Wirral University Teaching Hospital NHS
NHS Foundation Trust

Board of Directors

Public Board

30 November 2016

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MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 30th NOVEMBER 2016
COMMENCING AT 9.00AM IN THE
BOARD ROOM
EDUCATION CENTRE, ARROWE PARK HOSPITAL

AGENDA

1	**Apologies for Absence** Chairman	v
2	**Declarations of Interest** Chairman	v
3	**Patient's Story** Director of Nursing and Midwifery	v
4	**Ward Accreditation Programme, Gold Award Presentation** Director of Nursing and Midwifery	p
5	**Chairman's Business** Chairman	v
6	**Chief Executive's Report** Chief Executive	d

7. Quality and Safety

7.1	**Bi-monthly Nurse Staffing Report** Director of Nursing and Midwifery	d
7.2	**Appraisal and Revalidation Annual Report** Interim Medical Director	d

8. Performance and Improvement

8.1 Integrated Performance Report

8.1.1 Integrated Dashboard and Exception Reports Chief Operating Officer	d
8.1.2 Month 7 Finance and Cost Improvement Programme Report Director of Finance	d
8.1.3 Assurance on Agency Spend Director of Finance / Director of Workforce	d

9. Governance

9.1	**Report of the Quality and Safety Committee** Chair of Quality and Safety Committee	d

9.2	**Charitable Funds Proposal** Director of Finance	d
9.3	**CQC Compliance and Action Plan Progress** Director of Nursing and Midwifery	d
9.4	**Board of Directors**	
	9.4.1 Minutes of the Previous Meeting • 26 October 2016	d
	9.4.2 Board Action Log Director of Corporate Affairs	d

10. Standing Items

10.1	**Items for BAF/Risk Register** Chairman	v
10.2	**Items to be considered by Assurance Committees** Chairman	v
10.3	**Any Other Business** Chairman	v
10.4	**Date and Time of Next Meeting** Wednesday 25th January 2017	v

Board of Directors	
Agenda Item	6
Title of Report	Chief Executive's Report
Date of Meeting	30 November 2016
Author	David Allison, Chief Executive
Accountable Executive	David Allison, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	ALL
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To Note
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

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

Internal

- **Cerner Phase 3 "Go Live" Update**

I am pleased to be able to confirm that our planned "go live" of Wirral Millennium Phase 3 went ahead at 8am on Saturday 26 November.

This means that our colleagues in Critical Care and Theatres will be using Millennium as their patient record and they'll benefit from having their electronic medical devices connected to the system so patient data will be sent to their record automatically. Colleagues across the organisation will also start prescribing and administering IV Infusions on Millennium.

At the time of writing there was also another "go live" planned on Monday 28th November paperless patient records with the introduction of electronic medical noting for all inpatients.

Building on the roll out and development of Wirral Millennium over the last eight years, this go live will further cement our position as the most digitally advanced Trust in the country and as a Centre of Global Digital Excellence.

Regulatory

- **NHS Improvement (NHSI)**

The Trust met with NHSI on the 1st November 2016 to discuss progress against the financial plan; strategic plan and operational plan. NHSI were supportive of all actions being taken by the Trust however outlined its expectation that the Trust should continue to work with our health economy partners to look for opportunities to reduce the system control total of £5M which they recognise will need their support as well as that of NHS England.

NHSI also stressed the importance of the health economy progressing at pace with the proposals for an Accountable Care Organisation by April 2017 and again offered their support in this regard.

A full review of operational performance was undertaken with NHSI acknowledging the sustained improvement in A & E performance; the plans being undertaken to improve RTT performance although there was recognition that some of the actions being implemented would support achievement of the target in the long term but was likely lead to a deterioration in the short term. The Trust was also asked to produce a case study for NHSI which outlined the award winning work undertaken to manage and control CPE infections which it could share with other organisations.

Finally NHSI recognised that the Trust had made significant improvements and a recommendation therefore would now be made to remove the Section 111 enforcement condition from the Trust's Provider Licence.

- **Care Quality Commission (CQC)**

The Trust met with the CQC on 10th November 2016. The CQC was supportive of the action being taken to not only address the areas for improvement from the last inspection

but also to ensure compliance against the fundamental standards at a minimum of a "good" rating.

The Trust and the CQC discussed arrangements for a further inspection in 2017 and the two options being debated by the regulator. Further details of the Trust's journey of transformation and preparedness can be found in the full report contained on the agenda.

External

- **Winter Planning – a health and social care economy approach**

Planning for winter this year will be extremely challenging, operationally the Trust has an increase in admissions compared to 2015 this has been exacerbated by a significant reduction in community provision. Our winter ward has actually been open all summer as a step down ward for medically fit patients. This has now changed into an acute ward as more patients become ill at this time of year.

As part of our plans we have opened ten beds at Elder Home at Clatterbridge. We also have 'discharge to assess' beds where patients who are medically fit, but require ongoing treatment are no longer in an acute bed and these assessments are taking place in the community. As the Wirral health and social care economy moves forward with a 'home first' model of care, 'discharge to assess' is now also taking place in people's own homes. The work in our community is aimed at improving patient flow. If this is successful it may be rolled out further. This is all against a background of positive feedback from Emergency Care Improvement Programme (ECIP) on internal processes to support non-elective flow.

Strategy

- **Sustainability and Transformation Plan STP**

The draft Sustainability and Transformation Plan (STP) for Cheshire and Merseyside was published on 16th November 2016 This sets out how the health and care system can remain fit for the future and respond successfully to the growing demands that are being placed on it, alongside ambitious ideas to improve the health of people living and working in the region. The document sets out a shared core purpose to ensure that the people of Merseyside and Cheshire become healthier than they are now and can continue to have access to safe, good quality and sustainable services.

Further details of how these plans are being developed will be provided over the coming weeks however I would remind members that the Trust's strategy as outlined in its strategy booklet remains the focus of our attention.

- **Joint Engagement Event with Primary Care Wirral and Trust Medical Leaders**

Earlier this month the Trust hosted a very successful joint event with Primary Care Wirral GP's and Practice Managers. 25 Trust colleagues attended including members of the Senior Management Team, a Non-Executive Director and 18 Medical Leaders, along with 20 GPs and Practice Managers. The event was an opportunity to develop working relationships and provided an overview of Trust and Primary Care developments prior to an engagement session. From this some great ideas were generated about how we can

improve the way we deliver care for Wirral patients. The Board will be updated on developments as outcomes from the event are taken forward.

Celebrating Success

- **Flu Vaccination Rates**

The Board will know that vaccinating against flu is a key element of the Trust's Health & Wellbeing plan and has been a contributing factor to our low sickness absence rate. We do have a local and national target of 75% for all front line staff to be vaccinated and I am pleased to say that in just 7 weeks we have hit the target and achieved 75.8%, that equates to 3599 staff.

- **Library Quality Assurance Framework**

As part of the Trust's Learning and Development Agreement (LDA) with Health Education England (HEE) North West the library and knowledge service (LKS) is required to submit a self-assessment against the national standards contained in the NHS Library Quality Assurance Framework (LQAF). This assessment is then verified by the Health Care Libraries Unit Team.

The Trust's library and knowledge service is confirmed as 99% (96% in 2015) compliant with the national standards and therefore has slightly improved its green rating, which is a fantastic result.

David Allison
Chief Executive

November 2016

BOARD OF DIRECTORS	
Agenda Item	7.1
Title of Report	Nurse Staffing Report - September / October 2016
Date of Meeting	30 November 2016
Author	Clare Pratt, Deputy Director of Nursing Tracey Lewis, Head of Clinical Excellence & Organisational Development Johanna Ashworth-Jones, Senior Analyst
Accountable Executive	Gaynor Westray, Director of Nursing and Midwifery
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Strategic Objective: To be the top NHS Hospital in the North West; Delivering consistently high quality secondary care services; Supported by financial, commercial and operational excellence. Risk 1 and 2
Level of Assurance • **Positive** • **Gap(s)**	**Positive** • Introduction of Specialty reporting of staffing fill rates and CHPPD allows for easier comparison of staffing data • An Associate Director of Nursing Report has been introduce to provide an auditable trail which provides details from Ward Sisters/Charge Nurses and Matrons on mitigating actions taken to address staffing shortfalls **Gaps** • There has been in increase in staff reported incidents relating to staffing levels
Purpose of the Paper	Discussion
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment	No

1 Executive Summary

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

2 Recruitment Strategy

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

The total Trust vacancy rate for the registered nursing and midwifery workforce in October 2016 was reported as 2.5% which has remained significantly better than the national average of 10%.

When reviewing the vacancy rate for in-patient and Emergency Department Band 5 posts the Trust's electronic staff records (ESR) data identified a vacancy rate of 6.10% for October 2016, this equates to 42.25 WTE Band 5 posts.

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

	February 2016	March 2016	April 2016	May 2016	June 2016	July 2016	August 2016	Sept 2016	Oct 2016
Establishment	707.66	707.66	707.66	689.88	689.88	**691.22**	**692.40**	692.40	692.40
Actual Numbers	658.9	661.82	664.92	653.58	653.02	**656.05**	**648.2**	648.53	650.15
Vacancies	48.76	45.84	42.74	36.3	36.86	**35.17**	**44.2**	43.87	42.25
Vacancies %	6.89%	6.48%	6.04%	5.26%	5.34%	**5.09%**	**6.38%**	6.34%	6.10%

Current Band 5 vacancy position by division for October 2016

Surgery, Women and Children's

- Vacancy rate is 3.07% equating to 7.18 WTE Band 5 posts
- Vacancies within this division remains very low

Medicine and Acute

- Vacancy rate is 7.65 % equating to 35 .07 WTE Band 5 posts
- The Division have experienced some difficulties in recruiting to registered nurse posts and the Associate Director of Nursing is exploring alternative staffing models and skill mix to meet the varying needs of each speciality

The Trust along with our local healthcare partners has been approved as a test site to deliver a training programme for the new Nursing Associate role. This exciting opportunity will enable us to change the future nursing workforce. We will pilot a 2 year work based learning programme, delivered in conjunction with University of Chester leading to a foundation degree supporting our current support staff to become a qualified Nursing Associate.

3 Care Hours Per Patient Day (CHPPD)

Lord Carter's final report, *operational productivity and performance in acute hospitals recommended* that all Trusts start recording Care Hours per Patient Day (CHPPD) – a single, consistent metric of nursing and clinical support workers deployment on in-patient wards. This metric will enable Trusts to have the right staff mix in the right place at the right time, delivering the right care for patients.

Traditional Safer Staffing returns did not allow for planned staffing to be altered from month to month to reflect seasonal variance or closure of beds for operational issues. The use of CHPPD hours to support the review of staffing levels provides further assurance for where staffing fill rates may have decreased but CHPPD has remained static. As CHPPD is based on a comparison of the actual staffing levels and ward activity this is recognised as being a better reflection of staffing levels.

The Department of Health (DoH) Efficiency Centre has developed a Model Hospital Portal to allow comparison of hospital data across the range of Carter recommendations. This Portal does not currently allow for direct monthly comparisons with other organisations as the information displayed is several month out of date (March 2016) however, once this data has been updated and displayed, the Trust will explore best way to benchmark, communicate and share innovative solutions to staffing efficiencies.

The Trust has been collecting CHPPD data for 6 months, this now enables some analysis to be undertaken on this initial data. Table 2 below details the CHPPD for each ward from May to October 2016 against their overall staffing fill rate. The tables have been categorised into Directorate specialties to help provide some specialty comparisons although it should be acknowledged that there are also sub specialties within these such as Ward 23 which is a specialist stroke service within DME. Data has been reviewed to provide an "Average" for each individual ward and the range of CHPPD data for the 6 months to help inform if data is in line and provide some assurance where there are establishment changes, variances in fill rates and staffing pressures.

Table 2 - CHPPD

Orthopaedics	CHPPD information	Indicators	May	June	July	Aug	Sept	Oct
Ward 10	Average: **7.1** Range 6.2 -8.8	CHPPD	7.3	6.2	8.8	6.8	6.5	6.9
		Fill Rate	97%	96%	82%	87%	91%	92%
Ward 11	Average: **9** Range 7.6 - 10	CHPPD	9.9	9	10	8.9	8.4	7.6
		Fill Rate	94%	99%	83%	84%	77%	86%
Ward 12	Average: **10.5** Range 8.4 - 12.5	CHPPD	11.6	10.1	10.5	9.8	8.4	12.5
		Fill Rate	92%	94%	82%	83%	81%	65%
M1	Average: **11** Range 9.3 - 13.2	CHPPD	11.4	10.3	13.2	11.3	9.3	10.7
		Fill Rate	90%	82%	81%	70%	73%	75%
Park suite	Average: **13** Range 11.4 - 15.2	CHPPD	14.1	15.2	11.4	11.5	12.8	13.4
		Fill Rate	95%	97%	99%	111%	100%	91%

Surgical	CHPPD information	Indicators	May	June	July	Aug	Sept	Oct
Ward 17	Average: **6.2** Range 5.7 - 6.5	CHPPD	5.7	6.5	6.5	6.4	5.9	6
		Fill Rate	99%	120%	114%	101%	98%	99%
Ward 18	Average: **5.9** Range 5.7 -6.2	CHPPD	5.7	5.8	6.2	5.8	5.9	5.7
		Fill Rate	98%	97%	108%	99%	101%	100%
Ward 20	Average: **6** Range 5.8 - 6.7	CHPPD	5.8	6.2	5.9	6.7	5.8	5.8
		Fill Rate	99%	101%	95%	96%	96%	96%
ESAU	Average:**15.3** Range 13 - 17.3	CHPPD	17.3	15.9	15.5	14.8	15.2	13
		Fill Rate	100%	99%	99%	99%	98%	97%
M2	Average: **31.4** Range 23.7 - 35.4	CHPPD	23.8	32	30.3	35.4	23.7	43
		Fill Rate	100%	100%	100%	94%	96%	100%
Dermatology	Average: **12.7** Range 9.4 - 16	CHPPD	15.6	11.3	16	9.4	11.5	12.4
		Fill Rate	96%	100%	100%	100%	100%	100%

Women's & Children's	CHPPD information	Indicators	May	June	July	Aug	Sept	Oct
Children's	Average: **11.1** Range 8.1 - 14.9	CHPPD	8.1	10.7	10.7	14.9	11.7	10.2
		Fill Rate	89%	112%	110%	94%	111%	112%
Maternity	Average: **6.1** Range 5.7 - 6.7	CHPPD	6.3	5.9	5.7	5.8	6	6.7
		Fill Rate	98%	98%	98%	94%	94%	99%
Delivery Suite	Average: **35.9** Range 30.8 - 45.5	CHPPD	31.6	37.9	45.5	32.3	30.8	37.3
		Fill Rate	97%	104%	98%	96%	95%	95%
Ward 54	Average: **7.8** Range 6.4 - 9.1	CHPPD	9.1	7.4	8.2	8.1	7.5	6.4
		Fill Rate	100%	100%	97%	85%	92%	76%
Neonatal	Average: **12.6** Range 11 - 14.2	CHPPD	12.7	12.3	11	12.6	12.6	14.2
		Fill Rate	92%	79%	97%	100%	107%	92%

DME / Rehab	CHPPD information	Indicators	May	June	July	Aug	Sept	Oct
Ward 21	Average: **5.8** Range 5.1 - 6.4	CHPPD	5.8	5.3	5.1	6.4	5.8	6.1
		Fill Rate	95%	92%	94%	96%	92%	96%
Ward 22	Average: **6.1** Range 5.7 - 6.6	CHPPD	6.6	6	6.1	6.3	5.7	5.7
		Fill Rate	100%	107%	103%	99%	97%	99%
Ward 23	Average: **7** Range 6.7 - 7.3	CHPPD	6.7	7	7.3	7.2	7	6.8
		Fill Rate	100%	111%	111%	110%	98%	98%
Ward 24	Average: **6.8** Range 5.8 - 9.4	CHPPD	6.1	6.9	5.8	6	6.7	9.4
		Fill Rate	98%	111%	93%	96%	97%	98%
OPAU	Average: **8.4** Range 8.1 - 9.5	CHPPD	9.5	8.2	8.1	8.2	8.2	7.9
		Fill Rate	93%	94%	93%	96%	97%	105%
M2 Rehab	Average: **5.7** Range 5.4 - 6	CHPPD	6	5.9	6	5.8	5.4	4.9
		Fill Rate	100%	98%	98%	99%	96%	96%
CRC	Average: **6** Range 5.6 - 6.3	CHPPD	5.6	5.7	6.1	6.1	6	6.3
		Fill Rate	99%	100%	98%	97%	98%	106%

Medicine	CHPPD information	Indicators	May	June	July	Aug	Sept	Oct
Ward 26	Average: **6.2** Range 5.6 - 6.7	CHPPD	5.6	6.3	6.1	6	6.7	6.3
		Fill Rate	95%	107%	101%	97%	95%	96%
Ward 30	Average: **7.1** Range 6.6 - 7.5	CHPPD	7.3	6.6	7	6.9	7.5	7.2
		Fill Rate	100%	90%	90%	87%	91%	86%
Ward 32	Average: **7.9** Range 6.1 - 10.5	CHPPD	7.3	7.5	8.2	10.5	7.7	6.1
		Fill Rate	94%	96%	99%	98%	103%	91%
CCU	Average: **13.4** Range 12.2 - 16.3	CHPPD	12.6	12.3	12.4	12.2	16.3	14.4
		Fill Rate	100%	100%	100%	99%	100%	93%
Ward 33	Average: **5.9** Range 5.8 - 6	CHPPD	5.8	6	5.8	6	5.9	6
		Fill Rate	97%	98%	92%	90%	90%	86%
Ward 36	Average: **5.6** Range 5.5 - 6	CHPPD	5.6	5.6	5.6	6	5.5	5.5
		Fill Rate	99%	102%	107%	88%	87%	94%
Ward 37	Average: **7.2** Range 5.9 - 7.9	CHPPD	5.9	7.9	6.9	7.3	7.6	7.4
		Fill Rate	100%	100%	95%	99%	97%	101%
Ward 38	Average: 5.8 Range 5.5 - 5.9	CHPPD	5.7	5.8	5.5	5.9	6.4	5.6
		Fill Rate	99%	98%	94%	96%	106%	96%

Acute Care	CHPPD information	Indicators	May	June	July	Aug	Sept	Oct
MSSW	Average: **7.2** Range 5.9 - 8.8	CHPPD	8.8	8.5	5.9	7	6.3	6.4
		Fill Rate	95%	94%	86%	105%	84%	83%
AMU	Average: **12** Range 10.3 -14.9	CHPPD	10.5	10.6	10.3	11.4	14.9	14.3
		Fill Rate	99%	96%	92%	104%	97%	95%
EDRU	Average: **9.4** Range 7.8 -10.7	CHPPD	8.7	9.5	7.8	10.7	10.3	9.1
		Fill Rate	95%	101%	95%	101%	106%	103%
ITU	Average: **37** Range 32.6 -41.6	CHPPD	39.5	32.6	36.3	41.6	36.3	35.6
		Fill Rate	100%	91%	97%	96%	90%	88%
HDU	Average: **28** Range 24.3 -36.3	CHPPD	24.3	35.1	24.6	36.3	25.1	26.9
		Fill Rate	100%	98%	99%	96%	99%	93%

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

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

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

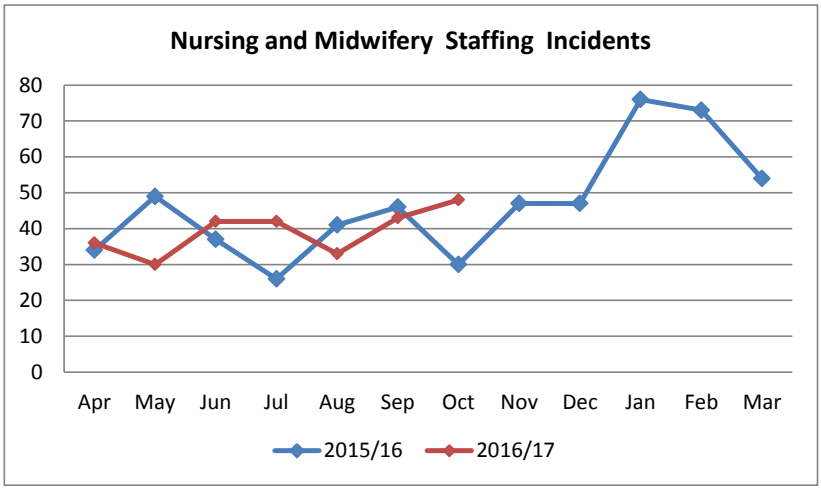
Ward 12: The Ward was safely staffed at all times according to the bed occupancy. The ward had minimum patients and correct staffing was in place to support the acuity of the patients, this is supported by high CHPPD.

