Wirral University Teaching Hospital NHS
NHS Foundation Trust

Board of Directors

Public Board

29 June 2016

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**MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 29 JUNE 2016
COMMENCING AT 9.00AM IN THE
BOARD ROOM
EDUCATION CENTRE, ARROWE PARK HOSPITAL**

AGENDA

1.	**Apologies for Absence** Chairman	v
2.	**Declarations of Interest** Chairman	v
3.	**Patient's Story** Director of Nursing and Midwifery	v
4.	**Chairman's Business** Chairman	v
5.	**Chief Executive's Report** Chief Executive	d

6. Performance and Improvement

6.1	**Integrated Performance Report**	
	6.1.1 Integrated Dashboard and Exception Reports Chief Operating Officer	d
	6.1.2 Month 2 Finance and Cost Improvement Programme Report Director of Finance	d

7. Governance

7.1	**External Assurance:** • **Board declaration – Corporate Governance Statement** Director of Corporate Affairs	d
7.2	**External Assurance:** • **NHS Quarter 4 Feedback Letter** Director of Corporate Affairs	d
7.3	**Approval of Risk Management Strategy** Medical Director	d
7.4	**Report of the Finance Business Performance and Assurance Committee** Chair of the Committee	d
7.5	**Board of Directors**	d
	7.5.1 Minutes of the Previous Meeting • **25 May 2016**	

7.5.2 Board Action Log
Director of Corporate Affairs

8. Standing Items

8.1	**Items for BAF/Risk Register** Chairman	v
8.2	**Items to be considered by Assurance Committees** Chairman	v
8.3	**Any Other Business** Chairman	v
8.4	**Date and Time of Next Meeting** Wednesday 27 July 2016 at 9am	v

Board of Directors	
Agenda Item	5
Title of Report	Chief Executive's Report
Date of Meeting	29 June 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.

Internal

Operationally delivering against the A&E 4 hour target remains extremely challenging. A meeting with ECIP (Emergency Care Intensive Support Programme) involving all key health and social care stakeholders on 25 May complemented the Trust on the good

progress made with the SAFER roll-out, Red/Green day initiative and adoption of the frailty model but was challenging of the wider economy with regards to improving alternatives to admission and discharge to assess. A further meeting with ECIP is scheduled for w/c 5 September in order to review progress.

Last month the Trust Board was informed that the Trust had been unable to sign up to the proposed Better Care Fund (BCF) given the 40% reduction in Intermediate Care bed funding without any further clarity on how alternative provision would be arranged or an understanding of the impact on hospital discharges. Whilst discussions are ongoing the Trust recognizes that with this position, our previous winter strategy involving Charlotte House and the emerging national picture where hospitals are being encouraged to seek greater influence over step down facilities, we need to seek assurance regarding provision. Given the lack of capacity externally the Trust is developing under utilised capacity at Clatterbridge Hospital to alleviate the pressure at Arrowe Park. Creating a virtual step down facility is an innovative step and the Trust will explore partnering with external organisations to enable this to happen in a clinically and financially sustainable manner.

The process of clinical engagement as part of the Medical Director appointment process has progressed well with two meetings of the Clinical Advisory Group and numerous off line meetings with key influencers. It is clear that the approach taken, and the desire to widen the discussion to include wider clinical leadership and engagement, has resonated well with the clinical body. Momentum will be maintained as part of the Clinical Engagement Strategy.

The Board should note the appointment of Chris Oliver as the Director of Operations reporting into Janelle Holmes as Chief Operating Officer, and the news that Mark Blakeman, Director of Informatics and Infrastructure, has been appointed to a similar role in NHS England. Discussions are currently taking place with NHS England and Cerner UK regarding suitable replacement candidates.

Regulatory

Good progress has been made with Deloitte regarding the 'Well Led' Review of the Trust. Verbal feedback is anticipated by 28 June which will inform the feedback workshop planned for the Board on 30.06.16.

The next Performance Review with NHSI (formerly Monitor) is scheduled for 30 June where it is anticipated that A&E, RTT, Finance and System control totals will form the basis of the review. Trajectories for A&E and RTT performance have been developed to support STF (Sustainability and Transformation Fund) monies and have been agreed with NHS I and the CCG. On this basis NHSI have confirmed that no enforcement action would be taken regarding RTT performance.

Professor James Barratt has successfully been appointed to the Guardian for Safe Working (as per Junior Doctors contract) and NHSI have been advised accordingly.

External

Contracts for Specialist Commissioning have now been signed and this brings to a conclusion the contract negotiation cycle for 2016/17.

The Trust has very recently been informed that the CCG intend to close the All Day Health Centre on the Arrowe Park site from 1 October 2016. Given that the Trust's Emergency Department deflect patients to this service we are seeking clarity on the potential impact and any proposed mitigating actions. A system wide capacity/demand model owned by

SRG (System Resilience Group) would ensure a better understanding of proposed actions and the Trust will push for this to be developed.

Strategy

The STP process has become dominant as we approach the end of June submission deadline. Given the pace and scope a largely fragmented approach is inevitable and PwC have been employed to bring coherence and alignment with emerging themes nationally. The Trust has been well positioned in this process, both at STP and LDSP level. A final draft is to be presented to all stakeholders on 23 June: Emerging themes are clustered around Demand Management, Collaboration for Productivity and Standardisation of Hospital Services.

Given that the Acute Care Alliance with the Countess of Chester is not only consistent with emerging strategy but to a significant degree shaping it, especially on a Cheshire and Wirral footprint, it is important that the work on this continues at pace. A separate Board paper informs further. Meetings have been held with Matthew Swindells, newly appointed Director for Commissioning Operations and Information at NHSE, and Lord Carter seeking support and further understanding. Both meetings have been extremely positive.

June has therefore been extremely hectic strategically but the Trust is well positioned and over the summer national feedback is expected so that plans for operational delivery can be developed so that implementation can commence from September.

Celebrating Success

Our Outpatient Parenteral Antimicrobial Therapy Service OPAT was the overall winner at the 2016 Advancing Healthcare awards for their work with GPs and community nurses to support them to give intravenous antibiotics to people at home, increasingly without them going anywhere near a hospital. This is a fabulous recognition.

David Allison
Chief Executive

June 2016

Board of Directors	
Agenda Item	**6.1.1**
Title of Report	**Integrated Performance Dashboard**
Date of Meeting	**29th June 2016**
Author	**John Halliday, Assistant Director of Information** **Chris Oliver, Director of Operations**
Accountable Executive	**Janelle Holmes** **Chief Operating Officer**
FOI status	**Document may be disclosed in full**
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	**All Strategic Objectives (1 through 7)** **All Key Measures (1A through 7D)** **All Principal Risks**
Level of Assurance • **Positive** • **Gap(s)**	**Partial with gaps**
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	**Discussion**
Data Quality Rating	**Silver – quantitative data that has not been externally validated**
FOI status	**Document may be disclosed in full**
Equality Impact Assessment Undertaken • **Yes** • **No**	**No**

1. Executive Summary

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

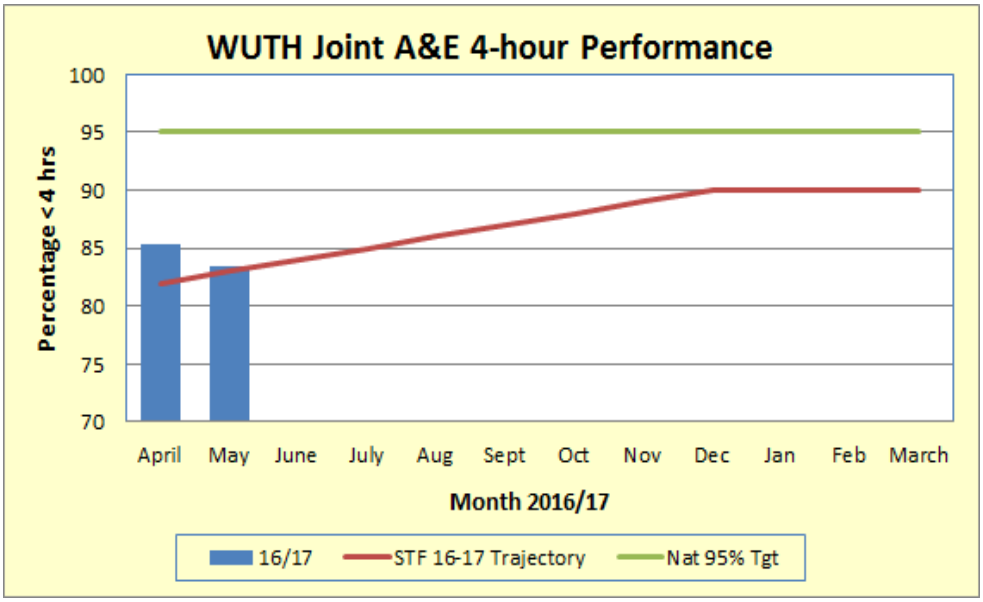
The key issues relating to external validation is achievement of the A&E and RTT targets, with detailed comments against each area below.

3. Detailed Explanation of Performance and Actions

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

Against the A&E standard of a minimum 95% of patients to be admitted, transferred or discharged within four hours, the month of May was 83.44% as measured across a combined ED and All Day Health Centre performance at the Arrowe Park site. ED alone was 77.67%.

The performance in May for the emergency access standard although not achieving the regulatory compliance level of 95% was above the STF trajectory of 83%, and is illustrated below.



The Task and Finish groups continue to meet and challenge on delivery and sustainability of improvements being made both within the Trust and with economy leads.

Externally there are there have been a number of changes to work streams in order to gain more traction against the health economy recovery plan following the ECIP feedback. The two main focusses are:

- Establishment of the single front door
- Discharge to Assess

Internally the work is focussed on:

- Rapid senior decision making as close to the front door as possible
- Appropriate utilisation of the organisational assessment units
- Tracking of monitoring of patients to reduce length of stay and expedite discharge.

A new capacity model and process has been implemented within the capacity meetings and there is a daily focus meeting held by the Chief Operating Officer within the ED to review performance and barriers.

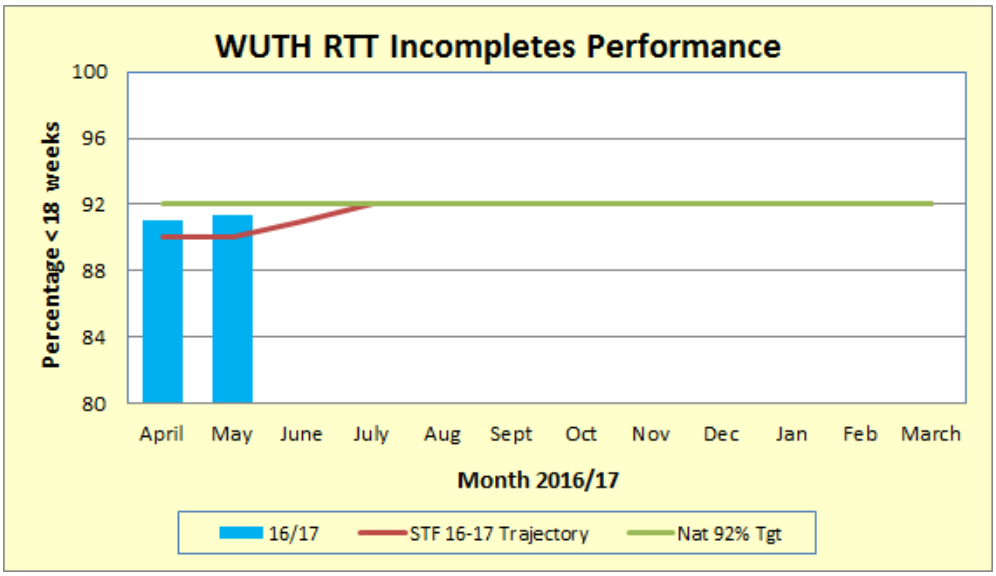
The Trust has made good progress in reducing the number of admissions sent directly to base wards with the number previously averaging at 80 patients per week to now under 20 based on 'assess to admit'

To strengthen this process the new Acute Ambulatory Care Unit opens on 27th June, which will further assist the pull of patients from the Emergency department. The new unit has additional capacity focused on ambulatory patients to avoid admission to base wards by utilising speciality in reach. The unit also has additional trolley capacity to negate the need to redirect patients to the Emergency department, unless on clinical need. It is anticipated that once this is fully operational all escalation capacity in the organisation will be closed whilst a review of the bed base is completed over the summer to inform 'winter planning'.

b. 18 Weeks RTT

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

As expected the Trust did not achieve the standard at the end of May, with the final position showing continual improvement being reported at 91.39% which delivered compliance against the STF trajectory of 90%, as illustrated below.



The national specialties that are not achieving and contribute to the Trust's overall failure are 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. Urology having previously been a failing speciality is now achieving compliance and this is expected to continue.

Good progress has been made by Divisional teams in cleansing the patient tracking lists enabling the Access and Performance meeting to focus on actual patient management ensuring corrective action is taken in advance of any non-compliance. Capacity and demand models continue to be produced at speciality level utilising the Intensive Management Support tools.

c. Infection Control

For C Difficile, there were zero cases considered avoidable in April and two in May. This is below the plan trajectory of three cases to the end of May.

d. Cancer

For Cancer access targets, the 62-day standard continues to be the most difficult to achieve, and this is reflected in performance levels at a national level. This particular standard also has an explicit line in the Sustainability & Transformation Fund (STF) trajectories, with the expectation the 85% standard will be achieved each month. Cancer waiting time performance is only finalised many weeks after month-end due to the time required to confirm diagnosis and share patient pathways between providers. The current performance against the 62-day Cancer standard for the current quarter is detailed in the dashboard.

e. Advancing quality indicators

As previously reported, improved performance is not expected until June's data is collected. Additional awareness raising has been undertaken, and a quality improvement workshop is scheduled for all teams in July to concentrate on one or two measures where they are failing and to review how they can improve performance. The teams are trying to get back to working real time so they are on the wards working alongside staff.

Particular details on the five areas not achieving:

- *Community Acquired Pneumonia:* the standards are not being achieved where it is reliant on treatment time from arrival in the ED.
- *AMI, AKI, and HF:* continued impact of staff sickness and depleted AQ resources.

Hip & Knee: compliance was 100% on all bar one measure – antibiotics within one hour of surgery. Four knee patients did not receive this, with the individual cases being followed up.

4. Recommendation

The Board of Directors are asked to;

Note the Trust's current performance to the end of May 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 continuing to maintain the focus on the improvements required in these areas.

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

Area	Indicator / BAF	Mar	April	May	Trend / Future Concern	*Target (for 'Green')*	Latest Period	Exec Lead
Meeting Our Vision	**Satisfaction Rates**							
	Patient - F&F "Recommend" Rate	97%	98%	98%		>=95%	May 2016	GW
	Patient - F&F "Not Recommend" Rate	2%	1%	1%		<=2%	May 2016	GW
	Staff Satisfaction (engagement)	3.79	3.78	3.78		>=3.69	Q4 2015/16	JM
	First Choice Locally & Regionally							
	Market Share Wirral	86.0%	82.3%	82.4%		>= 85%	Dec 2015 to Feb 2016	MC
	Demand Referral Rates	-1.1%	-6.8%	-1.1%		>= 3% YoY variance	Fin Yr-on-Yr to May 2016	MC
	Market Share Non-Wirral	9.4%	9.4%	9.1%		>=8%	Dec 2015 to Feb 2016	MC
	Strategic Objectives							
	Harm Free Care	95%	95%	96%		>= 95%	May 2016	GW
	HIMMs Level	5	5	5		5	May 2016	MB
Operational Excellence	**Key Performance Indicators**							
	A&E 4 Hour Standard *	80.22%	85.38%	83.44%		>=95%	May 2016	CO
	RTT 18 Weeks Incomplete Position *	90.46%	91.08%	91.39%		>=92%	May 2016	CO
	Cancer Waiting Time Standards *	On track	On track	On track		All met at Trust level	Q1 to May 2016	CO
	Infection Control *	0 MRSA; 35 C diff	0 MRSA; 0 C diff	0 MRSA; 2 C diff		0 MRSA Bacteraemia in month, and cdiff less than cumulative trajectory	May 2016	GW
	Productivity							
	Delayed Transfers of Care	3.4	Under review	Under review		<= 4	May 2016	CO
	Delayed Complex Care Packages	51	58	52		<= 45	May 2016	CO
	Bed Occupancy	97.6%	91.8%	91.2%		<=85%	May 2016	CO
	Bed Occupancy Medicine	93.3%	89.5%	93.7%		<=85%	May 2016	CO
	Theatre Utilisation	69.8%	68.5%	Under review		>=85%	May 2016	CO
	Outpatient DNA Rate	7.9%	8.3%	8.1%		<=6.5%	May 2016	CO
	Outpatient Utilisation	81.6%	81.3%	81.4%		>90%	May 2016	CO
	Length of Stay - Non Elective Medicine	5.3	5.5	5.0		<= 5.0	May 2016	CO
	Length of Stay - Non-elective Trust	4.7	4.9	5.5		<=4.2	May 2016	CO
	Contract Performance (activity)	-2.0%	-5.3%	-0.9%		0% or greater	May 2016	CO
	Finance							
	Contract Performance (finance)	-1.7%	0.0%	0.2%		On Plan or Above YTD	May 2016	DJ
	Expenditure Performance	0.4%	-0.7%	-1.0%		On Plan or Above YTD	May 2016	DJ
	CIP Performance	-8.8%	-23.2%	-15.2%		On Plan or Above	May 2016	DJ
	Capital Programme	10.5%	61.5%	76.8%		On Plan	May 2016	DJ
	Non-Core Spend	9.9%	10.4%	10.4%		<5%	May 2016	DJ
	Cash Position	215%	209%	748%		On plan or above YTD	May 2016	DJ
	Cash - liquidity days	-24.9	-28.4	-25.5		> 0 days	May 2016	DJ
A Healthy Organisation	**Clinical Outcomes**							
	Never Events	0	0	0		0 per month	May 2016	EM
	Complaints	36.7	35.8	35.4		<30 per month	12-mth ave to May 2016	GW
	Workforce							
	Attendance	95.9%	95.8%	95.8%		>= 96%	May 2016	JM
	Qualified Nurse Vacancies	5.7%	3.5%	4.1%		<=6.5%	May 2016	GW
	Mandatory Training	90.5%	89.7%	88.8%		>= 95%	May 2016	JM
	Appraisal	88.05%	87.81%	87.77%		>= 85%	May 2016	JM
	Turnover	9.3%	9.2%	9.4%		<10%	May 2016	JM
	Agency Spend	New metric	-9.2%	-5.2%		On plan	May 2016	GW
	Agency Cap	113	185	153		0	May 2016	JM
External Validation	**National Comparators**							
	Advancing Quality (not achieving)	3	4	5		All areas above target	March 2016	EM
	Mortality: HSMR	90.8	89.35	88.05		Lower CI < 0.90	April 2015 to Feb 2016	EM
	Mortality: SHMI	0.988	0.988	0.988		Lower CI < 90	Oct 2014 to Sept 2015	EM
	Regulatory Bodies							
	Monitor Risk Rating - Finance CoS	2	2	2		4	May 2016	DJ
	Monitor Risk Rating - Governance	Red	Red	Red		Green	May 2016	CO
	CQC	Amber	Amber	Amber		Overall CQC rating Requires Improvement	May 2016	EM
	Local View							
	Commissioning - Contract KPIs	7	4	3		<=2	May 2016	CO

Note: * Indicators of governance concern under NHS Improvement (Monitor) Risk Assessment Framework

Quarter	1
Period	01/04/2016 - 30/06/201

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			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted
Medicine	Haematology	0	0	0	6	0	6	100.00%	100.00%
	Lung	0	0	0	6	0	6	100.00%	100.00%
	Other	1	0	1	1	0	1	0.00%	0.00%
Med & Surg	Upper GI	5	0	5	8.5	0	8.5	41.18%	41.18%
Surgery	Breast	0	0	0	30.5	0	30.5	100.00%	100.00%
	Colorectal	3	0	3	16	0	16	81.25%	81.25%
	Head & Neck	3	0	3	5.5	0	5.5	45.45%	45.45%
	Skin	0	0	0	39	0	39	100.00%	100.00%
	Urology	6	0	6	33.5	0	33.5	82.09%	82.09%
Women's	Gynaecology	2	0	2	9	0	9	77.78%	77.78%
	Total	**20**	**0**	**20**	**155**	**0**	**155**	87.10%	87.10%

