Wirral University Teaching Hospital NHS
NHS Foundation Trust

# Board of Directors

# Public Board

## 27 July 2016

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**MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 27 July 2016**
**COMMENCING AT 9.00AM IN THE**
**BOARD ROOM**
**EDUCATION CENTRE, ARROWE PARK HOSPITAL**

# AGENDA

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

## 6. Performance and Improvement

| | | |
|---|---|---|
| **6.1** | **Integrated Performance Report** | |
| | **6.1.1 Integrated Dashboard and Exception Reports**<br>Chief Operating Officer | d |
| | **6.1.2 Month 3 Finance and Cost Improvement Programme Report**<br>Director of Finance | d |

## 7. Quality and Safety

| | | |
|---|---|---|
| **7.1** | **Hard Truths Commitment: Publishing of Staffing Data: 6 Monthly Update Report**<br>Director of Nursing and Midwifery | d |
| **7.2** | **Nurse Staffing Data: May/June 2016**<br>Director of Nursing and Midwifery | d |
| **7.3** | **Nursing and Midwifery Strategy – update**<br>Director of Nursing and Midwifery | d |
| **7.4** | **Health and Safety Annual Report**<br>Director of Workforce | d |
| **7.5** | **Safeguarding Annual Report**<br>Director of Nursing and Midwifery | |
| **7.6** | **Report of the Quality and Safety Committee**<br>Chair of the Committee | d |

## 8. Governance

| | | |
|---|---|---|
| **8.1** | **External Assurance:**<br>• **Board statement – Modern Slavery Act 2015**<br>Director of Corporate Affairs | d |
| **8.2** | **External Assurance**<br>• **NHSI Quarterly monitoring return**<br>Director of Finance | d |
| **8.3** | **NHSI – Single Oversight Framework Consultation**<br>Director of Corporate Affairs/Director of Finance | d |
| **8.4** | **Equality and Diversity – update**<br>Director of Nursing and Midwifery | d |
| **8.5** | **Research Annual Report**<br>Medical Director | d |
| **8.6** | **Board of Directors** | d |
| | **8.6.1 Minutes of the Previous Meeting**<br>• **29 June 2016** | |
| | **8.6.2 Board Action Log**<br>Director of Corporate Affairs | |

## 9. Standing Items

| | | |
|---|---|---|
| **9.1** | **Items for BAF/Risk Register**<br>Chairman | v |
| **9.2** | **Items to be considered by Assurance Committees**<br>Chairman | v |
| **9.3** | **Any Other Business**<br>Chairman | v |
| **9.4** | **Date and Time of Next Meeting**<br>Wednesday 28th September 2016 at 9am | v |

| Board of Directors | |
|---|---|
| **Agenda Item** | 5 |
| **Title of Report** | Chief Executive's Report |
| **Date of Meeting** | 27 July 2016 |
| **Author** | David Allison, Chief Executive |
| **Accountable Executive** | David Allison, Chief Executive |
| **BAF References**<br>• **Strategic Objective**<br>• **Key Measure**<br>• **Principal Risk** | ALL |
| **Level of Assurance**<br>• **Positive**<br>• **Gap(s)** | Positive |
| **Purpose of the Paper**<br>• **Discussion**<br>• **Approval**<br>• **To Note** | To Note |
| **Data Quality Rating** | N/A |
| **FOI status** | Document may be disclosed in full |
| **Equality Impact Assessment Undertaken**<br>• **Yes**<br>• **No** | N/A |

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

## Internal

- **Medical Director**

Following the resignation of Dr Evan Moore the Trust is currently out to advert to appoint permanently into this key position, with interviews being held in Mid-September, 2016. The Trust is currently considering interim arrangements which will be confirmed shortly.

- **Director of Education**

Following a robust recruitment process I am pleased to confirm that Professor James Barratt will be moving in to the role of Director of Education following Dr David Galvani's retirement.

## Regulatory

- **NHS Improvement**

The Trust and NHS Improvement met on the 30th June 2016 as part of the regular review process. The meeting was largely positive with key areas being discussed being financial, A & E, RTT and C difficile performance, our strategy and the role of the health economy in delivery financial sustainability.

NHSI has agreed to support the Trust in health economy discussions with NHS England with a view to progressing the work of the system resilience group and the plans to achieve the £5M system control total.

Full details of the Trust's current financial and operational performance can be found later on the agenda.

NHSI have now also issued the guidance on the tolerances and conditions for receiving the sustainability and transformation funding (STF) in the future. The Board will discuss further the impact of this on its strategy. I have attached an article from the HSJ which clearly articulates the current position.

- **Care Quality Commission**

The Trust and the Care Quality Commission met on the 11th July 2016 as part of the regular engagement process. The meeting again was largely positive with the key areas being discussed being patient flow and performance in the emergency department and particularly preparations for winter; the improvements being made to improve waiting times for community paediatrics; critical care; End of Life Care and the progress being made following the Maternity cultural review. Progress against the full action plan following the CQC inspection in September 15 was reviewed as part of this process.

The Trust will meet again in 6 weeks time and begin to discuss the timing of the next inspection.

- **Health Education England**

The Trust hosted a visit by Health Education England on the 5th July 2016 and although this went really well with good attendance across many disciplines, the Associate Dean did express disappointment at the lack of attendance from surgeons, despite pre-arranged and

agreed appointments. The feedback for other divisions was positive with good levels of engagement. The action plan following the visit is being progressed.

- **Single oversight framework Consultation**

NHS Improvement are currently out to consultation on it's new regulatory framework. The Trust will respond formally and further details can be found later on in the agenda.

## External

- **Junior Doctors Industrial Action**

It is reported that the government is expected to press on with imposition of the junior doctors contract which it had agreed with British Medical Association negotiators, after the deal was rejected by junior doctors balloted by the union. The Trust awaits further details.

- **Emergency Care Improvement Programme ECIP**

The Trust took part in several days of intensive support provided by the ECIP across the Wirral system in May 2016 with 3 areas for focus being agreed, these being:

1. Assess To Admit
2. Today's Work Today
3. Discharge To Assess

The formal letter from ECIP outlines the requirements in each area and the next steps in terms of a further visit planned for the week beginning 5th September 2016. Full details of the letter are attached.

- **System Resilience Group**

Following national concerns over the workings of these groups, the Accountable Care Officer of the CCG and myself have agreed that as from the next meeting I will take up the role of Chair of this group which is in line with NHSI expectations. A stronger presence and influence is expected from NHSI and NHSE in the future which will support the work on a health economy basis going forward.

## Strategy

- **Sustainability and Transformation Plan STP**

The submission of the STP was undertaken in line with expectations on the 30th June 2016. The Trust was fully engaged in the process ensuring that the local footprint for Wirral and Cheshire was appropriately articulated as well as understanding how the overarching STP would impact on the work of the Trust. Feedback on this first submission was provided to a small working group on the 20th July 2016, further details of which will be provided to Board Members when available.

- **Acute Care Alliance**

The Trust continues to work in collaboration with the CoCH to progress the work in clinical and non-clinical services in order to ensure sustainable and efficient services for our populations going forward. The Senior Management Team of both organisations have

begun to meet regularly to progress this agenda and the Board will receive a further update on this work as part of its private agenda.

## Celebrating Success

- **Flu Vaccination Rates**

The Director of Public Health, Fiona Johnstone, recently wrote to me to congratulate the Trust for the outstanding uptake of the seasonal influenza vaccination amongst our staff. She wrote “Achieving 79% coverage positions Wirral University Teaching Hospital amongst the highest rates of uptake in Cheshire and Merseyside. Furthermore, it is evident that there has been considerable effort to increase uptake since October 2015 at which point coverage was 34%.” At the request of the Director of Public Health the Trust has agreed to share its learning with other partner organisations.

- **Proud Team of the Quarter**

I am pleased to announce that the Proud Team of the Quarter is the Ophthalmology Theatre Team. Following the relocation of the Ophthalmology theatres to Clatterbridge the team has dealt with challenging circumstances, while still maintaining a high quality of service to patients. The project was also supported by the day case unit, anaesthetic department, M2 surgery and others.

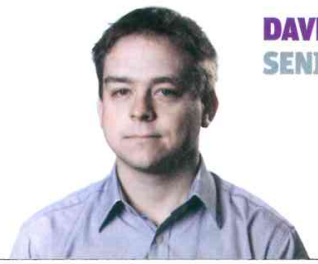
**David Allison**
Chief Executive

**July 2016**

# LEADER

@HSJEditor

hsj.co.uk/leader



**DAVE WEST**
SENIOR BUREAU CHIEF

THE 'RESET MOMENT'

# Reality bites as the NHS is told to face up to its failings

While the post-referendum political circus rolls on, the national NHS leadership is seeking to shift the focus back to reality with a jolt. A stark reminder of the service's financial challenge for the next couple of years will come this week, in a series of high profile national interventions billed as a "reset moment".

The context of this reset was partly contained within the diktat sent to finance directors last Thursday finalising terms of access to the £1.8bn sustainability and transformation fund (STF). This mechanism is intended to give the centre a tight grip on delivery through the year.

No trust will receive anything if it is not on track to meet its financial control total – ambitious targets about which many providers have serious reservations. A trust that is on track financially can still lose up to 30 per cent of its STF if it's not up to scratch against the big three waiting targets: accident and emergency, elective and cancer.

The above – in particular the money and A&E – are more or less set in stone as the NHS's top priorities this year, regardless of change in prime minister or government.

The letter also confirms HM Treasury still has its claws firmly dug into the NHS. Number 11 will be reviewing the STF on a rolling basis, it makes clear.

The reset will build on the intervention at the end of last month by NHS Improvement chief executive Jim Mackey, who in an understated letter kicked off what may become the biggest direct national intervention in the running of NHS providers since the birth of foundation trusts.

It will require a group of 20-30 trusts which had been planning wage bill growth of £400m this year to revisit them. There will also be a rapid move to huge consolidation across pathology, back office and locum-dependent elective services.

NHS chiefs will be made to understand the clear "consequences of failure" – over and above the loss of STF funding – for those trusts judged to be most seriously letting the side down on overspending or A&E performance.

**'There will be a harsh focus on around 40-50 trusts which are persistently failing in one or both of these areas'**

There will be a remorselessly harsh focus on around 40-50 trusts which are persistently failing in one or both of these areas.

But these are not the only big moves being made by the central bodies amid the post-referendum political vacuum. Friday saw NHS England launch its latest proposals for centralisation of congenital heart disease surgery, with three trusts put on notice to stop.

This may give NHS leaders reassurance such difficult and controversial decisions can and should be made, and will be backed at the top, despite the current political turmoil.

However, it is also concerning that, despite a review process that most acknowledged was significantly more robust than past attempts, the proposals met immediate and uncompromising challenge from those facing the loss of services.

Finally, recent days have seen the Care.data programme formally put out of its misery, new data sharing proposals put forward by Dame Fiona Caldicott, and three new senior appointments to bolster NHS England's efforts on technology.

By far the most notable among these was Keith McNeil as chief clinical information officer, an appointment which comes less than a year after Dr McNeil left his chief executive post at Cambridge University Hospitals, following a turbulent tech implementation and an "inadequate" rating from the Care Quality Commission.

Given the sharp rebuke which Dr McNeil delivered to the regulatory system at the time, his appointment by NHS England is a bold decision which will not please some senior figures.

It also sends a message which will need to be reiterated throughout the coming months of noisy browbeating over money and performance: genuine transformation takes time, it sometimes goes wrong, but it will also be supported. ●

**Emergency Care Improvement Programme**

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1 July 2016

Jon Develing
Chief Officer
Wirral Clinical Commissioning Group

Dear Jon

**ECIP Intensive Support Week 23 – 26 May 2016**

I am writing following several days of intensive support provided by the ECIP across the Wirral system in May 2016. As always, the level of engagement from the teams we met and worked with was high. Please pass on our thanks for their continued support for the programme. This letter confirms the feedback given to leaders from across the system at the end of the week.

The commitment of the clinical and leadership teams to provide safer, faster, better care for patients is clear to see. However, it is important to note that while good progress has been made against many of the concordat agreements, performance against the four hour standard has not consistently improved. We do recognise a significant improvement in performance over the last two weeks. It is in this context that the team wanted to provide feedback to help the system to prioritise its work in the coming months.

The system currently has an urgent care improvement plan that contains around one hundred actions. While there is some value to each of these actions, we recommend focussing on several key areas that will have a high impact. They can be summarised as below:

1. Assess To Admit
2. Today's Work Today
3. Discharge To Assess

These priorities follow the patient journey through the urgent care system. Beneath each of these, there are several high impact changes.

