Wirral University Teaching Hospital NHS
NHS Foundation Trust

Board of Directors
Public Board

24th May 2017

wuth.nhs.uk
@wuthnhs #proud

MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 24th MAY 2017
COMMENCING AT 9.00AM IN THE
BOARD ROOM
EDUCATION CENTRE, ARROWE PARK HOSPITAL

AGENDA

1	**Apologies for Absence** Chairman	v
2	**Declarations of Interest** Chairman	v
3	**Chairman's Business** Chairman	v
4	**Cyber-Attack** Director of IT and Information	v
5	**Chief Executive's Report** Chief Executive	d

6. Quality and Safety

6.1	**Patient's Story/Learning** Director of Nursing and Midwifery	v
6.2	**Nurse Staffing Report** Director of Nursing and Midwifery	d
6.3	**Report of the Quality and Safety Committee** • **Health and Safety Annual Report** • **NHS Staff Survey Action Plan** Chair of the Quality and Safety Committee	d

7. Performance and Improvement

7.1	**Integrated Performance Report**	
	7.1.1 Integrated Dashboard and Exception Reports Chief Operating Officer	d
	7.1.2 Month 1 Finance Report Director of Finance	d
7.2	**Workforce and Organisational Development Annual Report** Director of Workforce	d

8. Governance

8.1	**Report of the Audit Committee** Chair of the Audit Committee	d
8.2	**Approval of Annual Report and Accounts 2016/17**	d
	• **Annual Accounts 2016-17 and Audit Opinion** Director of Finance	d
	• **Quality Report and Audit Opinion** Medical Director	d
	• **Annual Report and Annual Governance Statement** Director of Corporate Affairs	d
8.3	**NHSI Provider Licence Board Declarations** Director of Corporate Affairs	d
8.4	**Board of Directors**	
	8.4.1 Minutes of the Previous Meeting – 26th April 2017	d
	8.4.2 Board Action Log Director of Corporate Affairs	d

9. Standing Items

9.1	**Items for BAF/Risk Register** Chairman	v
9.2	**Items to be considered by Assurance Committees** Chairman	v
9.3	**Any Other Business** Chairman	v
9.4	**Date and Time of Next Meeting** Wednesday 28th June	v

Board of Directors	
Agenda Item	5
Title of Report	Chief Executive's Report
Date of Meeting	24 May 2017
Author	David Allison, Chief Executive
Accountable Executive	David Allison, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	ALL
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To Note
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

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

Internal

- **Clifford Mann A & E Visit**

On the 9th May 2017 Dr Clifford Mann visited the Trust. Dr Clifford Mann was the President of the Royal College of Emergency Medicine until very recently and is currently working nationally with NHSE & NHSI as Clinical Lead for the Accident & Emergency

Improvement Plan. He is also developing the GIRFT metrics for Emergency Care. The visit was extremely productive with Dr Mann connecting the Trust with a number of areas of best practise across the country. In addition as part of the GIRFT work & its alignment with clinical variation WUTH offered to be involved in the development or piloting of the metrics to support the improvement agenda.

- **Health and Wellbeing Plan 2017-19**

The Health and Wellbeing Plan is a key objective within the Workforce and Organisational Development Strategy 2015-18. The plan was recently refreshed to incorporate the requirements of a National Commissioning for Quality and Innovation (CQUIN) for 2017-19 on Health and Well-being which has three components:

  - Improvement of health and wellbeing of NHS staff
  - Healthy food for NHS staff visitors and patients
  - Improving the uptake of flu vaccinations for front line staff within providers

The drivers underpinning the CQUIN includes the 'Five Year Forward View' published by NHS England which makes a commitment to ensure the NHS, as an employer, sets a national example in the support it offers its own staff to stay healthy. NHS organisations are expected to create an environment where health and wellbeing of staff is actively promoted and encouraged. Public Health England's challenge to reduce obesity through sugar reduction and the recommendation that all healthcare workers directly involved in patient care are vaccinated against influenza annually also underpin the need for the National CQUIN. Additionally, the staff survey and other sources collected by NHS England, shows that improving staff health and wellbeing leads to higher staff engagement, better staff retention and better clinical outcomes for patients.

The Trust's Health and Wellbeing Plan for 2017-19 is focused on five key areas:

  - Encouraging colleagues to become more physically active
  - Healthy lifestyle choices (drug and alcohol, smoking cessation and weight management)
  - Healthy food and drink
  - Supporting colleagues to reduce sickness absence
  - Mental health

There will be a range of activities introduced to build on the great work already taking place, such as Zumba, Pilates, Choir, Kung Fu, Flu Campaign, Healthy eating campaigns, Mindfulness and health and well-being events. New intranet pages have been developed along with a bi-monthly newsletter under the Happier and Healthier WUTH branding, where colleagues can find out about the range of activities and programmes taking place. The Plan will be monitored by the Trust's Health and Wellbeing Group, with assurance reports to the Workforce and Communications Group.

External

- **A & E 2017/18 Launch Event**

On 8th May the Trust was invited to participate in a teleconference with both regional directors for NHSE & NHSI (Richard Barker & Lyn Simpson). The call was specifically to thank the North for the work undertaken in Q4 to deliver A&E performance and also describe the work for 17/18. During the call it was confirmed that NHSE & NHSI regional directors would work together to avoid reporting duplication and on that basis the lead for

Wirral would be Richard Barker. There was a strong message delivered about performance being at 90% by September 2017 and 95% by March 2018 and that the Secretary of State was clear there would be no relaxation of the 95% standard. Each health economy was asked to review their progress against the 9 point improvement plan to be fed back through the A&E delivery Boards. They described that support from the regulators would be tailored to performance & fragility with higher performing trusts receiving 'light touch' support. Actions from this call are being monitored by the Wirral & West Cheshire A&E delivery Board.

- **Digital Leaders Programme**

I am pleased to announce that the Trust has agreed to sponsor the Digital Leaders Programme along with some other Global Digital Exemplar Sites. The Leaders Programme is aimed at clinical leaders who wish to take leadership in the digital arena. Sponsorship is limited to the use of the Trust's Name and Logo in support of the programme at this stage although the Trust has been invited to shape the programme going forward.

A range of large commercial organisations in this field are being approached to also sponsor this programme which will afford the Trust the opportunity to have its name linked to other successful leaders in the Digital arena.

- **Population Health**

We met as a Wirral health economy on Thursday 4th May to take forward plans to implement and exploit the Wirral Care Record as a tool for improved quality and safety of care and efficiency of care and overall population health management.

We covered the following areas:
- Leadership and programme management
- Clinical Pathway and operational enablers
- Population Health Intelligence
- Communication and engagement
- Expert advice e.g around Information Governance
- Commissioning and Contracting
- Technical

There was good support from the stakeholder organisations and a number of actions were agreed which will be taken forward through the Healthy Wirral Executive Group and the Digital Wirral programme will support and report on the subsequent projects as they are fully defined.

Regulatory

- **NHS Improvement**

The next Progress Review Meeting with NHS Improvement will take place on 1st June 2017. The Primary focus of the meeting will be to review the enforcement undertakings and additional licence condition Section 111 put in place by Monitor in 2015.

- **Care Quality Commission (CQC)**

In line with requirements, the Trust submitted its first CQC monthly monitoring return on the 12th May 2017. These monthly returns are designed to inform the CQC's inspection programme.

Strategy

- **Accountable Care**

PWC have now been commissioned to undertake a range of workshop with Healthy Wirral Partners with a view to accelerating arrangements for an Accountable Care Organisation. The first workshop is planned for 25th May 2017.

- **Sustainability and Transformation Plans STP**

In April 2017 NHSE published a 5 Year Forward View 5YFV refresh that the Cheshire and Merseyside 5YFV team and Cheshire and Wirral Local Delivery System LDS have produced a response. The Executive Team have reviewed the refreshed publication and the implications of an increased drive for accountable care as a vehicle to deliver the 5YFV. This response details the emerging priorities of the Cheshire and Wirral LDS to ensure health and social care is as joined up as possible providing best value and quality.

The Trust has been actively involved through representation in the High Quality Hospital Care workstreams which are developing a long list of options for Urgent Care, Women and Childrens and Cardiovascular services. The Trust is taking an active role in the 5YFV regionally by sharing best practice from our Global Digital Exemplar programme.

Celebrating Success

- **Nurses Day**
-

Dame Lorna Muirhead, The Lord Lieutenant of Merseyside opened the celebrations for International Nurses Day on Friday 12 May praising the nursing staff at Wirral's biggest employer for their tireless work throughout the year.

Margaret Kitching, Chief Nurse for NHS England North, Hazel Richards, Director of Nursing for NHS England North and Lorna Quigley WCCG also attended and presented at the celebratory event.

There was a morning of activities ranging from pampering sessions to yoga, supported by colleagues at Wirral Met and Trust staff aimed at promoting the importance of health and wellbeing of nursing staff at the Trust.

Gaynor Westray thanked the staff who have worked extremely hard during a challenging year for providing compassionate care for all of their patients and ensuring the highest possible standards of care.

David Allison
Chief Executive
May 2017

Board of Directors	
Agenda Item	6.2
Title of Report	Nurse Staffing Report March / April 2017
Date of Meeting	24th May 2017
Author	Clare Pratt, Deputy Director of Nursing Johanna Ashworth-Jones, Senior Analyst Tracey Lewis, Head of Clinical Excellence & Organisational Development
Accountable Executive	Gaynor Westray, Director of Nursing and Midwifery
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	1, 3
Level of Assurance **Positive** **Gap(s)**	**Positive** • Introduction of Specialty reporting of staffing fill rates and CHPPD allows for easier comparison of staffing data • An Associate Director of Nursing Report has been introduced to provide an auditable trail which provides details from Ward Sisters/Charge Nurses and Matrons on mitigating actions taken to address staffing shortfalls
Purpose of the Paper **Discussion** **Approval** **To Note**	For discussion
Reviewed by Executive Committee	
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken **Yes** **No**	No

1 Executive Summary

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

2 Recruitment Strategy

A key priority at Wirral University Teaching Hospital is to ensure appropriate nurse staffing levels are established and maintained. The previous investments in nurse staffing, as well as a robust recruitment plan, has ensured that the Trust has a stable nursing and midwifery workforce.

The total Trust vacancy rate for the registered nursing and midwifery workforce in March 2017 was reported as 5.79% which is a deteriorating position from 3.63% reported in February 2017. There was a further deterioration during April 2017 with a reported vacancy rate of 6.25%. Our vacancy rate remains significantly better than the national average of 10%.

When reviewing the vacancy rate for in-patient and Emergency Department Band 5 posts the Trust's electronic staff records (ESR) data identified a vacancy rate of 7.03% in March 2017 which equates to 46.81 WTE again this is a deterioration position from the previous month. During April the vacancy rate for in-patient and Emergency Department Band 5 posts with the Trust's electronic staff records (ESR) data identified a vacancy rate of 7.89% in April 2017 which equates to 52.56 WTE.

Table 1 - Band 5 Vacancies Inpatient and Emergency Department Registered Nurses

	May 2016	June 2016	July 2016	Aug 2016	Sept 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017
Establishment	690	690	691	692	692	692	682	674	674	675	666	665
Actual Numbers	654	653	656	648	649	650	645	634	634	634	619	613
Vacancies	36	37	35	44	44	42	37	40	40	41	47	52
Vacancies %	5.26	5.34	5.09	6.38	6.34	6.10	5.50	5.94	5.92	6.08	7.03	7.89

Current Band 5 vacancy position by Division

Division	March 2017	April 2017
Surgery, Women and Children's	5.09% - 11.1 WTE Band 5 posts	3.80% - 8.3 WTE Band 5 posts
Medicine and Acute	7.99% - 35.71 WTE Band 5 posts	9.89% - 44.26 WTE Band 5 posts

The Division of Medicine and Acute is currently implementing several incentives to attract and retain registrants. These include additional development posts, enhanced roles for Band 5 nurses and a review of rotational posts within the Division. There has been an increase in experienced Coronary Care Unit staff resigning to take up band 6 posts in Liverpool Heart and Chest Hospital. To help address the shortage of experienced, skilled staff on the Unit, Critical Care experienced bands 5 RNs are rotating 6 monthly to CCU. The Nurse Educators in critical care are currently developing an education programme to ensure that rotational staff get the best experience and development from this programme.
Ward 38 (Respiratory) is looking to introduce a similar rotational development post. This will encourage new staff to the organisation by developing a HDU/Ward rotational post.

The division has developed Band 3 CSW roles to support registered nurses in specialist areas. This role is well aligned for ED and assessment areas.

Medical wards are exploring ways for vacancy substitution of traditional nursing posts with other Healthcare professionals. Pharmacy has commenced a pilot of Band 5 pharmacy technicians supporting medicine safety at ward level including the administration of medicines.

Encouragingly the division has seen an increase in applicants applying for advertised posts, there is a rolling advert for the division especially for hard to recruit areas such as AMU, ward 27, and ward 36.

The Trust is working in collaboration with NHSP to support 19 CSW through the care certificate with placement on wards. These CSW will increase our local workforce; further recruitment onto this development is planned following the first cohort.

The Trust has approved the next phase of International recruitment with Placement Group with the aim of 50 nurses to be in post by October 2017. A project plan had been agreed that facilitates four overseas recruitment events with nurses starting in cohorts from July 2017. The first recruitment event took place 10-12 May in Spain and 10 nurses have accepted offers of employment with the Trust.

The Trust, along with our local healthcare partners, is a test site to deliver a training programme for the new Nursing Associate role. This exciting opportunity is enabling us to influence development of new roles that will build the future nursing workforce. Our 6 trainee nursing associates have commenced in post and the Trust is reviewing ward nursing establishments and vacancies to ensure effective and safe placement following qualification.

3 Temporary Staffing

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

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

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

4 Model Hospital Portal and Care Hours Per Patient Day (CHPPD)

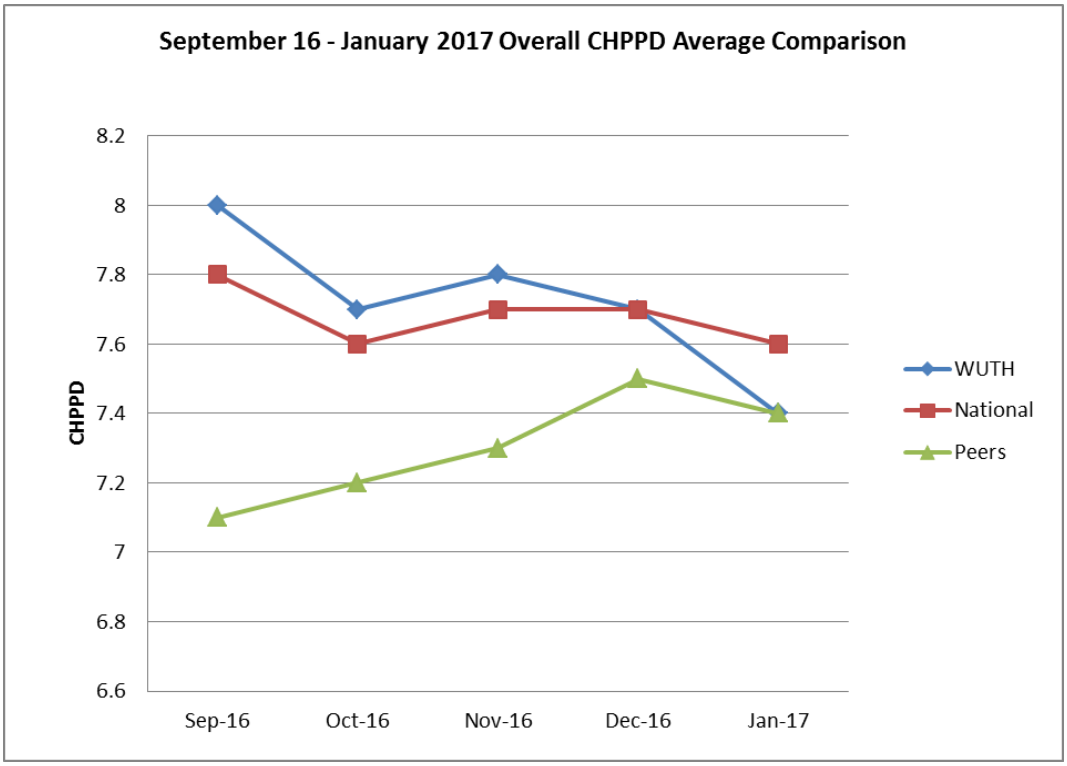
The Department of Health Efficiency Centre has developed a Model Hospital Portal to allow comparison of hospital data across the range of Carter recommendations. The latest data available for CHPPD is January 2017.

January 2017 data	WUTH	Regional Peers	National
Total CHPPD	7.4	7.4	7.6
RN CHPPD	4.3	4.5	4.7
CSW CHPPD	3.1	2.9	2.9

The latest data available for staff retention is December 2016, this demonstrates staff retention for registered nurses is above national and regional average. However turnover in Midwifery is higher at WUTH, which is a reflection of the outcomes of the cultural review and performance management. We anticipate that this position will improve with a regular review at Senior Nursing and Midwifery Team meeting

Staff Retention Data			
December 2016 data	WUTH	Regional Peers	National
Registered Nurses	90.5	88.4	87.3
Midwifery	82.5	92	88.3
Clinical Support workers	89.2	89.4	84.5

The line graph below displays the average CHPPD from September 2016 to January 2017 for WUTH compared with the National Average and regional peers. With the exception of January 2017 data, WUTH has had a slightly higher average CHPPD compared with that of the National average. It should be noted that the National average will consist of a variety of different types of hospital trusts which will range significantly in their local CHPPD.



Local monitoring of CHPPD continues. The last six months of overall staffing fill rates and CHPPD are displayed in the tables below. Fill rates that have been rated as red and denoted with a # symbol indicate that although staffing rates below funded establishment levels , the board have received previous reports to demonstrate that appropriate mitigation had been put in place .Mitigation for April 2017 is noted below

Orthopaedics	CHPPD information	Indicators	November	December	January	February	March	April
Ward 10 **7.6**	Average: **6.4** Range 6-8.8	CHPPD	6.6	6.6	6.5	6	5.9	6.6
		Fill Rate	93%	92%	92%	91%	90%	93%
Ward 11 **9.6**	Average: **8.4** Range 7.6 - 10	CHPPD	8.9	6.8	7.6	7.9	9.4	9.7
		Fill Rate	103%	93%	106%	103%	99%	119%
Ward 12 **12.8**	Average: **8.6** Range 8 - 12.5	CHPPD	9.5	8.8	8.8	8	8	8.7
		Fill Rate	84%	# 73%	87%	80%	89%	81%
M1 **13.4**	Average: **11.5** Range 9 - 14.2	CHPPD	11.3	12.4	9	14.2	11	11.2
		Fill Rate	# 78%	# 70%	82%	# 79%	82%	71%

Ward M1 is an elective orthopaedic ward which flexes the capacity against demand. The division reviews this on a daily basis and provides assurance that there is sufficient staffing for patient acuity

Surgical	CHPPD information	Indicators	November	December	January	February	March	April
Ward 17 **6**	Average: **6.1** Range 5.7 - 6.6	CHPPD	6.6	6.1	5.8	6.1	5.9	5.9
		Fill Rate	114%	108%	107%	110%	107%	106%
Ward 18 **5.9**	Average: **5.9** Range 5.7 -6.2	CHPPD	5.8	6	5.7	6.2	5.9	5.8
		Fill Rate	100%	95%	93%	95%	95%	94%
Ward 20 **6**	Average: 5.8 Range 5.6 - 6.7	CHPPD	5.8	6	5.6	5.8	5.7	5.6
		Fill Rate	98%	100%	97%	105%	98%	99%
ESAU **14.5**	Average:**13.4** Range 13 - 17.3	CHPPD	14.6	14.9	13.3	12.6	12.6	12.5
		Fill Rate	99%	95%	100%	97%	97%	99%
M2 **42.9**	Average: 26.1 Range 12 - 35.4	CHPPD	57.5	27	23	12	16.1	21.2
		Fill Rate	89%	96%	100%	100%	95%	94%
Dermatology **10.7**	Average: **11.5** Range 8.5 - 16	CHPPD	8.5	13.2	8.5	8.6	8.7	11.1
		Fill Rate	100%	100%	100%	100%	100%	100%

Women's & Children's	CHPPD information	Indicators	November	December	January	February	March	April
Children's **10.1**	Average: **10.8** Range 8.1 - 14.9	CHPPD	9.3	12.2	9.9	12.2	10	11.4
		Fill Rate	104%	98%	95%	97%	103%	107%
Maternity **7**	Average: 7.9 Range 5.7 - 10.9	CHPPD	7.6	7.6	6.6	7.6	10.9	6.8
		Fill Rate	95%	102%	98%	100%	98%	93%
Delivery Suite **36.6**	Average: **38.5** Range 30.8- 5.5	CHPPD	39	39	37.9	41.3	37.7	36.6
		Fill Rate	108%	121%	108%	106%	102%	101%
Ward 54 **7.8**	Average: 6.7 Range 6.4 - 9.1	CHPPD	7.2	7.9	6.3	6.6	4.7	7.5
		Fill Rate	#78%	84%	#75%	#71%	97%	92%
Neonatal **12.5**	Average: **12.6** Range 10.9-14.4	CHPPD	12.1	10.9	12.3	13.4	14.4	12.5
		Fill Rate	99%	93%	103%	90%	96%	99%

DME / Rehab	CHPPD information	Indicators	November	December	January	February	March	April
Ward 21 **6.3**	Average: **5.6** Range 5.1 - 6.4	CHPPD	6.5	5.8	6.3	6.3	6.1	6.4
		Fill Rate	105%	95%	109%	107%	105%	104%
Ward 22 **5.7**	Average: 5.9 Range 5.4 - 6.6	CHPPD	5.5	5.4	5.4	5.5	5.6	5.6
		Fill Rate	99%	96%	96%	97%	99%	98%
Ward 23 **7.3**	Average: **7** Range 6.7 - 7.8	CHPPD	7.8	6.9	6.7	7	6.8	7.2
		Fill Rate	97%	98%	97%	98%	99%	105%
Ward 27 **7.5**	Average: **6.7** Range 5.8 - 9.4	CHPPD	6.3	5.6	5.7	5.7	5.8	5.9
		Fill Rate	99%	97%	89%	91%	91%	96%
M2 Rehab **5.5**	Average: **5.6** Range 5.2 - 6	CHPPD	5.5	5.7	5.2	5.3	5.7	4.9
		Fill Rate	98%	97%	97%	96%	97%	92%
CRC **6**	Average: **6.4** Range 5.6 - 6.8	CHPPD	6.3	6.8	6.2	6.5	6.6	6.1
		Fill Rate	106%	107%	107%	114%	113%	98%

Medicine	CHPPD information	Indicators	November	December	January	February	March	April
Ward 26 **6.6**	Average: **6.1** Range 5.6 - 6.7	CHPPD	6	5.7	5.9	6.4	6.6	6.2
		Fill Rate	94%	94%	94%	102%	108%	96%
Ward 30 **8.1**	Average: **7** Range 6.2 - 7.5	CHPPD	7	7.4	6.2	6.3	6.6	6.3
		Fill Rate	90%	88%	87%	91%	97%	92%
Ward 32 **6.7**	Average: 5.9 Range 5.6 - 10.5	CHPPD	5.8	6	5.6	5.8	5.9	6
		Fill Rate	94%	91%	91%	94%	97%	95%
CCU **14.9**	Average: **12.5** Range 12.1 - 16.3	CHPPD	12.1	13.2	12.8	12.3	12.6	12.1
		Fill Rate	93%	87%	86%	89%	95%	91%
Ward 33	Average: 6.**2** Range 5.8 - 6.9	CHPPD	5.9	5.9	6	6.2	6.2	6.9
		Fill Rate	92%	90%	92%	95%	92%	97%
Ward 36 **6**	Average: **5.5** Range 5.2 - 6	CHPPD	5.6	5.5	5.2	5.3	5.7	5.5
		Fill Rate	94%	91%	90%	92%	95%	91%
Ward 37 **7.5**	Average: 6.4 Range 5.8 - 7.9	CHPPD	6.9	6.8	6.7	5.8	6.1	6.1
		Fill Rate	96%	91%	94%	100%	100%	101%
Ward 38 **5.7**	Average: **5.5** Range 3.2 - 5.9	CHPPD	5.6	5.7	5.7	5.3	5.4	5.5
		Fill Rate	98%	91%	99%	97%	103%	101%
Ward 25 **9.4**	Average: 9 Range7.5 - 11.4	CHPPD	11.4	9	7.5	7.1	10.4	9.1
		Fill Rate	119%	124%	122%	115%	110%	107%
Ward 24 (IPC)	Average : 6.5 Range 5.6 -7.2	CHPPD		7.2	6.8	7	5.6	5.8
		Fill Rate		100%	92%	98%	101%	93%

Acute Care	CHPPD information	Indicators	November	December	January	February	March	April
MSSW **8.2**	Average: 6.6 Range 5.9 - 8.8	CHPPD	7.2	6	6.3	7	6.9	6.4
		Fill Rate	89%	79%	84%	91%	90%	85%
AMU **10.6**	Average: 11.4 Range 9.5-14.9	CHPPD	9.5	13.8	14.2	10.3	10.5	9.9
		Fill Rate	91%	92%	97%	102%	105%	100%
EDRU **9.6**	Average: **9.4** Range 7.7-10.7	CHPPD	10.6	10.5	7.7	9.6	9.2	8.9
		Fill Rate	103%	99%	101%	99%	100%	105%
ITU **35.8**	Average: 29.4 Range 26.8-41.6	CHPPD	29.2	26.8	29.6	33.9	28.3	28.5
		Fill Rate	90%	94%	89%	#72%	#73%	64%
HDU **27.6**	Average: **24.5** Range 21.1 - 36.3	CHPPD	30.9	25.2	23.7	21.6	24.3	21.1
		Fill Rate	98%	96%	96%	95%	95%	91%

ITU is a specialist care area where patient acuity and bed occupancy can change. This area has also been highlighted as having increased numbers of staffing incidents forms during March and April but with low incident risk scores. Whilst overall fill rates have been RAG rated as Red, ADN assurance indicates safe staffing was in place at all times. Formal additional monitoring measures of staffing levels have been implemented and are detailed within the staffing incident section of this report.