Quarter 1 - April

Division	Tumour Group	Breaches			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted
Medicine	Haematology	0	0	0	2	0	2	100.00%	100.00%
	Lung	0	0	0	4.5	0	4.5	100.00%	100.00%
	Other	1	0	1	1	0	1	0.00%	0.00%
Med & Surg	Upper GI	5	0	5	7	0	7	28.57%	28.57%
Surgery	Breast	0	0	0	15	0	15	100.00%	100.00%
	Colorectal	1	0	1	9	0	9	88.89%	88.89%
	Head & Neck	1	0	1	2.5	0	2.5	60.00%	60.00%
	Skin	0	0	0	31	0	31	100.00%	100.00%
	Urology	4	0	4	17	0	17	76.47%	76.47%
Women's	Gynaecology	1	0	1	4	0	4	75.00%	75.00%
	Total	**13**	**0**	**13**	**93**	**0**	**93**	86.02%	86.02%

Quarter 1 - May

Division	Tumour Group	Breaches			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted
Medicine	Haematology	0	0	0	4	0	4	100.00%	100.00%
	Lung	0	0	0	1.5	0	1.5	100.00%	100.00%
	Other	0	0	0	0	0	0	N/A	N/A
Med & Surg	Upper GI	0	0	0	1.5	0	1.5	100.00%	100.00%
Surgery	Breast	0	0	0	14.5	0	14.5	100.00%	100.00%
	Colorectal	2	0	2	7	0	7	71.43%	71.43%
	Head & Neck	2	0	2	2	0	2	0.00%	0.00%
	Skin	0	0	0	8	0	8	100.00%	100.00%
	Urology	2	0	2	14.5	0	14.5	86.21%	86.21%
Women's	Gynaecology	1	0	1	5	0	5	80.00%	80.00%
	Total	**7**	**0**	**7**	**58**	**0**	**58**	87.93%	87.93%

Quarter 1 - June

Division	Tumour Group	Breaches			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted
Medicine	Haematology	0	0	0	0	0	0	N/A	N/A
	Lung	0	0	0	0	0	0	N/A	N/A
	Other	0	0	0	0	0	0	N/A	N/A
Med & Surg	Upper GI	0	0	0	0	0	0	N/A	N/A
Surgery	Breast	0	0	0	1	0	1	100.00%	100.00%
	Colorectal	0	0	0	0	0	0	N/A	N/A
	Head & Neck	0	0	0	1	0	1	100.00%	100.00%
	Skin	0	0	0	0	0	0	N/A	N/A
	Urology	0	0	0	2	0	2	100.00%	100.00%
Women's	Gynaecology	0	0	0	0	0	0	N/A	N/A
	Total	**0**	**0**	**0**	**4**	**0**	**4**	100.00%	100.00%

Board of Directors	
Agenda Item	6.1.2
Title of Report	Month 2 Finance Report
Date of Meeting	29th June 2016
Author	Gareth Lawrence Deputy Director of Finance
Accountable Executive	David Jago, 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 performance of the Trust at Month 2 (31st May 2016) of the 2016/17 financial year.
During the month of May the Trust has delivered a £(0.7)m deficit compared to the plan of £(0.5)m, with expenditure being above plan by £(0.4)m. The Trust has delivered £1.2m of efficiencies as at the end of May against the target of £1.4m. This delivery includes non-recurrent slippage allocated by divisions at some £0.35m
The cash position is positive with a cash balance at the end of May of £21.2m which is some £18.7m above plan reflecting the advance payment from Wirral CCG in relation to June's contract payments.
The overall Month 2 financial position delivers a financial sustainability risk rating of 2 which is in line with plan albeit with variance to individual metrics and limited overall headroom.

Income and Expenditure Performance

In March 2016 the Board of Directors 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							
	PLAN	MONTH 2			YTD		
	Full Year Plan	Plan	Actual	Variance	Plan	Actual	Variance
	£k	£k	£k	£k	£k	£k	£k
NHS Clinical Income	294,936	24,270	24,357	87	48,379	48,454	75
Other Income	29,987	2,437	2,510	72	4,867	4,961	94
Employee Expenses	(213,301)	(17,980)	(18,633)	(653)	(36,337)	(37,255)	(918)
All Other Operational Expenses	(97,768)	(8,148)	(7,850)	297	(16,347)	(15,979)	368
EBITDA	13,854	580	383	(197)	563	181	(382)
Post EBITDA Items	(13,673)	(1,102)	(1,076)	26	(2,201)	(2,181)	20
Net Surplus/(Deficit)	181	(522)	(693)	(170)	(1,638)	(2,001)	(362)
EBITDA %	4.3%	2.2%	1.4%	(0.7%)	1.1%	0.3%	(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 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 £246k lower than plan.

Expenditure is currently above plan for the month of May by £(356)k and £(550)k cumulatively.

Pay costs are £(653)k above plan in month and are cumulatively £(918)k above plan. The main drivers of the additional pay expenditure are the continued utilisation of escalation areas which has resulted in increased nursing, medical costs and support costs c£(300)k ytd. Escalation areas were closed during parts of May but operational pressures meant that these were re-opened. Further pressures in medical staffing with gaps in senior and junior has resulted in costs above plan particularly in the Emergency Department c£(300)k.

Non pay costs are £297k under plan in Month 2 and are £368k cumulatively under plan as a result of underspends on clinical supplies lines. Continuing underspends will be tracked in order to support the CIP where appropriate.

As part of the Sustainability and Transformation Fund (STF) the Trust agreed to an overall cap on agency of £8,112k for the financial year. At the end of May the Trust has spent £1,509k which is £(74)k above the plan. 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 and then to the Finance, Business and Performance Assurance Committee. 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 £11,200k. The target is split both divisionally and by respective work streams. As at the end of the Month 2 the Trust is £(154)k behind the target of £1,400k. The position has been supported by non-recurrent savings identified within the divisions as they continue to develop and deliver the various work streams. The non-recurrent savings supporting the ytd position equate to £352k.

The table below details the month 2 position for CIP by Division and by work-stream.

	YTD			In Year		
Theme	Monitor Plan	Actual	Variance	Monitor Plan	Forecast	Variance
	£k	£k	£k	£k	£k	£k
Productivity & Efficiency	420	226	(194)	3,573	2,869	(704)
Workforce	366	278	(88)	2,518	1,390	(1,128)
Cost Control & Management	202	182	(19)	2,449	2,221	(228)
Estate Management	134	76	(58)	999	861	(138)
Income	184	174	(10)	1,300	1,327	27
Other Schemes	70	285	215	361	833	472
TOTAL	1,375	1,221	(154)	11,200	9,501	(1,699)
Division	Monitor Plan	Actual	Variance	Monitor Plan	Forecast	Variance
	£k	£k	£k	£k	£k	£k
Medicine & Acute	438	234	(204)	3,060	1,279	(1,781)
Surgery, Women & Children	446	304	(143)	3,630	2,940	(690)
Clinical Support Services	218	168	(51)	1,700	1,105	(595)
Corporate	246	348	103	1,810	2,144	334
Central	26	167	141	1,000	2,034	1,034
TOTAL	1,375	1,221	(154)	11,200	9,501	(1,699)

The Trust is currently forecasting delivery of £9,501k of CIP compared to the £11,200k target. Work continues within the respective work streams to bridge the gap and to ensure delivery the identified schemes.

Of the schemes that have been identified (£9,501k) 28% are being delivered through income compared to the initial plan of 24%, the marginal increase is a result of non-clinical income schemes that have been identified within Divisions.

Expenditure accounts for 57% of the overall CIP target with 15% still to be identified. As clinical income opportunities are limited the Trust will continue to look at cost reduction opportunities in order to release these further savings.

The Trust has run various events recently to engage front line managers and clinicians in identifying further opportunities. The results of these sessions will be reported back through the Transformation Steering Group (TSG).

Of the £9,501k schemes that have been identified c£7,600k have been fully developed and approved by the Transformation Steering Group. Appendix 1 displays the current levels of schemes within the current programme and their expected delivery. The challenge remains to convert more ideas, plans and opportunities into expenditure releasing schemes as we progress throughout the year.

The above figures are exclusive of the health economy challenge of £5m that has been included within the submitted plans approved by the Board of Directors. The Trust has yet to receive a date from NHS Improvement regarding the health economy meeting where the health economy challenge will be discussed. It is the Trusts understanding that this will be arranged in the coming months.

Cash position and Financial Sustainability Risk Rating (FSRR)

The May cash position was £21.2m, which is £18.7m higher than plan and is a result of the early receipt of the contract income for June from Wirral CCG.

Capital expenditure is £0.9m under plan as at the end of May as a result of delayed start to some capital projects and there are no major concerns on this timing difference.

The overall position returns a FSRR of 2, which is in line with plan however the performance is close to a 1 which provides a risk on access to the Sustainability and Transformation Fund.

Conclusion

The Trust has delivered an in month deficit of £(693)k which is £(170)k adverse to plan as a result of higher than planned expenditure.

The cash position is positive and the May 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

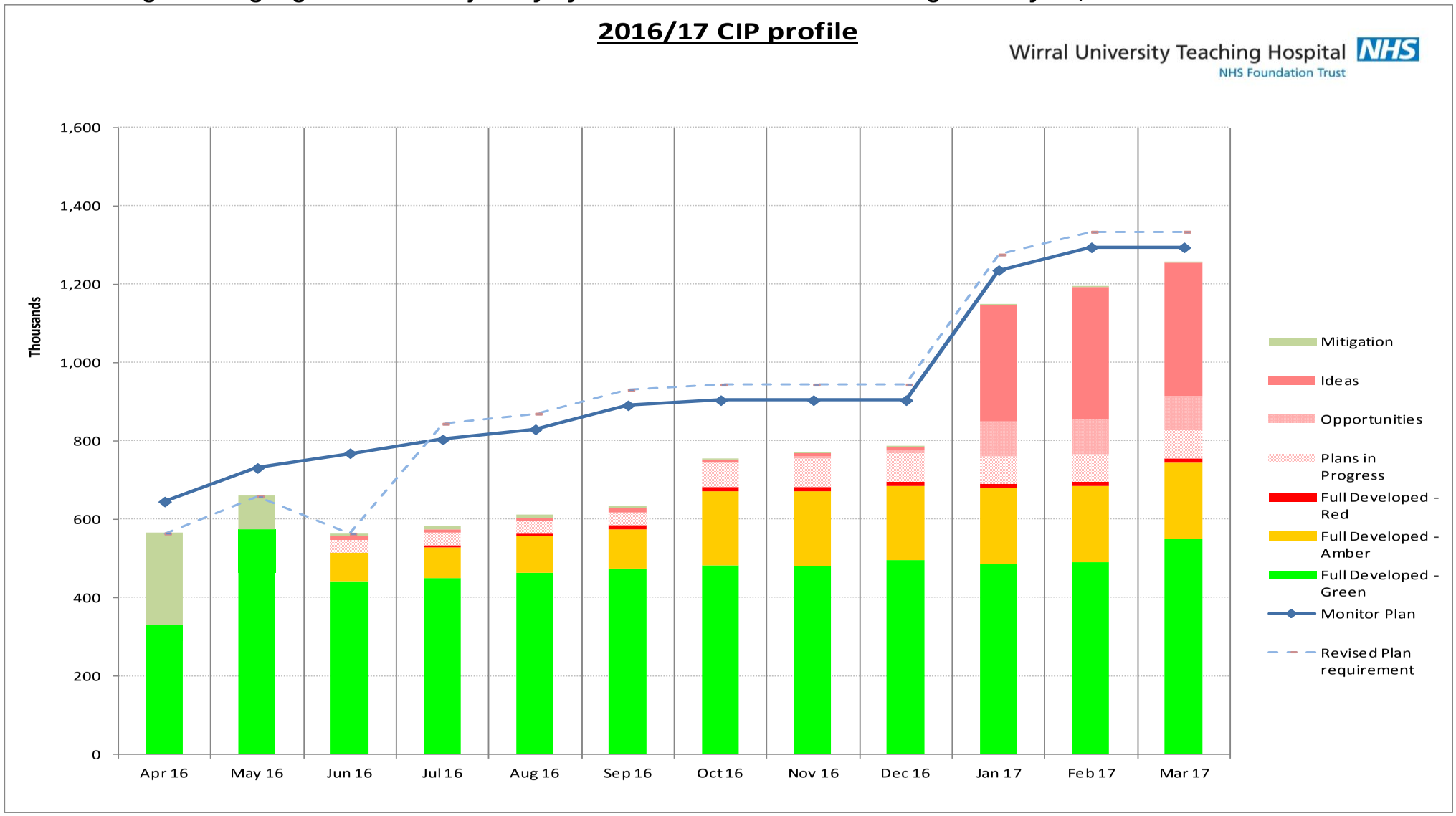
The Board of Directors are asked to note the contents of this report.

David Jago

Director of Finance
June 2016

Appendix 1: CIP Monthly Profile

The following chart highlights the CIP trajectory by Monitor Status and Risk Rating for the year, as at M2.



Board of Directors	
Agenda Item	7.1
Title of Report	Corporate Governance Statements – Board declaration
Date of Meeting	29th June 2016
Author	Carole Ann Self, Associate Director of Corporate Affairs
Accountable Executive	David Allison, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	ALL
Level of Assurance • **Positive** • **Gap(s)**	Gaps with mitigating action
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Approval
Data Quality Rating	N/A
FOI status	Document to be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

1. Executive Summary

The Board of Directors are required to respond 'confirmed ' or 'not confirmed' to each of the 20 Board statements that comprise the Corporate Governance Statement, setting out any risks and mitigating actions, and 'confirmed' or 'not confirmed' to the statement pertaining to governor training and AHSCs and governance. The self-certification must be submitted to NHS Improvement by 30th June 2016 .

The statements are presented with supporting evidence within a template suggested by KPMG having been reviewed by the Senior Management Team.

The key areas for discussion are those items which are marked as “not confirmed” at 4C, 5C and 5D.

Any relevant feedback from the Well Led Governance Review Session to be held on 29th June 2016 will be factored into the evidence.

2. Recommendation

The Board of Directors is asked to:

- Review each statement and the supporting evidence
- Approve the statements as recommended

1. The Board is satisfied that Wirral University Teaching Hospital NHS Foundation Trust applies those principles, systems and standards of good corporate governance, which reasonably would be regarded as appropriate for a supplier of health care services to the NHS	
Lead: Director of Corporate Affairs	**Recommendation:** Confirmed
Board Reports	Approval of Authorisation Matrix – April 16 Annual Governance Statement (May 2016) Integrated Performance Report / Board Dashboards, exception reporting - Monthly Chair of Audit Committee Reports Board Assurance Framework reviewed by Board – (October 2015) Financial Governance Review – (Jan 16) Well led Governance Review self-assessment (August 15) Board determines area of focus for sub-committees
Sub Board Evidence	Quality Governance Framework assessment was presented to Quality and safety Committee (May 2015) Review of Board Assurance Framework at Operational Management Team Review of Board Assurance Framework at every Quality and Safety and Finance Business Performance and Assurance Committee meeting Committee agendas aligned to gaps in assurance/issues in the Board Assurance Framework Review of workings of Board Assurance Framework at Audit Committee at every meeting
Independence Assurance	External Audit Plan Internal Audit Reports – all significant assurance in 2015/16 with the exception of one report Head of Internal Audit Opinion – Significant Assurance

2. The Board has regard to such guidance on good corporate governance as may be issued by NHSI from time to time	
Lead: Director of Corporate Affairs	**Recommendation:** Confirmed
Board Reports	Monitor Code of Governance (referenced in the Annual Report May 16) CEO Reports to the Board highlight changes in Annual Reporting Process – updates to the Board
Sub Board Evidence	Trust response to KPMG/Grant Thornton technical updates report at Audit Committee
Independence Assurance	External Audit technical update reports to Audit Committee NHS Improvement newsletter and updates sent by email to Chief Executive, Director of Finance, and Director of Corporate Affairs NHS Providers and NHSI training / seminars Director of Corporate Affairs members of North West Company Secretary Network and actively involved in NHS Providers Company Secretarial national work

3a. The Board is satisfied that the Wirral University Teaching Hospital NHS Foundation Trust implements effective Board and committee structures		
Lead: Director of Corporate Affairs		**Recommendation:** Confirmed
Board Reports	Committee Chairs reports to Board / minutes circulated to Board members Annual Governance Statement (May 2016) Review of Audit Committee (per Annual Report) (May 2016) Committee Terms of Reference reviewed and approved by Board Regular review of Corporate Governance at Board by Director of Corporate Affairs which evaluates effectiveness of changes made and prompts discussion on possible further improvements	
Sub Board Evidence	Committee Effectiveness discussed at Audit Committee and added to cycle of business	
Independence Assurance	McKinsey Review which led to change in governance structure KPMG Review, which led to the creation of F,BP & A Committee and a reduction in the number of groups reporting into sub-committees	
3b. The Board is satisfied that Wirral University Teaching Hospital NHS Foundation Trust implements clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees		
Lead: Director of Corporate Affairs		**Recommendation:** Confirmed
Board Reports	Authorisation Matrix approved (April 16) Committee Terms of Reference reviewed and approved by Board Corporate Governance Reviews by Director of Corporate Affairs Committee chairs reports to Board / minutes circulated to Board members Senior management and Board members statutory role and responsibilities table Governance and Performance Management Structure regularly updated – latest June 16	
Sub Board Evidence	Committees cycles of business and terms of reference Minutes of Committee meetings	
Independence Assurance	KPMG Financial Governance and Reporting Review – July 2014	
3c. The Board is satisfied that Wirral University Teaching Hospital NHS Foundation Trust implements clear reporting lines and accountabilities throughout its organization		
Lead: Chief Executive		**Recommendation:** Confirmed
Board Reports	Annual Governance Statement (May 2016)	

	Board Assurance Framework reviewed by Board October 15 Senior management and Board members statutory role and responsibilities table Governance and Performance Management Structure regularly updated – latest June 16
Sub Board Evidence	Quality Governance Framework assessment was presented to the May 2015 Quality and safety Committee Standing Financial Instructions and Scheme of Delegation Executive Director and Senior Management Team role descriptions Organisational charts Review of Senior Management Team roles and responsibilities by Remuneration Committee – Autumn 15 Risk Management Strategy
Independence Assurance	Internal Audit Report on QGAF – Significant Assurance
4a. The Board is satisfied that Wirral University Teaching Hospital NHS Foundation Trust effectively implements systems and/or processes to **ensure compliance** with the Licensee's duty to operate efficiently, economically and effectively	
Lead: Director of Finance	**Recommendation:** Confirmed
Board Reports	Annual Planning process Monthly Finance Reports to Board of Directors Quarterly/monthly compliance submissions to Monitor Annual Report and Accounts Monthly Integrated performance reports / dashboards/exception reporting
Sub Board Evidence	Finance, Performance and Business Development Committee review of quarterly returns Monthly and Quarterly Divisional Performance Reviews Quarterly licence review at Audit Committee Procurement Strategy and the Lord Carter Work Transformation Steering Group
Independence Assurance	Head of Internal Audit Opinion – significant assurance ISA 260 "clean" report Unqualified opinion on Value for Money assessment Unqualified opinion on financial statements Outputs of the reference cost index return which indicated that the Trust's costs are 9% less in total than the national mean for "like" services

	Positive feedback from NHSI via Progress Review Meetings on the improvements made to the financial governance and rigour in the organisation

4b. The Board is satisfied that the Trust effectively implements systems and/or processes for timely and effective scrutiny and oversight by the Board of the Licensee's operations	
Lead: Chief Executive	**Recommendation:** Confirmed
Board Reports	Annual Plan submission Board Cycle of Business Board Assurance Framework reviewed by Board October 15 Annual Governance Statement – May 2016 Quarterly/ Monthly Compliance Submissions to NHSI Monthly Integrated performance reports / dashboards/exception reporting Finance Monthly Report Reports from the Audit Committee, Quality and Safety and Finance, Business Performance and Assurance Committee
Sub Board Evidence	Quarterly licence review at Audit Committee Board Assurance Framework review by Quality and Safety Committee, Audit and Finance Business Performance and Assurance Committee at each of their meetings
Independence Assurance	Head of Internal Audit Opinion – Significant Assurance
4c. The Board is satisfied that the Trust effectively implements systems and/or processes to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions	
Lead: Medical Director	Recommendation: Not Confirmed
Board Reports	Quality Report – May 16 Board Assurance Framework reviewed by Board October 15 Monthly Integrated performance reports / dashboards/exception reporting Report from the Quality and Safety Committee CQC Compliance reports to the Board show good progress with the action plan following the inspection
Sub Board Evidence	Quality Governance Framework assessment was presented May 2015 CQC Compliance Reports to Quality and Safety Committee, Operational Management Team, Council of Governors and Senior Management Team meetings

