shown in note 1.6 to the financial statements and related disclosures are included in note 6.

Our application of materiality and an overview of the scope of our audit

Materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the judgements of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

We determined materiality for the audit of the Trust's financial statements as a whole to be £4,605,000, which is 1.5% of the Trust's gross operating costs. This benchmark is considered the most appropriate because we consider users of the Trust's financial statements to be most interested in how it has expended its revenue and other funding.

Materiality for the current year is lower than the level determined for the year ended 31 March 2015 to reflect increased public focus on the Trust's financial performance for the year.

We use a different level of materiality, performance materiality, to drive the extent of our testing and this was set at 60% of financial statement materiality for the audit of the Trust's financial statements.

We also determine a lower level of specific materiality for certain areas such as cash and cash equivalents, **senior manager** remuneration disclosed in the Remuneration Report, auditors' remuneration and related party transactions.

We determined the threshold at which we would communicate misstatements to the Audit Committee to be £250,000. In addition we communicated misstatements below that threshold that, in our view, warranted reporting on qualitative grounds.

Overview of the scope of our audit

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Chief Executive Officer as Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

We conducted our audit in accordance with ISAs (UK and Ireland) having regard to the Financial Reporting Council's Practice Note 10 'Audit of Financial Statements of Public Bodies in the UK (Revised)'. Our responsibilities under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code) and those standards are further described in the 'Responsibilities for the financial statements and the audit' section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

We are independent of the Trust in accordance with the Auditing Practices Board's Ethical Standards for Auditors, and we have fulfilled our other ethical responsibilities in accordance with those Ethical Standards.

Our audit approach was based on a thorough understanding of the Trust's business and is risk based, and in particular included an interim visit to evaluate the Trust's internal control environment including its IT systems and controls over key financial systems.

Other reporting required by regulations

Our opinion on other matters required by the Code is unmodified

In our opinion:

- the part of the Directors' Remuneration Report subject to audit has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual;
- the part of the Staff Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual; and
- the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the Trust's financial statements.

Matters on which we are required to report by exception

Under the ISAs (UK and Ireland), we are required to report to you if, in our opinion, information in the annual report is:

- materially inconsistent with the information in the audited financial statements; or
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit; or
- otherwise misleading.

In particular, we are required to report to you if:

- we have identified any inconsistencies between our knowledge acquired during the audit and the Directors' statement that they consider the annual report is fair, balanced and understandable; or
- the annual report does not appropriately disclose those matters that were communicated to the Audit Committee which we consider should have been disclosed.

Under the Code of Audit Practice we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust ARM or is misleading or inconsistent with the information of which we are aware from our audit; or
- we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in respect of the above matters.

Responsibilities for the financial statements and the audit

What the Chief Executive, as Accounting Officer, is responsible for:
As explained more fully in the Chief Executive's Responsibilities Statement, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Direction issued by Monitor and for being satisfied that they give a true and fair view.

What we are responsible for:
Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Code of Audit Practice and ISAs (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Certificate

We certify that we have completed the audit of the financial statements of Wirral University Teaching Hospital NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice issued by the Comptroller and Auditor General.

Karen Murray
Director
for and on behalf of Grant Thornton UK LLP
4 Hardman Square, Spinningfields, Manchester, M3 3EB

25 May 2016

Board of Directors	
Agenda Item	9.1
Title of Report	Quality Account – draft (version 11)
Date of Meeting	25.5.16
Author	Joe Roberts, Head of Assurance
Accountable Executive	Dr Evan Moore, Medical Director
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Strategic Objective 3 - To deliver consistently high quality secondary care services enhanced through the provision of regional specialist services Key Measure 3a - Implementation of quality improvement strategy to reduce mortality to 85 HSMR Key Measure 3b - Ensure that our harm-free care score is no lower 95% for each month of the year
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To approve
Data Quality Rating	Mixture of gold, silver and bronze data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	Not applicable

1. Executive Summary

The final draft of the Annual Quality Account has been circulated under separate cover to the Board in preparation for Board approval. The Quality and Safety Committee and the Audit Committee have already reviewed the Quality Account at their meetings in May.

2. Background

The Trust chose six priority areas on which to focus for its Quality Account in 2015/16: pressure ulcers; medicines management; nutrition and hydration; dementia care; readmissions and mortality. We set specific targets for each. They were not achieved in full, although

substantial progress was made towards each of them, and in any case the final position for the Hospital Standardised Mortality Ratio will not be known until later in the year.

In 2016/17 we propose to add two new priority areas – end of life care (where the Care Quality Commission inspection showed that we need to improve) and implementation of the SAFER bundle to improve patient flow and discharge. There is a risk that if we have too many priorities, we cannot focus effectively on each of them, so we have no true priorities. Therefore we plan to discontinue two priority areas where we have made most progress, namely dementia and mortality. Work will continue to improve quality in these areas although they will no longer be reported in the quarterly and annual Quality Account reports.