**Assess To Admit**

Clinicians from the system, with support from the ECIP team, audited a number of patient records, following recent admission. They agreed that around 30% of those admissions could have been managed without hospital attendance. The report of this audit has been shared with those involved. We recommend that the key themes are reviewed to see

whether changes could be made to reduce admissions. This audit could be repeated with the same purpose on a regular basis.

We believe that further work is required to ensure that the Single Point of Access (SPA) is effective. There are three priorities for the next stage of development of the SPA:

1. The SPA needs to have one number that says “yes” and works to use alternative pathways where clinically safe to do so.
2. The SPA needs to ensure that clinician to clinician conversations take place when urgent care referral or admissions are being considered. Particular focus should be given to the working relationship between primary care, the SPA and the new Acute Medical Unit.
3. Clinicians and leaders from across the system should review the outputs of the admissions audit and develop new pathways to reduce the number of unnecessary admissions to acute care. This audit should be repeated on a regular basis.

We have put the appropriate system leaders (in this case Val McGee) in contact with other systems where there is established good practice in this area.

The Acute Medical Unit at Arrowe Park has been redeveloped to allow greater use of ambulatory care. The Trust has been working with the Ambulatory Emergency Care Network to support this development. The systems and processes in the new unit need to support early senior assessment and ongoing review. This will support increased use of short stay and reduce deconditioning for older patients. Progress on this will be reviewed through the system’s work with the Ambulatory Emergency Care Network.

**Today’s Work Today**

Progress continues to be made on the implementation of the SAFER Bundle. We have challenged the Trust to ensure that this is fully embedded across all urgent care wards (including trauma) by September 2016, in preparation for winter. This will be supported by the introduction of the red and green days concept, which supports the principle of today’s work today. Red and green days are now being used successfully on four medical wards, demonstrating promising early results in both reducing length of stay and increasing discharges before midday. This work should also focus on the use of SAFER and red and green days in other inpatient areas, including intermediate care.

We have also worked recently with the Trust on operational site management. The Trust has reviewed its Standard Operating Procedure for site management and now works on the principles of the RESPONSE Model, which provides an agenda and framework for site management. Further work is required on escalation, and the Trust and system wide response to times of heightened pressure. ECIP support is available for this.

**Discharge To Assess**

There is little evidence of real progress on Discharge To Assess since our whole system visit in December 2015. The stranded patient metric remains high. This must now become the highest of priorities for the urgent care system, and we ask that a senior officer is named as the accountable sponsor of this work stream. Support remains available from ECIP; many systems are now making significant improvements to this part of the pathway. We would like to share this good practice with your teams and provide the practical support that will enable you to make decisions on care needs outside hospital and reduce length of stay. Particular focus should be given to:

1. End of life care
2. Early notification of assessment needs
3. Embedding a home first principle, ensuring that decisions about long term care needs are not made in an acute setting.

I hope that this feedback is helpful. We believe that focussing on the high impact changes outlined in this letter (which reflect the concordat agreement), along with accountable leadership for each work stream, will enable the urgent care system in Wirral to enter the winter period in a much stronger position. With this in mind, we have offered to repeat this visit during the week commencing 5 September 2016.

Steve Christian and I would welcome the opportunity to meet with you to discuss progress to date and confirm your support needs for the next stage of this journey.

Yours sincerely

Tim Gillatt

Intensive Support Manager

| Board of Directors | |
|---|---|
| **Agenda Item** | **6.1.1** |
| **Title of Report** | **Integrated Performance Dashboard** |
| **Date of Meeting** | **27th July 2016** |
| **Author** | **John Halliday, Assistant Director of Information**<br>**Chris Oliver, Director of Operations** |
| **Accountable Executive** | **Janelle Holmes**<br><br>**Chief Operating Officer** |
| **FOI status** | **Document may be disclosed in full** |
| **BAF References**<br><br>• **Strategic Objective**<br>• **Key Measure**<br>• **Principal Risk** | **All Strategic Objectives (1 through 7)**<br><br>**All Key Measures (1A through 7D)**<br><br>**All Principal Risks** |
| **Level of Assurance**<br><br>• **Positive**<br>• **Gap(s)** | **Partial with gaps** |
| **Purpose of the Paper**<br><br>• **Discussion**<br>• **Approval**<br>• **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**<br><br>• **Yes**<br>• **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 June 2016.

## 2. Summary of Performance Issues

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

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

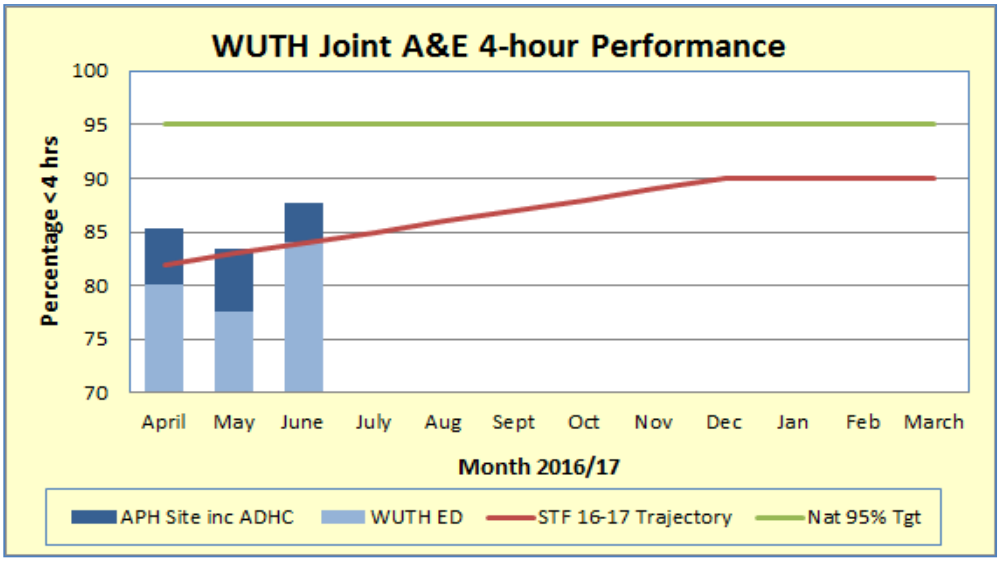
The key issues relating to external validation is achievement of the A&E and RTT targets, with detailed comments against each area below.

## 3. Detailed Explanation of Performance and Actions

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

Against the A&E standard of a minimum 95% of patients to be admitted, transferred or discharged within four hours, the month of June was 87.62% as measured across a combined ED and All Day Health Centre performance at the Arrowe Park site. ED alone was 84.06%.

The performance in June for the emergency access standard although not achieving the regulatory compliance level of 95% was above the Sustainability and Transformation Fun (STF) trajectory of 84%, and is illustrated below.



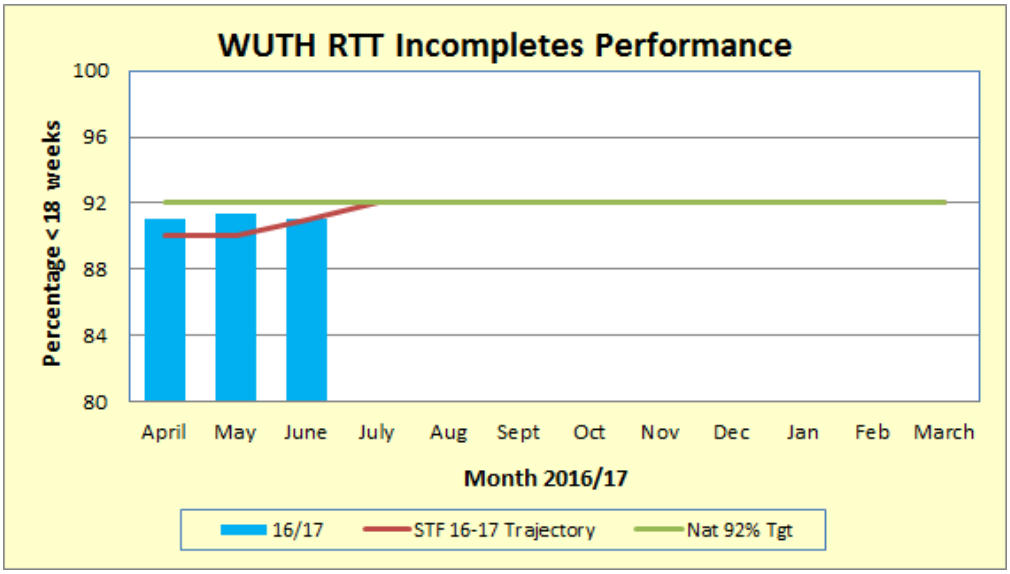
The Task and Finish groups continue to meet and challenge on delivery and sustainability of improvements being made both within the Trust and with economy leads.

The new Acute Ambulatory Care Unit opened on 27th June, which has provided additional ambulatory capacity to assist with the 'pulling' of patients from the Emergency department and avoiding the need for GP admissions to be redirected to the Emergency department.

### b. 18 Weeks RTT

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

As expected the Trust did not achieve the standard at the end of June, with the final position being reported at 91.00%. This delivered compliance against the STF trajectory of 91%, as illustrated below.




The national specialties that are not achieving and contribute to the Trust's overall failure are General Surgery (with the failing areas in colorectal, upper gastrointestinal surgery, and vascular), Oral Surgery, Trauma & Orthopaedics and "Other" which includes numerous specialties but notably Community Paediatrics.

Good progress has been made by Divisional teams in cleansing the outpatient patient tracking lists enabling the Access and Performance meeting to focus on actual patient management ensuring corrective action is taken in advance of

any non-compliance. Capacity and demand models continue to be produced at speciality level utilising the Intensive Management Support tools. It is intended this will be linked to job planning & contract agreements for 17/18 commencing in Q3 16/17.

A comprehensive piece of work has been agreed internally to commence in August 2016 to strengthen the management of RTT. This will include pathway mapping, tracking, reporting, data quality & ongoing staff training.

### c. Infection Control

For C Difficile, there have been three cases considered avoidable to the end June. This is below the maximum plan trajectory of five 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 indicators

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

From April the areas of AMI and Hip & Knee have been 'retired' from the national AQ programme.

## 4. Recommendation

The Board of Directors are asked to:

Note the Trust's current performance to the end of June 2016

**WUTH Integrated Performance Dashboard - Report on June for July 2016 BoD**

| Area | Indicator / BAF | April | May | June | Trend / Future Concern | *Target (for 'Green')* | Latest Period | Exec Lead |
|---|---|---|---|---|---|---|---|---|
| Meeting Our Vision | **Satisfaction Rates** | | | | | | | |
| | Patient - F&F "Recommend" Rate | 98% | 98% | 99% | | >=95% | June 2016 | GW |
| | Patient - F&F "Not Recommend" Rate | 1% | 1% | 1% | | <=2% | June 2016 | GW |
| | Staff Satisfaction (engagement) | 3.82 | 3.82 | 3.82 | | >=3.69 | Q1 2016/17 | JM |
| | **First Choice Locally & Regionally** | | | | | | | |
| | Market Share Wirral | 82.3% | 82.4% | 81.7% | | >= 85% | Jan to March 2015 | MC |
| | Demand Referral Rates | -0.3% | 0.5% | -2.9% | | >= 3% YoY variance | Fin Yr-on-Yr to June 2016 | MC |
| | Market Share Non-Wirral | 9.4% | 9.1% | 9.2% | | >=8% | Fin Yr-on-Yr to June 2016 | MC |
| | **Strategic Objectives** | | | | | | | |
| | Harm Free Care | 95% | 96% | 96% | | >= 95% | June 2016 | GW |
| | HIMMs Level | 5 | 5 | 5 | | 5 | June 2016 | MB |
| Operational Excellence | **Key Performance Indicators** | | | | | | | |
| | A&E 4 Hour Standard * | 85.38% | 83.44% | 87.62% | | >=95% | June 2016 | CO |
| | RTT 18 Weeks Incomplete Position * | 91.08% | 91.39% | 91.00% | | >=92% | June 2016 | CO |
| | Cancer Waiting Time Standards * | On track | On track | On track | | All met at Trust level | Q1 to June 2016 | CO |
| | Infection Control * | 0 MRSA; 0 C diff | 0 MRSA; 2 C diff | 0 MRSA; 3 C diff | | 0 MRSA Bacteraemia in month, and cdiff less than cumulative trajectory | June 2016 | GW |
| | **Productivity** | | | | | | | |
| | Delayed Transfers of Care | 2 | 10 | Under review | | <= 4 | June 2016 | CO |
| | Delayed Complex Care Packages | 58 | 53 | 51 | | <= 45 | June 2016 | CO |
| | Bed Occupancy | 91.8% | 91.2% | 93.1% | | <=85% | June 2016 | CO |
| | Bed Occupancy Medicine | 89.5% | 93.7% | 93.7% | | <=85% | June 2016 | CO |
| | Theatre Utilisation | Under review | Under review | Under review | | >=85% | June 2016 | CO |
| | Outpatient DNA Rate | 8.3% | 8.0% | 8.1% | | <=6.5% | June 2016 | CO |
| | Outpatient Utilisation | 81.3% | 81.4% | 77.35% | | >90% | June 2016 | CO |
| | Length of Stay - Non Elective Medicine | 5.5 | 5.4 | 4.7 | | <= 5.0 | June 2016 | CO |
| | Length of Stay - Non-elective Trust | 4.9 | 5.0 | 4.5 | | <=4.2 | June 2016 | CO |
| | Contract Performance (activity) | -5.3% | -0.9% | -1.6% | | 0% or greater | June 2016 | CO |
| | **Finance** | | | | | | | |
| | Contract Performance (finance) | 0.0% | 0.2% | 0.9% | | On Plan or Above YTD | June 2016 | DJ |
| | Expenditure Performance | -0.7% | -1.0% | -0.9% | | On Plan or Above YTD | June 2016 | DJ |
| | CIP Performance | -23.2% | -15.2% | -18.6% | | On Plan or Above | June 2016 | DJ |
| | Capital Programme | 61.5% | 76.8% | 66.8% | | On Plan | June 2016 | DJ |
| | Non-Core Spend | 10.4% | 10.4% | 10.3% | | <5% | June 2016 | DJ |
| | Cash Position | 209% | 748% | 51% | | On plan or above YTD | June 2016 | DJ |
| | Cash - liquidity days | -28.4 | -25.5 | -25.4 | | > 0 days | June 2016 | DJ |
| A Healthy Organisation | **Clinical Outcomes** | | | | | | | |
| | Never Events | 1 | 0 | 0 | | 0 per month | June 2016 | EM |
| | Complaints | 35.8 | 35.4 | 35.6 | | <30 per month | 12-mth ave to June 2016 | GW |
| | **Workforce** | | | | | | | |
| | Attendance | 95.8% | 95.8% | 95.8% | | >= 96% | June 2016 | JM |
| | Qualified Nurse Vacancies | 3.5% | 4.1% | 3.7% | | <=6.5% | June 2016 | GW |
| | Mandatory Training | 89.7% | 88.8% | 88.5% | | >= 95% | June 2016 | JM |
| | Appraisal | 87.81% | 87.77% | 87.39% | | >= 85% | June 2016 | JM |
| | Turnover | 9.2% | 9.4% | 9.7% | | <10% | June 2016 | JM |
| | Agency Spend | -9.2% | -5.2% | -3.9% | | On plan | June 2016 | GW |
| | Agency Cap | 185 | 153 | 142 | | 0 | June 2016 | JM |
| External Validation | **National Comparators** | | | | | | | |
| | Advancing Quality (not achieving) | 4 | 5 | 3 | | All areas above target | June 2016 | EM |
| | Mortality: HSMR | 89.35 | 88.05 | 88.38 | | Lower CI < 0.90 | April 2015 to Mar 2016 | EM |
| | Mortality: SHMI | 0.988 | 0.988 | 0.983 | | Lower CI < 90 | Jan to Dec 2015 | EM |
| | **Regulatory Bodies** | | | | | | | |
| | Monitor Risk Rating - Finance CoS | 2 | 2 | 2 | | 4 | June 2016 | DJ |
| | Monitor Risk Rating - Governance | Red | Red | Red | | Green | June 2016 | CO |
| | CQC | Amber | Amber | Amber | | Overall CQC rating Requires Improvement | June 2016 | EM |
| | **Local View** | | | | | | | |
| | Commissioning - Contract KPIs | 4 | 3 | 4 | | <=2 | June 2016 | CO |

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

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

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

**Quarter 1 - Total**

| Division | Tumour Group | Breaches | | | Treatments | | | Compliance | |
|---|---|---|---|---|---|---|---|---|---|
| | | Actual | Predicted | Total | Actual | Predicted | Total | Actual | Predicted |
| Medicine | Haematology | 0 | 0 | 0 | 11 | 0 | 11 | 100.00% | 100.00% |
| | Lung | 0 | 0 | 0 | 10 | 0 | 10 | 100.00% | 100.00% |
| | Other | 1 | 0 | 1 | 2.5 | 0 | 2.5 | 60.00% | 60.00% |
| Med & Surg | Upper GI | 5 | 0 | 5 | 11.5 | 0 | 11.5 | 56.52% | 56.52% |
| Surgery | Breast | 1 | 0 | 1 | 45 | 0 | 45 | 97.78% | 97.78% |
| | Colorectal | 4 | 0 | 4 | 23 | 0 | 23 | 82.61% | 82.61% |
| | Head & Neck | 4 | 0 | 4 | 6.5 | 0 | 6.5 | 38.46% | 38.46% |
| | Skin | 1 | 0 | 1 | 69 | 0 | 69 | 98.55% | 98.55% |
| | Urology | 7 | 0 | 7 | 44.5 | 0 | 44.5 | 84.27% | 84.27% |
| Women's | Gynaecology | 3 | 0 | 3 | 11 | 0 | 11 | 72.73% | 72.73% |
| | **Total** | **26** | **0** | **26** | **234** | **0** | **234** | 88.89% | 88.89% |

**Quarter 1 - April**

| Division | Tumour Group | Breaches | | | Treatments | | | Compliance | |
|---|---|---|---|---|---|---|---|---|---|
| | | Actual | Predicted | Total | Actual | Predicted | Total | Actual | Predicted |
| Medicine | Haematology | 0 | 0 | 0 | 2 | 0 | 2 | 100.00% | 100.00% |
| | Lung | 0 | 0 | 0 | 4.5 | 0 | 4.5 | 100.00% | 100.00% |
| | Other | 1 | 0 | 1 | 2 | 0 | 2 | 50.00% | 50.00% |
| Med & Surg | Upper GI | 5 | 0 | 5 | 7 | 0 | 7 | 28.57% | 28.57% |
| Surgery | Breast | 0 | 0 | 0 | 15 | 0 | 15 | 100.00% | 100.00% |
| | Colorectal | 1 | 0 | 1 | 9 | 0 | 9 | 88.89% | 88.89% |
| | Head & Neck | 1 | 0 | 1 | 2.5 | 0 | 2.5 | 60.00% | 60.00% |
| | Skin | 0 | 0 | 0 | 31 | 0 | 31 | 100.00% | 100.00% |
| | Urology | 4 | 0 | 4 | 17 | 0 | 17 | 76.47% | 76.47% |
| Women's | Gynaecology | 1 | 0 | 1 | 4 | 0 | 4 | 75.00% | 75.00% |
| | **Total** | **13** | **0** | **13** | **94** | **0** | **94** | 86.17% | 86.17% |

**Quarter 1 - May**

| Division | Tumour Group | Breaches | | | Treatments | | | Compliance | |
|---|---|---|---|---|---|---|---|---|---|
| | | Actual | Predicted | Total | Actual | Predicted | Total | Actual | Predicted |
| Medicine | Haematology | 0 | 0 | 0 | 4 | 0 | 4 | 100.00% | 100.00% |
| | Lung | 0 | 0 | 0 | 3.5 | 0 | 3.5 | 100.00% | 100.00% |
| | Other | 0 | 0 | 0 | 0 | 0 | 0 | N/A | N/A |
| Med & Surg | Upper GI | 0 | 0 | 0 | 2.5 | 0 | 2.5 | 100.00% | 100.00% |
| Surgery | Breast | 0 | 0 | 0 | 16 | 0 | 16 | 100.00% | 100.00% |
| | Colorectal | 2 | 0 | 2 | 8 | 0 | 8 | 75.00% | 75.00% |
| | Head & Neck | 3 | 0 | 3 | 3 | 0 | 3 | 0.00% | 0.00% |
| | Skin | 0 | 0 | 0 | 14 | 0 | 14 | 100.00% | 100.00% |
| | Urology | 2 | 0 | 2 | 15 | 0 | 15 | 86.67% | 86.67% |
| Women's | Gynaecology | 1 | 0 | 1 | 5 | 0 | 5 | 80.00% | 80.00% |
| | **Total** | **8** | **0** | **8** | **71** | **0** | **71** | 88.73% | 88.73% |

**Quarter 1 - June**

| Division | Tumour Group | Breaches | | | Treatments | | | Compliance | |
|---|---|---|---|---|---|---|---|---|---|
| | | Actual | Predicted | Total | Actual | Predicted | Total | Actual | Predicted |
| Medicine | Haematology | 0 | 0 | 0 | 5 | 0 | 5 | 100.00% | 100.00% |
| | Lung | 0 | 0 | 0 | 2 | 0 | 2 | 100.00% | 100.00% |
| | Other | 0 | 0 | 0 | 0.5 | 0 | 0.5 | 100.00% | 100.00% |
| Med & Surg | Upper GI | 0 | 0 | 0 | 2 | 0 | 2 | 100.00% | 100.00% |
| Surgery | Breast | 1 | 0 | 1 | 14 | 0 | 14 | 92.86% | 92.86% |
| | Colorectal | 1 | 0 | 1 | 6 | 0 | 6 | 83.33% | 83.33% |
| | Head & Neck | 0 | 0 | 0 | 1 | 0 | 1 | 100.00% | 100.00% |
| | Skin | 1 | 0 | 1 | 24 | 0 | 24 | 95.83% | 95.83% |
| | Urology | 1 | 0 | 1 | 12.5 | 0 | 12.5 | 92.00% | 92.00% |
| Women's | Gynaecology | 1 | 0 | 1 | 2 | 0 | 2 | 50.00% | 50.00% |
| | **Total** | **5** | **0** | **5** | **69** | **0** | **69** | 92.75% | 92.75% |

| Board of Directors | |
|---|---|
| **Agenda Item** | 6.1.2 |
| **Title of Report** | Month 3 Finance and Cost Improvement Programme Report |
| **Date of Meeting** | 27th July 2016 |
| **Author** | Gareth Lawrence<br>Deputy Director of Finance |
| **Accountable Executive** | David Jago, Director of Finance |
| **BAF References**<br>• **Strategic Objective**<br>• **Key Measure**<br>• **Principal Risk** | 7 |
| **Level of Assurance**<br>• **Positive**<br>• **Gap(s)** | Positive |
| **Purpose of the Paper**<br>• **Discussion**<br>• **Approval**<br>• **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**<br>• **Yes**<br>• **No** | No |

***Overview***

This paper provides an update to the Board of Directors on the financial performance of the Trust at Month 3 (30th June 2016) of the 2016/17 financial year.

During the month of June the Trust has delivered a £(165)k deficit compared to the plan of £(526)k. The improved performance against plan is a direct result of re-profiling the clinical income received by Wirral CCG under the agreed envelope.

The Trust has delivered £1,796k of efficiencies as at the end of June against the target of £2,143k. This delivery includes non-recurrent savings allocated by divisions of £380k.

Cash balances at the end of June stood at £1,653k which is c£1,798k below plan reflecting the non-payment of the Sustainability and Transformation Fund (STF) (£2,475k) that was due to be received in the initial plan. The delay in payment is due to issues at NHS Improvement (NHSI) / NHS England (NHSE) on agreeing performance tolerance levels which have since been agreed. To mitigate the cash balance risk the third drawdown tranche(£2.0m) of the working capital facility as agreed with NHSI is being drawn down in advance.

The overall Month 3 financial position delivers a financial sustainability risk rating (FSRR) of 2 which is in line with plan albeit with variance to individual metrics. Delivering the income and expenditure plan will be key in maintaining an FSRR of 2, with all the other metrics currently at 1.

As a result of delivering the financial plan for Q1 and achieving all the operational trajectories the Trust anticipates being able to access 100% of the STF for Q1 which equates to £2,475k.