Independence Assurance	Internal Audit Report – Quality Spot Checks – Significant Assurance Internal Audit Report – QGAF – Significant Assurance Internal Audit Report – Quality Account – Significant Assurance
Considerations	CQC undertook a comprehensive inspection in September 2015 and rated the Trust overall as "requires improvement". The Trust is progressing well with its action plan and the CQC has acknowledged that the Trust is on a journey of improvement. The Trust has declared non-compliant with CQC registration in its Annual Governance Statement
4d. The Board is satisfied that the Trust effectively implements systems and/or processes for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern)	
Lead: Director of Finance	**Recommendation:** Confirmed
Board Reports	Monthly Finance Reports Annual Plan submissions Annual Report and Account Report from the Audit Committee on the going concern assessment Reports from the Finance, Business Performance and Assurance Committee
Sub Board Evidence	Audit Committee – challenging of finances and accounts, accounting policies Audit Committee review of draft accounts and annual report Going concern review and positive support from External Audit
Independence Assurance	Head of Internal Audit Opinion – Significant Assurance Unqualified External Audit Opinion on the Annual accounts 2015/16 Internal Audit Reports on financial systems and processes – All significant assurance Although the Trust was found to be in breach of its Provider Licence for financial governance concerns in August 2015, it has for some months been congratulated on its financial rigour and financial outturn.
4e. The Board is satisfied that the Trust effectively implements systems and/or processes to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making	
Lead: Director of Infrastructure and Informatics	**Recommendation:** Confirmed
Board Reports	Board cycle of business Monthly Integrated performance reports / dashboards/exception reporting Briefings to Board members from the communication team on topical media interest stories or areas of immediate risk or concern
Sub Board Evidence	Committee cycle of business

	Governance Assurance and Performance Management Structure Monthly update of the work of the Board to the Operational Management Team Senior Management Team weekly performance reporting
Independence Assurance	Internal audit reports on payroll/human resources ESR – significant assurance Internal audit report on sickness absence recording – significant assurance Internal audit report on mandatory training recording – significant assurance Internal audit report on Friends and Family Test: systems and processes – significant assurance Head of Internal Audit Opinion – significant assurance
4f. The Board is satisfied that the Trust effectively implements systems and/or processes to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence	
Lead: Medical Director	**Recommendation:** Confirmed
Board Reports	Board Assurance Framework reviewed by Board October 15 Annual Governance Statement – May 2016 Committee reports to Board, including risk related matters on all agendas Risk escalation included as part of Board agenda Risk Management Strategy June 16
Sub Board Evidence	Quarterly Licence Review at Audit Committee Board Assurance Framework reviews at Quality and Safety at each of their meetings Monthly review of the risk register at the Operational Management Team Bi-Monthly review of risks at Quality and Safety Committee CQC risk register review at Operational Management Team
Independence Assurance	Head of Internal Audit Opinion – significant assurance Internal review of risk management process
4g. The Board is satisfied that the Trust effectively implements systems and/or processes to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery	
Lead: Director of Finance	**Recommendation:** Confirmed
Board Reports	Business plans presented and agreed at Board in accordance with SFIs Reports from Finance, Business Performance and Assurance Committee Annual Operational Plan and bi-annual review

	Formal review of all Business Cases above £250K by the Board Monthly progress reports against cost improvement programme
Sub Board Evidence	Monthly and Quarterly Divisional Performance Review meetings Weekly Transformation Steering Group Monthly Operational Management Team review of Business Case Recommendations Senior Management Team approval of Business Cases
Independence Assurance	Up until March 2016 the Trust used the skills of a Transformation and Recovery Director. NHSI agreed to remove the enforcement undertaking in this regard due to the substantive appointments made in operational and financial areas and the financial rigour displayed.
4h. The Board is satisfied that the Trust effectively implements systems and/or processes to ensure compliance with all applicable legal requirements	
Lead: Chief Executive	**Recommendation:** Confirmed
Board Reports	Board Assurance Framework reviewed by Board October 15 includes compliance with legislative requirements Quarterly and Annual Health and Safety Reports to the Board Annual Infection Prevention and Control Report to Board CQC compliance reports to the Board Review of Fit and Proper Persons Test by Remuneration Committee -update to Board – April 2015
Sub Board Evidence	Quarterly licence review at Audit Committee Board Assurance Framework reviewed by Quality and Safety and Finance, Business Performance and Assurance Committee at each meeting Remuneration Committee review of Fit and Proper Persons Test for Directors – April 15
Independence Assurance	Head of Internal Audit Opinion – Significant Assurance

5a. The Board is satisfied that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided	
Lead: Chief Executive	**Recommendation:** Confirmed
Board Reports	Board Development Programme including review of the Well Led Governance Framework; culture; Board effectiveness and risk appetite AQUA programme of work

	Good clinical outcomes reported – notably mortality rates and falls prevention programme Patient feedback- nationally very high Low vacancy rates in medical and nursing posts compared to national rates C difficile rates – significant improvements
Sub Board Evidence	Succession Planning Strategy North West Leadership Academy Executive Development Tool North West Leadership Academy Coaching for Clinicians Remuneration and Appointments Committee reports
Independence Assurance	Removal of enforcement undertaking in relation to the need for interim support at a senior level by NHSI in view of the substantive appointments made to the Director of Finance, Director of Nursing and Midwifery and Chief Operating Officer posts.

5b. The Board is satisfied that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations	
Lead: Director of Strategy	**Recommendation:** Confirmed
Board Reports	Robust Annual Planning Process Review of priorities and achievements in Quality Report Reports of Quality And Safety Committee to Trust Board CQC compliance reports and review of progress against action plans
Sub Board Evidence	Quality Account reports to Q&S Committee Workforce Dashboard to Q&S Committee Quality Impact Assessment at each Quality and Safety Committee Transformation Steering Group – QIA for each saving scheme in place signed off by Medical Director/Director of Nursing and Midwifery
Independence Assurance	Internal Audit Report – Quality Account – significant assurance Internal Audit Report – QGAF – significant assurance

5c. The Board is satisfied of the collection of accurate, comprehensive, timely and up to date information on quality of care	
Lead: Director of Infrastructure and Informatics	**Recommendation:** Not Confirmed
Board Reports	Monthly Integrated performance reports / dashboards/exception reporting Nursing staffing reports to the Board

	CQC compliance reports
Sub Board Evidence	CLIPPE Reports to Quality and Safety Committee Nurse staffing performance data to Quality and Safety Committee Workforce Dashboard to Quality and Safety Committee CQC inspection reports to Quality and Safety Committee and Operational Management Team
Independence Assurance	Internal audit reports on payroll/human resources ESR – significant assurance Internal audit report on sickness absence recording – significant assurance Internal audit report on mandatory training recording – significant assurance Internal audit report on Friends and Family Test: systems and processes – significant assurance Head of Internal Audit Opinion – significant assurance
Considerations	Qualified Opinion on RTT and A & E data as part of limited assurance review of quality account.

5d. The Board is satisfied that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care	
Lead: Chief Executive	**Recommendation:** Not Confirmed
Board Reports	Monthly Integrated performance reports / dashboards/exception reporting Nursing staffing reports to the Board leading to significant additional investment and now low vacancy rates Infection control reports to the Board leading to significant additional investment and now low C difficile rates and levels of CPE and MRSA NHS staff survey and action plan leading to significant improvement in staff engagement scores Patient Stories at the Board
Sub Board Evidence	CLIPPE Reports to Quality and Safety Committee Patient Stories at Quality and Safety Committee Nurse staffing performance data to Quality and Safety Committee Workforce Dashboard to Quality and Safety Committee
Independence Assurance	Internal audit reports on payroll/human resources ESR – significant assurance Internal audit report on sickness absence recording – significant assurance Internal audit report on mandatory training recording – significant assurance Internal audit report on Friends and Family Test: systems and processes – significant assurance

	Head of Internal Audit Opinion – significant assurance
considerations	Qualified Opinion on RTT and A & E data as part of limited assurance review of quality account.

5e. The Board is satisfied that the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources	
Executive Sign Off: Medical Director	**Recommendation:** Confirmed
Board Reports	Patient Stories Friends and Family Test results via Integrated performance report Clinical Service Reviews as part of Board Development Sessions NHS staff survey 2015 – most improved in the country Improved winter planning process for 2015 following feedback from staff Investment in nurse staffing and infection control processes
Sub Board Evidence	Governor led Annual Planning Advisory Committee Patient story at Quality and Safety Committee and Operational Management Team Patient Feedback Friends and Family Test Learning from Board Walkabouts Complaints reports Feedback from staff guardian via staff guardian annual report – May 15 (90 out of 92 concerns resolved)
Independence Assurance	Positive feedback from stakeholders on Quality Report

5f. The Board is satisfied that there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and **resolving quality issues** including escalating them to the Board where appropriate.	
Lead: Medical Director	**Recommendation:** Confirmed
Board Reports	Board and Committee risk escalation process included as a standing item for each agenda Risk Management Strategy outlines roles and responsibilities and risk escalation process Monthly Integrated Performance Report / Board Dashboards Priorities and Achievements in Quality Report

	Nurse staffing reports Reports from Quality and Safety Committee Reports from Audit Committee CQC compliance Reporting Whistleblowing process Reports of infection control issues Urgent Care Updates Board Walkabouts Introduction of Staff Guardian role
Sub Board Evidence	CLIPPE Reports to Quality and Safety Committee Ward audits to Quality and Safety Committee
Independence Assurance	Recognition for work on staff guardians and whistleblowing nationally

6. The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence	
Lead: Chief Executive	**Recommendation:** Confirmed
Board Reports	Remuneration and Appointments Committee reports Board Development Programme – including review of the Well Led Governance Framework; culture; Board effectiveness, team management profiling and risk appetite Review of capability and capacity reports to the Board and recruitment to substantive Executive and Senior Management positions
Sub Board Evidence	Succession Planning Strategy North West Leadership Academy Executive Development Tool North West Leadership Academy Coaching for Clinicians Workforce and OD strategy
Independence Assurance	NHSI has removed the enforcement undertaking in relation to the Trust needing interim support. If the Trust continues on its trajectory of improvement as planned, consideration will be given to applying for a removal of the section 111 early in the financial year 2016/17

Corporate Governance Statement

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

4	Corporate Governance Statement	Response	Risks and mitigating actions
1	The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	
3	The Board is satisfied that the Trust implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	
4	The Board is satisfied that the Trust effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements	Not confirmed	The Trust is compliant with all aspects of this section with the exception of (c) because of the findings of the CQC inspection undertaken in September 2015. The Trust has developed and is implementing at pace the action plan following the inspection which will address the areas highlighted for improvement.
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Not confirmed	The Trust is compliant with all aspects of this section with the exception of (c) and (d) because of the qualified position on the Quality Report in relation to A & E and RTT. The Trust has established task and finish groups to progress improvements in these areas, the outcomes of which will be reported to the Board. the Trust has also agreed to include reviews of these areas in its internal audit programme.
6	The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	

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

Signature **Signature**

Name **Name**

The board are unable make one of more of the above confirmations and accordingly declare:

A

B

C

Certification on AHSCs and governance and training of governors

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

5	Certification on AHSCs and governance	Response
	For NHS foundation trusts: • that are part of a major Joint Venture or Academic Health Science Centre (AHSC); or • whose Boards are considering entering into either a major Joint Venture or an AHSC. The Board is satisfied it has or continues to: • ensure that the partnership will not inhibit the trust from remaining at all times compliant with the conditions of its licence; • have appropriate governance structures in place to maintain the decision making autonomy of the trust; • conduct an appropriate level of due diligence relating to the partners when required; • consider implications of the partnership on the trust's financial risk rating having taken full account of any contingent liabilities arising and reasonable downside sensitivities; • consider implications of the partnership on the trust's governance processes; • conduct appropriate inquiry about the nature of services provided by the partnership, especially clinical, research and education services, and consider reputational risk; • comply with any consultation requirements; • have in place the organisational and management capacity to deliver the benefits of the partnership; • involve senior clinicians at appropriate levels in the decision-making process and receive assurance from them that there are no material concerns in relation to the partnership, including consideration of any re-configuration of clinical, research or education services; • address any relevant legal and regulatory issues (including any relevant to staff, intellectual property and compliance of the partners with their own regulatory and legal framework); • ensure appropriate commercial risks are reviewed; • maintain the register of interests and no residual material conflicts identified; and • engage the governors of the trust in the development of plans and give them an opportunity to express a view on these plans.	N/A
6	**Training of Governors**	
	The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed

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	

Where boards are unable to self-certify, they should make an alternative declaration by amending the self-certification as necessary, and including any significant prospective risks and concerns the foundation trust has in respect of delivering quality services and effective quality governance

The Board are unable make one of more of the confirmations on the preceding page and accordingly declare:

A

B

C

1 June 2016

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

Wellington House
133-155 Waterloo Road
London SE1 8UG

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Dear David

Q4 2015/16 monitoring of NHS foundation trusts

Our analysis of your Q4 submissions is now complete. Based on this work, the trust's current ratings are:

- Financial sustainability risk rating: 2
- Governance rating: Red

These ratings will be published on NHS Improvement's website later in June.

NHS Improvement is the operational name for the organisation which brings together Monitor and the NHS Trust Development Authority. In this letter, "NHS Improvement" means Monitor exercising functions under chapter 3 of Part 3 of the Health and Social Care Act 2012 (licensing), unless otherwise indicated.

The trust is subject to formal enforcement action in the form of an additional licence condition and/or enforcement undertakings. In accordance with NHS Improvement's Enforcement Guidance, such actions have also been published on our website.

NHS Improvement will raise any concerns arising from our review of the trust's Q4 submissions as part of our regular Progress Review Meetings.

A report on the aggregate performance of all NHS providers (Foundation and NHS trusts) from Q4 2015/16 will be available in due course on our website (in the News and alerts section), which I hope you will find of interest.

For your information, we will be issuing a press release in due course setting out a summary of the report's key findings.

We are developing the new Oversight Framework, which will be consulted on and will replace the Risk Assessment Framework in due course.

If you have any queries relating to the above, please contact your relationship manager Bev Tipping by telephone on 0203 747 0541 or by email on Beverley.Tipping@nhs.net

Yours sincerely

Paul Chandler
Regional Director

cc: Mr Michael Carr, Chairman, Mr David Jago, Director of Finance

Board of Directors	
Agenda Item	7.3
Title of Report	Risk Management Strategy Approval
Date of Meeting	29th June 2016
Author	Jan Eccleston, Associate Director of Risk
Accountable Executive	Dr Evan Moore, Medical Director
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	To be the Top NHS Hospital Trust in the North West for Patient, Customer and Staff Satisfaction
Level of Assurance **Positive** **Gap(s)**	Positive
Purpose of the Paper **Discussion** **Approval** **To Note**	Discussion and approval of the Risk Management Strategy
Data Quality Rating	Bronze – qualitative data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken **Yes** **No**	Yes Equality analysis completed on the strategy

1. Executive Summary

The Risk Management Strategy was approved by the Trust Board on the 27th May 2015 and was written as a 3 year strategy with a review date of May 2018. The new Associate Director of Risk was appointed in June 2016 and has been reviewing the risk management systems, processes, policies and procedure in place in the Trust.

This paper details the review that has been undertaken and requests the Board of Directors reviews and approves the revised Risk Management Strategy

2. Background

Risk management is the recognition and effective management of all threats and opportunities that may have an impact on patient safety, the Trust's reputation, its ability to deliver its statutory responsibilities and the achievement of its objectives and values.

The Trust is committed to using a systematic/holistic approach to risk management and recognises that the proactive and continuous management of risk is essential to the efficient and effective delivery of its service aims and objectives and that all actions contain inherent risks.

This Strategy identifies those individuals with responsibilities in the management of risk covering clinical, organisational and financial risk. It sets out the key risk management structures and processes and defines the objectives of and responsibility for each of these within the Trust.

3. Key Issues/Gaps in Assurance

The Risk Management Strategy has been completely rewritten for 2016. The document has been split from the previous version in that the operational aspects of practically getting a risk onto the risk register have been removed from the Strategy. A separate policy entitled the *Risk Escalation and Risk Register Policy* has been developed. This document details how staff should develop risks for the risk register and how they are approved and monitored.

A major change to this strategy is the change to the risk grading matrix. The matrix and guidance documents in use in the Strategy approved in 2015 were out of line with national grading descriptors and scores (i.e. in the 2015 strategy a moderate descriptor score was a 4 whilst nationally this is a 3). This new Strategy has brought the Trust back in line with national standards.

This updating of the matrix will result in the risk rating of incidents and risks changing. A risk that was for example a likelihood score of 4 x a consequence/impact score of 4 (moderate) would have had a risk rating of 16; this will now become a likelihood score of 4 x a consequence/impact score of 3 (revised moderate score) with a resultant risk rating of12 when scored against the revised matrix.

4. Next Steps

Training will be required for all staff involved in scoring risks and incidents. This will be delivered by the Risk Team and the Divisional Quality and Safety Specialists.

The Risk Register is under review at present in line with the CQC action plan. The scores and risks will be reviewed in line with this strategy once approved.

5. Conclusion

The Risk Management Strategy has been completely rewritten for 2016 taking into account national grading standards. The Strategy has been split to allow staff to access a separate policy that will show the operational aspects of logging and escalating a risk to the risk register.

6. Recommendations

The Board of Directors is asked to approve this strategy which is a three year strategy to March 2019.

Risk Management Strategy

June 2016 – March 2019

Foreword

Wirral University Teaching Hospital NHS Foundation Trust (the Trust) is an acute NHS Trust, employing 5000 staff with the Trust's services managed through three Divisions supported by corporate functions.

The Trust recognises it has a responsibility to manage both internal and external risks as a key component of good governance and is committed to embedding risk management into the daily operations of the Trust from the setting of objectives, to service and financial planning through to departmental processes.

We believe that effective risk management will help the Trust achieve its objectives and provide better services. In particular it will help deliver improved:

- care which is equitable, safe, patient centred, effective, and timely;
- strategic management and decision making;
- operational management; and
- financial management.

This Risk Management Strategy will assist the organisation in ensuring risks are either eliminated or reduced to an acceptable level to protect the Trust's patients and employees and its services (assets and finances). The Trust is aware that some risks will always exist and will not be totally eliminated and recognises the importance of managing these risks effectively.

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1. Introduction

The Trust is committed to using a systematic/holistic approach to risk management and recognises that the proactive and continuous management of risk is essential to the efficient and effective delivery of its service aims and objectives and that all actions contain inherent risks.

Risk management is central to the effective running of any organisation and is part of the organisational culture. At its simplest, risk management is good management practice and should not be seen as an end in itself, but as part of an overall management approach. The Board of Wirral University Teaching Hospital NHS Foundation Trust will ensure that decisions made on behalf of the organisation are taken with consideration to the effective management of risk.

This Strategy identifies those individuals with responsibilities in the management of risk covering clinical, organisational and financial risk. It sets out the key risk management structures and processes and defines the objectives of and responsibility for each of these within the Trust.

2 Aims

This Strategy will provide a framework to ensure that patients, visitors and staff are protected from harm and that systems are in place to ensure that all risks are proactively managed to safeguard against impropriety, malpractice, waste or failure to provide value for money.

The key aims of the Strategy will be to:

- provide the highest quality care without risk to the health of those involved and within resource allocations
- understand the risks that the Trust faces, their causes and measures to control them so that resources can be appropriately directed
- enhance the Trust's community profile and stakeholder confidence
- ensure that the Trust is compliant with statutory and regulatory requirements
- achieve best value for money, thereby maximising resources for patient services and care
- minimise the total cost of claims and other losses to the Trust through negligence and fraud and ensure that lessons are learned and changes in practice are implemented
- encourage and develop risk management as an integral part of the Trust's culture
- adopt an integrated approach to the management of risk and to integrate risk into the overall arrangements for clinical and corporate governance
- support the achievement of the Trust's strategic objectives as described in the Trust business plan
- have clearly defined roles and responsibilities for the management of risk
- encourage open and honest reporting of risk and incidents through the use of the Trust reporting systems

- establish clear and effective communication that enables information sharing
- foster an open culture which supports organisation wide learning

3. The Trust Board's Intent

The Wirral University Teaching Hospital NHS Foundation Trust Board is committed to leading the organisation forward to deliver a quality service and achieve excellent results, thereby ensuring that the organisation delivers the best care possible, in the right place and makes the very best possible use of public funds. The Board intends to use the risk management processes outlined in this Strategy as a means to help achieve this.