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

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

4 Reported Staffing Incidents

Up until October 2016 the Trust had seen an overall year on year reduction in the number of staffing incidents recorded however due to a significant increase in reported incident during October the Trust year on year total is slightly higher with 274 incidents recorded to date compared with 263 for the same period last year.



A monthly summary analysis review of Nursing and Midwifery specific staffing incidents is completed each month. During October there were two areas that featured significantly within the report who do not normally have any recorded incidents, these were, ITU and Bed Bureau. ITU recorded 7 incidents, a comparison against other staffing indicators shows that whilst staffing fill rate levels were lower than normal for this area, CHPPD figures remained in line and both the Ward Sister and Matron provided assurance that safe staffing was in place. ITU staffing has strict guidance in place which is adhered to by the department. In

recent months there have been several occasions when staff have been moved from ITU to HDU or CCU to support staff moves to base wards to ensure safe staffing. Whilst this has not been popular with ITU staff the Matron has met with them to explain the necessity of such moves and to enforce that ITU Network guidance on staffing levels continues to be met. A further engagement meeting with the ADNs and Deputy Director of Nursing has also been planned for early December. Bed Bureau recorded 6 incidents which in the main related to bed pressures within the organisation requirement for Hospital coordinators to work on wards to ensure safe staffing levels are provided when last minute sickness occurs.

Review of the remaining Nursing and Midwifery Staffing incidents indicate that many are based on staff's perception of staff shortages and on investigation by senior nursing team, staffing levels were safe or mitigating actions had been put in place. Targeted work has commenced to understand if staff from key areas are reporting inability to take breaks as this has been raised as a concern via the Staff Side reps.

5 Conclusion

- Benchmarking WUTH performance for Care Hours Per Patient Day (CHPPD) with other acute hospitals using model hospital portal will allow us to provide further assurance that safe staffing levels are in place and this can be used to address staff perception that staffing levels are low. This comparison work will be taken forward once real time reporting is available on the Portal
- The Trust continues to ensure all mitigating actions are in place to ensure that there are safe and appropriate nurse staffing levels at WUTH
- The Trust will continue with monthly Trust wide recruitment for registered nurses
- A small number of wards are reporting reduced staff fill rates whilst maintaining good levels of CHPPD and this may be indicative of over establishment. A full acuity review will be completed in Q1 2017 and these wards will be included in this review to ensure that we have the most effective use of workforce. In the interim, any shortfalls in staffing across the organisation will be supported by deployment of these staff prior to use of temporary staffing

6 Recommendations

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

BOARD OF DIRECTORS	
Agenda Item	7.2
Title of Report	Appraisal & Revalidation Report 2015/16
Date of Meeting	30 November, 2016
Author	Dr Debra King Associate Medical Director for Appraisal & Revalidation
Accountable Executive	Dr Mark Lipton Interim Medical Director
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	2,3,4,9,10,11,16,19,
Level of Assurance **Positive** **Gap(s)**	Positive
Purpose of the Paper **Discussion** **Approval** **To Note**	To note
Data Quality Rating	Silver – quantitative data that has not been externally validated Bronze – qualitative data
FOI status	Document may be disclosed in full Entire document is exempt under FOI
Equality Impact Assessment Undertaken **Yes** **No**	N/A

1. Executive Summary

Appraisal is a professional process of constructive dialogue, in which the doctor being appraised has a formal structured opportunity to reflect on his/her work and to consider how his/her effectiveness might be improved.

WUTH has a system in place for appraisal of senior medical staff which is quality assured.

The Senior Medical Staff Appraisal Policy has been updated and approved (November 2015).

Directorates are monitored for efficiency of the operational process.

There have been 6 missed appraisals and 20 incomplete appraisals in the year April 2015/ March 2016.

Revalidation is the process by which doctors are assessed on being up to date and fit to practice by their Responsible Officer. This is based on satisfactory annual appraisal. Where concerns arise in a doctor's practice this is appropriately investigated and action taken including remediation when appropriate. WUTH developed a remediation policy for senior medical staff in 2013.

88 doctors have been revalidated in the year April 2015/2016, and 11 have had their revalidation deferred.

WUTH is compliant with the annual organizational audit standards monitored by NHSE and is now monitored by providing a quarterly statement of compliance.

This is the seventh Board Report and the report refers to the appraisal year April 2015/March 2016.

2. Background

Annual Medical Appraisal for the Year 2015/16

1. Medical Revalidation was implemented in 2012 by the General Medical Council (GMC) to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

   Provider organisations have a statutory duty to support their Responsible Officer in discharging his/her duties under the Responsible Officer Regulations and it is expected that executive teams will oversee compliance by:

   - monitoring the frequency and quality of medical appraisals in their organisation
   - checking there are effective systems in place for monitoring the conduct and performance of their doctors
   - confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process
   - ensuring that appropriate pre-employment background checks are carried out to ensure that medical practitioners have the qualifications and experience appropriate to the work performed

2. The appraisal process at Wirral University Teaching Hospital has been in place since 2001, and is currently fit for purpose for the Revalidation process.

3. Successful annual appraisal will provide the foundation upon which the Responsible Officer will confirm a doctor's fitness to practice. Following a cycle of five successful annual appraisals the Responsible Officer will be able to recommend that a doctor should be revalidated.

~~4.~~ During the appraisal year 2015/2016 88 doctors have been revalidated and 11 have had their revalidation deferred, (deferral rate 11%). All of the deferrals were due to lack of some element of supporting information. The GMC have reported a national deferral rate of 22%.

5. WUTH currently has an SLA in place to provide RO and appraisal services to Wirral Community Trust and Wirral Hospice St John's.

6. WUTH investigates when concerns are raised about a doctor's practice and the Responsible Officer decides on appropriate action following local policies and procedures. This includes formal remediation programmes.

Management of Appraisal and Revalidation

7. Responsibility for Appraisal and Revalidation lies ultimately with the Medical Director as the Responsible Officer. The Associate Medical Director for Appraisal and Revalidation (AMD) and Clinical Lead for Appraisal (CL) are responsible for the successful performance of the process for all senior medical staff. The Appraisal and Revalidation Manager facilitates the process on a day to day basis.

8. At present, appraisals are undertaken by the AMD, DMD's, CD's and CSL's and these managers are expected to appraise as part of their management duties. Due to the number of appraisals that need to be undertaken in the Trust, there are also non-managerial consultants who have taken on the role of appraiser and this group should have the appropriate time allocated for this process in their job plan, as referenced in the Trust's Consultant Job Planning Policy.

9. Doctors are expected to use their SPA time to complete documentation and for the actual appraisal meeting.

The charts overleaf detail the activity levels for appraisal in WUTH, including the numbers who have undertaken the process and details of the exceptions.

TABLE 1: ACTIVITY LEVELS FOR APPRAISAL IN WIRRAL UNIVERSITY TEACHING HOSPITAL						
April 2015 – March 2016						
	Number of Senior Medical Staff for whom the trust has responsibility for appraisal and revalidation		Number of doctors who have had a completed appraisal as at 30.5.16		Number of doctors for whom a PDP has been agreed	
	Cons	SAS	Cons	SAS	Cons	SAS
A & E	8	4	8	4	8	4
Acute Med	9	1	9	1	9	1
Anaes	30	10	29	10	29	10
DME	16	2	16	2	16	2
ITU	12	0	11	0	11	0
Lab Med	11	0	11	0	11	0
Medicine	38	3	36	3	38	3
O & G	10	2	9	2	10	2
Ortho	15	4	15	4	15	4
Paeds.	20	2	19	2	19	2
Public Health	1	0	1	0	1	0
Radiology	19	1	18	1	18	1
Spec Surg	17	7	16	6	17	7
Surgery	28	6	27	5	27	5
Hospice	0	2	0	2	0	2
Wirral C Trust	0	0	0	0	0	0
TOTAL	234	44	226	42	229	43

In addition 31 doctors in training went through the Trust ARCP process led by the Director of Medical Workforce Planning.

TABLE 2: EXCEPTIONS TO THE APPRAISAL PROCESS AT WIRRAL UNIVERSITY TEACHING HOSPITAL			
APRIL 2015 – March 2016			
Division	**Grade**	**Status**	**Reason**
Surgery	Consultant	Missed	Maternity Leave
Surgery	Consultant	Missed	Sickness Absence
Surgery	Trust Grade	Missed	Leaving to go abroad, so chose not to have the appraisal
Medicine	Consultant	Missed	Maternity Leave
Medicine	Consultant	Missed	Sabbatical
Diagnostics	Consultant	Missed	Maternity Leave
Surgery	Consultant	Incomplete	Change of appraiser
Surgery	Consultant	Incomplete	Change of appraiser
Surgery	Consultant	Incomplete	Difficulties agreeing date
Surgery	Consultant	Incomplete	Appraiser had to cancel meeting at last minute
Surgery	Consultant	Incomplete	MAF not completed within the given timescale
Surgery	Consultant	Incomplete	MAF not completed within the given timescale
Surgery	Consultant	Incomplete	MAF not completed within the given timescale
Surgery	Consultant	Incomplete	MAF not completed within the given timescale
Surgery	Consultant	Incomplete	MAF not completed within the given timescale

Surgery	SAS	Incomplete	MAF not completed within the given timescale
Surgery	SAS	Incomplete	MAF not completed within the given timescale
Surgery	SAS	Incomplete	MAF not completed within the given timescale
Medicine	Consultant	Incomplete	Sickness
Medicine	Consultant	Incomplete	Wait for appraiser to be allocated
Medicine	Consultant	Incomplete	Wait for appraiser to be allocated
Medicine	Consultant	Incomplete	MAF not completed within the given timescale
Medicine	Consultant	Incomplete	MAF not completed within the given timescale
Medicine	Consultant	Incomplete	MAF not completed within the given timescale
Diagnostics	Consultant	Incomplete	Appraisal meeting interrupted by emergency
Diagnostics	Consultant	Incomplete	Conflict with appraiser

Missed appraisals are those which were due within the appraisal year but not performed, or MAF not returned.

Incomplete appraisals are those where, for example, the appraisal discussion has not been completed or where the personal development plan or appraisal summary have not been signed off within two calendar months of the doctors appraisal month. This accounts for the variance in the numbers in Table 1 above. Doctors may have a missed or incomplete appraisal but still have a PDP agreed.

Whist the number of incomplete appraisals are disappointing, WUTH compares well with similar DB's in the comparator report compiled by NHS England.
For example: WUTH had 91.7% completion of all appraisals as compared to 83.9% for same sector appraisal rate
WUTH had 4.2% approved missed or incomplete appraisals as compared to 8.7% for same sector appraisal rate
WUTH had 4.2% unapproved missed or incomplete appraisals as compared to 7.4% for same sector appraisal rate

Quality Assurance

10. Quality assurance of the appraisal process is essential if it is to be effective.

11. The responsibility for quality assuring the process lies with the AMD and CL for Appraisal and Revalidation who have an overseeing role. Medical managers (MD, DMD, CD, CSL) have responsibility to ensure that the process is fair and effective to meet the requirements of revalidation. The overall responsibility for the process lies with the Responsible Officer.

12. WUTH has a robust quality assurance process in place:

- 2015/16 saw the introduction of the excellence tool. This form is completed for one appraisal per appraiser per year by the AMD or CL. Its purpose is to quality assure the appraisal output completed by the appraiser.

- Appraisers receive an annual written performance review which includes feedback from doctors they have appraised; feedback from observation by ARM; excellence tool.

- The operational process of the appraisal system is audited by the appraisal manager each year so that the directorates can be monitored in terms of their compliance (see Table 3 overleaf).

TABLE 3 - AUDIT OF TIMELINE OF PROCESSING APPRAISAL FOLDERS

Directorate	Folders sent out for completion by the Appraisal Team. Target 6 weeks before appraisal date			Completed folders returned to the Appraisal Team for review prior to appraisal. Target 3 weeks.			Total % of folders returned to the Appraisal Team for review **before** appraisal meeting			Total % of folders returned from appraiser following appraisal Target 2 months form appraisal month		
	2013/2014	2014/2015	2015/2016	2013/2014	2014/2015	2015/2016	2013/2014	2014/2015	2015/2016	2013/2014	2014/2015	
A & E	92%	100%	100%	8%	15%	25%	75%	77%	67%	66%	100%	100%
Acute Med	100%	100%	100%	44%	29%	40%	88%	63%	100%	44%	100%	100%
Anaesthesia	100%	96%	98%	35%	29%	28%	88%	92%	93%	56%	98%	98%
Lab Medicine	94%	100%	100%	28%	27%	18%	100%	93%	100%	61%	100%	91%
Medicine	97%	95%	95%	41%	24%	22%	97%	100%	83%	51%	100%	83%
Spec Surgery	100%	100%	92%	18%	38%	21%	77%	90%	83%	68%	100%	92%
Surgery	100%	94%	88%	14%	26%	18%	93%	97%	100%	64%	94%	82%
DME	100%	100%	100%	38%	24%	22%	100%	100%	94%	25%	94%	100%
O & G	100%	82%	100%	9%	9%	17%	90%	100%	92%	82%	100%	83%
Paediatrics	95%	100%	95%	32%	20%	14%	100%	95%	100%	41%	95%	95%
Public Health	100%	100%	100%	100%	0%	100%	100%	100%	100%	100%	100%	100%
Radiology	100%	100%	95%	5%	30%	25%	76%	85%	95%	48%	100%	90%
Orthopaedics	100%	89%	100%	29%	21%	26%	94%	95%	95%	35%	89%	95%
Hospice	100%	100%	100%	100%	0%	50%	100%	100%	100%	100%	100%	100%
Wirral C Trust	100%	100%	N/A	33%	75%	N/A	100%	100%	N/A	100%	100%	N/A

The numbers returning appraisal documentation three weeks in advance of the appraisal meeting is still consistently low. Whilst this puts pressure on the appraiser to prepare in time, most appraisers are, however, willing to proceed if they receive the documentation within a week, and few appraisals are cancelled due to late submission of the MAF.

Development Needs

13. Appraisers:

- All appraisers MUST attend the Trust's 1 day training course before appraising. This course has an excellent reputation and is attended by many external delegates. The A&R Department is also requested to deliver training to other Trusts off site.
- There were 62 trained appraisers in WUTH as at 31 March 2016.
- The appraisers are invited to attend the Appraiser Support Group (ASG) twice a year where they can formally bring up any issues and they are kept up to date by the AMD.
- Appraisers were asked to complete a survey at the beginning of the 2015/2016 appraisal round to identify gaps in their skills/knowledge. Following this an Appraiser Refresher Day was devised and delivered in October 2015, and repeated in December 2015. 41 appraisers attended in total. Feedback is attached at Appendix A.

14. Doctors

Medical staff should be kept up to date on changes to the process as revalidation progresses. This is done as follows:

- Doctors can apply to attend the Trust 1 day course which runs at least four times annually and is updated continuously.
- Their appraisers will provide necessary guidance. Appraisers are updated at the bi-annual ASG meetings and by e-mail as necessary.
- New consultants are encouraged to attend the appraisal course so they are aware of what is expected of them, and what they can expect from the process.
- The ARM contacts new consultants and invites them to a meeting with her to discuss the hospital appraisal and revalidation process at the start of their post. This gives them the opportunity to ask questions about any concerns and also to know that support is available to them on an ongoing basis.
- The AMD presents a session on Appraisal and Revalidation as part of the "New consultant development programme".
- AMD updates as necessary at Medical Board meetings and by e-mail.
- The Appraisal Manager and AMD/CL are available to provide guidance and advice on an ongoing basis.

15. Responsible Officer:

These officers need appropriate training and support. The RO for WUTH attended the national RO training programme and was involved in the RO networks in the North Region in order to continue to be up to date and fit to practice in the role of a RO. The RO is appraised externally by NHS England (North). There are specific requirements for RO's to keep up to date and fit to practice including attending three out of four RO networks annually.

The RO and A & R team meet with the GMC employer liaison advisor (ELA) every 3 months. This is to discuss concerns from both parties about a doctor's practice e.g. never events. The ELA also updates the team on GMC processes.