***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 current performance against the submitted plan.

***Table 1:Summary Financial Statement***

| SUMMARY FINANCIAL STATEMENT | | | | | | | |
|---|---|---|---|---|---|---|---|
| | PLAN | MONTH 3 | | | YTD | | |
| | Full Year Plan £'000s | Plan £'000s | Actual £'000s | Variance £'000s | Plan £'000s | Actual £'000s | Variance £'000s |
| NHS Clinical Income | 294,936 | 24,662 | 25,210 | 548 | 73,041 | 73,664 | 623 |
| Other Income | 29,987 | 2,469 | 2,506 | 37 | 7,336 | 7,467 | 131 |
| Employee Expenses | (213,301) | (18,466) | (19,055) | (589) | (54,804) | (56,311) | (1,507) |
| All Other Operational Expenses | (97,768) | (8,090) | (7,687) | 403 | (24,437) | (23,666) | 770 |
| **EBITDA** | **13,854** | **575** | **973** | **398** | **1,136** | **1,154** | **17** |
| Post EBITDA Items | (13,673) | (1,101) | (1,137) | (37) | (3,302) | (3,319) | (17) |
| **Net Surplus/(Deficit)** | **181** | **(526)** | **(165)** | **361** | **(2,165)** | **(2,165)** | **(0)** |
| | | | | | | | |
| **EBITDA %** | **4.3%** | **2.1%** | **3.5%** | **1.4%** | **1.4%** | **1.4%** | **0.0%** |

An agreement has been reached with Wirral CCG for an envelope contract value for 2016/17 which covers c80% of the Trusts clinical income. The envelope will allow the Trust and wider health economy to look at innovative ways of dealing with increased demand over the coming year while having the security of an agreed income value. In the absence of the 'envelope' agreement the income position would have been £983k below plan. This can be broken down in to two elements: non achievement of activity plan £416k and the re-profile of clinical income into 12ths £567k.
During the period overall PbR activity under performed from an activity perspective, as casemix was richer in certain areas, this supported the position despite the increase in penalties of (c£0.3m). Non PbR income achieved plan.
Cumulatively all PODs are underperforming in terms of actual activity delivered against the initial plan, with the exception of NEL and EL excess bed days, and outpatient procedures. This predominantly reflects the impact of the junior doctor industrial action during April. However the position also reflects a richer case mix which has impacted the financial position in non-elective activity. The year to date over recovery in Non PbR areas, mainly reflects over performances in rehab., neonatal and direct access pathology activity.

The financial effect of penalties in relation to the 4 hr A&E breaches, RTT - 18 week access targets, (62 days) urgent GP referrals for cancer, and six weeks referrals for diagnostic tests are included with the recovery trajectories to access the Sustainability Transformation Fund (STF), cumulatively the Trust has achieved against all proposed targets during quarter 1.
The financial "envelope" agreed with the CCG is inclusive of all CQUINs payments, however proposed schemes will be shadow monitored on a quarterly basis.

Performance against other contracts overall is breakeven, with slight over performances in the Specialised Services contract, and West Cheshire.

Operational expenditure is currently above plan for the month of June by £ (187) k and £(737)k cumulatively.

Pay costs are £ (589) k above plan in month and are cumulatively £(1,507)k above plan. The main drivers of the additional pay expenditure are the continued utilisation of escalation areas which has resulted in increased nursing, medical costs and support costs c£(400)k ytd. Escalation areas continued to be utilised and due to the fluidity of their needs have been staffed by bank and agency which increases the financial pressure. Further pressures in medical staffing with gaps in senior and junior has resulted in costs above plan particularly in the Emergency Department c£ (300)k. Increase use of waiting list payments throughout Surgery have resulted in a c£(200)k pressure. Specialities have been tasked to continually review their capacity in line with the task and finish groups that have been implemented to support RTT (referral to treatment) performance.

Non pay costs are £403k under plan in Month 3 and are £770k cumulatively under plan materially as a result of non recurrent underspends on clinical supplies and other non-operating costs.

As part of the STF the Trust agreed to an overall cap on agency of £8,112k for the financial year. At the end of June the Trust has spent £2,235k on agency which is marginally above the plan £(83)k. Speciality reviews are currently being undertaken led by the Chief Operating Officer and Director of HR to assist in reducing the current levels of spend within the Trust. The Trust continues to work with all agencies and Trusts within the STP footprint on reducing the unit price of agency in line with NHSI targets. Compliance against this

measure continues to be reported through the Senior Management Team with exceptions signed off by the Executive Team.

***Cost Improvement Programme (CIP)***

The CIP target for 2016/17 is £11,200k. The target is split both divisionally and by respective work streams. As at the end of the Month 3 the Trust is £ (347)k behind the target of £2,143k. The position has been supported by non-recurrent savings identified within the divisions as they continue to develop and deliver the various work streams. The non-recurrent savings supporting the ytd position equate to £380k.

Table 2 below details the month 3 position for CIP by Division and by work-stream.

| | YTD | | | In Year | | |
|---|---|---|---|---|---|---|
| | Monitor Plan | Actual | Variance | Monitor Plan | Forecast | Variance |
| Theme | £000's | £000's | £000's | £000's | £000's | £000's |
| Productivity & Efficiency | 654 | 361 | (293) | 3,573 | 2,745 | (828) |
| Workforce | 544 | 343 | (201) | 2,518 | 1,633 | (885) |
| Cost Control & Management | 359 | 341 | (18) | 2,449 | 1,699 | (750) |
| Estate Management | 203 | 117 | (85) | 999 | 888 | (111) |
| Income | 276 | 262 | (14) | 1,300 | 1,292 | (8) |
| Other Schemes | 107 | 371 | 264 | 361 | 860 | 499 |
| | 2,143 | 1,796 | (347) | 11,200 | 9,116 | (2,084) |
| | | | | | | |
| Division | £000's | £000's | £000's | £000's | £000's | £000's |
| Medicine & Acute | 668 | 309 | (359) | 3,060 | 1,405 | (1,655) |
| Surgery, Women & Children | 711 | 460 | (251) | 3,630 | 2,691 | (939) |
| Clinical Support Services | 341 | 253 | (88) | 1,700 | 1,091 | (609) |
| Corporate | 380 | 522 | 142 | 1,810 | 2,342 | 532 |
| Central | 43 | 252 | 209 | 1,000 | 1,587 | 587 |
| | 2,143 | 1,796 | (347) | 11,200 | 9,116 | (2,084) |

The Trust is currently forecasting delivery of £9,116k of CIP compared to the £11,200k target. Work continues within the respective work streams to bridge the gap and to ensure delivery the identified schemes.

Of the schemes that have been identified (£9,116k) 27% are being delivered through income compared to the initial plan of 24%, the marginal increase is a result of non-clinical income schemes that have been identified within Divisions.
Cost reduction efficiencies account for 54% of the overall CIP target with 19% still to be identified. As clinical income opportunities are limited the Trust will continue to look at cost reduction opportunities in order to release these further savings.

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

Of the £9,116k schemes that have been identified c£8,049k have been fully developed as at month 3 and approved by the Transformation Steering Group. Appendix 1 displays the current levels of schemes within the current programme and their expected delivery. The challenge remains to convert more ideas, plans and opportunities into expenditure releasing schemes as we progress throughout the year.

The Board of Directors is reminded that the above figures are exclusive of the health economy challenge of £5,000k that has been included within the submitted plans approved

by the Board of Directors. This was discussed with NHSI as part of the recent PRM with the Trust.

***Cash position and Financial Sustainability Risk Rating (FSRR)***

The June cash position was £1,653k, which is £1,798k below plan. The main driver for the reduced cash balance was the non-payment of the STF allocation for Q1. The payment has been delayed by NHSI until at least August due to further guidance on rules regarding accessing the fund only being released in July. The reduction has been mitigated during July as a result of agreeing payment holidays with other NHS organisations (c£1,000k) and an advance draw down of £2,000k on the working capital facility.
Total working capital balances in month 3, excluding cash, show a total variance to plan of £3.136k. This is chiefly attributable to the non-receipt of STF allocation for Q1.

Capital expenditure is £1,195k under plan as at the end of June 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.

| Schemes | NHSI plan 2016-17 £'000 | Budget 2016-17 £'000 | Budget YTD £'000 | Actual YTD £'000 | Variance to budget YTD £'000 |
|---|---|---|---|---|---|
| Medical equipment - *Medicine and Acute Care* | 450 | 450 | 450 | 0 | 450 |
| Medical equipment - *Surgery, Women's and Children's* | 477 | 477 | 279 | 0 | 279 |
| Medical equipment - *Clinical Support and Diagnostics* | 613 | 613 | 0 | 0 | 0 |
| General IT | 500 | 500 | 100 | 36 | 64 |
| Cerner | 1,002 | 1,002 | 188 | 17 | 171 |
| Ward refurbishments - Ward 15 (AMU) | 400 | 400 | 0 | 198 | (198) |
| Ward refurbishments - *to be confirmed* | 400 | 400 | 0 | 0 | 0 |
| Relocation of Wirral Neuro - M2 | 801 | 801 | 401 | 24 | 377 |
| Backlog maintenance - APH and CGH | 1,300 | 1,300 | 150 | 127 | 23 |
| All other expenditures | 0 | 0 | 0 | 130 | (130) |
| | **5,943** | **5,943** | **1,568** | **532** | **1,036** |
| Unallocated resource - *contingency* | 866 | 866 | 216 | 57 | 159 |
| Donated assets | 0 | 6 | 6 | 6 | 0 |
| **Total capex (accruals basis)** | **6,809** | **6,815** | **1,790** | **595** | **1,195** |

The overall position returns a FSRR of 2, which is in line with plan. Without the current advantages that the Trust is obtaining via the envelope the FSRR would have been a 1 which is the highest level of risk associated to Foundation Trusts.

| | 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 | 25% | -26.6 | 1 | -25.4 | 1 |
| | **Capital Service Cover (times)** | Shows revenue available for capital service | 25% | 1.0 | 1 | 1.0 | 1 |
| Financial Efficiency | **I&E Margin (%)** | Shows underlying performance | 25% | -2.7% | 1 | -2.7% | 1 |
| | **I&E Margin Variance from Plan (%)** | Shows quality of planning and financial control | 25% | -0.5% | 3 | 0.0% | 4 |
| | **Overall Monitor FSRR** | | | | **2** | | **2** |

Whilst cash is below plan by £1,798k, FSRR liquidity is above plan by 1.2 days. This is primarily due to Trade and other receivables balances exceeding plan, and this is attributable to delays in the receipt of STF income, as mentioned above.

**Conclusion**

The Trust has delivered an in month deficit of £ (165) k which is £361k favourable to plan. This performance has only been delivered by re-profiling the clinical income we receive from Wirral CCG (WCCG) into 12$^{ths}$ which has benefitted the financial position by £567k. Without this adjustment the Trust would have failed to deliver the financial plan for Q1 and therefore would not have received under the recent correspondence to questions of 100% of the STF allocation for Q1 (c£2,475k).

The cash position is below plan for the month of June as a result of NHSI only issuing guidance on payment of the STF during July, actions have been undertaken to mitigate the loss of the central income during July. While the current financial plan delivers a FSRR of 2 which is line with plan this has only been achieved as a result of the financial envelope agreed with WCCG.