An Associate Director of Nursing (ADN) nurse staffing assurance report is in place to provide an auditable trail. The report provides details from Ward Sisters/Charge Nurses and Matrons on rational for variance from planned staffing, mitigating actions that have been taken and an overall sign off from the ADN to provide assurance that safe staffing was in place. This assurance report also helps monitor trends for both over 100% and under 100% fill rates to help inform divisions regarding staffing establishments. Following on from the introduction of

this report there is also an increased level of confidence in the data reported as all variances are reviewed at a greater level.

As confidence has grown in the CHPPD data Senior Nursing teams can now use this to help further inform correct establishment levels. The next stage in using CHPPD to support this is too review the difference in Registered Nurse to CSW ratios and compare a breakdown of CHPPD for Registered Nurses and CSWs across the clinical specialties.

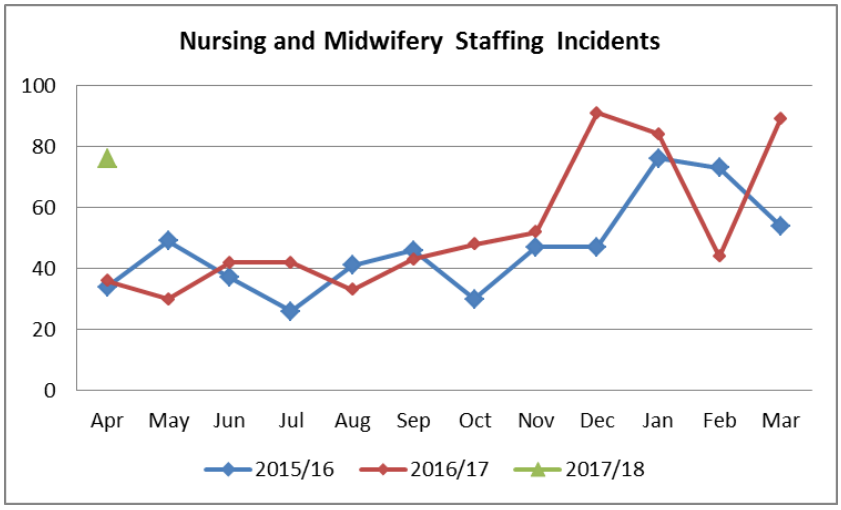
The Divisional Triumvirate has requested that a divisional average for CHPPD is included in future reports and this is displayed below.

Division	March 2017			April 2017		
	RN	CSW	Total	RN	CSW	Total
Medical Specialties	3.9	3.3	7.2	3.8	3.3	7
Surgical , Women's and Children's Division	6.3	3.	9.4	6.4	3.1	9.5

It is noted that there is a variation in the RN ratio, with medical specialties being lower than surgery, women and childrens, this information has been triangulated with data relating to vacancies , attendance and incidents and further work is planned including ensuring medical specialties is a priority within all recruitment , retention and reward initiatives.

5 Reported Staffing Incidents

The number of recorded Incidents during March and April 2017 were significantly higher than compared to previous years as displayed in the chart below. WUTH is proud to have a positive culture of incident reporting and whilst there has been an increase in the number of incidents the incident risk scores remain low. In 2016/17 there were a total of 634 Nursing and Midwifery related incidents compared with a total of 560 for 2015/16.



A monthly summary report highlighting themes and trends is reported to the Senior Nursing and Midwifery Team. During March and April 2017 Critical Care have featured as a frequently reported area. There has been a series of engagement and staff supportive work streams within critical care over the past few months; and the increase in incidents is reflective of the improvement work to encourage a positive reporting culture. There have been no notable patients harms and incident risk scores are low. The increase in incidents within this area has been placed on the divisional risk register to ensure formal senior monitoring and the Trust 'Freedom to Speak' Guardians visit the area frequently to support staff and encourage discussions with staff. It has been identified that there is currently outstanding vacancies, sickness and a diluted skill mix due to a high turnover of band 5 nurses with each new nurse requiring a period of supernumerary practice and the time taken

to become confident in critical care practice. To support this, the following additional provisions have been put in place:

- Daily staffing review by Band 7 sister to ensure adequate staffing
- Medical Division staffing plan overseen daily by Matron
- Introduction of enhanced payment with NHSP to encourage staff to move across from agency to NHSP
- Critical care full capacity SOP
- Reinforce the robust implementation of Trust attendance policy
- Cheshire and Mersey Critical care network agreement for transfer of critically ill patients if staffing is not at the required level

6 Conclusion

- Benchmarking WUTH performance for Care Hours per Patient Day (CHPPD) with other acute hospitals using model hospital portal allows us to provide further assurance that safe staffing levels are in place and this can be used to address staff perception that staffing levels are low. This comparison work will be taken forward once real time reporting is available on the Model Hospital Portal
- The Trust continues to ensure all mitigating actions are in place to ensure that there are safe and appropriate nurse staffing levels at WUTH
- The Trust will continue with monthly Trust wide recruitment for registered nurses in tandem with the new initiatives outlined in this report
- A full acuity review is currently under way and will be reported at the end of Q1 2017

7 Recommendations

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

Board of Directors	
Agenda Item	6.3
Title of Report	Report of the Quality & Safety Committee – 10 May 2017
Date of Meeting	24 May 2017
Author	Jean Quinn, Acting Chair of the Quality and Safety Committee
Accountable Executive	Gaynor Westray, Director of Nursing and Midwifery Dr Susan Gilby, Medical Director
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	 1, 2, 4, 5, 7 1a, 1b, 2a, 2b, 2c, 4a, 5a, 5b, 5c, 7a, 7b, 7c, 7d 1, 2, 3, 16, 17, 19
Level of Assurance • **Positive** • **Gap(s)**	Gaps with mitigating action
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion
Data Quality Rating	N/A
Review by Assurance Committee	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

This report provides a summary of the work of the Quality and Safety Committee which met on the 10 May 2017. Key focus areas are those which address the gaps in assurance/control in the Board Assurance Framework.

Patient Story

The Committee welcomed the family member of a patient who was admitted to The Trust and who suffered from dementia. The Committee was provided with an outline of the experiences of the patient and their family during their time at the Trust and the family member highlighted the importance of considering the needs of family and carers so that patients might receive more well-rounded, high quality patient care.

The family member agreed to attend an upcoming Senior Nurses Meeting to relay her experiences in order to promote greater awareness amongst clinical staff of the importance of including family members and carers in patient care and the Committee requested that consideration be given to improving methods of communication between staff and patient families and carers.

Board Assurance Framework

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

- Revision of the Risk 1 (Quality and Safety) risk descriptor to expand its scope to focus on quality and safety improvement rather than just CQC ratings. The Scoring had been increased to reflect the current work being undertaken to improve the safety culture
- Revision of the Risk 4 (Improving Clinical Outcomes) risk descriptor to increase its scope to the improvement of clinical outcomes, rather than the specific focus of 7 day working. The scoring had been increased to reflect the work the further work required to embed the Trust safety culture.

The Committee received an update in respect of cancer performance and noted that the Trust would fail to achieve the breast symptomatic diagnostic two week wait target for Q1. It was confirmed that the affected patients had been informed and that the Trust inability to achieve the constitutional target had not resulted in any treatment delays. The Committee requested that an update regarding Q2 performance be presented at a future meeting.

The Committee noted the Trust Risk Appetite Matrix as approved by the board in April 2017.

Annual Review of Committee Effectiveness

The Committee noted that the Annual Review of Committee Effectiveness (Appendix 1) was reflective of a period of transition for the Committee following implementation of the recommendations of the Well-Led Governance Review, which suggested the devolvement of its operational workload to its supporting Executive Working Groups. The Committee stated the importance of developing the role of its Executive Working Groups over the coming year to enable the Committee to focus on fulfilling its role as an Assurance Committee.

The Committee looked forward to receiving the outcomes of the Quality Governance Review, which reached its conclusion in April 2017, to further inform the reporting structures and processes of the quality and safety arm of the Trust's governance meeting structure.

Workforce & OD Dashboard Annual Report

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

- A sickness rate of 3.95% for March 2017, which was better than the Trust target of 4%
- A spike in nursing (5.79%) and medical (6.51%) workforce vacancy rates for which an action plan had been drafted and would be actioned
- The appraisal compliance rate for March 2017 was reported as 84.74%, which remained below the Trust target of 88%
- Mandatory training compliance was reported at 91.83% (Block A) and 87.45% (Block B) for March 2017 which was below the Trust targets of 95%.

The Committee received an in-depth report regarding the existing Trust CRB/DBS processes and noted its support of the existing procedures. The Committee requested that those staff who had not been subject to a DBS disclosure check during the reporting period be reviewed to ensure that the staff were not located in 'high risk' areas and therefore mandated to undergo a disclosure check.

The Committee also received an in-depth report pertaining to the Trust grievance process and noted the high sickness and grievance rate within particular services. The Committee agreed that a deep dive to identify the cause for the elevated sickness and grievance levels would be undertaken by the Workforce and Communications Group and the outcome presented at a future

meeting. The Committee was provided with further information on the relationship between the grievance and Raising Concerns processes and it was confirmed that monthly meetings of the Freedom to Speak Up Guardians facilitated raising concerns trend analysis. The Committee requested that future dashboard reports include a breakdown of the number of concerns raised by area.

Staff Engagement Update & NHS Staff Survey

The Committee supported the presented Staff Satisfaction and Engagement Action Plan (circulated separately to the Board of Directors via email) which had been developed in collaboration with Staffside, senior management and the wider workforce. The Committee noted the key areas for improvement as promotion of education and training, high quality appraisals and improved communication pathways between senior and front line staff.

The Committee recognised the challenging nature of the plan which had been developed with a view to enabling the Trust to rank within the top 20% of acute Trusts in the Staff Survey 2017. The plan was to be supported by a communications strategy which had been approved by the Staff Engagement Group.

The Committee noted that the Staff Friends and Family Test quarterly questionnaire had been amended to incorporate questions which would enable the Trust to track the impact of the Staff Satisfaction and Engagement Action Plan throughout the year. Any issues identified in year through the questionnaire would be presented to the Committee for consideration.

Quality Dashboard

The Committee welcomed the first iteration of the revised Integrated Quality Dashboard which would be further developed to include a full suite of metrics for use in various fora in order to negate the requirement for report duplication. The dashboard was also to be developed to include a narrative at the start of each section to enable the Senior Management Team to highlight any key areas for discussion and recommend courses of action to address issues identified.

The Committee reviewed each section of the Quality Dashboard which generated much discussion, particularly in respect of medicines safety, infection control, complaints, Alcohol Related Liver Disease (ARLD) and cancelled appointments. Consequently, the Committee requested that a deep dive into the partial booking project be provided at the July 2017 meeting.

Quality Account Draft Annual Report 2016/17

The Committee reviewed the Quality Account Draft Annual Report for 2016/17 which included an outline of performance against the six priority targets which were:

- Implementation of the SAFER bundle to improve patient flow and ensure safe discharges
- Ensuring patients are supported with eating and drinking when needed
- Reduce harm in relation to newly formed pressure ulcers
- Reduce the number of missed medication events
- Improve End of Life Care
- Reduce emergency readmissions within 30 days.

It was confirmed that the Quality Account Draft Annual report had been reviewed by the appropriate fora and as such; the Committee recommended that the Board of Directors approve the Quality Account Annual Report 2016/17.

The Committee noted that the scope of the priority targets for 2017/18 had been refined and would no longer include the emergency readmissions topic. Work was underway to develop the specific targets for each of the five remaining priority topics.

The Committee agreed that future Quality Account quarterly progress reports would be shared with colleagues at Healthwatch in-year.

Health and Safety Annual Report 2016-17

The Committee received the Health and Safety Annual Report 2016-17 (circulated separately to the Board of Directors via email) which drew out compliance with key legislation as previously requested by the Committee. It was confirmed that the Trust reported full compliance with all but two elements statutory elements of the Statutory and Mandatory Inspections for 2016/17 and action plans were in place to address the issues identified.

The Committee highlighted the following key issues as priorities during 2017/18:

- The action of recommendations made following the asbestos review conducted during 2016/17
- Embedding water safety best practice across the organisation.

Patient Safety Alerts

The Committee was pleased to note that 85 of 89 Patient Safety Alerts had been fully actioned since 2008 and it was confirmed that action plans were in place to address the 4 outstanding Patient Safety Alerts.

The Committee noted that Patient Safety Alerts were linked to the Trust Risk Register by the Risk Team and that following closure of all actions associated with an alert, shared learning was cascaded to the relevant staff.

CQC Compliance and Assurance Report

The Committee noted the delays experienced in conducting Care Quality Inspections (CQIs) during the reporting period due to the increased activity across the Trust. It was confirmed that the CQI programme was now back in line with the original schedule and work continued to re-inspect those areas initially assigned a rating of 'Requires Improvement'.

The Committee noted the importance demonstrating improved compliance with those measures listed under the 'Safe' domain. It was confirmed that the Trust would run two safety awareness weeks per annum and would imminently introduce regular Safety Summits to support the developed of improved compliance in this area. The outcomes of the CQI inspections would also be triangulated with the findings of the Ward Accreditation Programme to promote the Trust safety culture.

Director of Nursing and Midwifery Performance Report

The Committee received the Nursing and Midwifery Performance Report which highlighted the following key points:

- A response rate of 100% in Maternity for March 2017 with a response rate of 30%. Work was underway to identify examples of best practice to disseminate across the Trust
- An improved Emergency Department Friends and Family Test recommend rate of 88% for March 2017. Work was underway to increase the response rate of 12%
- A pilot of visibility boards, assisted technology and bay tagging had commenced with a view to reducing the number of falls across the Trust
- Report of 3 avoidable cases of C.diff to date against a threshold of 29 for 2017/18. The HPV Programme was scheduled to recommence in mid-May 2017
- The electronic clinical handover was introduced in April 2017 and would provide a record of handover discussions after the event.

The Committee noted that the End of Life Care Team had been relocated to a central location to provide ready access to patients. The Record of Care had now been confirmed as regular working practice however work continued to promote its use.

Medicines Optimisation Dashboard

The Committee welcomed the Medicine Optimisation Dashboard and was pleased to note the strong performance in respect of dispensing reliability, discharge prescription turnaround times and antimicrobial formulary compliance. It was confirmed that the performance metrics had been

adopted from such national guidance as the Carter Review or locally set stretch targets and future reports would also include a comparison of performance against an aspirational trajectory.

The Committee requested that future reports include a summation only, of the Root Cause Analysis and Local Reviews completed as a consequence of medicines incidents.

Assurance Reporting

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

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

Issues for escalation to the Board of Directors

There were no issues identified for escalation to the Board.

Cathy Maddaford
Chair of Quality and Safety Committee

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Quality and Safety Committee Annual Review of Effectiveness

May 2017

1. Purpose of the Report

This annual review of effectiveness has been prepared for the attention of the Board of Directors and reviews the work and performance of the Quality and Safety Committee during 2016/17 in satisfying its terms of reference.

2. Remit of the Committee

The Committee is a Non-Executive led Committee which is established as an Assurance Committee of the Board of Directors. Its purpose is to provide the Board with assurances in respect of delivery of the Trust's Quality Improvement Strategy and service delivery in respect of clinical effectiveness, safety and patient and staff experience. It is also responsible for assessing the impact of performance and compliance with both national and local requirements.

3. Membership of the Committee

The membership of the Committee is as follows:

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

The following officers also regularly attend the Committee

- Director of Corporate Affairs
- Divisional Representation

Other officers of the Trust are invited to attend as requested by the Committee.

Changes in the role of Chair took place during 2016/17 as part of the annual review of Non-Executive portfolios. During this review it was decided that the previously serving Committee Chair would remain as a member of the Committee in place of a member of Audit Committee until such a time as a further review of Non-Executive portfolios takes place.

4. Compliance with Terms of Reference

The terms of reference of the Committee are reviewed annually and the last review date was January 2017.

The Quality and Safety Committee met 6 times during 2016/17 as follows:

- 18th May 2016
- 13th July 2016
- 14th September 2016
- 9th November 2016
- 11th January 2017
- 8th March 2017

All meetings have been quorate.

The Chair of the Committee submits a report to the next available Board of Directors meeting. The minutes of the meeting are circulated to all members of the Board of Directors.

5. Review of Effectiveness

The Committee agreed that it would undertake key pieces of work under the following headers for 2016/17:

- Risk
- Clinical Effectiveness and Safety
- Patient Experience
- Workforce
- Staff Satisfaction and Engagement
- Governance

The work plan for the Committee was established and approved in May 2016 to support this.

5.1 Risk

The Board of Directors undertook a full review of the Board Assurance Framework (BAF) in September 2016 which resulted in the Quality and Safety Committee being assigned 10 of the 20 strategic risks outlined in the BAF. The Committee agenda is framed around the key areas of delegation in the BAF to enable members to focus on key issues and gaps in assurance.

The Committee was not required to receive or monitor any risks above 15 relating to quality and safety throughout 2016/17, other than those contained within the BAF.
The Committee has reviewed the BAF at each of its meetings during 2016/17 and throughout the reporting period has recommended to the Board risks for removal and inclusion in the BAF in addition to specific items for inclusion as recorded at each of its meetings. The Committee recommended the following in respect of the content of the BAF throughout the reporting period:

- The CQC risk descriptor was reviewed to broaden the scope of the risk so that it provided assurance on quality and safety. Performance against CQC requirements would continue to be monitored within the BAF and the Trust CQC rating considered one indicator of the organisations overall quality and safety performance
- The 7 Day Working risk descriptor be revised to focus on clinical outcomes to make the risk multifactorial, of which 7 day working would be one factor. The

revised risk descriptor, and a suite of appropriate key performance indicators, will be presented to the Committee in early 2017/18

- The C. difficile risk score was reduced to reflect the substantial work undertaken to maintain the improved infection prevention and control processes which had resulted in a significant decrease in the number of avoidable cases attributed to the Trust throughout the reporting period.

The Committee reviewed the circumstances which led to the Never Events reported during 2016/17 and actively interrogated the processes employed by the Trust to ensure appropriate dissemination of the key learning points identified as a result of such incidents. The Committee will receive the outcomes of the Royal College of Ophthalmologists review, to be carried out in early 2017/18, which has been commissioned by the Trust following the Never Events that occurred within the speciality during the reporting period.

5.2 Clinical Effectiveness and Safety

The Committee agreed the Trust Quality Improvement Strategy (QIS) for 2016-19 in May 2016. To maintain focus on the QIS, members restructured the Committee agenda in September 2016 to ensure discussions were framed around the objectives outlined within the strategy. The Committee has also begun to revise the indicators within the Clinical Quality Dashboard to ensure the quantitative data provided to the Committee enables timely identification of key trends and developments in respect of the QIS objectives.

In response to the recommendations of the externally led Well Led Governance Review, conducted in 2016/17, the Committee agreed a revised remit and approach to the dissemination of work amongst its sub-groups. This was reflected within the revised Terms of Reference in September 2016 and included the introduction of sub-group chairs reports in order to draw out the key topics of discussion, actions to be taken and items for escalation following each sub-group meeting to enable the Committee to both receive assurance and focus its discussion on key issues.

The Committee has received an update at each of its meetings in respect of Trust progress against both the regulatory and internal action plans which were drafted following the CQC inspection of September 2015 when the Trust was rated as 'Requires Improvement'. Progress updates have included the outcomes of the internal Care Quality Inspections and Divisional Deep Dives which provided assurance in regarding the Trust capability to fulfil the CQC Fundamental Standards of Care. The Committee was pleased to note the progress made to resolve the issues identified during the last inspection but noted that further work is required to realise sustainable improvements within the 'Safety' domain.

The Committee received the outcomes reports of external reviews conducted during 2016/17 which included the:

- **Maternity Cultural Review** – Following review of the outcome report produced by Robertson Cooper in Spring 2016, the Committee requested that the Trust undertake a programme of communication to raise staff awareness regarding their social media responsibilities.

- **Health Education England North West Visit** – Disappointment was voiced by the Committee regarding the limited clinical participation during the visit. The Trust action plan, developed in response to the recommendations made following the visit, was to be monitored by the Workforce and Communications Group (WGC) with regular progress updates to be provided the Committee via the WCG Chairs Reports.

The Committee received the Clinical Audit Annual Report for 2015/16 with regular updates on 2016/17 clinical audit performance provided to the Audit Committee. In line with its Terms of Reference, throughout 2017/18 the Committee will take on a more active role in the monitoring of the Clinical Audit governance processes and progress against the Clinical Audit Plan.

During 2016/17 the Committee was provided with updates in respect of the potential impact of the Trust Cost Improvement Programme which further facilitated Committee evaluation of the risks to quality of care.

5.3 Patient Experience

At each meeting the Committee is provided with a patient story which outlines the positive and less positive experiences of the Trusts patients and carers. Through this medium, the Committee was alerted to issues regarding the limited opportunity for patients to provide qualitative feedback on their experiences and it was requested that the Friends and Family Test Questionnaire be reviewed to facilitate such communication.

The Committee received regular updates in respect of the Trust's Friends and Family Test performance via the minutes and Chair's reports of the Clinical Governance Group throughout the reporting period.

The Committee received the Adult Palliative and End of Life Care Strategy for 2016-19 which had been developed in collaboration with partners in the community. The Strategy was designed to enable the Trust to deliver the required improvements at an acceptable pace and had been revised to incorporate the feedback following the CQC inspection in September 2015 and support improved leadership and team working across the local health economy. The Committee received progress updates on the End of Life Care throughout 2016/17 via a variety of reports including the CQC Progress Report and Quality Account Updates.

The Committee was not required to receive any national patient's surveys during 2016/17.

5.4 Workforce, Staff Satisfaction and Engagement

The Committee received an in-depth update on the progress against the Workforce and OD Strategy 2015-18 in November 2016 and after review agreed that the priority areas remained in line with the key objectives of the Trust. As a result of the ambitious timescales assigned to some of the programmes of work, the Committee requested and receive more frequent reporting of progress against the strategy at its subsequent meetings.