3. Key Issues / Gaps in Assurance

As well as the local performance indicators which the Trust selected itself, we are required to include our performance against national indicators. Our external auditors are required by NHS Improvement to audit the data for two of these – 18 weeks referral to treatment (incomplete pathways), and the 4-hour Accident and Emergency target.

The audit identified issues with data quality for the 18 week target. The auditors were not able to agree the 'clock start' date (i.e. the date which our Trust received the referral) to original records in approximately one-third of the cases in their sample.

External Audit have also taken the view, based on their interpretation of national audit guidance, that we should not include the Walk-in Centre at Arrowe Park within our calculations for the four-hour target as the centre is managed by Wirral Community Trust, and our Trust is not responsible for the management of the clinical services delivered there. In response, we have restated the figures compared to previous drafts of this report, so that now they reflect only the performance of our own Emergency Department, and not the Walk-in Centre.

The auditors have indicated that they intend to issue a qualified audit opinion on the Quality Account, due to the 18 week indicator. The 18 week incomplete pathways indicator was also audited last year and discrepancies were found in the quality of the data then. On that occasion, the previous auditors exercised their discretion not to issue a qualified audit report subject to an action plan being developed, although we are advised that due to stricter guidance being issued to external auditors by NHS Improvement, this option is no longer available.

Additional measures were put in place to improve data quality following that audit, although we acknowledge that these have not had the impact which we might have hoped for. We understand that it has been difficult for many Trusts to calculate this indicator reliably; a number of organisations received qualified audit opinions last year, and this is why NHS Improvement has instructed that it be audited at all Foundation Trusts. The final conclusion will be presented to the Board next week.

External Audit also reviewed the rest of the draft report for completeness and accuracy. In response, we made a number of small changes to layout, format and wording although these did not significantly affect the content of the report. The Trust also added a short commentary describing how it would fulfill the Duty of Candour. Draft 8 of the report was discussed by the Audit Committee on Thursday 19th May.

The Trust circulated the draft report for consultation to key stakeholders in the local health economy – the Local Authority; the Clinical Commissioning Group; and Health Watch Wirral. Each provided a comprehensive response to the consultation and their statements are included as appendices to the report.

4. Next Steps

Remaining actions for the Quality Account are as follows:

- A very small number of figures (shown in yellow in the attached document) will be updated after new data is published by the Health and Social Care Information Centre

on 20th May (after the deadline for papers to be issued to the Trust Board). These are not expected to make any significant change to the conclusions of the report.

- The External audit opinion will be added as an appendix, once received.
- The final version of the Quality Account will need to be signed by the Chairman and Chief Executive.
- The Quality Account will then be submitted to NHS Choices and made available to view on the Trust's external website.

5. Conclusion

During 2015/16 the Trust made progress in challenging circumstances, and this is evident from the statistics and commentary included in this Quality Account.

6. Recommendation

The Board is asked to approve the draft Quality Account.

Audit Committee	
Agenda Item	9.1
Title of Report	Draft Annual Report including Annual Governance Statement
Date of Meeting	19 May 2016
Author	Carole Self, Director of Corporate Affairs
Accountable Executive	Carole Self, Director of Corporate Affairs
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	All
Level of Assurance • **Positive** • **Gap(s)**	Full
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Recommendation to the Board
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**	N/A

1. Executive Summary

The draft Annual Report including the Annual Governance Statement has been circulated to members under separate cover as the Trust is not permitted to publish the document to the wider public until this has been laid before Parliament.

The Audit Committee reviewed the draft Annual Report including Annual Governance Statement at its meeting on the 19th May 2016 and agreed subject to minor changes, to recommend this to the Board for approval. These changes have now been made.

The draft report has been supplied to the External Auditors who have concluded that this is consistent with the requirements.

2. Next Steps

The final text for the Annual Report along with the Annual Accounts will be submitted to NHS Improvement on the 27th May 2015 before noon.

The period between the 27th May 2016 and submission to Parliament is to allow Trusts time to format the document to the standards required for publication.

The final Annual Report and Accounts must be sent to the Parliamentary Clerk at the Department of Health by the 24th June 2016 for laying before Parliament.

Once the Annual Report and Accounts are laid before Parliament the Trust will present these to the Annual Members Meeting.

3. Recommendations

The Board is asked to approve the Annual Report and the Annual Governance Statement.

Board of Directors	
Agenda Item	9.2
Title of Report	Chair of Audit Committee Report
Date of Meeting	19 May 2016
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
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

The Audit Committee meeting to review in detail and make recommendations to the Board on the statutory Annual returns was held on the 19 May 2015. As is usual at this meeting the Chief Executive was invited to attend to support the presentations to Committee and in particular to present the Annual Governance statement.

Annual Report and Accounts

The Committee reviewed in detail the following:

- The Annual Report and Accounts for 2015/16
- The Quality Account
- The Annual Governance Statement
- The Annual Audit Committee Report
- The External Audit Opinions on both the financial statements and the Quality Report
- Letters of representation by the Board on the Financial Statements and Quality Account.