**Recommendations**

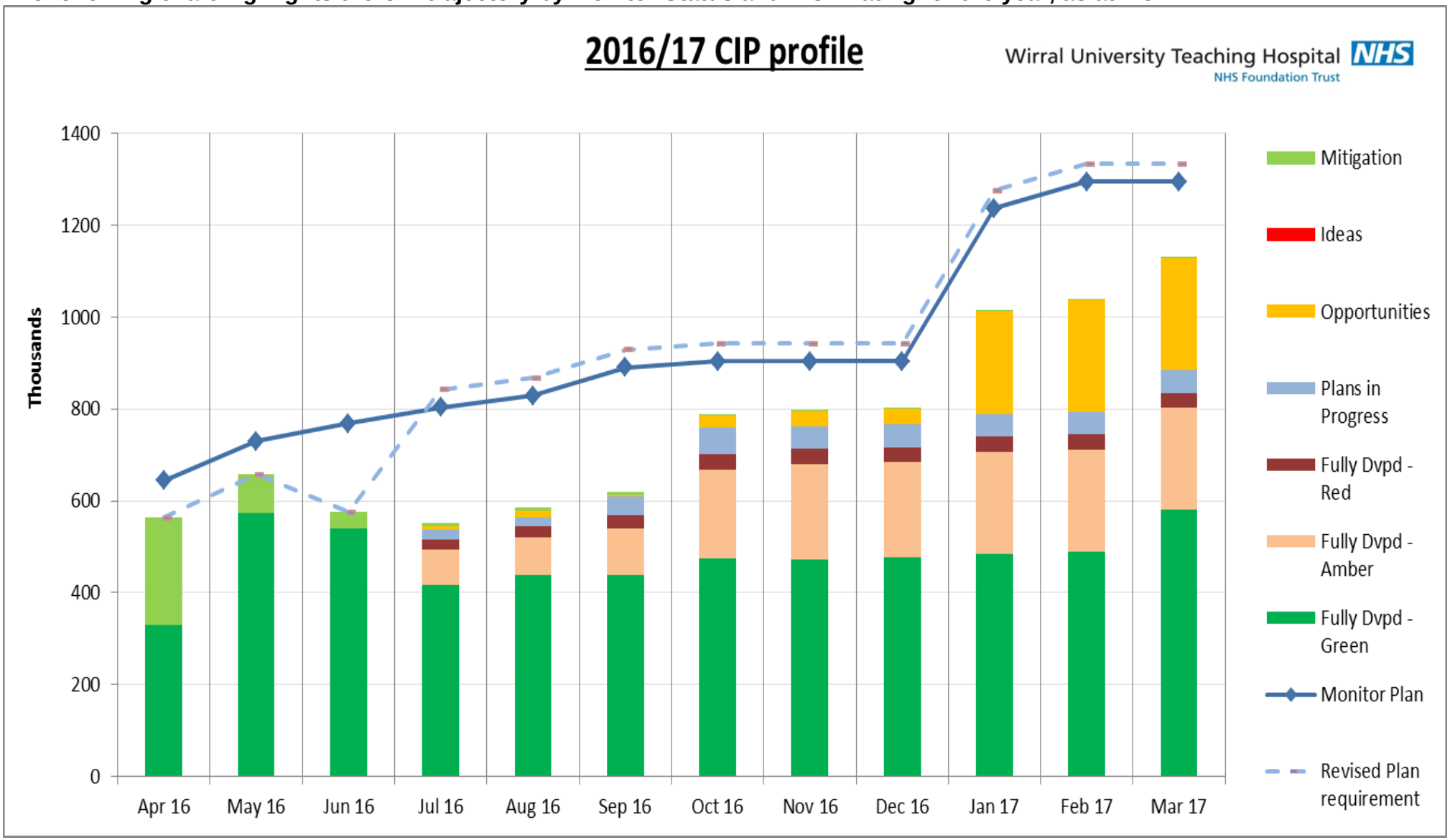
The Board of Directors are asked to note the contents of this report.

**David Jago**

Director of Finance
July 2016

**Appendix 1: CIP Monthly Profile**

**The following chart highlights the CIP trajectory by Monitor Status and Risk Rating for the year, as at M3.**



| BOARD OF DIRECTORS | |
|---|---|
| **Agenda Item** | 7.1 |
| **Title of Report** | Hard Truths Commitment: Publishing of Staffing Data: 6 Monthly Update Report |
| **Date of Meeting** | 27 July 2016 |
| **Author** | Clare Pratt, Deputy Director of Nursing |
| **Accountable Executive** | Gaynor Westray, Director of Nursing and Midwifery |
| **BAF References**<br>• **Strategic Objective**<br>• **Key Measure**<br>• **Principal Risk** | Strategic objectives: To be the top NHS Hospital in the North West; Delivering consistently high quality secondary care services; Supported by financial, commercial and operational excellence.<br>1A Risks 2799 & 2798<br>1B Risks 1908 & 1909<br>3A Risks 2837 & 2611<br>3B Risks 2799, 2837 & 2798<br>7A Risks 2798 |
| **Level of Assurance**<br>• **Positive**<br>• **Gap(s)** | Positive:<br>Systems and processes are in place to monitor safer staffing levels.<br><br>Gaps:<br>Safer staffing in rehabilitation and assessment areas has yet to be reviewed using a specialist acuity based tool |
| **Purpose of the Paper** | For discussion and approval |
| **Data Quality Rating** | Silver – quantitative data that has not been externally validated |
| **FOI status** | Document may be disclosed in full |
| **Equality Impact Assessment** | N/A |

## 1. Executive Summary

This paper provides the 6 monthly update on Trust progress to meeting the requirements of 'Hard Truths: The Journey to Putting Patients First' Expectations, Accountability and Responsibility.

## 2. Background

Safe nurse staffing levels were a feature of the Francis, Keogh and Berwick Reports published in 2013. The National Quality Board issued guidance in November 2013, 'How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability'. This document informs this paper and is augmented with the June 2015 publication of the National Institute for Care and Healthcare Excellence (NICE) guidance.

The Government has made a number of commitments in 'Hard Truths: The Journey to Putting Patients First' (2014) to make this information more publically available.

The Director of Nursing and Midwifery has taken steps to ensure that the Trust has responded to meet the milestones set out in the guidance published on 31 March 2014.

The expectations of the Board of Directors have been presented previously and are re-presented with an update to demonstrate focus and progression of the nursing and midwifery staffing agenda.

| Expectation | Progress |
|---|---|
| **Recommendation 1**<br>The Board of Directors has responsibility for the quality of care provided to patients and as a key determinant of quality takes full and collective responsibility for nursing, midwifery and care staffing capacity and capability | • The Director of Nursing and Midwifery is provided with information on staffing capacity and capability on a monthly basis by the Associate Directors of Nursing. This information is collated and presented to the Board of Directors on a bi-monthly basis |
| **Recommendation 2**<br>Processes are in place to enable staffing establishments to be met on a shift-to-shift basis | • The Trust continues to work on a minimum requirement of 1 Registered Nurse (RN) to 8 patients during the day and 1 RN to 10 patients at night as per funded establishments<br>• The nurse staffing escalation guide has been circulated to all ward sisters / charge nurses and hospital clinical co-ordinators this provides guidance and supports decision making if concerns are raised with regard to staffing<br>• All matrons hold daily staffing meetings to determine whether or not planned staffing requirements are met and to take action where there may be a shortfall<br>• Staffing plan with agreed potential moves is prepared for out of hours periods<br>• Close workings with NHSP to ensure improvement in fill rates for temporary staffing is ongoing<br>• Previous reports have highlighted that in order to support the provision of additional beds it has been necessary to move staff from their base wards. Whilst this has still happened on occasion, a proactive approach to staffing of escalation beds through planned nurse recruitment has reduced the need to move staff and as a result improved morale has been reported across all wards |

| | |
|---|---|
| **Recommendation 3**<br>Evidence based tools are used to inform nursing, midwifery and care staffing and capability. | • Evidence based tools are utilised across the Trust<br>• Within the past 2 years all General Wards have been assessed using the Safer Nursing Care Tool (SNCT) recommended by the Selford Group<br>• The Emergency Department staffing has been reviewed in line with the 'British Emergency Department Staffing Tool' Assessment (BEST) and draft NICE guidance for Emergency Department nurse staffing published in January 2015<br>• Critical Care adhere to Cheshire and Merseyside Critical Care Network (CMCCN) service specification guidance<br>• Neonatal Unit utilise British Association of Perinatal Medicine (BAPM) standards to inform staffing levels although cots are not closed when staffing falls below BAPM standards<br>• A second phase of the Birthrate plus assessment, primarily focusing on antenatal care, is currently underway<br>• Scottish Children's Acuity Measurement in Paediatric Settings (SCAMPs) is being undertaken on the Paediatric Ward on a continual basis to allow us to gather a rich baseline. This will be analysed with assistance of Liverpool Children's Hospital<br>**Next Steps**<br>• Identification of appropriate tool to use on Clatterbridge Rehabilitation Centre (CRC) and assessment areas |
| **Recommendation 4**<br>Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns. | • At the monthly Strategic Nursing and Midwifery Team meeting, the Director of Nursing and Midwifery, Deputy Director of Nursing and the Associate Directors of Nursing review the staffing incidents report for the previous month and feedback actions taken within the divisions. Positive staff survey feedback indicates an improving engagement score<br>• Following a recent series of whistleblowing to CQC an independent review was undertaken into "fear of raising concerns" within the Midwifery services. Assurance was given to the Director of Nursing that there was no evidence found to substantiate these concerns<br>• Staff Guardian contacts have increased and a further Staff Guardian has been recruited |
| **Recommendation 5**<br>A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments | • Staffing levels are set and monitored through the clinical division and senior nursing team. Information on safe staffing is made available to Board of Directors |

| | |
|---|---|
| **Recommendation 6**<br>Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties | • Data from the first submission of Care Hours Per Patient Day (CHPPD) demonstrates that Care Hours across the Trust follows the trend of other organisations<br>• Ward sisters have supervisory status. During the winter period it was reported that due to the requirement to safely staff additional wards, ward sisters and charge nurses had been required to work clinically to ensure minimum staffing levels were achieved. This position has since improved due to the positive impact of the recruitment strategy, improvement in staff attendance rates and the effective management of patient flow. In future, ward sisters ensure that this is recorded on eroster to allow for monitoring<br>• Uplift to cover training and sickness has been adjusted to ensure that establishments match requirements. |
| **Recommendation 7**<br>Boards receive monthly updates on workforce information and staffing capacity. Capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review | • Monthly safe staffing data is collected and reported each month on the Trust internet<br>• Monthly staffing reports include information on vacancies and number of occurrences of patient harm during the month<br>• The Board of Directors receives formal bi-monthly reports<br>• Monthly workforce information presented as part of integrated Board dashboard |
| **Recommendation 8**<br>NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift | • Daily nurse staffing data is displayed outside each ward. This process is audited via Matron audits and Care Quality Inspections (CQI) to ensure compliance<br>• Monthly staffing data is displayed on ward viswalls |
| **Recommendation 9**<br>Providers of NHS services take an active role in securing staff in line with their workforce requirements | • The workforce forward plan is completed annually<br>• Recruitment strategies are in place to fill vacancies in a timely way<br>• Eroster are currently being cleansed to ensure they are an accurate reflection of staffing on each ward |
| **Recommendation 10**<br>Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract | • A copy of this six monthly staffing report is presented to the Wirral Clinical Commissioning Quality and Risk meeting for information and progress |

**3. Conclusion and Recommendations**

Good progress has been made to meet the recommendations of 'Hard Truths: The Journey to Putting Patients First' Expectations, Accountability and Responsibility and systems and process are now firmly embedded to provide assurance of safe staffing or to allow concerns to be appropriately escalated. Care Hours Per Patient day (CHPPD) data collection has been commenced and will continue to be reported through the bi-monthly safer staffing report.

The Board of Directors are asked to receive this update and discuss the content.

| BOARD OF DIRECTORS | |
|---|---|
| **Agenda Item** | 7.2 |
| **Title of Report** | Publishing of Nurse Staffing Data: May/June 2016 |
| **Date of Meeting** | 27 July 2016 |
| **Author** | Clare Pratt, Deputy Director of Nursing<br>Tracey Lewis, Head of Clinical Excellence & Organisational Development<br>Johanna Ashworth-Jones, Senior Analyst |
| **Accountable Executive** | Gaynor Westray, Director of Nursing and Midwifery |
| **BAF References**<br>• **Strategic Objective**<br>• **Key Measure**<br>• **Principal Risk** | Strategic objectives: To be the top NHS Hospital in the North West; Delivering consistently high quality secondary care services; Supported by financial, commercial and operational excellence.<br>1A Risks 2799 & 2798<br>1B Risks 1908 & 1909<br>3A Risks 2837 & 2611<br>3B Risks 2799, 2837 & 2798<br>7A Risks 2798 |
| **Level of Assurance**<br>• **Positive**<br>• **Gap(s)** | **Positive**<br>• The Trust was well prepared to commence reporting on Care Hours Per Patient Day and successfully submitted the required reports for May and June 2016<br>• All Registered Nurses due for revalidation in May and June 2016 have successfully achieved this status<br>• The Trust's recruitment plan continues to have a positive impact on staffing levels and the Trust's fill rates with overall 97% for May and June 2016 |
| **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 a review of nurses currently being supported through preceptorship .The report also includes the details of the actual hours of Registered Nurses / Midwives and Clinical Support Workers time on ward day shifts and night shifts versus planned staffing levels for May 2016 and June 2016 as reported to NHS England each month.

## 2 Recruitment Strategy

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

For June 2016 electronic staff records (ESR) data shows a vacancy rate now at 5.34% which equates to 36.86 WTE for band 5 inpatient and Emergency Department Registered Nurses. This is an improving position, and the Trust vacancy rate for Registered Nurses is well below the national average of 10%.