Whilst reviewing safe staffing in early 2017, the Committee was alerted to staffing challenges experienced within the Medical and Acute Division as a consequence of a number nursing vacancies within the Division. The Committee requested construction of a plan outlining the mitigating actions to be employed to support recruitment and reviewed the plan in spring 2017.

The Committee received an in-depth review of the outcomes of the NHS Staff Survey for 2016 which saw the Trust maintain the positive performance reported in 2015. The Committee agreed that the areas highlighted for improvement would be supported with an action plan which would be presented to the Committee in May 2017.

5.5 Governance

The Committee has received reports from all its supporting Executive Working Groups throughout 2016/17 and has reviewed and approved the following terms of reference for its supporting Executive Working Groups in 2016/17:

- Clinical Governance Group – May 2016

Following receipt of the outcomes of the Quality Governance Review which commenced in February 2017, a review of the remit of the sub-groups of the Quality and Safety Committee will be undertaken and the updated Terms of Reference presented to the Committee for approval.

The Committee received the following annual reports during 2016/17:

- Clinical Audit
- Safeguarding
- Accountable Officer Controlled Drugs
- Incidents, Legal Services, Claims and Complaints
- Emergency Planning and Business Continuity
- Health and Safety
- Quality Account
- Staff Guardian

The Committee received quarterly updates on Health and Safety and focused on areas of concern associated with estates and staff incidents.

The Committee reviewed the Trust response to the Lampard Review in which the Trust confirmed compliance with 8 of the 9 recommendations assigned to NHS Trusts. The Committee debated the recommendation regarding three yearly DBS checks for staff and volunteers and noted its support to maintain the local approach to DBS checks, which fulfilled any legal requirements.

The Committee undertook a range of “deep dives” on behalf of the Board with a view to providing assurance in complex areas. The following areas were reviewed in 2016/17:

- **Staff Guardian Annual Report –** The Committee noted the positive work of the Staff Guardian initiative which had resulted in significant national interest.

- **Cancer Performance by Action Speciality** – The Committee noted the mitigating actions put in place across those tumour groups experiencing challenges which posed risks to operational performance. This included an outline of the tracking methodology which provided assurance on the processes employed to ensure patients receive consistent monitoring.
- **Peer Review of the Cancer of Unknown Primary Service** – The Committee noted Trust compliance with the Quality Surveillance Programme measures for the service with the exception of the Malignancy of unknown Origin/CUP Patient Investigation and Management Policy Measure. This was raised at network and national level as it was expected that the measure would be amended to reflect a more suitable core membership of the CUP MDT, resulting in full compliance.
- **One to One Maternity Clinical Review** – The Committee noted that the Trust had begun to collaborate with One to One Midwives to develop improved clinical pathways for its services users. It was requested that consideration be given to the development of performance indicators and triggers which would monitor the effectiveness of the revised clinical pathways.
- **Procedures of Low Clinical Value (PLCV)** – The Committee received a quality impact assessment outlining the changes to PLCV and stated the importance of monitoring the quality of care for patients affected by the commissioning changes which would restrict suitability of patients for PLCV to a strict criterion.

In line with its Terms of Reference, the Committee is also undertook an annual review of Trust compliance against the NHS Constitution and received and recommended the Annual Quality Account to the Board of Directors for approval.

6 Priorities for 2017/18

The Committee will focus on the following priorities for 2017/18:

- Monitoring the progress against the recommendations received following the outcomes of the review by the Royal College of Ophthalmologists
- Monitor progress of implementation of the recommendations of the Quality Governance Review, including revision of the remit of the Committee's sub-groups
- Further embed the recommendations of the Well-Led Governance Review pertaining to the scope and remit of the Committee
- Revise the Clinical Quality Dashboard to provide assurance of the positive progress of the Quality Improvement Strategy
- Monitoring compliance against the CQC Fundamental Standards of Care
- Monitoring of Clinical Audit governance processes and progress against the Trust Clinical Audit Plan.

Cathy Maddaford
Chair of Quality and Safety Committee

May 2017

Board of Directors	
Agenda Item	**7.1.1**
Title of Report	**Integrated Performance Dashboard**
Date of Meeting	**24th May 2017**
Author	**Anthony Middleton, Director of Operations** **John Halliday, Assistant Director of Information**
Accountable Executive	**Janelle Holmes** **Chief Operating Officer**
FOI status	**Document may be disclosed in full**
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	**All Strategic Objectives (1 through 7)** **All Key Measures (1A through 7D)** **All Principal Risks**
Level of Assurance • **Positive** • **Gap(s)**	**Partial with gaps**
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	**Discussion**
Data Quality Rating	**Silver – quantitative data that has not been externally validated**
FOI status	**Document may be disclosed in full**
Equality Impact Assessment Undertaken • **Yes** • **No**	**No**

1. Executive Summary

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

2. Summary of Performance Issues

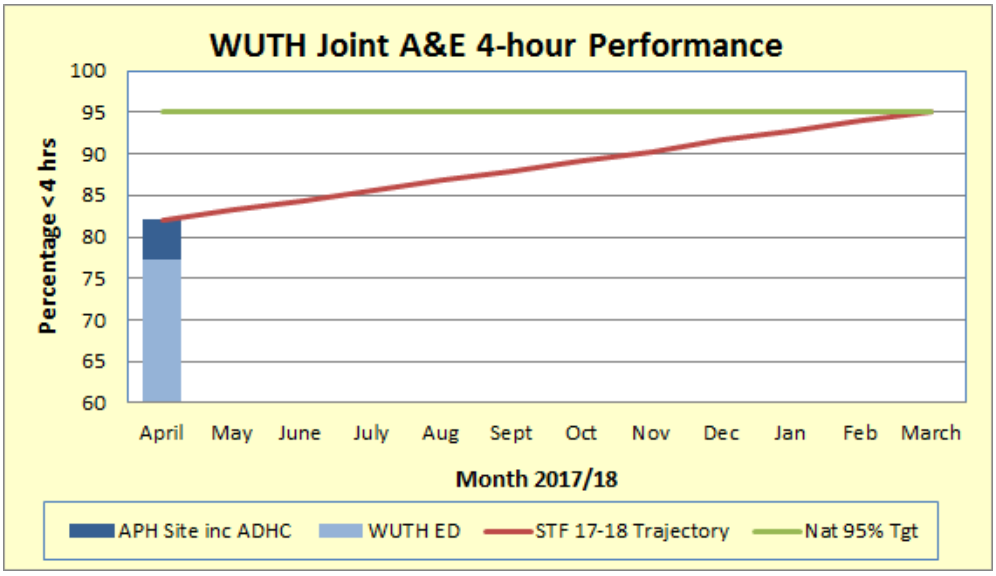
The key issues relating to external validation is achievement of the A&E and RTT targets, with detailed comments against each area below.

3. Detailed Explanation of Performance and Actions

a. A&E 4 Hour Target

Against the A&E standard of a minimum 95% of patients to be admitted, transferred or discharged within four hours, the month of April was 82.21% as measured across a combined ED and All Day Health Centre performance at the Arrowe Park site. ED alone was 77.36%.

The performance in April for the emergency access standard did not achieve the regulatory compliance level of 95%, however the Sustainability and Transformation Fund (STF) trajectory of 82.0% was achieved, as illustrated below.

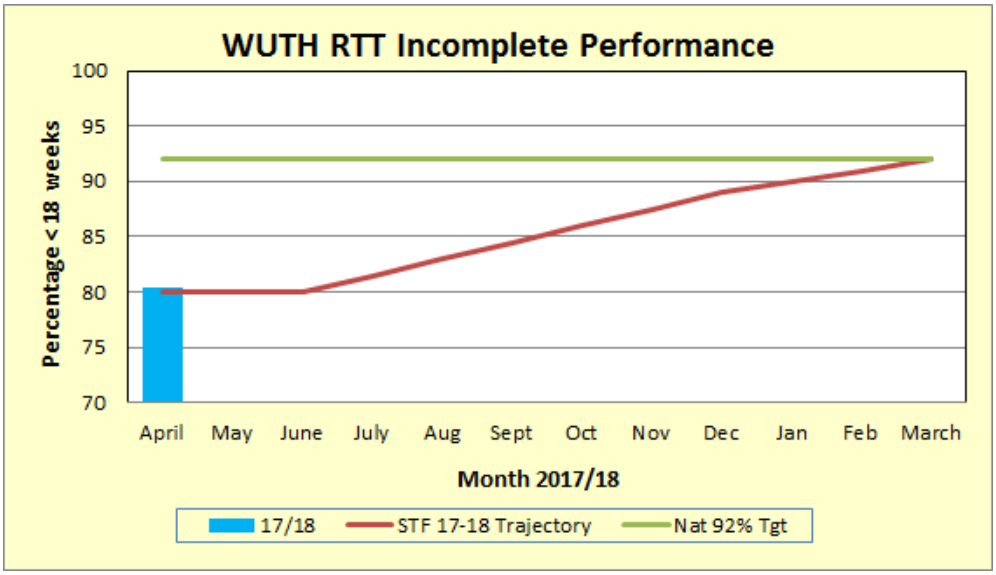


b. 18 Weeks Referral To Treatment (RTT)

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

However, the STF trajectory at the end of April was met by a slight margin, with the final position being reported at 80.34% against a trajectory of 82%. The Trust reported five 52 week breaches and a full Root Cause Analysis has been completed and patient treatment plans are in place.

Reporting improvements have been put into place to increase the visibility of long waiters to enable appropriate scheduling.



Work is continuing with NHS Improvement and the national Intensive Support Team (IST) on our recovery plan to deliver improved performance back up towards the standard. The latest feedback from IST has given positive assurance that the revised administrative and reporting solutions implemented across the Trust are robust for RTT management. Operational and financial teams are at the point of finalising detailed plans to address the backlog and deliver long term stability in the delivery of this key standard.

c. Diagnostic Six Weeks Wait

Although a supportive measure for RTT, the standard that patients should wait less than six weeks for a diagnostic test is a key performance metric in its own right. Waiting times against a subset of 15 diagnostic investigations are measured at the end of every month. The threshold standard is that a minimum of 99% of patients waiting should have waited less than 6 weeks. WUTH performance for the end of April was 99.81%.

d. Cancer

For Cancer access targets, the 62-day standard continues to be the most difficult to achieve, and this is reflected in performance levels at a national level. This particular standard also has an explicit line in STF trajectories, with the expectation the 85% standard will be achieved each month. Cancer waiting time performance is only finalised many weeks after month-end due to the time

required to confirm diagnosis and share patient pathways between providers. The current performance against the 62-day Cancer standard for the current quarter is detailed in the dashboard. Although challenging the Trust does not foresee non-compliance with this cancer standard.

The Trust is focusing intensely on challenges relating to the delivery of the two week standard for referrals with breast symptoms for quarter one. A recent surge in demand outstripped available planned capacity, resulting in growing waits to be seen. Additional capacity has been planned around the bank holiday week when tradiitonallt capacity falls but this still remains a significant risk in terms of quarter 1 delivery. It should be noted that this is not the case for patients referred under the general cancer two week pathway, with that expected to be achieved.

e. Infection Control

For C Difficile, there have been four hospital acquired cases in the month of April, with two of these clinically judged to be avoidable. The trajectory for the financial year 2017/18 is the same as 2016/17 with a maximum total of 29 hospital acquired avoidable cases for the full year.

4. Recommendation

The Board of Directors are asked to:

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

WUTH Integrated Performance Dashboard - Report on February for May 2017 BoD

Area	Indicator / BAF	Feb	Mar	Apr	Trend / Future Concern	*Target (for 'Green')*	Latest Period	Exec Lead
Meeting Our Vision	**Satisfaction Rates**							
	Patient - F&F "Recommend" Rate	99%	100%	99%		>=95%	April 2017	GW
	Patient - F&F "Not Recommend" Rate	0%	0%	0%		<=2%	April 2017	GW
	Staff Satisfaction (engagement)	3.78	3.78	3.78		>=3.69	Q4 2016/17	JM
	First Choice Locally & Regionally							
	Market Share Wirral	80.6%	81.0%	81.4%		>= 85%	Nov 2016 to Jan 2017	AM
	Demand Referral Rates	-7.9%	-8.7%	-43.7%		>= 3% YoY variance	Fin Yr-on-Yr to April 2017	AM
	Market Share Non-Wirral	7.0%	6.8%	7.8%		>=8%	Nov 2016 to Jan 2017	AM
	Strategic Objectives							
	Harm Free Care	96%	96%	96%		>= 95%	April 2017	GW
	HIMMs Level	5	5	5		5	April 2017	MB
Operational Excellence	**Key Performance Indicators**							
	A&E 4 Hour Standard	77.61%	81.30%	82.21%		>=95%	April 2017	AM
	RTT 18 Weeks Incomplete Position	83.15%	83.93%	80.34%		>=92%	April 2017	AM
	Diagnostics 6 Week Standard	99.80%	99.80%	99.81%		>=99%	April 2017	AM
	Cancer Waiting Time Standards	On track	On track	Concern 1 standard		All met at Trust level	Q1 to April 2017	AM
	Infection Control (c Diff cumulative YTD)	1 MRSA; 13 C diff	1 MRSA; 13 C diff	1 MRSA; 13 C diff	0 MRSA; 2 C diff	0 MRSA Bacteraemia in month, and cdiff less than cumulative trajectory	April 2017	GW
	Productivity							
	Delayed Transfers of Care	39	46	43		Metric redefined	April 2017	AM
	Delayed Complex Care Packages	84	110	97		<= 45	April 2017	AM
	Bed Occupancy	91.1%	90.6%	88.9%		<=85%	April 2017	AM
	Bed Occupancy Medicine	95.3%	94.2%	93.7%		<=85%	April 2017	AM
	Theatre Utilisation	88.2%	88.8%	91.6%		>=85%	April 2017	AM
	Outpatient DNA Rate	7.4%	7.7%	8.0%		<=6.5%	April 2017	AM
	Outpatient Utilisation	82.2%	80.9%	81.4%		>90%	April 2017	AM
	Length of Stay - Non Elective Medicine	5.5	5.8	5.2		<= 5.0	April 2017	AM
	Length of Stay - Non-elective Trust	4.9	5.2	4.8		<=4.2	April 2017	AM
	Contract Performance (activity)	-4.2%	-3.7%	3.5%		0% or greater	April 2017	AM
	Finance							
	Contract Performance (finance)	-1.6%	-1.9%	-2.6%		On Plan or Above YTD	April 2017	DJ
	Expenditure Performance	-2.2%	-3.1%	2.2%		On Plan or Below YTD	April 2017	DJ
	CIP Performance	0.0%	0.0%	-73.5%		On Plan or Above	April 2017	DJ
	Capital Programme	22.4%	-1.2%	89.1%		On Plan	April 2017	DJ
	Non-Core Spend	9.3%	9.4%	9.4%		<5%	April 2017	DJ
	Cash Position	76.0%	-32.0%	296.0%		On plan or above YTD	April 2017	DJ
	Cash - liquidity days	-32.9	-16.7	-16.1		> 0 days	April 2017	DJ
A Healthy Organisation	**Clinical Outcomes**							
	Never Events	1	1	0		0 per month	April 2017	SG
	Complaints	32	35	19		<30 per month	April 2017	GW
	Workforce							
	Attendance	95.61%	96.05%	95.62%		>= 96%	April 2017	JM
	Qualified Nurse Vacancies	3.63%	5.79%	6.25%		<=6.5%	April 2017	GW
	Mandatory Training	91.84%	91.83%	91.62%		>= 95%	April 2017	JM
	Appraisal	83.68%	84.74%	83.06%		>= 85%	April 2017	JM
	Turnover	10.51%	11.04%	11.04%		<10%	April 2017	JM
	Agency Spend	12.6%	12.5%	36.5%		On plan	April 2017	GW
	Agency Cap	103	151	161		0	April 2017	JM
External Validation	**National Comparators**							
	Advancing Quality (not achieving)	2	3	2		All areas above target	April 2017	SG
	Mortality: HSMR	92.01	91.54	89.61		Lower CI < 0.90	April 2016 to Jan 2017	SG
	Mortality: SHMI	0.983	0.983	0.966		Lower CI < 90	Oct 2015 to Sept 2016	SG
	Regulatory Bodies							
	NHSI - Use of Resources (UoR) Rating	3	3	3		1 or 2 (NHSI amended Oct 2016)	April 2017	DJ
	CQC	Amber	Amber	Amber		Overall CQC rating Requires Improvement	April 2017	SG
	Local View							
	Commissioning - Contract KPIs	7	8	7		<=2	April 2017	AM

Quarter	1
Period	01/04/2017 - 30/06/2017

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

Quarter 1 - Total

Division	Tumour Group	Breaches			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted
Medicine	Haematology	0	0	0	3	4	7	100.00%	100.00%
	Lung	0	0.5	0.5	4	5	9	100.00%	94.44%
	Other	0	0	0	1	1	2	100.00%	100.00%
Med & Surg	Upper GI	0	2	2	0	5.5	5.5	N/A	63.64%
Surgery	Breast	1	1	2	15.5	14	29.5	93.55%	93.22%
	Colorectal	1	1	2	6	8	14	83.33%	85.71%
	Head & Neck	1.5	1	2.5	2	2	4	25.00%	37.50%
	Skin	0	1	1	21.5	24	45.5	100.00%	97.80%
	Urology	6.5	3	9.5	14.5	20	34.5	55.17%	72.46%
Women's	Gynaecology	0	2	2	0	7	7	N/A	71.43%
	Total	**10**	**11.5**	**21.5**	**67.5**	**90.5**	**158**	85.19%	86.39%

Quarter 1 - April

Division	Tumour Group	Breaches			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted
Medicine	Haematology	0	0	0	3	1	4	100.00%	100.00%
	Lung	0	0	0	3	1	4	100.00%	100.00%
	Other	0	0	0	0	1	1	N/A	100.00%
Med & Surg	Upper GI	0	1	1	0	3	3	N/A	66.67%
Surgery	Breast	1	0	1	14.5	0	14.5	93.10%	93.10%
	Colorectal	1	0	1	5	2	7	80.00%	85.71%
	Head & Neck	1.5	0	1.5	2	0	2	25.00%	25.00%
	Skin	0	0	0	18.5	4	22.5	100.00%	100.00%
	Urology	5.5	0	5.5	13.5	4	17.5	59.26%	68.57%
Women's	Gynaecology	0	1	1	0	3	3	N/A	66.67%
	Total	**9**	**2**	**11**	**59.5**	**19**	**78.5**	84.87%	85.99%

Quarter 1 - May

Division	Tumour Group	Breaches			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted
Medicine	Haematology	0	0	0	0	3	3	N/A	100.00%
	Lung	0	0.5	0.5	1	4	5	100.00%	90.00%
	Other	0	0	0	1	0	1	100.00%	100.00%
Med & Surg	Upper GI	0	1	1	0	2.5	2.5	N/A	60.00%
Surgery	Breast	0	1	1	1	14	15	100.00%	93.33%
	Colorectal	0	1	1	1	6	7	100.00%	85.71%
	Head & Neck	0	1	1	0	2	2	N/A	50.00%
	Skin	0	1	1	3	20	23	100.00%	95.65%
	Urology	1	3	4	1	16	17	0.00%	76.47%
Women's	Gynaecology	0	1	1	0	4	4	N/A	75.00%
	Total	**1**	**9.5**	**10.5**	**8**	**71.5**	**79.5**	87.50%	86.79%

Quarter 1 - June

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

Board of Directors	
Agenda Item	7.1.2
Title of Report	Month 1 Finance Report
Date of Meeting	24th May 2017
Author	Gareth Lawrence, Deputy Director of Finance
Accountable Executive	David Jago, Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	8 8c,8d
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To discuss and note
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

Overview

This paper provides an update to the Board of Directors on the month 1 financial performance of the Trust for the 2017/18 financial year.

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

At the end of April 2017 the Trust has delivered an overall deficit of £2.2m which is in line with the profile of the financial plan submitted.

The Trust has a £0.5m adverse variance to the CIP plan having delivered £0.2m in month compared to the planned £0.7m.This is a disappointing start to the Trusts' challenge to deliver £15.0m of savings.

The cash position at the end of April was £6.8m which is £5.1m more than plan. This variance is primarily due to 2016/17 closing cash being higher than plan and working capital movements.

The month 1 position includes the full Sustainability and Transformation funding that has been offered to the Trust of £0.4m.This is due to both the financial plan being met and delivery of submitted April A&E 4 hour trajectory of plan at 82.0% with actual performance at 82.18%.

The Trust has achieved an overall Use of Resources (UoR) Rating of 3 which is in line with plan.

Income and Expenditure Performance

Income and expenditure statement — Wirral University Teaching Hospital NHS Foundation Trust

Year ending 31 March 2018 Position as at 30th April 2017.	YTD Budget £k	YTD Actual £k	YTD Variance £k	Year-end forecast Board-approved Budget £k	Year-end forecast Actual £k	Year-end forecast Variance £k
Clinical Income	24,745	24,092	(654)	303,692	303,692	0
Non NHS Clinical Income	195	221	26	2,337	2,337	0
Other Income	2,250	2,220	(31)	32,479	32,479	(0)
TOTAL INCOME	27,190	26,532	(658)	338,508	338,508	(0)
Pay	(18,042)	(19,131)	(1,089)	(221,300)	(221,300)	0
Other operating expenditure	(10,994)	(9,258)	1,736	(113,458)	(113,458)	0
TOTAL EXPENDITURE	(29,037)	(28,389)	647	(334,758)	(334,758)	0
Finance costs	(351)	(340)	11	(4,319)	(4,319)	(0)
Surplus/(deficit) before impairments and transfers	(2,197)	(2,197)	0	(569)	(569)	0
Remove capital donations/grants I&E impact	12	13	1	142	142	(0)
Adjusted financial performance surplus/(deficit) including STF	(2,185)	(2,184)	1	(427)	(427)	0
Less sustainability & transformation fund (STF)	(444)	(444)	0	(8,875)	(8,875)	0
Adjusted financial performance surplus/(deficit) excluding STF	(2,629)	(2,628)	0	(9,302)	(9,302)	0
Control total excluding STF	(2,629)	(2,628)	0	(9,302)	(9,302)	0

The table above identifies the current performance of the Trust in relation to the plan submitted to NHSI in March 2017.

PbR activity is currently above plan by £0.6m as a result of over performance in Elective/Day case, Non Elective and A&E activity. This has been offset with under performance in Non-PbR(£0.5m) and PbR excluded drugs(£0.7m matched by expenditure).

Expenditure is currently above plan as a result of non delivery of CIP (£0.5m) and above plan continued escalation wards (£0.3m) that have remained open during April.

The Trust is currently discussing with Health and Social care partners potential opportunities of supporting these costs in the short term albeit initial response received is not positive

The Trust continues to perform well in controlling agency costs with £0.4m spent in month compared to the ceiling of £0.7m issued by NHSI. This continued performance ensures that the Trust continues to deliver a UoR Rating of 3.

As a result of the adverse performance in expenditure and CIP delivery the position includes the release of £0.7m from the CQUIN risk reserve that was built into the financial plan.

The Trust Board is asked to note that as a result of a high level of un-coded activity(c 3,500 spells) the M1 income position includes a high level of estimates. The estimate has been based on the actual coded spells in month by specialty and POD. Plans have been put in place to improve the coding position in the short to medium term to ensure recruitment and retention of clinical coding capacity and capability.

Cost Improvement Programme (CIP)

The CIP for 2017/18 is £15m that is split as a target both divisionally and workstream led. As at the end of the Month 1 the Trust is behind the target of £0.7m by £0.5m. The Trust currently has £4m of fully built up schemes with opportunities and plans of a further £8.1m leaving a current shortfall of £2.9m.

The table below details the month 1 position for CIP.