The Committee recommended some changes to the documents as outlined in the cover report to these documents on the Board agenda and subject to these changes recommend their adoption by the Board.

As part of the presentation to the Board, the Committee also requested that a rationale for the WGA mismatches over £250k be included.

In making these recommendations to the Board, the Committee wished to bring to the attention of the Board a matter arising from the External Audit opinion:

- Qualified Limited Assurance on the Quality Accounts
  Qualifications relate to data quality issues identified for the national indicators; RTT incomplete pathways and A&E indictors. In respect of A&E the Quality Account has been amended to separate A&E Department activity from the on site Walk-in Centre as the latter's data is held by the Community Trust and is unable to be verified by WUTH Auditors. Regarding RTT, an internal review of the audit sample is to be undertaken to ensure mid-year changes to guidance are accurately applied and External Auditors are to undertake a further audit of an additional sample of case notes before coming to their final opinion.

The Committee requested that should it not be possible to reach an agreement with third parties in respect of the WGA mismatches over £250k, a report is to be presented to the Audit Committee outlining rationale and impact.

It is recommended to the Board that approval be granted regarding:

- **The Annual Report and Accounts for 2015/16**
- **The Quality Account**
- **The Annual Governance Statement**
- **The Annual Audit Committee Report**
- **The External Audit Opinions on both the financial statements and the Quality Report**
- **Letters of representation by the Board on the Financial Statements and Quality Account.**

Internal Audit Actions

The Committee were pleased to receive the updated Internal Audit Actions Outstanding Recommendations Summary with substantial progress having been made with the majority of actions having been completed.

Audit Committee Effectiveness

The Committee completed independently an effectiveness review via a matrix recommended by the incoming Director of Finance and were pleased to note the consistent view of the members and officers of the Audit Committee in respect of the Committee's effectiveness. Due to the imminent turnover of members of the committee a review of the workplan against the terms of reference will be done, both as a developmental and training exercise for new committee members, a chance to evaluate the current effectiveness against this workplan and an opportunity to set targets for improvement in the new financial year. All will be reported to the Board for discussion and approval.

Cathy Bond
Audit Committee Chair

Board of Directors	
Agenda Item	9.3
Title of Report	Board Declaration – General Condition G6
Date of Meeting	25 May 2016
Author	Carole Ann Self, Director of Corporate Affairs
Accountable Executive	David Allison, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	7D Compliance with Legislative requirements
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Approval
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

1. Executive Summary

The Board is required to respond "Confirmed" or "Not Confirmed" to the following statements in relation to General Condition 6 – Systems for compliance with license conditions as outlined below as part of its annual declaration procedure:

1. *Following a review for the purposes of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution*

2. *The Board declares that the Licensee continues to meet the criteria for holding a licence*

For the year 2014/15 the Board decided to declare "confirmed" against both statements having sought advice from NHSI (formerly Monitor) in relation to the investigation into the Breach of the Trust's Provider Licence which at the time was underway but not concluded. The Board reviewed the steps put in place to achieve compliance and concluded that to declare anything other than "compliance" would prejudice the outcome of the investigation and not recognize the work undertaken.

The Board is now asked to consider the following ahead of making its declaration:

- In 2015/16 the Board was found to be in breach of its Provider Licence; however NHSI has since acknowledged the work undertaken by the Trust to improve its financial rigour and decision making which resulted in a financial out-turn broadly in line with the revised plan.

- The Trust has struggled with achievement of the A & E 4 hour access standard; the target for avoidable C difficile cases and the 18 week referral to treatment time target. The Trust has been working with closely with partners to improve performance in A & E as it is acknowledged that this is not just an acute provider issue, it has also enlisted the support of ECIST in its pursuit to ensure that all areas of best practices were being implemented, an example of this would be the SAFER start and bundle. Although the Trust ended the year just over the number of avoidable cases of C difficile, it did implement a robust action plan which has been adhered to since implemented in Autumn 2015. The impact of this is that the Trust not only significantly prevented a further increase of avoidable cases of C difficile being reported in 2015/16 it also led to only one possible avoidable case being reported in 2016/17 to date. Non -compliance with RTT was multifactorial as follows:

    1. In part it was due to the national initiative over Christmas and New Year to ensure there were the maximum amount of beds available over this period
    2. A small part was attributable to the junior doctors industrial action
    3. In part it was due to the lack of progress to address the waiting times in the community paediatric service
    4. In part due to underperformance against surgical activity plans

    The Trust continues to experience difficulties with points 3 and 4 although this is being addressed through the work of the task and finish group specifically looking at these issues.

In summary although the Trust has experienced both financial and operational performance issues in 2015/16, it is acknowledged both internally and externally that it has undertaken significant action to reduce these wherever possible. It is also acknowledged that the Trust is not alone in experiencing issues in all of these areas.

