Wirral University Teaching Hospital NHS
NHS Foundation Trust

Board of Directors

Public Board

28th June 2017

wuth.nhs.uk
@wuthnhs #proud

MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 28th JUNE 2017
COMMENCING AT 9.00AM IN THE
BOARD ROOM
EDUCATION CENTRE, ARROWE PARK HOSPITAL

AGENDA

1	**Apologies for Absence** Chairman	v
2	**Declarations of Interest** Chairman	v
3	**Chairman's Business** Chairman	v
4	**Chief Executive's Report** Chief Executive	d

5. Quality and Safety

5.1	**Patient's Story/Learning** Director of Nursing and Midwifery	v
5.2	**CQC Compliance and Action Plan Progress Update** Medical Director	d

6. Performance and Improvement

6.1 Integrated Performance Report

6.1.1 Integrated Dashboard and Exception Reports d
- **Progress against 9 Point A&E Action Plan**

Chief Operating Officer

6.1.2 Month 2 Finance Report d
Director of Finance

7. Governance

7.1	**Sustainability and Transformation Plan Funding** Director of Finance	d
7.2	**Board of Directors**	d
	7.2.1 Minutes of the Previous Meeting – 24th May 2017	d
	7.2.2 Board Action Log Director of Corporate Affairs	

8. Standing Items

8.1	**Items for BAF/Risk Register** Chairman	v
8.2	**Items to be considered by Assurance Committees** Chairman	v
8.3	**Any Other Business** Chairman	v
8.4	**Date and Time of Next Meeting** Wednesday 26th July 2017	v

Board of Directors	
Agenda Item	4
Title of Report	Chief Executive's Report
Date of Meeting	28 June 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

Whilst good progress is being made with internal initiatives and activity remains on plan, concern remains and efforts are focused on improvements to A&E Performance and CIP delivery.

Following on from the terrible fire at Grenfell Tower in London, NHS Estates and Facilities have written to all Trusts seeking information regarding cladding of buildings. I can confirm to Board that we have no over-cladding and that any other cladding is fire retardant in compliance with building regulations.

After an extensive delay, WUTH have finally gained clarity on Ascension's strategic approach to the UK regarding procurement partnerships. Disappointingly there will be no progress until 2019/20 and so effectively there will be no joint working in the medium term.

External

- **Digital Wirral Programme**

The Digital Wirral programme received a real boost on 14th June 2017 when, following the lifting of the period of "purdah" post-election, we were notified that the first of the funding amounts for the work we have planned was to be released for the Trust to draw down.

The amount is £3.9 million in PDC capital which is the first instalment of nearly £10 million due to be provided to the Trust as follows:

Milestone	Amount (£k)	Financial year	Capital or Revenue	Date Due
	£3861k	2017/18	£3861k Capital	June 2017
	£3860k	2017/18	£1125k Capital £2735k Revenue	October 2017
	£2278k	2018/19	£456k Capital £1822k Revenue	July 2018

The details are subject to an in depth re-planning exercise now that the funding is to be provided.

Regulatory

- **NHS Improvement**

The Trust met with NHSI on 1st June 2017 as part of its regular progress review programme. As advised last month the focus of the meeting was on evidencing compliance with the undertakings in the Provider Licence Breach in 2015.

NHSI acknowledged the significant amount of work undertaken on leadership and governance in particular and recognised the improvement in financial rigour and the work being undertaken to achieve the cost improvement programme.

In order to comply with all the undertakings, the Trust needs to improve ED performance and whilst they recognised the huge amount of work being undertaken internally and how the Trust was trying to influence partners externally, performance was still low regionally.

An A&E summit is being proposed by Regulators which should allow the Trust to use this as the platform for securing support to progress with whole system wide conversation.

Strategy

- **Accountable Care**

The Board will recall previous discussions and presentations around our participation in Healthy Wirral, which involves all local authority, commissioning and provider stakeholders. The Healthy Wirral Partnership Board commissioned PwC to facilitate a series of 3 workshops aimed to move forward our collective thinking around the route to delivering Accountable Care for the people in Wirral. We have now had 2 of the 3 workshops, and this has enabled more clarity of understanding of what Accountable Care means, the process by which we need to take this forward and benefits we might see from this model of care. The 3rd and final workshop is scheduled for 29th June, a week after the next Healthy Wirral Partnership Board on 22nd June. These 2 meetings are key to arriving at a shared commitment to the next steps for enabling Accountable Care in our local health system. In the meantime, we are actively participating in some great examples of real clinically lead partnership with other providers and with primary care showing how we might deliver accountable care. We are progressing the work on a pilot for a model of care that will keep the older 50 population living healthy, happy independent lives with reduced incidence of crisis. We are responding to the CCG tender for MSK services and we continue to explore the ways in which together with other stakeholders we can maintain the trajectory to achieving agreed 4 hour performance.

- **Acute Care Collaboration**

We continue to build on the strength of our relationship with Countess of Chester Hospital to explore how together we can improve care pathways, reduce unwarranted variation and make the best use of collective resources. As a Global Digital Exemplar site, we are working closely with colleagues at CoCH to enable digital collaboration which in turn will be a key enabler to population health management in Wirral & West Cheshire. We are making progress on a number of specific care pathways and are intending to define with more clarity a set of initiatives together that will deliver high quality hospital care for the residents of Wirral & West Cheshire consistent with the intent of the Cheshire & Merseyside STP. Naturally, we are also continuing to work with other partners in Cheshire & Merseyside STP and beyond.

- **Doing the Basics Brilliantly**

Whilst working collaboratively with partners within Wirral and with our neighbours is an important part of strategy for long term clinical and financial sustainability, we are of course relentlessly focussed on achieving our own standards and developing the component plans that will allow us to deliver. Underpinned by are PROUD values and our focus on quality & safety, we are developing further specific plans that will deliver our 3 key themes (excellent services, shaping our own future, maximizing value) and our 10 programs of work that sit within these themes.

Celebrating Success

- **League of Friends**

The Arrowe Park Hospital League of Friends Annual General Meeting was held on 12th May 2017 and the Clatterbridge Hospital League of Friends Annual General Meeting on 14th May 2017.

Both events were attended by the Chief Executive and Director of Nursing and Midwifery and the Trust would like to offer its thanks to both organisations for their continued support and contributions which help support the delivery of high quality patient care and enhance patient experience.

David Allison
Chief Executive
June 2017

Board of Directors	
Agenda Item	5.2
Title of Report	CQC Compliance and Action Plan Progress Update
Date of Meeting	28.6.17
Author	Joe Roberts, Head of Assurance Dr Melanie Maxwell, Associate Medical Director
Accountable Executive	Dr Susan Gilby, Medical Director Gaynor Westray, Director of Nursing
BAF References	Risk 1 - the Trust does not promote a culture of quality and safety resulting in patient harm, poor patient experience, poor staff engagement and failure to meet statutory fundamental standards of care
Level of Assurance	Positive
Purpose of the Paper	To note
Data Quality Rating	Bronze
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken	Not applicable

1. Executive Summary

The attached report includes the results of Care Quality Inspections completed to date, including the ratings given to the nine wards/departments that have been inspected since the last report. It includes a thematic analysis of the CQIs to date, describing areas of improvement (eg staffing levels, premises and record keeping,) and key issues that require further action (e.g. medicines management, sharing learning). There are examples of actions taken in the last quarter to address some of these.
We are currently achieving good/outstanding in 61% of inspected areas (this was 70% in 2015); work is ongoing through divisional ward improvement plans with corporate support to improve this over the coming months.
The report describes the newly formed project group to prepare for the next CQC inspection. There is also a reminder of the changes made to the new inspection framework as CQC moves away from whole assessment to targeted service review and a trust-wide well led assessment.

There is an overview of the progress against the CQC action plans. MIAA have reported "significant assurance" for the robustness of monitoring and assurance against them from ward to Board. An action plan is in place against the two recommendations.

2. Background

The Trust received a rating of "requires improvement" in 2015. A number of additional processes were put in place to improve our compliance with these standards including regulatory and divisional plans, Care Quality Inspections (to provide diagnostics and test change/ provide assurance); deep dives (to hold divisions and departments to account for their improvement actions and gain assurance).
There is an expectation that CQC will re-inspect the service during 2017 a project group has recently come together prepare for this.

3. Key Issues

The top five issues identified in the CQIs are medicine storage; issues with premises and estates, poor signage; out of date patient information – all have improved over time. Tidiness and clutter; confidentiality and issues with infection prevention and control have all increased since 2015, confidentiality has improved considerably in 2017.

The CQI programme will have completed a review of every area by the end of July with a targeted approach to re-inspection, full or partial based on a risk assessment throughout the rest of the summer. A timetable to deliver this is in draft but will be dependent on participation by staff.

4. Next Steps

We will continue to undertake Care Quality Inspections in line with the revised arrangements that were approved by the Senior Management Team in January. The next round of inspections will take place on 27th June.

A project group has been formed to prepare the Trust for a future CQC inspection. This has started to meet fortnightly and is chaired by the Deputy Director of Nursing. The key tasks include communicating with staff, revising the CQIs to take account of the revised CQC inspection methodology, and developing a tool to allow the divisions to self-assess the ratings for their core services. CQC published their response to the consultation about their new approach to inspections; their proposals were supported by the majority of respondents and will be implemented almost in their entirety.

5. Conclusion

It has been challenging to maintain the CQI programme but we are returning to normal activity levels. The domain within the inspection process which gives greatest cause for concern continues to be 'Safe', for which the majority of wards inspected so far are rated as 'requires improvement'.
Going forward the pace of change needs to increase and additional assurance may be needed for specific themes such as medicine storage.

6. Recommendation

The Board are asked to note this report.

CQC Update – June 2017

Care Quality Inspections

Ward Visits: April – June 2017:

Domain	*Ante-natal*	*Critical Care*	*AMU / MSSW*	*Ward 22**	*Ward 27*	*CRC*	*Emergency Department*	*Ward 25*	*Dermat-ology IP*
Caring	G	G	G	Good	G	O	RI	G	O
Effective	G	G	G	RI	G	G	G	RI	G
Responsive	RI	G	G	RI	RI	G	G	G	G
Safe	RI	RI	RI	RI	G	RI	RI	RI	RI
Well led	G	G	G	RI	G	G	G	RI	G
Overall rating	***Good***	***Good***	***Good***	***Requires Improvement***	***Good***	***Good***	***Requires Improvement***	***Requires Improvement***	***Good***

NB: G=good; RI=requires improvement; O=Outstanding *Decanted to ward 19, HPV cleaning in progress.

Current Ratings for Key Lines of Enquiry (June 2017):

	Outstanding	Good	Requires Improvement	Inadequate
*Caring**	7	25	4	0
Effective	1	23	13	0
Responsive	4	23	10	0
Safe	1	10	25	0
Well Led	2	26	9	0
Overall ward rating	***1***	***21***	***15***	***0***

* Delivery Suite was not scored for caring as no patients were interviewed.

The Safety domain is the key area of concern (68% rated Requires Improvement) and within that, the focus is on Medicine Management. Ward Sisters are expected to ensure practices on the ward are up to date and the medicines room is in good order supported by the ward pharmacists. Matrons also complete a monthly audit with action plans agreed and monitored where required. Following CQIs, the CQC Compliance Manager will visit the ward to offer support. It is also a key part of ward accreditation; currently work is ongoing to align the two timetables to provide a more consistent view of practice.

Following inspections the Ward Sister/Departmental Manager works with their Matron to develop an improvement plan. The Divisional Management Teams monitor these, (in line with standard operating process). Depending on the issues identified, time to reassessment by the corporate team will vary. For example, last month issues identified on ward 22 required immediate action with a repeat assessment of the Medicine Management KLOEs within a week of return to their base ward; the key issues raised had all been addressed. However, if the issues relate to training and learning lessons the time to reassessment will be longer. Full reassessment of a domain will depend on capacity.