Summary as at Month 1	YTD		In Year		
	Actual		Forecast		Trend
NHSi Plan (Target)	£689k		£15,000k		
Fully Developed TSG approved schemes	£178k		£3,968k		
Overperformance/ (Gap) v NHSi Plan	-£511k	-74.2%	-£11,032k	-73.5%	
Latest Forecast performance on TSG approved schemes	£152k		£3,993k		⇧
Over/ (Under)performance compared to TSG approved schemes	-£26k	-14.6%	£25k	0.6%	
Latest Forecast including mitigation	£152k		£3,993k		⇧
Performance Variance (Latest Forecast to NHSi Plan)	-£537k	-78.0%	-£11,007k	-73.4%	
Latest Forecast adjusted for risk	£152k		£3,048k		
Performance Variance (Latest Forecast to NHSi Plan)	-£537k	-78.0%	-£11,952k	-79.7%	

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

Included within appendix 1 is the CIP profile for the 2017/18 financial year.

Cash position and Use of Resources (UoR)

The April cash position was £6.8m, which is £5.1m above plan. This variance is primarily due to 2016/17 closing cash exceeding prudent planning assumptions (£3.6m), favorable working capital movements (£1.2m), and the cash effects of capital slippage (£0.3m).

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

The overall position returns a UoR Rating of 3, which is in line with plan.

Conclusion

The Trust has delivered a deficit position in line with plan but only as a result of releasing a material element of the CQUIN risk reserve. It is vital going forward that costs reduce safely in order to support the delivery of the CIP and overall financial plan.

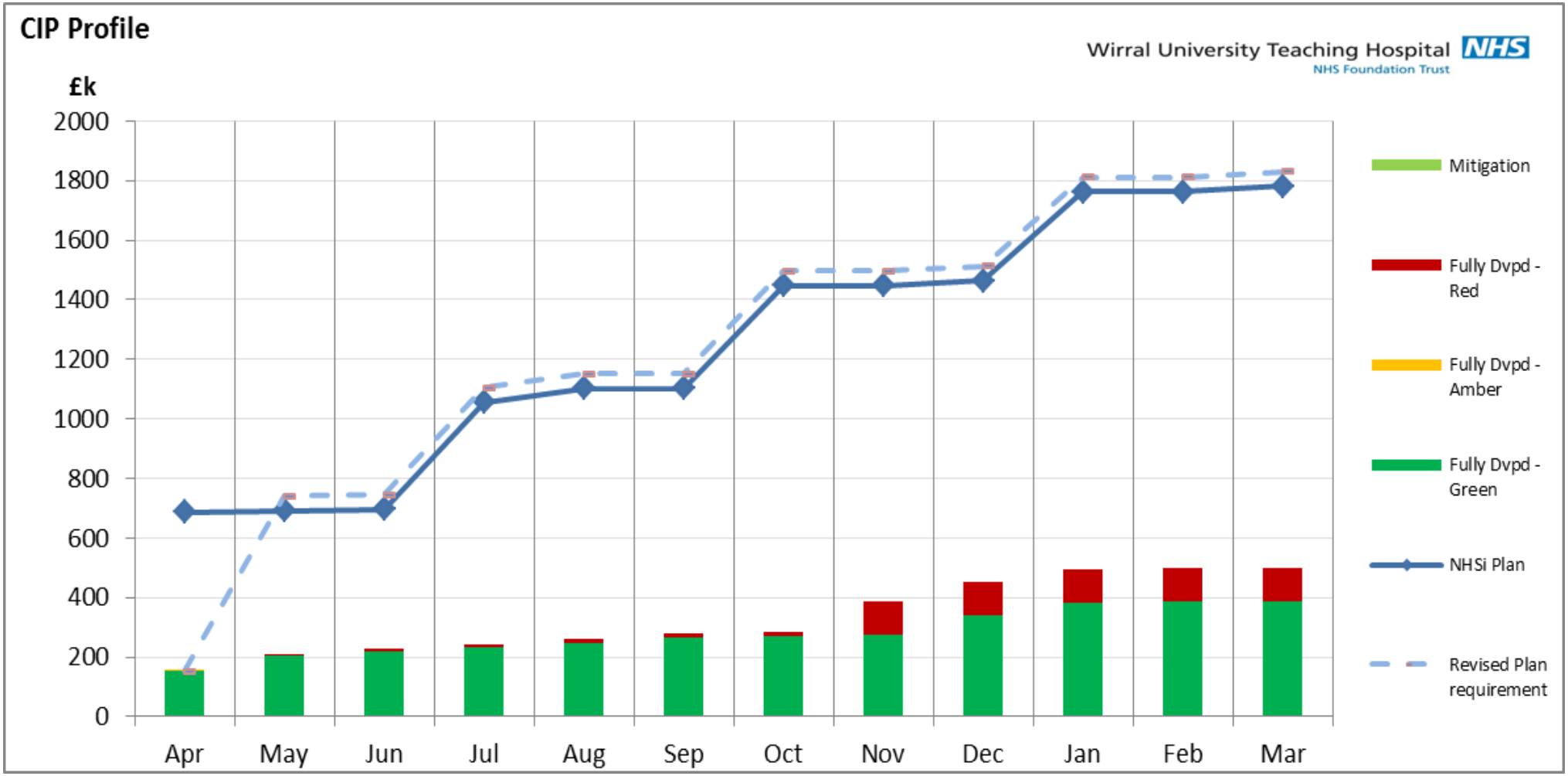
The cash position remains positive, and the Trust has delivered a UoR of 3 in line with planned assumptions.

Recommendations

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

David Jago
Director of Finance
May 2017

Appendix 1 – CIP Profile



Agenda Item	7.2
Title of Report	Workforce and Organisational Development Annual Report
Date of Meeting	24th May 2017
Author	James Mawrey, Director of Workforce Lynn Benstead, Deputy Director of OD Lawrence Osgood, Deputy Director of Workforce
Accountable Executive	James Mawrey, Director of Workforce
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	 1, 5 1c, 5a, 5b 3, 5
Level of Assurance **Positive** **Gap(s)**	Full
Purpose of the Paper **Discussion** **Approval** **To Note**	This report is presented to provide assurance that appropriate actions are being taken within the Trust to address issues relating to Workforce and Workforce KPI's as well as NHS and Statutory requirements. The Trust Board is asked to note the contents of the report.
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**	Equality and Diversity is a common thread that runs through all policies and procedures across the Trust. Data contained in this report continues to support the Trust equalities agenda, and includes information on ethnicity, gender breakdown of staff, age profile, sexual orientation and religious belief.

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Workforce Information

Annual Report

2016/17

April 2017

Contents

1. Introduction and Executive Summary

1. This report is presented to provide assurance that appropriate actions are being taken within the Trust to address issues relating to the Workforce agenda.

2. Board members will be aware that separate reports have been provided to the Quality & Safety Committee on matters (non-exhaustive) such as:-

   a. Delivery against the Workforce & OD Strategy - previously agreed by the Trust Board.
   b. Delivery against the Staff Engagement plan.
   c. Delivery / performance against Health & Safety Legislation and good practice.

3. The report shows that the Trust made progress towards achieving some of its Workforce targets as well as working towards embedding the values that underpin our patient experience. The key matters (non-exhaustive) to note are:

- Trust values continue to be embedded in HR processes including recruitment, appraisal, remuneration and training. Further work is required to develop the organisational culture needed and this is a priority area for the Executive Team.
- The Trust continues to monitor the key characteristics of the workforce such as proportions in different staff groups, pay band, age, length of service, protected characteristics, turnover etc. in order to inform the workforce strategy and departmental planning. There are no specific matters to escalate to the Trust Board in this regard and fuller details are contained within the report.
- Trust sickness absence during 2016/17 was better than the stretch target of 4% for 8 of the 12 months. Of the remaining months 2 were below 4.2%, however there was an anticipated winter spike during December and January.
- Overall staffing numbers remained roughly the same as last year but there was movement between staff groups, largely due to skill mix changes, included in this :-
  - 28 wte decrease in Nursing and Midwifery in year and corresponding 29 WTE increase in Additional Clinical Services, which includes Clinical Support Workers.
  - Continued increase of Medical Workforce with 24 more consultants in post than 2 years ago (headcount).
- The 2016 National Staff Survey, announced in March 2017, showed the Trust had maintained the significant improvements made in the previous Survey when which we were noted as the most improved Trust in the country/UK (for those Trust's using Quality Health as the NHS Staff Survey provider). The Quality & Safety Committee have recently agreed the Staff Engagement Plan for 17/18 which details the steps that will be taken to achieve our aspirations of being in the top 20% of employers in the North West for Staff Engagement levels.
- Significant work has been done to support managers in improving appraisal compliance; However the Trust has not achieved its Appraisal compliance target of 88% with compliance being 84.74% at March 2017.
- The Mandatory Training Block A compliance rate at 31st March 2017 is high at 91.83 %. This is a rise from last year (90.49% at March 2016), however it is below the 95% KPI. The Mandatory Training Block B compliance rate at the 31 March 2017 was 87.45% % which falls below the 95% target rate but is a slight rise from 87.31% at March 2016. A Mandatory Training Roadmap has been introduced to support managers in increasing compliance by September 2017

- The Trust has continued to lead the way across Wirral and Cheshire for its approach to apprenticeships. In 2016-17 the Trust supported 79 apprentices/trainees and saw 22 of its young apprentices progressing onto permeant roles within the Trust. The Trust hosted an Apprenticeship open day on Monday 06th March 2017 to showcase the apprenticeship opportunities available at the Trust. This event was attended by over 400 young people.
- The Wirral University Teaching Hospital Library and Knowledge Service was one of the top scoring services in the North West in the Libraries Qualities Assurance Framework (LQAF) accreditation with a score of 99% in its assessment. The Trust has been consistent in achieving the highest standard of accreditation for the last 6 Years.
- The Trust has established a highly effective and well regarded Freedom to Speak Up (FTSU) Staff Guardian team to enable staff to speak up safely. The Team was recognised nationally for best practice by both NHS Employers and the National Guardian Office, invited to establish and host first regional network meeting held in December 2016 and to chair the National FTSU Conference in March 2017. National Staff Survey results 2016 have shown further improvement in the number of staff who would feel secure raising concerns and an increase in the percentage of staff who feel confident the organisation would address their concern.

4. The Board is asked to:

1. Note the details of the Annual Workforce Report.
2. Highlight any specific additional assurance / workforce information required.

2. Trust values

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

2.2 Our vision is underpinned by our PROUD core values and behaviours which define the standards of the organisation and individuals within it. Our PROUD core values are woven into our HR processes including recruitment, induction, appraisal, remuneration and training. Further work is required to develop the organisational culture needed and this is a priority area for the Executive Team.

2.3 In 2016/17 we have further embedded our PROUD core values by:

- Communicating our Staff Charter that sets out expectations values and behaviours for all staff and piloting a compact agreement in specific areas
- Engaging with our leaders on “The PROUD Way” related to staff engagement.
- Refreshing the appraisal process to give added prominence to values and behaviours
- Embedding Trust values and behaviours into Leadership programmes.
- Promotion of PROUD messages through Trust communications.
- Refreshed Team Brief
- Most successful PROUD Awards held in September 2016 with over 500 nominations
- Introduced PROUD individual Recognition Scheme

5

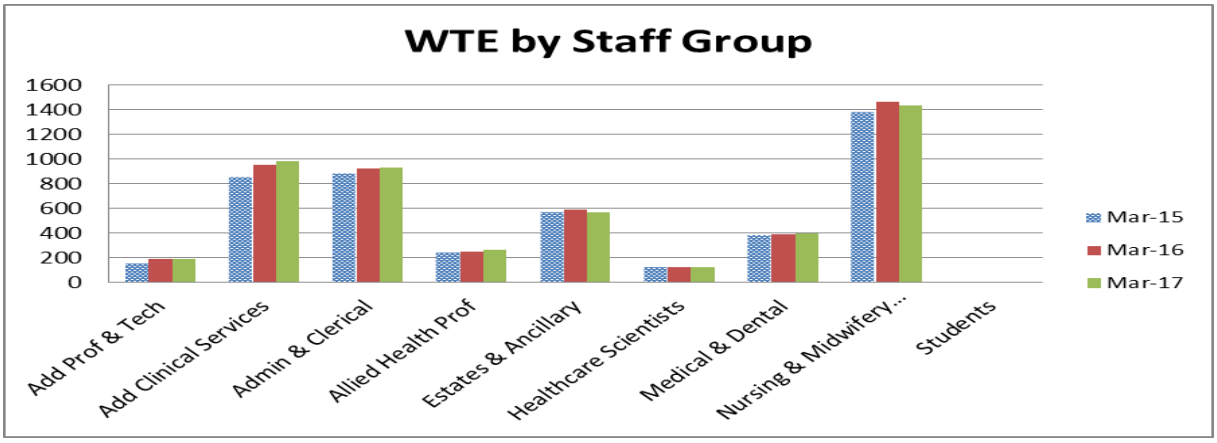
3. Trust Workforce Profile

3.1 Headcount and WTE

The Trust employs 5893 staff, (4888.61 Whole Time Equivalent March 2017). The number of whole time equivalent staff has increased by 2.78wte during 2016/17 (4885.83 wte March 2016).

During 2016/17 the vacancy control system has continued with signoff of any recruitment or increases in staff hours by a panel consisting of Directors and very senior managers. Divisional Directors / senior corporate managers present their cases to this panel and are challenged on the need for the increase and whether alternatives have been sufficiently explored.

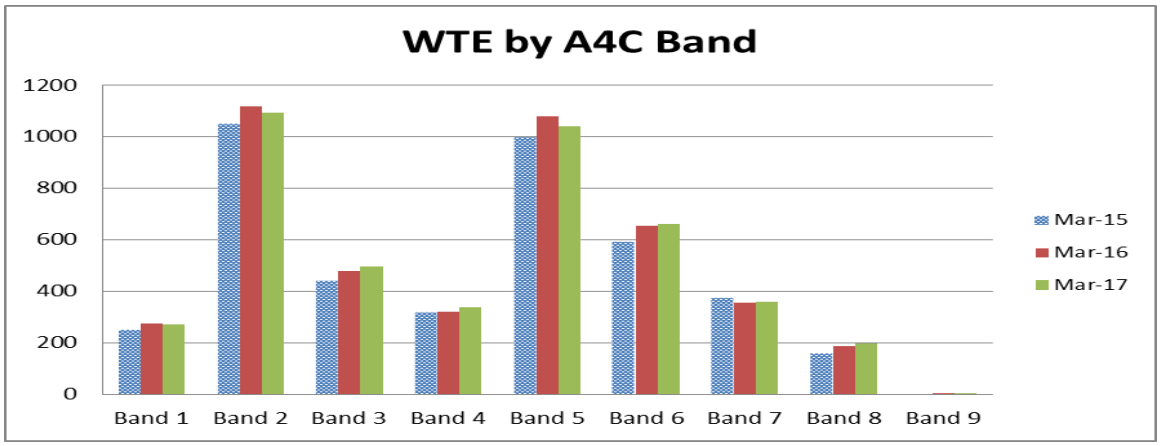
3.2 Staffing Group –Headcount and WTE



There has been an overall slight increase in wte staff numbers this year (2.78wte). Skill mix changes have resulted in Additional Clinical Services having by far the largest increase (29.72wte), this staff grouping includes clinical support workers. Nursing & Midwifery (N&M) have seen a decrease of 28.65wte. N&M overall vacancy Rate at 5.79% (March 2017) is low compared to other organisations. In order to reduce vacancies further HR&OD has developed a nurse recruitment and retention plan which includes Newly Qualified recruitment, Corporate led recruitment, Overseas Recruitment, Advertising, Earn, Learn and Return programme, Nursing Associate Pilot and Advanced Nurse Practitioner Strategy.

Numbers of consultants continues to increase with 24 more in post than 2 years ago (headcount). During 2016/17 there have been 26 substantive Consultant appointments and as at end of March 2017 a further 12 substantive appointments are confirmed. Please note in addition to the Medical & Dental numbers above there are 183 junior doctors hosted by Whiston but working in this Trust. The junior doctor contract has been implemented for all WUTH employed Doctors in Training.

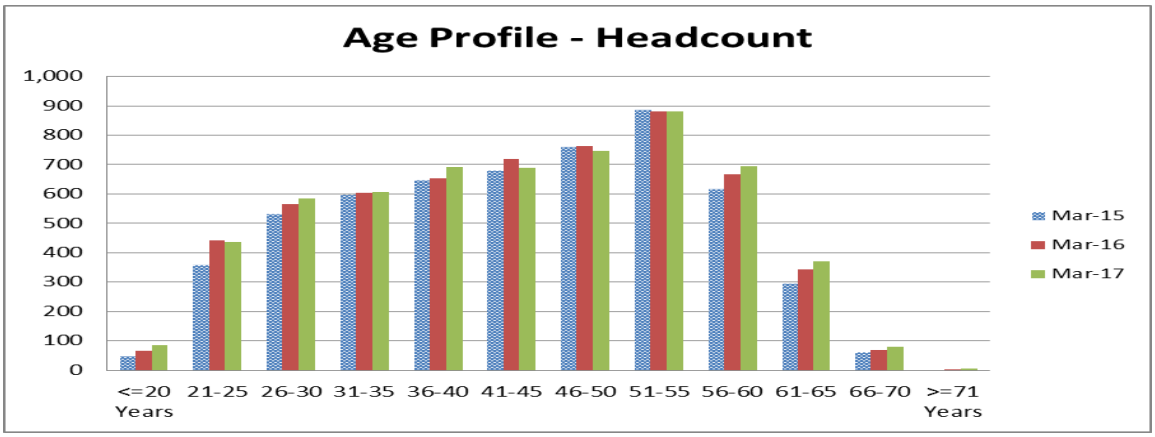
3.3 Agenda for Change Whole Time Equivalent staffing (WTE)



	Band 1-3	Band 4-7	Band 8-9	Non A4C	Total
Wirral University Teaching Hospital NHS Foundation Trust	38%	49%	4%	9%	100%
Lancashire Teaching Hospitals NHS Foundation Trust	36%	51%	4%	9%	100%
University Hospital of South Manchester NHS Foundation Trust	29%	55%	6%	11%	100%
Countess of Chester Hospital NHS Foundation Trust	38%	49%	4%	10%	100%
Blackpool Teaching Hospitals NHS Foundation Trust	31%	58%	4%	6%	100%
Central Manchester University Hospitals NHS Foundation Trust	26%	63%	7%	4%	100%
Salford Royal NHS Foundation Trust	28%	50%	7%	16%	100%
Stockport NHS Foundation Trust	34%	53%	4%	9%	100%
University Hospitals of Morecambe Bay NHS Trust	35%	52%	5%	9%	100%
Wrightington, Wigan and Leigh NHS Foundation Trust	38%	49%	4%	9%	100%
Aintree University Hospitals NHS Foundation Trust	34%	51%	5%	10%	100%
East Lancashire Hospitals NHS Trust	35%	53%	4%	8%	100%

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

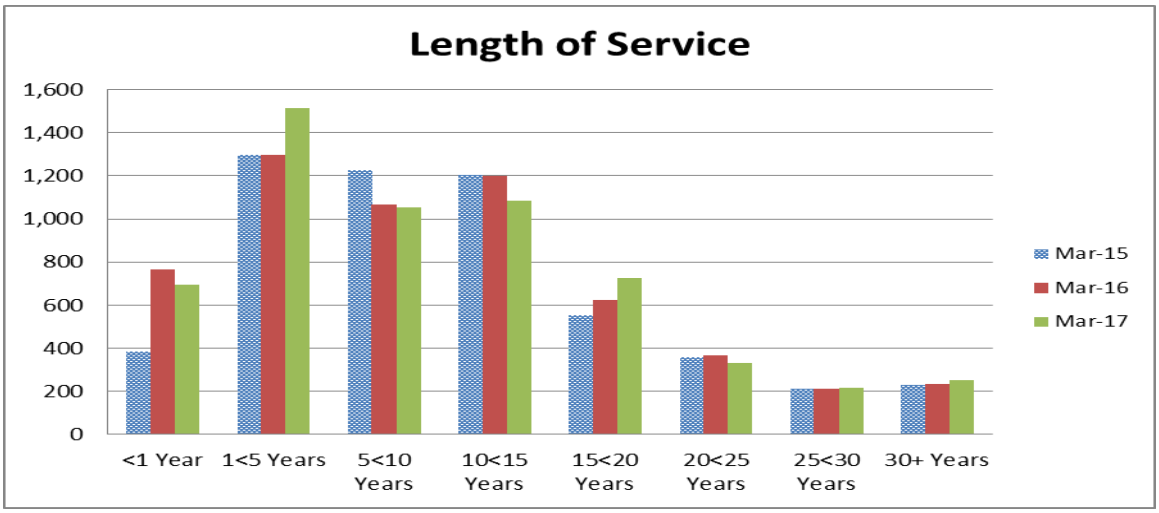
3.4 Age Profile



It can be seen that the age profile of the Trust remains relatively stable, however there are some significant movements with reduced numbers of staff in their forties and

increased numbers of older staff and younger staff. In line with apprentice recruitment the numbers of staff under 20 has significantly increased. However the largest numbers of employees are aged between 46 and 60. The increase in numbers of staff over 60 is in line with the national trend towards an ageing workforce, increasingly, staff are remaining in work up to and beyond their pensionable age which in terms of risk, lowers the risk of the staff taking their skills away from the organisation – however this introduces another risk in terms of larger numbers of staff of pensionable age who may be more likely to leave at any time than younger staff. Divisional managers and HR monitor key staff in this category such as consultants and ensure succession planning is considered for these staff. Currently the Trust has 27 consultants aged over 60 out of its 267 consultant workforce.

3.5 Length of NHS Service.



The biggest increases between 2016 and 2017 have occurred in category of 1<5 years NHS service' which reflects the previous year's recruitment of more apprentices and more newly qualified nurses.

3.6 Flexible Working

Nearly half of Trust staff work on a part time basis (49%), many through choice and some through recruitment of A&C staff to maximum 35 hour per week posts. Having a substantial proportion of staff working on other than a full time basis is beneficial to staff trying to balance work and life and is beneficial to the Trust. The potential benefits of part time working to the Trust include:

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

There are some disadvantages in that having headcount high in relation to whole time

equivalent (wte) does increase staff recruitment and development costs, however on balance the advantages above make part time staff an attractive proposition.

3.7 Turnover and Vacancies

A total of 647.59 wte staff (excluding rotational training doctors and honorary staff) joined the Trust in 2016/17, indicating that the Trust remains attractive to new employees. Reasons for leaving are broadly attributed to natural turnover e.g. 'Voluntary Resignation/Other', 'Flexi retirement' or 'Voluntary Resignation – Relocation'.

Turnover (rolling 12 months % by staff group).

Staff Group	Mar-16	Mar-17
Trust	9.27%	11.04%
Add Prof Scientific and Technic	6.93%	11.76%
Additional Clinical Services	7.70%	11.12%
Administrative and Clerical	9.55%	13.48%
Allied Health Professionals	12.38%	8.90%
Estates and Ancillary	5.55%	7.37%
Healthcare Scientists	10.71%	6.79%
Senior Medical and Dental	8.42%	8.16%
Nursing and Midwifery Registered	9.03%	10.57%
Students	0.00%	0.00%

Turnover has increased overall in 2016/17 when compared to 2015/16 but remains within healthy boundaries for an organisation undergoing change. Whilst which staff stay and leave is key in individual workplaces the overall Trust figures are monitored to optimal rates. Up to 10% turnover can be healthy for a whole organisation as it brings in fresh talent and enables organisational change. Up to 14% is desirable in times of change but beyond 14% would usually be considered excessive and less than 5% may be equally undesirable.

Turnover has significantly increased this year amongst Administrative and Clerical Staff, this group now has the highest turnover in the Trust.

Vacancies.

Mar-17	Trust	Corporate	Clinical Support	Medicine & Acute	Surgery, W&C
Staff In Post (excluding Dr's in Training)	4771.20	1168.83	739.59	1368.07	1612.18
Vacancy % (excludes all M&D Staff)	6.65%	9.19%	4.45%	6.92%	5.36%
Vacancy # (excludes all M&D Staff)	319.88	116.48	32.87	90.20	80.33
N&M Vacancy %	5.79%	-4.34%	6.06%	7.33%	4.80%
N&M Vacancy #	88.22	-1.78	1.95	53.31	34.74
N&M Band 5 (Inpatient Areas & ED) %	7.03%	N/A	N/A	7.97%	5.09%
N&M Band 5 (Inpatient Areas & ED) #	46.81	N/A	N/A	35.71	11.10
Consultants Vacancy %	6.51%	0.00%	11.03%	7.91%	4.14%
Consultants Vacancy #	17.00	0.00	4*	7.88	5.12

Note a negative vacancy figure may indicate that an area is temporarily over-established
*Actual number of posts in the recruitment process

A significant proportion of the Corporate vacancies are in Facilities. Consultant recruitment remains a priority and HR&OD are working with Divisions to address some

hard to fill posts. The Nursing Band 5 vacancies are reviewed each month by the Senior Nursing Team and the nurse recruitment and retention plan specifically targets band 5 nurses.