**Table 1 - Band 5 Nursing Vacancies**

| | February 2016 | March 2016 | April 2016 | May 2016 | June 2016 |
|---|---|---|---|---|---|
| Establishment | 707.66 | 707.66 | 707.66 | 689.88 | 689.88 |
| Actual Numbers | 658.9 | 661.82 | 664.92 | 653.58 | 653.02 |
| Vacancies | 48.76 | 45.84 | 42.74 | 36.3 | 36.86 |
| Vacancies % | 6.89% | 6.48% | 6.04% | 5.26% | 5.34% |

Current vacancy position by division for June 2016:

Surgery, Women and Children's: Vacancy rate is 3.06 % equating to 7.16 WTE Registered band 5 Nurses.

Medicine and Acute: Vacancy rate is 6.51% equating to 29.7 WTE Registered band 5 Nurses.

The majority of the vacancies remain within Medicine and Acute Division and are within specialist areas; the Division now holds monthly recruitment events which focus on the specialist areas as well as general in-patient wards. HR/OD has updated the recruitment strategy to maximise recruitment of newly qualified graduates and return to practice nurses. To date of the 27 Students due to graduate in September 2016, 16 have accepted posts to start their nursing career at WUTH. Consideration must be given to support the division of surgery going over established staffing levels for an agreed period as 5 of these graduates have requested the division of surgery and will be accommodated by other Trusts if we cannot place them in their chosen division. This over establishment will be for a 6 week period until the additional ward opens as part of the Trust winter plan.

**2.1 Preceptorship and support**

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

**Table 2 - Preceptorship Numbers (NMC)**

| | Commenced in Trust | On Preceptorship June 2016 |
|---|---|---|
| Q1 April - June 2015 | 13 | 3 |
| Q2 July - September 2015 | 42 | 15 |
| Q3 October - December 2015 | 4 | 2 |
| Q4 January - March 2016 | 8 | 8 |
| Q1 April - June 2016 | 8 | 8 |
| EU Nurses (Nov 2015-April 2016 ) | 36 | 32 |
| Total | 111 | 68 |

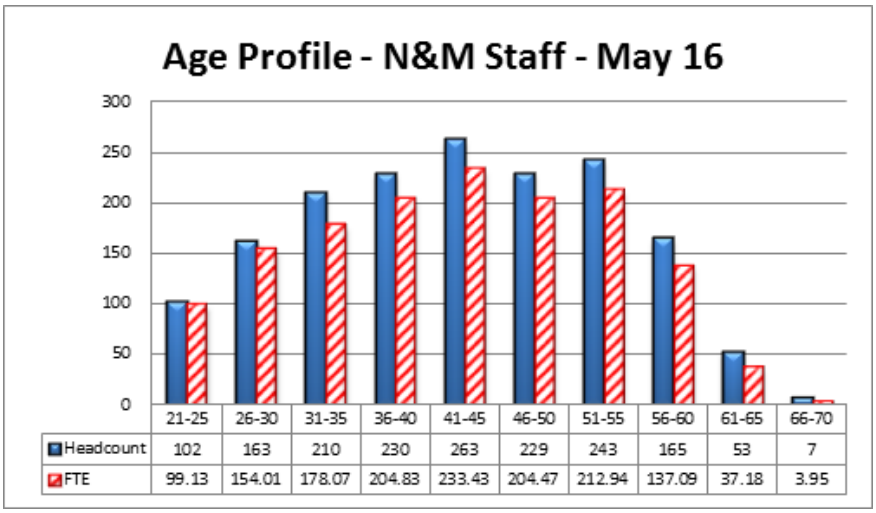
To ensure that the nurses currently on preceptorship are well supported we have developed 57 registrants through an in house preceptor training programme plus 605 of our NMC registrants have successfully completed the mentorship module (Multi Professional learning and support in practice) and have the skills and experience to support our new recruits.

The Trust secured 12 months funding for our recruitment and retention facilitator from Health Education England. The postholder is currently providing support to all areas and focusing on the implementation on the new North West recommended preceptorship standards due to be published July 2016.

## 3 Age Profile

Table 3 below demonstrates the age demographics of the nursing workforce. This review highlights that 15% of the current nursing workforce fall in the 51-55 years age group and as such may choose to retire in the next five years. This workforce data is considered as part of our recruitment strategy to mitigate against risks.

**Table 3 – Age Profile**




| | 21-25 | 26-30 | 31-35 | 36-40 | 41-45 | 46-50 | 51-55 | 56-60 | 61-65 | 66-70 |
|---|---|---|---|---|---|---|---|---|---|---|
| Headcount | 102 | 163 | 210 | 230 | 263 | 229 | 243 | 165 | 53 | 7 |
| FTE | 99.13 | 154.01 | 178.07 | 204.83 | 233.43 | 204.47 | 212.94 | 137.09 | 37.18 | 3.95 |

## 4 Monthly Safe Staffing Report

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

Trust agreed Indicators:

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

These parameters provide information for the Board of Directors on how the Trust is progressing towards safe staffing. The overall fill rate for May and June 2016 is maintained at 97%. Table 4 below shows compliance for fill rate for both RN and CSW shifts, both for day and night shifts for the month of May and June 2016.

**Table 4 – Compliance Fill Rate**

| | May 2016 | | | June 2016 | | |
|---|---|---|---|---|---|---|
| **Day Shift** | **Green** | **Amber** | **Red** | **Green** | **Amber** | **Red** |
| Number of wards compliant with RN fill rate | 24 | 13 | 0 | 21 | 14 | **3** |
| Number of wards compliant with CSW fill rate | 27 | 9 | | 25 | 10 | **2** |

| | May 2016 | | | June 2016 | | |
|---|---|---|---|---|---|---|
| **Night Shift** | | | | | | |
| Number of wards compliant with RN fill rate | 29 | 7 | 1 | 26 | 10 | **2** |
| Number of wards compliant with CSW fill rate | 33 | 2 | | 30 | 6 | **1** |

June 2016 has seen a slight decrease in the number of wards with a fill rate of 95% and above for all shifts. The increase in areas in amber and red can, for most of the wards, be attributed to planned staff alignment were formal financial establishments have not been changed but staffing resources have been re-utilised to cover additional beds in other areas. Matrons produce a daily staffing plan to ensure that areas are safely staffed.

Table 5 displays the lowest fill rate for each shift for each month (January – June 2016):

**Table 5 – Lowest Fill Rate**

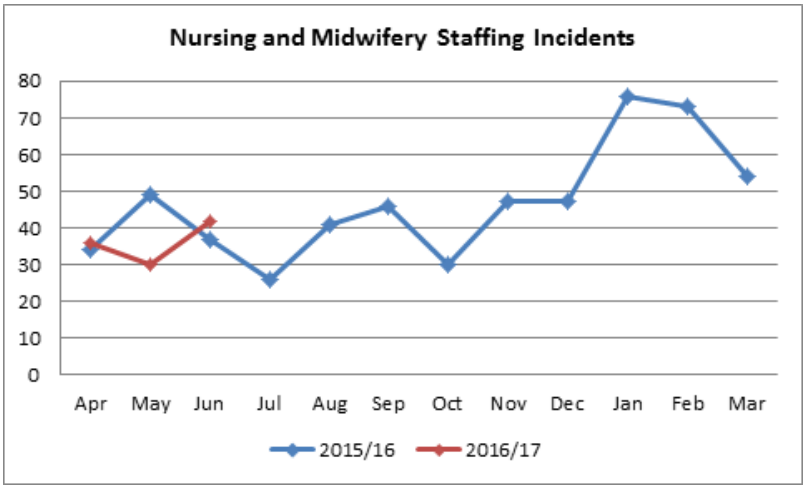
| | January 2016 | February 2016 | March 2016 | April 2016 | May 2016 | June 2016 |
|---|---|---|---|---|---|---|
| RN Days Lowest Fill Rate | Ward 30 88.8% | Neonatal 93.4% | Ward 33/HAC 88.8% | Ward 38/37 85.4% | M1 87.1% | Ward 12 76.2% |
| CSW Days Lowest Fill Rate | Maternity 91.9% | Maternity 94.8% | Ward 33/HAC 86.5% | CRC 96.3% | Delivery suite 84% | M1 78.5% |
| RN Nights Lowest Fill Rate | Maternity 81.8% | Maternity 86.5% | Maternity 66.% | EDRU 87.3% | EDRU 79.6% | Neonatal 73.1% |
| CSW Nights Lowest Fill Rate | Maternity 83.3% | Maternity 94.4% | Maternity 66.% | Ward 21 89.6% | M1 80.6% | M1 70.0% |

- Maternity fill rates for January, February, and March 2016 were escalated to the Associate Director of Nursing for Surgery, Women and Children's Division and the Head of Midwifery. On review the escalation policy, which includes utilising the role of the Advanced Midwifery Practitioner had been implemented and community midwives staff have supported the in-patient service, however, this was not reflected in the staffing levels submitted by the division, hence resulting in the recording of staffing levels as being lower that than the actual levels
- Ward 12 for RN days has a smaller staffing establishment than most wards due to the number of beds and therefore any variance will have a greater effect on the percentage fill rate. At all times the ward remained safe with the Ward Sister utilised clinically
- CSW fill rate on ward M1, for both day and night shifts has reduced however when reviewed it is evident that staff from ward M1 had been relocated to support other clinical areas. During this time the patient acuity on M1 was lower and could therefore be safely staffed with the reduced staffing levels
- Neonates' staffing levels were below planned in June 2016. This was due to a high percentage of Level 3 babies increasing the required staffing levels. The ward sisters and co-ordinators worked clinically to ensure babies were nursed safely

## 5 Reported Staffing Incidents

After a period of reduced reported staffing incidents, there was an increase in June 2016. Ante Natal Clinic is the department with the highest reported incidents (5 incidents). This has been as a result of staff being relocated to both the Delivery Suite and Maternity Ward during periods of increased activity. The introduction of the ward profile dashboard will include this data to enable comparison between ward areas and clear actions required.

| January 2016 | February 2016 | March 2016 | April 2016 | May 2016 | June 2016 |
|---|---|---|---|---|---|
| 76 | 73 | 54 | 36 | 30 | 42 |




## 6. Care Hours Per Patient Day (CHPPD)

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

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

The report recommended that all Trusts start recording Care Hours per Patient Day (CHPPD) – a single, consistent metric of nursing and clinical support workers deployment on 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.

In line with guidance WUTH started reporting CHPPD in June 2016 based on May's staffing data. The table below details the CHPPD for each ward for May and June 2016 against their overall staffing fill rate.

| Ward | May Overall CHPPD | June Overall CHPPD | May Fill Rate | June Fill Rate |
|---|---|---|---|---|
| ITU | 39.5 | 32.6 | 100% | 91% |
| delivery suite | 31.6 | 37.9 | 97% | 104% |
| HDU | 24.3 | 35.1 | 100% | 98% |
| M2 | 23.8 | 32.0 | 100% | 100% |
| ESAU | 17.3 | 15.9 | 100% | 99% |
| Dermatology | 15.6 | 11.3 | 96% | 100% |
| Park Suite | 14.1 | 15.2 | 98% | 97% |
| Neonatal | 12.7 | 12.3 | 92% | 79% |
| CCU | 12.6 | 12.3 | 100% | 100% |
| 12 | 11.6 | 10.1 | 92% | 94% |
| M1 | 11.4 | 10.3 | 90% | 82% |
| AMU | 10.5 | 10.6 | 99% | 96% |
| 11 | 9.9 | 9.0 | 94% | 99% |
| OPAU | 9.5 | 8.2 | 93% | 94% |
| 54 | 9.1 | 7.4 | 100% | 100% |
| MSSW | 8.8 | 8.5 | 95% | 94% |
| EDRU | 8.7 | 9.5 | 95% | 101% |
| children's | 8.1 | 10.7 | 89% | 112% |
| 30 | 7.3 | 6.6 | 100% | 90% |
| 10 | 7.3 | 6.2 | 97% | 96% |
| 32 | 7.3 | 7.5 | 94% | 96% |
| 25 | 7.0 | 5.2 | 93% | 90% |
| 23 | 6.7 | 7.0 | 100% | 111% |
| 22 | 6.6 | 6.0 | 100% | 107% |
| 53 | 6.3 | 5.9 | 98% | 98% |
| 24 & cdiff | 6.1 | 6.9 | 98% | 111% |
| M2 Rehab | 6.0 | 5.9 | 100% | 98% |
| 37 | 5.9 | 7.9 | 100% | 100% |
| 21 | 5.8 | 5.3 | 95% | 92% |
| 20 | 5.8 | 6.2 | 99% | 101% |
| 33 & HAC | 5.8 | 6.0 | 97% | 98% |
| 38 & LAU | 5.7 | 3.4 | 99% | 98% |
| 18 | 5.7 | 5.8 | 98% | 97% |
| 17 | 5.7 | 6.5 | 99% | 120% |
| 36 | 5.6 | 5.6 | 99% | 102% |
| CRC | 5.6 | 5.7 | 99% | 100% |
| 26 | 5.6 | 6.3 | 95% | 107% |

Although the CHPPD data is in its infancy the data provides a greater level of assurance in terms of consistency of delivery of care an example of this would be the data provided regarding the staffing fill rate for June 2016 for Ward M1 whilst the overall fill rate for June 2016 reduced from 90% to 82% with 3 of the 4 shift rates being below 80% the CHPPD only

reduced by just over 1 hour with CHPDD being 11.4 in May 2016 and 10.3 in June 2016. This indicates that the actual staff hours match the care hours required by patient group. Further monitoring and analysis will continue to review the CHPPD and the Trusts await further national information in order to benchmark and support staffing establishments.