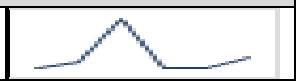
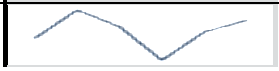
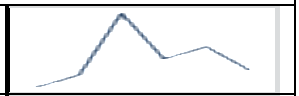
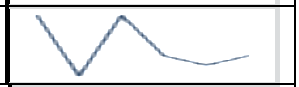
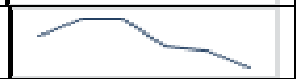
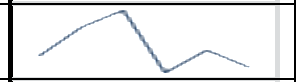
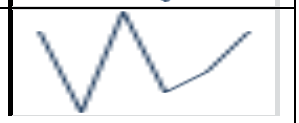
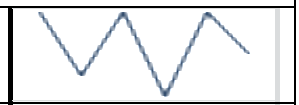
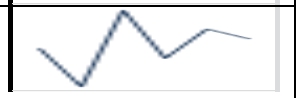
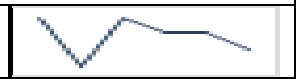
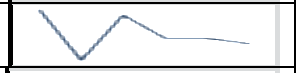
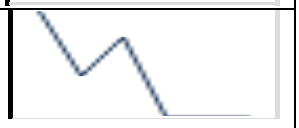
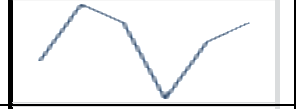
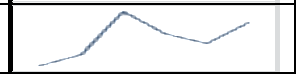
Care Quality Inspections – Long-term Overview

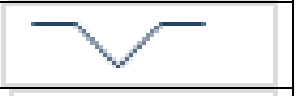
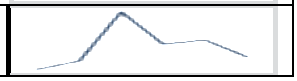
The inspections has highlighted some common themes. In most cases the issue is local to the ward or department visited and will be addressed through the improvement plans; in other instances the CQI team leader may escalate issues, for example a ward's emergency access code did not work and

had been reported but not repaired; following discussion with estates it was completed immediately. Where there are corporate issues they will be highlighted with the relevant corporate team for action for example, there was variability in safeguarding knowledge by staff and work is ongoing to ensure staff are properly trained; this is monitored through training reports. We have experienced better informed staff on more recent CQIs.

The table below compares the issues identified in the mock CQC inspections 2015, and the Care Quality Inspections (CQIs) between January 2016 and May 2017. It also shows the changes over time for CQIs by quarter; however, these charts are affected by variable numbers of CQIs completed, the areas inspected and the teams themselves.

A similar number of inspections took place in the two time periods. However, the 2015 data will include more departmental assessments than the CQIs where key lines of enquiry differ somewhat:

Issue	CQC inspections 2015 (n=49)	CQIs to May 2017 (n=45)	Change (Pre-Post)	Change over time for CQIs Q1 2016-Q2 2017*
Medicines storage	85	61	-24	
Premises and furniture	60	43	-17	
Patient information and signage	54	42	-12	
Tidiness and clutter	33	41	+8	
Confidentiality	30	41	+11	
Infection prevention and control	20	39	+19	
Completion of patient assessments & observations (e.g. MUST, Falls; patient rounding)	20	34	+14	
Risk and incidents – awareness and shared learning	20	33	+13	
Equipment – checks and maintenance, shortages, age	39	32	-7	
Safeguarding	24	29	+5	
Nutrition and hydration	27	28	+1	
Security	34	25	-9	
Other medicines management issues (medicines reconciliation, PGDs, drug administration)	28	23	-5	
Responding to patients (e.g. call bells, pain relief)	16	23	+7	
Staff morale, internal communication and leadership visibility	12	18	+6	
Staff identification	6	15	+9	

Issue	CQC inspections 2015 (n=49)	CQIs to May 2017 (n=45)	Change (Pre-Post)	Change over time for CQIs Q1 2016-Q2 2017*
Staffing levels	20	13	-7	
Record keeping	15	7	-8	
Training - compliance, availability	4	6	+2	
Dignity and respect / poor staff attitude	13	5	-8	
Other / miscellaneous issues	27	38	+11	

(NB: by quarter inspections completed mode was 7 but ranged from 5-10)

Medicines storage remains the most common type of issue identified. Although there has been some improvement (the results of the monthly audits presented to Clinical Governance Group by the Director of Pharmacy show a similar picture of gradual improvement), there remains work to do. The ongoing improvement work is described above. In the last quarter following inspection feedback, pharmacy have condemned medicine storage cupboards in ED where the locks were faulty, replaced a fridge thermometer that was recording outside the acceptable range, and are reviewing the process for returns in Clatterbridge; in addition we have asked estates to check the keypad on ward 25 door as we have found the door unlocked on repeated checks. There are a number of fridges with broken shelves; these have been reordered to ensure medicines are safely stored.

Issues relating to premises and estates are less common, which may reflect changes in the Estates Department and their structures and processes. For example, it was common to find broken toilets in 2015, this is rare now. More recent examples of change include work on ward 19 to secure ward access (completed), repair the fire exit (in progress) and recalibrate the call bells (completed). We noted there were no call bells in HDU an issue not previously identified; these were ordered. However, there is assessment work being undertaken to ensure the underlying system there is fit for purpose in that area.

There are also fewer issues relating to patient information – in 2015, out-of-date or poor quality patient information leaflets were common in many services but these were updated and revised before the CQC inspection. We should note that many of these leaflets are now reaching their two-year review date. Recent inspections at Clatterbridge noted that patient liaison information was out of date and this was replaced. Similarly a corporate leaflet requires amending to include details relevant to Clatterbridge.

Staffing levels appear less frequently in inspection reports now, showing the impact of the additional investment and uplift in nursing staff numbers which took effect from late 2015 onwards. This may correlate with a reduction in the number of issues relating to poor staff attitude.

As we have moved to paper-lite working, record keeping issues have reduced following the trolley replacement work. However, confidentiality issues have increased and this reflects computers being left displaying patient data. All staff are educated to manage this; additional reminder messages have also been put out through a number of media. Individuals are challenged when seen by the inspection team and others including IG walk arounds). This breach is being noted less often in 2017 CQIs.

Poor infection control practice has been noted more frequently in CQIs, although it does appear to have reduced over time. Whilst many practices are routine across the wards, there are some differences that impact on the recording. For example, the recent CQI on ward 25 has identified an educational gap; staff are unaware they should wash their hands on entering and leaving the ward and there is no information for visitors and carers entering the isolation ward. The latter is now being developed and the ward are planning to install new signage to raise awareness. Meanwhile we are asking the IPCT to review the education given to ensure the different requirements for the isolation unit are discussed.

A number of other issues relating to patient care have, however, been observed more frequently in inspections. These include: responding to call bells and pain relief (we have seen an increase in intentional rounding being completed), awareness of safeguarding issues (training available), and variability in completion of patient assessments or observations.

We have developed the inspections since 2015 to enhance consistency and reflect changes in the CQC inspection framework. They will undergo further review as we prepare for the next inspection.

Preparing for the next CQC Inspection

A project group has been formed to prepare the Trust for a CQC inspection which is anticipated in the coming months (likely to be unannounced or at very short notice). The group is chaired by the Deputy Director of Nursing and includes representatives from the three clinical divisions and corporate departments (e.g. Infection Control, Safeguarding, Quality & Safety, Estates, Communications, Clinical Excellence).

Recognising that the inspection could come at any time, we have drafted a rolling 30-day plan. Staff engagement and communication form a major part of the plan. We will use existing channels such as the 'Little Gems' newsletters, Start the Week e-mail bulletin, Leaders' Forum, ward safety huddles, and so on. Specific screen savers are in development and KLOE packs are being prepared for each ward.

Care Quality Inspections will continue; there are 3 wards and 12 out-patient/departments areas that have not been inspected in the last 12 months, theatre inspections are also required, these should all be completed by the end of July; in addition, full re-inspections of key areas based on existing intelligence (Wards 22, 24, 25 and 38) will be completed by mid-August and then specific domains for the remainder of wards using a risk based approach will be completed by the end of September 2017. A timetable for the inspections and reviews is in draft. Additional support will be given to wards by the corporate teams as needed. For example, the Safeguarding team are notified of wards where knowledge is lower than expected for some intensive education delivered locally; ward pharmacists are deployed to support ward Sisters with medicines issues. Reactivating the Ward Accreditation programme and aligning it with the CQIs is in setup to provide a more robust assessment of performance.

With the Trust periodically being at full capacity, we recognise that it is not always possible for front line staff to be released to take part in inspection teams. Thus we are making greater use of clinically-trained staff from corporate departments including Quality & Safety, Corporate Nursing and Infection Control to undertake specific KLOE reviews.

Some changes are being made to the CQI questionnaires to reflect changes to the CQC's inspection model. These take effect from the end of June, with the first real CQC inspections under the new

model commencing in September. Additional questions include information governance and how we use volunteers within our services.

The changes to the inspection process are:

- Replacing full comprehensive inspections with targeted unannounced inspections of core services, and a Trust-wide 'well led' assessment
- Separating some services for ratings purposes, for example dividing outpatients from diagnostic imaging, and maternity from gynaecology

Each division will assess the performance and compliance of its core services against CQC's five domains. We have developed a tool, based on the CQC's inspection framework and Key Lines of Enquiry, to facilitate this. The intention is to minimise the amount of documentation to be completed while enabling the divisional leadership to focus on the key issues. These divisional self-assessments can form the basis of an overall Trust self-assessment which we will be required to complete as part of the new annual Provider Information Return. This is currently in draft form, undergoing consultation.

Prior to our last CQC inspection, the mock inspection programme had visited 51 wards/departments and 71% were rated as "good" or "outstanding"; 3 wards remained a concern and were considered inadequate (wards 24, 25 (new isolation ward), EDR all had significant environmental and/or staffing challenges at the time). Currently 61% of wards/departments visited are rated good or outstanding. The project group needs to develop a trajectory for delivering good/outstanding in all areas in conjunction with the divisions based on delivering the agreed improvement plans.

Progress of CQC Action Plans

The two action plans (regulatory and divisional) were last updated on 19th May and are being updated further during the week commencing 19th June.

The main issues remaining in the regulatory action plan are as follows:

- **Protecting Vulnerable People training:** this programme was introduced in October 2016 but participation has so far fallen short of the trajectory of 8.2% of the relevant workforce per month; limited e-learning has been introduced but is not yet feasible for most staff in clinical areas because of the hardware and software specifications of many of our computers. Safeguard staff have visited the wards to provide face to face teaching, training sessions are available, and access is possible through the libraries on both sites, or at home. Replacing the hardware across the organisation is part of ongoing plans.
- **Radiology Capacity and Demand:** it remains difficult to recruit to vacant posts for Radiologists, although one new Consultant has been recruited; activity continues to be outsourced to meet demand. Performance against targets is greatly improved (six-week diagnostic standard consistently met; improved reporting turnaround times with none being longer than two weeks by early June 2017). However, this arrangement does represent a substantial financial pressure on the service.

- **Consolidation of Risk Register:** a great deal of work was done in Quality and Safety during late 2016 and early 2017 to merge risk register entries and reduce the overall number of risks; however this work has now ceased as there has been a change of focus, with the divisions now given greater autonomy and responsibility for their own risks (and training to exercise this responsibility). The new Senior Management Team Group, consisting of senior managers and divisional triumvirates, will oversee risk management as part of its terms of reference.

The main issues still remaining in the consolidated divisional plan are as follows:

- **Seven-day working:** we do not yet have full seven day working in all medical specialties; we continue to monitor our performance against the national seven day working standards through a biannual audit which contributes to a nationwide benchmarking programme. The last published data (Oct 2016) showed we were fully compliant with diagnostic and interventional standards (5 and 6) apart from access to echocardiograms at the weekend (work in progress to identify demand & capacity); we were partially compliant with senior review (standards 2 &8), similar to regional and national averages during the week and below both at the weekend. All analysis to date of outcome shows no difference between weekday and weekend performance (LoS/readmissions/deaths/FFT). The March 2017 audit report is due imminently. Divisions are aware of the gaps in service and are considering this within business cases; for example the request for an additional surgeon for the emergency/acute service.

- **Improving patient flow:** our actions were based around the SAFER programme which has proven difficult to sustain over time; the Acute and Medical Division are now working with the Transformation Team to implement and embed SAFER using a 'Plan, Do, Study, Act' approach.