3.8 Equality and Diversity

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

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

Ethnicity	Total Number of WUTH Staff	% of WUTH Staff	% Wirral Population (2011 Census)	Wirral Population (2011 Census)
White: British	5,286	89.70%	94.70%	303,682
White: Irish	40	0.68%	0.88%	2,667
White: Gypsy or Irish Traveller	1	0.02%	0.03%	77
White: Other White	90	1.53%	1.23%	3,730
Mixed: White and Black Caribbean	4	0.07%	0.32%	964
Mixed: White and Black African	7	0.12%	0.18%	558
Mixed: White and Asian	4	0.07%	0.31%	949
Mixed: Other Mixed	11	0.19%	0.27%	815
Asian or Asian British: Indian	184	3.12%	0.44%	1,344
Asian or Asian British: Pakistani	21	0.36%	0.07%	226
Asian or Asian British: Bangladeshi	6	0.10%	0.28%	851
Asian or Asian British: Chinese	16	0.27%	0.54%	1,653
Asian or Asian British: Other Asian	42	0.71%	0.34%	1,042
Black or Black British: African	26	0.44%	0.13%	389
Black or Black British: Black Caribbean	3	0.05%	0.06%	189
Black or Black British: Other Black	4	0.07%	0.04%	117
Other Ethnic Group/Not Specified	148	2.51%	0.18%	530
All Groups	**5,893**	**100%**	**100%**	**319,783**

The Trusts gender split, disability, and sexual orientation groupings are as shown in the tables below:

Gender	Total
Female	4678
Male	1215
Grand Total	**5893**

Disabled	Total
No	2456
Not Declared	307
Undefined	3049
Yes	81
Grand Total	**5893**

Sexual Orientation	Total
Bisexual	21
Gay	29
Heterosexual	2869
I do not wish to disclose my sexual orientation	481
Lesbian	17
Undefined	2476
Grand Total	**5893**

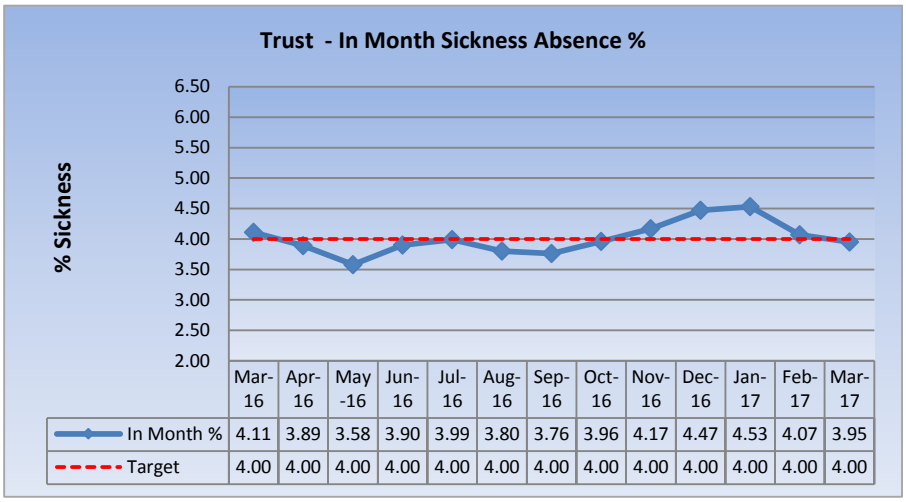
The gender split reflects the largely female nursing workforce, age bandings are detailed in the section above and reflect the overall high retention rates for staff. The disabled and sexual orientation groupings are showing a large number of undefined or not declared/ disclosed preferences. There is evidence that people are more reluctant to share information about disabilities and sexual orientation with their employer, this is not restricted to the NHS but is an issue across employment in general, however due to the roll out of ESR Employee Self Service, members of staff are now able to view and amend their personal details. HR&OD will be launching a communication campaign in 2017 to promote disclose by staff of protected characteristics.

The Trust has an established Equality and Diversity Action Plan which is monitored at the Patient and Family Experience Group and reported to the Clinical Commissioning Group as part of the Quality Contract Schedule. Key to this is our Workforce Race Equality Standard, and work will commence in June to prepare this year's data and report to measure our progress. Work has also begun to prepare for the Workforce Disability Equality Standard which will be introduced in April 2018.

4. Staff Health and Wellbeing

4.1 Sickness Absence.

Overall Trust sickness absence during 2016/17 was better than the Trust stretch target of 4% for 8 of the 12 months. Of the remaining months 2 were below 4.2%, however there was an anticipated winter spike during December and January when rates were around 4.5%.



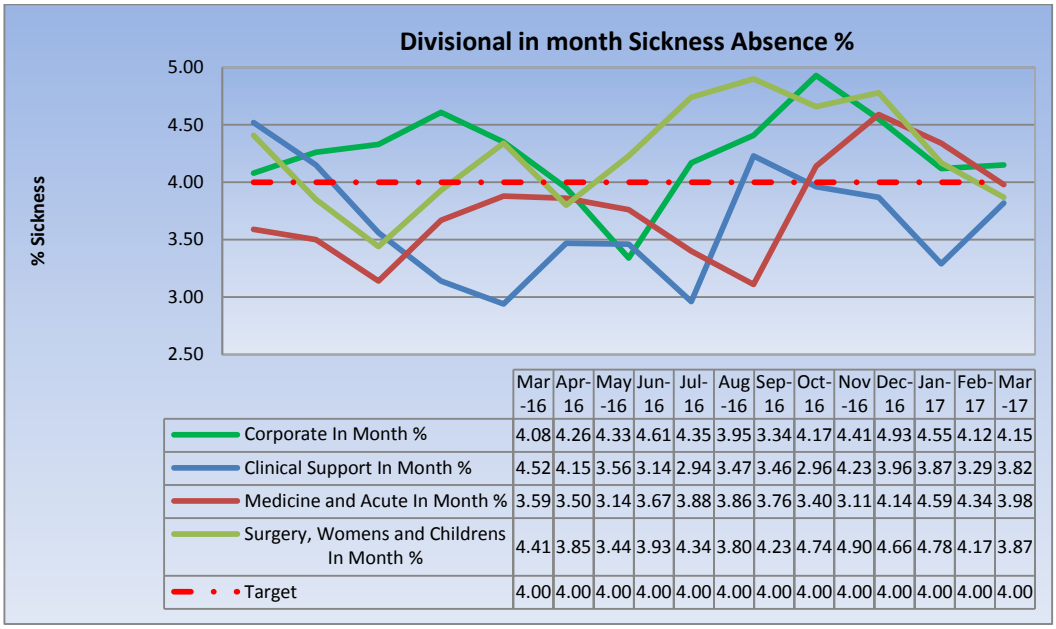
	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
In Month %	4.11	3.89	3.58	3.90	3.99	3.80	3.76	3.96	4.17	4.47	4.53	4.07	3.95
Target	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00

Reasons for sickness are continually monitored by HR&OD in order to target actions to improve attendance. The top five reasons for 2016/17 are in the table below, with the figures for the previous year. Compared to the previous year there is proportionally less absence due to Anxiety/stress/depression and less due to back problems which might indicate successful interventions such as mindfulness sessions and manual handling training / ergonomic assessments. With a number of norovirus outbreaks throughout the year the proportion of Gastrointestinal absences has increased.

Absence Reason	2015/16	2016/17
S10 Anxiety/stress/depression/other psychiatric illnesses	25.30%	24.73%
S12 Other musculoskeletal problems	11.37%	11.34%
S25 Gastrointestinal problems	8.63%	9.09%
S11 Back Problems	8.77%	7.52%
S28 Injury, fracture	7.81%	7.51%

In response to the above HR&OD are refreshing their Health and Wellbeing Strategy and associated wellbeing plan. The refresh incorporates the requirements of the 2017-19 national CQUIN related to organisational commitment to health and wellbeing for staff, healthy eating and drinking, and flu. The plan brings together a variety of initiatives providing a comprehensive approach to Health & Wellbeing based on DoH and NICE guidance of best practice. An intensive flu vaccination campaign has seen the highest percentage of Trust staff vaccinated this winter (79.2%). Anxiety/Stress/Depression remains the major factor in absence and targeted actions are being taken to address this including stress audits, review of stress policy, departmental and individual stress risk assessments, training on stress awareness, self-help guides and Mindfulness sessions that are being provided to staff out of hours.

Clinical Support division have had the strongest performance with regards to sickness absence with all but one month in 2016/17 achieving the 4% stretch target. Corporate had the weakest performance with only 2 months achieving the Trust 4% stretch target. HR&OD are supporting Corporate / Divisional Managers to address worsening areas and in particular are focusing support to the Estates and Ancillary staff group whose sickness rates are particularly high.



	Mar -16	Apr-16	May -16	Jun-16	Jul-16	Aug -16	Sep-16	Oct-16	Nov -16	Dec-16	Jan-17	Feb-17	Mar -17
Corporate In Month %	4.08	4.26	4.33	4.61	4.35	3.95	3.34	4.17	4.41	4.93	4.55	4.12	4.15
Clinical Support In Month %	4.52	4.15	3.56	3.14	2.94	3.47	3.46	2.96	4.23	3.96	3.87	3.29	3.82
Medicine and Acute In Month %	3.59	3.50	3.14	3.67	3.88	3.86	3.76	3.40	3.11	4.14	4.59	4.34	3.98
Surgery, Womens and Childrens In Month %	4.41	3.85	3.44	3.93	4.34	3.80	4.23	4.74	4.90	4.66	4.78	4.17	3.87
Target	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00

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

4.2 Health and Wellbeing Plan

Underpinning the strong performance in terms of sickness absence is the Health and Wellbeing plan. Several events were held throughout the year focused on all aspects of health and wellbeing, including both physical and mental health. A series of Trust wide mindfulness sessions were initiated in 2016/17 and launched at a 'Mind Matters' day focusing on mental health issues and the positive support available to staff. Healthy challenge pledges based on the health and well-being plan were also introduced across the Trust.

A wellbeing survey was undertaken to identify areas that were important to staff and the feedback was used to develop an events calendar which promoted healthy eating, physical activity, smoking cessation, sensible drinking, mental health support, chaplaincy services, sexual health services, musculoskeletal advice and cholesterol testing.

A Listening into Action (LiA) work stream was established in October 2016 and the feedback gained from staff about health and wellbeing led to increased access to health and wellbeing support and information via a newsletter and website. A 'chill out' zone in the library was created where staff can access resources on mental health, find out about support available from community services, chaplaincy, charities, alcohol and drugs services, citizens advice bureau, cancer support services and local gyms.

In terms of physical activity, a standard operating procedure has been developed for all physical activities taking place on site to ensure risk management procedures are followed. Activities including zumba, karate, singing, pilates have also been set up and made available to all staff.

A weekly fruit and vegetable stall is now in place on both hospital sites offering fresh produce at affordable rates to encourage healthy eating.

The Schwartz rounds also continue to support this agenda along with the Trust's attendance management policy and development programme for senior leaders and managers. The combined efforts and continued focus on health and wellbeing, sickness absence management and staff engagement has gained national recognition - being highly commended in the HSJ Value in Healthcare Awards 2016 and recently announced as a shortlisted entry in 2017, with winners to be announced in May 2017.

4.3 Occupational Health (OH) Service

The OH service was successful in renewing their **Effective, Quality Occupational Health Service (**SEQOSH) accreditation in 2016/17, having been accredited for the first time last year.

The team have continued to provide support and service provision to the Wellbeing agenda. The flu vaccination campaign protected 79% of the Trust's front line staff and with a quicker uptake than previous years. Other support to the wellbeing agenda included counselling, mindfulness, health surveillance, stress management, cognitive behavioural therapy and the development of an in-house TB service.

The Department has also maintained its external OH service contracts with neighbouring NHS and non-NHS organisations. The Chief Executive of Clatterbridge Cancer Centre wrote:

"*The services provided by the Occupational Health team supports new and current staff to remain well, providing personalised care and support and also support and guidance to managers. Individually and collectively you have gone above and beyond the day job with far too many people to mention putting in extra hours and showing patience, determination and the spirit to ensure success*".

5. Staff Engagement

5.1 Staff Satisfaction and Staff Engagement is a key element of the Workforce & Organisational Development Strategy. The Workforce & Organisational Development Strategy articulates our vision which is to have a healthy organisational culture, a sustainable and capable workforce, working in an integrated manner with partners and where the leadership and management of our people is effective and conducted in a manner that improves staff experience and lets us demonstrate that we have put our values into action.

5.2 The results of the 2016 National Staff Survey and management recommendations were presented to the Trust by the Chief Executive of Quality Health on 8th March, 2017. During this presentation he noted that he was very pleased to report that the Trust had sustained their 'meteoric' improvements made in the previous year. Notwithstanding these comments the Trust has rightly set aspirational targets to be in the top 20% of organisations in the North West for Staff Engagement levels.

Highlights from the 2016 Staff Survey include the following:

		2014	2015	2016
Q21a	"Care of patients / service users is my organisation's top priority"	53%	66%	71%
Q21b	"My organisation acts on concerns raised by patients / service users"	56%	67%	70%
Q21c	"I would recommend my organisation as a place to work"	41%	58%	62%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	52%	66%	69%
KF1.	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.29	3.67	3.73
KF29	% Staff reporting errors, near misses and incidents witnessed		88%	94%
	Overall Staff Engagement Score	**3.48**	**3.79**	**3.78**

5.3 The following provides a very high level / non exhaustive summary of the actions taken in 2016/17:-

- Listening into Action on 3 levels - Annual CEO staff engagement events and Wave 7 and 8 LiA Teams including Winter Planning, learning from incidents and internal communications. LiA Huddles have been completed across the Trust with 779 improvement actions identified and most actioned by department managers and their teams.
- Focus on rewards and recognition through the PROUD Team of the Quarter, Individual Recognition Scheme, national and regional award recognition and highly successful annual PROUD Awards.
- Winners of the Patient Experience (PENNA) Awards 2016 for Staff Engagement, Shortlisted by HPMA (Healthcare People Management) Awards for the LiA 100 Day Challenge (Staff Engagement) and Highly Commended by HSJ Value in Healthcare Awards 2016
- Extended the Trust Board Partners scheme in January 2016 following a positive review
- Held senior leaders events focused on employee engagement and organized CEO Back to the Floor Programme
- Supported implementation of the Leadership and Management Development Framework
- Supported engagement in the development of a draft Medical Engagement Plan, aligned to the Trust's Culture and Engagement Plan
- Ensured regular positive communications via Start the Week, News Bulletin, intranet, Team Brief and CEO Forum. Also made greater use of social media, refreshed communications campaign based on Staff Friends and Family Test.
- Established a highly effective and well regarded Freedom to Speak Up Staff Guardian team to enable staff to speak up safely, following staff engagement through LiA.
- Supported Health and wellbeing agenda through promotional events and Schwartz Rounds
- Corporate nurse recruitment campaign
- Quality Review of personal development plans with revised training and guidance

The Quality & Safety Committee recently supported the Staff Engagement action plan which sets out the steps that will now be taken to improve staff engagement levels, with the clear aspiration of moving into the top 20% of organisations in the North West for Staff Engagement levels.

6. Staff Development

6.1 Leadership

The Trust continues to build on its Leadership and Management Framework to address the competency requirements of leaders and managers to deliver transformation schemes and accountability for people management. HR&OD provide a host of internal development opportunities throughout the year. These programmes are advertised in the annual Leadership and Organisational Development Prospectus. The Team also provide bespoke programmes such as team building, cultural development etc. as requested by Divisions.

The most requested / attended Leadership and Management programmes in 2016-17 were as follows;

- Middle Managers Leadership and Development
- Leadership and Communication Skills for Supervisors
- Resilience Skills
- Coaching Skills for Leaders
- HR Skills for Managers
- Appraisal Skills

Consultant Development Programme

The third new Consultant Development Programme finished in April 2017. The Trust developed the programme in order to support Consultants during their first 12 months with the Trust. The aim of the programme was: To raise awareness of the role of the Consultant and the importance of personal impact in interacting with and leading and influencing their team, locally, corporately and externally; To understand the strategic and financial issues and the roles that they play as Clinical Leaders in the delivery of service improvement and quality of care; To understand how to deliver and develop safe and effective clinical practice set against managing targets, finance and systems. The feedback has been excellent and positive comments on future programme content have been received.

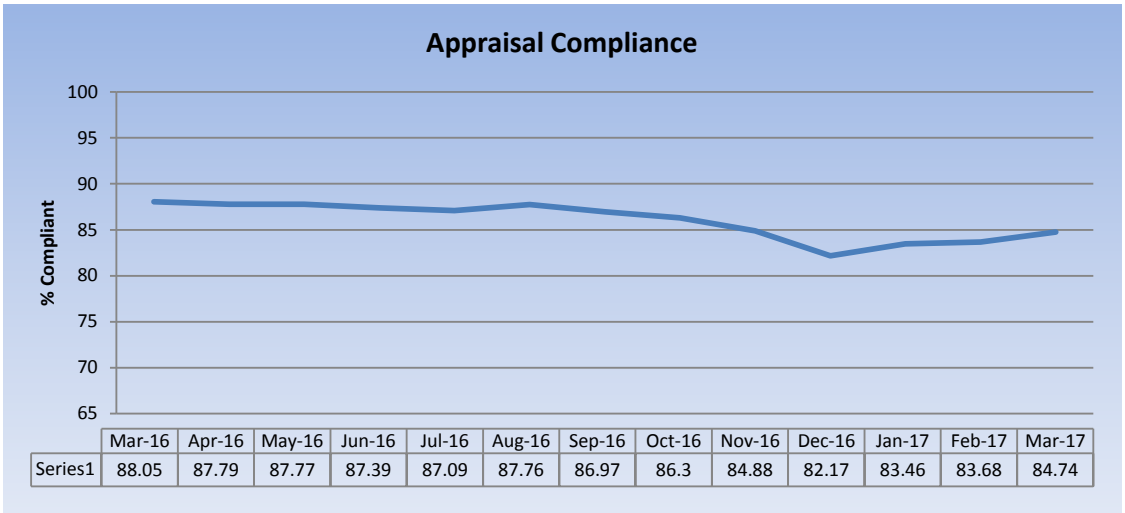
Clinical Leadership Programme

The Clinical Leaders Development Programme in 2016/17 had 14 Consultant participants from WUTH. The programme aims to provide a supportive environment in which clinicians can develop and expand their leadership knowledge and skills, reflect on their capabilities and explore new ways of behaving. This programme will support the process of talent management and succession planning for clinical leadership roles.

6.2 Appraisal

The Trust appraisal levels for the first three quarters of the year decreased and therefore were not achieving its compliance target of 88% (84.74% at March 2017). Levels in the last quarter showed improvement. Corporate Division is performing above its KPI of 88%, all other Divisions are performing below their KPI of 88%

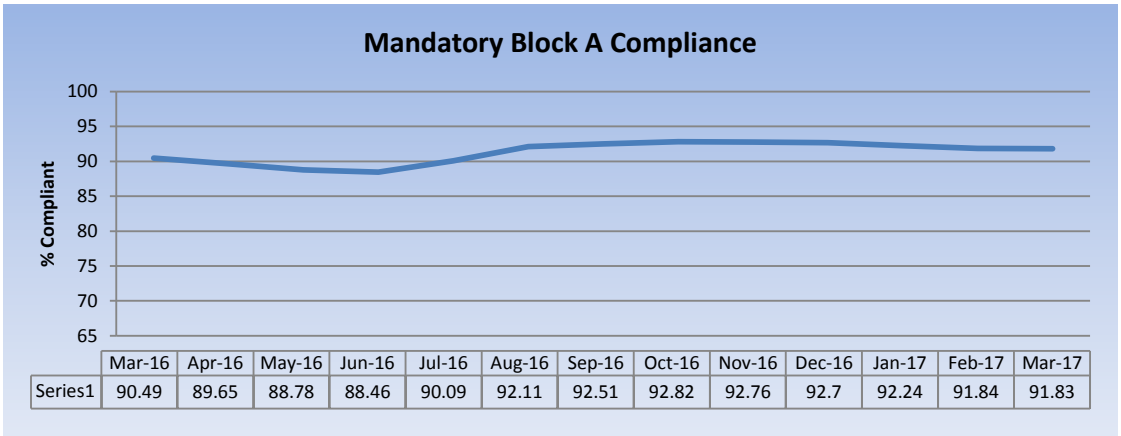
The Leadership and Development Team continue to provide support and training to both staff and managers around the benefits and importance of appraisals. There is now a focussed plan in place to achieve compliance during the summer months.



	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Series1	88.05	87.79	87.77	87.39	87.09	87.76	86.97	86.3	84.88	82.17	83.46	83.68	84.74

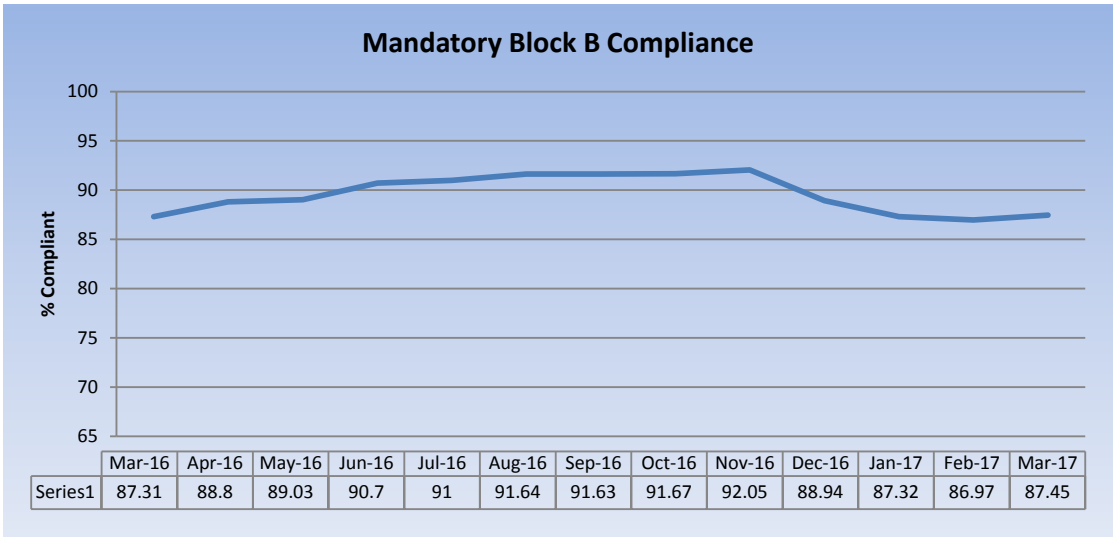
6.3 Mandatory Training

The Mandatory Training Block A compliance rate at 31st March 2017 is high at 91.83 %. This is a rise from last year (90.49% at March 2016), however it is below the 95% KPI. Clinical Support Division and Corporate Division have achieved the KPI of 95%, but Medicine and Acute Division and SW&C are below the KPI. Divisions have been issued with monthly trajectories and a Mandatory Training Roadmap to support them in achieving and maintaining their KPI of 95% by September 2017.



	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Series1	90.49	89.65	88.78	88.46	90.09	92.11	92.51	92.82	92.76	92.7	92.24	91.84	91.83

The Mandatory Training Block B compliance rate at the 31 March 2017 was 87.45% % which falls below the 95% target rate but is a slight rise from 87.31% at March 2016. All Divisions are performing below their KPI of 95%. Compliance for this training had increased throughout 2016-17, but impacts of full capacity during December and January had a negative effect.