3. Recommendation

On balance the recommendation is to submit a declaration of “Confirmed” for both statements on the basis that all reasonable precautions were taken to comply with the Provider Licence. The Trust has also agreed an improvement trajectory with NHSI for both RTT and A & E standards which recognizes the difficult environment Acute Trusts are working within.

The blank declaration form that needs to be submitted to NHSI by 31st May 2016 is attached. The Board will note that this provides the opportunity to include some narrative where necessary.

Board "Certification G6"

Declarations required by General condition 6 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	
	AND	
2	The board declares that the Licensee continues to meet the criteria for holding a licence.	

Signed on behalf of the board of directors, and having regard to the views of the governors

Signature Signature

Name		**Name**	
Capacity	[job title here]	**Capacity**	[job title here]
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations 1 or 2 above.

A

B

Board of Directors	
Agenda Item	9.4
Title of Report	Report of the Quality & Safety Committee 18 May 2016
Date of Meeting	25 May 2016
Author	Dr Jean Quinn, Chair of the Quality and Safety Committee
Accountable Executive	Evan Moore, Medical Director
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	1,3,4,5,6,7 1a,1b,3a,3b,4a,5b,6b,7a,7c,7d 1445,1908,1909,2328,2485,2611,2678
Level of Assurance • **Positive** • **Gap(s)**	Gaps with mitigating action
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

This report provides a summary of the work of the Quality and Safety Committee which met on the 18 May 2016. Key focus areas are those which address the gaps in assurance/control in the Board Assurance Framework.

Board Assurance Framework (BAF)

The Committee's agenda reflected the gaps in assurance/control on the BAF and was structured such that it allowed for greater focus on the most significant risk areas. The Committee reviewed the risk ratings as a result of the Senior Management Team review and noted the one new risk relating to; the actions being taken following the Maternity Cultural Review. The Committee agreed that the further risk for inclusion in relation to the junior doctors contract was awaiting the outcome of current negotiations.

The Committee also supported the proposal to rate risks in relation to access targets against the improvement trajectory agreed with NHS Improvement, this would allow greater visibility on

progress. To ensure that the focus on provider licence compliance was not, the Committee agreed to encapsulate these under the general provider licence risk.

The Committee noted the increased risk ratings for those risks pertaining to partnership and the decreased risk ratings for those risks relating to C difficile. The Committee reviewed how the change in risk ratings had impacted on the overall risk profile and agreed that monitoring mitigating actions for risks relating to access standards would be key.

The Committee supported the recommendation to await the outcome of the forthcoming risk appetite development session with the Board before making any further changes to the BAF.

Workforce and OD Dashboard

Good performance was reported, the key highlights being:

- Sickness absence rates were reported at 4.11% for March 2016 which was a vast improvement on the same time in the previous year when this was 4.59%
- The Trust's flu vaccination rate was reported at 79.2% which was the highest uptake the organisation has ever achieved
- The vacancy rate for Nursing and Midwifery was reported at 5.73% which remains significantly better than the national average and the overall consultant vacancy rate was reported at 1.14% which was very low
- Appraisal rates were reported at 88.05% which is just above the Trust appraisal target of 88%

The Committee was pleased to note the ongoing adaptation of safeguarding training in line with CQC recommendations to offer staff level one training in a face to face setting.

Staff Guardian Annual Report 2015/16

The Committee was pleased to receive the first Staff Guardian Annual Report which detailed the positive work of Staff Guardians in increasing the profile of the Raising Concerns Policy and supporting staff through the Raising Concerns process. The scheme also has seen the refresh of HR policies, procedures and processes, the reenergising of attitudes and behaviours and the introduction of a proactive approach to management of staffing levels amongst other actions.

Staff Guardians have been well received with positive feedback from both the National Staff Survey and other organisations resulting in significant national interest and the scheme having been shortlisted for the prestigious Health Service Journal Award.

Maternity Cultural Review

The Committee was pleased to receive the external Maternity Cultural Review undertaken by Robertson Cooper in early 2016 which is to be presented to the Board in May 2016. The Committee noted the many positives identified by the report and reviewed areas identified for improvement for which a programme of work is to be undertaken to engage with staff.

Because of the recent activity on social media, the Committee sought assurance on guidance for staff in this respect: Internet Terms of Usage Policy is in place and enforced when required however additional work is required to raise awareness of staff responsibilities in respect of social media.

CQC Compliance and Assurance Report

The Committee received an overview of the results of the Care Quality Inspections (CQI) undertaken in February 2016 within wards 10, 11, 18 and 20. All wards received an overall score of "good" however areas for improvement have been identified and will be addressed as part of the action plan.

WHO Checklist Audit

The Committee was advised that improvements in utilising the WHO Checklist are apparent following the audit in February 2016 however in order to further instil the process a relaunch of the Steps to Safer Surgery will take place in June 2016 alongside continuous promotion of safety culture.