- **Medicines management, particularly in Medical Specialties:** monthly audits and the Care Quality Inspections have shown some improvement, but issues with medicines storage remain common around the Trust. Pharmacy staff are working alongside the nursing teams to embed good practice. Prior to the previous inspection ward sisters were completing daily sweeps of their wards including the storage areas and this good housekeeping reduced many of the storage issues raised. This is being re-introduced.

- **Improved management information about risks and incidents:** the procurement process for new risk management software is on hold as external review of the functionality has demonstrated potential to make the system fit for purpose in the short term. External support is in place to rapidly upskill the risk team to enable this.

MIAA Audit of CQC Action Plan

Mersey Internal Audit Agency have recently completed an audit of our CQC Action Plans as part of their annual audit plan. The objective of the audit was to *"review the Trust's CQC improvement action plan and the established system and processes to ensure ongoing compliance with CQC outcomes for reporting to the Board"*.

The audit was graded as 'Significant Assurance'. The audit report stated that, *"WUTH has demonstrated it has robust governance systems and processes for monitoring and assurance against the CQC action plans operationally and onto the Board. There are some weaknesses in the design and / or operation of controls which could impair the achievement of the objectives in the system, function or process. However, either their impact would be minimal or they would be unlikely to occur"*.

There were two recommendations in the report. We have accepted and are implementing both. The recommendations were as follows:

- To prioritise those areas which have not yet been inspected as part of the CQI programme according to 'triggers' such as serious incidents reported, complaints, nursing assessment scores and health and safety inspection outcomes – *this information is included in Corporate Nursing's Ward Profiles*

- To review the terms of reference of the Patient and Family Experience Group to include a requirement to discuss patient experience-related issues which arise from CQC inspections and action plans. The terms of reference have been reviewed to include the additional responsibilities and they will be incorporate din to the cycle of business.

Conclusion:

The Trust has robust mechanisms in place to be clear about its strengths and weaknesses. These are being addressed at divisional and corporate level as appropriate. Examples have been given above of how issues that have been identified have been actioned and where progress has been made as a result. There appears to have been some slippage from our assessment position in 2015; however, we have also evolved the assessment and quality assurance that will mean scores are not directly comparable. We do need to increase the pace of improvement. Enabling the matrons to focus on quality and ensuring the ward sisters have time within their day to complete ward sweeps will deliver this.

We have a multi-disciplinary project group, drawn from across the Trust, to plan and manage preparations for the CQC assessment. The key programmes of work include: accelerating the Care Quality Inspection process to achieve full coverage of all patient-facing areas; updating our approach to match CQC's new way of working; staff training; staff engagement and communications; and driving improvement where common themes are identified across wards and divisions. This group will also need to hold Divisions to account for their improvement plan delivery.

Board of Directors	
Agenda Item	**6.1.1**
Title of Report	**Integrated Performance Dashboard**
Date of Meeting	**28th June 2017**
Author	**Anthony Middleton, Director of Ops / Deputy COO** **John Halliday, Assistant Director of Information**
Accountable Executive	**Janelle Holmes** **Chief Operating Officer**
FOI status	**Document may be disclosed in full**
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	**All Strategic Objectives (1 through 7)** **All Key Measures (1A through 7D)** **All Principal Risks**
Level of Assurance • **Positive** • **Gap(s)**	**Partial with gaps**
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	**Discussion**
Data Quality Rating	**Silver – quantitative data that has not been externally validated**
FOI status	**Document may be disclosed in full**
Equality Impact Assessment Undertaken • **Yes** • **No**	**No**

1. Executive Summary

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

2. Summary of Performance Issues

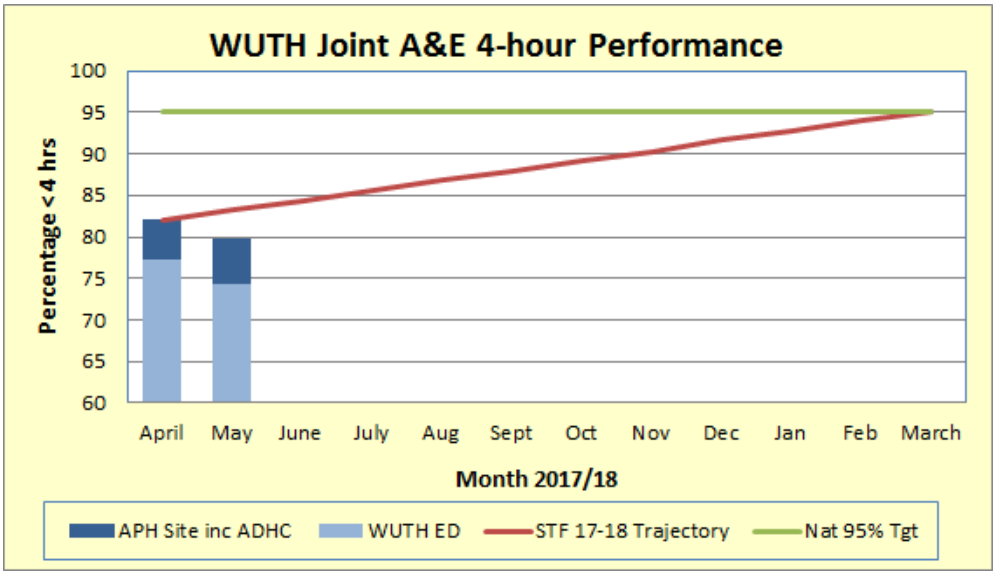
The key issues relating to external validation is achievement of the A&E and RTT targets, with detailed comments against each area below.

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 May was 79.76% as measured across a combined ED and All Day Health Centre performance at the Arrowe Park site. ED alone was 74.32%.

The performance in May therefore did not achieve the regulatory compliance level of 95% or the Sustainability and Transformation Fund (STF) trajectory of 83.2%, as illustrated below.



At the time of writing the June trajectory of 84.40% is being achieved with the aim to deliver higher and recoup the cumulative performance. This improvement is due to a combination of factors including:-

- A focus on ring-fencing assessment / treatment space for patients presenting with minor conditions
- Streaming of patients at the front door to the all-day health centre

- A trial using WUTH GP trained medics for minor illness/injury in spare clinical space within the all-day health centre

- Improved dialogue and high level intervention for patients requiring complex packages of care post discharge.

Longer term stability is critical and under the governance of the A&E delivery board a 9 point plan has been developed which all parties are working towards. There are some real financial and operational challenges to delivering the plan at pace, but some components are being brought forward to July.

- GP Streaming by October 17
- Patient Flow - D2A, Trusted assessor,7 day discharge capability
- Reduce DTOC - £1billion social care funding
- Specialist Mental health - 24/7 50% by March 18
- NHS 111 - 30% of all calls by March probably looking at more like 50% with streaming to other clinicians.
- GP access 50% access evenings & weekends by 2018, 100% by 2019
- Bolstering Care Home Support
- Standardisation of WIC, UCC, MI Units - public are confused so go to ED. Will be outlining minimum standard at all to avoid confusion.
- Ambulance response - see & treat / hear & treat in place by end of the year.

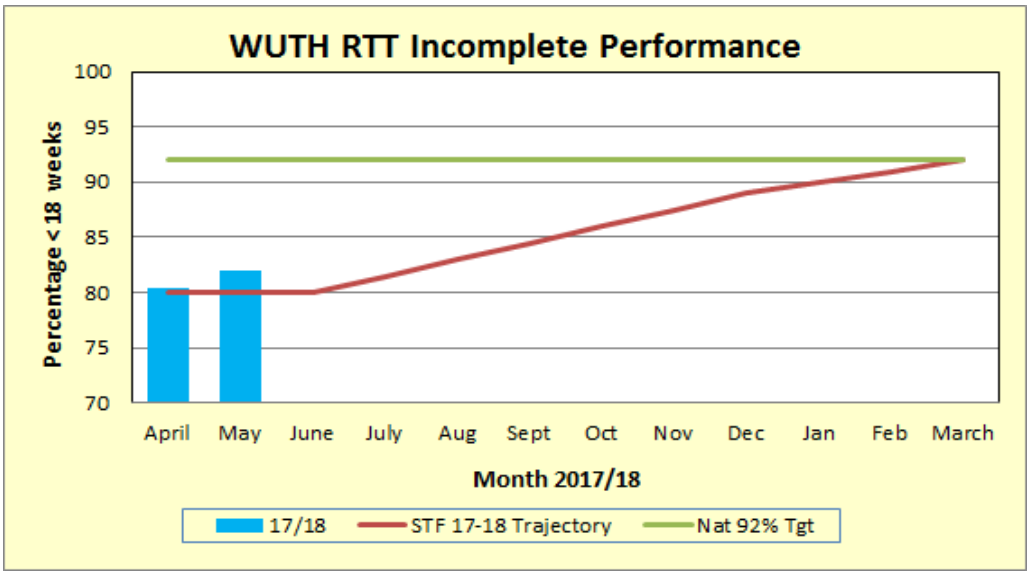
b. 18 Weeks Referral To Treatment (RTT)

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.

In line with continuing expectations, the Trust did not achieve the national standard at the end of May; however it was able to demonstrate improvement on the previous month with the final position being reported at 82.05% which met the STF trajectory.

The Trust did report three 52 week breaches and a full Root Cause Analysis has been completed and patient treatment plans are in place. Patient choice as well as the wide scale data issues are the 2 issues accounting for breaches.

The data issues are being addressed and there is economy wide transparency in this process under the newly formed RTT Executive group.



The objective remains to achieve the requisite 92% standard no later than March 2018. The Trust is currently delivering its elective plan and has developed robust plans to address the backlog to that timescale. Discussions have taken place with the independent sector to provide some additional capacity to tackle the backlog, with the health economy well sighted on the financial pressure this will incur.

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 May was 99.63%.

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 expects full compliance with this cancer waiting time 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. The surge in demand in April outstripped planned capacity, resulting in growing waits to be seen. Additional capacity has been put on, and this standard was achieved for May, and will also be achieved in June. However overall performance for the quarter combined is likely to be below the national standard.

e. Infection Control

For C Difficile, there have been three avoidable hospital acquired cases in the month of May. This brings the total to five which is above the in-year trajectory to the end of May. The HPV programme has been re-established and a programme of priority wards has been approved. This will be supported by the use of Ultra Violet light technology for use in side rooms and utility rooms on wards affected by C Difficile.

There was as a single hospital-acquired MRSA bacteraemia case in May, a post infection review has been undertaken and lapse in care have been identified these being incomplete MRSA screening; delay in referring problems with PICC line therefore patient received numerous peripheral cannulations. Outcomes / learning from the review has been shared across clinical areas.