	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Series1	87.31	88.8	89.03	90.7	91	91.64	91.63	91.67	92.05	88.94	87.32	86.97	87.45

6.4 Training Sessions

The Trust ESR system recorded 39,142 training completions between April 2016 and March 2017. This includes Leadership Development, Clinical Excellence, Mandatory, In addition in 2016/17 HR&OD:

- facilitated the access of 266 CDP modules.
- supported 219 staff members in undertaking clinical academic modules at university.
- supported 79 apprentices/trainees and saw 22 of its young apprentices progressing onto permeant roles within the Trust.
- ensured 100% of newly qualified or new to Trust nurses received preceptorship.
- ensured 100% compliance with NMC registrants completing revalidation.
- Library & Knowledge Service received a compliance score of 99% against the national Library Quality Assurance Framework (LQAF) criteria. This is a further increase from 96% in 2015/16.
- enabled the pilot of Physician Associate and Nursing Associate new roles.
- lead the Advanced Nurse Practitioner Strategy; currently there are 34 fully qualified ANPs to support medical rotas.

7. Workforce Information and Systems

7.1 Agency Spend

HR&OD have played a major role in 2016/17 in delivering on the Trust's agency spend reduction target (£1 million below Agency Ceiling). The number of agency breaches compares well with peer organisations according to feedback and data shared with the Trust by NHSI through 2016/17. Systems and mechanisms for weekly reporting to NHSI have been developed during the year. In addition HR&OD have provided the Board with assurance that controls and processes are in place to ensure the Trust complies with the new IR35 regulations

7.2 Electronic Staff Record (ESR)

During 2016/17 HR&OD successfully implemented ESR Self-Service. Benefits of ESR self-service are:

- Paper free HR processes.

- Managers can now electronically view, report and manage absence, turnover and training.
- Managers can access Business Intelligence reports which will give key information on staffing.
- Employees can now electronically view, access and amend their own data.
- Employees can now electronically view payslips/P60s/Total Reward Statement and apply for/manage their annual leave.

8. Employee Relations

8.1 Formal ER Cases

Employee Relations Formal Cases		
	2015/16	**2016/17**
Disciplinaries in year.	33	54
Disciplinaries – Bullying & Harassment	10	10
Grievances in year	44	67
Grievances – Bullying & Harassment	17	11
Concerns raised in Year	92 (22 PIDA recordable)	97 (27 PIDA recordable
Trust Board Appeals in year	3	9
Employment Tribunals in year	5	4

There has been a general increase in employee relations cases this year, much of which can be attributed to the increased emphasis on raising concerns and increased action in relation to sickness absence management. There have been 4 employment tribunals, one of which resulted in a minor finding of discrimination. Actions are being taken to implement lessons learned from that case.

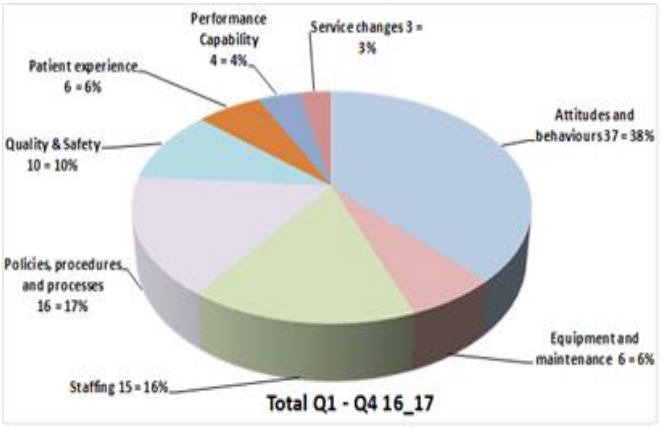
8.2 Raising Concerns

The Trust has established a highly effective and well regarded Freedom to Speak Up (FTSU) Staff Guardian team to enable staff to speak up safely.

Achievements in 2016/17 include:

- Shortlisted for National Award and recognised nationally for best practice by both NHS Employers and the National Guardian Office.
- Invited to establish and host first regional network meeting held in December 2016 and to chair the National FTSU Conference in March 2017.
- 97 concerns raised and acted upon.
- National Staff Survey results 2016 have shown further improvement in the number of staff who would feel secure raising concerns, rising by a further 2% to 66% and 7% improvement since the 2014 staff survey. There has been a further 7% increase in the percentage of staff who feel confident the organization would address their concern rising from 51% to 58% which is 11% increase since the 2014 staff survey.

The main themes arising from concerns raised include: procedures and processes, attitudes and behaviours and staffing.



No. of Concerns Raised Q1 - Q4 2016/17		
Division	**No. of concerns raised**	**No. of concerns open at 31.03.17**
Surgery, Women & Childrens	40	4
Medical & Acute	26	6
Diagnostics & Clinical Support	6	0
Corporate Services	22	5
Unspecified	3	0
Total	**97**	**15**

8.3 Bullying and Harassment

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

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

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

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

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

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

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

Policy.

The results from the audit for 2016-2017 demonstrated that the Trust compliance with the policy was as follows:

- Trust policy states that bullying and harassment is unacceptable
- No grievances received as a result of the informal processes failing because of inadequate action.
- Audit of cases demonstrated that the Trust was compliant with all process for addressing concerns in all but one case. This area of non-compliance is addressed in recommendations below.
- In all cases audited, the appropriate support was offered.
- WUTH has remained in the main on par with National average responses in respect of bullying and harassment in the national staff survey. It is noted that the national average figures show better responses for the reporting of incidents. Recommendations to improve on this are noted below.

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

As good practice, and to support the ongoing application of the policy in addressing bullying and harassment recommendations for action will be made and supported by regular reporting to Workforce and Communications Group. The following recommendations will be taken forward:

- Promoting awareness of the Bullying & Harassment policy in dealing professionally and effectively with workplace issues.
- Reporting of audit outcomes and recommendations widely throughout the Trust.
- Trust-wide communications specific to reporting, support and options of addressing bulling and harassment issues including further promotion of staff guardians.
- Reporting Harassment, Bullying or Abuse – identify location of spikes in National Staff Survey, promote Trust commitment, policy, how to report, and review effectiveness of reporting mechanism.
- Promotion of the in-house mediation services.

9. Next Steps

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

1. We will further develop the evidential behaviors that underpin the Trust values. Cultural transformation will be a key work programme for the Trust.

2. Continuing to work towards meeting our key staffing metrics, this will support the Trust in managing our activity, improve patient care and work within staffing budgets.

3. Implementing Trust Staff Engagement plan in light of the findings of the NHS Staff Survey 2016.

4. The Trust will further develop our Leadership training of senior managers and

clinicians. A focus on fully utilising the opportunities of the apprenticeship reforms will be evident.

5. Encourage disclosure by staff of protected characteristics (e.g. sexuality, disability). Continue compliance with Workforce Race Equality Standard and Workforce Disability Equality Standard.

10. Conclusions

10.1 As a result of this workforce analyses, the Trust can be satisfied that there are no significant areas of concern which are unique to this organisation, although there are some areas where performance needs to be improved and where specific actions will be taken to address.

11. Recommendation

The Board is asked to:

1. Note the details of the Annual Workforce Report.
2. Highlight any specific additional assurance / workforce information required.

Board of Directors	
Agenda Item	8.1
Title of Report	Chair of Audit Committee Report
Date of Meeting	24 May 2017
Author	Cathy Bond, Chair of the Audit Committee
Accountable Executive	David Allison, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	All
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion
Reviewed by Assurance Committee	Not applicable
Data Quality Rating	Not applicable
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	Not applicable

The Audit Committee meeting to review in detail and make recommendations to the Board of Directors on the statutory Annual returns was held on the 19th May 2016. As the Chief Executive was not in attendance, his support of the presentations to the Committee, and in particular the Annual Governance Statement, had been extended prior to the meeting.

Annual Report and Accounts

The Committee reviewed in detail the following:
- The Annual Report and Accounts for 2016/17
- The Quality Account
- The Annual Governance Statement
- The External Audit Opinions on both the Financial Statements and the Quality Report
- Letters of Representation by the Board on the Financial Statements and Quality Account.

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

As part of the presentation to the Board, the Committee also requested that an outline of the potential future impact to the Trust due to the reduction of Tax Payers Liability and restrictions as a consequence of the 2016/17 asset revaluation be included.

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

- Going Concern Statement – External Auditors had been provided with further information regarding NHS Improvement (NHSI) agreement of the Trust's System Control Total in order to support the Going Concern Statement and negate the inclusion of an Emphasis of Matter narrative. Although inclusion of an Emphasis of Matter would not prevent the Trust from receiving an unqualified audit opinion, the Finance Team would continue to strive to evidence the agreement to ensure that the Going Concern Statement presented to the Board of Directors for approval would not include an Emphasis of Matter.
- Qualified Limited Assurance on the Quality Accounts - Qualifications relate to data quality issues identified for the national indicator; Referral to Treatment Time (RTT) incomplete pathways. It was confirmed that all data quality errors had been identified in cases which had not been subject to the Trust's revised internal review procedures. External Audit recognised the time required to fully embed the renewed processes and voiced support of the Trust approach to addressing RTT data quality.

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

- The Annual Report and Accounts for 2016/17
- The Quality Account
- The Annual Governance Statement
- The External Audit Opinions on both the Financial Statements and the Quality Report
- Letters or Representation by the Board on the Financial Statements and Quality Account

The Committee extended its thanks to the Finance Team for the work undertaken in-year in order to produce a comprehensive, robust and appropriate set of accounts

Audit Committee Effectiveness Report

The Committee agreed that the Annual Review of Committee Effectiveness (Appendix 1) reflected the work carried out by the Committee throughout 2016/17 and outlined the outcomes of the Audit Committee workshop which took place in February 2017. The Committee was pleased to note the improved effectiveness against a comparable review conducted in January 2013.

The Committee approved its priorities for 2017/18 subject to the inclusion of a request to the Quality and Safety Committee to report on the outcomes of the 2016/17 Never Events review to enable the Committee to gain assurance of Trust processes for the identification and management of systemic issues.

Board Assurance Framework

The Committee received the updated Board Assurance Framework (BAF) and noted that the Risk Appetite Matrix had received approval from the Board of Directors at its April 2017 meeting.

The Committee discussed the effectiveness of BAF management processes and was pleased to note External Audit support of the Trust BAF. It was confirmed that the presentation of the BAF at future Assurance Committee meetings would be tailored to focus discussion on those risks specifically assigned to the relevant Assurance Committee.

The Committee noted that targeted risk training had commenced with the Divisions and a risk session would take place with the Medical and Acute Division at the end of May 2017 to further explore the Divisions key risks and inform the content of the BAF.

Compliance with Licence Review

The Committee noted the content of the compliance with licence review which would underpin the Board Declarations to NHSI in May 2017. The Committee requested that future iterations of the report include a performance trajectory for each licence provision.

Internal Audit

The Committee noted that Internal Audit had commenced the work against the Internal Audit Plan for 2017/18 and outcome reports would be presented to the Committee in due course.

The Committee received the Internal Audit Actions Outstanding Recommendations Summary and noted in particular the progress against those recommendations made following the Quality Spot Checks and Standards of Business Conduct reviews.

The Committee reviewed the outstanding Threat and Vulnerability Management action and in light of the recently highlighted cyber threat requested that the action be reviewed to confirm its appropriateness. The Committee noted that an update on additional cybersecurity controls would be presented to the Board of Directors in May 2017.

Cathy Bond
Audit Committee Chair

Appendix 1

Board of Directors	
Agenda Item	8.1a
Title of Report	Annual Review of Committee Effectiveness
Date of Meeting	24th May 2017
Author	Cathy Bond – Chair of Audit Committee Gemma Herbertson – Corporate Governance Manager
Accountable Executive	Cathy Bond – Chair of Audit Committee
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	All
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion
Reviewed by Executive Committee	N/A
Data Quality Rating	Bronze – qualitative data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

1. Executive Summary

The Audit Committee is established as an Assurance Committee of the Board of Directors and is a Non-Executive led Committee. Its purpose is to scrutinise the Trust's risk and assurance structure and processes to ensure they are effective and support all aspects of the Trust's business.

In February 2017 the Audit Committee members conducted an in-depth review of the Committees performance, facilitated by the Trusts internal auditors, Mersey Internal Audit Agency (MIAA),

which sought Committee member views on current performance and future developments. The full findings of the effectiveness review are outlined within Appendix 1.

2. Background

The Audit Committee first commenced a review of its effectiveness in May 2016 however, following a revision to the Non-Executive Director portfolios in July 2016, the Committee agreed to postpone a full review of Committee effectiveness until early 2017. This was to enable newer members to gain greater familiarity with the remit and conduct of the Committee so that they were able to contribute a more informed opinion and gain the most value from the annual appraisal.

The Terms of Reference of the Committee were reviewed and updated in September 2016 and the Audit agenda was framed around the Committee Terms of Reference in order to provide assurance to the Board of Directors across a range of activities including corporate, clinical, financial and risk governance and management.

The Audit Committee met 5 times during 2016/17 in order to discharge its duties, all meetings have been quorate and a Chairs report submitted to the Board of Directors following each meeting to outline the key areas of discussion and actions to be undertaken to address any issues identified.

The Audit Committee work programme for 2016/17 covered the following:

- Review of the effectiveness of the revised Board Assurance Framework management processes
- Review of the Risk Management System and Processes
- Review and recommendation of the Annual Report, Annual Accounts and Annual Governance Statement to the Board
- Review of the Scheme of Reservation and Delegation and Standing Financial Instructions
- Review of compliance against the Trust's Provider Licence
- Review of risks and controls around financial management, including losses, special payments and financial assurance
- External Audit Reports
- Internal Audit Reports
- Fraud Reports
- Review of Clinical Audit

3. Conclusion

The effectiveness review, supported by MIAA considered all areas of Committee responsibility. It was noted that since the precious review improvements in the work done by Audit Committee had been made. As ever, there are still areas where increased focus is required and this forms part of the ongoing priorities for 2017/18. These are:

- IT Service Continuity
- Water Safety
- Nurse Staffing Levels
- Data Quality
- Clinical Handover of Care
- Sustainability and Transformation Planning and Partnership Engagement
- Achievement of the Trust's System Control Total
- Never Event review processes (findings report to be received from Quality and Safety Committee)

4. Recommendations

The Board is asked to:

- Note the improvements in effectiveness of the Committee.

Mersey Internal Audit Agency

Audit Committee Workshop Session

(March 2017)

Wirral University Teaching Hospital

NHS Foundation Trust

Contents

1. Introduction and background

The effective operation of the Trust Committees is a significant component of the Trust's assurance arrangements and in this context it was timely to take stock of current Committee operations, its challenges in the future, and how those challenges might be addressed.

2. Overall Approach

The session was led by Tim Crowley and Adrian Poll from MIAA and was structured as follows:

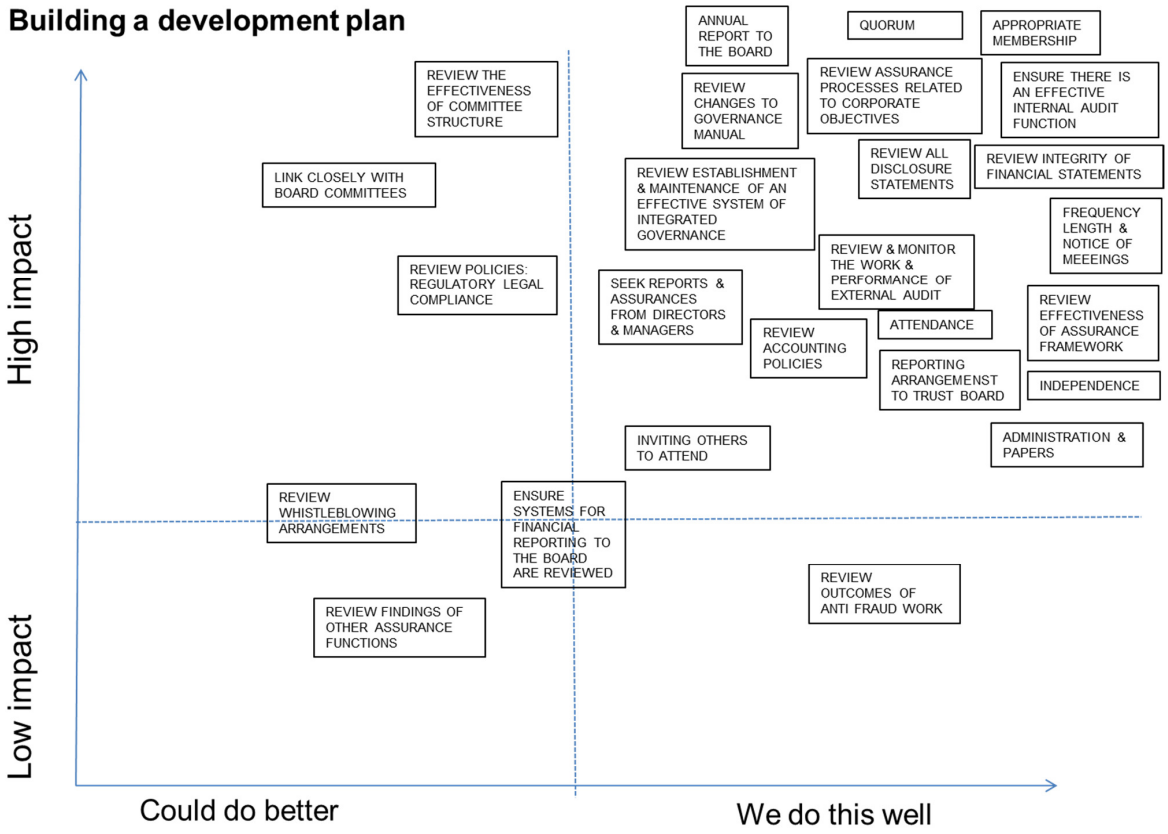
i. **Current performance and impact**: gain agreement through discussion on what the Committee currently does well, where it makes an impact and where it could do things differently.

ii. **Principles**: gain consensus on the principles for delivery of the Committee's duties (as per the Terms of Reference) and consider wider aspects of interaction within the organisation.

iii. **Build a development plan:** setting out the challenges as a prompt for how we get from our current position to where we want to be.

3. The Facilitated Session Discussion and Outcomes

In order to understand views on current activity a process was used to evaluate the performance of the Committee in respect of its key duties. As well as discussing how well each duty was being performed, each duty was evaluated in terms of its impact. The participants were asked to consider these issues and their conclusions are set out below:



Essentially, the figure above can be helpful in making sure the Committee continues to focus upon the duties it is doing well that have a high impact; stops doing things that add little value; and considers how to improve performance for duties that are not being done that well but could make a high impact if done better.

Looking to the top right hand corner of the diagram above shows that some of the duties and core responsibilities e.g. review of financial statements and other disclosures (importantly the Committee's role in this is recognised by the Board), review of Board Assurance Framework, reporting to the Board, review of internal audit and external audit findings, membership and administration are performed well.

Looking to the top left hand corner there is recognition that the duties in respect of reviewing the work of other Committees, reviewing other assurance functions and effectiveness of the committee structure could be enhanced.

Summarised below are some of the discussions from the facilitated session:

- **Review establishment and maintenance of an effective system of integrated governance –** whilst members felt this was happening there is the potential for more clarity on how this is done.
- **Link closely with Board Committees –** it was considered that this could be more formalised in approach, whereby the work of other committees could be fed in to the Audit Committee to inform the workplan.
- **Review findings of other assurance functions –** whilst high level issues are seen by the Committee, it was felt that this is an area for improvement.
- **Ensure system for financial reporting to the Board are reviewed –** the Committee considered that its remit here is as 'work in progress.'
- **Review assurance processes related to Corporate Objectives –** members agreed that this is done through review of the Board Assurance Framework, although there is potential for wider discussions to be undertaken.
- **Review the effectiveness of the committee structure –** members reflected that this had been done historically, and whether the Committee needs to revisit this.
- **Review policies: Regulatory/Legal compliance –** members agreed to reassess whether this is done for all clinical requirements.

The actions generated from the discussion are summarised in the development plan at Appendix A.

4. Conclusion and Way Forward

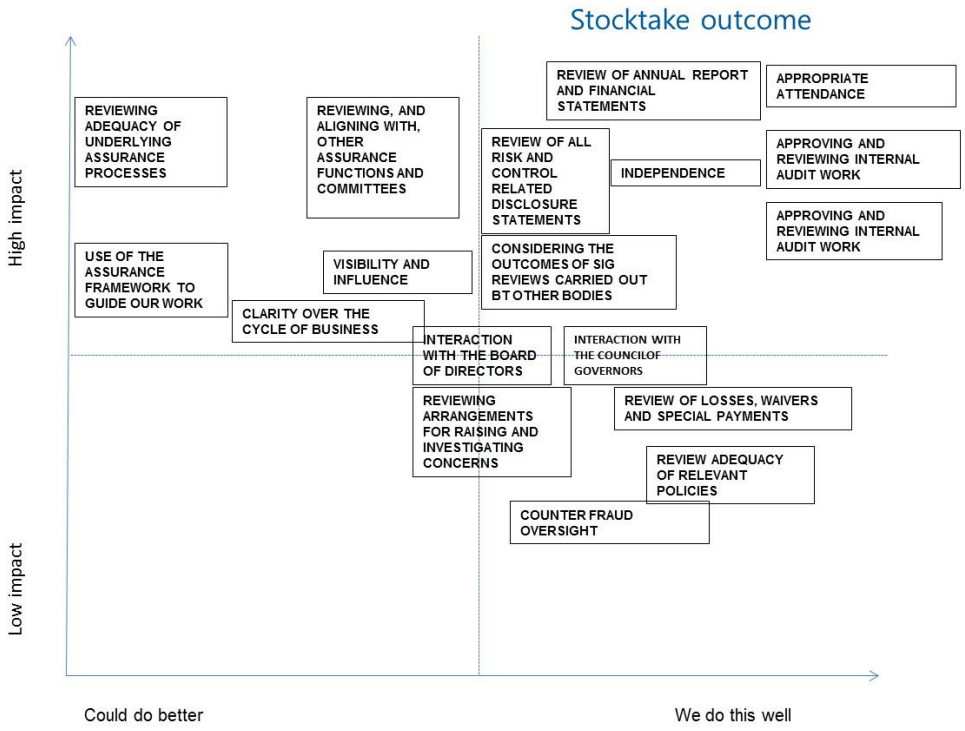
As the Committee reviews and updates its workplan, this exercise should be used to provide greater clarity as to their duties. In turn this should provide further opportunity for reflection to maintain the momentum of the continued evolution and embedding of the Committee's role and remit.

Appendix A – Audit Committee Development Plan

Actions	Responsibility
A1. Workplan: To reflect periodically that the Committee is ensuring a review of integrated governance is being achieved. This will ensure clarity of purpose.	Audit Committee
A2. Coordination of Committees: Allow for more formalised review of the work of other Committees. Ie. Keeping more of a formal record of when issues have been passed over	Audit Committee / Director of Corporate Affairs
A3. Board Assurance Framework: To record in the BAF improvements that have been made as a result of interaction with other committees	Audit Committee / Director of Corporate Affairs
A4. Other Assurance Functions: To consider how the work of other assurance functions is considered/reviewed by the Committee.	Audit Committee

Appendix B: Comparison to previous Workshop (Jan 2013)

A similar stocktake exercise was undertaken in January 2013, the findings of which are detailed below.



When compared to the current exercise it is evident that a number of areas identified as 'could do better' have now moved into the 'we do this well' category for example, use of the Assurance Framework, cycle of business, interaction with the Board and influence. Links with other committees and other assurance functions have been identified as areas for development from the recent assessment with actions noted under Appendix A above.