## 7 Next steps

- Continue with the programme of Monthly Trust wide recruitment for Registered Nurses, including overseas recruitment
- Continue to update the Board of Directors on a bi-monthly basis

## 8 Conclusion

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

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

## 9 Recommendations

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

# Monthly Safe Staffing Report - May 2016

| | | | RNs | | | | CSW's | | | | RNs | | | | CSW's | | | | Quality indicators | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Days | | | | | | | | Nights | | | | | | | | | | | | | | |
| Specialty | Ward | Beds | Total monthly planned staff hours | Total monthly actual staff hours | Variance | % RN | Total monthly planned staff hours | Total monthly actual staff hours | Variance | % CSW | Total monthly planned staff hours | Total monthly actual staff hours | Variance | % RN | Total monthly planned staff hours | Total monthly actual staff hours | Variance | % CSW | Falls (moderate and above) | Pressure ulcers (Grade 2 and above) | Cdiff (Reportable to PHE) | MRSA (Reportable to PHE) | Sickness & Absence | RN Vacancies (WTE) | CSW Vacancies (WTE) |
| Orthopaedics | 10 | 28 | 1784.75 | 1725.25 | 59.5 | 96.7% | 1263.25 | 1221.5 | 41.75 | 96.7% | 1069.5 | 1046.5 | 23 | 97.8% | 1069.5 | 1058.2 | 11.3 | 98.9% | 0 | 0 | 0 | 0 | 6.16 | -3.72 | -1.87 |
| Orthopaedics | 11 | 25 | 1784.75 | 1680.5 | 104.25 | 94.2% | 1426 | 1217.4 | 208.6 | 85.4% | 1069.5 | 1058 | 11.5 | 98.9% | 713 | 713 | 0 | 100.0% | 0 | 0 | 0 | 0 | 4.26 | -0.57 | 1 |
| Orthopaedics | 12 | 16 | 1204.5 | 1076 | 128.5 | 89.3% | 906.75 | 794 | 112.75 | 87.6% | 713 | 701.5 | 11.5 | 98.4% | 356.5 | 365.5 | +9 | 102.5% | 0 | 3 | 0 | 0 | 1 | 0.16 | 0 |
| DME | OPAU | 23 | 1591 | 1436.25 | 154.75 | 90.3% | 1426 | 1328.75 | 97.25 | 93.2% | 1069.5 | 938 | 131.5 | 87.7% | 1069.5 | 1069.5 | 0 | 100.0% | 0 | 0 | 0 | 0 | 4.46 | 0.00 | -1 |
| Colorectal | 17 | 30 | 1947.5 | 1935.1 | 12.4 | 99.4% | 1263.25 | 1251.75 | 11.5 | 99.1% | 1069.5 | 1063.35 | 6.15 | 99.4% | 713 | 713 | 0 | 100.0% | 0 | 0 | 0 | 0 | 6.7 | -0.15 | -1 |
| General Surgery | 18 | 29 | 1784.75 | 1740.65 | 44.1 | 97.5% | 1263.25 | 1205.1 | 58.15 | 95.4% | 1069.5 | 1069.5 | 0 | 100.0% | 713 | 713 | 0 | 100.0% | 0 | 1 | 0 | 0 | 1.28 | -1.47 | 1 |
| Urology | 20 | 30 | 1740.5 | 1728 | 12.5 | 99.3% | 1355.25 | 1325 | 30.25 | 97.8% | 1069.5 | 1069.5 | 0 | 100.0% | 713 | 713 | 0 | 100.0% | 0 | 0 | 0 | 0 | 0.84 | 0.72 | 1 |
| DME | 21 | 31 | 1784.75 | 1702.55 | 82.2 | 95.4% | 1581 | 1528.65 | 52.35 | 96.7% | 1255.5 | 1147.5 | 108 | 91.4% | 1069.5 | 1069.5 | 0 | 100.0% | 2 | 0 | 1 | 0 | 6.96 | 2.39 | 0 |
| DME | 22 | 30 | 1591 | 1591 | 0 | 100.0% | 1426 | 1426 | 0 | 100.0% | 1069.5 | 1069.5 | 0 | 100.0% | 1069.5 | 1069.5 | 0 | 100.0% | 0 | 1 | 1 | 0 | 2.62 | 0.00 | -1 |
| Stroke | 23 | 26 | 1947.5 | 1805.75 | 141.75 | 92.7% | 1263.25 | 1275.75 | +12.5 | 101.0% | 1069.5 | 1081 | +11.5 | 101.1% | 713 | 816.5 | +103.5 | 114.5% | 2 | 0 | 0 | 0 | 2.46 | 0.12 | 0 |
| DME | 24 & cdiff | 38 | 1728.5 | 1614.7 | 113.8 | 93.4% | 1619.75 | 1608.35 | 11.4 | 99.3% | 1069.5 | 1058 | 11.5 | 98.9% | 1069.5 | 1069.5 | 0 | 100.0% | 1 | 1 | 0 | 0 | 2.82 | 5.04 | 0 |
| General Medicine | 26 | 29 | 1627.5 | 1429 | 198.5 | 87.8% | 1426 | 1373.5 | 52.5 | 96.3% | 1116 | 1116 | 0 | 100.0% | 1116 | 1086.5 | 29.5 | 97.4% | 1 | 0 | 0 | 0 | 2.98 | -0.28 | -2 |
| Haematology | 30 | 22 | 1591 | 1591 | 0 | 100.0% | 1069.5 | 1069.5 | 0 | 100.0% | 1007.5 | 1007.5 | 0 | 100.0% | 710 | 710 | 0 | 100.0% | 0 | 0 | 0 | 0 | 2.2 | 2.48 | 0 |
| Cardiology | 32 | 31 | 1984 | 1840.5 | 143.5 | 92.8% | 1426 | 1265.35 | 160.65 | 88.7% | 1426 | 1403 | 23 | 98.4% | 1069.5 | 1069.5 | 0 | 100.0% | 0 | 0 | 0 | 0 | 3.89 | -0.07 | 1 |
| Cardiology | 33 & HAC | 29 | 1627.5 | 1585.8 | 41.7 | 97.4% | 1302 | 1221.5 | 80.5 | 93.8% | 1069.5 | 1069.5 | 0 | 100.0% | 1069.5 | 1058 | 11.5 | 98.9% | 1 | 0 | 0 | 0 | 2.87 | 1.09 | 2 |
| Gastro | 36 | 32 | 2127 | 2114.5 | 12.5 | 99.4% | 1426 | 1384.25 | 41.75 | 97.1% | 1426 | 1345.5 | 80.5 | 94.4% | 1189.5 | 1258.5 | +69 | 105.8% | 0 | 3 | 0 | 0 | 0.92 | 4.53 | 1 |
| Respiratory | 38 & LAU | 35 | 2173 | 2150 | 23 | 98.9% | 1488 | 1488 | 0 | 100.0% | 1426 | 1426 | 0 | 100.0% | 1069.5 | 1058 | 11.5 | 98.9% | 1 | 0 | 0 | 0 | 1.08 | -1.91 | 0 |
| Maternity | 53 | 38 | 1426 | 1414 | 12 | 99.2% | 713 | 690 | 23 | 96.8% | 1069.5 | 1035 | 34.5 | 96.8% | 713 | 690 | 23 | 96.8% | 0 | 0 | 0 | 0 | 3.77 | 5.04 | 7 |
| Gynaecology | 54 | 16 | 878 | 878 | 0 | 100.0% | 713 | 713 | 0 | 100.0% | 713 | 713 | 0 | 100.0% | 356.5 | 356.5 | 0 | 100.0% | 0 | 0 | 0 | 0 | 0.8 | 0.00 | -2 |
| General Medicine | AMU | 24 | 2304 | 2298.75 | 5.25 | 99.8% | 1782.5 | 1785.5 | +3 | 100.2% | 1619.75 | 1607.45 | 12.3 | 99.2% | 1441.5 | 1418.5 | 23 | 98.4% | 0 | 0 | 0 | 0 | 4.59 | 3.49 | 0 |
| General Medicine | MSSW | 21 | 1947.5 | 1773.8 | 173.7 | 91.1% | 1426 | 1426 | 0 | 100.0% | 1263.25 | 1145.5 | 117.75 | 90.7% | 1069.5 | 1081 | +11.5 | 101.1% | 0 | 0 | 0 | 0 | 4.59 | 3.49 | 0 |
| Emergency | EDRU | 10 | 796.6 | 796.6 | 0 | 100.0% | 356.5 | 356.5 | 0 | 100.0% | 550.25 | 437.85 | 112.4 | 79.6% | 356.5 | 356.5 | 0 | 100.0% | 0 | 0 | 0 | 0 | 0.87 | -1.67 | 0 |
| | Parksuite | 8 | 713 | 713 | 0 | 100.0% | 713 | 713 | 0 | 100.0% | 713 | 678.5 | 34.5 | 95.2% | 0 | 0 | 0 | - | 0 | 0 | 0 | 0 | 2.89 | -2.60 | 1 |
| Surgical Assessment | ESAU | 12 | 1204.5 | 1227.5 | +23 | 101.9% | 1069.5 | 1046 | 23.5 | 97.8% | 1069.5 | 982.75 | 86.75 | 91.9% | 713 | 782 | +69 | 109.7% | 0 | 0 | 0 | 0 | 12.32 | 2.54 | -4 |
| Critical Care | ITU | 11 | 3708 | 3708 | 0 | 100.0% | 356.5 | 365.5 | +9 | 102.5% | 3565 | 3553.5 | 11.5 | 99.7% | 356.5 | 345 | 11.5 | 96.8% | 0 | 0 | 0 | 0 | 5.43 | | |
| Critical Care | HDU | 6 | 1426 | 1426 | 0 | 100.0% | 356.5 | 356.5 | 0 | 100.0% | 1426 | 1426 | 0 | 100.0% | 356.5 | 356.5 | 0 | 100.0% | 0 | 0 | 0 | 0 | 5.43 | 5.00 | -1 |
| Maternity | delivery suite | 10 | 2139 | 2090 | 49 | 97.7% | 356.5 | 299.5 | 57 | 84.0% | 2139 | 2139 | 0 | 100.0% | 356.5 | 333.5 | 23 | 93.5% | 0 | 1 | 0 | 0 | 8.99 | 5.04 | 7 |
| Neo Natal | Neonatal | 24 | 3700 | 3467.25 | 232.75 | 93.7% | 0 | 0 | 0 | - | 3565 | 3214 | 351 | 90.2% | 0 | 0 | 0 | - | 0 | 0 | 0 | 0 | 1.23 | 4.09 | 1 |
| Children's | childrens | 27 | 1552.5 | 1363.5 | 189 | 87.8% | 356.5 | 356.5 | 0 | 100.0% | 1426 | 1220.5 | 205.5 | 85.6% | 356.5 | 356.5 | 0 | 100.0% | 0 | 0 | 0 | 0 | 0.15 | -0.53 | 0 |
| Orthopaedics | M1 | 20 | 1428.25 | 1244 | 184.25 | 87.1% | 906.75 | 815.5 | 91.25 | 89.9% | 713 | 713 | 0 | 100.0% | 356.5 | 287.5 | 69 | 80.6% | 0 | 0 | 0 | 0 | 4.51 | 2.26 | 1 |
| General Surgery | M2 | 26 | 195.5 | 195.5 | 0 | 100.0% | 195.5 | 195.5 | 0 | 100.0% | 149.5 | 149.5 | 0 | 100.0% | 149.5 | 149.5 | 0 | 100.0% | 0 | 0 | 0 | 0 | 0 | / | / |
| DME | CRC | 20 | 1460 | 1405.4 | 54.6 | 96.3% | 1929.75 | 1745.78 | 183.97 | 90.5% | 713 | 713 | 0 | 100.0% | 1069.5 | 1242 | +172.5 | 116.1% | 0 | 0 | 0 | 0 | 0.05 | 0.11 | -2 |
| Neuro & Rehabilitation | M2 Rehab | 20 | 1232.95 | 1220.45 | 12.5 | 99.0% | 903.65 | 903.65 | 0 | 100.0% | 713 | 713 | 0 | 100.0% | 713 | 713 | 0 | 100.0% | 0 | 0 | 0 | 0 | 3.62 | 0.39 | -1 |
| Dermatology | Dermatology | 12 | 713 | 628 | 85 | 88.1% | 713 | 717 | +4 | 100.6% | 356.5 | 356.5 | 0 | 100.0% | 356.5 | 356.5 | 0 | 100.0% | 0 | 0 | 0 | 0 | 3.52 | 0.77 | 0 |
| Geriatric Medicine | 25 | 30 | 930 | 862.5 | 67.5 | 92.7% | 697.5 | 594 | 103.5 | 85.2% | 697.5 | 686 | 11.5 | 98.4% | 1069.5 | 1029 | 40.5 | 96.2% | 0 | 1 | 0 | 0 | | 1.90 | 0 |
| Cardiology | CCU | 8 | 713 | 713 | 0 | 100.0% | 232.5 | 232.5 | 0 | 100.0% | 713 | 713 | 0 | 100.0% | 232.5 | 232.5 | 0 | 100.0% | 0 | 0 | 0 | 0 | 3.89 | -0.07 | / |
| Respiratory | 37 | 10 | 413.25 | 413.25 | 0 | 100.0% | 232.5 | 232.5 | 0 | 100.0% | 356.5 | 356.5 | 0 | 100.0% | 356.5 | 356.5 | 0 | 100.0% | 0 | 0 | 1 | 0 | 1.08 | -1.91 | 0 |
| **Totals** | | 837 | 58900.55 | 56585.05 | 2315.5 | | 36941.9 | 35528.78 | 1413.12 | | 42596.25 | 41223.4 | 1372.85 | | 25872.5 | 26053.2 | +180.7 | | | | | | | | |