Clinical Governance

16. Clinical Governance issues are detailed below:

- Complaints are recorded on a database for medical staff and this summary is provided for appraisal so that the doctor can reflect on them at their appraisal.
- Clinical Incidents reported by and about a doctor are recorded on a database and this summary is provided for appraisal so that the doctor can reflect on them at their appraisal.
- Dr Foster data is provided. This data is not useful for all specialties in terms of accurately recording the performance of an individual. The data is more useful for surgical than medical specialities. Data cannot be provided for SAS doctors.
- Data by its nature will reflect the performance of a team rather than an individual and teams are constantly changing. There needs to be a method of retrieving data which is more useful and informs an individual on his/her performance. This is a national problem which is being discussed on an ongoing basis.
- Other data included in the MAF is managing diagnostic test results.
- Each Department has a Consultant Clinical Governance lead who as part of their role should keep doctors updated on relevant national guidance and alerts.

Responding to Concerns and Remediation:

17 A Medical Staff Remediation Policy is now in place. This document includes advice on remediation and resources available locally and nationally which WUTH can access. It was identified that one of the resources required was coaching and to this end a coaching strategy was implemented in 2014. There are eleven consultants who are fully trained coaches and are actively coaching senior medical staff. To date 41 doctors have had a coach. Between April 2015 and March 2016 11 doctors were coached. The coaching process is led by the AMD and managed by the Appraisal and Revalidation Manager. Coaching is a resource which is helping senior doctors to further develop their skills and their clinical service. Coaches are kept up to date and fit to practice in line with the coaching strategy and this process is quality assured.

18 There are 9 members of staff who have gone through investigations or remediation processes in the period 1 April 2015 to 31 March 2016, the details are shown below:

Doctors	**Type of concern**	**Type of Intervention**
1	Competence	RCA completed, coaching, communication course, audit of practice
1	Conduct	Coaching, communication course
1	Health	Occupational Health
1	Conduct	Investigation – restriction to practice; behavioural contract; communication course; coaching; mentoring; E&D Training
1	Conduct	Preliminary investigation – coaching; mentoring; team building
1	Conduct	Assessment, coaching

Recruitment and engagement background checks

19 The Appraisal and Revalidation Manager ensures that there is RO to RO communication when WUTH employs a doctor, requesting information on past appraisals, previous concerns or GMC restrictions to practice etc. The doctor is fully informed about this process when WUTH employs them. This requires close working with HR Shared Services. Whilst this process works for permanent staff, there are still some difficulties in being informed of short term locums, and therefore the list of who the RO is responsible for is not always clear.

Conclusion and Next Steps

20**.** The conclusion and next steps are outlined below:

- A robust appraisal process has been in place at WUTH since 2001.
- Appraisal has been implemented successfully at WUTH, and with its quality assurance process WUTH continues to be "fit for purpose" for the revalidation process.
- All aspects of a doctor's professional work (interactions with colleagues and patients, critical incidents and complaints) must be reflected upon. Without this evidence no doctor can be revalidated. There have however, been recent national cases where reflections by trainees were subsequently used against them in court. To ensure that doctors have the skills to produce thoughtful reflections, but which keep staff safe from incriminating themselves and others, the A&R Department is to develop and deliver a session on reflective writing in the next appraisal round.
- WUTH's "Procedure for Handling Concerns about Conduct, Performance and Health of Medical and Dental Staff" is in need of review as it is out of date (2006). This process of amendment began in July 2012, led by HR. This point is carried over from last years' report to board.

Recommendations

21. The Board is asked to note the report and agree to receive the next report on the 2016/17 position in November 2017.

Professor Debra King
Associate Medical Director for Appraisal & Revalidation

Mrs Amanda Branson
Appraisal & Revalidation Manager

October 2016

APPENDIX A

Appraiser Refresher Day Evaluation

Introduction and Background

As part of the quality assurance process of an appraisal system, it is essential that appraisers are kept up to date and fit to practice in their role.

An electronic questionnaire was put together In order to ascertain what areas WUTH's appraiser group would like to be updated on, and following the results, an Appraiser Refresher Day was developed

Evaluation of Appraiser Training Day – 1 October 2015

Following completion of the day, the participants were asked to complete an evaluation form. The breakdown of results for each part of the training day are shown below.

Quantitive Data

Key to evaluation scores: **1 = Poor 2 = Average 3 = Good 4 = Very Good 5 = Excellent**

Venue

	Number of Responses
1	
2	
3	**5**
4	**5**
5	**2**
Comments: **No problems, convenient**	

Organisation of course

	Number of Responses
1	
2	
3	
4	**6**
5	**6**
Comments: **Good**	

Appraiser Forum: Process

	Number of Responses Content	Number of Responses Presentation
1		
2		
3	1	1
4	5	5
5	6	6
Comments:		

Dr Foster

	Number of Responses Content	Number of Responses Presentation
1		
2		
3	5	4
4	2	3
5	5	4
Comments: Very useful Not really relevant to me, but interesting Excellent discussion		

Appraiser Forum: Handling Difficult Appraisals

	Number of Responses Content	Number of Responses Presentation
1		
2	1	1
3	2	2
4	3	3
5	6	6
Comments: Good Again excellent discussion		

Remediation Policy

	Number of Responses Content	Number of Responses Presentation
1		
2		
3	2	1
4	8	8
5	2	2
Comments: Ok, less useful Good discussion		

Mentoring

	Number of Responses Content	Number of Responses Presentation
1		
2		
3	2	3
4	8	6
5	2	2
Comments:		

New Guidance around evidence for recognition as a trainer

	Number of Responses Content	Number of Responses Presentation
1		
2		
3	4	3
4	6	6
5	2	2
Comments: Very enthusiastic		

Coaching

	Number of Responses Content	Number of Responses Presentation
1		
2		
3		
4	9	8
5	2	2
Comments:		

Qualitative Data

Did the training session meet your expectations? Please comment as necessary.

Comments:
A good day Very useful day Well organised and delivered course Yes, excellent day. Thank you The whole day was well organised and well presented. A very good refresher Yes x4 Yes. Appraisers should be encouraged to bring more 'challenging' experiences for general discussion Yes, important to give new vigour to process

What was the most useful part of the day?

Comments:
Process **Remediation discussion** **Everything!** **Handling difficult appraisals** **Difficult appraisal** **Further information about how to analyse Dr Foster data** **Listening and discussing with colleagues** **Dr Foster discussion, need to build on this** **Overall review of process**

What was the most unhelpful part of the day?

Comments:
Mentoring **Remediation talk could be shortened** **Dr Foster presentation a bit woolley** **Nothing**

What further updates would be helpful in the future?

Comments:
Coaching **Repeat to update annually. Lunchtime meetings difficult to get to because of clinical work** **Video of reconstruction of difficult appraisal etc**

Amanda Branson
28 October 2015

Appraiser Refresher Day Evaluation

Introduction and Background

As part of the quality assurance process of an appraisal system, it is essential that appraisers are kept up to date and fit to practice in their role.

An electronic questionnaire was put together In order to ascertain what areas WUTH's appraiser group would like to be updated on, and following the results, an Appraiser Refresher Day was developed

Evaluation of Appraiser Training Day – 18 December 2015

Following completion of the day, the participants were asked to complete an evaluation form. The breakdown of results for each part of the training day are shown below.

Quantitive Data

Key to evaluation scores: **1 = Poor 2 = Average 3 = Good 4 = Very Good 5 = Excellent**

Venue

	Number of Responses
1	
2	
3	**3**
4	**9**
5	**4**
Comments: **Adequate** **Comfortable** **Convenient/familiar** **Awful coffee** **Comfortable, appropriate sized room**	

Organisation of course

	Number of Responses
1	
2	
3	
4	9
5	7
Comments: **Well paced and supported** **V good content** **As one would expect from the appraisal team – excellent** **Very useful both for being a good appraiser and also for personal development**	

Appraiser Forum: Process

	Number of Responses Content	Number of Responses Presentation
1		
2		
3	2	2
4	11	11
5	3	2

Comments:
Good
Stimulated good discussion
Well done, but knew this
Really useful discussion. Lots of interesting points raised. Hopefully some will be addressed and sorted out

Dr Foster

	Number of Responses Content	Number of Responses Presentation
1		
2		
3	5	4
4	6	7
5	3	3

Comments:
Frustrating – outdated model. Why oh why?
Slightly side tracked into trust issues rather than appraisal orientated
Helpful tips learnt. Good to have handouts because some of the slides were too busy
Confirmed my suspicions
A lot of discussion but not particularly helpful or well organised

Appraiser Forum: Handling Difficult Appraisals

	Number of Responses Content	Number of Responses Presentation
1		
2		
3	1	1
4	11	11
5	4	4

Comments:
Excellent discussion and actually enjoyed the role playing (amazingly)
Useful roleplay
Enjoyed the roleplay
More about difficult situations – un-cooperative, or poor MAF, not just doctor in difficulty
Very helpful discussion

Remediation Policy

	Number of Responses Content	Number of Responses Presentation
1		
2	3	2
3	7	8
4	4	5
5	2	1

Comments:
Too much information and in fairness probably suffered post prandial need for z's
Boring and technical
Rather dull

Coaching

	Number of Responses Content	Number of Responses Presentation
1		
2		
3	2	1
4	7	7
5	6	7

Comments:
Some extremely interesting slides used. V good explanation of coaching
Will bear this option in mind
Best I have had on coaching, well done

Qualitative Data

Did the training session meet your expectations? Please comment as necessary.

Comments:
Yes x4
Yes – it is good to feel supported
Yes! I had high expectations (as these events organised by Debra and Amanda are usually extremely good) and wasn't disappointed. Lunch and refreshments were also v good
Valuable annual session, very useful
Excellent. Learnt a lot. Better than expected
Much better forum than lunchtime meetings
Yes, enjoyable day. Gained some useful hints and tips. Thank you
Yes. Still unsure if I could analyse Dr Foster data
Yes, morning session more of an opportunity to discuss deficiency in Trust etc than teaching session

What was the most useful part of the day?

Comments:
Chance to speak to fellow appraisers – closely followed by coaching talk
Lunch was good. Role of coaching
Discussion with colleagues who clearly have the same problems/experiences that I have
Appraisal forums by Dr Crowe/Dr King
Useful update
Good update on Dr Foster data
Ability to discuss, ask questions. Provide feedback re process etc
A chance to talk with colleagues
Forum to feedback, challenging process/support
Interaction, no 'lecturer'
Talk on coaching and meeting other colleagues to discuss
Dr Foster
Networking with colleagues (which is an all too rare event). Dr Foster discussions were very helpful
Coaching talk – very informative

What was the most unhelpful part of the day?

Comments:
Remediation
The remediation policy presentation was not particularly useful.
Difficult to keep focus. Perhaps half a day would be better
Dr Foster

What further updates would be helpful in the future?

Comments:
Further updates on MAF and Dr Foster
Annual update
Good MAF, bad MAF

Amanda Branson
22 December 2015

Board of Directors	
Agenda Item	**8.1.1**
Title of Report	**Integrated Performance Dashboard**
Date of Meeting	**30th November 2016**
Author	**Chris Oliver, Director of Operations** **John Halliday, Assistant Director of Information**
Accountable Executive	**Janelle Holmes** **Chief Operating Officer**
FOI status	**Document may be disclosed in full**
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	**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 October 2016.

2. Summary of Performance Issues

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

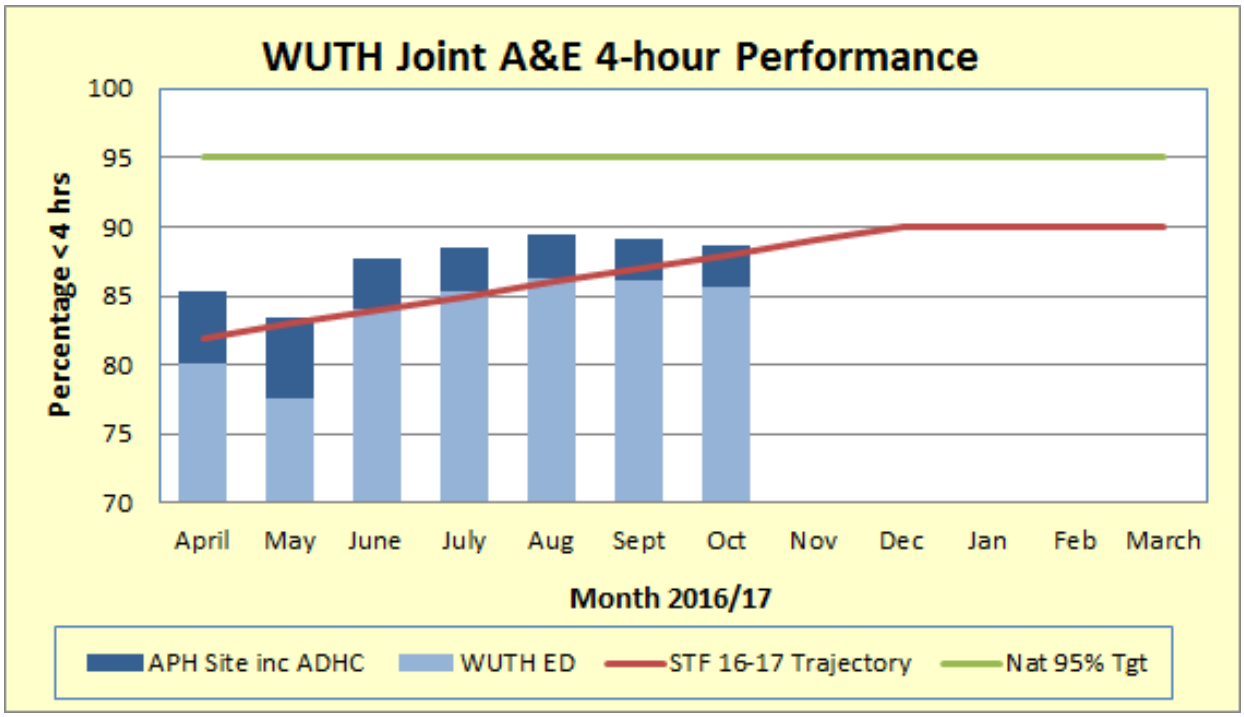
The key issues relating to external validation is achievement of the A&E and RTT targets, with detailed comments against each area below.

3. Detailed Explanation of Performance and Actions

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

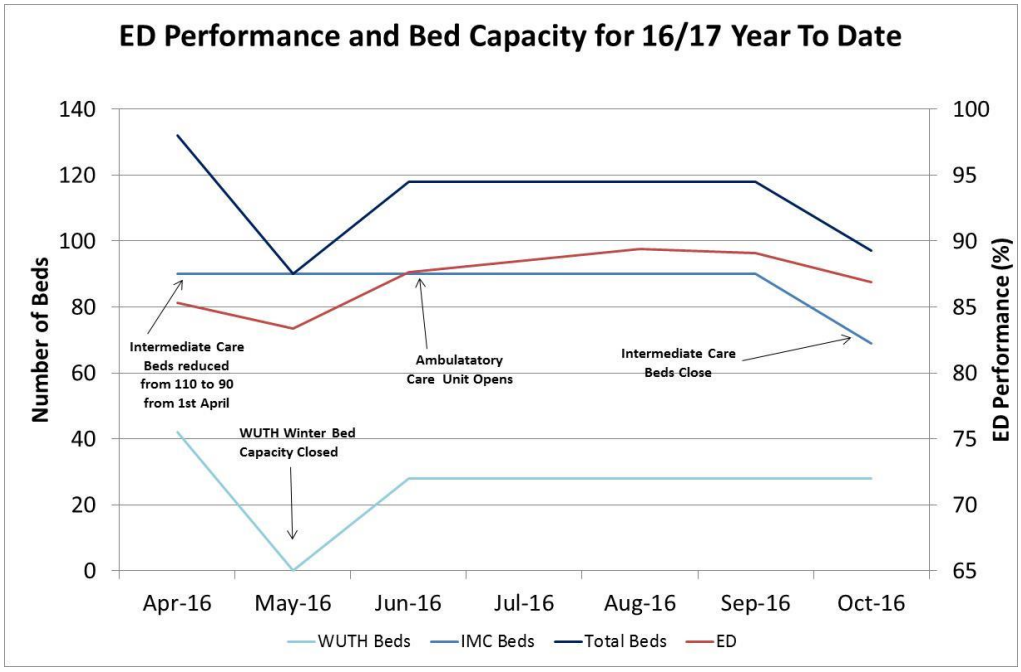
Against the A&E standard of a minimum 95% of patients to be admitted, transferred or discharged within four hours, the month of October was 88.59% as measured across a combined ED and All Day Health Centre performance at the Arrowe Park site. ED alone was 85.70%.

The performance in October for the emergency access standard although not achieving the regulatory compliance level of 95% was above the Sustainability and Transformation Fund (STF) trajectory of 88.0%, and is illustrated below.



Although performance achieved the required STF trajectory it is a deterioration against September's position, performance in October was impacted by a further reduction in community beds, taking this provision to a total of 69 beds

from an April position of 110 beds. The table below illustrates the link between bed capacity, both internal and external compared to A&E performance.

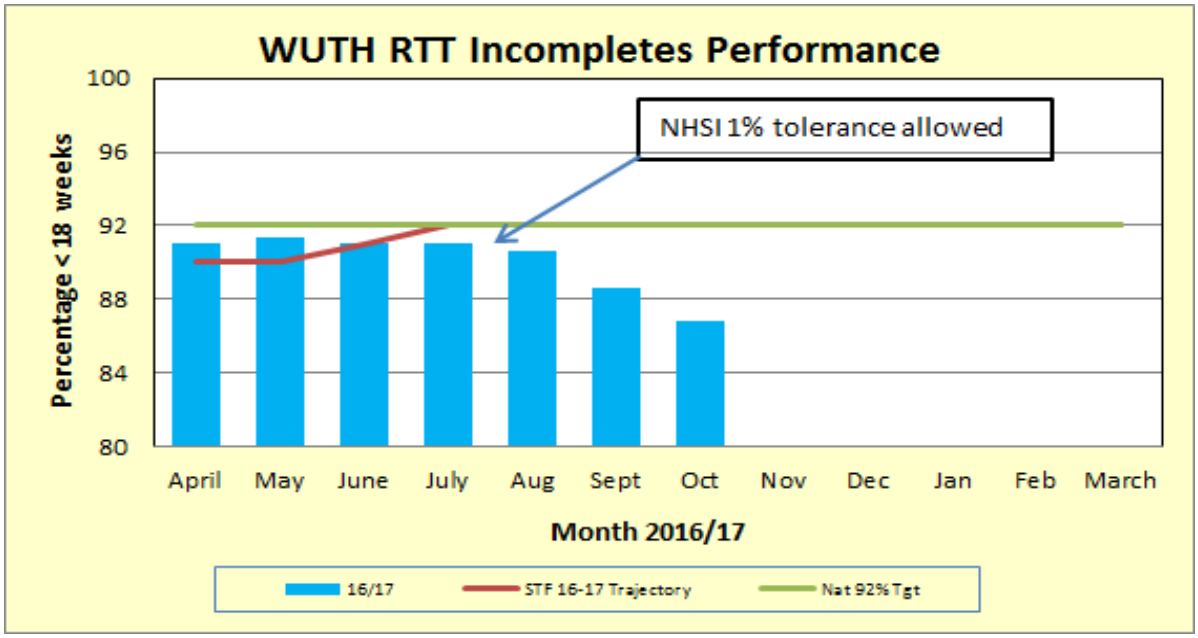


The impact of the reduction in community beds was discussed at the Trust's review meeting with NHSI and is subsequently being taken forward via the A&E Delivery Board, chaired by WUTH and with NHSI attendance.

b. 18 Weeks RTT

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

As expected the Trust did not achieve the national standard and STF trajectory at the end of October, with the final position being reported at 86.80%.