Facilitated Session Participants

Name	Title
Cathy Bond	Non-Executive Director (Committee Chair)
Graham Hollick	Non-Executive Director
John Sullivan	Non-Executive Director
David Jago	Director of Finance
Gemma Herbertson	Corporate Governance Manager

MIAA Key Contacts

Name:	Tim Crowley
Title:	Managing Director, MIAA
Telephone:	0151 285 4500
Email:	Tim.crowley@miaa.nhs.uk

Name:	Adrian Poll
Title:	Senior Audit Manager, MIAA
Telephone:	0151 285 4521
Email:	Adrian.poll@miaa.nhs.uk

Board of Directors	
Agenda Item	8.2
Title of Report	Financial Accounts and Letter of Representation 2016/17
Date of Meeting	24 May 2017
Author	Deborah Harman Assistant Director of Finance – Financial Services
Accountable Executive	David Jago Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	8. Strategic Objective – Enabled by financial, commercial and operational excellence
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Approval
Data Quality Rating	Gold – externally validated data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

1. Executive summary

The Trust is required under the National Health Service Act 2006 to prepare annual accounts. These accounts must comply with HM Treasury-approved directions issued by NHS Improvement, in exercising statutory functions conferred on Monitor. In particular, the accounts must comply with the Department of Health Group Accounting Manual (DH GAM).

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

The purpose of this paper is to present the 2016/17 letter of representation and annual accounts to the Trust Board for approval.

2. Letter of representation

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

3. Annual accounts

Draft annual accounts and foundation trust consolidation (FTC) schedules were submitted to NHS Improvement on 26 April 2017. Copies were provided to the Trust's external auditor, Grant Thornton UK LLP.

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

The draft accounts are to be circulated to members separately.

4. 2016/17 accounts headlines

The Director of Finance will present key messages from the Trust's annual accounts. Headline financial metrics for 2016/17 are noted below.

	£m
Deficit	(11.9)
Income	324.9
Expenditure	(336.7)
Cash	5.4
Borrowings	17.5
Capital expenditure	6.9

5. Conclusion

The draft annual accounts have been prepared in accordance with IFRSs and sector-specific accounting guidance. Grant Thornton UK LLP is currently in the process of completing audit processes. A final ISA 260 report of the auditor's summary findings will be presented to this meeting of the Board of Directors.

The Audit Committee meeting of 24 May 2017 is expected to recommend to the Board of Directors the approval of the letter of representation and the accounts.

The final accounts will be submitted to NHS Improvement on or before 31 May 2017, presented within the Trust's Annual Report and Accounts 2016/17.

6. Recommendation

The Trust's Board of Directors is asked to accept and approve the 2016/17 letter of representation and annual accounts.

Deborah Harman
Assistant Director of Finance – Financial Services

May 2017

Grant Thornton UK LLP
4 Hardman Square
Spinningfields
Manchester
M3 3EB

24 May 2017

Dear Sirs

Wirral University Teaching Hospital NHS Foundation Trust

Financial Statements for the year ended 31 March 2017

This representation letter is provided in connection with the audit of the financial statements of Wirral University Teaching Hospital NHS Foundation Trust for the year ended 31 March 2017 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view in accordance with International Financial Reporting Standards and the accounting policies detailed in the NHS Foundation Trust Annual Reporting Manual (the ARM) issued by NHS England.

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

Financial Statements

i As Trust Board members, we have fulfilled our responsibilities under the National Health Services Act 2006 for the preparation of the financial statements in accordance with the ARM, the Department of Health Group Accounting Manual 2016-17 (GAM) and International Financial Reporting Standards which give a true and fair view in accordance therewith.

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

iii The Trust has complied with all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance. There has been no non-compliance with requirements of the Care Quality Commission or other regulatory authorities that could have a material effect on the financial statements in the event of non-compliance.

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

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

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

vii Except as disclosed in the financial statements:

a there are no unrecorded liabilities, actual or contingent;

b none of the assets of the Trust has been assigned, pledged or mortgaged; and

c there are no material prior year charges or credits, nor exceptional or non-recurring items requiring separate disclosure.

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

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

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

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

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

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

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

Information Provided

xv We have provided you with:

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

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

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

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

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

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

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

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

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

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

Annual Report

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

Annual Governance Statement

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

Approval

The approval of this letter of representation was minuted by the Trust's Board at its meeting on 24 May 2017.

Yours faithfully

Name……

Position……

Date……

Name……

Position……

Date……

Signed on behalf of the Board

Board of Directors	
Agenda Item	8.2
Title of Report	Quality Account Annual Report
Date of Meeting	24.5.17
Author	Joe Roberts, Head of Assurance
Accountable Executive	Mrs Gaynor Westray, Director of Nursing and Midwifery Dr Susan Gilby, Medical Director
BAF Reference	Risk 2 - Patient Experience: The challenging NHS environment impacts on patient satisfaction impacting on clinical outcomes & public confidence
Level of Assurance	Full
Purpose of the Paper	For discussion
Data Quality Rating	Mixture of gold, silver and bronze data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken	Not required

1. Executive Summary

The final draft of the Quality Account for 2016/17 has been circulated separately to members. Earlier drafts were reviewed by the Clinical Governance Group at their meetings in March and April, by the Quality and Safety Committee on 10th May, and by the Audit Committee on 19th May. The draft report was also presented to Wirral Borough Council's Health and Care Performance Panel on 16th May.

2. Background

Since the Health and Social Care Act 2009, every Trust has been required to produce a Quality Account which describes the performance of its clinical services during the previous financial year. The annual report of the Quality Account should measure performance against both mandatory national targets, and local targets which each organisation has set for itself because they are important from the point of view of patient experience, patient

safety or clinical effectiveness. The format and content of the report is prescribed by national regulations although there is limited flexibility to amend it.

Some changes have been made to the report since the draft that was presented to the Audit Committee. The principal changes were to update section 3.2.2 and appendix 2 (clinical audit) with some information that only became available very late in the production process for the report; and to include in the appendices the written feedback received from our external statutory consultees, which is copied verbatim. The only other changes were very minor changes to phrasing or presentation, and were made in the interests of clarity or in response to feedback from readers.

3. Key Issues

Performance against our targets: We have made progress with our six self-selected priority topics during the year, although the targets have not been achieved in full. Five of the priority topics have been carried forward into the new financial year; readmissions has been discontinued.

Some of the specific targets for the five priorities have changed since last year. The intention behind the change is that they should be reliably measurable. During the year some aspects of our targets proved difficult to measure in practice, such as 'right patient right bed' for the Patient Flow priority, or the percentage of patients receiving assistance with eating and drinking, for which we are reliant on a questionnaire which has a low response rate. For nutrition and hydration, the Quality Account will focus on MUST nutritional screening, and involvement by dieticians, in the year ahead.

External Audit: Grant Thornton LLP, External Auditors, have audited the Quality Account alongside their audit of the Trust's financial accounts. They focused on three performance indicators within the report. Two of these were national targets – the four-hour target for Accident and Emergency, and 18 weeks referral to treatment (incomplete pathways) and one was a local performance indicator – the percentage of deaths at the Trust that were reviewed under the 2016 Mortality Review Framework.

The auditors issued a qualified audit opinion for the following reasons:

Having tested the mandated indicator for incomplete pathways for 2016/17 included in the Quality Report this is qualified, as six errors were identified in relation to the clock start and end times from the cases tested. However, we are pleased to note that, although this indicator was also qualified in 2015/16, there is clear evidence that the Trust has acted upon recommendations made last year to improve data quality.

Our testing of the mandated indicator for A&E 4 hour wait for 2016/17 (Arrowe Park Hospital A&E patients only) found no evidence that this indicator was not

reasonably stated in all material respects in accordance with relevant guidelines on calculation. The indicator was qualified in 2015/16.

Our testing of the indicator selected by governors for 'percentage of deaths at the Trust that were reviewed under the 2016 Mortality Review Framework' for the calendar year 2016 found no evidence that this indicator was not reasonably stated in all material respects in accordance with relevant guidelines on calculation. In line with NHS Improvement's Guidance, we do not express any assurance in respect of this indicator.

Core Indicator Data: Some of the data in section 2.4.5 (Core Indicators) is up to a year old; this has also been the case in previous years. The data is provided by NHS Digital and is the most recent that was available on their portal on 18th May. No further updates are scheduled by NHS Digital prior to the deadline for publication of Quality Accounts.

Summary Report: It is recognised that the annual Quality Account can appear lengthy and cumbersome because of the mandatory content – this is stipulated by the regulations, but which is not always understandable by, or of interest to, the lay reader. Therefore, for the first time we have followed the example of several other Trusts by also producing a more user-friendly summary version; this was reviewed at the last two meetings of CGG and will be made available on our website alongside the full document.

4. Next Steps

Final approval of report: following approval by the Board, the Quality Account will be signed by the Chairman and Chief Executive, and made available on our website and on NHS Choices.

5. Conclusion

The Quality Account describes an extremely busy and challenging, but productive year at Wirral University Teaching Hospitals.

6. Recommendation

The group is asked to discuss and approve the report so that it can be published.

Audit Committee	
Agenda Item	8.2
Title of Report	Draft Annual Report including Annual Governance Statement
Date of Meeting	24 May 2017
Author	Carole Self, Director of Corporate Affairs
Accountable Executive	Carole Self, Director of Corporate Affairs
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	All
Level of Assurance • **Positive** • **Gap(s)**	Full
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Recommendation to the Board
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

1. Executive Summary

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

The Audit Committee reviewed the draft Annual Report including Annual Governance Statement at its meeting on the 19th May 2017 and specific feedback regarding the recommendation will be provided via the Chair of Audit Committee report.

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

2. Next Steps

The final text for the Annual Report along with the Annual Accounts will be submitted to NHS Improvement on the 31st May 2017 before noon.

The period between the 31st May 2017 and submission to Parliament is to allow Trusts time to format the document to the standards required for publication.

The final Annual Report and Accounts must be sent to the Parliamentary Clerk at the Department of Health by the 26th June 2017 for laying before Parliament.

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

3. Recommendations

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

Board of Directors	
Agenda Item	8.3
Title of Report	NHS Provider Licence – Board declaration
Date of Meeting	24th May 2017
Author	Carole Ann Self, Director of Corporate Affairs
Accountable Executive	David Allison, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	ALL
Level of Assurance • **Positive** • **Gap(s)**	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

NHS Foundation Trusts are required to self-certify whether or not they have complied with the conditions of the NHS Provider licence, have the required resources available if providing commissioner requested services, and have complied with governance requirements.

As a Trust we need to self-certify the following as soon as possible after the financial year end:

- That as a Provider we have taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (**Condition G6 (3))**
- That as a Provider we have complied with required governance arrangements (**Condition FT4 (8)**)
- If providing commissioner requested services, that we as a Provider have a reasonable expectation that required resources will be available to deliver the designated service (**Condition CoS7(3))**

Although not a licence condition, Providers are expected to certify that it has provided the necessary training to its Governors, as required in s151(5) of the Health and Safety Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

It is up to each NHS Foundation Trust how it carries out the processes of determining compliance however any process should ensure that the Board understands clearly whether or not it can confirm compliance.

The Board must sign off the self-certifications no later than:

a. G6/CoS7 – 31ST May 2017
b. FT4 – 30th June 2017

For the year 2015/16, the Board decided to declare "Not confirmed" for G6 as a result of non-compliance with A & E 4 hour access standard; the RTT standard and the target for avoidable C difficile rates. The Audit Committee has reviewed on a quarterly basis compliance against this licence condition and although improvements have been made to C difficile, it is currently RAG rating compliance at RED although there is recognition for the work being undertaken to improve both A & E and RTT compliance. The template for this declaration is attached at **Appendix 1.**

For the year 2015/16, the Board decided to declare "Confirmed" with CoS7 against statement 3a. The recommendation is the same this year although the Director of Finance will update the Board on the discussions with the Audit Committee on 19th May 2017 in this regard which may inform the declaration further. The template for the declaration is included in **Appendix 1**.

For the year 2015/16, the Board decided to declare "Confirmed" for all sections of the FT4 licence condition with the exception of sections 4 and 5. As previously requested by Board Members, the table at **Appendix 2** provides evidence to support each declaration and includes areas for consideration by the Board ahead of the formal approval. The Audit Committee also reviews quarterly compliance against FT(4) which is currently RAG rated as AMBER as this reflects many aspects of compliance but notes the concern in particular areas as highlighted in the table. The template for FT4 declaration is attached at **Appendix 3**.

The recommendation to declare "Not Confirmed" for section 4 and 5 in summary is in recognition of the work the Trust is undertaking on the safety culture in the organisation and the "requires improvement" rating for CQC; the work that is being undertaken to improve management information and data quality and the outcomes of the Well Led Governance review.

The template for the certification in relation to Training for Governors is attached at **Appendix 4.**

Unlike in previous years, the Trust is not required to submit a return or information to NHSI in regards to these declarations. The templates provided by NHSI are for the Trust to use as they choose to.

From July 2017, NHSI will contact a select number of NHS Trusts and Foundation Trusts to ask for evidence that they have self-certified. This will be either through providing the templates if we have used them, or by providing relevant Board minutes and associated papers recording sign off**.**

2. Recommendation

The Board of Directors is asked to:

- Review each statement and the supporting evidence
- Consider whether the recommended declarations reflect the views of the Board and if so, formally approve these.

Worksheet "G6 & CoS7"

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

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

1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Not confirmed	Please complete the explanatory information in cell E36

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this	Confirmed	Please fill details in cell E22

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		Please Respond

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

To be agreedat Board Meeting

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

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

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

A NHSI and CQC are aware of non-compliance with the 4 hour A & E standard and RTT compliance and are supportive of the actions being taken by the Trust with regards to the cleansing of the waiting list, the training and data quality processes. The Trust saw improvement in the data quality processes for A & E in 2016/17 which resulted in an unqualified opinion from the Auditors however further work is still required to support an unqualified opinion for RTT. NHSI are fully supportive of the work the Trust is undertaking with partners to improve out of hospital care provision which in turn will improve patient flow in the hospital.

Compliance and Evidence Review for the "FT4" declaration – May 17

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	
Recommendation: Confirmed	
Board Reports	▪ Annual Governance Statement highlights improved systems and processes implemented (May 2017) ▪ Chair of Audit Committee Reports ▪ Board Assurance Framework revised and reviewed by Board – (October 2016) ▪ Board determines area of focus for sub-committees
Sub Board Evidence	▪ Review of Board Assurance Framework (BAF) at every Quality and Safety and Finance Business Performance & Assurance Committee meeting ▪ BAF training at Divisional and Corporate Services Level – BAF guidance embedded ▪ Committee agendas aligned to gaps in assurance/issues in the BAF ▪ Audit Committee review of BAF methodology review and impact at every meeting
Independence Assurance	▪ Internal Audit Reports – all "significant assurance" in 2015/16 with the exception of 3 reports, all of which were rapidly re-visited to ensure that all the high level recommendations were implemented ▪ Head of Internal Audit Opinion – "Significant Assurance" ▪ Well led Governance Review (September 16)
2. The Board has regard to such guidance on good corporate governance as may be issued by NHSI from time to time	
Recommendation: Confirmed	
Board Reports	▪ Monitor Code of Governance (referenced in the Annual Report May 17) ▪ Chair of Audit Committee Report to the Board
Sub Board Evidence	▪ Trust response to 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 ▪ Legal update incorporates changes to governance framework from NHSI – single oversight framework Oct 16 and NHS Standards of business conduct changes due June 17

3. The Board is satisfied that the Wirral University Teaching Hospital NHS Foundation Trust has established and implements: **a. Effective Board and Committee Structures** **b. Clear responsibilities for the Board, for Committees reporting to the Board and for staff reporting to the Board and those Committees** **c. Clear reporting lines and accountabilities throughout the organisation**	
Recommendation: Confirmed	
Board Reports	▪ Assurance Committee Chairs reports to Board ▪ Assurance Committee Terms of Reference reviewed and approved by Board ▪ Outcome of Review of Committee Effectiveness Reports to Board ▪ Governance, Assurance and Performance Structure reviewed and updated by the Board ▪ Review and approval of standing orders, standing financial instructions, scheme of reservation and delegation and constitution undertaken in March 2017
Sub Board Evidence	▪ All Assurance Committees undertake a review of effectiveness against Terms of Reference. ▪ Senior management and Board members statutory roles and responsibilities Matrix
Independence Assurance	Well Led Governance Review – Sept 16 ▪ *Criterion 3A – Are there clear roles and accountability in relation to Board and quality governance? – Amber/Green assessment* ▪ *Criterion 3B – Are there clearly defined processes for escalating and resolving issues and managing performance? – Amber/Green Assessment*
4a. The Board is satisfied that Wirral University Teaching Hospital NHS Foundation 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 healthcare 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 Condition 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** **h. To ensure compliance with all applicable legal requirements**	
Recommendation: **Not Confirmed**	
Board Reports	▪ Operational Plan submission ▪ Monthly Finance Reports to Board of Directors ▪ Quarterly/monthly compliance submissions to NHS Improvement ▪ Annual Report and Accounts ▪ Annual Governance Statement highlights improved systems and processes implemented (May 2017) ▪ Board Assurance Framework revised and reviewed by Board – (October 2016) ▪ Monthly Integrated performance reports / dashboards/exception reporting ▪ Assurance Committee Chairs Reports to the Board ▪ Agency spend was £7.1M for 2016/17 which was c £1.0M lower than the required ceiling ▪ Initial Hospital Pharmacy Transformation Plan was rated as Green and commended as an exemplar by NHSI in late 2016 ▪ Delivery of Cost Improvement Programme in 2016/17 ▪ Nurse vacancy rates consistently below national levels in 2016/17 as a result of a wide range of initiatives to recruit, retain and develop roles fit for the future workforce ▪ Quality Report – May 17 ▪ Formal review of all Business Cases above £250K by the Board ▪ CQC compliance reports
Sub Board Evidence	▪ Finance, Business Performance and Assurance Committee review of quarterly returns ▪ Report from the Finance Business Performance and Assurance Committee and Audit Committee on the "going concern assessment" ▪ Monthly and Quarterly Divisional Performance Reviews ▪ Quarterly licence review at Audit Committee ▪ Procurement Strategy and the Lord Carter Work ▪ Legal report to the Audit Committee ▪ CQC "deep dives"/ Care Quality inspections/ward accreditations ▪ Introduction of safety summits

	▪ Improvements in Maternity Care, End of Life Care and Critical Care
Independence Assurance	▪ Head of Internal Audit Opinion – "significant assurance" ▪ Unqualified opinion on Value for Money assessment ▪ Unqualified opinion on financial statements ▪ Reference cost return for 2015/16 submitted in July 16 showed a reference cost index of 94 which indicates that the Trust costs are 6% 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 resulting in a positive amendment to the control total for 2017/18 ▪ Internal Audit Reports – all "significant assurance" in 2015/16 with the exception of 3 reports, all of which were rapidly re-visited to ensure that all the high level recommendations were implemented ▪ Access to working capital and contract for services going forward ▪ Unqualified External Audit Opinion on the Annual accounts 2016/17 ▪ Internal Audit Reports on financial systems and processes – All "significant assurance" ▪
Considerations	▪ Qualified Opinion on RTT data as part of limited assurance review of Quality Account although improvements noted as part of well documented cleansing programme ▪ The Trust is in the process of developing a new integrated quality dashboard to aid decision making ▪ Financial and Governance Breach and additional licence condition section 111 ▪ Never Events ▪ Organisational focus on the safety culture **Well Led Governance Review** ▪ *Criterion 4B – Is the Board assured of the robustness of the information? Amber/Red assessment*
5a. The Board is satisfied that the systems and/or processes referred to in section 4 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 Licensee, 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** **f. That there is clear accountability for care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate**	
Recommendation: Not Confirmed	
Board Reports	▪ Refreshed Executive Team in 2016/17 ▪ Significant investment in the Service Transformation Team enabled the delivery of the CIP programme in 2016/17 ▪ Approved risk appetite matrix in April 2017 ▪ Good clinical outcomes reported ▪ Patient feedback- nationally very high ▪ Low vacancy rates in medical and nursing posts compared to national rates ▪ C difficile rates – significant improvement in 2016/17 achieving national recognition ▪ Monthly integrated performance dashboards
Sub Board Evidence	▪ Coaching in place for all Executive Team Members ▪ Executive Members involvement in national leadership programmes ▪ Improved Quality Impact Assessment process introduced for all cost improvement programme schemes and post evaluation review
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. ▪ Current review by NHSI of the Trust's application to remove the additional licence condition section 111 ▪ Unqualified Opinion on A & E data as part of limited assurance review of Quality Account ▪ NHS staff survey 2016 – maintained position from 2015 and improved in many areas ▪ National recognition for the Staff Guardian Scheme **Well Led Governance Review** ▪ *Criterion 1A – Does the Board have a credible strategy and robust plan to deliver? – Amber/Green assessment*

	▪ *Criterion 2A – Does the Board have the skills and capability to lead the organisation? – Amber/Green assessment* ▪ *Criterion 2B – Does the Board shape an open, transparent and quality focused culture? Amber/Green assessment* ▪ *Criterion 2C – Does the Board support continuous learning and development across the organisation? – Amber/Green assessment* ▪ *Criterion 3C – Are stakeholders actively engaged on quality, financial and operational performance? – Amber/Green assessment* ▪ *Criterion 4A – Is appropriate information on organisational and operational performance being analysed and challenged? – Amber/Green assessment*
Considerations	▪ Qualified Opinion on RTT data as part of limited assurance review of Quality Account ▪ Recently commissioned quality governance review to focus on governance below Assurance Committee level to ensure that accountability and responsibility is undertaken in the right place ▪ The Trust is in the process of developing a new integrated quality dashboard to aid decision making ▪ Never Events in Theatres and Opthalmology ▪ Need to procure new risk management system although mitigating actions put in place to effectively manage risk **Well Led Governance Review** ▪ *Criterion 1B – Is the Board aware of potential risks to the quality, sustainability and delivery of services? – Amber/Red assessment* ▪ *Criterion 4B – Is the Board assured of the robustness of the information? Amber/Red assessment*
6. The Board is satisfied that there are systems to ensure that the Licensee 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	
Recommendation: **Confirmed**	
Board Reports	▪ Refreshed Executive Team in 2016/17 ▪ Significant investment in the Service Transformation Team enabled the delivery of the CIP programme in 2016/17 ▪ Low vacancy rates in medical and nursing posts compared to national rates

	▪
Sub Board Evidence	▪ Coaching in place for all Executive Team Members ▪ Executive Members involvement in national leadership programmes ▪ Education and Leadership Programme for all levels within the Trust
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. ▪ Current review by NHSI of the Trust's application to remove the additional licence condition section 111 ▪ NHS staff survey 2016 – maintained position from 2015 and improved in many areas **Well Led Governance Review** ▪ *Criterion 2A – Does the Board have the skills and capability to lead the organisation? – Amber/Green assessment* ▪ *Criterion 2C – Does the Board support continuous learning and development across the organisation? – Amber/Green assessment*

Corporate Governance Statement (FTs and NHS trusts)

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

1	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee 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	[including where the Board is able to respond 'Confirmed']	Please complete Risks and Mitigating actions
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	[including where the Board is able to respond 'Confirmed']	Please complete Risks and Mitigating actions
3	The Board is satisfied that the Licensee has established and 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	[including where the Board is able to respond 'Confirmed']	Please complete Risks and Mitigating actions
4	The Board is satisfied that the Licensee has established and 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	Not confirmed	The Trust is compliant with many aspects of this section however in view of the qualified opinion on RTT data although it is acknowledged that as a result of the data cleansing programme that improvements have been made and because of the work the Trust has identified and is progressing at pace on its safety culture, the Trust has decided to declare Not Confirmed.	Please complete both Risks and Migitating actions & Explanatory Information
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 Licensee, 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 Licensee 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 many aspects of this section however in view of the Trust's own self-assessment of its data quality which was supported through the Well Led Govemance Review and the work being undertaken on the integrated quality dashboard, the Board as decided to declare Not Confirmed.	Please complete both Risks and Migitating actions & Explanatory Information
6	The Board is satisfied that there are systems to ensure that the Licensee 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	[including where the Board is able to respond 'Confirmed']	Please complete Risks and Mitigating actions

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____ **Signature** _____

Name [ ] **Name** [ ]

Further explanatory information should be provided below where the Board has been unable to confirm declarations under

A [ ]

Worksheet "Training of governors"

Certification on training of governors (FTs only)

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

2 Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee 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	OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

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

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF PUBLIC MEETING

26 APRIL 2017

BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL

Present

Michael Carr	Chairman
David Allison	Chief Executive
Cathy Bond	Non-Executive Director
Susan Gilby	Medical Director
Andrea Hodgson	Non-Executive Director
Janelle Holmes	Chief Operating Officer
David Jago	Director of Finance
Cathy Maddaford	Non-Executive 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
Jayne Kearley	Member of the Public
Alan Sharples	Member of the Public
Gemma Herbertson	Corporate Governance Manager
Steve Evans	Public Governor

Apologies

Graham Hollick	Non-Executive Director

*denotes attendance for part of the meeting

Reference	Minute	Action
BM 17-18/001	**Apologies for Absence** Noted as above	
BM 17-18/002	**Declarations of Interest** None	
BM 17-18/003	**Chairman's Business** The Chairman advised the Board of the following recent consultant appointment: • Dr Raghavan – Consultant Paediatrician	
BM 17-18/004	**Chief Executive's Report** The Chief Executive presented the report and highlighted the following areas for discussion: **New Director of Strategy** – the Chief Executive was pleased to announce that Mr Terry Whalley would join the Trust on the 1st June 2017. **Divisional Resilience Plans** – the Chief Executive outlined the key changes to the leadership in the Division of Surgery Womens and Children in order to support operational demand and strategic decision making.	