4. Recommendation

The Board of Directors are asked to:

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

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

Area	Indicator / BAF	Mar	April	May	Trend / Future Concern	*Target (for 'Green')*	Latest Period	Exec Lead
Meeting Our Vision	**Satisfaction Rates**							
	Patient - F&F "Recommend" Rate	100%	99%	99%		>=95%	May 2017	GW
	Patient - F&F "Not Recommend" Rate	0%	0%	1%		<=2%	May 2017	GW
	Staff Satisfaction (engagement)	3.78	3.78	3.78		>=3.69	Q4 2016/17	JM
	First Choice Locally & Regionally							
	Market Share Wirral	81.0%	81.4%	81.6%		>= 85%	Dec 2016 to Feb 2017	AM
	Demand Referral Rates	-8.7%	-43.7%	-34.4%		>= 3% YoY variance	Fin Yr-on-Yr to May 2017	AM
	Market Share Non-Wirral	6.8%	7.8%	6.6%		>=8%	Dec 2016 to Feb 2017	AM
	Strategic Objectives							
	Harm Free Care	96%	96%	96%		>= 95%	May 2017	GW
	HIMMs Level	5	5	5		5	May 2017	PC
Operational Excellence	**Key Performance Indicators**							
	A&E 4 Hour Standard	81.30%	82.21%	79.76%		>=95%	May 2017	AM
	RTT 18 Weeks Incomplete Position	83.93%	80.34%	82.05%		>=92%	May 2017	AM
	Diagnostics 6 Week Standard	99.80%	99.81%	99.63%		>=99%	May 2017	AM
	Cancer Waiting Time Standards	On track	Concern 1 standard	Concern 1 standard		All met at Trust level	Q1 to May 2017	AM
	Infection Control (c Diff cumulative YTD)	1 MRSA; 13 C diff	0 MRSA; 2 C diff	1 MRSA; 5 C diff		0 MRSA Bacteraemia in month, and cdiff less than cumulative trajectory	May 2017	GW
	Productivity							
	Delayed Transfers of Care	46	43	48		Metric redefined	May 2017	AM
	Delayed Complex Care Packages	110	97	90		<= 45	May 2017	AM
	Bed Occupancy	90.6%	87.7%	90.7%		<=85%	May 2017	AM
	Bed Occupancy Medicine	94.2%	91.5%	94.5%		<=85%	May 2017	AM
	Theatre Utilisation	88.8%	92.8%	90.9%		>=85%	May 2017	AM
	Outpatient DNA Rate	7.7%	8.0%	8.6%		<=6.5%	May 2017	AM
	Outpatient Utilisation	80.9%	81.4%	81.2%		>90%	May 2017	AM
	Length of Stay - Non Elective Medicine	5.8	5.2	5.7		<= 5.0	May 2017	AM
	Length of Stay - Non-elective Trust	5.2	4.8	5.3		<=4.2	May 2017	AM
	Contract Performance (activity)	-3.7%	3.5%	3.2%		0% or greater	May 2017	AM
	Finance							
	Contract Performance (finance)	-1.9%	-2.6%	-1.3%		On Plan or Above YTD	May 2017	DJ
	Expenditure Performance	-3.1%	2.2%	1.1%		On Plan or Below YTD	May 2017	DJ
	CIP Performance	0.0%	-73.5%	-67.6%		On Plan or Above	May 2017	DJ
	Capital Programme	-1.2%	89.1%	28.5%		On Plan	May 2017	DJ
	Non-Core Spend	9.4%	9.4%	9.4%		<5%	May 2017	DJ
	Cash Position	-32.0%	296.0%	218.0%		On plan or above YTD	May 2017	DJ
	Cash - liquidity days	-16.7	-16.1	-15.0		> 0 days	May 2017	DJ
A Healthy Organisation	**Clinical Outcomes**							
	Never Events	1	0	0		0 per month	May 2017	SG
	Complaints	35	19	20		<30 per month	May 2017	GW
	Workforce							
	Attendance	96.05%	95.62%	95.59%		>= 96%	May 2017	JM
	Qualified Nurse Vacancies	5.79%	6.25%	6.04%		<=6.5%	May 2017	GW
	Mandatory Training	91.83%	91.62%	91.57%		>= 95%	May 2017	JM
	Appraisal	84.74%	83.06%	82.20%		>= 85%	May 2017	JM
	Turnover	11.04%	11.04%	10.68%		<10%	May 2017	JM
	Agency Spend	12.5%	36.5%	29.8%		On plan	May 2017	GW
	Agency Cap	151	161	207		0	May 2017	JM
External Validation	**National Comparators**							
	Advancing Quality (not achieving)	3	2	3		All areas above target	May 2017	SG
	Mortality: HSMR	91.54	89.61	86.91		Lower CI < 0.90	April 2016 to Feb 2017	SG
	Mortality: SHMI	0.983	0.966	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)	May 2017	DJ
	CQC	Amber	Amber	Amber		Overall CQC rating Requires Improvement	May 2017	SG
	Local View							
	Commissioning - Contract KPIs	8	7	8		<=2	May 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	1	1	9	4	13	100.00%	92.31%
	Lung	0	1	1	4.5	8	12.5	100.00%	92.00%
Other	Other	0	0.5	0.5	1.5	1	2.5	100.00%	80.00%
Med & Surg	Upper GI	0	2	2	4	4.5	8.5	100.00%	76.47%
Surgery	Breast	1	2	3	28.5	18.5	47	96.49%	93.62%
	Colorectal	3	2	5	16	10	26	81.25%	80.77%
	Head & Neck	1.5	1.5	3	2	4	6	25.00%	50.00%
	Skin	0	3	3	49.5	24	73.5	100.00%	95.92%
	Urology	6.5	9	15.5	21	28.5	49.5	69.05%	68.69%
Women's	Gynaecology	0	1.5	1.5	1.5	6.5	8	100.00%	81.25%
	Total	**12**	**23.5**	**35.5**	**137.5**	**109**	**246.5**	91.27%	85.60%

Quarter 1 - April

Division	Tumour Group	Breaches			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted
Medicine	Haematology	0		0	3		3	100.00%	
	Lung	0		0	3.5		3.5	100.00%	
Other	Other	0		0	0.5		0.5	100.00%	
Med & Surg	Upper GI	0		0	1		1	100.00%	
Surgery	Breast	1		1	18.5		18.5	94.59%	
	Colorectal	2		2	6		6	66.67%	
	Head & Neck	1.5		1.5	2		2	25.00%	
	Skin	0		0	18.5		18.5	100.00%	
	Urology	5.5		5.5	14.5		14.5	62.07%	
Women's	Gynaecology	0		0	0.5		0.5	100.00%	
	Total	**10**		**10**	**68**		**68**	85.29%	

Quarter 1 - May

Division	Tumour Group	Breaches			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted
Medicine	Haematology	0	0	0	5	0	5	100.00%	100.00%
	Lung	0	0.5	0.5	1	4	5	100.00%	90.00%
Other	Other	0	0	0	1	0	1	100.00%	100.00%
Med & Surg	Upper GI	0	1	1	3	1.5	4.5	100.00%	77.78%
Surgery	Breast	0	1	1	10	4.5	14.5	100.00%	93.10%
	Colorectal	1	1	2	10	1	11	90.00%	81.82%
	Head & Neck	0	1	1	0	2	2	N/A	50.00%
	Skin	0	2	2	28	2	30	100.00%	93.33%
	Urology	1	4	5	5.5	12.5	18	81.82%	72.22%
Women's	Gynaecology	0	1	1	1	3	4	100.00%	75.00%
	Total	**2**	**11.5**	**13.5**	**64.5**	**30.5**	**95**	96.90%	85.79%

Quarter 1 - June

Division	Tumour Group	Breaches			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted
Medicine	Haematology	0	1	1	1	4	5	100.00%	80.00%
	Lung	0	0.5	0.5	0	4	4	N/A	87.50%
Other	Other	0	0.5	0.5	0	1	1	N/A	50.00%
Med & Surg	Upper GI	0	1	1	0	3	3	N/A	66.67%
Surgery	Breast	0	1	1	0	14	14	N/A	92.86%
	Colorectal	0	1	1	0	9	9	N/A	88.89%
	Head & Neck	0	0.5	0.5	0	2	2	N/A	75.00%
	Skin	0	1	1	3	22	25	100.00%	96.00%
	Urology	0	5	5	1	16	17	100.00%	70.59%
Women's	Gynaecology	0	0.5	0.5	0	3.5	3.5	N/A	85.71%
	Total	**0**	**12**	**12**	**5**	**78.5**	**83.5**	100.00%	85.63%

Board of Directors	
Agenda Item	6.1.2
Title of Report	Month 2 Finance Report
Date of Meeting	28th June 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 2 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 May 2017 the Trust has delivered an overall deficit of £3.1m which is in line with the profile of the financial plan submitted.

The Trust has a £1m adverse variance to the CIP plan having delivered £0.2m in month and £0.4m for the year compared to the planned £1.4m. This is a disappointing start to the Trusts' challenge to deliver £15.0m of savings.

The cash position at the end of May was £6.5m which is £4.4m more than plan. This variance is primarily due to 2016/17 closing cash being higher than plan and a capital cash underspend.

The month 2 position includes the full Sustainability and Transformation funding that has been offered to the Trust of £0.9m. While the Trust has delivered the YTD performance on the financial plan, A&E performance is currently behind trajectory but this position is forecast to improve as discussed in the performance section of the Board.

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 summary — Wirral University Teaching Hospital NHS Foundation Trust

Year ending 31 March 2018 Position as at 31 May 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	49,539	48,915	(624)	303,693	303,693	0
Non-NHS clinical income	262	365	103	1,566	1,566	0
Other income	4,890	4,596	(294)	34,288	34,288	0
Total operating income	54,691	53,876	(815)	339,547	339,547	0
Pay	(36,747)	(38,323)	(1,576)	(221,376)	(221,376)	0
Other expenditure	(18,990)	(16,603)	2,387	(106,045)	(106,045)	0
Total operating expenditure before depreciation and impairments	(55,737)	(54,926)	811	(327,422)	(327,422)	0
EBITDA	(1,046)	(1,049)	(3)	12,125	12,125	0
Depreciation and net impairment	(1,351)	(1,324)	27	(8,353)	(8,353)	0
OPERATING SURPLUS / (DEFICIT)	(2,397)	(2,373)	24	3,772	3,772	0
Net finance costs and gains / (losses) on disposal	(709)	(710)	(1)	(4,340)	(4,340)	0
ACTUAL SURPLUS / (DEFICIT) per annual accounts	(3,106)	(3,083)	23	(568)	(568)	0
Reverse net impairment	0	0	0	0	0	0
SURPLUS / (DEFICIT) before impairments and transfers	(57,088)	(56,249)	839	(335,775)	(335,775)	0
Reverse capital donations/grants I&E impact	24	0	(23)	142	142	0
DEL net impairments *(damage, not revaluation)*	0	0	0	0	0	0
ADJUSTED FINANCIAL PERFORMANCE SURPLUS / (DEFICIT) (AFPD)	(3,083)	(3,083)	0	(426)	(426)	0
CONTROL TOTAL	(3,083)	(3,083)	0	(426)	(426)	0
AFPD excluding STF	(3,971)	(3,971)	0	(9,301)	(9,301)	0
CONTROL TOTAL excluding STF	(3,971)	(3,971)	0	(9,301)	(9,301)	0

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

PbR activity is currently above plan by £1.1m YTD 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(£0.9m) and PbR excluded drugs(£1.1m matched by expenditure).

Expenditure is currently above plan as a result of non delivery of CIP (£1m) and operational overspends across the Trust.
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 £0.9m spent YTD compared to the ceiling of £1.3m issued by NHSI. While this is a positive position agency has increased in month and will continue to be closely reviewed. 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 £1.2m from the CQUIN risk reserve that was built into the financial plan. This remains a risk to the Trust as this funding stream has not yet been released by the CCG. The Trust continue to be in discussions with NHSI so that they can authorize the transfer of the funds.

Further non recurrent support of £0.6m has also been released in month after reviewing year end accruals. This non recurrent support will deteriorate the underlying position of the Trust.

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 2 the Trust is behind the YTD target of £1.4m by £1m. The Trust currently has £4.9m of fully built up schemes with opportunities and plans of a further £7.6m leaving a current shortfall of £2.5.

The table below details the month 2 position for CIP.

Summary as at Month 2	YTD		In Year		
	Actual		Forecast		Trend
NHSi Plan (Target)	£1,380k		£15,000k		
Fully Developed TSG approved schemes	£451k		£4,845k		
Overperformance/ (Gap) v NHSi Plan	-£929k	-67.3%	-£10,155k	-67.7%	
Latest Forecast performance on TSG approved schemes	£398k		£4,861k		⇧
Over/ (Under)performance compared to TSG approved schemes	-£53k	-11.7%	£16k	0.3%	
Latest Forecast including mitigation	£398k		£4,861k		⇧
Performance Variance (Latest Forecast to NHSi Plan)	-£982k	-71.1%	-£10,139k	-67.6%	
Latest Forecast adjusted for risk	£398k		£3,603k		
Performance Variance (Latest Forecast to NHSi Plan)	-£982k	-71.1%	-£11,397k	-76.0%	

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

The table below further breaks down the CIP performance by Division.