Cancer Performance Action Plan by Speciality

The Committee was pleased to receive a deep dive into cancer performance and noted the mitigating actions put in place across those tumour groups with issues, challenges and risks which impact on performance.

The Committee were also provided with an overview of tracking methodology and assured of the tracking processes across all tracking systems to ensure that patients receive consistent monitoring.

Health and Safety Annual Report

The Committee reviewed the Health and Safety Annual Report and were pleased that Internal Auditors (MIAA) and external inspectors had provided positive feedback on the established health and safety processes and systems with all actions contained within the action plan for 2015/16 completed.

Following review of the report the Committee requested that a deep dive into sharps incidents and asbestos be presented to provide assurance on the progress of ongoing action plans. In view of this the full report together with an update would be presented to the Board in June 16.

Draft Quality Account Annual Report

The Committee received the Draft Quality Account, the final version of which will be presented to the Board in May 2016. The draft report focused on 6 priority areas and substantial progress towards targets was noted for each.

The Committee noted the data quality issues identified by external auditors in respect of 18 weeks referral to treatment (incomplete pathways) and the 4-hour Accident and Emergency Target which may result in the issue of a qualified audit opinion on the Quality Account. However, it is hoped that issues pertaining to 4-hour Accident and Emergency data can be rectified following the separation out of figures relating to the Walk-In Centre located on the Arrowe Park site.

It was requested that the action plan be reviewed to more evenly distribute actions across the senior management team.

CQC Audit of Puerperal Sepsis

The Committee received the CQC Audit of Puerperal Sepsis which was undertaken as a result of the Trust being identified as a statistical outlier by the CQC. The report highlighted areas for improvement for which an action plan has been drafted with all actions due by September 2016.

Further work is to be undertaken at the request of the Committee to ascertain whether the Cerner Sepsis Database can be utilised for further analysis in this area.

Quality Improvement Strategy

The Committee was pleased to receive the Quality Improvement Strategy for 2016-19, agreeing the areas of focus. A further report is to be presented to the Committee outlining how the plan will be managed including all key milestones/targets.

Dr Jean Quinn
Chair of Quality and Safety Committee

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF MEETING

27 APRIL 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
Janelle Holmes	Chief Operating Officer
Graham Hollick	Non-Executive Director
Gareth Lawrence	Acting Director of Finance
Jean Quinn	Non-Executive Director
John Sullivan	Non-Executive Director
Gaynor Westray	Director of Nursing and Midwifery

Apologies

Cathy Maddaford	Non-Executive Director

In attendance

Carole Self	Director of Corporate Affairs
Chris Oliver	Interim Director of Operations
Mike Coupe	Director of Strategy*

Public attendance

Amanda Farrell	Divisional Director – Medical and Acute Division
Kate Jury	Deloitte
Jane Kearley	Member of the public
Len Smith	Public Governor

*denotes attendance for part of the meeting

Reference	Minute	Action
BM16-17/001	**Apologies for Absence** Noted as above	
BM16-17/002	**Declarations of Interest** None	
BM16-17/003	**Patient Story** The Director of Nursing and Midwifery provided the Board with the feedback from the parents of a 15 year who attended the Childrens Emergency Department with a laceration to the forehead. The feedback was positive and thanks were extended to the staff for being caring and understanding.	

Reference	Minute	Action
BM16-17/004	**Chairman's Business** The Chairman updated the Board on the successful visit by the Mayor Mr Rowland on the 20th April 2016. The visit focused on caring for patients with dementia and the feedback from the Mayor was very positive in terms of how caring staff were and the positive environment. Thanks were extended to the Director of Nursing and Midwifery and the staff for organising this visit. The Medical Director was congratulated on his recent appointment to the Chief Medical Director/Deputy Chief Executive of Betsi Cadwaldar although clearly this would be a loss for the Trust. The Medical Director provided an update on the junior doctors strike, the preparations for the withdrawal of emergency care and how this was being managed. No adverse incidents had been reported and the hospital was described as calm.	
BM16-17/005	**Chief Executive's Report** The Chief Executive provided an update on the following: **CCG** – he confirmed that the contract negotiations had been completed. The Board congratulated the Chief Executive and Acting Director of Finance in concluding these successfully. **National Information Board** – the Board was pleased to note that the Trust had been ranked 4th by the HSJ in the recent digital maturity index as this recognised the good work over many years. The Chief Executive advised the Board that he had invited Matthew Swindells formerly of Cerner and now NHSE to address North West Chief Executives at a meeting on the 10th June to look challenges and opportunities in the Cheshire and Merseyside STP. **Staff Guardians** – the Chief Executive confirmed that 90 of the 92 concerns raised had been concluded; 70% of all concerns were raised and concluded in the same month. The Board confirmed that the Quality and Safety Committee was due to review the themes raised at its meeting in May and therefore a summary should be provided thereafter for the Board. **Celebrating success** – the Board extended its congratulations to the Emergency Department for being awarded the PROUD team of the Quarter and to the Occupational Health Team having achieved the SEQOHS accreditation.	**CS/JM**
BM16-17/006	**Vanguard Programme Update** The Director of Strategy presented the Vanguard Programme Update which included the notification from NHS England that there would not be any Vanguard funding in this financial year. The Board was advised that this was the picture nationally with most Vanguards schemes similarly being affected. The Board was advised that Wirral Partners had suggested that Vanguard be subsumed into Healthy Wirral although the Programme Management	