Board members will recall the Trust commenced on an RTT improvement programme and a full action plan has now been developed and presented to the senior management team. The plan focuses on cleansing of patients lists, training of staff to ensure correct procedures are followed when managing an 18 week pathway as well as recruitment of a patient tracking team and the development of performance and data quality reports.

The Trust has undertaken a sample audit across all points of delivery within the incomplete pathway. The audit findings will be built into the revised RTT trajectory to be submitted to NHSI by the end of November. It is expected that RTT performance will reduce to circa 80% by March 2017 as cleansing of the patient tracking list continues and waiting list initiatives remain on hold except for those specialities requiring additional capacity to meet cancer standards.

NHSI have been briefed on the action plan and the expected impact on performance and are assured in the actions the Trust is taking to sustainably improve performance.

c. Infection Control

For C Difficile, there have been two cases in the month of October, however only one of these was considered avoidable. The year-to-date position is therefore 9 cases, and below the maximum plan trajectory of 15 cases for this period.

d. Cancer

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

e. Advancing Quality (AQ) indicators

The two areas not achieving are Heart Failure and Acute Kidney Injury.

Heart Failure - there has been a significant deterioration in performance in August with an Appropriate Care Score of 46%. This is in part due to an incomplete data set being submitted due to staff sickness; we have requested that the data set is reopened so the additional information can be added and performance can then be more accurately reported. The challenge remains providing a 72 hour specialist review(particularly for patients with a short length

of stay on the assessment unit) and discussion of the discharge information prior to discharge. Plans are reviewed on a monlthy basis at the Heart Failure Meeting ; this area will form part of the clinical variations work programme and there are on going discussions about how we might use Cerner to support this.

Please note, this target is being retired in September 2016 and future reports will be using the national audit data, reported quarterly.

Acute Kidney Injury - the month on month improvement has continued with the Appropriate Care score being 43% in August 2016 (30% improvement from June). One measure failed the target – specialist review within 12 hours of first AKI 3 alert (47%). This is being addressed through the SHO champion who is working with the team to ensure reviews are undertaken at the weekend, In addition, there has been a project to develop link nurses for AKI, of which 20 have been recruited. It is expected that the improvements seen will continue and we would expect to meet the target for the remaining months of 2016. However, it is not possible to achieve the full year target due to the low compliance levels earlier in the year.

4. Recommendation

The Board of Directors are asked to:

Note the Trust's current performance to the end of October 2016.

WUTH Integrated Performance Dashboard - Report on October for November 2016 BoD

Area	Indicator / BAF	August	Sept	Oct	Trend / Future Concern	*Target (for 'Green')*	Latest Period	Exec Lead
Meeting Our Vision	**Satisfaction Rates**							
	Patient - F&F "Recommend" Rate	98%	97%	99%		>=95%	October 2016	GW
	Patient - F&F "Not Recommend" Rate	1%	1%	0%		<=2%	October 2016	GW
	Staff Satisfaction (engagement)	3.97	3.97	3.97		>=3.69	Q2 2016/17	JM
	First Choice Locally & Regionally							
	Market Share Wirral	81.4%	82.3%	81.4%		>= 85%	May to July 2016	MC
	Demand Referral Rates	-5.8%	-6.1%	-6.1%		>= 3% YoY variance	Fin Yr-on-Yr to Oct 2016	MC
	Market Share Non-Wirral	9.0%	8.8%	9.0%		>=8%	May to July 2016	MC
	Strategic Objectives							
	Harm Free Care	96%	94%	98%		>= 95%	October 2016	GW
	HIMMs Level	5	5	5		5	October 2016	MB
Operational Excellence	**Key Performance Indicators**							
	A&E 4 Hour Standard	89.43%	89.08%	88.60%		>=95%	October 2016	CO
	RTT 18 Weeks Incomplete Position	90.58%	88.61%	86.80%		>=92%	October 2016	CO
	Cancer Waiting Time Standards	On track	On track	On track		All met at Trust level	Q3 to Oct 2016	CO
	Infection Control	0 MRSA; 4 C diff	0 MRSA; 8 C diff	0 MRSA; 9 C diff		0 MRSA Bacteraemia in month, and cdiff less than cumulative trajectory	October 2016	GW
	Productivity							
	Delayed Transfers of Care	32	59	33		Metric definition redefined	October 2016	CO
	Delayed Complex Care Packages	60	56	57		<= 45	October 2016	CO
	Bed Occupancy	88.4%	89.6%	90.7%		<=85%	October 2016	CO
	Bed Occupancy Medicine	89.1%	90.2%	90.3%		<=85%	October 2016	CO
	Theatre Utilisation	Under review	Under review	Under review		>=85%	October 2016	CO
	Outpatient DNA Rate	8.4%	8.5%	7.8%		<=6.5%	October 2016	CO
	Outpatient Utilisation	81.7%	81.6%	81.4%		>90%	October 2016	CO
	Length of Stay - Non Elective Medicine	4.9	4.7	5.3		<= 5.0	October 2016	CO
	Length of Stay - Non-elective Trust	4.6	4.4	4.6		<=4.2	October 2016	CO
	Contract Performance (activity)	-3.1%	-3.7%	-3.9%		0% or greater	October 2016	CO
	Finance							
	Contract Performance (finance)	0.5%	0.0%	-0.5%		On Plan or Above YTD	October 2016	DJ
	Expenditure Performance	-1.8%	-1.3%	1.1%		On Plan or Below YTD	October 2016	DJ
	CIP Performance	-15.1%	6.2%	10.8%		On Plan or Above	October 2016	DJ
	Capital Programme	58.4%	57.8%	63.6%		On Plan	October 2016	DJ
	Non-Core Spend	10.2%	10.0%	9.8%		<5%	October 2016	DJ
	Cash Position	38%	6%	-23%		On plan or above YTD	October 2016	DJ
	Cash - liquidity days	-25.7	-26.2	-26.5		> 0 days	October 2016	DJ
A Healthy Organisation	**Clinical Outcomes**							
	Never Events	1	0	0		0 per month	October 2016	ML
	Complaints	21	17	18		<30 per month	October 2016	GW
	Workforce							
	Attendance	95.7%	95.7%	95.7%		>= 96%	October 2016	JM
	Qualified Nurse Vacancies	2.9%	2.3%	2.5%		<=6.5%	October 2016	GW
	Mandatory Training	92.1%	92.5%	92.8%		>= 95%	October 2016	JM
	Appraisal	87.76%	86.97%	86.30%		>= 85%	October 2016	JM
	Turnover	9.98%	10.21%	10.16%		<10%	October 2016	JM
	Agency Spend	1.1%	2.1%	6.2%		On plan	October 2016	GW
	Agency Cap	183	171	118		0	October 2016	JM
External Validation	**National Comparators**							
	Advancing Quality (not achieving)	2	3	2		All areas above target	October 2016	ML
	Mortality: HSMR	79.96	83.06	88.46		Lower CI < 0.90	April to July 2016	ML
	Mortality: SHMI	0.983	0.983	0.983		Lower CI < 90	Jan to Dec 2015	ML
	Regulatory Bodies							
	NHSI - Use of Resources (UoR) Rating	2	2	3		1 or 2 (NHSI amended Oct 2016)	October 2016	DJ
	CQC	Amber	Amber	Amber		Overall CQC rating Requires Improvement	October 2016	ML
	Local View							
	Commissioning - Contract KPIs	5	5	5		<=2	October 2016	CO

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

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

Quarter 3 - Total

Division	Tumour Group	Breaches			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted
Medicine	Haematology	1	0	1	3	2	5	66.67%	80.00%
	Lung	0	0	0	2	5	7	100.00%	100.00%
	Other	0	0	0	1.5	0	1.5	100.00%	100.00%
Med & Surg	Upper GI	0	1	1	0	4	4	N/A	75.00%
Surgery	Breast	0	0	0	10	10	20	100.00%	100.00%
	Colorectal	4	0	4	9	0	9	55.56%	55.56%
	Head & Neck	1.5	0	1.5	2	1	3	25.00%	50.00%
	Skin	1	0	1	27.5	0	27.5	96.36%	96.36%
	Urology	4.5	0	4.5	16.5	2	18.5	72.73%	75.68%
Women's	Gynaecology	1	0	1	1.5	3	4.5	33.33%	77.78%
	Total	**13**	**1**	**14**	**73**	**27**	**100**	82.19%	86.00%

Quarter 3 - October

Division	Tumour Group	Breaches			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted
Medicine	Haematology	1	0	1	3	2	5	66.67%	80.00%
	Lung	0	0	0	2	5	7	100.00%	100.00%
	Other	0	0	0	1.5	0	1.5	100.00%	100.00%
Med & Surg	Upper GI	0	1	1	0	4	4	N/A	75.00%
Surgery	Breast	0	0	0	10	10	20	100.00%	100.00%
	Colorectal	4	0	4	9	0	9	55.56%	55.56%
	Head & Neck	1.5	0	1.5	2	1	3	25.00%	50.00%
	Skin	1	0	1	27.5	0	27.5	96.36%	96.36%
	Urology	4.5	0	4.5	16.5	2	18.5	72.73%	75.68%
Women's	Gynaecology	1	0	1	1.5	3	4.5	33.33%	77.78%
	Total	**13**	**1**	**14**	**73**	**27**	**100**	82.19%	86.00%

Quarter 3 - November

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

Quarter 3 - December

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

Board of Directors	
Agenda Item	8.1.2
Title of Report	Month 7 Finance and Cost Improvement Programme Report
Date of Meeting	30th November 2016
Author	Gareth Lawrence, Deputy Director of Finance
Accountable Executive	David Jago, Executive Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	 8 8c,8d
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To note
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

Overview

This paper provides an update to the Board of Directors on the financial performance of the Trust at month 7 (31st October 2016) of the 2016/17 financial year.

At the end of October (month 7) the Trust has reported a YTD deficit of £(5.5)m inclusive of £1.5m impairments, therefore the normalised deficit is £(4.0)m which is £(0.8)m adverse to plan. The adverse variance is partially a result of the Trust failing to deliver the agreed RTT trajectory associated with the Sustainability and Transformation fund (STF) and lower NHS clinical income in Month 7 largely around below plan income performance from other associate commissioners.

The year to date financial position has been supported by non-recurrent and technical adjustments which do not support the underlying financial position of the Trust c£(6.5m).

The Trust has delivered £6.0m of efficiencies as at the end of October against the target of £5.6m and is forecast to be £1.2m higher than plan this year (in-year slippage has been mitigated by non-recurrent savings).

Cash balances at the end of October stood at £2.1m which is some £0.7m below plan. The YTD cash position has been supported by lower than planned capital expenditure. This has been offset by EBITDA performance and movements on working capital. Cash for the next two quarters of the financial year is forecast to be under plan with further additional cash support being required.

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

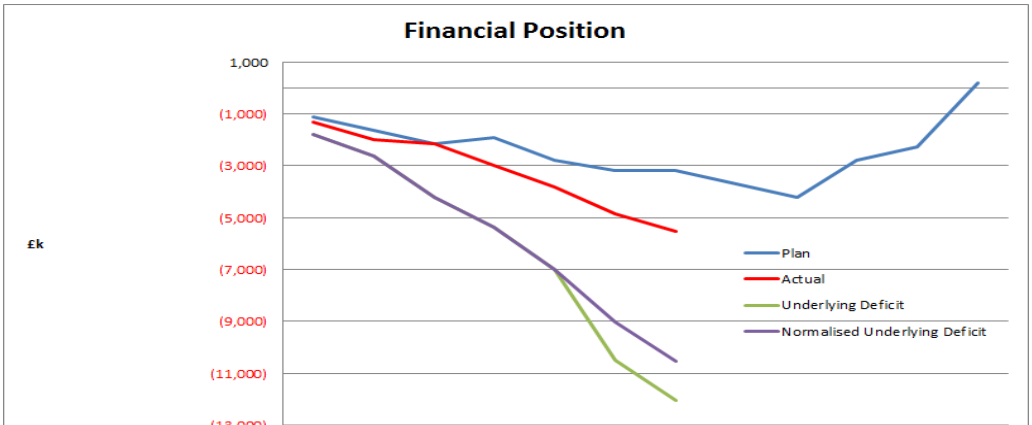
Income and Expenditure Performance

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

Table 1: Summary Financial Statement

	Board Approved Plan £m	Month 7			YTD			Forecast		
		Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
NHS Clinical Income	294.936	24.964	24.046	(0.918)	171.778	170.861	(0.917)	294.936	290.332	(4.604)
Other Income	29.987	2.519	2.618	0.098	17.285	18.355	1.070	29.987	30.821	0.834
Employee Exepnses	(213.306)	(18.092)	(18.417)	(0.325)	(127.338)	(130.307)	(2.969)	(213.306)	(223.504)	(10.198)
Other Operational Costs	(97.763)	(8.251)	(7.967)	0.284	(57.053)	(56.189)	0.865	(97.763)	(96.370)	1.393
EBITDA	**13.854**	**1.140**	**0.279**	**(0.861)**	**4.672**	**2.721**	**(1.950)**	**13.854**	**1.279**	**(12.575)**
Post EBITDA	(13,673)	(1.158)	(0.980)	0.178	(7.868)	(8.266)	(0.398)	(13.673)	(13.255)	0.418
Net Surplus/(Deficit)	**0.181**	**(0.018)**	**(0.701)**	**(0.683)**	**(3.196)**	**(5.545)**	**(2.348)**	**0.181**	**(11.976)**	**(12.157)**
Normalised Net Surplus/(Deficit)	**0.181**	**(0.018)**	**(0.697)**	**(0.679)**	**(3.196)**	**(4.017)**	**(0.821)**	**0.181**	**(10.448)**	**(10.629)**
EBITDA %	**4.3%**	**4.1%**	**1.0%**		**2.5%**	**1.4%**		**4.3%**	**0.4%**	

Table 2: Underlying Financial Performance



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	(1,116)	(1,638)	(2,164)	(1,898)	(2,777)	(3,177)	(3,196)	(3,706)	(4,230)	(2,793)	(2,284)	181
Actual	(1,307)	(2,001)	(2,165)	(2,998)	(3,811)	(4,844)	(5,545)					
Underlying Deficit	(1,808)	(2,647)	(4,234)	(5,372)	(6,992)	(10,496)	(12,062)					
Normalised Underlying Deficit	(1,808)	(2,647)	(4,234)	(5,372)	(6,992)	(9,035)	(10,534)					

As previously reported to the Board of Directors agreement has been reached with Wirral CCG for an envelope contract value for 2016/17 which covers c80% of the Trusts clinical income. In the absence of the 'envelope' agreement the income position would have deteriorated by £3.3m. This can be analysed into two elements: non achievement of activity plan £2.6m and the re-profile of clinical income into 12ths £0.7m.

During the period overall PbR activity under performed from an activity perspective. Cumulatively all PODs are underperforming in terms of actual activity delivered against the initial plan, with the exception of A&E attendances, that predominantly reflects the increase in emergency demand. Penalties increased by £753k, in relation to readmissions, NEL marginal rate and outpatients FUP caps. However, as a result of the financial envelope the penalties do not affect the financial position.

The underperformance in PbR areas is partially offset by over performance in non PbR as a result of increased Neonatal, Pathology Direct Access and rehabilitation activity.

The Trust has delivered all conditions of the STF with the exception of RTT performance since July 16. This has resulted in c£0.3m of the STF being withheld by NHS Improvement and is reflected in the year to date position. The Trust does not envisage RTT trajectories will be achieved for the remainder of the year.

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

Performance against other associate contracts such as West Cheshire (£0.1m) and Liverpool CCG (£0.2m) continue to perform above plan cumulatively. However, this is offset by the Specialised Services contracts (NHSE £(0.3)m and Dental £(0.2)m) which continue to report below plan performance.

Operational expenditure is largely on plan for the month of October year but remains cumulatively £(2.1)m above plan.

Pay costs exceeded plan by (£0.3m)in month, and are showing a cumulative overspend of (£3.0m). The issues as previously reported to the Board of Directors driving the current cumulative adverse performance in pay are:

- A reduction in the provision of intermediate care beds within the health economy has resulted in an increased unplanned demand for non-elective beds within the Trust. As a result of this pressure escalation beds have remained open driving the adverse pay performance (c£0.7m ytd). The Trust is continuing to work with the health economy to try to reduce this pressure going forward and is currently reviewing the winter plan as a senior team.
- Other operational pressures in medical staffing costs have continued during the month. Within the Emergency Department, the medical staffing position has improved in month, but there remains a pressure of approximately (£0.4m) in the year to date position. There are further critical medical staffing gaps in other specialties, resulting in premium agency or locum staff being utilised to cover the gaps of (c£0.6m) ytd. WLIs have remained minimal in October as the focus is to utilise core capacity to deliver RTT targets, spend is now marginal in a couple of specialties for achieving RTT and cancer targets (c£0.4m ytd).
- Non–delivery of cost improvement plans in relation to pay work-streams of (£1.1m) comprises some of the pay overspend, this has been partially mitigated by non-recurrent vacancy support £0.6m. A further (£0.4m) cumulatively reflects numerous additional pressures across the other pay categories

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

Agency spend, during October is lower than plan by £0.2m and is cumulatively below the NHSI ceiling rate by £0.3m. This improvement reflects the work the Trust is undertaking on managing agency costs across the organization. The cumulative spend on non-core staffing is £12.7m representing c10% of the total pay spend but has shown an improvement to 8% in October.

Non pay costs are £0.3m below plan in October and cumulatively £0.9m lower than plan. In October there was a £0.1m underspend on drugs (largely activity related high cost pass-through drugs) and £0.2m improvement on other operating costs (premises) which largely relates to a renegotiated contract variation for the Cerner system and lower energy costs.