The objective of the Risk Management Strategy is to create a culture that encourages staff to:

- identify and control risks which may adversely affect the Trust's operational ability;
- compare one risk to another using the grading system explained in section 15.
- where possible, eliminate or transfer risks or else reduce them to an acceptable and cost effective level; and
- otherwise ensure the Trust Board openly accepts the remaining risks.

Definitions of the terms used in this Risk Management Strategy are included in Appendix 1.

Strategic Objectives

The following are the strategic aims that have been agreed by the Trust Board.

- To be the top NHS Trust in the North West for patient and staff satisfaction
- To deliver consistently high quality secondary care services enhanced through the provision of regional specialist services within available resources
- To 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 ensure our people are aligned with our vision
- To guarantee the sustainability of the Trust through the transformation of service provision and system performance
- To maximise the benefits of innovation in clinical and organisational practice, enabling technologies and the role of the Trust as a teaching institution
- Enabled by financial, commercial and operational excellence

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

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

To support achievement of the organisational objectives, and in order to fulfil its responsibilities, the Board has developed a management system which allows decisions to be taken in a structured and equitable way. This Risk Management Strategy is a key component within that management system.

4. Scope

This Strategy is intended for use by all directly employed, agency staff and contractors engaged on Wirral University Teaching Hospital NHS Foundation Trust business in respect of any aspect of that work. It is recognised that actions contain inherent risks.

The key strategic risks are identified and monitored by the Board, and operational risks are managed on a day-to-day basis by staff throughout the Trust. In order that progress in managing all risks can be acknowledged, the Wirral University Teaching Hospital NHS Foundation Trust Board Assurance Framework and Risk Register provide a central record of risks to the organisation.

The Trust is committed to working in partnership with staff to make risk management a core organisational process and to ensure that it becomes an integral part of the Trust philosophy and activities. This will be achieved by building and sustaining an organisational culture, which encourages appropriate risk taking, effective internal control systems and accountability for organisational learning in order to continuously improve the quality of services. As part of this, the Trust undertakes to ensure that adequate provision of resources, including financial, personnel, training and information technology is as far as reasonably practicable made available. It is imperative that managers and clinicians ensure that the message "risk management is everybody's responsibility" is well understood and acted upon in the Trust.

The Department of Health requires the Chief Executive to sign Governance Statement annually on behalf of the Board. This outlines how risks are identified, evaluated and controlled, together with confirmation that the effectiveness of the system of internal control has been reviewed.

The Trust has, and will continue to enter into, agreements with other organisations for the provision of clinical and non-clinical services. These will be set out as Service Level Agreements (SLAs).

5. Strategic and Significant Risks

The Board Assurance Framework identifies and quantifies all risks that may potentially compromise the organisation's ability to meet its strategic objectives. These strategic risks to the organisation are identified by the Wirral University Teaching Hospital NHS Foundation Trust Board and recorded on the Board Assurance Framework. Gaps identified in controls or assurances, and the associated treatments to address them, contribute to the Trust's Risk Register. The process for creating and maintaining the Board Assurance Framework and Risk Registers is also described in the Trust's Risk Escalation and Risk register Policy.

Key risks cannot be considered in isolation, they will be derived from the prioritisation of risks fed up through the whole organisation and in this way the Organisational Risk Register will contribute to the Board Assurance Framework.

6. The Way We Work

All members of staff have an important role to play in identifying, assessing and managing risk. To support staff in this role, Wirral University Teaching Hospital NHS Foundation Trust provides a fair and consistent environment. This encourages a culture of openness and willingness to admit mistakes. All staff are encouraged to report any situation where things have, or could have, gone wrong. Balanced in this approach is the need for the Trust to provide information, counselling and support, and training for staff in response to any such situation.

At the heart of this Strategy is the desire to learn from events and situations in order to continuously improve management processes, including patient and staff safety. Where necessary, changes will be made to the Trust's systems to enable this to happen.

In the interest of openness and the process of learning from mistakes, formal disciplinary action will not usually be taken as a result of a risk management investigation. However, a serious breach of health and safety regulations, or an act or omission constituting serious negligence causing loss or injury, are examples of gross misconduct, following which the Wirral University Teaching Hospital NHS Foundation Trust 's Disciplinary Policy will be applied.

Disciplinary action may, therefore, be appropriate where it is found that a member of staff has acted:

- illegally - against the law; or
- maliciously - intending to cause harm which s/he knew was likely to result; or
- recklessly - deliberately taking an unjustifiable risk where s/he either knew of the risk or s/he deliberately closed his/her mind to its existence, e.g. working outside of agreed Trust/National Policy.

Should disciplinary action be appropriate, this will be made clear as soon as the possibility is identified. The investigation would then be modified to take account of personnel policies with advice from Human Resources and in line with appropriate Human Resources policies.

7. Accountabilities, Responsibilities and Organisational Framework

7.1 Organisational Structure

An organisational structure, to help manage delegated responsibility for implementing risk management systems within the Trust, is illustrated and explained in Appendix 2 and 3. The Terms of Reference for the Committees which report to the Board are included in the Corporate Governance Manual.

All members of staff have an individual responsibility for the management of risk, and all levels of management must understand and implement the Trust's Risk Management Strategy and supporting processes.

An outline of the specific risk management responsibilities relating to the structure is described below.

7.2 Chief Executive

The Chief Executive is the Accountable Officer of the Trust and as such has overall accountability and responsibility for ensuring it meets its statutory and legal requirements and adheres to guidance issued by the Department of Health in respect of Governance. This responsibility encompasses risk management, health and safety, financial and organisational controls and governance. The Chief Executive has overall accountability and responsibility for:

- ensuring the Trust maintains an up-to-date Risk Management Strategy endorsed by the Board;
- promoting a risk management culture throughout the organisation;
- Ensuring that the Annual Governance Statement contains the appropriate assurance requirements;
- ensuring that there is a framework in place which provides assurance to the Trust management of risk and internal control; and
- ensuring that risk issues are considered at each level of business planning from the corporate process to the setting of staff objectives.
- decisions taken to eliminate or reduce risk as far as is reasonably practicable;
- sharing with stakeholders concerns which may impact on them and the wider population;
- having in place an effective system of risk management and internal control. The system of internal control is based on an ongoing risk management process designed to identify the strategic/principle risks to the achievement of the organisation's objectives, to evaluate the nature and extent of those risks and to manage them efficiently and economically as far as is reasonably practicable;
- signing the Governance Statement annually and present it to the Board for approval with this statement forming part of the statutory accounts and annual report; and
- set out its commitment to the risk management principles in the Trust Statement of Intent, which is a legal requirement under the Health and Safety at Work Act 1974.

The following Directors have particular responsibilities in respect of assurance and the management of risk, summarised below. The Chief Executive will delegate responsibilities in relation to partnership working as appropriate.

Lead Director	Risk Areas
Medical Director	Clinical Risk Management Non-Clinical Risk Management Risk Management Strategy Serious Incidents Requiring Investigation L itigation; Claims, Inquests, Legal Advice Policies and Procedures Medicines Management

Lead Director	Risk Areas
	Clinical Audit, Internal Audit Tracking Research Governance Clinical Strategy Clinical Leadership Providing advice to the Board on medical issues Responsible Officer for GMC Caldicott Guardian – delegated to an Associate Medical Director Nominated lead for CQC
Director of Nursing and Midwifery	Systems for Patient Experience Patient Survey Complaints and Patient Advice Liaison Service (PALS) Infection Control Director of Infection, Prevention Control Safeguarding (Children and Adults) – Including the Prevent agenda Providing advice to the Board on nursing issues
Director of Workforce	Health, Safety and Fire Public Interest Disclosure (Whistleblowing) Human Resources Organisational Development Leadership Development Talent Management and Coaching Staff Wellbeing (including Occupational Health) Staff Engagement Professional Registration Recruitment Reward and Remuneration HR Policy and Employee Relations Training and Development
Director of Finance	Operating Framework Contracts Financial Governance and Risk Management Security and Local Security Management Specialists Counter Fraud Procurement Advising on the Audit Plan Business Planning SLAs, Tenders and Contracting Delivery of QIPP including establishing - Planning and Implementation of Recovery Plan/CIP Clinical Coding
Director of Corporate Affairs	Corporate Governance Board Governance External Inspections Communications and Public Engagement Website Management CQC registration
Director of Operations	Emergency Preparedness Business Continuity

Lead Director	Risk Areas
	Major Incident Planning
Director of Infrastructure and Informatics	Information Information Governance Subject Access Senior Information Risk Owner Estates Management (including equipment services) Information and IT Medical Records
Director of Strategy	Strategy and Partnership

7.3 Medical Director

The Medical Director will provide medical leadership to ensure the Trust undertakes this function in accordance with best practice, legal and statutory duties.

The Medical Director will have responsibility for:

- The development and implementation of the Risk Management Strategy
- Ensuring that systems are in place to provide services to patients that are legally and professionally acceptable and with consideration of ethical decisions and practice
- The management and investigation of adverse incidents
- Working closely with the Chair, Chief Executive, Executive Directors and Associate Director of Risk Management to implement and maintain appropriate risk management strategies and processes, ensuring that effective governance systems and clinical risk processes are in place to assure the delivery of Trust objectives and preservation of public sector values lead and participate in risk management oversight at the highest level, covering all risks across the organisation, on a Trust-wide basis, acting independently from individual Service Lines; work closely with the Chief Executive and Directors to support the provision of Corporate, Service Lines and Directorate level risk registers;

The Medical Director has delegate authority to the:

- The Associated Medical Director who has responsibility for the provision of advice and guidance in respect of the Caldicott Principles as the organisation's Caldicott Guardian.

7.4 Chief Operating Officer

The Chief Operating Officer has line management responsibility for the following:

- Director of Operations
- Director of Infrastructure and Informatics
- Director of Workforce

7.5 Director of Nursing and Midwifery

The Director of Nursing and Midwifery will provide nursing leadership to ensure the Trust undertakes this function in accordance with best practice, legal and statutory duties.

7.6 Director of Corporate Affairs

The Director of Corporate Affairs will develop and oversee the effective execution of the Board Assurance Framework and ensure effective processes are embedded to rigorously manage the risks therein, monitoring the action plans and reporting to the

Board and relevant Committees.

The Director of Corporate Affairs is providing support and facilitation of the Board of Directors, Council of Governors, Audit committee and Assurance committees in discharging their duties and responsibilities as outlined; and ensuring that the Trust's corporate governance arrangements meet best practice and are reviewed periodically for effectiveness.

7.7 Executive Directors

Executive Directors are accountable and responsible for ensuring that the Service Lines and/or corporate functions are implementing the Risk Management Strategy and related policies. Each Director is accountable for the delivery of their particular service. They will ensure that the systems, policies and people are in place to deliver high quality safe services that operate effectively; are focused on key risks and that drive the delivery of the organisation's objectives.

Executive Directors are responsible for ensuring that the Board Assurance Framework and the risk management reporting timetable are delivered to the Board. This includes any risks identified in the service level agreements managed by Directors.

7.8 Director of Finance

The Director of Finance is responsible for:

- The Director of Finance is responsible for:
- Systems of financial control;
- Implementing the Trust's financial policies and ensuring that they are maintained;
- Providing financial advice to the Trust and its Board of Directors;
- Standards of business conduct and Counter fraud;
- Preparing and maintaining Trust accounts.

7.9 Director of Workforce

The Director of Human Resources and Organisational Development is responsible for:

- recruitment, and therefore implicit in this activity is checking on professional registration of employees where appropriate, maintenance of training registers and staff records, particularly of new starters and their attendance on induction and mandatory training courses and is responsible for communicating the training Strategy to all employees of the Trust;
- ensuring employees have job descriptions containing reference to their responsibilities and contribution to the success of the Trust risk management process; and
- the drafting and monitoring of employment policies and identifying any risk associated with contractual agreements.

7.10 Clinical Directors

Clinical Directors are responsible for implementation of the Trust's relevant strategies and policies which support its risk management approach.

Specifically they will:

- ensure a risk management forum (safety, quality and standards committee) is maintained within their area which will encourage integration of risk management;

- co-ordinate the risk management processes which include: risk assessments, incident reporting, the investigation of incidents/near misses and the management of the risk register;
- ensure there is a system for monitoring the application of risk management within their area and that risks are treated in accordance with the risk grading action guidance contained in section 16 of this document;
- provide reports to the appropriate committee of the Board that will contribute to the Trust-wide monitoring and auditing of risk;
- ensure staff attend relevant mandatory and local training programmes;
- ensure a system is maintained to facilitate feedback to staff on risk management issues and the outcome of incident reporting; and
- ensure the specific responsibilities of managers and staff in relation to risk management, Health and Social Care Act 2012 and clinical governance are identified within the job description for the post and those key objectives are reflected in the individual performance review/staff appraisal process.

7.11 Director of Infrastructure and Informatics

The Director of Infrastructure and Information is responsible for the mitigation of risks relating to:

- Information technology;
- Data protection;
- Information governance;
- Data storage and security.
- Estates
- Fire

The Director of Infrastructure and Information is also the Senior Information Risk Owner (SIRO). The SIRO is responsible for:

- Owning the Organisation's Information Risk Policy.
- Acting as champion for information risk on the Board.
- Implementing and leading the Information Governance (IG) risk assessment and management processes within the Organisation.
- Advising the Board on the effectiveness of information risk management across the organisation.

7.12 Director of Pharmacy and Medicines Management

The Director of Pharmacy and Medicines Management oversees the systems and processes relating to medicines on behalf of the trust board of directors, this includes reviewing, supporting mitigation and escalation of risks relating to pharmacy and medication (as appropriate).

7.13 Associate Director of Estates

The Associate Director of Estates is responsible for the mitigation of environmental risk including:

- Fire safety and fire safety training;
- Water integrity (Legionellae);
- Control of asbestos, plant, machinery & equipment;
- Food safety;

- Construction, Design and Management (CDM);
- Security;

7.14 Associate Medical Director

The Associate Medical Director is the Trust Caldicott Guardian. The Caldicott Guardian is responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing.

7.15 Associate Director of Risk Management

The Associate Director of Risk is the organisational lead for the development, co-ordination and implementation of effective risk management strategies across the Trust. This includes ensuring an integrated approach to patient safety.

The Associate Director of Risk has lead responsibility for the Trust's Safeguard database relating to the Risk Register, incident reporting (including serious incidents), complaints, concerns, inquests and claims management. The Associate Director of risk is responsible for ensuring that Risks, Incidents, Inquests, Claims & Assurance are managed effectively throughout the trust.

7.16 Risk Manager

The Risk Manager is responsible for:

- Advising the organisation on governance and risk issues enabling the organisation to achieve Governance and Risk objectives
- Development of the Risk Strategy, Policy and relevant policies
- Lending expert opinion/advice on the risk management process.
- Supporting the development of the Board assurance Framework
- Producing risk management reports and dashboards to assist WUTH in its risk management activity

The Risk Manager is responsible for the development and maintenance of the organisation wide risk management systems and processes. The Risk Manager has responsibility for maintaining and developing the Trust's Safeguard database relating to the Risk Register and incident reporting (including serious incidents).

The Risk Manager will support the Corporate Department Leads for monitoring and review of risk in their areas, liaising with them monthly to review and update risks and action plans as appropriate.

In liaison with the Corporate Department Leads the Risk Manager will review the risk register in its entirety annually to ensure all risks are accurate, there are no duplications and they remain relevant.

7.17 Health and Safety Manager

The Health and Safety Manager will provide advice on health and safety related risk assessments and risks to be entered on to the risk register.

7.18 Head of Facilities

The Head of Facilities is responsible for the mitigation of environmental risk including:

- Food safety

- Clinical and non-clinical waste

7.19 Triumvirate for Clinical Divisions/Heads of Corporate Departments

Accountability for the Clinical Divisions lies with the Divisional Medical Director, the Divisional Director and the Associate Director of Nursing and is known as the Triumvirate.

Each Triumvirate/ Head of Corporate Department is accountable for the management of risk within their Division/Corporate Department. They will ensure that the risks in their risk registers are regularly reviewed. They are responsible for implementing and monitoring any identified risk management control measures needed within their designated area(s) ensuring that they are appropriate and adequate. Risks will be monitored organisationally if they score 10 or above using the Trust risk scoring matrix. Action must be undertaken by management in the Department/Division or area where the risk has been identified.

7.20 Clinical Service Lead (Women's Services)

Working closely with the Obstetric Consultant Clinical Governance Lead and Head of Midwifery, the Clinical Service Lead (CSL) is responsible for the day to day clinical management of the Obstetric Services, providing professional leadership.

7.21 Head of Midwifery

Working closely with the CSL, they are responsible for the day to day management of maternity services in all care settings, providing professional leadership for the midwifery aspects of clinical risk management.

7.22 Divisional Quality and Safety Managers

The Divisional Quality and Safety Managers work with three clinical Divisions; Medical Specialities and Acute Care, Surgery, Women and Children's and Clinical Support. They co-ordinate the risk management, governance and assurance agenda in the Divisions and provide real time information to support risk mitigation. They are responsible for the day to day direction of the risk agenda in the Divisions managing the Divisional Clinical Governance Teams and structures to ensure that the risk, governance and assurance agenda is managed, monitored and escalated appropriately

7.23 Supervisors of Midwives (SoMs)

Supervisors of Midwives play a proactive and reactive role in the risk management systems and processes within the Maternity Service. Supervisors work alongside but separate to the management team when investigating incidents or situations involving poor practice. Where appropriate, SoMs formulate action plans and escalate concerns to the Local Supervisory Authority (LSA) via the processes outlined.

7.24 Corporate Services Departmental Leads

There is no Divisional Quality and Safety Lead for the Corporate Services Division. Therefore the Manager for each department within the Corporate Services Departments is responsible for the review and monitoring of risk within their own areas with the support for monitoring and review by the Risk Manager.

7.25 Other Managers and Matrons in the Trust

All managers have a delegated responsibility for the identification and management of risk

in their Departments, Wards, and any other areas. Risk management is integral to their day to day management responsibilities and managers are authorised to mitigate risks identified at a local level wherever possible.

If risks cannot be mitigated locally, issues should be escalated in the management lines of accountability and action undertaken by management in the Department, Division or area where the risk has been identified as far as possible.

In addition all Managers and Matrons have a responsibility for:

- Ensuring effective communication and distribution of all policies and guidelines to staff.
- Ensuring that staff have suitable and sufficient information, instruction, training and supervision to perform their duties in accordance with the organisation's standards.
- Monitoring compliance with their own standards and implementation of the organisation's procedures.
- Taking appropriate action in the event of significant errors or deviations to accepted practices.
- Ensuring their business plans take account of risk management issues which will be monitored through the performance review process.

7.26 All Staff

All members of staff, irrespective of profession, grade or discipline, including locums and those with honorary contracts are responsible for:

- Compliance with Trust strategies, policies, procedures and guidelines;
- Working within their own level of competence;
- Providing safe standards of clinical practice through compliance with the regulations of appropriate professional bodies.
- Identifying risks and reporting of all incidents and near misses;
- Escalation of risk, incidents and near misses as required;
- Attending risk management training as required for the post;
- Participating in risk assessment processes as necessary.
- Using any safety equipment, personal protective equipment and adopting safe working practices;
- Co-operating with management, representatives of enforcement agencies and auditors in respect of Health & Safety issues, investigation of incidents, complaints and claims.
- Taking responsible care of their own health and safety and the safety of anyone else who may be affected by what they do whilst at work.
- Being aware of emergency procedures e.g. resuscitation, evacuation and fire precaution procedures pertaining to their service area.

7.27 Contractors

Specific risks identified by the Trust will be shared with any other relevant organisation working in partnership with the Wirral University Teaching Hospital NHS Foundation Trust. Likewise, the Trust expects that any relevant risks identified by partners will be shared with the organisation.

It is the responsibility of each contractor employed by Wirral University Teaching Hospital

NHS Foundation Trust to ensure that all staff working on their behalf is fully conversant with the health and safety requirements for the activity for which they are engaged.