Divisional Summary	YTD			In Year			FYE			Pipeline (IYE)		
	Target	Actual	Variance to NHSI Plan	Target	Forecast	Variance to NHSI Plan	Target	Forecast	Variance to NHSI Plan	Plans In Progress	Opportunity	Surplus/ (Gap)
Division	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k
Medicine and Acute	386	65	(322)	4,200	566	(3,634)	4,200	240	(3,960)	657	776	(2,201)
Surgery	325	206	(119)	3,530	2,049	(1,481)	3,530	1,551	(1,979)	900	981	400
Women and Children	135	10	(126)	1,470	63	(1,407)	1,470	34	(1,436)	0	0	(1,407)
Diagnostics and Clinical Support	221	22	(199)	2,400	622	(1,778)	2,400	829	(1,571)	397	37	(1,404)
Corporate	313	96	(216)	3,400	1,049	(2,351)	3,400	915	(2,485)	231	3,044	924
Central			0		0	0		0	0	0	0	0
TBC		0	0		512	512		515	515	0	628	1,140
TOTAL FUILY DEVELOPED PRE ADJUSTMENT FOR RISK	1,380	398	(982)	15,000	4,861	(10,139)	15,000	4,083	(10,917)	2,125	5,466	(2,548)
Adjustment for Risk					(1,258)	(1,258)		(1,115)	(1,115)	(1,062)	(4,920)	(5,982)
TOTAL FUILY DEVELOPED AFTER RISK	1,380	398	(982)	15,000	3,603	(11,397)	15,000	2,968	(12,032)	1,062	547	(8,530)

The in-year forecast on fully developed schemes is £4.9m, £10.1m behind the NHSI requirement. The graph showing the profile of this is included in appendix 4. Whilst this shortfall is of concern, there are plans in progress with an estimated in year value of £2.1m expected to come to TSG for approval this month with a further £5.5m of opportunities identified. It is recognised that the pace of conversion of opportunities needs to be accelerated in order to reduce the gap between the plan requirement and the value of fully developed schemes. Work is underway with the divisional and corporate leads to move these schemes into fully developed plans with the individual portfolio review meetings chaired by the Director of Operations and STT providing in depth challenge and support across progress on both the transformation agenda and CIP performance. CIP performance has also been escalated to SMT with particular focus on the delivery of the corporate directorate targets and again it is anticipated that there will be a significant advance within this area this month.

It should however, be recognised that there is risk associated with this and the challenge to deliver the £15m target in year has previously been highlighted to the Board of Directors

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

The Trust's Balance Sheet is at Appendix 2 – *Statement of Financial Position (SOFP).* Capital variances to plan (£1.6m) are primarily due to actual brought-forward balances for 2017/18 exceeding those in plan. Capital expenditure is £0.1m under plan during May as a result of delayed starts to some capital projects. May's working capital variances to plan are all within acceptable tolerances, and are due to controlled variations in the working capital cycle.

The month-on-month variance in borrowings is due to a drawdown in the Trust's working capital facility of £1.2m, in addition to the recognition of a new finance lease (£0.3m). This finance lease represents the full variance to plan for borrowings.

The May cash position was £6.5m, which is £4.4m above plan. This variance is primarily due to 2016/17 closing cash exceeding prudent planning assumptions (£3.6m) and the cash effects of capital slippage (£0.8m). Further detail of the Trust's cash position is at Appendix 3 – *Statement of Cash Flows*.

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 the CQUIN risk reserve and utilising non recurrent savings. 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
June 2017

Appendix 1
Income & Expenditure

Income and expenditure statement (SoCI)

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Year ending 31 March 2018 Position as at 31 May 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
NHS clinical income						
Elective	3,483	3,813	329	22,534	22,534	0
Daycase	4,178	4,229	50	26,899	26,899	0
Elective excess bed days	164	140	(24)	1,063	1,063	0
Non-elective	14,785	15,456	671	90,511	90,511	0
Non-elective excess bed days	357	443	85	2,191	2,191	0
A&E	2,028	2,134	106	12,453	12,453	0
Outpatient	5,262	5,244	(18)	34,148	34,148	0
Diagnostic imaging	384	317	(67)	2,472	2,472	0
Maternity	940	856	(84)	5,622	5,622	0
Non PbR	11,545	10,781	(764)	69,802	69,802	0
HCD	3,414	2,357	(1,057)	20,485	20,485	0
CQUINs	2,070	2,081	11	6,398	6,398	0
Other income	40	177	137	240	240	0
STF	888	888	0	8,875	8,875	0
Total clinical income	**49,539**	**48,915**	**(624)**	**303,693**	**303,693**	**0**
Non-NHS clinical income						
CRU / RTA / ICR income	108	76	(32)	647	647	0
Other income	154	289	135	919	919	0
Total non-NHS clinical income	**262**	**365**	**103**	**1,566**	**1,566**	**0**
Other income						
Education & training	1,630	1,608	(22)	9,780	9,780	0
R&D	68	68	(0)	408	408	0
Non-patient services to other bodies	1,546	1,778	232	9,277	9,277	0
Other income	1,646	1,143	(503)	14,824	14,824	0
Total other income	**4,890**	**4,596**	**(294)**	**34,288**	**34,288**	**0**
Total operating income	**54,691**	**53,876**	**(815)**	**339,547**	**339,547**	**0**
Pay costs	(36,747)	(38,323)	(1,576)	(221,376)	(221,376)	0
Drug costs	(4,241)	(3,865)	376	(29,220)	(29,220)	0
Clinical supplies	(5,140)	(5,483)	(343)	(30,933)	(30,933)	0
Other costs	(9,609)	(7,255)	2,354	(45,893)	(45,893)	0
Depreciation and net impairment	(1,351)	(1,324)	27	(8,353)	(8,353)	0
Total operating costs	**(57,088)**	**(56,249)**	**839**	**(335,775)**	**(335,775)**	**0**
Operating surplus / (deficit)	**(2,397)**	**(2,373)**	**24**	**3,772**	**3,772**	**0**
Operating surplus / (deficit) %	**-4.38%**	**-4.40%**		**1.11%**	**1.11%**	
Net finance costs and gains / (losses) on disposal	(709)	(710)	(1)	(4,340)	(4,340)	0
Actual surplus / (deficit) per annual accounts	**(3,106)**	**(3,083)**	**23**	**(568)**	**(568)**	**0**
Reverse net impairment	0	0	0	0	0	0
Surplus / (deficit) before impairments and transfers	**(3,106)**	**(3,083)**	**23**	**(568)**	**(568)**	**0**
Reverse capital donations/grants I&E impact	24	0	(23)	142	142	0
DEL net impairments *(damage, not revaluation)*	0	0	0	0	0	0
Adjusted financial performance surplus / (deficit) (AFPD)	**(3,083)**	**(3,083)**	**0**	**(426)**	**(426)**	**0**
Control total	**(3,083)**	**(3,083)**	**0**	**(426)**	**(426)**	**0**
AFPD excluding STF	**(3,971)**	**(3,971)**	**0**	**(9,301)**	**(9,301)**	**0**
Control total excluding STF	**(3,971)**	**(3,971)**	**0**	**(9,301)**	**(9,301)**	**0**

Appendix 2
Statement of Financial Position (SOFP)

Actual as at 01.04.17 £k		Actual as at 30.04.17 £k	Actual as at 31.05.17 £k	Variance (monthly) £k	Plan as at 31.05.17 £k	Actual as at 31.05.17 £k	Variance (to plan) £k	Forecast 31.03.18 £k	Plan 31.03.18 £k
	Non-current assets								
145,789	Property, plant and equipment	145,354	145,252	(102)	143,539	145,252	1,713	145,166	145,166
12,216	Intangibles	12,019	11,822	(197)	11,921	11,822	(99)	10,080	10,080
950	Trade and other non-current receivables	859	859	0	1,612	859	(753)	1,612	1,612
158,955		**158,232**	**157,933**	**(299)**	**157,072**	**157,933**	**861**	**156,858**	**156,858**
	Current assets								
3,881	Inventories	3,802	3,627	(175)	4,051	3,627	(424)	4,051	4,051
16,389	Trade and other receivables	16,511	18,028	1,517	20,323	18,028	(2,295)	20,760	20,760
0	Assets held for sale	0	0	0	0	0	0	0	0
5,390	Cash and cash equivalents	6,868	6,480	(388)	2,037	6,480	4,443	2,257	2,257
25,660		**27,181**	**28,135**	**954**	**26,411**	**28,135**	**1,724**	**27,068**	**27,068**
184,615	**Total assets**	**185,413**	**186,068**	**655**	**183,483**	**186,068**	**2,585**	**183,926**	**183,926**
	Current liabilities								
(31,059)	Trade and other payables	(33,121)	(33,241)	(120)	(32,301)	(33,241)	(940)	(32,172)	(32,172)
(3,341)	Other liabilities	(3,484)	(3,441)	43	(4,130)	(3,441)	689	(3,696)	(3,696)
(1,015)	Borrowings	(1,015)	(1,086)	(71)	(1,015)	(1,086)	(71)	(1,014)	(1,014)
(668)	Provisions	(671)	(668)	3	(664)	(668)	(4)	(664)	(664)
(36,083)		**(38,291)**	**(38,436)**	**(145)**	**(38,110)**	**(38,436)**	**(326)**	**(37,546)**	**(37,546)**
(10,423)	**Net current assets/(liabilities)**	**(11,110)**	**(10,301)**	**809**	**(11,699)**	**(10,301)**	**1,398**	**(10,478)**	**(10,478)**
148,532	**Total assets less current liabilities**	**147,122**	**147,632**	**510**	**145,373**	**147,632**	**2,259**	**146,380**	**146,380**
	Non-current liabilities								
(9,154)	Other liabilities	(9,126)	(9,097)	29	(9,097)	(9,097)	0	(8,812)	(8,812)
(26,708)	Borrowings	(27,542)	(28,980)	(1,438)	(28,742)	(28,980)	(238)	(27,627)	(27,627)
(2,221)	Provisions	(2,203)	(2,189)	14	(2,101)	(2,189)	(88)	(1,969)	(1,969)
(38,083)		**(38,871)**	**(40,266)**	**(1,395)**	**(39,940)**	**(40,266)**	**(326)**	**(38,408)**	**(38,408)**
110,449	**Total assets employed**	**108,252**	**107,366**	**(886)**	**105,433**	**107,366**	**1,933**	**107,972**	**107,972**
	Financed by								
	Taxpayers' equity								
72,525	Public dividend capital	72,525	72,525	0	72,525	72,525	0	72,525	72,525
4,575	Income and expenditure reserve	2,378	1,492	(886)	240	1,492	1,252	2,779	2,779
33,349	Revaluation reserve	33,349	33,349	0	32,668	33,349	681	32,668	32,668
110,449	**Total taxpayers' equity**	**108,252**	**107,366**	**(886)**	**105,433**	**107,366**	**1,933**	**107,972**	**107,972**