Cost Improvement Programme (CIP)

The CIP target for 2016/17 is £11.2m. The target is split both by divisional and the respective work streams. As at the end of the Month 7 the Trust is £0.4m ahead of the target of £5.6m. This position has been supported through a review of depreciation and other non-recurrent mitigation adjustments.

The table overleaf demonstrates the month 7 position for CIP by division and by workstream:

	YTD			In Year			Recurrent		
	NHSI Plan	Actual	Variance	NHSI Plan	Forecast	Variance	NHSI Plan	Forecast	Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Theatres/ Elective Pathway	0.7	0.6	(0.1)	1.5	1.5	0.0	1.5	1.6	0.1
Outpatients (Medical & Surgical)	0.4	0.1	(0.3)	0.7	0.2	(0.5)	0.7	0.3	(0.4)
Patient Flow - EL & NEL	0.3	0.0	(0.3)	0.8	0.0	(0.8)	0.8	0.0	(0.8)
Radiology	0.1	0.2	0.1	0.2	0.4	0.2	0.2	0.5	0.3
Pathology	0.2	0.0	(0.2)	0.4	0.1	(0.3)	0.4	0.3	(0.1)
Nurses & Therapies Staffing	0.3	0.3	0.0	0.6	0.7	0.1	0.6	1.1	0.5
A&C Review - Clinical/ Non Clinical/ Management	0.6	0.2	(0.4)	1.0	0.4	(0.6)	1.0	0.4	(0.6)
Medical Staffing	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Central HR Initatives	0.4	0.3	(0.1)	0.7	0.8	0.1	0.7	1.2	0.5
COCH Collaboration	0.0	0.0	0.0	0.3	0.0	(0.3)	0.3	0.0	(0.3)
Pharmacy Services & Medicines Management	0.2	0.5	0.3	0.4	0.9	0.5	0.4	0.5	0.1
Procurement & Inventory Management	0.7	0.3	(0.4)	1.3	0.9	(0.4)	1.3	1.0	(0.3)
IT Enabled	0.1	0.1	0.0	0.2	0.2	0.0	0.2	0.1	(0.1)
Special Purpose Vehicles/ Contract optimisation	0.0	0.0	0.0	0.5	0.0	(0.5)	0.5	0.0	(0.5)
Estates/ Site Review	0.2	0.1	(0.1)	0.6	0.2	(0.4)	0.6	0.2	(0.4)
Facilities	0.3	0.2	(0.1)	0.4	0.5	0.1	0.4	0.5	0.1
Coding	0.6	0.6	0.0	1.0	1.0	0.0	1.0	1.0	0.0
Central Commercial Opportunities & Private Patients	0.1	0.1	0.0	0.3	0.2	(0.1)	0.3	0.3	0.0
Divisional & Departmental Schemes	0.2	0.4	0.2	0.4	0.7	0.3	0.4	0.8	0.4
Other	0.2	2.0	1.8	(0.1)	3.7	3.8	(0.1)	1.4	1.5
	5.6	**6.0**	**0.4**	**11.2**	**12.4**	**1.2**	**11.2**	**11.2**	**0.0**
Medicine & Acute	1.7	0.8	(0.9)	3.1	1.5	(1.6)	3.1	1.6	(1.5)
Surgery, Women & Children	1.9	1.0	(0.9)	3.6	2.9	(0.7)	3.6	3.8	0.2
Clinical Support Services	0.9	0.6	(0.3)	1.7	1.0	(0.7)	1.7	1.0	(0.7)
Corporate	0.9	1.4	0.5	1.8	2.6	0.8	1.8	2.0	0.2
Central	0.2	2.2	2.0	1.0	4.4	3.4	1.0	2.8	1.8
	5.6	**6.0**	**0.4**	**11.2**	**12.4**	**1.2**	**11.2**	**11.2**	**0.0**

The latest in year forecast has increased to £12.4m which is an improvement of £0.5m in comparison to Month 6; this is as a result of additional savings identified to reduce waiting list payments, inflation avoidance and a reduction in the contract price with Cerner. It is of note that £11.6m of the in year forecast is secured through fully developed green risk rated schemes or via other mitigation.

As of Month 6 an assessment was made in relation to the recurrent value of schemes rag rated green for inclusion within the base budget and CIP requirements for 17/18 and 18/19, this equated to £8.3m. It is of note that the requirement for efficiencies for 17/18 is far greater than the Trust has delivered in previous years (£15m compared with circa £6m) and as such there needs to be focus on commencing activity to realise the benefits with effect from April 2017 whilst still monitoring the delivery of all 16/17 schemes.

During month 7 the recurrent value of fully developed green risk rated schemes has increased to £9.5m. This is a £1.2m improvement on the M6 reported position, and will be included as part of the delivery plan towards the 2017/18 CIP target.

It is of note that the above figures are exclusive of the health economy challenge of £5m that has been included within the submitted plans approved by the Board of Directors.

Cash position and Financial Sustainability Risk Rating (FSRR)

The October cash balance position was £2.1m, which is £0.7m below plan. While the cash position is above plan this has been supported by slippage on the capital programme. The Board of Directors attention is brought to the non- cash nature of some of the savings delivered thus and the potential loss of elements of the STF as a result of RTT performance will put strain on the cash position going forward and result in a need for further cash support.

As a result of this forecasted pressure discussions have begun with NHS Improvement to increase the working capital facility available to the Trust in line with the updated 13 week cashflow shared with them in mid-October.

Capital expenditure is £3.0m under plan as at the end of October as a result of delayed start to some capital spends as detailed in the table below; there are no major concerns on this timing difference.

Year ending 31 March 2017 Position as at 31 October 2016	2016-17 Capital budget £m	2016-17 Forecast £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
Funding					
Depreciation	6.809	6.809	4.530	1.538	2.992
Additional external (donations / grant) funding	0.111	0.111	0.111	0.111	0.000
Total funding	**6.920**	**6.920**	**4.641**	**1.649**	**2.992**
Expenditure - schemes					
Medical equipment - *Medicine and Acute Care*	0.450	0.450	0.450	0.377	0.073
Medical equipment - *Surgery, Women's and Children's*	0.477	0.477	0.417	0.045	0.372
Medical equipment - *Clinical Support and Diagnostics*	0.613	0.613	0.613	0.000	0.613
General IT	0.500	0.500	0.299	0.071	0.228
Cerner	1.002	1.002	0.741	0.018	0.723
Ward refurbishments - Ward 15 (AMU)	0.400	0.400	0.348	0.400	(0.052)
Ward refurbishments - *to be confirmed*	0.400	0.400	0.008	0.008	0.000
Relocation of Wirral Neuro - M2	0.801	0.801	0.801	0.019	0.782
Backlog maintenance - APH and CGH	1.300	1.300	0.350	0.341	0.009
All other expenditures	0.000	0.000	0.000	0.205	(0.205)
Unallocated resource - contingency	0.866	0.866	0.503	0.054	0.449
Donated assets	0.111	0.111	0.111	0.111	0.000
Total expenditure (accruals basis)	**6.920**	**6.920**	**4.641**	**1.649**	**2.992**

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

	Metric	Descriptor	Weighting %	Year to Date Plan		Year to Date Actual	
				Metric	*Rating*	*Metric*	*Rating*
Continuity of Services	**Liquidity (days)**	Shows ratio of liquid assets to total costs	20%	-28.5	4	-26.5	4
	Capital Service Cover (times)	Shows revenue available for capital service	20%	1.4	3	0.9	4
Financial Efficiency	**I&E Margin (%)**	Shows underlying performance	20%	-1.6%	4	-2.1%	4
	I&E Margin Variance from Plan (%)	Shows quality of planning and financial control	20%	-0.5%	2	-0.5%	2
Agency	**Agency**	Shows agency spend against cap	20%	-0.1%	1	-6.2%	1
	Overall NHSI UoR Rating				**3**		**3**

Conclusion

The Trust delivered the Q2 financial position but has further deteriorated the position in October by £(0.7)m. Focus still remains on delivering the Q3 position with the Board of Directors sighted on levels of risk in delivering Q3 while discussions continue with regulators around the health economy gap that will impact the Trusts performance during Q4. The Board are asked to note the non-recurrent support within the position and the additional pressure this will put on the underlying financial position of the Trust entering into Q3/4 and 2017/18 planning.

The cash position is below plan and the next two quarters are forecast to be significantly below plan which is being addressed with NHS Improvement around the increase of the working capital facility.

While the current financial plan delivers a UoR of 3 which is line with plan this has only been achieved as a result of the actions described above.

Recommendations

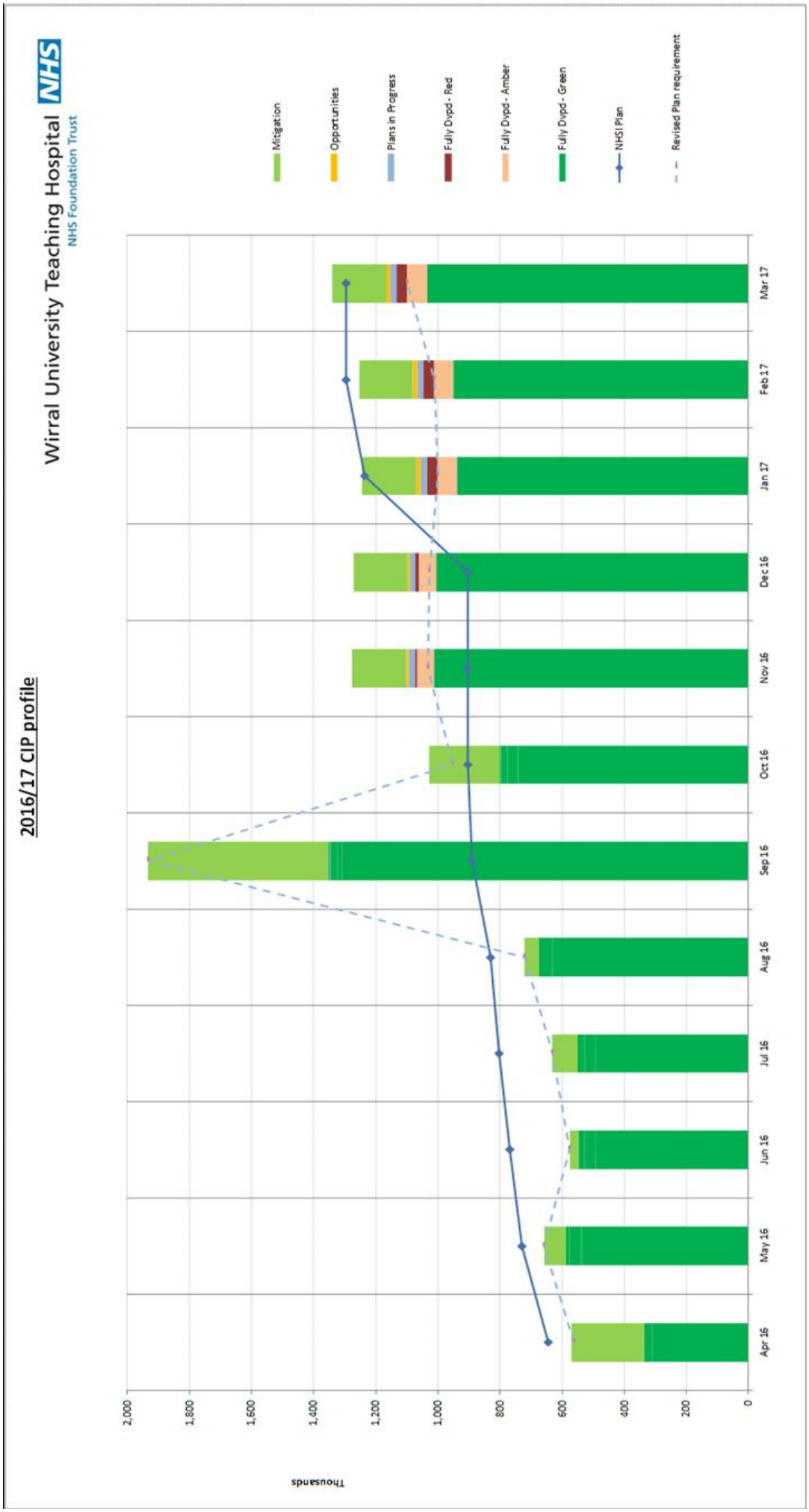
The Board of Directors are asked to note the contents of this report.

David Jago

Director of Finance
November 2016

Appendix 1: CIP Monthly Profile

The following chart highlights the CIP trajectory by Monitor Status and Risk Rating for the year, as at M7.



TRUST BOARD	
Agenda Item	8.1.3
Title of Report:	NHSI Agency Self Certification Checklist
Date of Meeting:	30.11.2016
Author:	Ann Lucas, Assistant Director of Workforce
Accountable Executive:	David Jago, Executive Director of Finance James Mawrey, Director of Workforce
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	1A 3B 7A
Level of Assurance • **Positive** • **Gap(s)**	Gaps due to further work that needs to be done to meet some of the checklist criteria
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Approval Required
Data Quality Rating	Silver - quantitative data that has not been externally validated
FOI status	**Document includes FOI exempt information**
Equality Impact Assessment Undertaken • **Yes** • **No**	**No**

1 Executive Summary

1.1 The purpose of this paper is to present to the Board:

- an update on processes and controls that are in place within the Trust to control and further reduce agency spend
- the completed NHS Improvement (NHSI) agency self-certification checklist for discussion, approval and sign off by the Trust Chair and Trust Chief Executive – as shown in appendix 2.

1.2 Agency caps were introduced in November 2015 and further stepped up and enhanced in July 2016 and again more recently in October 2016. The October enhancements include a self-certification checklist for all providers to complete and submit to NHSI by 30 November, agreed by the Board and signed by the Trust Chair and Chief Executive.

1.3 Every Trust is required to have an executive director as the lead for agency cap compliance and this is the Director of Finance for WUTH. The process is managed by the Director of Workforce and both work very closely with the Director of Nursing and Midwifery, Medical Director and Chief Operating Officer.

1.4 A full review of controls and processes has been completed as part of this self-certification. The Trust is able to assure NHSI that controls and processes are in place to fully meet the criteria laid down in the checklist or has robust plans in place to more closely achieve them.

1.5 The Board is asked to recommend approval of the self-certification checklist prepared and shown in appendix 2 for sign off by the Chair and Chief Executive for submission to NHSI.

2 Background

2.1 The Board of Directors will be aware that NHSI requires all Trusts to meet an overall agency spend reduction target and comply with specified agency rules. Performance against target and the background to the agency rules is explained below.

2.2 The target, performance to date and forecast outturn for the Trust's overall agency spend is summarised in the following table:

Agency spend	Target	Actual/Forecast-Outturn	Variance
Cumulative Month 1 – 7	£4.885m	£4.582m	£0.303m
Full Year	£8.113m	£6.771m	£1.342m

2.3 Weekly reports - Since November 2015 NHS Trusts have been required to report weekly on the number of shifts worked by agency/locums that either breach the specified caps (as laid down in the document 'Agency Rules' published in March 2016 by NHS Improvement), and, those taken on via a non-NHSI approved framework agency. With effect from 04 July 2016 NHS Trusts have also been required to report on the number of wage cap breaches – in addition to agency cap and framework breaches. Wage caps relate to the maximum amount an agency worker receives per hour (as opposed to the total hourly rate the Trust pays the agency for the worker). Overall performance on agency caps breaches within the Trust has improved since caps were introduced – with week

commencing 31 October 2016 seeing 97 breaches compared to a peak of 233. This is despite NHSI extending the criteria and lowering the value of the cap twice since first introducing. The first north monthly regional agency performance report from NHSI has just been published and shows WUTH as having a ranking of 29 out of 73 for agency spend verses ceiling and 27 out of 73 for agency spend as a percentage of total staff cost (with rank 1 being the lowest spend and cost respectively). So WUTH is showing as better than average across the north region.

2.4 NHSI additional requirements – In October 2016 NHSI stepped up the actions and reporting requirements to build on achievements to date, to further reduce agency expenditure across the NHS. These requirements together with actions taken to date are summarised in appendix 1. The rules place emphasis on promoting transparency, better data, stronger accountability by Boards and additional reporting of high cost overrides. These additional requirements included the submission of a Board self-certification checklist which is the subject of this paper.

2.5 Board self-certification checklist - NHSI advised that where Trusts are heavily reliant on agency staff they need to consider changing the way services are delivered, such as changing roles or implementing shared service models. These actions form part of the self-certification checklist that Boards have been asked to review, complete and submit to NHSI by 30 November – see appendix 2. The checklist is to be signed by both the Trust Chair and the Trust Chief Executive. NHSI will be following up with some Trusts to make sure that agreed actions have been taken.

2.6 Interims and Very Senior Manager roles (i.e. non clinical/non-medical posts) – NHSI believes that the NHS often gets poor value for money from agency managerial staff and should be aiming to radically reduce and ideally eliminate reliance on these staff, instead using internal NHS solutions. If Trusts can't fill roles internally they must then look to the STP footprint, then the wider NHS. NHSI have published guidance ('Interim agency very senior manager approval process' October 2016) stating that from 31 October any such contracts with a daily rate over £750 require prior approval by NHSI. All requests must be submitted on an NHSI business case approval form and will be reviewed by a sub-committee of NHSI Agency Implementation Group.

2.7 Shifts costing more than £120 per hour and all framework overrides above price cap – these must be personally signed off by the Chief Executive.

2.8 Collective action - NHSI believe that going off-framework is often indicative of poor planning and poor agency procurement behaviour and that collective action is the most effective way to tackle high spending - they expect providers to operate collaboratively to achieve this.

2.9 Data sharing - from November NHSI will start to share data on agency expenditure for all Trusts in the region and will hold regional workshops, as well as ensuring that agency spend is a key component in STP discussions. NSHI expect STP's to ensure the agency rules and the new enhanced controls are implemented across the footprint, to reduce excess cost and provide safe services within the system control total. NHSI will soon publish quarterly reports showing Trust level data on agency spend – it is expected to include the best and worst performing Trusts against ceiling and relative to workforce costs.

2.10 Further data collections to be requested from January 2017 – NHSI have informed providers at a recent regional meeting that additional reporting requirements will be introduced in January 2017.

3 Key Issues

3.1 The Board checklist includes 16 criteria and is divided into five areas:

(i) Governance and accountability
(ii) High quality timely data
(iii) Clear process for approving agency use
(iv) Actions to reduce demand for agency staffing
(v) Working with your local health economy

3.2 All of the areas listed within the checklist have now been reviewed and the completed self-certification being presented for approved to be submitted to NHSI is that shown in appendix 2. The following points explain the contents of appendix 2:

(i) Comments in the 'yes' column (highlighted in green) outline the steps taken and the processes and controls that are in place to explain to NHSI how WUTH is complying with each of the 16 points in the checklist.