8. Systems and Processes for Managing Risk

Wirral University Teaching Hospital NHS Foundation Trust operates three major systems to facilitate the management of risk throughout the organisation. These are each described in detail in the following documents:

- Incident Reporting and Management Policy
- Risk Escalation and Risk Register Policy
- Corporate Governance Manual

The Incident Reporting and Management Policy and the Risk Escalation and Risk Register Policy use the same risk grading process to assess risks in terms of frequency and severity of outcome. The risk assessment process is described in section 16 of this policy.

9. Systems for Monitoring the Effectiveness of the Strategy

An annual report on risk management in Wirral University Teaching Hospital NHS Foundation Trust based on all available relevant information will be produced by the Associate Director of Risk. This report will be reviewed by the Clinical Governance Group and Quality and Safety Committee.

10. Measuring Performance and Review

The effective implementation of this Risk Management Strategy will facilitate the delivery of a quality service and, alongside staff training and support, will provide an improved awareness of the measures needed to prevent, control and contain risk.

Wirral University Teaching Hospital NHS Foundation Trust will:

- ensure all staff and stakeholders have access to a copy of this Risk Management Strategy;
- produce a register of risk across the Trust which will be subject to regular review by the Board;
- communicate to staff any action to be taken in respect of risk issues;
- develop policies, procedures and guidelines to assist in the implementation of this Strategy;
- Ensure that risk management training is available to staff
- ensure that training programmes raise and sustain awareness throughout the Trust of the importance of identifying and managing risk;
- Ensure all Board Members, Directors, Senior Managers and Staff receives risk management training commensurate with their roles and responsibilities.
- ensure that staff have the knowledge, skills, support and access to expert advice necessary to implement the policies, procedures and guidelines associated with this Strategy; and

- monitor and review the performance of the Trust in relation to the management of risk and the continuing suitability and effectiveness of the systems and processes in place to manage risk.

11. Equality Impact Assessment

This policy has been impact assessed with regards to potential impact on race, gender, disability, age, LGB, religion/ belief, carers and other characteristics and there are no areas in the policy that contravene equality and diversity guidance.

12. Other Relevant Policies

All documents in the Wirral University Teaching Hospital NHS Foundation Trust Policy Schedule are relevant, in particular:

- Health & Safety Policy
- Risk Escalation and Risk Register Policy
- Incident Reporting and Management Policy
- Claims Handling Policy
- Complaints Policy
- Raising Concerns at Work Policy
- Disciplinary Policy, Procedure and Rules
- Major Incident Plan
- Corporate Governance Manual

13. Wirral University NHS Foundation Trust Stakeholders

Key stakeholders include:

- Patients and carers;
- Staff (directly employed, bank and agency);
- Commissioners of services including general practitioners;
- NHS Improvement
- The CQC
- Contractors including suppliers and service providers e.g. cleaning contractor; and
- Local Authorities.

14. Communication with Stakeholders

Systems of communication with stakeholders that contribute to minimising risk are in place. These systems include the Wirral University Teaching Hospital NHS Foundation Trust website at: http://www.wuth.nhs.uk/patients-and-visitors/, regular meetings, annual in patient and staff surveys, publications, the annual general meeting, and the Public Board Meetings.

Communication with staff is particularly important and is mainly effected via line

management at team meetings. Any urgent or particularly important messages are communicated by email and twice weekly Trust bulletins are circulated to all staff.

This Risk Management Strategy is available to all staff and to other stakeholders on the Trust website. The introduction of new or significantly revised risk management policies is supported by appropriate staff training.

15. Risk Management Escalation Process

Risk management means having in place a corporate and systematic process for reporting and evaluating the impact of risk in a cost effective way and having staff with the appropriate skills to identify and assess the potential for risk to arise.

The Risk Management Process provides a framework by which organisational risks are identified, reviewed and monitored. This is achieved through the following stages:
Risks are:

- Identified from a diverse range of sources including
    - Proactive methods such as business planning processes, including review of the Board Assurance Framework, routine risk assessments undertaken corporately and by services, identification of operational risks via Divisional Governance Groups and internal audit findings and recommendations
    - Reactive methods such as analysis of incident and near miss reporting, findings of serious untoward incident investigations, analysis of claims, complaints and concerns and recommendations following external regulator inspection reports
- Recorded on the on-line Risk Register (by the Risk Team)
- Subject of robust and effective reporting and review arrangement
- Linked to the Board Assurance Framework as required
- Subject to effective monitoring

Risk Register
In the context of being open and transparent, all staff are actively encouraged to enter perceived risks onto the Risk Register. Appropriate leads will oversee divisional/corporate department operational risks with support from the Divisional Quality and Safety Managers/Risk Manager.

The Risk Register is a database that holds the main record of all identified risks to Wirral University Teaching Hospitals NHS Foundation Trust's objectives and operations. The Organisational Risk Register is a dynamic document located on Safeguard and is readily accessible.

Divisional Risk Register
The review and management of Divisional Risk Registers will be integral to the function of monthly Divisional Management Team Meetings.

Board Assurance Framework
The Board Assurance Framework (BAF) is a high level document that records the key risks that could impact on The Trust achieving its strategic objectives. It provides a framework for reporting key information to the Board. It provides assurance about where risks are being

managed effectively and objectives are delivered and will also identify which of the Trust's objectives are at risk because of gaps in controls or assurance.

Key risks cannot be considered in isolation, they will be derived from the prioritisation of risks fed up through the whole organisation and in this way the Organisational Risk Register will contribute to the Board Assurance Framework.

Risk Grading Tool

The same grading tool is used in Wirral University Teaching Hospital NHS Foundation Trust for all risk processes (risk assessment, risk register, and incident reporting assessment). Risks are measured according to the following formula: Likelihood x Impact = Risk Rating

Risk Likelihood

Risks are first judged on the likelihood of the risk being realised. Consider the descriptions below.

Measures of Likelihood

The following table gives descriptions of the likelihood of a risk occurring.

Level	Descriptor	Description	Frequency Descriptors
1	Rare	May occur only in exceptional circumstances	Not expected to occur for years (1 - 5%)
2	Unlikely	Not expected but could occur at some time	Expected to occur at least annually (6 - 25%)
3	Possible	May/will occur at some time	Expected to occur at least monthly (26 – 50%)
4	Likely	Will probably occur but not a persistent issue	Expected to occur at least weekly (51 – 75%)
5	Almost Certain	Likely to occur on many occasions, a persistent issue	Expected to occur at least daily (76 - 100%)

Impact/Consequence

Situations are then judged to evaluate if the risk were to be realised, what the outcome would most likely be. Any risk graded with an impact of 5 MUST be escalated to the appropriate Triumvirate and Divisional Quality and Safety Specialist.

In terms of risk tolerance levels, these may be adjusted to reflect the position of the Trust and this will be agreed with the Board at its annual review.

The following table is a guide to the categories available for measuring the impact:

Measures of Impact Table

Descriptor	Insignificant/no harm	Minor/low harm	Moderate impact/harm	Major impact/harm	Catastrophic impact/harm

Score	1	2	3	4	5
Injury (physical and psychological) to patients	Adverse event leading to minor injury not requiring first aid	Minor injury or illness, first aid treatment required Short term injury/harm < 1month	Any incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm. Moderate increase in treatment is defined as return to surgery, an unplanned readmission, prolonged episode of care, extra time in hospital or as and outpatient , cancelling of treatment or transfer to another area such as ITU as a result of the incident	Major injuries / long term incapacity or disability (e.g. loss of limb/miss diagnosis mis treatment leading to poor prognosis).	Incident leading to death or major permanent incapacity where the outcome is directly attributable to a safety incident Significant number of people affected (screening errors)
Infection control	Unnecessary exposure to a known infection control risk	Hospital acquired colonisation affecting one or more patients, member of staff or the public	Hospital acquired infection affecting one or more patients, members of staff/the public or where a bay closure occurs	MRSA Bacteraemia with eventual recovery Hospital acquired infection affecting > 1 bay	Part 1 of death certificate stating hospital acquired infection Hospital acquired infection affecting > 1 ward
Medicines Management	Incorrect medication prescribed or dispensed but not taken	Wrong drug or dosage administered, with no adverse effects Failure in monitoring with no adverse effects. Failure to prescribe or administer a medicine with no adverse effects. Breach of medicine storage requirements which does not result in patient harm. Minor CD register discrepancies	Wrong drug or dosage administered with potential adverse effects. Failure in monitoring with potential adverse effects, failure to prescribe or administer a medicine with potential adverse effects. Significant breach of medicines management policies	Wrong drug or dosage administered with adverse effect. Failure in monitoring causing adverse effects, failure to prescribe or administer a medicine causing adverse effects. Breach of medicines management statutory requirements resulting in patient harm. Medicine diversion	Wrong drug or dosage administered resulting in death Failure in monitoring causing adverse effects, failure to prescribe or administer a medicine causing death.
Information Governance	Less than 5 people affected or risk assessed as low e.g. files were encrypted	Serious potential breach & risk assessed high e.g. unencrypted clinical records lost. Up to 20 people affected.	Serious breach of confidentiality e.g. up to 100 people affected.	Serious breach with either particular sensitivity e.g. sexual health details, or up to 1000 people affected.	Serious breach with potential for ID theft or over 1000
Health & Safety / Non clinical impact	Minimal injury requiring no/minimal intervention or treatment No time off work	Minor injury or illness, requiring minor intervention, will resolve in 6 days or less Staff injury requiring time off work or light duties for 6 days or less	Injury or illness, requiring intervention, is expected to resolve within one month Staff injury requiring time off work or light duties for 7-35 days reportable under RIDDOR	Major injuries / dangerous occurrences reportable under RIDDOR	An accident at work resulting in a fatality Significant permanent disability where outcome is directly attributable to a health and safety incident
Objectives / Projects	Insignificant project slippage Barely noticeable reduction in scope or	Minor project slippage Minor reduction in scope or quality	Serious overrun on project Reduction in scope or quality	Project in danger of not being delivered Failure to meet secondary objectives	Unable to deliver project Failure to meet primary objectives

Descriptor	Insignificant/no harm	Minor/low harm	Moderate impact/harm	Major impact/harm	Catastrophic impact/harm
Score	1	2	3	4	5
Patient Experience/Quality	Unsatisfactory patient experience not directly related to patient care	Overall treatment or service suboptimal Unsatisfactory patient experience directly due to clinical care – readily resolvable	Treatment or service has significantly reduced effectiveness Unsatisfactory management of patient care – local resolution (with potential to go to independent review)	Non-compliance with national standards with significant risk to patients if unresolved	Totally unacceptable level or quality of treatment/service
Complaints / Claims	Locally resolved verbal complaint	Justified written Complaint peripheral to clinical care	Justified formal complaint involving lack of appropriate clinical care, short term Below excess non clinical claim. Clinical litigation possible. Justified complaint	Non clinical claim above excess level. Clinical litigation expected/almost certain. Multiple justified complaints	Multiple claims or single major claim Litigation certain
Service or Business Interruption	Interruption in a service (up to 1 hour) which does not impact on the delivery of patient care or the ability to continue to provide service	Short term (1-4 hours) disruption to service with minor impact on patient care	Some disruption in service with u nacceptable i mpact on patient care. Temporary loss of ability to provide s ervice (4 – 8 hours)	Sustained loss of service (8 hours – 2 days) which has serious impact on delivery of patient care resulting in major contingency plans being invoked.	Loss / Interruption of service more than 2 days Permanent loss of core service or facility
Environmental Impact	Minimal or no impact on the environment including contamination, not directly coming into contact with patients, staff or members of the public	Minor impact on the environment	Moderate impact on the environment	Major impact on the environment	Catastrophic impact on the environment
Staffing and Competence	Short term low staffing level temporarily reduces service quality (less than 1 day)	Ongoing low staffing level reduces service quality Minor error due to ineffective training / implementation of training	Late delivery of key objective/service due to lack of staff. Moderate error due to ineffective training or implementation of training Ongoing problem with staffing levels (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective / service due to lack of staff. Major error due to ineffective training / implementation of training Unsafe staffing level (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non delivery of key objective / service due to lack of staff. Loss of key staff. Critical error due to ineffective training / implementation of training Ongoing unsafe staffing levels No staff attending mandatory training on an ongoing basis
Financial: including damage, loss, fraud and claims	Negligible organisational/ personal financial loss (£<5k)	Minor organisational / personal financial loss (£6k - £99k)	Significant organisational / personal financial loss (£100k-250k)	Major organisational / personal financial loss (£251 - £999k)	Severe organisational / personal financial loss (>£1 million)

Descriptor	Insignificant/no harm	Minor/low harm	Moderate impact/harm	Major impact/harm	Catastrophic impact/harm
Score	1	2	3	4	5
Statutory duty/ Inspection / Audit	Small number of recommendations which focus on minor quality improvement issues No or minimal impact or breach of guidance/statutory guidance	Recommendations made which can be addressed by low level of management action. Breach of statutory legislation reduced performance rating if unresolved	Challenging recommendations that can be addressed with appropriate action plan Single breach in statutory duty Challenging external recommendations/improvement notice	Enforcement action Multiple breaches in statutory duty Low performance rating; critical report	Severely critical report Multiple breaches in statutory duty Prosecution Complete system change required
Adverse Publicity / Reputation	Rumours, no media coverage; potential for public concern Little effect on staff morale	Local media coverage – short-term reduction in public confidence Element of public expectation not being met Minor effect on staff morale / public attitudes.	Local media – long term adverse publicity. Significant effect on staff morale and public perception of the organisation	National media / adverse publicity, less than 3 days. Public confidence in the organisation undermined Use of services Affected	National / International media / adverse publicity, >3 days. MP concern (Questions in Parliament). Total loss of public confidence

Note: Financial threshold of risk approved by the Trust Board.

Calculating the risk rating

The assessor(s) must assess the risk to see which description in the likelihood and impact/consequence best fit the identified risk. The two numbers are multiplied together to establish the risk rating.

The ratings which are applied to the risk being assessed are based on 2 criteria:

- Potential impact of the risk
- Likelihood of that impact resulting

The effectiveness of controls in place must be considered when calculating the risk rating of the risk.

Risks should always be assessed as they are now (including current controls), including any known foreseeable changes.

Each risk is given a Risk Score which is recorded on the Trust's Risk Register. The Risk Score determines at what level the risk needs to be managed, with what urgency and the extent to which control measures are required.

Measurement of Risk

Based on the above judgments, a risk assessment can be made of the potential future risk to stakeholders and the organisation as follows:

Likelihood	Impact				
	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5

Almost certain 5	5	10	15	20	25
Likely 4	4	8	12	16	20
Possible 3	3	6	9	12	15
Unlikely 2	2	4	6	8	10
Rare 1	1	2	3	4	5

Definition of Risk

The following table explains how risks should be categorised at the risk assessment stage:

Very Low	1-3	Low	4-6	Moderate	8-12	High	15-25

Action that are/may be required based on the risk grading

The following tables give guidance as to the actions taken based on the risk assessment, risk score and outlines who has authority to act.

Risk Score	Remedial Action	Decision to agree risk	Risk QA/Approval	Escalated to Committee
1-6	Ward / Department Manager	DQSM	Risk Manager	DMT
8-12	Triumvirate/ Head of Corporate Department	DQSM	Risk Manager 15 plus Medical Director	DMT 10+ OMT
15 -20	Triumvirate/ Head of Corporate Department	DQSM	Risk Manager 15+ Medical Director 20+ Board of Directors	DMT OMT 15+ Quality and Safety 20 Trust Board
20-25	Triumvirate/ Head of Corporate Department / Executive Director	Board of Directors	Risk Manager 15+ Medical Director 20+ Board of Directors	DMT OMT 15+ Quality and Safety 20+ Trust Board

Risk Acceptance

Once the risk has been quantified and no further actions are possible to mitigate it then the risk can either be accepted or more information/actions can be requested.

It is not always possible to identify and then fully implement actions that eliminate or minimise a risk. Where this is the case, it is essential that the significance of the risk that remains is understood and the Trust, in accordance with this Strategy, confirms that it is prepared to

accept that level of risk. This is known as the residual risk.

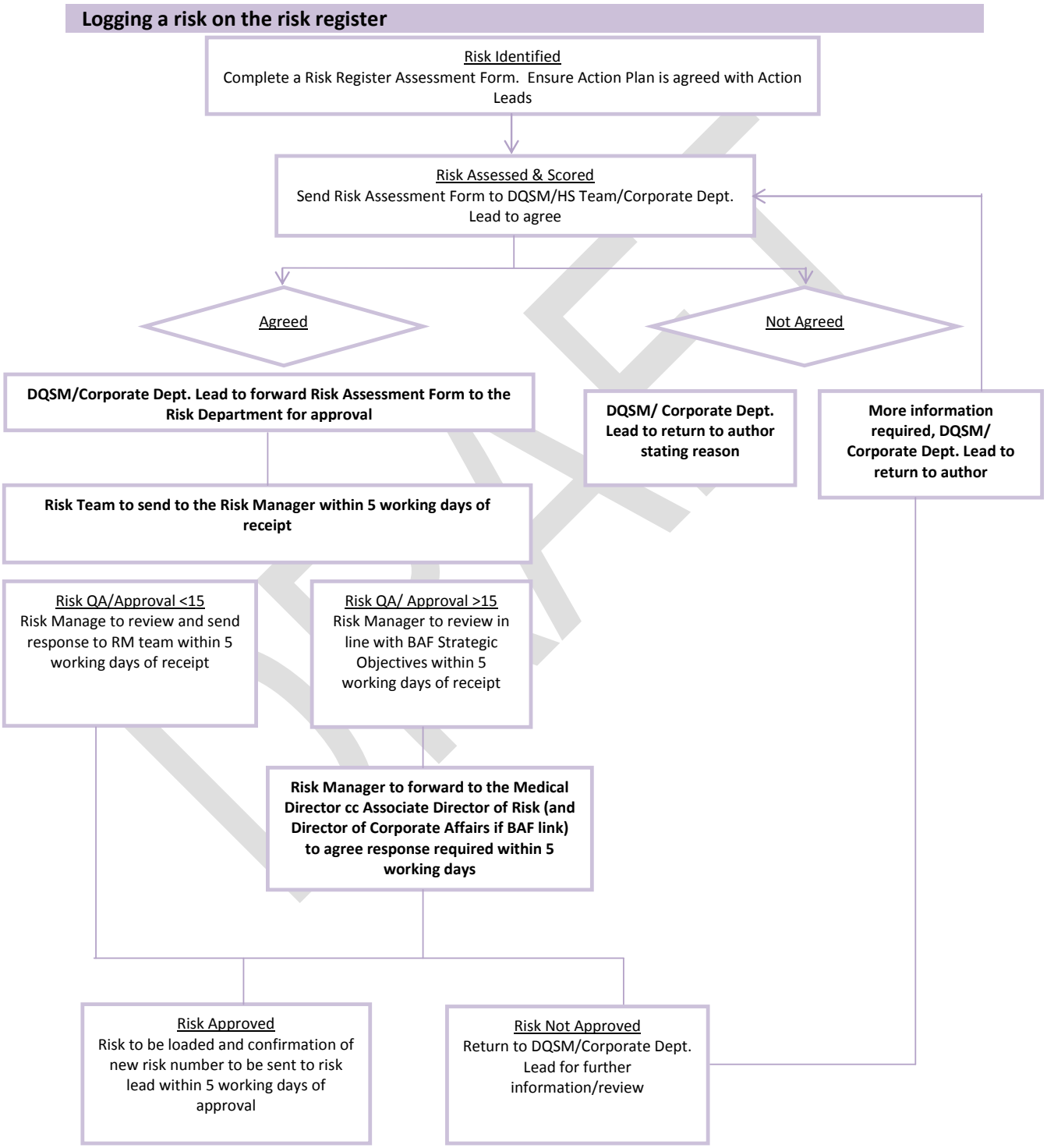
Very low and low risks can be accepted as requiring no further action. On reviewing this type of risk it may, however, be decided that some cost effective action would reduce the risk still further. Where risks are classed as moderate or high and all appropriate steps have been taken to mitigate (control) the risk and where further reduction would not be reasonably practicable then OMT or the Trust Board can/may decide that no further action is necessary and the risk is accepted.

Risks that are placed onto a risk register will be reviewed at regular intervals of no less than quarterly. For managed/accepted risks a review of every 6 months is acceptable with the risk being sent back to OMT/the Board every 12 months for re acceptance.