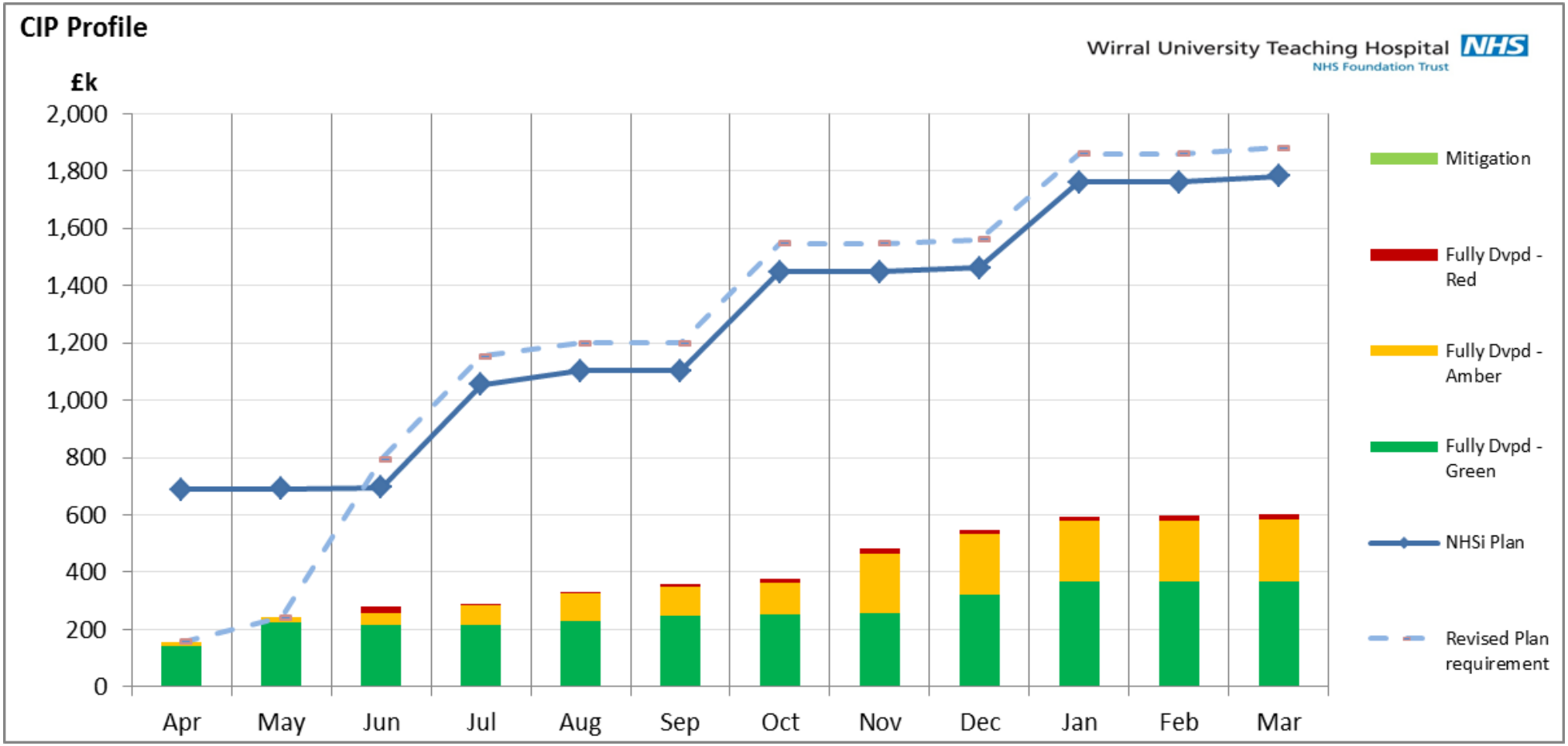
Appendix 3
Statement of Cash Flows

	Month			Year to date			Full Year	
	Actual	Plan	Variance	Actual	Plan	Variance	Forecast	Plan
	£k	£k	£k	£k	£k	£k	£k	£k
Opening cash	**6,868**	**1,736**	**5,132**	**5,390**	**1,752**	**3,638**	**1,752**	**1,752**
Operating activities								
Surplus / (deficit)	*(886)*	*(859)*	*(27)*	*(3,083)*	*(3,055)*	*(28)*	*(568)*	*(568)*
Net interest accrued	*91*	*26*	*66*	*154*	*64*	*90*	*982*	*982*
PDC dividend expense	*277*	*277*	*0*	*554*	*554*	*0*	*3,326*	*3,326*
Unwinding of discount	*1*	*3*	*(2)*	*1*	*39*	*(38)*	*35*	*35*
(Gain)/loss on disposal	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Operating surplus / (deficit)	(517)	(553)	36	(2,374)	(2,398)	24	3,775	3,775
Depreciation and amortisation	662	676	(14)	1,324	1,351	(27)	8,353	8,353
Impairments / (impairment reversals)	0	0	0	0	0	0	0	0
Donated asset income (cash and non-cash)	(27)	0	(27)	(27)	0	(27)	(27)	0
Changes in working capital	(831)	331	(1,162)	1,211	1,143	68	(243)	(270)
Other movements in operating cash flows	0	0	0	0	0	0	0	0
Investing activities								
Interest received	2	7	(5)	4	14	(10)	82	82
Purchase of non-current (capital) assets [1]	(876)	(1,360)	484	(1,082)	(1,860)	778	(7,964)	(7,964)
Sales of non-current (capital) assets	0	0	0	0	0	0	0	0
Receipt of cash donations to purchase capital assets	0	0	0	0	0	0	0	0
Financing activities								
Public dividend capital received	0	0	0	0	0	0	0	0
ITFF loan principal drawdown	0	0	0	0	0	0	0	0
Support funding [2] principal drawdown	1,200	1,200	0	4,200	4,200	0	9,600	9,600
ITFF loan principal repaid	0	0	0	0	0	0	(1,014)	(1,014)
Support funding [2] principal repaid	0	0	0	(2,166)	(2,166)	0	(7,666)	(7,666)
Interest paid	0	0	0	0	0	0	(1,064)	(1,064)
PDC dividend paid	0	0	0	0	0	0	(3,326)	(3,326)
Capital element of finance lease rental payments	0	0	0	0	0	0	0	0
Total net cash inflow / (outflow)	**(388)**	**300**	**(688)**	**1,090**	**285**	**806**	**505**	**505**
Closing cash	**6,480**	**2,037**	**4,444**	**6,480**	**2,037**	**4,444**	**2,257**	**2,257**

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

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

Appendix 4
CIP Profile



Trust Board	
Agenda Item	7.1
Title of Report	Sustainability and Transformation Partnership Funding requirements
Date of Meeting	28th June 2017
Author	Gareth Lawrence Deputy Director of Finance
Accountable Executive	David Allison Chief Executive Officer
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Risk 13
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper	To approve
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

1. Executive summary

The purpose of this paper is to approve the Trusts allocation of funding to support the Sustainability and Transformation Partnership (STP) during 2017/18. The Trust Board are also asked to note the high level schemes that have been identified for the funding to be utilised on and the overall programme of work that the STP will be undertaking.

The STP have requested £1.6m of funds from NHS organisations to support the development and delivery of the identified programmes of work. The Trust allocation of the required support equates to £57k.

2. Background

The "Next Steps" document was published on the 31st March 2017; this document set out a series of practical and realistic steps for the NHS to deliver a better, more joined up and more responsive service. Following this release the STP membership group was presented with the Cheshire and Merseyside response which was approved by the group on the 24th May 2017.

At the time of its approval the Group agreed that further resource would be required in order to deliver the programmes of work identified within the document.

The full programme costs for the four strategic work streams and the eight cross cutting themes in 2017/18 were set out at the May membership meeting and totalled some £7m. Positive contributions from NHS England (NHSE) and other existing sources reduced the further funding required for a full year down to £2m. However, recognising that the decision to proceed was not made until the end of May the pro-rata ask of the system for 2017/18 is £1.6m. In line with previously agreed charging mechanism it was agreed that this would be charged out to all NHS organisations within the STP based on a 50% fixed contribution and a 50% fair share contribution.

3. STP Programmes

The total cost of the resource required to support the STP programmes of work for 2017/18 is c£7m. The following programmes of work have been funded by sources external to the STP:

Programme		Funded By
▪ Out of Hospital/Prevention at scale	-	NHSE
▪ Cancer pathways	-	Alliance
▪ Neuro pathway	-	Vanguard
▪ Women & Children	-	Vanguard
▪ GP Five Year Forward View	-	NHSE

The funding required from the NHS Organisations within the STP will support the following programmes:

- Clinical Support Services
- Corporate Services
- Cardiovascular Disease (CVD)
- High Quality Hospital Care
- Learning Disabilities
- Mental Health
- Urgent Care

The funding provide by the STP members will be split between programme management, communication and engagement, as well as being utilised to bring in specialist skills and advice.

4. Cost/CQUIN

The cost of supporting the STP programmes for the Trust is £57k. This has been calculated by a 50% fixed allocation to all organisations and a further 50% allocated by respective size.

Within the CQUIN's allocation for 2017/18 0.5% (c£1.1m) relates to agreement to work within the STP process. To access this resource the Trust must demonstrate that plans have been approved by respective Trust Boards within the STP. Through the approval of this support the Trust will be demonstrating alignment to the overall STP plan.

5. Conclusion

The Trusts allocation to support the continued development of the STP programmes is £57k. The support of the STP work is key in delivering the FYFV and the Trust's CQUIN allocation for 2017/18.

6. Recommendation

The Trust Board is asked

- To approve the Trust contribution to the STP for 2017/18
- To note the programme of schemes the overall funding will be supporting.

David Allison
Chief Executive Officer
June 2017

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF PUBLIC MEETING

24 MAY 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
Graham Hollick	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
Colin Maher	Member of the Public
Gemma Herbertson	Corporate Governance Manager
Terry Whalley	Incoming Director of Strategy
James Mawrey	Director of Workforce*
Paul Charnley	Director of IT and Information*

Apologies

*denotes attendance for part of the meeting

Reference	Minute	Action
BM 17-18/035	**Apologies for Absence** Noted as above	
BM 17-18/036	**Declarations of Interest** None	
BM 17-18/037	**Chairman's Business** The Chairman advised the Board of the following recent consultant appointment: • Dr Suzanne Amin – Consultant Radiologist	
BM17-18/038	**Cyber-Attack** The Director of IT and Information provided the Board with an update on the current position in the Trust and that of its partners in relation to the recent Cyber-attack. The Director of IT and Information confirmed that the Trust had not been infected but it had been affected by the recent cyber-attack. He confirmed that 300 servers had all been patched and were up to date; 95% of the	

Reference	Minute	Action
	Trust's approx. 3400 laptops and PCs had been updated and that the Trust was working with vendors in relation to its medical devices. The Board was updated on the position with neighbouring partners as follows: • Royal Liverpool closed their network which impacted on out of hours radiology services however the Trust did ensure that a radiologist was available on the Trust site during this period. • Microbiology services in Manchester were shut down and operated under business continuity arrangements • Cheshire Wirral Partnership were infected and again operated under business continuity arrangements. Mental Health patients were treated in the main Emergency Department without any concerns. • Southport and Ormskirk were badly infected for a week. • Aintree lost 2 CT scanners • NWAST reporting facility was intermittent The Director of IT and Information reiterated to the Board the importance of the work undertaken by the Trust before the attack as well as during the attack which allowed the Trust to remain safe. He reminded members of the action raised at Audit Committee some time ago relating to preparedness for a cyber-attack which had been invaluable. He also gave praise for the work of Helen Nelson, Head of Emergency Preparedness who co-ordinated activity during this period. The Board sought to understand what would happen if the Trust had been infected. The Director of IT and Information confirmed that the Trust would have taken action in line with other Trusts and shut down its networks, isolated its machines and moved into a "back up" position. The Board sought and received confirmation that the "back up" systems had been tested albeit not for this particular scenario. The Board was pleased to note that the work undertaken by the Trust over a number of years had improved the resilience of its network on this occasion. The Director of IT and Information confirmed that there was learning from this event not only for this Trust but for all organisations particularly in terms of co-ordination across NHS organisations which would be progressed at pace. The Chief Executive advised the Board that cyber security was a key part of the STP digital strategy and it had been recently agreed that the Trust's Director of IT and Information would lead on this work across the STP footprint of Cheshire and Merseyside.	
BM 17-18/039	**Chief Executive's Report** The Chief Executive presented the report and highlighted the following areas for discussion: **Clifford Mann A & E Visit** – the Board was advised that the visit had validated the plans that both the Medical Director and Chief Operating Officer had for challenging the way the department works and recommended that the Trust mandated the proposed patterns of work. The Medical Director	