(ii) Comments in the 'no' column (highlighted in red) outline steps that WUTH needs to take to ensure existing processes are strengthened and are not yet fully achieved or embedded.

(iii) SMT have approved the content of this proposed submission.

(iv) The checklist is supported by a standard operating procedure (SOP) outlining processes and controls that must be followed by all managers and booking team members with respect to agency worker or locum recruitment. This includes all the necessary authorisation forms and flowcharts and has been communicated across the organisation.

3.3 The Assistant Director of Workforce is working closely with the Chief Operating Officer, Director of Operations and Divisional Directors to review their current agency use including steps to eliminate all agency staff working in non-front facing services and reassessing critical areas.

3.4 A weekly report is prepared for Trust Senior Management team which includes an:

- Update on the top 20 highest cost agency workers
- Those agency workers employed for six months or more.
- Year to date spend on all areas on non-core pay which are reviewed in relation to vacancy and sickness rates
- Weekly agency breaches for approval and submission to NHSI

4 Conclusion

4.1 New NHSI reporting requirements and the need to further reduce agency spend within the Trust to deliver financial targets, means further tightening of the governance and accountability framework for agency staff. The self-assessment checklist provides assurance that robust controls are in place and will be enhanced further to place downward pressure on agency spend whilst maintaining safe services to patients.

5 Next Steps

5.1 The NHSI Board self-assessment checklist will be submitted to NHSI by 30 November.

5.2 Work will continue to carry out and deliver the actions within the checklist and outlined within this report to further reduce agency spend and move closer to full compliance of agency cap rules ensuring any breaches that do occur will be for patient safety reason only.

6 Recommendation

6.1 The Board is asked to discuss and approve the recommendation that the attached Board self-certification checklist is agreed and signed off on behalf of the Board by the Chair and Chief Executive for submission to NHSI by 30 November.

Summary of NHSI additional required actions

(As per letter to NHS Providers 17 October 2016)

Action	Steps to take and when	Lead	Action taken
Data submission: • Monthly agency spend by cost centre/service line	Submit data by 12pm 24 October 2016	Finance	COMPLETED Return submitted
Data submission: • A list of the top 20 highest earning agency staff (anonymised) • A list of agency staff that have been employed for more than six consecutive months (anonymised)	Submit data by 12pm 31 October 2016	HR	COMPLETED Return submitted
Board, together with **CFO**, **HR Director**, **Nursing Director** and **Medical Director** to discuss and complete agency self-certification checklist	Submit completed checklist by 30 November 2016	HR	Checklist for approval attached as per appendix 2
Chief Executive to personally sign off on: • All shifts by individuals costing more than £120 per hour • All framework overrides above price cap	Embed action in the Trust starting 22 November 2016 Note: Sign off should be prospective unless from exceptional circumstances Any retrospectives should be signed off within one week	HR (Divisions to be responsible for completing the form and processing)	SMT have agreed that all such requests be submitted to vacancy panel on the appropriate approval form and if agreed submitted to SMT for approval and sign off by CE Note: One locum Consultant Radiologist currently on a rate in excess of £120 – under review.
Trusts required to secure approval from NHSI in advance of: • Signing new contracts with **agency senior managers** where the daily rate exceeds £750 including on costs • Extending or varying existing contracts where the daily rate exceeds £750 including on costs **or** incurring additional expenditure to which they are not already committed	Completion of NHSI business case approval form Rules effective from 31 October 2016	HR (Divisions to be responsible for completing template)	SMT have agreed that any such proposals are presented to SMT for approval to submit to NHSI Note: No such contracts are in place in the Trust at this time

	Self-certification checklist Please discuss this in your board meeting	Yes - please specify steps taken	No. We will put this in place - please list actions
Governance and accountability			
1	Our trust chief executive has a strong grip on agency spending and the support of the agency executive lead, the nursing director, medical director, finance director and HR director in reducing agency spending.	This is a priority item on the weekly agenda of the Trust Senior Manager Team which is chaired by the Chief Executive and includes nursing, medical, finance, HR and all other directors. The Director of Finance is the agency executive lead. This agenda item is supported by a weekly report on agency spend, including updates on action plans and cap breaches. Agency spend reductions plans and impact on clinical services is also reviewed by the Chief Operating Officer with Divisional Directors at a weekly operations performance meeting.	
2	Reducing nursing agency spending is formally included as an objective for the nursing director and reducing medical agency spending is formally included as an objective for the medical director.	Formal objective set for both Director of Nursing and Midwifery and Medical Director	
3	The agency executive lead, the medical director and nursing director meet at least monthly to discuss harmonising workforce management and agency procurement processes to reduce agency spending.	Agency executive lead is the Director of Finance and meets weekly with Director of Nursing and Midwifery, Medical Director and other Executives and Directors. A weekly progress report on agency spend, including cap breaches, is received and approved at that meeting.	
4	We are not engaging in any workarounds to the agency rules.	The Trust is not engaged in any workarounds to the agency rules.	
High quality timely data			
5	We know what our biggest challenges are and receive regular (eg monthly) data on: - which divisions/service lines spend most on agency staff or engage with the most agency staff - who our highest cost and longest serving agency individuals are - what the biggest causes of agency spend are (eg vacancy, sickness) and how this differs across service lines.	Monthly reporting of agency spend by division and cost centre/service line is in place and includes rankings of highest spend areas, longest serving agency workers and reasons for the agency cover. This report together with weekly cap breach information is presented to Trust Senior Management Team weekly; Finance Strategy Performance Group monthly; Finance Business Performance Accountability Group bi monthly; and circulated to Heads of Service weekly.	

	Self-certification checklist Please discuss this in your board meeting	Yes - please specify steps taken	No. We will put this in place - please list actions
Clear process for approving agency use			
6	The trust has a centralised agency staff booking team for booking all agency staff. Individual service lines and administrators are not booking agency staff.	Medical staffing team centrally book all medical locum/agency staff All other bookings are centralised via NHS Professionals with the exception of: - some Pharmacy agency workers that go through the same Vendor Managed Service as the medical locums - two agency workers that have been booked direct and approved by an Executive Director and whose contracts are due to come to end in January; there will be no exceptions after this date Controls are in place within the Procurement team to flag any requisitions for agency workers that are not supported by a signed approval form and that do not go via the centralised medical staffing team or NHSP route.	
7	There is a standard agency staff request process that is well understood by all staff. This process requires requestors and approvers to certify that they have considered all alternatives to using agency staff.	A process is in place using standardised documentation and is supported by a Standard Operating Procedure (SOP) - both the documentation and the SOP have been widely communicated and are understood across the organisation	
8	There is a clearly defined approvals process with only senior staff approving agency staff requests. The nursing and medical directors personally approve the most expensive clinical shifts.	Non-breach Nursing agency are approved by use of 'golden keys' via the NHSP system and only for agreed critical areas as authorised by the Director of Nursing and Midwifery. All breaches and any other nursing agency is approved by Director of Nursing and Midwifery at the weekly vacancy panel. Non-breach Medical agency are approved by the Clinical Service Leads and only for agreed critical areas as authorised by the Medical Director. All breaches and any other request for agency medical staff is authorised by the Medical Director at the weekly vacancy panel.	

	Self-certification checklist Please discuss this in your board meeting	Yes - please specify steps taken	No. We will put this in place - please list actions
Actions to reducing demand for agency staffing			
9	There are tough plans in place for tackling unacceptable spending; eg exceptional over-reliance on agency staffing services radiology, very high spending on on-call staff.	Non-core spend review meetings set up and chaired by the Chief Operating Officer - action plans in place to reduce unacceptable spend and over reliance on agency workers. Actions and all other aspects of agency and non-core spend is reviewed weekly at the Operational Performance Meetings and reported weekly to Senior Management Team chaired by CEO.	
10	There is a functional staff bank for all clinical staff and endeavour to promote bank working and bank fill through weekly payment, auto-enrolment, simplifying bank shift alerts and request process.	NHS Professionals provide a managed service to the Trust for bank and agency workers, which is a fully automated on-line system. It includes weekly pay and attendance at Trust induction to ensure all new staff have the opportunity to register as bank workers as they come into post.	Auto-enrolment is being discussed with NHSP. This will need to be managed as a project and involves a high level of resource from NHSP who are currently assessing current time lines when they would be available to do this. A project plan will drawn up once agreed.
11	All service lines do rostering at least 6 weeks in advance on a rolling basis for all staff. The majority of service lines and staff groups are supported by eRostering.	Job planning and rosters are done at least 6 weeks in advance.	
12	There is a clear process for filling vacancies with a time to recruit (from when post is needed to when it is filled) of less than 21 days.		Not all posts are filled within 21 days - this is a highly challenging target to achieve. KPI's are however in place with HR. All jobs are advertised within 5 working days of being approved by vacancy panel. Jobs are advertised for 14 days or less. Once adverts are closed the recruiter pack is sent to managers within 2 working days. Actions is being taken to further streamline this process and involves maxmising the use of the functionality within NHS Jobs. Further improvements will also be made as a result of the recent introduction of the Electronic Staff Record Self Service module which has streamlined and automated the vacancy control process. The above KPI's within the HR team are being met. Divisions are currently reviewing their own process time before and after being processed by HR.

	Self-certification checklist Please discuss this in your board meeting	Yes - please specify steps taken	No. We will put this in place - please list actions
13	The board and executives adequately support staff members in designing innovative solutions to workforce challenges, including redesigning roles to better sustain services and recruiting differently.	Prior to a board member authorising any agency shift the process requires managers to demonstrate they have considered innovative solutions and must state this on the authorisation form.	
14	The board takes an active involvement in workforce planning and is confident that planning is clinically led, conducted in teams and based on solid data on demand and commissioning intentions.	Annual planning cycle includes workforce plans to ensure aligned with financial and service plans which are fed by the divisions and based on demand and commissioning intentions.	The Trust recognises that there is more work to do in this area and is further developing its capacity and demand planning process as a foundation for workforce planning.
Working with your local health economy			
15	The board and executives have a good understanding of which service lines are fragile and currently being sustained by agency staffing.	Critical areas and 'hard to fill' specialties have been identified and agreed at Executive level. Monthly reports are produced for committees of the Board that show top 20 agency use service areas.	
16	The trust has regular (eg monthly) executive-level conversations with neighbouring trusts to tackle agency spend together.	Discussions are on-going with neighbouring Trusts as part of the Directors of Finance agenda, Directors of HR colloborative network agenda and strategic partnership meetings - including the viability of bringing rota's together for challenged specialities.	Further discussions are to be initiated across the STP footprint to address the possibilites of colloorative banks, more formal sharing of local information, improved 'marketing' of the flexibility of substative contracts, pooled annualised regional contracts and consideration of how the national agenda can be influenced.

Signed by [Date]

Trust Chair: [Signature]

Trust Chief Executive: [Signature]

Please submit signed and completed checklist to the agency inbox (NHSI.agencyrules@nhs.net) by 30 November 2016

Board of Directors	
Agenda Item	9.1
Title of Report	Report of the Quality & Safety Committee – 9 November 2016
Date of Meeting	30 November 2016
Author	Cathy Maddaford, Chair of the Quality and Safety Committee
Accountable Executive	Gaynor Westray, Director of Nursing and Midwifery
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	 1, 2, 4, 5, 7 1a, 1b, 2a, 2b, 2c, 4a, 5a, 5b, 5c, 7a, 7b, 7c, 7d 1, 2, 3, 16, 17, 19
Level of Assurance • **Positive** • **Gap(s)**	Gaps with mitigating action
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

This report provides a summary of the work of the Quality and Safety Committee which met on the 9 November 2016. Key focus areas are those which address the gaps in assurance/control in the Board Assurance Framework.

Review of the Remit of the Quality and Safety Committee

The Committee agreed its revised remit and the proposed approach to the dissemination of work items amongst appropriate Executive Committees, with progress updates to be included as part of Chair Reports, as recommended by the Well-Led Governance Review.

The Committee noted its agreement to development of a revised Workplan to reflect the Committees revised scope.

Workforce and OD Dashboard

Good performance was reported, the key highlights being:

- Sickness rates for September 2016 were reported as 3.76% which benchmarked well against comparable organisations,
- The Trust continued to report low vacancy rates in both Nursing and Midwifery (2.31%) and consultancy (4.90%) positions,
- An increase in Mandatory Training compliance was visible at 92.51% for September 2016 however further work was required in order to attain the Trust KPI of 95%,
- A Trust response rate of 37% against a national average of 31% was noted for the NHS Staff Survey,
- The Trust reported a high uptake of the flu vaccine which was at 62% following an initial four week period and thanks were extended to the nursing and occupational health staff who had administered vaccinations to date.

The Committee was advised of the ongoing consultation regarding proposed changes to apprenticeship delivery arrangements. It was confirmed that the operational and financial implications would be considered by the Senior Management Team and the Committee requested that the outcome of the consultation and its implications were presented at a future meeting.

Workforce and OD Strategy Progress Report

The Committee received the report which outlined the progress against year two of the Workforce and OD Strategy and agreed that the Trust focus would remain on the four key areas of:

- Healthy Organisational Culture,
- Sustainable Workforce,
- Capable Workforce,
- Effective Leadership and Managers.

The Committee requested that more frequent reporting of progress against the strategy was presented at future meetings.

Health Education England North West Visit Review

The Committee received the formal feedback following the Health Education England (HEE) visit of 5 July 2016 and although the Trust had had performed in comparison, was disappointed to note the weaknesses identified in respect of clinical representation during the visit.

The Committee noted that work had commenced to further strengthen the current education governance structure to support the completion of a robust action plan which would address the issues identified. This would be further supported by the development of an internal action plan which would address additional actions identified by the Trust.

The Committee noted that a formal response would need to be issued by the Trust ahead of the 2 January 2017 deadline.

CQC Progress Report

The Committee received the CQC Progress Report which highlighted the receipt of 'Good' ratings for all wards and departments subject to a Care Quality Inspections (CQIs) during the review period under the revised robust inspection regime. The Committee requested that work was undertaken to develop mitigating actions to address the key themes for improvement which had been identified during the most recent CQIs.

The Committee was pleased to note the positive outcomes of the most recent CQC Divisional Deep Dive which took place on 14 October 2016 which had seen all Clinical Divisions assign overall ratings of 'Good' following vigorous self-assessments. The Committee was advised that areas for improvement had however been identified and work would be undertaken to address the issues identified.

The Committee noted that in addition to addressing the actions outlined within the regulatory action plan, work would continue to enhance the Trust performance in respect of all the fundamental standards ahead of the CQC re-inspection.

Board Assurance Framework

The Committee received the Board Assurance Framework (BAF) and noted that there had been no change to the risk scores. The Committee agreed that as significant progress had been made in respect of Risk 1 (CQC Rating) the Clinical Governance Group was to be requested to review the risk score.

The Committee welcomed the revised BAF management process which would incorporate contributions from Divisions and Executive Committees and was pleased to note that full details of the revised procedure for the management of the Trust strategic risks would be presented to the Board of Directors at its December 2016 meeting.

One to One Maternity Clinical Review - Outcomes

The Committee noted that Trust had begun to collaborate with One to One and Wirral Clinical Commissioning Group to improve the clinical pathway for One to One service users.

The Committee requested that the Director of Nursing and Midwifery gave consideration to the development of performance indicators and triggers which would monitor the effectiveness of the improvements made to the clinical pathway for patients under the care of One to One .

Quality Impact Assessment – Procedures of Low Clinical Value

The Committee was alerted to the receipt of notification from Wirral Clinical Commissioning Group in September 2016 on its decision to serve notice in respect to changes to referral processes for a number of Procedures of Low Clinical Value (PLCV), with a proposal for further expansion of the list of affected PLCV currently out to consultation until January 2017.

The Committee noted the importance of monitoring the quality of care for those patients affected by the process changes which would see patients meet strict nationally set criteria ahead of referral for treatment for which responsibility for adhering to the guidance would sit primarily with referring General Practitioners.

The Committee was advised that the potential impact to activity and financial performance as a result of the process changes had been discussed that the Finance, Business Performance and Assurance Committee.

Health and Safety Quarterly Report – Q2 2016/17

The Committee noted the following points of the Health and Safety Quarterly Report:

- The commencement of the Asbestos survey which was anticipated to reach completion towards the end of November 2016,
- The positive response to the Health and Wellbeing Listening into Action event held during October 2016 and the further work required to continue to improve staff wellbeing,
- The work to be undertaken by the Water Safety Group to address the issues identified during the Mersey Internal Audit Agency Water Safety Review which assigned the Trust Limited Assurance.

Wirral Millennium Phase 3 Go Live Preparations

The Committee received an update in respect of Wirral Millennium Phase 3 which was scheduled to “go live” on 26 November 2016. The Committee noted the issues identified during the latter part of Phase 3 implementation and the confidence of the Informatics Team to resolve the issues sufficiently to ensure the launch of the majority, if not all, planned modules within the planned deadline.

The Associate Director of Informatics confirmed that a formal “go live” decision would be undertaken on 24 November 2016 following evaluation of any outstanding issues and the outcomes of the technical dress rehearsal.

Assurance Reporting

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

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

The Committee noted its agreeance to the value realised as a result of the revised format for assurance reporting from its supporting Executive Committees.

Cathy Maddaford
Chair of Quality and Safety Committee

Trust Board	
Agenda Item	9.2
Title of Report	Charitable Funds Proposals
Date of Meeting	30 November 2016
Author	Deborah Harman Assistant Director of Finance – Financial Services
Accountable Executive	David Jago Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	7.Strategic Objective – Supported by financial, commercial and operational expertise 7D. Compliance with legislative requirements
Level of Assurance • **Positive** • **Gap(s)**	Gaps - current arrangements
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Approval
Data Quality Rating	Bronze
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 present to the Trust Board a summary of proposals for formal ratification. The proposals are intended to:

- create administrative efficiency;
- enable greater compliance with current statute and guidance;
- provide clarity and support to Trust staff and donors; and
- improve marketing and income potential through the creation of a fundraising function, and a Charity brand with fund 'sub-brands'.

2. Background

Detailed findings, recommendations and proposals have been presented to The Trust's Senior Management Team (June 2016), the Charitable Funds Committee (September 2016), and Trust Board (October 2016). The proposals were agreed in principle, subject to minor requested amendments which have been incorporated into this paper.

3. Proposals regarding the structure, strategy and policies of the Trust's Charity

Further details on the findings and rationale behind each proposal are included in the October 2016 Trust Board paper. The proposals offered for ratification are outlined below.