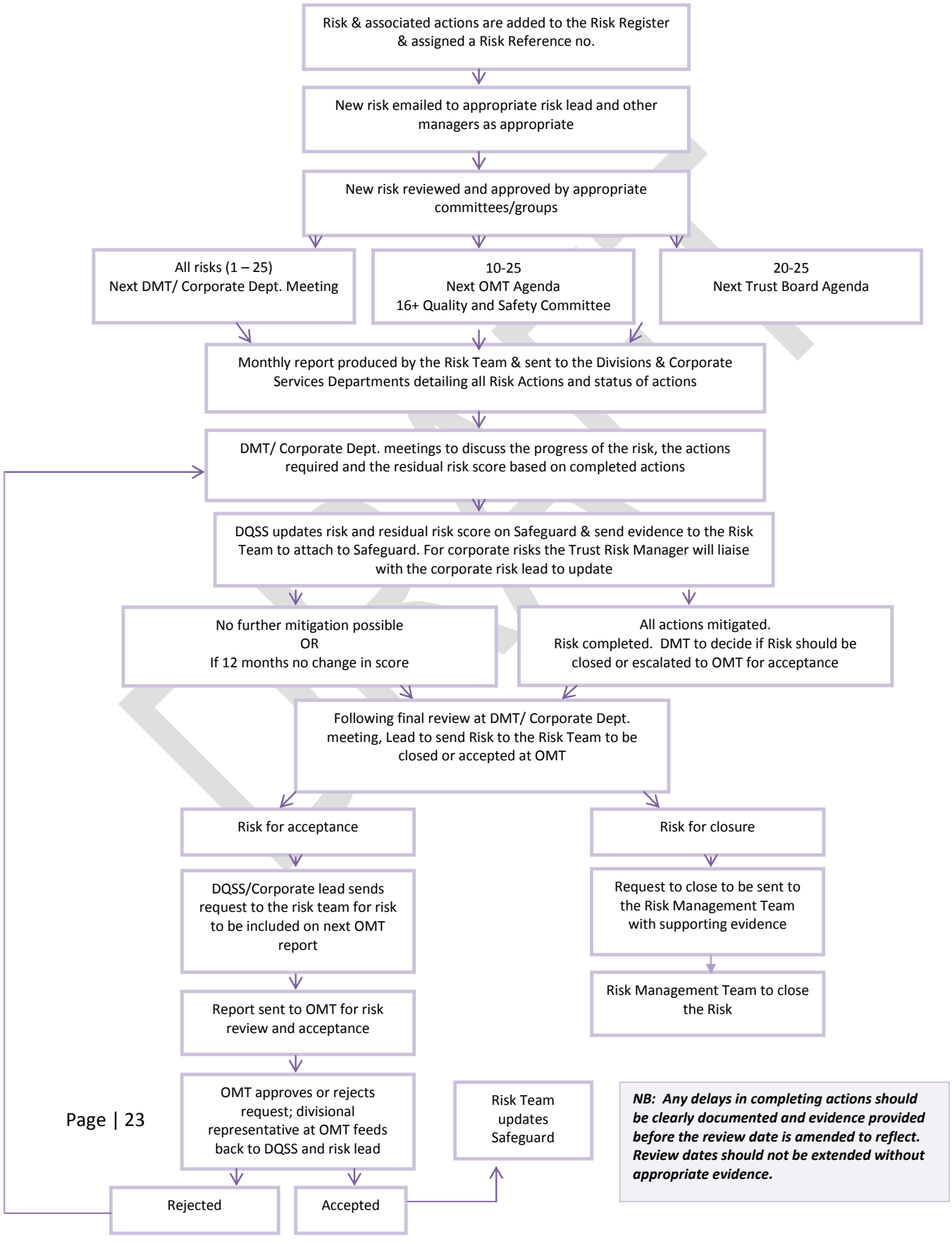
The risk registers are managed via the Safeguard system and each risk is allocated a risk owner. The Risk Owner is responsible for taking appropriate action to minimise its impact and ensuring the risk is kept up to date.

16. Diagram of Flow of Risks

The following flow chart demonstrates the flow of risk from identification to assessment and management according to severity.



Risk Monitoring and Review



NB: Any delays in completing actions should be clearly documented and evidence provided before the review date is amended to reflect. Review dates should not be extended without appropriate evidence.

APPENDIX 1 - Definitions

Hazard
A ***Hazard*** is something that has the potential to cause harm or adverse outcome. In terms of business risk it is what is seen as a threat to not achieving corporate objectives.

Risk
A ***Risk*** is the chance or likelihood that harm or adverse outcome will arise from a hazard (or threat) and includes the severity of the injury or the impact on the Trust.

Control Measures (Controls)
Control Measures sometimes referred to just as controls are the precautions that are put into place to reduce the risk.

Risk Profiling
Risk profiling is a tool which allows risks to be analysed and rated.
The process is based on three factors;

- Likelihood of exposure to risk and of harm being caused.
- Impact or the severity of harm caused
- Controls in place (and their effectiveness) to manage the identified risk.

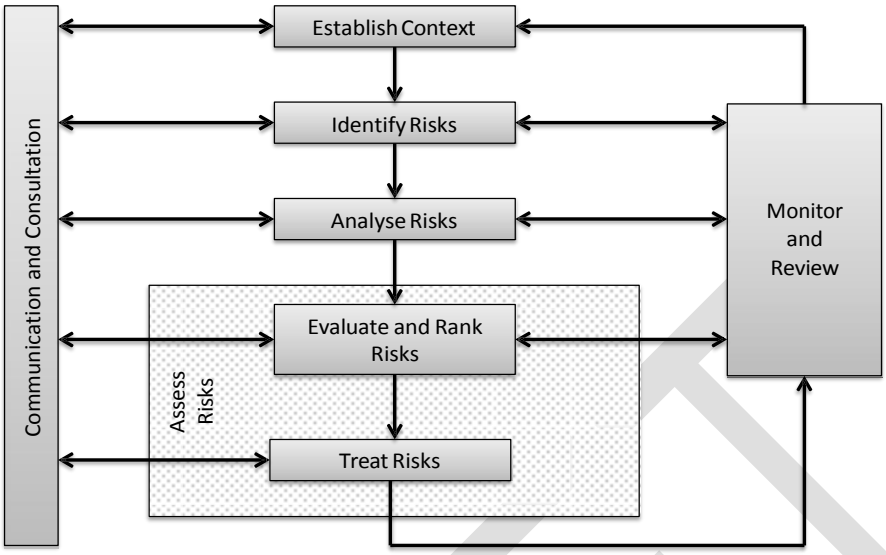
Risk Assessment
Risk assessment involves:

- Identify the hazards, including tasks activities and situations
- Determine who may be exposed to the hazard
- Evaluate the risk
- Introduce control measures
- Record the findings
- Review the assessment

This is a legal requirement for all significant risks

Risk Register
A Risk Register provides the repository for all risk assessments. It therefore allows the Trust to understand its risk profile as long as it is a dynamic tool and is used at all levels of the organisation. It is described as:
"A log of all risks of all kinds that threaten an organisation's success in achieving its' declared aims and objectives. It is a dynamic document, which is populated through the organisation's risk assessment and evaluation process. This enables risk to be quantified and ranked, and information about risks to be collated and analysed. It therefore provides a structured approach to decision-making about whether or how risks should be treated."

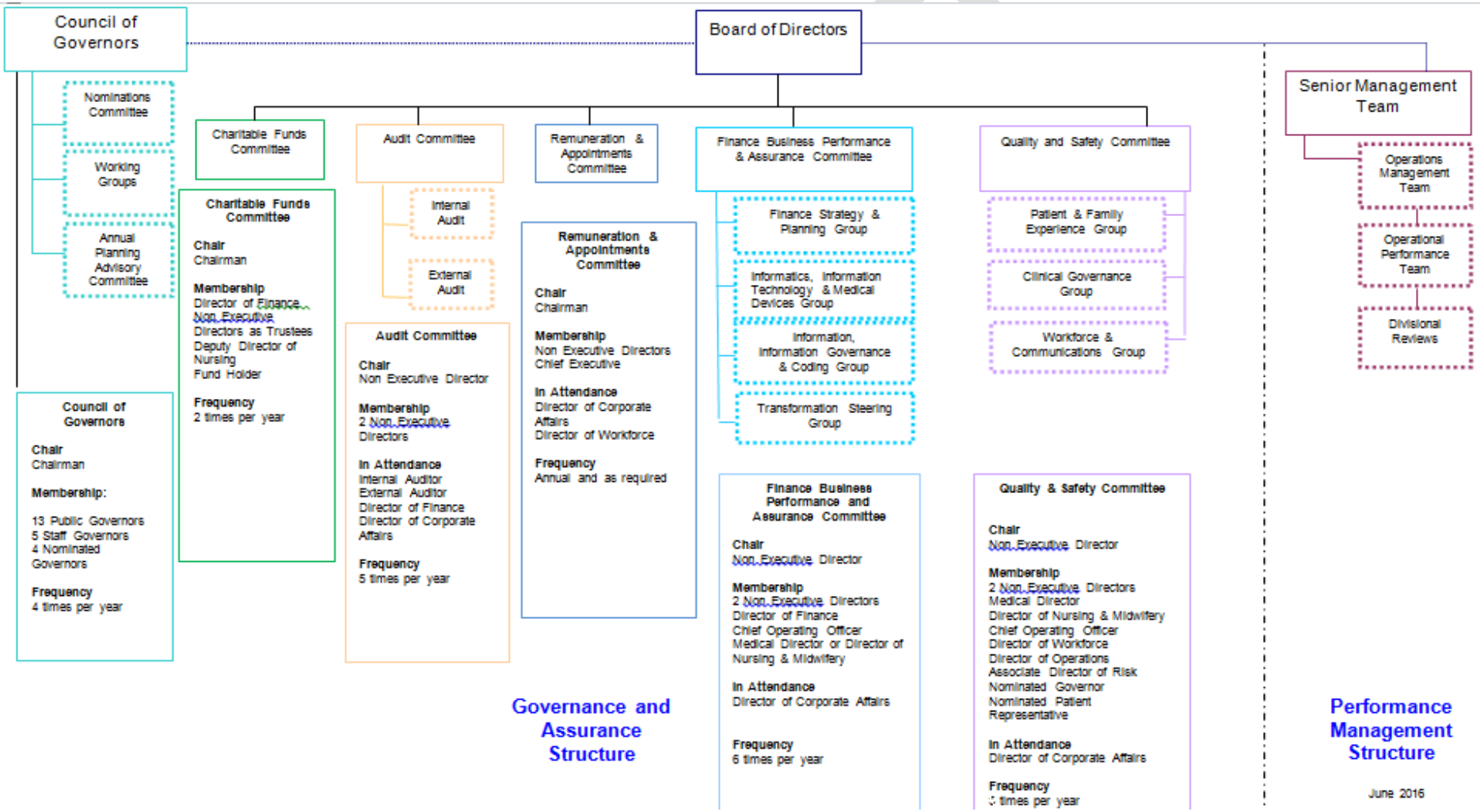
Risk Management Process
The risk management process is "the systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risk". It is described in the following diagram:



Risk Management Overview from AS/NZS 4360:1999

Significant/principle risks are those which, when measured according to the risk grading tool at section 16, are assessed to be 'High'. The Board will take an active interest in the management of significant principle risks.

APPENDIX 2 - Organisational Structure for Risk Management and Assurance



Appendix 3 - Roles and Responsibilities of Committees Responsible for Risk Management

Trust Board of Directors

The Board of Directors at the Trust is a unitary Board and as such each member of the Board is ultimately equally responsible for the organisation's system of integrated governance and internal control – clinical, financial and organisational. The Board of Directors is required to produce statements of assurance which declare that it is doing its 'reasonable best' to ensure that the Trust meets its objectives and protects patients, staff, the public and other stakeholders against risks of all kinds.

The Board of Directors review and are aware of the risk register in the following ways:

- The Organisational Risk Register is available on the intranet at all times for review in full by any staff member including Board members.
- Where a risk scores 20 or above using the Trust risk scoring matrix, the risk will be escalated to the Board following discussion with the Medical Director and will be escalated to the first available Operations Management Team (OMT).
- The Board of Directors defines the structure of the Board Assurance Framework (BAF) such that it meets its assurance requirements and drives the Board's agenda. The BAF is the means by which the Board holds itself to account and identifies the principal risks that would prevent achievement of the Trust's strategic goals and/or regulatory compliance. The BAF defines the control systems in place to mitigate these risks and confirms the assurances that the Board wishes to receive throughout the year to evidence the effective operation of controls and mitigation of principal risks. The Board utilises the BAF as a working document and reviews the BAF structure and content at least annually.
- Members of the Board receive the minutes of the Audit Committee, Quality and Safety Committee and the Finance, Business Performance and Assurance Committee for information. The Board of Directors also receives a Report on Key Assurances and Risks from the Chairs of the Audit Committee, Quality and Safety Committee and Finance, Business Performance and Assurance Committee.

Audit Committee

Directors and senior management are responsible for implementing the Trust policies and procedures and a key source of assurance to the Board of Directors is the Audit Committee. This is the Board Committee with overarching responsibility for the scrutiny of the risk management systems and processes and the maintenance of an effective system of internal control on behalf of the Board.

The Audit Committee oversees arrangements in place relating to Counter Fraud and Corruption which are compliant with Department of Health requirements and are also subject to external audit. Its roles and responsibilities are described in the terms of reference.

The audit committee receives a risk process dashboard which provides a high-level summary of incident and risk management throughout the Trust. The dashboard submits ongoing data showing where the Trust is or is not meeting key targets from the Incident Reporting and Management Policy and the Risk Management Strategy; for example the number of risks opened and closed each month, the number of risks accepted

each month, the number of out of date risks each month and the detail of any new risks with a risk rating of 15 or greater.

Quality and Safety Committee
The Quality and Safety Committee is responsible to the Board of Directors for assuring the quality of patient care and service delivery in respect of clinical effectiveness, safety, and patient and staff experience. The Committee has specific objectives on monitoring high level risk, clinical effectiveness and safety, patient and staff experience, staff engagement and governance through a range of reports. The Committee has a role to support the integration of clinical, organisational and financial risk management and promotion of a holistic approach to management of risk.

The committee receives notification of all new 15 plus risks (both organisational and strategic) added to the risk register.

Finance, Business Performance and Assurance Committee
The Finance, Business Performance and Assurance Committee is an assurance committee of the Board of Directors.

The Committee receives direct reports from the Finance Strategy and Planning Group, The Informatics, information Technology and Medical Devices Group, the Information, Information governance and Coding group and the Transformation steering group. The Committee has specific objectives on monitoring high level risk from these areas and additional areas as appropriate.

The committee receives notification of all new 15 plus Finance risks (both organisational and strategic) added to the risk register.

Clinical Governance Group (CGG)
The Group is a strategic group led by the Medical Director. Its primary purpose is to oversee the execution of the Clinical and Quality Improvement Strategies and associate key delivery plans.
CGG objectives are:

- To be proactive to ensure that the Trust is aware of clinical governance issues.
- To ensure the Trust is aware of new developments that could impact on the quality and safety agenda.
- To oversee the development and approval of plans for the implementation of Trust wide clinical governance and patient experience issues.
- To scrutinise strategies and plans for the implementation of Trust wide clinical governance and monitor progress in implementing specific proposals.
- To escalate clinical governance and proposals with financial implications as necessary for approval by the EDT.
- To ensure clinical governance or concerns are investigated, discussed and actioned at the appropriate level in the organisation as they arise.
- To monitor compliance with the Care Quality Commission (CQC) registration and performance manage outstanding action plans.
- CGG is the key committee to oversee and develop the Quality Account prior to approval by the Board of Directors and to monitor progress via the Quarterly Quality Account Reports.
- To assess, receive and monitor risks in accordance with the Risk Management Strategy

The CGG will support the integration of clinical, organisational and financial risk management with that of the business planning process. It will promote a holistic approach to managing risk that will encourage all staff to provide safe, effective, timely and efficient care to patients.

The CGG meets on a monthly basis with a minimum 10 meetings per year. The Executive Director leading the CGG will take responsibility for communicating key issues between EDT, the CGG and other teams / staff to ensure that operational actions are delivered and risks managed and communicated in a timely way.

Operations Management Team (OMT)
The primary purpose of this Group is to oversee the execution of this Strategy and associated policies. It is responsible for providing assurance to the Committees' of the Board of Directors.

OMT is responsible for the monitoring and review of risks as follows:

- Any risks identified by Divisions and Corporate Departments which are scored 10 or above using the Trust risk scoring matrix are presented to the group. Group members provide a quality assurance role with respect to risk scores and mediate on risk scores where there is disagreement about consequence or likelihood.
- Any risks relating to CQC outcomes are presented to the group.
- Receive summary reports from each Divisional Management Team meeting in order to escalate any concerns or problem areas.

The OMT is also responsible for the management of operations within the Trust. Members of this Team are senior members of Trust staff with key management responsibilities. These responsibilities include risk management.

The OMT is responsible for accepting risks which cannot be mitigated any further. If the OMT considers further mitigation to be appropriate the risk will be returned to the appropriate team for further management.

Health and Safety Partnership Team (HSPT)
The Health and Safety Partnership Team is central to risk management of non-clinical risks within the organisation. This "committee" reviews risks, agrees mitigation plans and escalates risk in line with the Trust's escalation policy and procedure. Its roles and responsibilities are described in the terms of reference.

HSPT will:

- Discuss and agree mitigation plans escalated from their subcommittees;
- Discuss risk issues directly as they arise if urgent;
- Escalate risk issues which cannot be resolved to Workforce and Communication group in line with the Trust escalation process;
- Escalate risk issues which score 10 or above using the Trust risk matrix to OMT.

Divisional Management Teams (DMTs)
These team meetings are responsible for reviewing all divisional risks pertaining to their area, ensuring robust action plans are in place and monitoring action plans to ensure that they are completed on time. They will escalate risks which are outside of their control or which have financial implications which cannot be managed internally. To support management action a Risk Summary Report is produced each month to highlight key issues for management action in relation to policies, risk, incidents, complaints and claims.

DMTs will also:

- Discuss, agree and monitor mitigation plans for all risks belonging to their Division;
- Ensure that risks are reviewed in a timely manner;
- Ensure that actions taken to mitigate risks are reflected in the residual risk score
- Ensure that risks are fully mitigated prior to closure
- Review the risk register in its entirety annually to ensure all risks are accurate, there are no duplications and they remain relevant.
- Review monthly incidents, complaints and claims which occur in the Division.

Sub Groups to Board Committees (as per appendix 2)

These committees are responsible for reviewing all risks pertaining to their area, ensuring robust action plans are in place and monitoring action plans to ensure that they are completed on time. They will escalate risks which are outside of their control or which have financial implications which cannot be managed internally. To support management action a Risk Summary Report is produced each month which highlights key issues for management action in relation to policies, risk, incidents, complaints and claims.