Reference	Minute	Action
	confirmed that a meeting was scheduled with ED consultants and the Chief Operating Officer for later in the day to progress this. Clifford Mann also provided some useful suggestions for improvement which the Trust was progressing. **Health and Wellbeing Plan** – the Board was pleased that the Trust was encouraging staff to be proactive in this regard. **A & E 2017/18 Launch Event –** the Chief Executive outlined the main purpose for the teleconference given the national focus on A & E and the launch of the 9 point plan which covered the whole of the health and social care system which was now being progressed through the A & E Delivery Board supported by NHSE/NHSI colleagues. The Board sought to understand whether the Commissioners were working with the system to change contracting arrangements in order that partners were incentivised to do the right thing. The Chief Executive reported that social care commissioning and the administration of the Better Care Fund was much more visible although the schemes within it required much more detail. The Board debated the potential risk of penalties for non-adherence to the 9 point plan and was advised that penalties would not apply directly as the Trust had signed up to the control total however there is a risk of loss of STF funding for non-achievement of A & E. With regards to the partners, there is no risk of penalties even though the 9 point plan is mandated. The Board requested that the Trust report on those elements in the 9 point plan that were associated with the Trust as part of future reporting in this area. **Digital Leaders Programme** – the Board was advised of the link between this programme and the Global Digital Exemplar (GDE) status in that a key part of this relates to training of clinical staff. The Board requested an update on the release of GDE monies and was advised that this was still not available despite being assured that this would be received before Christmas. The Chief Executive advised the Board that the Trust had had to revise its plans again to minimise the risk of expenditure exposure in this regard. The Board asked specifically whether the Trust was incurring expense that might not be covered. The Director of Finance advised that this related to one post only in Pharmacy where there was nominal risk. **Population Health** – the Chief Executive reminded members that this work commenced as part of the Vanguard project and the development of a series of registries and now the Wirral Care Record. He confirmed that partners had agreed to a follow up meeting to progress this work at pace. **NHS Improvement** – the Chief Executive outlined the focus for the next Progress Review Meeting which was due to take place on 1st June 2017. **Accountable Care** – the Board was updated on the plans in relation to accelerating accountable care which included the facilitated discussion planned for 25th May 2017 with all partners. **Sustainability and Transformation Plans STP –** the Chief Executive confirmed that a membership meeting was being held later that day. He reported that the changes proposed in relation to governance were welcomed as this acknowledged the amount of work and therefore governance requirements at a local level. **Nurses Day** – the Director of Nursing and Midwifery reported on the positive feedback from the day. She gave thanks to partners who provided yoga and pamper sessions. **Manchester Bombing** – the Chief Executive took the opportunity to report on the Manchester bombing. Although not directly involved as a hospital, he	**JH**

Reference	Minute	Action
	was aware how much this had affected colleagues in neighbouring hospitals and the Trust was therefore supportive of them. He did confirm that the Trust was providing paediatric resource along with many others as these had been exhausted in Manchester. The Board sought and received assurance that the Trust was reviewing its emergency preparedness in view of the increase in terror levels to the critical level.	
BM 17-18/040	**Patient Story/Learning** The Director of Nursing and Midwifery reported upon an e-mail complaint from a mother who had given birth to a baby girl in March of this year. Although the new mum reported on the amazing care of theatre and recovery staff, she was disappointed that not all staff were professional and reported that she felt that some staff did not care, particularly on ward 54. The complaint sighted concerns with monitoring of a catheter which would have been of more concern if this lady had been on her own. The Director of Nursing and Midwifery confirmed that the concerns were being addressed with her teams.	
BM 17-18/041	**Nurse Staffing Report** The Director of Nursing and Midwifery presented the Nurse Staffing Report covering the period March and April 2017. She highlighted concerns with nurse vacancy rates despite the strong recruitment strategy. The Board was advised of the current vacancy rates between Medicines and Acute and Surgery these being 9.89% and 3.8% respectively which had prompted the Trust to look at vacancy substitution which involved creating roles in various bands and disciplines to support more tradition roles. The Director of Nursing and Midwifery cited an example of pharmacy technicians supporting wards with the medicine safety agenda and updated the Board on the partnership work with NHS Professionals to ensure that Trust is safely staffed. The Board reviewed CHPPD rates by ward and was updated by exception on the 2 areas rated at red for fill rates as follows: **M1-** the Board was advised that the bed base flexes with demand and acuity and had been reduced on the occasions reported. The Director of Nursing and Midwifery confirmed that daily reviews were undertaken and assurance has been provided that there was sufficient staffing for patient acuity during the period reported. **ITU –** the Director of Nursing and Midwifery advised that the bed occupancy and acuity in this area changes regularly. She did say that there had been an increase in the number of incidents reported all of a low level and in the main related to staff feeling upset at having to move to support other areas of greater need in the Trust. She confirmed that the Freedom to Speak up Guardian was working with the team as this was impacting on turnover which was increasing. She also advised that a rotational rota was being implemented to address the concerns together with terms and conditions to support this. The Board was advised that CHPPD data was now available although it was proving difficult to compare between Divisions. The Director of Nursing and	

Reference	Minute	Action
	Midwifery confirmed that Ward 19 was now closed which would help with fill rates and enable the HPV programme to progress and ultimately improve staff morale. The Board sought to understand the main reasons for the increase in vacancy rates and the turnover in ITU. The Director of Nursing and Midwifery confirmed that some staff were genuinely tired, some had been promoted internally and some had been lost to other Trusts. She updated the Board on the work being undertaken to look at how the Trust ensured that it valued staff all the time. The Board sought assurance that the balance between registered nurses and other substitution posts were right in terms of acuity ratios. The Director of Nursing and Midwifery updated the Board on the acuity audits being undertaken with the first results being available at the end of Quarter 1. The Board sought to establish the consequences of having near 10% vacancy rates in Medicines and Acute and in particular the impact on sickness rates. The Director of Nursing and Midwifery confirmed that there had to date been no impact on sickness rates. She updated the Board on recruitment initiatives being deployed and the recent recruitment of 10 spanish nurses and the work being undertaken to scope nurses from the Phillipines as well as an update on the 6 Associate Nurse Pilot posts which was reported as working very differently to support wards. The Board supported all the actions being taken. The Board sought and received assurance again on the overall establishment rates as these show an overall reduction in Band 5 staffing levels. The Chief Executive reminded members of the Trust's commitment to over recruit in this area but pointed out the issue was not related to a cap on recruitment, it was associated with the difficulties with availability of nurses nationally. The Board sought to establish to what extent the Trust was working with other organisations to pool resources where possible. The Director of Nursing and Midwifery confirmed that she was working closely with the Community Trust and the Countess of Chester to ensure that nurses have experience across a range of settings. She highlighted a local issue involving theatre staff being attracted to the private sector because of the attractive terms and the work therefore she was undertaking to retain staff using internal initiatives.	
BM17-18/042	**Report of the Quality and Safety Committee** Dr Quinn presented the report from the Quality and Safety Committee following the meeting on the 10th May 2017. She highlighted the following areas: **Patient story –** the emphasis on the need to involve carers in the treatment plans of patients with Dementia was highlighted **Board Assurance Framework –** changes to the risk scores and emphasis in quality and safety and clinical outcomes respectively was highlighted. **Breast Symptomatic Breach –** Dr Quinn confirmed that no patients had come to any harm as a result of an increase in demand recently**.** **Annual Review of Committee Effectiveness –** although the Trust awaited the outcome of the quality governance review, the Committee reported performance against its terms ofreference and the focus for the future. The	

Reference	Minute	Action
	Medical Director confirmed that the quality governance review had been received and reported at the Senior Management Team on the previous day. She suggested that the actions plans developed as a result of the review should form part of a Board workshop in July. **Workforce and OD** – the Committee shared the Board's concern with rising vacancy rates and the work being undertaken to address this. Dr Quinn updated the Board on the work undertaken to comply with the Lampard recommendations in relation to CRB/DBS checks. She advised that the Committee recommended that those staff who had not been subject to a DBS disclosure check during the reporting period be reviewed to ensure that these staff were not located in "high risk" areas as classified by the Trust. The Committee reported on the in-depth review into grievance processes and agreed to report further on the cause for elevated sickness and grievance levels at a future meeting. **Quality Dashboard** – Dr Quinn reported on the work being undertaken to improve integrated performance reporting and noted how even the embryonic dashboard had promoted a wider discussion. **Quality Account** – Dr Quinn reported on the review of this year's Quality Account on behalf of the Board which included the decision, previously supported by the Board, to streamline the priorities against SMART objectives. **Health and Safety Annual Report** – Dr Quinn confirmed that the Committee undertook a full review of the work undertaken during 2016/17 on behalf of the Board and was pleased that all areas were reporting compliance with the exception of two elements for which action plans were being progressed. Two key issues highlighted were the recommendations from the asbestos review and the best practice in relation to water safety being embedded across the Trust. **Patient safety alerts –** the Board was updated on the work it delegated to the committee in respect of action being taken in response to patient safety alerts. Dr Quinn confirmed that 85 of the 89 alerts received had been actioned with actions plans in place in relation to the outstanding 4. **CQC Compliance and Assurance Report** – the Committee was pleased to note that the internal care quality inspections had started again and that the focus was on the domain of "safe". **Director of Nursing and Midwifery Performance Report** – the Board noted the typographical error in relation to maternity recommend rates. The response rate was 30% in this area with the recommend rate being 100%. **Medicines Optimisation Dashboard** - this was reported positively as it provided the Trust with the necessary information to monitor more effectively compliance and incident rates. The Board sought and received assurance that where workforce issues had been reported that this was triangulated with targets not being met and incidents being raised with a view to ensuring action was being taken appropriately. The Board noted that the full Health and Safety Annual Report had been received under separate cover and the preventative work being undertaken in relation to asbestos to ensure that the Trust is aware of where the potential vulnerabilities are. The Board agreed that it was indeed a positive report and formally approved this.	

Reference	Minute	Action
BM 17-18/043	**Integrated Performance Report** • **Integrated Dashboard and Exception Reports** The Chief Operating Officer presented the integrated performance dashboard and advised the Board that there would be a change in reporting as a result of the new Director of Operations and Performance commencing employment and that this would include an element of forecasting. She highlighted the following areas out of the report: **A & E 4 Hour Access Standard** – the Board was advised that the Trust did not hit the agreed target for April and that May was proving to be extremely challenging although it was expected that performance in June would enable the Trust to achieve the quarter. The Board sought to establish the position on discharge as the use of the Full Capacity Protocol appeared to be frequent and concerns were raised as to the impact on staff. The Chief Operating Officer reported approx. 50 patients on the integrated discharge teams list with 80-100 patients at anytime being in the hospital who were medically optimised which was the equivalent of 3-4 wards. The Board queried how the Trust was sure it had the right capacity when it was operating at Full Capacity so often. The Chief Operating Officer agreed and reminded members of the work being undertaken on bed modelling which was due to be completed by the end of May. The Board debated the work being undertaken on admission advoidance and step down; the absence of targets for delays in continuing healthcare turnaround and the exacerbation of the issue as a result of the closure of Eastham walk in centre by the Community Trust as they were unable to staff it. The Board agreed that accelerating an accountable care system where all partners were regulated to do the right thing was the only way forward for the population of Wirral. **18 Week Referral to Treatment Times RTT –** the Chief Operating Officer updated the Board on the work of the Intensive Support Team IST who were focussing on the most complex areas with a view to reporting their findings by close of play that day. The Board was updated on the plans to reduce the backlog waiting list through internal initiatives and external activity recognising that this would take some time although improvements were expected over the year. The Board noted the number of 52 waiters reported and sought to establish whether the Trust expected to see many more. The Chief Operating Officer advised that this was likely to be the case as the Trust continued to cleanse the patient waiting list. She reiterated the process put in place to protect patients by reviewing all long waiters ie 30 week plus within each speciality to ensure no patient harm incurred. The Board sought to understand how feasible it was to achieve an improvement trajectory during a busy holiday period. The Chief Operating Officer confirmed that the trajectory did not include the backlog as the IST team were clear that the Trust could not accurately forecast as a whole until the cleansing work had been undertaken.	