Reference	Minute	Action
	Board would have to be trimmed down and the projects re-visited to ensure the focus was through collaborating organisations and concentrating on Healthy Intent; Elderly services; unscheduled care; progressing towards an Accountable Care System and health and social care urgent care contracting. The Board recorded its disappointment however it welcomed the opportunity to focus on integration and the opportunity for a different way of working across organisations.	
BM16-17/007	**Annual Operational Plan** • **Review of performance against 2015/16 objectives** The Board noted the report and the progress made during the year; specifically in the improved staff satisfaction results and the progress in information technology which had been recognised in the Digital Maturity Index. The Board recognised that the challenges reported in operational and financial performance was in the context of the broader NHS which was itself under significant pressures. The Board accepted the report subject to the inclusion of performance in both attendance and appraisal rates, both of which were of note. • **2016/17 Annual Plan** The Chairman reminded the Board that it had seen the plan a number of times and to concentrate therefore on the decisions taken more recently. The two key changes were confirmed as the demand, capacity and access standards and the financial position. The Acting Director of Finance advised that the plan now included the contract activity for 16/17 set against 15/16 activity levels. The contract assumed that A & E attendances would remain unchanged whilst non-elective admissions would reduce this was based on the health economy commitment to progress with initiatives such as the pilot to divert patients to Victoria Central for Minor medical emergencies and the medium term plan for this service to be kite-marked accordingly. The Chief Executive confirmed that the activity levels were consistent with the local delivery STP and allowed all parties therefore to focus on a single version of activity to ensure the right behaviours are deployed. The Board was concerned that the Trust had experienced significant difficulties with the achievement of the A & E standard as a result of activity levels and sought to understand therefore how this could be improved in 16/17 and in turn how the Board would monitor improvement. The Chief Executive acknowledged the concerns particularly in light of recent events following the reduction in the Better Care Funding and Vanguard Funding which have led to the CCG decommissioning a number of discharge schemes and the Local Authority looking to reduce the number of care home beds available. The Chief Operating Officer confirmed that the work of the Task and Finish Group would focus on tracking performance and variances which would be reported into the contracting meetings. If activity did continue to rise then the contract	**MC**

Reference	Minute	Action
	monitoring meetings would review this as part of the review of thresholds in the contract. The Board sought to understand what assurance the Trust had that activity levels would not increase further. The Chief Executive confirmed that the negotiations had been based on capacity vs demand; the need to achieve 18 week compliance and the need to remain in a financial envelope affordable to the CCG. The contract allows for an element of risk to be mitigated if there should be any material change in referrals or demand. The Board discussed how the Trust would engage with the CCG and GP partners to enact the change in behaviour required to deliver the health economy strategy and agreed that the next few weeks would be used to articulate how partners measure "value" and use this to inform 2017/18 contractual arrangements. The Board reviewed the changes made to the income, expenditure and cost improvement section of the annual plan following the conclusion of the contractual negotiations resulting in a financial envelope as previously discussed. The Board was reminded of the sensitivity analysis in the document as previously discussed. The Board was pleased with the progress made; extended its thanks to everyone involved in the process and agreed to ratify the report.	
BM16-17/008	**Integrated Performance Report** **7.1.1 Integrated Dashboard and Exception Reports** The Chief Operating Officer presented the performance report focussing on the following areas: **A & E 4 hour standard** – this was reported for March as 80.22%. April to date performance was reported as improving at 84.72% which was on track with the performance improvement trajectory. The Board was updated on the establishment of the task and finish group which was designed to focus on the internal actions to improve performance and patient flow. **18 weeks** – performance for March was reported at 90.46%. The focus of work was on determining capacity and demand and reviewing the job planning templates. The Board sought to establish the actual impact of the junior doctors industrial action on the achievement of this target. The Acting Director of Finance confirmed that more than 20% of capacity was lost in April; 8% due to inpatient activity and 14% in outpatient activity. He did clarify however that the performance on activity ahead of the plan was below expected levels, however because there was no tolerance in the system, this led to the Trust slightly underachieving overall. The Board was conscious of the need not to lose sight of some of the more fundamental underlying difficulties frustrating compliance by focussing too much on the current junior doctors dispute. The Board sought and	