APPENDIX 4 – Reporting Schedule

Committee Meeting	Frequency	Name of Report	Summary of report
Board of Directors	Monthly	20 plus risks	Monthly Report produced by the Risk Management Team sent for escalation and review of all new and ongoing 20 plus risks; risk also escalated when the risk is loaded
	Annual	Risks with a consequence score of 5 report	Annual report detailing all risks on the risk register with a consequence (impact) score of 5 regardless of the likelihood score
Divisional Management Team (DMT): • Medicine and Acute • Surgery, Women's and Children's • Clinical Support **Corporate Departments:** • Pharmacy • HR/OD • Informatics • Estates and Facilities • Corporate Nursing • Finance	Monthly	DMT Report	Monthly Report produced by the Risk Management Team sent for escalation and review of: • All new risks • All ongoing 15 plus risks • All out of date risks • All risks due to expire • All incidents reported • All new and, closed and settled claims • All new and ongoing complaints • All new and ongoing PALS • All High Scoring Out of date RCAs • All High Scoring Ongoing RCAs • All INR related serious incidents
Clinical Governance Group	Monthly	CLIPPE	Quarterly Report including contributions from Complaints and Patient Experience, Legal Services, Risk Management, Infection Control, Falls and Pharmacy detailing a full analysis of all Complaints, Litigation, Incidents , PALS and Patient Experience to be escalated and communicated from Ward to Board and shared externally with the Clinical Commissioning Group (CCG).
	Monthly	CQC Compliance Status Report	Monthly report produced by the Head of Assurance showing the current status of CCQC compliance.
	Monthly	CQC Risk Register	Report produced by Risk Management Team sent for escalation and review of all new and ongoing CQC risks.
	Quarterly	Serious Incident trend analysis report	Quarterly Report produced by the Risk Management Team detailing all reported and completed RCAs and SBARs during the previous quarter to be escalated and communicated from Ward to Board and shared externally with the Clinical Commissioning Group (CCG).
	Annual	Contingency Business Plan	Annual plan produced by the Emergency Planning Coordinator
	Annual	Monitor Major Incident Plan	Annual plan produced by the Emergency Planning Coordinator
Operations Management Team (OMT)	Monthly	10 plus risks	Monthly Report produced by the Risk Management Team sent for escalation and review of all new 10 plus risks.
	Monthly	Accepted Risks	Monthly Report produced by the Risk Management Team after request received from Division for risks to be agreed as accepted OR If there has been no change in risk score in a 12 month period.
	Monthly	Divisional/Corporate Departments	Report produced by the Risk Management Team populated from the Divisional Quality and Safety

Committee Meeting	Frequency	Name of Report	Summary of report
		quality & safety exception report Summary	Team reviews detailing any risk management exceptions to give assurance and enable any issues to be escalated through the organisation to CGG of robust risk and incident management processes including: • Policies • Risk Registers • Complaints / PALS • Claims / Inquests • RCAs • External reviews • NICE Gap analysis
	Monthly	CQC Compliance Status Report	Monthly report produced by the Head of Assurance showing the current status of CCQC compliance.
	Monthly	CQC Risk Register	Report produced by Risk Management Team sent for escalation and review of all new and ongoing CQC risks.
	Annual	Trust Risk Management Strategy Performance /Compliance with Annual Review	Annual report produced by the Risk Management Team to **OMT with escalation to Quality & Safety Committee and Finance Business & Assurance Committee. Full review and approval reserved for the Board of Directors.**
Trust wide Clinical Governance Team (TWCGT)	Bi Monthly	All Completed RCAs remaining serious	Monthly Report produced by the Risk Management Team detailing all completed RCAs which have remained serious after investigation.
	Bi Monthly	Trust Q&S assurance exception report	Report produced by the Risk Management Team populated from the Divisional Quality and Safety Team reviews detailing any risk management exceptions to give assurance and enable any issues to be escalated through the organisation to CGG of robust risk and incident management processes including: • Policies • Risk Registers • Complaints / PALS • Claims / Inquests • RCAs • External reviews • NICE Gap analysis
	Bi Monthly	Serious Incident (SI) Reviews	Monthly Report produced by the Risk Management Team detailing shared learning from completed RCAs.
	Quarterly	Serious Incident trend analysis report	Quarterly Report produced by the Risk Management Team detailing all reported and completed RCAs and SBARs during the previous quarter to be escalated and communicated from Ward to Board and shared externally with the Clinical Commissioning Group (CCG).
	Quarterly	CLIPPE	Quarterly Report including contributions from Complaints and Patient Experience, Legal Services, Risk Management, Infection Control, Falls and Pharmacy detailing a full analysis of all Complaints, Litigation, Incidents , PALS and Patient Experience to be escalated and communicated from Ward to Board and shared externally with the Clinical Commissioning Group (CCG).

Committee Meeting	Frequency	Name of Report	Summary of report
	Annual	Risk Annual report	Annual Report produced by the Risk Management Team providing an overview of risk management highlighted throughout the year to be escalated and communicated from Ward to Board.
	Annual	Incidents Annual report	Annual Report produced by the Risk Management Team providing an overview of all incidents reported throughout the year to be escalated and communicated from Ward to Board.
	Annual	Claims and Inquests Annual Report	Annual Report produced by the Legal Services Team providing an overview of all claims and inquests managed throughout the year to be escalated and communicated from Ward to Board.
Quality and Safety Committee	Bi-Monthly	Never Events	Report produced by Risk Management Team identifying new Never Events reported.
	Bi monthly	15 plus risks	Report produced by the Risk Management Team sent for escalation and review of all new 15 plus risks.
	Bi monthly	Serious Incident Graph	Graph produced by Risk Management Team identifying new Serious incidents reported.
	Quarterly	CLIPPE	Quarterly Report including contributions from Complaints and Patient Experience, Legal Services, Risk Management, Infection Control, Falls and Pharmacy detailing a full analysis of all Complaints, Litigation, Incidents , PALS and Patient Experience to be escalated and communicated from Ward to Board and shared externally with the Clinical Commissioning Group (CCG).
	Quarterly	Serious Incident trend analysis report	Quarterly Report produced by the Risk Management Team detailing all reported and completed RCAs and SBARs during the previous quarter to be escalated and communicated from Ward to Board and shared externally with the Clinical Commissioning Group (CCG).
	Annual	Trust Risk Management Strategy Performance /Compliance with Annual Review	Annual report produced by the Risk Management Team to OMT with escalation to Quality & Safety Committee and Finance Business & Assurance Committee. Full review and approval reserved for the Board of Directors.
Finance, Business Performance & Assurance Committee	Bi-Monthly	15 plus risks	Report produced by the Risk Management Team sent for escalation and review of all new Corporate Department 15 plus risks.
Health and Safety Partnership Group	Quarterly	Health and Safety Non-Clinical Data Analysis	Report produced by the Health and Safety Team showing a full analysis of all non-clinical incidents.

Consultation, Communication and Implementation

Consultation Required	Authorised By	Date Authorised	Comments
Equality Analysis	Jan Eccleston	21st April 2016	Full Equality Analysis not required
Policy Author Checklist	Jan Eccleston	21st April 2016	
Other Stakeholders / Groups Consulted as Part of Development	Clinical Governance Group, Audit Committee Members, Hospital Management Board members, All Divisional Quality and Safety Managers, Health and Safety Manager, Risk Management Team		
Trust Staff Consultation via Intranet	27th April – 11th May 2016		

Date notice posted in the News Bulletin.		Date notice posted on the intranet	

Describe the Implementation Plan for the Policy / Procedure / Strategy (Considerations include; launch event, awareness sessions, communication / training via DMTs and other management structures, etc.)	By Whom will this be Delivered?
▪ Inform Division/Corporate Quality and Safety Management teams ▪ Incorporate into Quality and Safety based training ▪ Build on the risk tools, systems and processes used and further embed in the organisation ▪ Promote a culture of openness in terms of reporting and learning from incidents for both staff and patients ▪ Ensure that the lessons learnt from incidents, complaints and claims are shared and disseminated across the Trust to foster Trust-wide learning ▪ Use the Trust intranet to publicise and improve access to risk management information including risk management tools	All Trust staff groups named in the document.

Version History

Date	Ver	Author Name and Designation	Summary of Main Changes
Dec 2011	01	Pam Lees, Head of Quality and Safety	Integration of Proactive Risk Assessment Procedure and Risk Identification, Management and Escalation Policy into the Risk Management Strategy and Policy. Reflects approved changes in committee structure. Adjusted risk grading matrix to reflect NPSA matrix and order of matrix adjusted to reflect that consequence is considered prior to likelihood.
May 2012	02	Pam Lees, Head of Quality and Safety	Further detail/clarification on role of committees, insertion of links, revised Trust Wide Governance Structure to reflect reporting changes.
			Updated to provide clarity in section 9.1.7

June 2012	03	Pam Lees, Head of Quality and Safety	
February 2013	04	Evan Moore, Medical Director	Revised Governance structure and reporting mechanisms incorporated. Changes checked for NHSLA compliance Circulated to EDT members for comments
March 2013	4.1	Sarah Mattocks, Risk Manager	Addition of "Chemotherapy Prescribing" to the Risk Scoring Matrix.
May 2013	4.2	Melanie Maxwell, Associate Medical Director	Clarification of reporting. Update structures
September 2013	4.3	Joe Roberts, Head of Assurance	Additional information regarding Board risk training in section 9.6 to provide clarification for NHSLA Standard 3.6, and corresponding KPI; change in information reported to Risk Management Group
November 2013	4.4	Sarah Mattocks, Risk Manager	Information governance descriptor added to risk scoring matrix
March 2014	4.5	Sarah Mattocks, Risk Manager	Updated risk scoring matrix added to policy
June 2014	4.6	Maryellen Dean; Associate Director of Risk Management	Review of the strategy to reflect current processes
February/March 2015	5.0	Tracey Bills, Risk Manager	Review Strategy processes in line with MIAA recommendations, annual report recommendations and CQC advice. Risk Management Group disbanded and therefore all reference omitted from strategy. Removal of 041d – Learning from Experience from Other Associated documents.
July 2015	5.1	Tracey Bills, Risk Manager	Inclusion of Sub Committees to the Board for the review of Corporate Department risks.
February 2016	5.2	Jan Eccleston, Associate Director of Risk	Full review and rewrite

Board of Directors	
Agenda Item	7.4
Title of Report	Report of the Finance Business Performance & Assurance Committee 24 June 2016
Date of Meeting	29 June 2016
Author	Graham Hollick, Chair of Finance Business Performance and Assurance Committee
Accountable Executive	David Allison, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	5A, Risk 2718, 6B, 7B, Risk 1927 and 2550, 7C Risk 2328, 7D, Risk 2689
Level of Assurance • **Positive** • **Gap(s)**	Gaps with mitigating actions
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

Board Assurance Framework (BAF)

The Committee was provided with an update on the BAF and the planned works of the Senior Management Team to develop a Board Statement of Risk and renew the BAF prior to its presentation to the Board in July 2016.

M2 Financial Position

The Committee reviewed the cumulative year to date deficit position at M2 which was reported as £400k above plan (at £2.0m compared to planned deficit at £1.6m), in the main attributable to pay costs as a result of staffing escalation areas, waiting list initiatives to meet Referral to Treatment (RTT) targets, agency to cover medical staffing gaps/pressures and non-core spend to support operational staffing issues.

The cash position was reported as £18.7m ahead of plan. The Committee was advised that this was as a result of receipt of June contract income in advance (c£19m) and did not therefore positively affect the trust's liquidity ratio.

The Financial Sustainability Risk Rating (FSRR) was reported as level 2 (with minimal headroom on the I&E metric of circa £170k before this metric fell from 3 to 2 driving the overall FSRR down to level 1) and mitigating actions to ensure cash preservation have been implemented to sustain the rating.

The Committee was advised that underspend of Capital Expenditure was as a result of delays in receipting medical equipment. Work has been undertaken with the Divisions to address the issue and revise plans to ensure that delivery lead in times were accounted for. The Committee requested that a risk detailing the issue be added to the Trust's risk register.

The risks and appropriate mitigations were outlined in relation to income, expenditure, CIP and cash.

Cost Improvement Programme at Month 2

The Committee reviewed progress of the CIP programme at M2. The programme reported a cumulative negative variance of £154k (following the application of a £400k mitigation in respect of in year identified non recurrent savings) to date with an in year forecast of £9.5m this being is £1.7m short of the NHS Improvement plan for 2016/17 at M2.

Progress against the CIP plan for 2016/17 was outlined which included £8.1m of schemes that had been fully developed and approved; £0.4m of plans in progress and £0.7m of opportunities. £2.0m of unidentified schemes was reported with £0.4m of these in the "ideas" stage. Further schemes to bridge the gap of £1.6m of unidentified schemes were being sought and where possible, in year mitigations were being reviewed to determine their viability as recurrent savings. The Committee requested that details be provided on schemes which were failing to deliver and the mitigating actions allocated to the divisions to address the gap.

Performance Report

Key points from the performance report included:

- The non-achievement of the constitutional RTT target for May 2016, however continual improvement is demonstrated with the Trust achieving a final position of 91.39% compliance against the Sustainability and Transformation Fund (STF) trajectory of 90%.
- Two avoidable cases of C difficile were identified during May 2016,however the Trust remains below the cumulative plan trajectory of three cases to the end of May. The Committee was alerted to two further cases of C difficile identified during June 2016, one of which is considered to be avoidable.
- A & E 4 hour standard – performance of 83.44% was reported for May 2016. The Committee was advised of mitigating actions put in place during w/c 13 June 2016, which has seen achievement of 85.7% to date for June 2016, this being above the 84% STF trajectory. The opening of the Acute Ambulatory Care Unit during w/c 27 June 2016, an increased trolley base and changes to bed management processes are anticipated to further support achievement of the standard.
- The 62-day consultant upgrade to first treatment remains the most difficult cancer access target to achieve as reflected at national level. A detailed breakdown on performance at specialist level for this target was presented to the Committee however final figures to confirm achievement of the 85% target in line with STF trajectories are unavailable until month end but expected to be on track.

Agency Cap Compliance Report

The Committee received a report outlining the Trusts compliance levels against the price caps for agency staff, introduced in November 2015 by NHS Improvement. The Committee noted the progress to date to reduce agency costs, however specialist by specialist reviews are to be conducted in key areas to address rota compliance and develop a substantive medical workforce. Review outcomes will be submitted to the Finance, Strategy and Planning Group in June 2016 and will be utilised to identify potential mitigations and inform the plans of the Transformation Steering Group. The committee requested that monitoring against monthly compliance be included in papers.

Reference Costs

The Committee reviewed the paper for the reference cost submission, due to be submitted in July. The Committee took assurance form the work of internal and external audit on data quality which informed the self-assessment. The Committee agreed to recommend to the Board that authority be delegated to the Director of Finance and Chairman to authorise the Trust reference costs for submission.

Service Line Reporting (SLR)

The Committee reviewed the actions taken by the Division of Medical and Acute in relation to SLR. The interim Divisional Director outlined how some of the opportunities identified as part of the Lord Carter Review were being taken forward. The Committee was pleased with the report and recommended that activity levels be included in future.

Graham Hollick
Chair of Finance Business Performance and Assurance Committee

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF MEETING

25 MAY 2016

BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL

Present

Michael Carr	Chairman
David Allison	Chief Executive
Cathy Bond	Non-Executive Director
Andrea Hodgson	Non-Executive Director
Graham Hollick	Non-Executive Director
Janelle Holmes	Chief Operating Officer
Gareth Lawrence	Acting Director of Finance
Cathy Maddaford	Non-Executive Director
Evan Moore	Medical Director
Jean Quinn	Non-Executive Director
John Sullivan	Non-Executive Director
Gaynor Westray	Director of Nursing and Midwifery

In attendance

Carole Self	Director of Corporate Affairs
Mike Coupe	Director of Strategy*
James Mawrey	Director of Workforce*
Danielle Sweeney	Deloitte
Jane Kearley	Member of the Public

Apologies

*denotes attendance for part of the meeting

Reference	Minute	Action
BM 16-17/030	**Apologies for Absence** Noted as above	
BM 16-17031	**Declarations of Interest** None	
BM 16-17/032	**Patient Story** The Director of Nursing and Midwifery presented to the Board a compliant from a patient suffering with back pain who visited the Emergency Department and whose experience lacked care, compassion and leadership. The Board was updated on the resolution meetings held with the patient following the complaint where it was acknowledged that there were delays in care and poor communication. The Director of Nursing and Midwifery was now pleased to report that following a series of meetings and improvements in the Emergency Department with additional nurses and clinical support being put in place; the introduction of safety huddles and improvement patient group directives in relation to pain relief that the patient's latest visit to the department was a wonderful experience.	
BM 16-17/033	**Chairman's Business** The Chairman updated the Board on the recent appointment of a Consultant Gastroenterologist Dr Sagar. He requested an update on the	

Reference	Minute	Action
	latest Junior Doctors Strike and contractual negotiations. The Medical Director advised the Board on the process for approving the latest contractual arrangements negotiated between the Department of Health and the Junior Doctors Committee. He confirmed that all the planning undertaken for any future industrial action had now been put on hold with the exception of the recruitment of the Safe Working Guardian. The Board expressed their thanks for the co-operation and goodwill of Junior Doctors and staff during the dispute although it regretted the inconvenience to patients. The Chairman advised the Board that he had plans to meet with the Director of Corporate Affairs and the Chief Executive to progress the Board Development Programme following the recent Risk Appetite session. The Board also agreed to review the implementation of the Junior Doctors Contract as part of their Development work.	**CS**
BM 16-17/034	**Chief Executive's Report** The Chief Executive presented the report and highlighted the following areas for discussion: **The Better Care Fund (BCF)** – the Chief Executive provided the Board with the rationale for the Trust being unable to sign up to the BCF submission as a result of a lack of consultation and assurance. The planned 40% reduction in intermediate care beds as part of the plan posed a significant risk to the Trust and its ability to discharge medically fit patients. The Board was advised that the absence of full sign up may lead to the process being externally validated. **Cerner** - The Board noted the good work being undertaken in collaboration with Cerner and was updated on the forthcoming HSJ Modernising Healthcare Summit at which the Chief Executive was presenting. **Maternity Cultural Review** – the Board was updated on the positive support from CQC and NHS Improvement as the Trust implemented the action plan following this review. **HPMA Shortlisting** – Board expressed their congratulations to Mr James Mawrey following him being shortlisted for the HR Director of the year, him being 1 of only 3 candidates shortlisted. The Board sought to understand whether the Trust had articulated what it required from the Better Care Fund. The Chief Executive confirmed that this was the case and despite not being able to sign up to the submission he was pleased that the Local Authority was now progressing with the work required to bridge the gap in the intermediate care market although he was still concerned that the local authority would de-commission care home provision before commissioning an alternative.	
BM 16-17/035	**Vanguard Programme Update** The Board was updated on the action being taken following the transfer of the Vanguard project into the Healthy Wirral Programme. It was updated on the financial support from the Local Authority of £500K to progress with	

Reference	Minute	Action
	the diabetes and respiratory projects for the year 15/16 although it was acknowledged that this funding was not recurrent. The Chief Executive advised that the difficulty would be to re-design the services, whilst improving the quality of care without reliance on additional funding going forward. The Board was pleased to hear that it was unlikely that there would now be any redundancies following the absence of Vanguard funding going forward. It acknowledged that future reports would now focus on the Healthy Wirral Programme.	
BM 16-17/036	**Integrated Performance Report** The Chief Operating Officer presented the Integrated Performance Report and highlighted the following: **A & E 4 Hour standard** – the Chief Operating Officer drew the Board's attention to the A & E performance trajectory now included in the report. She advised that at the end of April the Trust was above the improvement trajectory although it was acknowledged that there was significant work to be undertaken to improve flow. The Board was advised that the new Assessment Unit would "go live" in June with the full agreement of clinicians to this new way of working. The Chief Operating Officer confirmed that she was confident that if this unit was used as planned the Trust would see an improvement in its trajectory. **Advancing Quality** – it was reported that the time to antibiotic treatment in respect of pneumonia was expected to improve following an awareness raising campaign and the visual prompts now put in place. The sickness and vacancy levels in specialist nurses to undertake the AKI had prompted concerns that this work had not been fully embedded which was now being addressed. **Elective Activity** – 4 days of lost activity during April was reported as much of the potential loss of activity due to the junior doctors action had been mitigated. The Division was looking to clawback this over the next few months. **Referral to Treatment Time (RTT) –** the Board was advised that the Trust did not achieve the 92% RTT target in April although it was confirmed that if all the planned activity had been delivered the target would have been achieved. The establishment of the task and finish group to focus on patient flow would provide improvements going forward although it was recognised that following the agreement in principle to progress with data cleansing of the RTT waiting list, this could take a little while longer. The impact of this work would be established ahead of a full programme of work being implemented. **C difficile –** 1 unavoidable case of C difficile was reported demonstrating that the robust action plan was continuing to have the impact required. The Chief Operating Officer provided assurance as to the monitoring and review process which now included weekly access and performance meetings and the new operational management team meeting on a monthly basis which focussed on performance, finance and activity with plans to include corporate teams going forward.	