3.1 Proposal 1 – a specialty funds structure – 'Big 8'

The Charity currently comprises 108 funds, the majority of which contain extremely small balances. The existing structure is highly devolved and inflexible, as it does not support the development of strategy, including strategic spending decisions as directed by the Charitable Funds Committee. This structure is also administratively burdensome, and does not support an effective fundraising function.

Proposal 1 therefore contains the following actions.

a. The creation of a 'Big 8' structure – that is, 8 restricted-by-specialty funds and a general fund, which will constitute 8 sub-brands of the 'parent' Charity brand. The identification of 'Big 8' specialities will be completed through consultation with the divisions, subject to formal approval through the Charitable Funds Committee.

b. The mapping of existing funds into the new, streamlined 'Big 8' structure, in a manner consistent with Charity Commission guidelines. This will include a requirement that minor fund balances are spent down to zero before transition.

c. Reassignment of financial limits – fund-holding will be transferred to senior management (divisional directors), advised locally by clinicians and specialty steering groups. Financial limits are to increase from £1k to £10k, supported by the compliance measures in Proposal 3. The Charitable Funds Committee will be the fund-holder for the general fund, and will approve expenditure plans over £10k.

3.2. Proposal 2 – objectives – a new Mission Statement

Because the Charity exists solely to purchase goods/services for the Trust, its Mission is an expression of *what it intends to purchase*. It represents the Corporate Trustee's interpretations of the prevailing statutes and best-practice guidance on charitable spend, and is expressed in detail through the expenditure-side policy mentioned in Proposal 3.

A revised proposed Mission Statement for ratification is as follows.

> *"To further improve the quality of WUTH's patient care, by purchasing medical equipment, improving our facilities and by directly enhancing the patient experience in other imaginative ways. This is achieved through the spontaneous generosity of the general public and by fundraising activities, events and appeals."*

3.3 Proposal 3 – governance and compliance improvements

The Charity does not currently have any staff-facing policies. Certain activities to date are not fully in line with best practice, Charity Commission guidance, statute, or – inevitably – the wishes of the Charitable Funds Committee or Trust Board.

Detailed policies addressing both the Charity's income-side and expenditure-side activity have been approved in principle through freestanding papers by the Charitable Funds Committee (September 2016) and Trust Board (October 2016).

- The Fundraising and Income Guidance policy document seeks to outline the approved ways of generating and handling charitable income, and the help available to staff who wish to fundraise.

- The Expenditure Guidance policy document seeks to outline to staff which goods or services may or may not be purchased through the Charity, with additional information and guidance on charitable purchasing, in line with the Mission Statement under Proposal 2.

It is proposed that both policies are formally ratified by Board, to have the status of 'Charity policy' in the first instance. The Expenditure Guidance policy document will have immediate effect, and the Income and Fundraising Guidance policy will apply with effect from the start date of the new Head of Fundraising, although the broad principles contained within the document may be applied with immediate effect.

It is acknowledged that communications around the launch of both documents will be key to their success, and that this would constitute 'step one' of a difficult journey in terms of 'hearts and minds'. Financial Services intend to work closely with the Director of Finance and the Communications Team to ensure that the message is pitched for the best outcome. Financial Services will also follow up with key stakeholders and create supplementary resources such as 'page to view FAQs' for local noticeboards.

3.4 Proposal 4 – 'professionalising' and growing the Charity – Head of Fundraising, brand and systems

This proposal contains the following actions.

a. Recruitment of a Head of Fundraising to Financial Services (Band 8a, midpoint c. £56k including on-costs), with a modest fundraising budget (c. £5k) with immediate effect, with costs to be recharged to the Charity via the administration fee.

b. Implementation of an integrated financial ledger / fundraising and donor database system, to improve administration and support the development of income streams (c. £15k including VAT, with annual maintenance and support costs of £4kpa).

c. A modest one-off brand and marketing budget (£12k), to develop the 'parent' Charity brand and the 'Big 8' sub-brands, including document templates and fundraising materials, for ultimate approval by the Charitable Funds Committee Any 'top up' costs would be requested as a variation to the administration fee on an annual basis.

3.5 Proposal 5 – non-recurring resource in Financial Services to make things happen

The proposals listed above represent a transformational project which is not part of Financial Services' business-as-usual work-plan. The department understands what to do and how to do it, and is capable and experienced, but is not resourced to perform this work.

It is proposed that Financial Services recruit temporary cover (Band 7, midpoint c. £26k including on-costs) to commence as soon as possible and this has been catered for in the 2017/18 financial plan.

4. Summary of costs

In summary, the proposed cost estimates are as follows.

		One-off costs	Recurring costs	Charged to
Proposal 4a	HoF costs		£61k pa	Charity
Proposal 4b	System costs	£15k	£4k pa	Charity
Proposal 4c	Brand and materials	£12k		Charity
Proposal 5	Temporary support	£26k		Trust

5. Recommendations

The Trust Board is asked to approve Proposals 1 to 5, for a relaunch of the Charity with provisional effect from 1 April 2017, subject to successful completion of preparatory stages, including recruitment and system implementation.

Deborah Harman

Assistant Director of Finance – Financial Services
November 2016

BOARD OF DIRECTORS	
Agenda Item	9.3
Title of Report	CQC Progress Report
Date of Meeting	30.11.16
Author	Joe Roberts, Head of Assurance
Accountable Executive	Gaynor Westray, Director of Nursing and Midwifery
BAF References	Risk 1 - Fully comply with our registration with the Care Quality Commission
Level of Assurance	Positive
Purpose of the Paper	To note
Data Quality Rating	Mixture of gold, silver and bronze data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken	Not applicable

1. Executive Summary

This report provides the Board with an update on our preparedness for re-inspection by the Care Quality Commission, in particular: the progress of our action plans; the results of recent internal Care Quality Inspections; the outcome of the recent engagement meeting with the CQC; the results of the 'deep dive' event in October; and the next steps. It also summarises two recent CQC publications on information governance and the state of care nationally, to provide context and insight into what the Trust can expect from the next inspection.

2. Background

The action plan and the internal Care Quality Inspections are monitored by the following committees and groups in the Trust: Clinical Governance Group; Operational Management Team; and the Quality and Safety Committee, all of which receive more detailed information. This report is an overview for the Board as a whole.

3. Key Issues

Of the 26 wards / departments inspected so far as part of the Care Quality Inspections, 14 were rated good and 11 as requiring improvement, at the time of their original inspections. Of the five domains covered by the inspection, Safe is the one with the largest number of wards

requiring improvement. This is in line with national trends, and medicines management is the single most common issue arising in this section of the inspections. In recent months it has been more common for wards to achieve a good rating overall and the results of Trust initiatives such as recruitment of additional nursing staff, and improving response times for estates and facilities jobs, are visible at the ward level. The Trust has started to re-visit the areas that were visited earlier in the year to confirm that positive changes have been made.

4. Gaps in Assurance

Progress to date is good, but the report does highlight actions in the action plans which are behind the original schedule (although still on track to be completed) which the Trust is progressing now at pace. The assurance work has identified some further areas for improvement, namely: medicines management; nutrition and hydration; the Advancing Quality initiatives; and improving internal transfers of patients between wards.

5. Next Steps

The Trust will be increasing the frequency of Care Quality Inspections, and organizing a further 'Deep Dive' event to maintain improvements made. A further update of the Trust's self-assessment will be undertaken periodically together with continued communication of improvements that the Trust has made since the inspection and what is still required from staff with the re-introduction of the 'Little Gems' newsletters.

6. Recommendation

The Board is asked to note this report and the work being undertaken.

CQC Board Update November 2016

Action Plan

The Regulatory Action Plan, which responds to the 'must do' actions from the inspection report shows good progress being made. An updated version has recently been shared with the Care Quality Commission. The principal issues which remain are the following:

Regulatory Action Plan

- *Urgent access referral criteria for Diagnostics* – further changes to these new draft guidelines are being made following consultation with our local GPs through the Clinical Commissioning Group.
- *Cleansing of risk register* – the Trust is working through the older risks and consolidating similar or duplicated risk entries, although this has proven a more complex and time consuming task than originally expected.
- *Developing individual quality dashboards in Acute & Medical specialties* – the Trust has individual quality dashboards in place however the "real time" information boards will not be available until the new risk management system has been implemented.

Care Quality Inspection Programme

Since the last Board meeting, four wards and departments have been visited as part of the CQI programme. The ratings given were as follows:

Fracture Clinic (Surgery): **Good**
Ward 21 (Acute & Medical Specialties): **Requires Improvement**
Ward 26 (Acute & Medical Specialties): **Good**
Ward 33 (Acute & Medical Specialties): **Not rated**

The findings are reported in greater detail to the Clinical Governance Group, Operational Management Team and the Quality and Safety Committee. Ward Sisters receive immediate verbal feedback at the end of each inspection visit. The Quality and Safety Team then agree the ratings given for each of the five questions and for the ward as a whole, and issue the written report to divisional management within one week. The report is a two-page document in bullet point format which clearly differentiates between short term actions which need to be completed as soon as possible, and longer-term actions, e.g. those which may require financial investment or more staff education.

In total, **26** wards and departments have been inspected since the programme started in its current form in December 2015. Of these, **14** were rated "Good" and **11** as "requiring improvement" at the time of their inspections. None were rated either as outstanding or inadequate. One ward (ward 33) was not given an overall rating as it was not possible to complete the 'well led' section of the assessment at the time. The domain of the inspection with the most 'requires improvement' ratings is Safe – 18 of 26 areas required improvement. This matches the trends in CQC inspections, where over 70% of Acute Trusts in England are rated as requiring improvement for Safe. Medicines management was a consistent theme from our visits.

It is important for the Board to note the increase in wards being rated as "Good" overall in recent months. Out of the last 7 inspections, 6 were rated as "Good".

Over the past year the internal inspection process has been must more robust, for example by making some areas in the inspection programme 'red flag issues', whereby a ward cannot achieve 'Good' for a relevant section in the inspection if it fails against that area. Examples of these fundamentals standards of care include:

- Evidence of delayed responses to call bells
- Evidence of lack of patient confidentiality

The Associate Medical Director and Quality & Safety colleagues have started to revisit areas which were rated as requiring improvement to check that the recommended actions have been completed. A programme of dates for CQIs for 2017 has also been compiled, with the intention that every clinical area will have been inspected by the time of the actual CQC visit. The intention is to also increase the frequency of inspections from monthly to fortnightly.

Inspection Preparedness

Engagement Meeting with CQC

The Trust held a routine engagement meeting with CQC on 10th November whereby good progress made to date on the action plan was noted, this included the work which the Trust was undertaking to rationalise the risk register; the redesign of the Board Assurance Framework and the change in focus of the Operational Management Team to enable it to focus on risk management.

The Trust shared its self-assessment with CQC who acknowledged the Trust's candid approach to this and the wide range of information on which it was based. There was recognition that failure to meet constitutional targets for referral to treatment and emergency department waits could impact on the Responsive domain however CQC stressed the importance of the Trust's continued approach to risk assessment, safety and improvement as evidence through its work in this area. CQC welcomed the Trust's frank assessment of performance in medicines management and record keeping and the work the Trust was undertaking to improve this. There was acknowledgement by both parties that compliance against all fundamental standards was essential with particular emphasis on the domain of "safe" when considering inspection ratings. The Trust is aware that achievement of a minimum of a "Good" rating for the Safe domain was fundamental in achieving an overall "Good " rating in any inspection and for providing the right environment for patients and staff.

There was discussion regarding the scope and timescales of a future re-inspection. Following the publication of new guidance, there are now two options for Trusts like ours which are rated as 'requires improvement':

Option 1 – CQC undertake an unannounced inspection in one Core Service area; this is followed up with a review against the Well Led Domain, then followed up with a review of evidence in those areas after that. The Trust would receive an assessment of that area but that would not lead to a change in overall rating; in other words the Trust would remain at 'requires improvement' overall.

Option 2 – full comprehensive Inspection – this would lead to a change in overall rating, subject of course to the Trust attaining the required "Good" standard.

The Trust is aspiring to achieve a "Good" rating. This would reflect the progress it has made and would further improve staff morale and public confidence; it means that option 2 would be preferable from the Trust's perspective.

Deep Dive Event

The Trust held its third 'Deep Dive' event on Friday 14th October. The leadership triumvirates of each of the three clinical divisions gave presentations about the progress of their action plans. There were also presentations on topics which had not featured prominently in the original inspection report although deemed essential in terms of compliance against all the fundamental standards of care. These were: Advancing Quality, nutrition and hydration, medicines management, and mandatory training.

The clinical divisions were asked to self-assess the core services (as defined by CQC) for which they are responsible. End of Life Care was not featured in this 'deep dive' meeting hence the reason why that core service is not in the ratings below. The **self-assessed** ratings were as follows (the arrows indicate whether the rating has improved, declined, or remained the same since September):

Division	Core Service	Self-assessed Rating
Acute and Medical Specialties	Accident and Emergency	Good ⇔
	Critical Care	Good ⇔
	Medicine (including care of the elderly)	Good ⇔
Clinical Support and Diagnostics	Outpatients and Diagnostic Imaging	Good ⇧
Surgery, Women's and Childrens	Children and Young People's Services	Good ⇔
	Maternity	Good ⇔
	Surgery	Good ⇔

A number of examples of good practice, and positive service developments, were cited. These included:

- Considerable improvement had been observed in the main Outpatient department at Arrowe Park at a recent Care Quality Inspection
- The laboratories had recently achieved ISO accreditation subject to completing some additional actions
- The Surgical division now has a manager in post whose role is dedicated to improving patient flow
- The Critical Care team has become more proactive in reporting incidents and risks
- Five of the eight wards assessed so far under the Corporate Nursing ward accreditation scheme had achieved a gold score for nutrition and hydration

Gaps in Assurance

- *Medicines Management* – At the 'deep dive', the Director of Pharmacy presented the results of audits of medicines storage, controlled drugs, missed medications, Patient Group Directives, oxygen prescribing, and assessment and prescribing for Venous Thrombo-Embolism. These highlighted where further improvement was required.
- *Advancing Quality* - A number of new topics have been added to the initiative over the past year, which inevitably means that there is room for improvement in all of them (hence their inclusion in the first place). The improvements will depend on greater ownership by senior clinicians, more education, and improved decision support in the form of new care pathways and more responsive IT systems.
- *Nutrition and Hydration* – the results of the 2016 PLACE assessment (a benchmarking exercise for premises and patient experience) showed a marked decrease in patient satisfaction with meals, coinciding with changes to catering arrangements in the past year.

- *Infection Control* – good progress was reported in all areas, and particularly in Critical Care, although there is more work to do to embed responsibility for infection prevention and control in all areas.
- *Internal patient transfers* – this was not discussed at the "Deep Dive", however the Trust has recognised that further work is required to standardise the process for internal transfers of patients from one ward in the hospital to another which it is now progressing at pace.

National Reports from CQC

Information Governance

In July the CQC published the report of a nationwide review of data security, defined as availability, security and confidentiality, across hospitals and primary care. They found that there had been relatively few data breaches in the NHS (533 reported in the previous year), but these had been costly, both financially and in their impact on patients and on the Trusts' reputations. The vast majority resulted from errors and poor practices rather than malicious acts. Common risk factors found in organisations included: avoiding access controls by sharing smartcards or passwords; complex, bureaucratic systems which created an incentive for workarounds; use of outdated IT hardware, operating systems or web browsers which could not accept security patches; poor quality training; and failure to learn lessons from earlier incidents.

For NHS Trusts, the main source of assurance is the Information Governance Toolkit, an annual self-assessment which covers confidentiality, records management, data quality and information sharing. The CQC report recommended that Trusts needed to get more external assurance rather than just relying on their own judgements.

At this Trust the IG Toolkit is managed by the Information Governance & Records Department who collect and evaluate the evidence to support the Trust's assessment. In the past five years the Trust has scored itself as Level 2 – Satisfactory (green). There are three levels, and Level 1 is considered a fail while Level 3 is outstanding. MIAA review the self-assessment each year. In 2016 MIAA checked a sample of fifteen indicators in the toolkit, fourteen of which were supported by MIAA.

The CQC report made a number of recommendations for Trusts, but also for CQC themselves. They already cover information governance in their inspections but indicated that in future they would look at information governance in greater detail – they would develop a more detailed inspection tool and also develop their Inspectors' skills in this area. This will mean that inspections will focus more heavily on information governance in the future rather than creating a new standard. The new inspection tool has not yet been published but should be in place by April 2017. The Trust is already factoring in this change in its preparations for the next inspection.

CQC State of Care Report 2016

CQC recently published their State of Care Report. This is an annual report which reviews the results of their inspection activity across the whole of health and social care during the previous twelve months, highlighting trends and lessons for care providers.

CQC have found evidence that quality is deteriorating in some areas, as the pressure placed on social care by reduced budgets and a rapidly ageing population is now impacting on secondary care too. Nationwide, there has been an average increase of 3% in unplanned acute admissions year-on-year; Accident and Emergency attendances are at the highest level ever recorded; and over a six-month period bed occupancy rates were at 91% compared to an optimal maximum of 85%. 80% of Acute Trusts are in financial deficit and 61% are rated by CQC as 'requires improvement'. By contrast, 83% of GP practices and 71% of care homes achieved a 'Good' rating.

All Acute Trusts have now had their full inspection, so CQC are now re-inspecting these organisations to check whether improvements have been made. During the year, 26 Trusts were re-inspected. Four previously inadequate Trusts came out of special measures, but six went into special measures. Overall, 47% of organisations did not change their rating following re-inspection, and one in twelve actually deteriorated. In terms of themes from the re-inspections, improvement in staffing levels and recruitment was widely evident, although some poor examples of safety culture were observed. Of the five domains covered by each inspection, Safe is the one which is the greatest challenge for hospitals. When the report was written (July 2016), 71% of Trusts were rated as 'requires improvement' for safe, 20% "good" and 9% "inadequate". None achieved an outstanding rating for this domain.

At the time of the report, five Acute Trusts were rated as outstanding overall: Newcastle-upon-Tyne; Northumbria; West Sussex; Frimley Park; and Salford Royal. The report includes case studies which show how these Trusts achieved such high ratings. Common factors include: inspirational leadership; clinical engagement in service reconfiguration; close working relationships with social care, community services and end of life care; and higher levels of consultant staff meaning that junior doctors receive more support.