Reference	Minute	Action
	received confirmation that the Trust was taking all the necessary action to try and achieve performance in April however this would not be known for a couple of weeks. **C difficile** – the Board noted the continued progress in this area and the success of the action plan. The Board debated how it would review and assess performance going forward in view of the provider licence requirement to achieve NHS constitutional standards versus achieving compliance against the submission of improvement trajectories for A & E and 18 weeks. The Chief Operating Officer confirmed that this work was being undertaken. The Board sought to understand whether the underperformance in the AQ targets was related to recording or was a potential risk to patients. The Medical Director confirmed that AKI and community acquired pneumonia was associated with recording; sepsis however related to issues with IV fluids and the interaction with the blood gas machine. Work was progressing in all 3 areas to improve performance. The Board agreed that the amended style of reporting was helpful although it would be useful to progress even further to include early warning indicators. The Board noted the performance against the cancer standards which although showed achievement on an aggregate level still had areas where further work was being progressed. **7.1.2 Month 12 Finance Report** The Acting Director of Finance reported the M12 performance which brought to an end a very challenging year for the Trust and the NHS as a whole. The M12 deficit was reported as £15.4M although this was still subject to Audit. The year-end cash position was reported at £3.5M which was £1.9M higher than plan. The Financial Sustainability Risk Rating FSRR was reported at 2 in line with the plan. The Acting Director of Finance outlined the concessions and agreements made to conclude the year-end negotiations and inform the 2016/17 contract which had avoided the need for arbitration and had maintained good relationships. The Board congratulated the Executive on the delivery achievement in line with expectations and the conclusion of negotiations with the CCG. The Board further sought to understand how the risk was finally shared. The importance of the year-end deal was that both parties managed delivery in line with expectations which was a good signal as the Wirral progresses towards an Accountable Care System. The Board queried the significant change in post EBITBA items and why this had impacted on performance for M12. The Acting Director of Finance confirmed that this was the result of a desk top exercise which was	

Reference	Minute	Action
	reported to the Finance Committee in January and concluded in March 16. The desktop review could have resulted in a risk or an opportunity, the conclusion was this enabled a reduction in depreciation charges which led to the final position. The Board extended its thanks to the Acting Director of Finance and the Finance team and formally accepted the report.	
BM16-17/009	**Chair of the Audit Committee Report** Mrs Bond reported on the work of the Audit Committee which included the decision to include changes to legislation that impact on the Audit Committee's work in its workplan. This was the result of the External Audit questionnaire. The Board was pleased to note that the work on the incident web-holding file that had resulted in a significant reduction in the backlog which was now 118 from the previous position of over 1000. The oldest incident was now within compliance levels although the Board agreed that this work needed to continue. The Board noted the work undertaken at Audit Committee in relation to the standing financial instructions and the scheme of delegation which had resulted in the development of a new authorisation matrix, as presented. The Board was advised of the plans to disseminate this work and ensure that all managers with delegated financial responsibility undertook training before authorisation would be permissible. The Board sought clarity on the terminology of "authority" in the matrix which was provided by the Acting Director of Finance. The Chief Executive confirmed that the changes had been fully reviewed and supported by the senior management team. The Board approved the authorisation matrix.	
BM16-17/010	**Report of the Finance Business Performance and Assurance Committee** Mr Hollick presented the report on the work of the Finance Business Performance and Assurance Committee. This included the changes approved by the Committee to the terms of reference for its supporting groups and the recommendation to the Board to the revised terms of reference for the Committee which were subsequently approved by the Board. Mr Hollick outlined the work of the Committee on the review of the Cost Improvement Programme and the review of the "going concern" statement which the Board subsequently approved. The Director of Corporate Affairs advised the Board that the Committee had recommended that the risk associated with commissioner affordability be removed from the Board Assurance Framework and replaced with the risk of managing demand and referral levels in the future. The change	

Reference	Minute	Action
	was a result of the agreement of a financial envelope for 16/17. She also advised that the Committee had recommended that the replacement of the risk in relation to competition in the market be replaced with the risk associated with the development of the Accountable Care System/Organisation. The Board approved both recommendations.	
BM16-17/011	**Review of Register of Interests** The Board accepted the register of interests as presented subject to the following minor amendments: • Mrs Hodgson confirmed that she was no longer the interim CFO for the Universities Superannuation Scheme Ltd • Mr Allison confirmed that NWLA stood for the North West Leadership Academy The Board was pleased that the register of interests now also included the full senior management team and accepted the register accordingly.	**CS**
BM16-17/012	**Equality and Diversity Annual Report** The Director of Nursing and Midwifery presented the Equality and Diversity Annual Report highlighting the positive performance in terms of access to services through clear processes and pathways. There was good recognition of the Trust responding to a variety of different needs. The Board reviewed the outcomes of the Equality Delivery System 2 self-assessment and sought to understand what the Board could do to improve the "undeveloped" rating for inclusive leadership. The Director of Nursing and Midwifery confirmed that this was more to do with how the Trust provided evidence of engagement on the equality and diversity agenda outside of the organisation. The Board noted its disappointment with the lack of sight on the self-assessment or the scheme ahead of publication. The Board agreed that the Workforce and Communication Group would receive an update on the Workforce and OD aspects related to this report, specifically including a review of the current position and what further steps needed to be taken in 2016/17 related to this critical matter. The Board agreed to receive assurance that all the necessary steps had been taken via the Chair of the Quality and Safety Committee Report in July 2016.	**GW/JM**
BM16-17/013	**Monitor Financial Commentary – M12** The Board approved the text and the governance declarations as presented.	
BM16-17/014	**Board of Directors** The Minutes of the Board of Directors Meetings held on 27 March 2016 were confirmed as an accurate record.	