Reference	Minute	Action
	The Board sought to understand why the trajectory did not forecast compliance with the 95% target during the year 2016/17. The Chief Operating Officer confirmed that the improvement trajectory was that which had been submitted as part of the operational plan approved by the Board and approved by NHSI; that was not to say however that the Trust would not aim to achieve higher levels wherever possible. The Board acknowledged the link between the plan and the release of the sustainability and transformation funding of £9.9M. Following the External Audit review of A & E performance the Board sought to understand the legitimacy of reporting performance on a combined Arrowe Park and Walk In Centre basis. The Chief Operating Officer confirmed that it was appropriate to report on a combined basis and indeed not to do so would be unreasonable in terms of the Trust's ability to deliver the 95% target on its own without the need to deflect appropriate patients to the walk in centre. The Board accepted the explanation but requested that the report included both sets of figures in the future. The Board sought to understand why the Trust could not include the activity of Victoria Central in its figures in light of the pilot to deflect patients with minor medical conditions to the site. The Chief Executive advised that he acknowledged the frustration and that was the reason why the health economy was progressing with plans to contract for urgent care on an alternative basis which was now planned to be in place for April 2017. The Board sought to understand what level of assurance could be provided that elective activity would not reduce as a result of securing the financial envelope. The Chief Operating Officer confirmed that the weekly access and performance meeting would provide the route for monitoring and review to ensure the Trust remained on track to achieve the agreed plan. The Board was advised that the Trust would also track activity performance against a payments by result contract to ensure the focus remained throughout the year. The Director of Corporate Affairs advised the Board that as a result of non compliance with the RTT target in April this would trigger a governance concern with NHSI. She did confirm however that NHSI had approved the improvement trajectory so was unclear therefore as to what potential action NHSI might take. The Chief Executive reiterated that the Trust needed to also understand fully the impact of the cleansing work planned on the waiting list as part of the dialogue with NHSI. The Board requested that the trajectory for RTT be included in the performance report to aid with monitoring and review. The Board agreed that a full review of the performance report was now required and that careful consideration would need to be given to what was deemed to the important for the Board to review to avoid the report becoming unmanageable.	**JH** **JH**
BM 16-17/037	**Month 1 Finance Report** The Acting Director of Finance reported the position at Month 1. He	

Reference	Minute	Action
	confirmed that the Trust delivered a £1.3M deficit compared to the plan of £1.1M, with expenditure being above plan by £0.2M. He reported that expenditure was above the agency trajectory using a 1/12th methodology although it was acknowledged that NHSI had not as yet released it plan for performance tracking. The Board was assured that action was being taken to address this with the closure of the escalation beds in May and the speciality by speciality non-core spend reviews being undertaken by the Director of Workforce and the Chief Operating Officer which were due to conclude at the end of June. The cash position was reported positively with a cash balance at the end of April of £5.7M this being £2.9M above plan. The Board was reminded of the availablility of the working capital facility now in place. The cost improvement programme reported an underachievement of £70K in April resulting in increased emphasis on non-recurrent schemes to be identified and implemented to allow for time for the transformation schemes to be developed. The Board was advised that the Trust was working on closing the £3M gap and that M2 was forecast to be improved. Clinical income was reported to have been largely on plan and overall the financial envelope contract had resulted in a favourable monthly out turn of £400K. The Board sought to understand how the Trust was accounting for the sustainability and transformation funding (STF). The Acting Director of Finance advised that this was to be paid in arrears and was profiled in equal 12ths. The Board sought to understand whether the £5M CIP attributed to the health economy was factored into the plans. The Acting Director of Finance advised that this was not included. The Chief Executive reported that the meeting with NHSE and NHSI and the Commissioner to address this was delayed as a result of the number of Trusts that were still undertaking contractual negotiations. He also advised the Board that the Trust was in negotiation on a range of things to bridge the gap citing examples such as pharmacy and aspects of the commissioning support unit. The Board confirmed that it was helpful to know that the STF funding was paid in arrears which should allow for at least 3 quarters of this to be paid in the year. The Chief Executive confirmed that he would provide a briefing to the next Board on the plans to address the £5M gap. The Board sought to understand what contingency plans were in place to manage additional activity to avoid opening escalation beds. The Chief Operating Officer confirmed that the Trust was currently undertaking a bed management review which would be concluded in 2/3 weeks at which time she would be able to respond accordingly. The Director of Nursing and Midwifery confirmed that the new assessment unit would help with patient flow in the future. The Board sought clarity as to the impact of a Payment by Results contract based on M1 performance in that whether this would have triggered a FSRR rating of 1. The Acting Director of Finance confirmed that this would have been the case.	

Reference	Minute	Action
	The Board sought assurance on the Trust's ability to deliver the CIP programme based on M1 performance. The Chief Executive confirmed that performance was not a result of able people deviating from detailed plans more that it was the result of tracking performance on an equal 12ths basis when in reality delivery would be in the latter part of the year. The Board was advised that the Trust had taken the initiative to bolster the PMO team to ensure that the focus was transformation which should bring the results desired.	
BM 16-17/038	**Francis Hard Truths – Nurse Staffing Report** The Director of Nursing and Midwifery presented the nurse staffing report which provided the Board with staffing data including vacancy rates, age profile of the nursing workforce and a breakdown of years of experience in the workforce. The report also included 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 and April 2016 as reported to NHSE each month. The Board was advised that the current vacancy rate for registered nurses was 6.04% although this was higher in Medicine and Acute as outlined in the report. The Director of Nursing and Midwifery advised that the majority of vacancies in medicine fell within specialist areas and to address this the Division were holding monthly recruitment events to focus on specialist areas. At the Board's request the Director of Nursing and Midwifery reported on the number of staff supported through the in house perceptorship programme, this being 605. She was pleased to report that the Trust had also secured funding for 12 months for a recruitment and retention facilitator. The Board was advised of the focus on retention in view of the length of service profile of this cohort of workers. The Director of Nursing and Midwifery reported an improvement in fill rates for March and April although there were a couple of occasions in maternity where performance fell well below expected levels. She confirmed that each time the situation was risk assessed and staff were moved accordingly which included community midwives being redeployed to ensure safe levels applied. The Board was advised that if safe levels were not in place the Trust would have asked for a divert which hadn't been the case. Maternity rates for April had improved with the lowest fill rate for CSW Days was 96.3% ie above the 95% threshold. The Board was updated on the progress being made to record Care Hours Per Patient Day (CHPPD) as advised by Lord Carter in his review. The Director of Nursing and Midwifery confirmed that reporting was required from the end of May and would help with the elimination of unwarranted variation in reporting staffing levels. She confirmed that the methodology was not easy to apply but the benefits would be worthwhile and the availability of benchmarking would help this Trust in particular. The Board reviewed the next steps outlined in the report.	

Reference	Minute	Action
	The Board sought assurance on the escalation processes in view of the comments in the recent maternity cultural review. The Director of Nursing and Midwifery confirmed that staffing escalation was well documented and evidenced with 4 hourly checks being undertaken. The Board also sought assurance on plans to address the loss of bursaries in the future and the impact on nurse recruitment. The Director of Nursing and Midwifery advised that the Trust was working with the universities as well as looking at new ways of funding working in collaboration with the Countess of Chester. She confirmed that the key was to ensure that the new approach attracted students as well as being financially acceptable to the Trust. The Chief Executive recommended that the impact of technology be exploited when reporting on CHPPD in the future. The Board sought to understand how the recruitment strategy had been adapted to take into account the age profile of nurses. The Director of Nursing and Midwifery updated the Board on the "growing your own" programme and how the Trust was supporting nurses to develop their portfolios by removing historic barriers. The Director of Workforce advised that the Trust's workforce plan was updated on an annual basis and reported to Health Education England.	**GW**
BM 16-17/039	**Workforce Annual Report** The Director of Workforce presented the Workforce Annual Report reminding members of the 2 year plan approved in 2015. He reported a strong year in terms of the workforce indicators with the NHS staff survey being the most improved in the country. The work undertaken to improve attendance levels had resulted in a further 16000 days being put back into the system. The focus on the appraisal system had also yielded results with achievement of the target. The overall view was that the Trust took the workforce seriously. The work with staff guardians was outlined with a full review of the themes from this work being presented to the Quality and Safety Committee in May. The Board congratulated the Director of Workforce on the excellent report which was the result of a lot of hard work in the Trust. It was acknowledged however that further work was required to improve mandatory training levels. The impact of the changes in the NHS pension were explored with the conclusion being that the majority of staff would be unaffected although it was recognized that the changes impacted, in the main, upon consultants. The Board gave their thanks to the Director of Workforce and took the opportunity to congratulate him on being shortlisted for the HPMA HR Director of the year and wished him every success with this.	

Reference	Minute	Action
BM 16-17/040	**CQC Compliance Progress Update** The Medical Director presented the updated version of the CQC action plan which showed the progress made since submission in April to date. He advised the Board as to how the Trust was also progressing with actions to improve all elements raised in the report. The Board was pleased with the amount and range of work being undertaken particularly given the short amount of time since the development of the plan. It sought to understand how the Trust would quantify the impact of the actions taken and also how the Trust would develop the plan to ensure the journey of transformation continued. The Medical Director suggested that the impact could be seen particularly through the improved levels of staff engagement and satisfaction citing an example of the improvements to toilets and showers which had allowed the leadership to be judged by its action rather than words. The Board Partner visits and internal care quality inspections had provided the Senior Management Team with some of the softer intelligence in terms of impact which was extremely useful. The Board was updated on the engagement visit by CQC undertaken on 19th May 2016 which was largely positive and supportive of all the actions being taken. The one area where greater pace was expected was in End of Life Care. The Medical Director confirmed that the Senior Management Team had now approved the appointment of 2 further palliative care consultants as well as retaining the skills of the nurse facilitator. The Board was reminded that the work in this area relied on strong health economy partnerships and to that end partners were meeting again that afternoon to agree how they could work differently and at pace. The Board was advised of the likelihood of a further inspection before the end of the calendar year. The Board agreed to continue to receive reports on a quarterly basis until at least the next inspection.	**EM**
BM 16-17/041	**Annual Report and Accounts 2015/16** The Chairman requested that Mrs Bond, Chair of the Audit Committee provide the Board with an overview of the Committee's review and recommendations on the Annual Report and Accounts ahead of formal approval. Mrs Bond confirmed that the Committee had reviewed all the end of year documents with the Chief Executive in attendance to present the Annual Governance Statement. She advised the Board that the Committee received a presentation on the key points in the accounts which had led to the Committee recommending that in the Board presentation this should include the rationale for the Whole Government Accounts WGA mismatches above £250K. The Committee was more than happy to recommend the approval of the Annual Accounts. Mrs Bond confirmed that the Auditors had provided an unqualified opinion on the accounts and in her opinion the report was one of the "cleanest" on a set of accounts she had ever seen. She extended thanks to the Acting Director of Finance and	

Reference	Minute	Action
	his team for all the hard work undertaken and commended the Trust on achieving a "clean" value for money conclusion and the Use of Resources Opinion as well as recognising the work of the Finance Business Performance and Assurance Committee in their review of the Going Concern statement which supported the Auditors in terms of them reaching their opinions. The Board was advised of the review undertaken on the Annual Report and in particular the Annual Governance Statement and the Annual Audit Committee report which enabled the Committee to recommend these to the Board for approval. Mrs Bond confirmed that the Audit Committee took assurance from the review of the Quality Report undertaken by the Quality and Safety Committee in terms of content and therefore focussed its attention on the Audit Opinions and the 3 indicators which formed part of the Limited Assurance Report. She confirmed that the local indicator chosen by Governors in relation to adherence to the MUST tool was found to be in line with expectations. The two national indicators however in relation to A & E 4 hour standards and referral to treatment times RTT were qualified by the Auditors. The initial concern from the Auditors in relation to A & E performance including the walk in centre figures was addressed with the Quality Report being amended to separate these figures out. The audit did find 3 errors out of a sample of 25 A & E attendances, the Trust requested that a further extended audit be undertaken to cover a further 15 cases. This work was undertaken and although it did not reveal any further errors, the identification of the initial 3 errors was enough to qualify the audit opinion. The audit on RTT originally revealed 13 errors out of a sample of 25 start and stop times from a total patient list of 22,000 at any time. Mrs Bond reminded the Board that the previous auditors had taken the view that provided patient wait times were validated at the end of the process this was satisfactory as to check the whole pathway of patients was felt not to offer value for money. She confirmed that the Committee challenged the auditors in their findings citing that the regulations associated with start and stop times had changed during the course of the year and therefore requested that the sample check be re-visited to ensure compliance with the changes. The re-visit resulted in 8 of the original 13 errors being found to be correct however this still resulted in a qualified opinion being concluded which the Trust had to accept. The Board was advised that the Committee had agreed to look at some internal audit checks in the year to prevent this happening again. The Board was advised that the letters of representation for both the financial statements and the quality report were standard and therefore did not require any further representation from the Trust. The Board thanked Mrs Bond and the Committee for this work. • **Annual Accounts 2015-16 and Audit Opinions** The Acting Director of Finance provided an overview of the 2015/16 financial statements which included the key results arising from the audit which were that:	

Reference	Minute	Action
	➢ It was agreed that the Trust was a going concern ➢ The audit opinion was unqualified ➢ The value for money conclusion was unqualified ➢ The ISA260 (audit findings) report was "clean" ➢ No internal control deficiencies were identified The Board reviewed the headlines from the accounts in relation to cash, the financial out-turn and the capital programme as well as reviewing the primary financial statements. In line with the recommendations from the Audit Committee, the Board reviewed the Agreement of Balances (AOB) and in particular the variances over £250K which had been investigated in detail. The Board reviewed the outstanding AOB 5 of which the Trust had correctly accounted for. The balance of £368K with the Community Trust related to disputed charges for the occupancy of Victoria Central and St Catherines and the £380K with East Cheshire NHS Trust related to a variance in the Department of Health instructions which was acknowledged would result in mismatches. Mrs Bond confirmed that the Audit Committee sought and received assurance that the set of standards were consistent in terms of their approach and if there was a benefit to both organisations than the Trust would be willing to amend, if not that the Trust would maintain its approach. The Board was updated on the final adjustments undertaken to the accounts following circulation, these included: ➢ Off payroll updated – included an up to date note ➢ Remuneration report – updated to reflect correct P11d information ➢ Notes updated – to reflect remuneration report and final AOB adjustments The Board sought to understand whether the impairments had impacted on the Income and Expenditure position. The Acting Director of Finance confirmed that this was not the case and that it had only reduced depreciation. The Board also sought assurance on the outcomes of the desktop revaluation of assets and was advised that this was subject to periodical review as part of the audit work programme. The Board commended the Acting Director of Finance and his team on the excellent piece of work. The Board approved the annual accounts, the audit opinions and the letter of representation. • **Quality Report and Audit Opinion** The Medical Director presented the Quality Report and Audit Opinion noting the earlier discussion on the limited assurance report and the qualified opinion. The Board was reminded of the review undertaken of the Quality Report by the Quality and Safety Committee and the previous approval given in	

Reference	Minute	Action
	relation to the priorities for 2016/17 which would see mortality and readmissions replaced by the work of SAFER and End of Life Care. The Board approved the Quality Report, audit opinion and letter of representation. • **Annual Report and Annual Governance Statement** The Director of Corporate Affairs presented the Annual Report and Annual Governance Statement for approval by the Board. She confirmed that the Audit Opinion had concluded that the Annual Report had been produced in line with the regulators requirements and although this had not been produced as a marketing tool, it should still provide the Trust, its employees and the public with a good account of the work undertaken in the year. The Board agreed that it did reflect what the Trust had achieved and delivered over the past 12 months which had been significant. The Board offered it's thanks to the Director of Corporate Affairs for producing this work. The Board approved the Annual Report including the Annual Governance Statement. The Board noted the timescales for submission to NHS Improvement and the process for laying the Annual Report before Parliament. Thanks were extended to the Executives and their teams for this work. The Board concluded that it was good to reflect on the progress made and how the Trust had overcome many challenges despite the financial position.	
BM16-17/042	**Chair of the Audit Committee Report – 19 May 2016** In view of the discussion on the Annual Report and Accounts the Board accepted the report as presented noting the work the Committee had undertaken to review its own effectiveness.	
BM16-17/043	**Board Declaration – General Licence Condition G6** The Director of Corporate Affairs presented the options for the Board declaration against general licence condition G6. She reminded Board members of the considerations taken into account in last year's declaration in order to provide the Board with the context for this year's submission. The Director of Corporate Affairs advised the Board that it could take a view that it had taken all reasonable endeavours to comply with its licence or it could take a view that because the Trust was in breach that it could not confirm. The Board reviewed the considerations highlighted in the report and agreed that these were appropriate and valid however it concluded that it should declare "not confirmed" to both statements in view of the current breach of its licence. The Board approved the decision to declare "not confirmed" to both statements however agreed that the narrative in the report should accompany the statement**.**	**CS**

Reference	Minute	Action
BM16-17/044	**Report of the Quality and Safety Committee – 18 May 2016** Dr Quinn, Chair of the Quality and Safety Committee presented the Board with an update of the work undertaken at its meeting on 18th May 2016. Dr Quinn advised the Board of the concerns with the number of Red Rated risks in the Board Assurance Framework (BAF) in relation to partnership working and health economy assurance and although the Committee agreed with the ratings it would look for greater assurance in the future. The Board was updated on the work that the Committee undertook to review the trends highlighted in the Staff Guardian Annual Report which centred around policies and procedures; attitudes and behaviours and staffing levels. The work of the internal care quality inspections was highlighted and in particular how the Committee sought a greater level of triangulation between the work of the ward audits and this work to ensure outcomes aligned, acknowledging that these measured different points in time. Compliance with the WHO checklist was reported as improving although it was accepted that this needed to be 100% with barriers to achievement being cited as cultural. The Board was updated on the review of the action plans to improve cancer performance in each speciality. The Board was pleased that the CQC puerperal sepsis report had not revealed incidences of non-compliance but was concerned with some of the observations made as part of the audit as it felt some of the issues raised should be part of the care offering afforded to all patients. The Chairman acknowledged that this had been Dr Quinn's last Quality and Safety Committee in her role as Chair and therefore extended thanks to her for the work undertaken in ensuring that the Committee was such a credible and effective body.	
BM 16-17/045	**Board of Directors** The Minutes of the Board of Directors Meetings held on 27th April 2016 were confirmed as an accurate record subject to Dr Moore being included as present. **Board Action Log** The Board action log was updated as recorded	
BM 16-17/046	**Items for BAF/Risk Register** The Board requested that the £5M gap in CIP be included in the BAF	**CS**

Reference	Minute	Action
BM16-17/047	**Items to be considered by Assurance Committees** The Board agreed that the Finance Business Performance and Assurance Committee should ensure that activity was being monitored on a shadow basis in view of the financial envelope and that data capture and control for the new care hours per patient per day was in place.	
BM 16-17/048	**Any Other Business** The Board acknowledged that it would be the last meeting for Mr Gareth Lawrence in his Acting Director of Finance role and wanted to ensure him that the Board did not want him to lose visibility. It thanked him for his excellent work as the Acting Director of Finance and not just for how he had undertaken the position but for how he had managed the whole finance office which had rapidly gained organisational confidence and supported the External Audit opinion on the accounts. The Board looked forward to his continuing contribution.	
BM 16-17/049	**Date and Time of Next Meeting** Wednesday 29 June 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 – June 2016

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 25.05.16						
1	BM16-17/033	Include progress on the implementation of the junior doctors contract as part of the Board Development Programme	CS		July 16	
2	BM16-17/036	Include performance for A & E and RTT against the trajectory and compliance targets	JH	**Completed**	June 16	**Charts included in agenda item 7.1.1**
3	BM16-17/036	Full review of the performance report to be undertaken to avoid this becoming unmanageable	JH			
4	BM16-17/037	Exploit the impact of technology when reporting CHPPD in the future	GW			
5	BM16-17/040	Board to continue to receive CQC updates until the next inspection on a quarterly basis	EM		September 16	
6	BM16-17/043	Submit "not confirmed" on the G6 compliance declaration with supporting narrative	CS	**Completed**		**NHSI advised the Trust to submit "confirm" to statement 2 as the Trust still met the criteria for holding a licence**
7	BM16-17/046	Include the CIP £5M gap in the Board Assurance Framework	CS		July 16	
Date of Meeting 27.04.16						

8	BM16-17/007	Include attendance and appraisal performance in the achievement of 2015/16 objectives	MC			
9	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	**Completed**		
10	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		July 16	
11	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 to include updates on the Cancer work and the raising concerns themes - Completed**	May 16	
12	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						
13	BM15-16/297	Present the Medical Engagement Strategy	EM/JM	**This work is underway**	May16	
14	BM15-16/299	Update on the number of discharges before noon as a result of the SAFER roll out	CO		April 16	
15	BM15-16/300	Include the number of staff on either preceptorship or mentorship programmes in future nurse staffing reports	GW	**Included in the Report to the Board in May 2016 - completed**	May 16	
16	BM15-16/300	Circulate to members the impact of the nursing investment from a financial perspective in order to complete the evaluation process.	GW		April 16	

Date of Meeting 27.01.16						
17	BM15-16/243	Provide a weekly progress report on A & E in light of current performance	CO	**ongoing**		
18	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	
Date of Meeting 28.10.15						
19	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	
20	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						
21	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						
22	BM 15-16/015	Provide the Board with a monthly update on CQC improvement against compliance	EM/CS	**In light of action from 25.05.16 – this action recorded as completed**	September16	