Next Steps

In anticipation of a re-inspection the following actions are underway, or about to commence:

- *Care Quality Inspections* – these will increase in frequency in the new year, ensuring that every clinical area has been inspected at least once prior to the CQC's visit
- *Further Deep Dive event* – a fourth 'deep dive' meeting will be arranged, focusing on the 'Safe' domain within the inspection (date to be confirmed)
- *Self-Assessment* – the Trust-wide self-assessment against the Fundamental Standards will be reviewed monthly to reflect updated performance data, external accreditations and new service developments
- *Supplementary Action Plan* – as mentioned earlier in this report there are some issues which were not included in the inspection report but have been identified by the Trust which are now being progressed.
- *Information Governance* – MIAA will be reviewing the Trust's evidence for the Information Governance toolkit in December 2016. The Trust has planned to introduce its own walkarounds to check information governance practice in the hospital, either as part of the CQIs or as a stand-alone exercise.
- *Staff Awareness raising* – prior to the last inspection the Trust organised drop-in briefings for staff and published regular newsletters. These will resume together with the production of two new 'Little Gems' newsletters, covering Consent and Mental Capacity, and the Record of Care for end of life patients, which will be circulated shortly.

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF MEETING

26 OCTOBER 2016

BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL

Present

Michael Carr	Chairman
David Allison	Chief Executive
Cathy Bond	Non-Executive Director
Andrea Hodgson	Non-Executive Director
Graham Hollick	Non-Executive Director
Janelle Holmes	Chief Operating Officer
David Jago	Director of Finance
Mark Lipton	Interim Medical Director
Cathy Maddaford	Non-Executive Director
Jean Quinn	Non-Executive Director
John Sullivan	Non-Executive Director
Gaynor Westray	Director of Nursing and Midwifery

In attendance

Carole Self	Director of Corporate Affairs
Mike Coupe	Director of Strategy*
Robert Howell	Lead Governor
Jane Kearley	Member of the Public

Apologies

*denotes attendance for part of the meeting

Reference	Minute	Action
BM 16-17/163	**Apologies for Absence** Noted as above	
BM 16-17/164	**Declarations of Interest** None	
BM 16-17/165	**Patient Story** The Director of Nursing and midwifery provided feedback from an ex member of staff whose relative recently required our care. The service provided was reported as quick and efficient with the transfer from Xray to the ward being good. .	
BM 16-17/166	**Chairman's Business** The Chairman recorded the Board's congratulations to Dr Sue Wells upon her appointment as the new Medical Director for Wirral Clinical Commissioning Group.	
BM 16-17/167	**Chief Executive's Report** The Chief Executives focussed on the following areas from his report:	

Reference	Minute	Action
	Director of IT and Informatics – the Chief Executive confirmed that Mr Paul Charnley had been successful in being appointed to this post and that he would commence in the role from the beginning of December 2016. The Board was advised that there would be a period of handover from Mr Blakeman the current post-holder during the month of November 2016. **Cerner Phase 3 "Go Live" Update** – the Board was advised that the latest version of the software had arrived and subject to testing, the Trust would review preparedness for "Go Live" on the 7th November 2016 with a view to progressing or pausing. **NHS Improvement** – the Chief Executive confirmed that the next Progress Review Meeting was planned for 1st November 2016 and that the agenda had now been agreed. The Board was updated on the formal letter sent to NHSI which highlighted significant concerns in-year with the delivery of the system control total of £5M following the meeting with partners and NHSE on the 22nd September 2016 and also the recurrent implications of this non-delivery. **Care Quality Commission** – the preparations for the next inspections were outlined to the Board, with good progress being reported through the Divisional Reviews on the previous day. The Board was advised that the Trust would discuss dates for the next inspection with the regulator at its next meeting on 10th November 2016. **Heath Education England** – the Chief Executive highlighted receipt of the report to the Board following the visit in July 2016 and confirmed that the response was currently being prepared by the Trust. It was reported that the Quality and Safety Committee would review the full report and associated action plan at its meeting in early November 16. **A&E Delivery Board** – the Chief Executive updated the Board on the feedback received by NHSE on the establishment and operation of the Wirral Delivery Board which was positive. The feedback for the Delivery Board in West Cheshire was less assured and the Chief Executive as the now Chair of the Board confirmed that he had written to partners with his expectations. **Sustainable Development Management Plans (SDMP)**– the Board noted the recommendation from the Northern England Sustainability and Health Network and the work that was underway in the Trust to develop a SDMP building on the good work to date. **Flu Vaccination Rates** – the Board was pleased that the Trust had achieved a vaccination rate of 43% of all front line staff in a period of two weeks. The overall national target of 75% was deemed therefore to be achievable. **Global Digital Exemplar (GDE)** – the Chief Executive reported on the recent NHSE workshop for selected sites, he advised that the Trust was not only one of only 12 Trusts to be selected but now one of only 6 that were part of the fast track programme. **NHS Staff Survey** – a 32% response rate to date was reported which was above the national average. **Associate Nurse Role** – the Board was pleased to be advised that the Trust had been successful in its bid to be one of the pilot sites for the Nurse Associate Role, being one of 11 out of a total of 48 applicants.	
BM 16-	**Integrated Performance Report**	

Reference	Minute	Action
17/168	The Chief Operating Officer presented the Integrated Performance Report and highlighted the following: **A & E 4 hour standard** – the Chief Operating Officer reported performance for August at 89.08% across all sites with ED alone reporting at 86.05% for the same period. Although performance was below the national standard it was above the Sustainability and Transformation Fund STF trajectory of 87%. The Board was advised that the Trust now ranked 50 out of 130 Trusts in terms of performance and in the top 5 locally. The Board was advised of some of the downside in terms of performance reporting that had resulted from the introduction of the new models of care which were best for patients. The work being undertaken in the ambulatory care unit was impacting on the demoninator for this measure which is currently the subject of discussion with NHSI. **Referral to Treatment Times** – the Board was updated on the current position which was below the national standard and the STF trajectory at the end of September with performance reported at 88.61%. The Board sought and received an update on the causes recognising previous decisions to cease waiting list initiatives in all areas except cancer; the move away from post month end validation and the improvement plan being progressed which included the requirement for additional information management reports to enable Divisions to forecast a recovery trajectory. The rolling out of IMAS to support the demand and capacity work was outlined to the Board. The Chief Operating Officer outlined as requested the prioritisation approach taken in relation to RTT which was mandated nationally. She also outlined how the Trust had prioritised specific areas therefore citing community paediatrics and cancer as examples. The Board supported the action being taken acknowledging that whilst this would lead to a deteriorating position in the short term this would be better for patients and the Trust in the longer term. The Chief Executive advised the Board that this would be a focus for discussion with NHSI on the 1st November 2016. The Board discussed the potential regulatory and financial consequences of non-achievement. The Director of Corporate Affairs confirmed that the current non-achievement did constitute a governance concern under the new Single Oversight Framework hence the reason for discussion with the regulator. The Director of Finance confirmed that the financial risks of non-achievement had already been factored into the forecast although he had been alerted to an appeal process which was due to be circulated from NHSI, which recognised the national pressures, which the Trust should be able to enact. The Board agreed that the work on management information would support the recommendations outlined in the Well Led Governance Review which was to be reviewed in December 16. **Cancer** – the Chief Operating Officer confirmed that all Cancer targets were on track to achieve with no issues to report. **Advancing Quality** – the Board was advised that the Clinical Governance Group had undertaken a “deep dive” into this area of work, the outcome of which would be reported to Quality and Safety Committee in November 16. There were areas of improvements in some key areas which were noted by the Board. **C difficile** – the Director of Nursing and Midwifery reported 8 new cases in September, 4 of which had been classified as unavoidable. She confirmed	

Reference	Minute	Action
	that the prevalence of CPE had impacted on the number of reported cases and updated the Board on the action being taken to mitigate this in the future. The overall number of avoidable cases was confirmed as still below the trajectory and well below that reported at the same time last year. The Board sought to understand the reasons for the slight deterioration in the 95% harm free care score which had up until now been consistently achieve. The Chief Operating Officer confirmed that his was attributable to the number of patients being admitted with pressure ulcers from nursing homes which had impacted on the data.	
BM 16-17/169	**Month 6 Finance Report** The Director of Finance reported a £429K surplus in month. The year to date deficit was reported at £4.8M inclusive of £1.4M of technical adjustments made. The Financial sustainability risk rating FSRR was reported at 2 in line with plan. The Board was advised that the FSRR would now be replaced with the Use of Resources Metric going forward. The Director of Finance advised that the Trust under this new measureable would be a level 3 with 1 being good and 4 being the worse. The Board was advised of the loss of £100K STF funding due to the non-achievement of RTT and the underperformance in PbR areas which had been partially offset by over performance in non PbR as a result of increased neonatal and pathology direct access increases. The Director of Finance reminded members of the re-phasing of the income plan undertaken earlier in the year and advised of the slight loss now being experienced in September. The Board reviewed the non-core pay expenditure in month and the increase in agency costs despite waiting list initiatives being ceased. The process of review of these costs was reiterated with successful recruitment being undertaken in key areas such as A & E and Radiology. Performance against the cost improvement plan was reported at £5.1M of savings against the plan of £4.7M. The Director of Finance advised that the technical adjustments equates to £1.3M of savings. The cash position was reported as above plan although the Board was advised that the technical adjustments would impact on this going forward. The Board was advised that an application of £3.6M of additional cash had been made, the requirement for which had been previously discussed. The Board was concerned that the underlying adverse financial position was being masked by the technical adjustments and although the Board was cited on the need for cash, the actual amount had not been agreed and formally signed off by the Board. The Director of Finance advised that the process by which NHSI asked Trusts to submit their cash requests had been unexpected and agreed that this process needed to be improved in the future. Although the Board understood the need for one-off short term measures that have had to be taken this year, it was concerned that this would impact on the longer term future viability of the Trust. The	

Reference	Minute	Action
	underperformance in activity without taking out costs was of real concern. The Director of Finance outlined the financial impact of having escalation capacity open for the majority of the year in addition to the de-commissioning of services outside the hospital as a result of re-directing of funding from the Better Care Fund. The Board recommended that the Trust clarify what could have been funded in a much better way in order to inform future spending decisions and show clearly the impact on activity as it did not currently have a clear line of sight on this. The Director of Finance agreed to circulate a breakdown of the underlying financial pressures and the overall impact of commissioner funding decisions. The Chief Executive reported that he was pleased with the Trust's response to cessation of WLIs and the rigour undertaken in relation to use of agency. The Board was advised that the agency gap was in the main in relation to the shortage of junior doctors, despite the Trust being in a better position, relatively speaking, than other organisations. The Board requested that the full list of assurances outlined by NHSI be circulated to members ahead of the discussion at the November Board Meeting.	**DJ/JH** **DJ/CS**
BM 16-17/170	**Operational Plan** • **2017-18 Objectives** The Director of Strategy presented the report confirming that the strategic aims remained unchanged however some of the metrics had been refined as outlined in the report and some required more work. The Board reviewed the timetable outlined in the report which had necessitated the need for an additional private Board Meeting being held on the 23rd November to sign off the draft plan, details of which will be circulated separately. The Board also agreed to hold its private Board Meeting and development session in December on the 16th to enable formal sign off of the final plan, again details to be circulated separately. The Board debated the impact on financial planning as a result of the lack of confidence in the external agenda. The Chief Executive advised that the Trust was not relying on the benefits of joint working from the LDSP/STP work this year and need to factor in the financial pressures being experienced by the CCG which was impacting on decision making. The Board expressed the lack of confidence in delivery of activity levels going forward based on historical performance. The Chief Operating Officer empathised with this sentiment but provided assurance that the work being undertaken on demand and capacity would improve this significantly. The Board also sought to understand how contract negotiations were being prepared for this year in view of the current climate; the financial status of the CCG; the emerging role of the STP and the fact that this would cover a 2 year period. The Chief Executive agreed that the Trust needed to consider how to best position itself as it was clear the commissioner could not afford the levels of activity required to meet RTT standards going forward and therefore the focus had to be on working	

Reference	Minute	Action
	together at a health economy level. The Board approved the objectives for 2017/18. • **2016/17 Mid-Year Review** The Board noted the good progress made as outlined in the report.	
BM 16-17/171	**External Assurance** • **NHSI Quarterly Monitoring Return** The Board noted the NHSI Monitoring Return and its submission.	
BM 16-17/172	**Report of the Finance Business Performance and Assurance Committee** The Chair of the Finance Business Performance and Assurance Committee FBPAC updated the Board the following areas: **Procedures of Low Clinical Value** – a full review of the financial impact of the Commissioners decision to stop of range of these procedures although it was acknowledged that further work was required to establish the resource implications. The Board was advised of the Commissioner plans to announce the inclusion of further procedures. **Agency Cap** – the Committee reviewed the detailed report which outlined all the reasons for any breaches and the corrective action being taken to support the Chief Executive in being able to sign off these going forward. **Winter planning** – the significant financial risk was outlined for Q3 and Q4 without any support centrally for this which would impact on the forecast out-turn. The Chief Executives shared the Board's concerns in this regard and provided a view from other Trusts which was not dis-similar. The pressure to open beds in the hospital was increasing hence the need to help the local economy to meet to their responsibilities.	
BM 16-17/173	**Board of Directors** The Minutes of the Board of Directors Meetings held on 28th September 2016 were confirmed as an accurate record subject to the amendment to the first name of the new public governor in Birkenhead, Tranmere and Rock Ferry as this should read Frieda. **Board Action Log** The Board action log was updated as recorded	
BM 16-17/174	**Items for BAF/Risk Register** The Board requested that the following risks be included on the BAF: • The risk of not being able to sign the contract in December and the potential implications	**CS**

Reference	Minute	Action
	• The potential regulatory implications of non-compliance with the RTT improvement trajectory	
BM16-17/175	**Items to be considered by Assurance Committees** The Board requested the following: **FBPAC** – additional focus on agency spend **QSC** – focus on the actions being taken in response of the Health Education England Report following the visit in July 16; any quality issues associated with RTT and the review of the work of the Clinical Governance Group in respect of Advancing Quality.	**CS**
BM 16-17/176	**Any Other Business** The Chairman reminded the Board of the Annual Members Meeting planned for 23rd November 2016. The Board acknowledged the imminent department of Mr Mark Blakeman, Director of Informatics and Infrastructure and thanked him for his contribution over the last 3 years particularly in relation to the work on Cerner and the successful bid to become a Global Centre of Digital Excellence	
BM 16-17/177	**Date and Time of Next Meeting** Wednesday 30th November 2016 at 9.00 a.m. in the Boardroom, Education Centre, Arrowe Park Hospital.	

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Chairman

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Date

ACTION LOG
Board of Directors
Updated – November 2016

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 26.10.16						
1	BM16-17/169	The Director of Finance agreed to circulate a breakdown of the underlying financial pressures and the overall impact of commissioner funding decisions.	DJ/JH		November 16	
2	BM16-17/169	Circulate the full list of assurances outlined by NHSI ahead of discussion at the November Board	DJ/CS	**Completed**		
3	BM16-17/174	Include in the BAF: • The risk of not being able to sign the contract with the CCG in December and the potential implications • The potential regulatory implications of non-compliance with the RTT improvement trajectory	CS			

4	BM16-17/175	Items to be considered by Assurance Committees: • FBPAC to focus on agency spend • QSC to focus on the actions being taken in response to Health Education England Report following the visit in July 16; any quality issues associated with RTT and the review of the work of clinical governance group in respect of advancing quality.	CS			
Date of Meeting 28.09.16						
5	BM16-17/142	The Board agreed to ensure the BAF reflected the latest position with regards to the £5M system control total and the deterioration in the financial position of the CCG.	CS	**Completed**	Oct 16	
Date of Meeting 27.07.16						
6	BM16-17/100	Levels of staffing reduced in May and June – clarify how many of these were Band 5 nurses	GW		Sept 16	
7	BM16-17/100	Nurse staffing data – revisit the numbers included on table 4 in the report to ensure correct	GW		Sept 16	
8	BM16-17/102	The Board recommended that the Trust review its compliance against the boiler exhaust omissions.	MB			

9	BM16-17/	Items to be considered by assurance committees: • FBPAC – an update on how the Divisions are progressing with the demand and capacity work • Consider the learning from this and how this might inform the finance report going forward	JH/DJ	**All capacity and demand work undertaken and subject to Executive Challenge by Director of Finance and Chief Operating Officer. This will also drive budget setting at speciality level.**	Sept 16	
Date of Meeting 29.06.16						
10	BM16-17/069	Review the corporate governance statements in relation to the CQC action plan; data quality and compliance with statutory access targets	CS	**The Board have agreed to review this work at the Development event in Dec**	Dec 16	
11	BM16-17/071	Review the risk management process report for Audit Committee in view of the need for greater oversight of this going forward	EM/CB	**Scheduled for the December Audit Committee**	Sept 16	
Date of Meeting 25.05.16						
12	BM16-17/033	Include progress on the implementation of the junior doctors contract as part of the Board Development Programme	CS	**Agreed to defer this until later in the financial year in light of current position**	July 16	
13	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**		
14	BM16-17/037	Explore the impact of technology when reporting CHPPD in the future	GW			
15	BM16-17/040	Board to continue to receive CQC updates until the next inspection on a quarterly basis	EM	**Included on the agenda for September**	September 16	
Date of Meeting 30.03.16						

17	BM15-16/297	Present the Medical Engagement Strategy	EM/JM	**This work is underway and will be progressed further upon the commencement of the new Medical Director**	May16	
18	BM15-16/299	Update on the number of discharges before noon as a result of the SAFER roll out	CO		April 16	
19	BM15-16/300	Circulate to members the impact of the nursing investment from a financial perspective in order to complete the evaluation process.	GW		April 16	
Date of Meeting 27.01.16						
20	BM15-16/243	Provide a weekly progress report on A & E in light of current performance	CO	**Trust above STF trajectories for Q1 and Q2 to date. Board of Directors to continue to receive updates as part of monthly Board of Directors Performance Report.**		
21	BM15-16/244	Further work recommended on the performance report to ensure that the anticipated impact of planned action was captured, together with the risks, which would aid with future evaluation and analysis	MB	**This work will be undertaken as part of the action plan from the well led Governance review**	March 2016	
Date of Meeting 28.10.15						
22	BM 15-16/163	Surgical Activity -The Board asked for consideration to be given to reporting routinely how and where beds were being protected as well as where these had been absorbed hence impacting on performance.	MB/SG	**This work will be undertaken as part of the action plan from the well led Governance review**	November 2015	

23	BM 15-16/163	RTT - The Board requested that further consideration be given to implementing an "early warning system" thus using the technology the Trust has.	MB/SG	**This work will be undertaken as part of the action plan from the well led Governance review**	November 2015	
Date of Meeting 30.09.15						
24	BM 15-16/132	The Board requested that the actions being taken to address areas of under performance in the performance report ranked in terms of desired impact, where possible, to aid with review.	MB	**This work will be undertaken as part of the action plan from the well led Governance review**	October 2015	