Reference	Minute	Action
	Diagnostic Six Week Wait – No issues with performance reported **Cancer** – the Chief Operating Officer confirmed that there were no issues to report in relation to 62 day waits. She confirmed that the 2 week breast symptomatic wait reported earlier in the meeting was not recoverable for quarter 1 although the Trust would achieve the overall 2 week wait standard for direct and GP referrals. She reassured the Board that although there had been a slight delay in the diagnostics recently, there had not been any delay in treatment. The Board was advised that plans were in place to track progress closely in this area and of the introduction of a GP with special interest in this area from July 17. **Infection Control** – 4 reported C difficile toxins were reported of which 2 were classed as avoidable against the threshold of 29. The total number of avoidable C difficile cases for the year to date was reported as 3. **M1 Finance and Cost Improvement Programme Report** The Director of Finance presented the M1 finance and cost improvement report and highlighted the following areas: • The overall deficit at the end of April 2017 was reported at £2.2M which was in line with the profile of the financial plan submitted. • Use of Resources was reported at 3 in line with the plan • Cash was reported at £6.8M which was £5.1M above plan • The Cost Improvement Plan delivered £0.2M in month compared to the planned £0.7M • Payment by results PBR activity was reported above plan by £0.6M as a result of over performance in elective/day case, non-elective and A & E activity. This was however offset by under performance in non-PBR activity of £0.5M and PBR excluded drugs of £0.7M. The Director of Finance confirmed that the Surgical Division had delivered its activity plan in month although Medicine and Acute was below plan by £0.5M mainly associated with PBR drugs. Key activity areas were reported upon, these being trauma and orthopaedics which was above plan; outpatients which was below plan including ophthalmology; A & E was above plan. The Board was concerned with the amount of escalation costs which were above the allocation for the whole year. The Director of Finance also advised the Board of the use of CQUIN resource to the sum of £700k out of a total allocation of £1.3M in order to meet the STF trajectory. The Board sought to establish whether the CIP position at Month 1 was recoverable and how confident the Trust was with the Divisional plans. The Director of Finance confirmed that he was confident with the Divisional plans although he did agree that these needed pace and that a savings plan of 4.6% of operating expenditure was a challenge but the Trust did deliver the challenge last year. He also reported that the RTT backlog challenge was not factored into the plan which for surgery alone represented a cost pressure of £6.5M. The Chief Operating Officer outlined the rigour put in	

Reference	Minute	Action
	place by the Service Transformation Team which was monitored through the Transformation Steering Group to risk assess all schemes to ensure no impact on quality which was in line with the Trust's agreed appetite for risk. The Chief Executive advised that the national focus that all Trusts should live within their means and deliver the A & E access standards was inevitably very difficult to achieve. The Chief Operating Officer concurred with this sentiment especially as many of the whole system schemes would not impact until October 2017 and although relationships with partners continues to improve it is this Trust that is expected to absorb the costs in the meantime. The Board sought to establish whether there was any way to relate costs with the impact on target and recommended if there was to include this in future performance reports.	
BM 17-18/044	**Workforce and Organisational Development Annual Report** The Director of Workforce presented the Annual Report and highlighted the following areas of good performance in 2016/17: attendance levels; education and training days; mandatory training; appraisal rates; vacancy levels which were below the national average and agency spend which remained strong and below the ceiling. The Board was advised that there was certainly more work to do particularly in those areas highlighted in the NHS staff survey and associated with organisational development and the culture of the organisation. The Board acknowledged the improvements made in areas of mandatory training and appraisal rates in particular but sought further assurance on succession planning and skills training as this appeared to be absent. The Director of Workforce agreed that there was more work to do and the apprenticeships throughout the organisation would support this. The Board sought further information on the increase in the admin and clerical numbers as these appeared to have increased over the last 3 years when the expectation would be that these would reduce. The Director of Workforce agreed but advised that the IT enabled schemes needed to implement the systems before the Trust could make the changes that would drive the savings. Whilst the Board welcomed the positive report, it did note the absence of identified action to address areas of concern, citing vacancy rates in Medicine and Acute and the work required to develop new roles to ensure the Trust had a sustainable workforce for the future. The Board also requested an update on E-learning as this would free up staff time and improve compliance with mandatory training. The Director of Workforce confirmed that the E Learning packages were available however further work was required to make these available and "live" and he was working with the Director of IT and Information in this regard. The Board sought to establish whether the under-performance in mandatory training, although high, posed a risk to the organisation. The Medical Director agreed with the potential concern as this had been discussed with Senior Managers and at the Quality and Safety Committee particularly in	

Reference	Minute	Action
	relation to safeguarding training. She advised that the target of compliance by October 17 was not ambitious enough and had therefore put actions in place to address this by putting on a Trustwide event and using Audit days to improve overall mandatory training compliance. The Medical Director outlined the areas for improvement in respect of the culture associated with values and respect that had been noted in the quality governance review and the leadership survey. She confirmed that she had been reinforcing these values and the need for respect at each large forum she has been addressing and was putting in place actions to address this. She advised that if staff did not feel safe to raise concerns this would pose a risk to the organisation and also impact on recruitment hence the reason why this was a priority for the new few months.	
BM17-18/045	**Report of the Audit Committee** The Chair of Audit Committee confirmed that at its meeting on the 19th May 2017, the Committee reviewed in detail, in terms of complying with the guidance, 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 Account • The Letters of Representation by the Board on the Financial Statements and Quality Account. The Board was advised that the External Audit Opinion of the Accounts was "unqualified" and in view of NHSI's agreement of the Trust's Control Total, the External Auditor could also support the Going Concern Assessment. The Board was also advised that the Finance Team had been working with the External Auditors with a view to negating the need for an Emphasis of Matter statement in relation to continuing resources and funding being required from NHSI. The Chair of Audit Committee was pleased to confirm that these discussions had concluded and that the External Auditor had removed the need for the Emphasis of Matter statement. The Board was pleased to note that there were no mistakes in the Accounts which was a significant accolade for the Director of Finance and his team. The Board was advised that the Trust had received a "qualified" Limited Assurance Report on the Quality Account in relation to data quality issues identified in the national Referral to Treatment Time indictors incomplete pathways. It was confirmed however that all data quality errors had been identified in cases which had not been subject to the Trust's revised internal review procedures and there was recognition by the External Auditor that it would take time to fully embed the renewed processes and that it was supportive of the action being taken by the Trust. The Chair of Audit Committee confirmed that the sample of 25 revealed 6 errors, 1 of which should not have been included with the other 5 being recorded as a detriment to the Trust not the patient. The Board was also advised that the External	

Reference	Minute	Action
	Auditor was pleased with the changes made by the Trust and therefore did not make any further recommendations for improvement. The Chair of Audit Committee recommended to the Board that approval be granted for 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 Account and the Letters of Representation by the Board on the Financial Statements and Quality Account. She confirmed that the Letters of Representation were standard which was positive. The Chair of Audit Committee also presented the Annual Audit Committee Effectiveness Report for 2016/17 which included the priorities for 2017/18. This was supported by the Board.	
BM17-18/046	**Approval of Annual Report and Accounts 2016/17** • **Annual Accounts 2016/17 and Audit Opinion** The Director of Finance outlined the key results arising from the Audit as follows: • The Trust is agreed to be a **going concern** • The Audit Opinion was **unqualified** • The Value for Money Conclusion was **unqualified** • The ISA 260 (Audit Findings) report was **"clean"** • There were no internal control deficiencies identified The Board was provided with the key account headlines for capital; cash and the overall financial outturn position. The Director of Finance also outlined each of the key primary statements as follows: • The statement of comprehensive income • The statement of financial position • The statement of changes in equity • The statement of cash flows The Board was provided with a breakdown in the movement of capital assets and the impact of the single site revaluation and asset lives as requested by the Audit Committee. The agreement of balances included confirmation that all submissions were made in accordance with the national timetables and that the final count of variances over £250k was 3 which had been investigated in detail, and all relate to instances where the Trust's accounting treatment was correct. The Director of Finance confirmed that 23 Trusts last year across a variety of sectors had an Emphasis of Matter Statement included and that this had been raised significantly this year. He confirmed that if the Trust had not managed to negate this statement this would not have affected the going concern assessment.	

Reference	Minute	Action
	The Board sought and received assurance that the reference to possible litigation claims in the letters of representation was appropriate in view of the information provided by the NHS Litigation Authority which the Trust relied upon for the accounts. The Board formally approved the Annual Accounts and the letters of representation. • **Quality Account and Audit Opinion** The Medical Director presented the Quality Account and Audit Opinion noting the previous discussion on the qualified position with regards to RTT incomplete pathway data. She confirmed that the appropriate review had also been undertaken at the Quality and Safety Committee and that as previously discussed the Trust had not set any new priorities for 2017/18 preferring instead to focus on achieving outcomes for those already in existence. The Board was pleased to note that no errors were found on the A & E data and that the External Auditor had managed to undertake the audit on the Mortality Reviews as requested by Governors. The Board noted an error in the Quality Account as this referenced the Health and Social Care Act 2009 and not 2012 which would be amended. The Board formally approved the Quality Account and Audit Opinion. • **Annual Report and Annual Governance Statement** The Director of Corporate Affairs presented the Annual Report including the Annual Governance Statement (AGS) noting that the changes requested by the Audit Committee to the AGS in relation to Cyber Security had now been included. The Director of Finance tabled an updated remuneration report, having now received the correct information from the NHS Pensions Benefit Agency in relation to the Chief Executive. He confirmed that all other text remained unchanged. The Board formally approved the Annual Report including the remuneration report and the Annual Governance Statement.	
BM17-18/047	**NHSI Provider Licence Board Declarations** The Director of Corporate Affairs presented the recommended Board declarations in respect of the NHS Provider Licence. The Board was reminded of the requirements to self-certify as follows: • That as a Provider the Trust had taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution **(Condition G6 (3))** • That as a Provider the Trust had complied with required governance arrangements **(Condition FT4 (8))** • If providing Commissioner requested services that as a Provider that	

Reference	Minute	Action
	he Trust had a reasonable expectation that required resources would be available to deliver the designated service **(Condition CoS7 (3))** The Board was also reminded that as in previous years, the Trust was required to confirm that it had provided all the necessary training to Governors in order to undertake their statutory role. The Director of Corporate Affairs outlined the recommendations for each of the declarations as follows and the rationale for each of these as detailed in the report: • G6 **– Not Confirmed** • FT4 - sections 1, 2, 3 and 6 **Confirmed** and sections 4 and 5 **Not Confirmed** • CoS7 – **Confirmed against statement 3a** The Board agreed that the declarations were consistent with the Trust's quarterly review at the Audit Committee; current operational performance; the findings of the Well Led Governance Review and the "requires improvement" rating from the CQC. The Board formally approved the declarations as recommended and the rationale for each of these. The Board also supported the statement on Governor Training. The Board was advised that unlike in previous years, the Trust was not required to formally submit a return to NHSI in relation to the declarations and that the templates and supporting information were evidence of the Board's decision. The Board was also advised that from July 2017 NHSI would contact a select number of Trusts with a view to asking for evidence to support the self certifications.	
BM17-18/048	**Board of Directors** The Minutes of the Board of Directors held on the 26th April 2017 were confirmed as an accurate record. **Action Log** The Board accepted the action log as presented and agreed that action numbers 5 and 6 were now completed.	
BM17-18/049	**Items for the BAF/Risk Register** The Board requested that the Director of Finance review the financial risks in relation to possible further intervention or special measures and that the Director of IT and Information review the IT risk in relation to Cyber Security.	**DJ** **PC**
BM 17-18/050	**Items to be considered by the Assurance Committees** The Board agreed the following focus areas for the assurance committees:	

Reference	Minute	Action
	Finance Business Performance and Assurance Committee – review the 9 point A & E mandated action plan in particular those points specifically aimed at the Trust.	
BM17-18/051	**Any Other Business**	
BM 17-18/052	**Date and Time of Next Meeting** Wednesday 28th June 2017 at 9.00am in the Boardroom, Education Centre, Arrowe Park Hospital.	

……..……
Chairman

……..
Date

ACTION LOG
Board of Directors
Updated – June 2017

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 24.05.17						
1	BM17-18/039	Provide regular reports on the A & E 9 point action plan – specifically those areas that relate to the Trust	**JH**		June 17	
2	BM17-18/049	Review the financial risks on the BAF in relation to possible further intervention or special measures	**DJ**		July 17	
3	BM17-18/049	Review the IT risk on the BAF in relation to cyber security	**PC**		July 17	
Date of Meeting 26.04.17						
4	BM17-18/006	Provide a trajectory to achieve "good" in the next CQC inspection	**SG**		June 17	
5	BM17-18/013	Provide details of what "good" looks like under the Equality and Diversity indicator for inclusive leadership	**GW**		June 17	
6	BM17-18/013	Ensure Equality and Diversity is covered throughout the Trust's Mandatory training programme	**GW**		June 17	
Date of Meeting 25.01.17						
7	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						

8	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	
9	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**		
10	BM16-17/037	Explore the impact of technology when reporting CHPPD in the future	**GW**		April 17	**Update will be provided at March Board**
11	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						
12	BM15-16/297	Present the Medical Engagement Strategy	**SG/JM**	**Included as part of Board Development session in June**	May16	