Reference	Minute	Action
	Board Action Log The Board action log was updated as recorded	
BM16-17/015	**Items for BAF/Risk Register** The Board agreed to record the risk in relation to achievement of the control total; the implementation of the junior doctors contract and the early risks identified as a result in the forthcoming change of Medical Director.	
BM16-17/016	**Item to be considered by Assurance Committees** The Board agreed to the following: Quality and Safety Committee to focus on the performance of community paediatrics; the themes from raising concerns and the review of cancer target achievement by speciality Finance Business Performance and Assurance Committee to focus on demand, capacity and achievement of access targets; the achievement of financial targets and the review of thresholds. The Board agreed that A & E monitoring and review would be undertaken at the Board.	**CS** **CS**
BM16-17/017	**Any Other Business** The Medical Director advised the Board of a Never Event that occurred in March 16 but was only evident 6 weeks later. The event was in relation to the extraction of incorrect teeth to create space. The orthodontist noted that the incorrect teeth were extracted at his review appointment and had now planned his treatment accordingly with the space that had been created. There was no harm to the patient; the family were advised of the incident as were the regulators. The Root Cause Analysis is underway. The Board was reminded of the forthcoming development session on risk appetite which had been rearranged to the 19th May 2016.	
BM16-17/018	**Date and Time of Next Meeting** Wednesday 25 May 2016 at 9.00 a.m. in the Boardroom, Education Centre, Arrowe Park Hospital.	

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Chairman

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Date

ACTION LOG
Board of Directors
Updated – May 2016

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 27.04.16						
1	BM16-17/005	Q & S committee to review themes from the concerns raised with staff guardians	CS/JM	**Completed – updated included in Chairs report for May 16**		
2	BM16-17/007	Include attendance and appraisal performance in the achievement of 2015/16 objectives	MC			
3	BM16-17/011	Amend the register of interests as follows: Remove the reference for Mrs Hodgson in her interim CFO role for the Universities Superannuation Scheme Ltd Describe in full NWLA	CS			
4	BM16-17/012	Update the Board on the improvements being made to the Equality and Diversity Agenda through the Chair of Q & S report	GW/JM			
5	BM16-17/016	Q & S committee to focus on community paediatrics; the themes from the raising concerns work and the review of cancer target by speciality	CS	**The Chair of Q & S report include updates on the Cancer work and the raising concerns themes.**	May 16	
6	BM16-17/016	FBP&AC to focus on demand, capacity and achievement of access targets; achievement of financial targets and review of thresholds	CS		June 16	
Date of Meeting 30.03.16						

7	BM15-16/297	Present the Medical Engagement Strategy	EM/JM	**This work is underway**	May16	
8	BM15-16/299	Update on the number of discharges before noon as a result of the SAFER roll out	CO		April 16	
9	BM15-16/300	Include the number of staff on either preceptorship or mentorship programmes in future nurse staffing reports	GW		May 16	
10	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	
11	BM15-16/301	Provide an updated report on community paediatrics which clearly articulates what success looks like	AH/MW/ CO	**Included in the private part of the agenda due to commercial in confidence sensitivities**	May 16	
Date of Meeting 27.01.16						
12	BM15-16/241	Provide a monthly progress report on community paediatrics	CO	**Included in the private part of the agenda due to commercial in confidence sensitivities**	May 2016	
13	BM15-16/243	Provide a weekly progress report on A & E in light of current performance	CO	**ongoing**		
14	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	**Chief Operating Officer to review performance reporting and dashboard**	March 2016	

15	BM15-16/245	The Board agreed to review capacity and capability of the nursing workforce in future reports by including a suite of indicators and metrics which focus on mentorship/ perceptorship and safety	GW	**Metrics under development – to be included in report for April 16 - completed**	March 2016	
16	BM15-16/250	Undertake a review of the Board's risk appetite as part of the risk management review	CS	**Session planned for May 16 - completed**	March 2016	
Date of Meeting 28.10.15						
17	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	**Chief Operating Officer to review performance reporting and dashboard**	November 2015	
18	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	**Chief Operating Officer to review performance reporting and dashboard**	November 2015	
Date of Meeting 30.09.15						
19	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	**Chief Operating Officer to review performance reporting and dashboard**	October 2015	
Date of Meeting 29.04.15						
20	BM 15-16/015	Provide the Board with a monthly update on CQC improvement against compliance	EM/CS	**Ongoing**	March 16	