Reference	Minute	Action
	HSJ Modernising Healthcare Summit – the Board was advised that the Summit was hosted in conjunction with NHS Providers and that the key focus was on the next steps of the 5 Year Forward View; improving A & E performance; financial sustainability; improving mental health and primary care and the importance of the Sustainability and Transformation Plans nationally. **Care Quality Commission** – the Board agreed to discuss this as part of the planned agenda item. **Accountable Care** – the Chief Executive updated the Board on the 2 workshops held on this subject with Deloittes. **Sustainability and Transformation Plans** – the Board was updated on the 4 workstreams associated with reducing demand; maximising back office synergies; high quality hospital care and working differently. The Board was pleased to note that the Chief Executive and Medical Director were leading on the clinical variation and digital work under the high quality hospital care worksteam. The Board was pleased at the Trust's involvement at an STP level but sought to understand the outcomes and measures of success for this work. The Chief Executive agreed that it was only now that recommendations and focus on the establishment of key topics was being drawn out. The Medical Director confirmed that some programmes were much more developed than others citing sepsis and hip and knee as examples that could demonstrate a financial impact in this year if all Trusts mobilised best practice evidence. The Board sought and received assurance that the Executive had sufficient capacity and support to progress this agenda. **HPMA 'HR Team of the Year'** – the Board was pleased to note that the Trust had been shortlisted in this category and awaited the outcome on the 22nd June 2017. The Board was updated on the current picture with regards to Norovirus which had impacted significantly on patient flow and the ability of the Trust to manage its infection prevention and control agenda in line with agreed plans. The Trust reported an improving position.	
BM 17-18/005	**Patient Story/Learning** The Director of Nursing and Midwifery highlighted a complaint involving a 73 year old gentleman who having attended the Emergency Department in November 2016 with pneumonia and multiple co-morbidities passed away on the 1st December 2016 on a general ward. The complaint raised the issue of date of death and timeliness of death verification as this gentleman's death was incorrectly recorded as 2nd December as verification took place after 12.00 pm. This error inevitably caused the family huge distress as they had already informed family and friends. The Board was advised that the wife and the daughter of the gentleman had been invited in to understand the delays that can occur with verification and the action put in place to ensure this did not happen again. The actions to resolve this issue included changes to Junior Doctor induction to raise the importance and priority associated with verification and that Senior Nurses could now verify expected deaths as part of their portfolio. The Board was advised that the family was pleased with the changes and requested that their complaint and the subsequent actions taken be raised with the Board.	

Reference	Minute	Action
BM 17-18/006	**CQC Compliance and Action Plan Progress Paper** The Medical Director presented the progress paper and advised the Board of the changes to the CQC registration to reflect that the quality and safety agenda had transferred from the Director of Nursing and Midwifery to herself. She confirmed however that this work would in reality be undertaken jointly by herself and the Director of Nursing and Midwifery. The Board was advised of the progress made in the CQC action plans following the last inspection although the impact of the actions undertaken was currently being assessed. Two key areas in the action plan which was receiving additional attention were in relation to safeguarding training and capacity in radiology. The Medical Director advised that the baseline assessment for safeguarding training was quite low so she had recommended an increase in training undertaken and its availability particularly in the Emergency Department and in Paediatrics to ensure patients received the benefits of this. The radiology capacity issue was reported as ongoing although there was some good news in relation to consultant retention and recruitment which would ease the situation. The Medical Director confirmed that she was working with the Radiology team to ensure that these jobs were as attractive as possible. The Board was updated on the developments to improve medicines safety with the introduction of a new integrated medicines management dashboard which would enable the Trust to consider the other elements that impact on patient safety including agency usage rates and incident trend analysis. The Medical Director confirmed that this was due to be reviewed at the Quality and Safety Committee in May 2017. The Medical Director advised the Board that the Care Quality Internal Inspection (CQI) process had evidenced progress in many areas with the key focus on the “safe” element. She confirmed that the introduction of Safety Summits and Safety “Bites” had been announced at the recent CEO forum and would be in place over the next few weeks. The Director of Nursing and Midwifery explained how the Ward Accreditation programme supported the CQI programme and informed the priority areas for review. The Director of Nursing and Midwifery also advised of the re-introduction of the “little gems” communication programme and that Deprivation of Liberty and the Mental Capacity Act training was now a mandatory requirement. The Board sought to understand how non-compliance with the 4 hour A & E standard and Referral to Treatment RTT standard would be viewed by the CQC. The Medical Director advised that the CQC would expect, as we would as a Trust, that everything possible was being done to ensure that patients were not coming to harm despite having to wait. Regular monitoring in the Emergency Department was being undertaken to ensure this is the case including the essentials such as regular hydration and MEWS scoring. The introduction of harm reviews as part of the RTT process as previously discussed would ensure that although patients might wait longer than 18 weeks in some cases again they would not suffer harm as a result of this.	

Reference	Minute	Action
	The Board agreed that the focus should be on all the fundamental standards of care however agreed that safety was paramount. The Board concurred with the view that CQC compliance was not about inspection preparation but about business as usual. The Board sought to understand what the issues were in relation to medicines safety and was advised that this related to missed doses and medicine storage which was now much more visible in the integrated dashboard and would therefore enable the Trust to take targeted action to improve this. The Board was pleased with the overall assessment of compliance but sought to understand how this demonstrated progress and what therefore was the trajectory to achieving "good". This was considered essential if the Board was to determine whether the action being taken was enough. The Board sought and received assurance that clinical handovers were now electronic in the Emergency Department and the Assessment Units with a view to rolling this out to the base wards shortly. The Director of Nursing and Midwifery advised that this would ensure that both the referrer and the receiver of patients were both obligated to provide sufficient information including details of any incidents to ensure the safe transfer and care of patients. The Director of Nursing and Midwifery confirmed that electronic handover for Medical Staff was part of the next programme of work in this area. It was suggested that there were many good examples in other organisations as to how Trust's had prepared staff for inspections so that they had the opportunity to showcase what they were good at and how they had identified their key risks.	**SG**
BM 17-18/007	**Integrated Performance Report** • **Integrated Dashboard and Exception Reports** The Chief Operating Officer presented the integrated performance dashboard highlighting in particular the following areas: **A & E 4 Hour Access Standard** – the Board was advised that current performance was at 82% which although an improvement was still significantly below the required target. The norovirus outbreak was reported as impacting on patient flow and therefore performance in the Emergency Department (ED). Key initiatives to improve compliance were confirmed as: • **Streaming from ED** – the Chief Operating Officer advised that the pilot had been run over 3 days with feedback due 2nd May. She confirmed that the CCG were looking at ways it could implement this fully by September as part of the National Directive. • **Ambulance Arrivals** – the Board was advised of the pilot undertaken to ascertain whether a primary nurse triage of ambulance arrivals in the hub would enable safe and effective streaming of ambulance presentations. The objective of the pilot was to reduce the ambulance handover delay and if appropriate stream patients from	

Reference	Minute	Action
	the ED to either the Walk in Centre or into the Department's own minor's workflow. Early results showed clear benefits so the Trust was looking to incorporate the model into business as usual from May 17. The Board sought to establish whether the 18% of ambulance deflected from Majors as a result of this pilot demonstrated that further training was required in the Directory of Service ie 111. The Chief Operating Officer reported that the issue was the alternatives to ambulance transfer which were hampered due to the varying opening times offered under the Directory of Services which was at best confusing. She reported that even if a paramedic deemed that a patient did not need to be conveyed to ED, quite often patients still self-presented. The Chief Executive outlined the work being proposed to involve clinicians more in the 111 service as this had been traditionally risk adverse and was therefore exacerbating attendances at A & E. • **Social Care Funding** – the Board was advised of the work being undertaken to ensure that additional funding for social care through the Better Care Fund was being reviewed in its totality to ensure its effectiveness. This included a review of all new initiatives going forward. The Board was pleased with the increased dialogue across the health economy however sought assurance as to how the capacity in the whole of the Health and Social Care Economy was progressing. The Chief Operating Officer provided an update on the work being undertaken on bed modelling outside of the hospital to support the work undertaken inside the hospital noting that this had not been undertaken anywhere else nationally and was therefore innovative and would take 22 weeks to complete effectively. The Board was assured that work would still progress during this time to ensure that medically optimised patients were supported to move into the most appropriate setting. **18 Week Referral to Treatment Times RTT –** the Chief Operating Officer updated the Board on this ongoing work in conjunction with External Advisors. She also advised upon the review of governance arrangements and the establishment of the Improvement Board which would be in place next month. **Diagnostic Six Week Wait** – No issues with performance reported **Cancer** – No issues with performance reported **Infection Control** – the Board was advised of the risk that Norovirus posed to compliance with the management and prevention of C difficile. **M12 Finance and Cost Improvement Programme Report** The Director of Finance presented the M12 finance and cost improvement report and highlighted the following areas: Normalised deficit for the end of year was reported at £10.4M and although below plan the adverse variance was well understood by NHSI as reported in September 16 as:	

Reference	Minute	Action
	➢ Non achievement of STF targets £3M ➢ Non delivery of the health economy challenge £5M ➢ Continued operational pressures Cost Improvement Plan (CIP) was reported as £11.2M delivered as per the plan, £3M of which was non-recurrent Cash was reported as £5.4M and while this was below the initial plan it was higher than forecast as a result of the Trust agreeing with regulators and the Department of Health to retain the delayed STF Q3 payment. The Board recognised that the cash balance was also the result of the cash preservation initiatives undertaken by the Trust. The Board sought to establish how the Trust would manage the difficult cash position going forward. The Director of Finance confirmed that the 13 week rolling cash programme would receive much more focus at the Finance Business Performance and Assurance Committee; the accessibility of draw down cash facilities; the anticipated GDE funding of £4M and the review of trade creditors from 35 – 43 days was being explored for larger organisations. Clinical Income was reported as £5.6M below plan. Issues with below plan performance were in part attributed to the activity levels in Trauma and Orthopaedics; Colorectal and Ophthalmology. The Trust was also seeking to establish a "top up" payment with NHSE for Intestinal Failure to support the costs associated with this complex area. Births were also reported as below those planned for which may be associated with the Womens and Childrens review being undertaken at a Cheshire and Merseyside level. The Board sought to establish whether changes to activity reporting was anticipated given the importance of achievement. The Director of Finance advised that activity was measured on a daily basis and subject to a weekly challenge. Plans were in place to review the performance dashboard and subject to the review of case mix performance in Surgery to date looked strong. The Chief Operating Officer reported over-performance on activity in Medicine and Acute also. The underlying deficit was reported at £22.9M, this reflected the non-recurrent savings of £3M and the income gains of £5.2M associated with the contractual position. Use of Resources was reported at 3 which was below the plan at 2 although the drivers for this were well understood by Board members. The Board also understood that if it were not for the strong performance against agency spend that this would move to a 4. Liquidity metrics were reported as better than plan. The increased working capital facility going into 2017/18 provided the Trust with greater cash resilience going forward. The Director of Finance advised that NHSI colleagues had advised that this facility would now be classed as non-recurrent until 2021 which would help with liquidity also. The Chair of Finance Business Performance and Assurance Committee agreed that the year-end out-turn was a real achievement given all the operational pressures and the CIP challenge and the Committee therefore recognised the work that had to be undertaken to deliver this. She advised	

Reference	Minute	Action
	that the new Payment By Results PBR contract for 2017/18 would be closely monitored by the Committee particularly given the key risks to activity in the Division of Surgery Womens and Children. The Board was advised that the review at the Committee of the demand and capacity and bed modelling work was encouraging and the work undertaken to remain below the agency cap was an excellent achievement although it was acknowledged that there was more work to do. The Director of Finance advised that the non-core medical locum and bank spend was the focus of attention for NHSI were challenging targets to achieve in this area in 2017/18. The Chair of Audit Committee reiterated the comments with regards to the year-end out turn and also the work undertaken with NHSI which resulted in additional support for 2017/18. The Board queried whether the funding for intermediate care beds had been forthcoming and also what assurance there was that additional funds would be available for this winter. The Director of Finance confirmed that the A & E Delivery Board had agreed to fund the intermediate care beds on a fair shares agreement basis. He confirmed that the Trust had paid its share of the cost although to date the CCG had not. The Board was advised that the risk of non-payment currently resided with the Local Authority although it was acknowledged that any non-payment would still impact on the Trust as this would be taken from the BCF. The Board was pleased to note that any slippage in deployment of the BCF initiatives that enable better patient flow would be available to the Trust and that in fact the BCF had already picked up the costs of community beds from April.	
BM 17-18/008	**NHS Improvement Quarterly Return** The Board supported the commentary in respect of the Quarterly Return due to be submitted on 28th April 2017 in that it reflected well the performance of the organisation.	
BM17-18/009	**Operational Plan** The Director of Finance presented the updated operational plan narrative 2017/18 – 2018/19 which was subsequently submitted to NHSI in 2016. The Board was advised that the revised report took into account the revised financial control totals for 2017/18 previously agreed by the Board. The Director of Finance drew the Board's attention to the financial forecasts and modelling section of the report as this outlined the changes to the agreed control total and the assumptions made in terms of its delivery which in summary related to the health economy challenge of moving to a more sustainable financial position; the developments in the social care funding arena which were required to improve patient flow and protect elective activity and that the developments in the A & E streaming model would not adversely affect the Trust in delivering a sustainable A & E service as a result of lost income. The Board was reminded of the actions taken to bridge the gap between the 2017/18 revised plan and the reliance on the Strategic Estates Partner to support the Trust with this work.	

Reference	Minute	Action
	The Board requested the following areas be revised: ➢ **Culture** – on page 38 of the pack. The Board agreed that the work in relation to safety needed to be referenced here and overall that this was light and did not reflect the Trust's focus in this area. ➢ **Assumptions** – on page 41 – include the further challenge required of the cost improvement plan here The Board reviewed the approach deployed in relation to the capital scheme programme based on priority and risk stratification. The Board acknowledged that the scheme was over prescribed and access to capital therefore in the future would be key hence the work being undertaken to identify a strategic estates partner. The Board was advised that the issue in relation to radiology equipment was being addressed through the GDE route. The Chair of the Audit Committee sought to establish the impact on limited capital on safe quality care. The Chair of Finance Business Performance and Assurance Committee advised that the review of backlog maintenance had received a good level of review and focus at the Committee where it had been recognised that should any areas arise that need urgent/immediate action, the scheme would be re-prioritised in order to address any key risks. The Board sought to establish whether the dependency on the revised A & E trajectory versus the national target should be highlighted. The Director of Finance recommend that the document remain unchanged as the Trust had submitted its revised trajectory without challenge and was being encouraged to appeal Q4 STF in view of this. The Board supported the recommendation. The Board approved the revised Operational Plan subject to the agreed changes.	**DJ**
BM17-18/010	**Report of the Audit Committee** The Chair of Audit Committee presented the report which summarised the key focus of the meeting held on 07 April 2017. She confirmed that the Chief Executive was in attendance at this meeting as part of his end of year review as Accountable Officer. The Board was advised of the Committee's recommendation for the draft Risk Appetite Matrix to be approved by the Board acknowledging that this reflected the work undertaken in the Board workshops and the Board's desire to handle and mitigate risks in either a cautious, moderate or open manner. The Board approved the risk appetite matrix. The Board was updated on the work being undertaken to improve clinical audit processes to ensure that this offered the maximum value and benefit for the organisation and patients. The Medical Director confirmed that more oversight of the clinical audit plan and allocation of resource would be undertaken by the Quality and Safety Committee going forward. The Board was pleased to note the Head of Internal Audit Opinion as "significant assurance" as this reflected the Trust's programme of work and	

Reference	Minute	Action
	improvement and the rapid action taken to address the Limited Assurance Reports in year. The Board also noted the two Internal Audit Reports received in month relating to Standards of Business Conduct and Combined Financial Systems both of which received "significant assurance". The Chair of the Audit Committee highlighted the difficulties this year in determining the "going concern" assessment. The Committee was pleased that a thorough review of the elements that would inform this assessment had been undertaken at the Finance Business Performance and Assurance Committee and noted that continuation of service provision and reliance and availability of external borrowing would be key in the final assessment. The Board was advised that the Trust's auditors were receiving guidance from the National Audit Office as to how to handle these assessments in view of how many Trusts nationally were in deficit. The Board was advised that the Trust would continue to work with Auditors to resolve this matter however the accounts would not be qualified if the outcome was an issue being raised as an emphasis of matter. The Board was advised that the Auditors had advised verbally that at the time of the meeting no data quality errors had been found in A & E or RTT although there was an acknowledgement that there may be errors found in RTT but that improvements had been made.	
BM17-18/011	**Report of the Finance Business Performance and Assurance Committee** The Chair of Finance Business Performance and Assurance Committee presented the report which summarised the key focus of the meeting on 21 April 2017**.** The Terms of Reference and Review of Committee Effectiveness Report were presented for review and approval by the Board. The Board was advised that the Terms of Reference had been amended to take account of the work being undertaken by the Executive Working Groups and the inclusion of the Director of Workforce in the membership. The priorities for the Committee going forward highlighted the range of transformation initiatives that would be required in the future. The Board approved the Terms of Reference and supported the direction of travel for the Committee. The Board was advised of the plans to prioritise risks in the Board Assurance Framework in the future to ensure that SMART actions were being taken to mitigate these. The review of the budget at a micro level was undertaken as part of the overarching annual plan. The going concern assessment was supported subject reference to the access to working capital in the future. The Board was advised of the need to undertake more work and triangulation in relation to non-core spend and that the Committee had reviewed progress being made in relation to the procurement and the Carter initiatives.	
BM17-18/012	**Review of Register of Interests – Board Declaration** The Director of Corporate Affairs presented the register of interests of Executive, Non-Executive and Senior Management Team Members as part	

Reference	Minute	Action
	of its annual review process to ensure that conflicts of interests could be identified and managed accordingly. The Board reviewed the register and agreed that there were no declarations that constitute a material conflict and that it would continue to undertake a review of the register on an annual basis.	
BM 17-18/013	**Equality and Diversity Annual Report** The Director of Nursing and Midwifery presented the Equality and Diversity Annual Report. She updated the Board on the requirements of the Equality Delivery System 2 (EDS2) and the outcomes of the Trust's latest self-assessment in each of the indicators. The Board was advised that the Trust was achieving in 12 of the 18 indicators with actions being taken to improve the remaining 6 areas. The Director of Nursing and Midwifery outlined the refreshed approach undertaken to conduct this self-assessment which would now be externally verified. The Board acknowledged the improvements made to the indicator "inclusive leadership" however requested further details of what "good" would look like in order that they could support a trajectory of improvement. The Board also noted that equality and diversity was not currently identified as an essential part of the Trust's training programme and agreed that this should be a theme within all training as opposed to a separate training item itself. The Director of Nursing and Midwifery outlined some of the improvements made in relation to access to services. Of particular note was the designation of an Access Champion within the Facilities Department; the "one stop shop" translation and interpretation service now in place; the changes to the procurement process to ensure compliance with the Equality Act 2010 and the chaplaincy service in the Trust which is multi-faith and seeks to support patients, relatives and staff from all faiths, and none. The Board was updated on the work to achieve the required standard for Accessible Information and how the Trust had engaged with patient and staff representatives and external key stakeholders to map out the actions required on implementation. The work undertaken to engage with diverse groups was reported positively as was the work being undertaken to understand the experience of patients. The Board agreed to continue to promote equality and diversity and take every opportunity to raise the profile of this important area.	**GW** **GW**
BM17-18/014	**Board of Directors** The Minutes of the Board of Directors held on the 29th March 2017 were confirmed as an accurate record. **Action Log**	

Reference	Minute	Action
	The Board accepted the action log as presented	
BM17-18/015	**Items for the BAF/Risk Register** None	
BM 17-18/016	**Items to be considered by the Assurance Committees** The Board agreed the following focus areas for the assurance committees: **Finance Business Performance and Assurance Committee** – capital and IT **Quality and Safety Committee** – review of the new quality dashboard and the work of equality and diversity	
BM17-18/017	**Any Other Business** The Board expressed its thanks to Mr Chris Oliver, Director of Operations, as he embarked on his new role at Mid Cheshire Trust.	
BM 17-18/018	**Date and Time of Next Meeting** Wednesday 24th May 2017 at 9.00am in the Boardroom, Education Centre, Arrowe Park Hospital.	

……..……
Chairman

……..
Date

ACTION LOG
Board of Directors
Updated – May 2017

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 26.04.17						
1	BM17-18/006	Provide a trajectory to achieve "good" in the next CQC inspection	**SG**			
2	BM17-18/009	Amend the draft Operational plan ahead of submission to include a stronger reference to the work being undertaken on culture in the organisation and the further challenge in relation to this years CIP under the assumptions section	**DJ**	**Completed**		
3	BM17-18/013	Provide details of what "good" looks like under the Equality and Diversity indicator for inclusive leadership	**GW**		June 17	
4	BM17-18/013	Ensure Equality and Diversity is covered throughout the Trust's Mandatory training programme	**GW**		June 17	
Date of Meeting 29.03.17						
5	BM16-17/296	Review how compliance with CHPPD and red ratings that had been challenged were reported in the future	**CP/GW**		May 17	
6	BM16-17/296	Include information on CQIs, ward accreditations, complaints, compliments and incidents for all wards red rated in month to provide a holistic view of the care provided	**CP/GW**		May 17	

7	BM16-17/309	**QSC** – to review quality account priorities and methodology for agreeing this	**SG**	Included on the QSC agenda for May 17 **- Completed**		
8	BM16-17/309	**Audit Committee** – to review the 2 limited assurance reports in relation to water safety and IT service continuity	**CS**	Included on the agenda for April 17 **- Completed**		
Date of Meeting 22.02.17						
9	BM16-17/273	Quality and Safety Committee to review patient safety alert audits as part of its work programme	**CS**	Included on the agenda for May 17 **- completed**	May 17	
Date of Meeting 25.01.17						
10	BM16-17/244	The Board agreed that the reporting of Advancing Quality Indicators needed to be strengthened	**SG**		March 17	**Being reviewed as part of the Quality Governance Review**
Date of Meeting 25.05.16						
11	BM16-17/033	Include progress on the implementation of the junior doctors contract as part of the Board Development Programme	**SG**	**Agreed to defer this until later in the financial year in light of current position**	July 16	
12	BM16-17/036	Full review of the performance report to be undertaken to avoid this becoming unmanageable	**JH**	**This work will be undertaken as part of the action plan from the well led Governance review and the Quality Governance review undertaken in April 17**		
13	BM16-17/037	Explore the impact of technology when reporting CHPPD in the future	**GW**		April 17	**Update will be provided at March Board**
14	BM16-17/040	Board to continue to receive CQC updates until the next inspection on a quarterly basis	**SG**	**Ongoing – last report in April 17**		
Date of Meeting 30.03.16						
15	BM15-16/297	Present the Medical Engagement Strategy	**SG/JM**	**This work is underway and will be progressed further now the new Medical Director is in post**	May16	

16	BM15-16/299	Update on the number of discharges before noon as a result of the SAFER roll out	**CO**	This work was reported to FBPAC in April 17 and reported up to the Board - **Completed**	April 16	