| Overall Staffing Hour totals (Rounded to the nearest hour) | Fill Rate | 97% | Total Planned Hours | 164311.2 | Total Actual Hours | 159390.43 | Variance | 5282.17 |
|---|---|---|---|---|---|---|---|---|

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

Wirral University Teaching Hospital NHS
NHS Foundation Trust

#PROUD TO CARE FOR YOU

# Monthly Safe Staffing Report - June 2016

| | | | RNs | | | | CSW's | | | | RNs | | | | CSW's | | | | Quality indicators | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Days | | | | | | | | Nights | | | | | | | | | | | | | | |
| Specialty | Ward | Beds | Total monthly planned staff hours | Total monthly actual staff hours | Variance | % RN | Total monthly planned staff hours | Total monthly actual staff hours | Variance | % CSW | Total monthly planned staff hours | Total monthly actual staff hours | Variance | % RN | Total monthly planned staff hours | Total monthly actual staff hours | Variance | % CSW | Falls (moderate and above) | Pressure ulcers (Grade 2 and above) | Cdiff (Reportable to PHE) | MRSA (Reportable to PHE) | Sickness & Absence | RN Vacancies (WTE) | CSW Vacancies (WTE) |
| Orthopaedics | 10 | 29 | 1732.5 | 1798 | +65.5 | 103.8% | 1222.5 | 1030.5 | 192 | 84.3% | 1035 | 1035 | 0 | 100.0% | 1035 | 989 | 46 | 95.6% | 0 | 3 | 0 | 0 | 0.09 | -2.11 | -1.07 |
| Orthopaedics | 11 | 25 | 1732.5 | 1695.75 | 36.75 | 97.9% | 1380 | 1085.25 | 294.75 | 78.6% | 1035 | 924 | 111 | 89.3% | 690 | 901 | +211 | 130.6% | 0 | 0 | 0 | 0 | 0.01 | 0.43 | 1 |
| Orthopaedics | 12 | 16 | 1170 | 891 | 279 | 76.2% | 877.5 | 747 | 130.5 | 85.1% | 690 | 667 | 23 | 96.7% | 345 | 414 | +69 | 120.0% | 0 | 0 | 0 | 0 | 0.04 | 0.16 | 0 |
| DME | OPAU | 18 | 1545 | 1381.25 | 163.75 | 89.4% | 1380 | 1275.75 | 104.25 | 92.4% | 1035 | 759 | 276 | 73.3% | 690 | 690 | 0 | 100.0% | 0 | 0 | 0 | 0 | 2.04 | 0.00 | -1 |
| Colorectal | 17 | 29 | 1890 | 1851.5 | 38.5 | 98.0% | 1222.5 | 1335.25 | +112.75 | 109.2% | 1035 | 996 | 39 | 96.2% | 690 | 1219 | +529 | 176.7% | 1 | 0 | 0 | 0 | 0.03 | -0.15 | -1 |
| General Surgery | 18 | 29 | 1732.5 | 1680.75 | 51.75 | 97.0% | 1222.5 | 1106 | 116.5 | 90.5% | 1035 | 1012 | 23 | 97.8% | 690 | 713 | +23 | 103.3% | 0 | 0 | 0 | 0 | 0.01 | -1.47 | 1 |
| Urology | 20 | 29 | 1692.25 | 1623.5 | 68.75 | 95.9% | 1326 | 1337.75 | +11.75 | 100.9% | 1035 | 1035 | 0 | 100.0% | 690 | 747.5 | +57.5 | 108.3% | 0 | 1 | 0 | 0 | 0.01 | 0.72 | 1 |
| DME | 21 | 30 | 1732.5 | 1608.25 | 124.25 | 92.8% | 1530 | 1422 | 108 | 92.9% | 1215 | 1035.5 | 179.5 | 85.2% | 1035 | 1002 | 33 | 96.8% | 0 | 0 | 0 | 0 | 8.14 | 2.07 | -1 |
| DME | 22 | 29 | 1545 | 1545 | 0 | 100.0% | 1380 | 1502 | +122 | 108.8% | 1035 | 1012 | 23 | 97.8% | 1035 | 1288 | +253 | 124.4% | 1 | 1 | 0 | 0 | 3.71 | 0.00 | -1 |
| Stroke | 23 | 26 | 1890 | 1788.23 | 101.77 | 94.6% | 1222.5 | 1210 | 12.5 | 99.0% | 1035 | 1035 | 0 | 100.0% | 690 | 1035 | +345 | 150.0% | 1 | 0 | 0 | 0 | 2.12 | 1.04 | -1 |
| DME | 24 | 29 | 1682.5 | 1591.85 | 90.65 | 94.6% | 1567.5 | 1898.52 | +331.02 | 121.1% | 1035 | 1035 | 0 | 100.0% | 1035 | 1345.5 | +310.5 | 130.0% | 0 | 1 | 0 | 0 | 13.88 | 3.52 | -1 |
| General Medicine | 26 | 29 | 1575 | 1389.5 | 185.5 | 88.2% | 1380 | 1527.5 | +147.5 | 110.7% | 1080 | 1057 | 23 | 97.9% | 1080 | 1448 | +368 | 134.1% | 0 | 2 | 1 | 0 | 3.48 | -0.28 | -1 |
| Haematology | 30 | 22 | 1545 | 1373 | 172 | 88.9% | 1035 | 948 | 87 | 91.6% | 975 | 802.5 | 172.5 | 82.3% | 690 | 678.5 | 11.5 | 98.3% | 0 | 0 | 0 | 0 | 0.03 | 2.48 | 0 |
| Cardiology | 32 | 31 | 1920 | 1852.35 | 67.65 | 96.5% | 1380 | 1247.9 | 132.1 | 90.4% | 1380 | 1345.5 | 34.5 | 97.5% | 1035 | 1012.45 | 22.55 | 97.8% | 0 | 0 | 0 | 0 | 0.04 | -0.07 | 1 |
| Cardiology | 33 & HAC | 29 | 1575 | 1483 | 92 | 94.2% | 1260 | 1157 | 103 | 91.8% | 1035 | 1023.5 | 11.5 | 98.9% | 1035 | 1092 | +57 | 105.5% | 0 | 1 | 0 | 0 | 0.06 | 1.28 | 2 |
| Gastro | 36 | 36 | 2063 | 1990.5 | 72.5 | 96.5% | 1380 | 1575 | +195 | 114.1% | 1380 | 1219 | 161 | 88.3% | 1155 | 1270 | +115 | 110.0% | 0 | 0 | 1 | 0 | 0.03 | 4.53 | 1 |
| Respiratory | 38 & LAU | 37 | 1428 | 1345.25 | 82.75 | 94.2% | 885 | 867.25 | 17.75 | 98.0% | 690 | 690 | 0 | 100.0% | 690 | 684 | 6 | 99.1% | 1 | 1 | 0 | 0 | 0.01 | -2.71 | 0 |
| Maternity | 53 | 38 | 1380 | 1345.5 | 34.5 | 97.5% | 690 | 690 | 0 | 100.0% | 1035 | 1023.5 | 11.5 | 98.9% | 690 | 655.5 | 34.5 | 95.0% | 0 | 0 | 0 | 0 | 0.05 | 5.66 | -6 |
| Gynaecology | 54 | 16 | 855 | 855 | 0 | 100.0% | 690 | 690 | 0 | 100.0% | 690 | 678.5 | 11.5 | 98.3% | 345 | 345 | 0 | 100.0% | 0 | 0 | 0 | 0 | 0.02 | 0.00 | -2 |
| General Medicine | AMU | 23 | 2070 | 1990.9 | 79.1 | 96.2% | 1725 | 1695.45 | 29.55 | 98.3% | 1567.5 | 1491.75 | 75.75 | 95.2% | 1395 | 1307.35 | 87.65 | 93.7% | 1 | 0 | 0 | 0 | 0.05 | 5.41 | -3 |
| General Medicine | MSSW | 21 | 1460.5 | 1380.95 | 79.55 | 80.1% | 1380 | 1379 | 1 | 99.9% | 1222.5 | 1002 | 220.5 | 82.0% | 1035 | 1041 | +6 | 100.6% | 0 | 0 | 0 | 0 | 0.05 | 5.41 | -3 |
| Emergency | EDRU | 11 | 690 | 684.25 | 5.75 | 99.2% | 345 | 333.5 | 11.5 | 96.7% | 532.5 | 567.25 | +34.75 | 106.5% | 345 | 345 | 0 | 100.0% | 0 | 0 | 0 | 0 | 0.19 | -1.67 | 0 |
| | Parksuite | 8 | 690 | 690 | 0 | 100.0% | 690 | 660.75 | 29.25 | 95.8% | 690 | 690 | 0 | 100.0% | 264.5 | 241.5 | 23 | 91.3% | 0 | 0 | 0 | 0 | 0 | -3.52 | 0 |
| Surgical Assessment | ESAU | 12 | 1170 | 1164.5 | 5.5 | 99.5% | 1035 | 1022.25 | 12.75 | 98.8% | 1035 | 966 | 69 | 93.3% | 690 | 713 | +23 | 103.3% | 0 | 0 | 0 | 0 | 0.13 | 3.38 | -3 |
| Critical Care | ITU | 12 | 3450 | 3240.75 | 209.25 | 93.9% | 345 | 310.5 | 34.5 | 90.0% | 3450 | 3162.5 | 287.5 | 91.7% | 345 | 299 | 46 | 86.7% | 0 | 2 | 0 | 0 | 4.91 | | -1 |
| Critical Care | HDU | 6 | 1380 | 1368.5 | 11.5 | 99.2% | 345 | 345 | 0 | 100.0% | 1380 | 1368.5 | 11.5 | 99.2% | 345 | 322 | 23 | 93.3% | 0 | 1 | 0 | 0 | 4.91 | 5.00 | -1.09 |
| Maternity | delivery suite | 10 | 2070 | 2070 | 0 | 100.0% | 345 | 345 | 0 | 100.0% | 2070 | 2070 | 0 | 100.0% | 345 | 402.5 | +57.5 | 116.7% | 0 | 0 | 0 | 0 | 0.17 | 5.66 | -6 |
| Neo Natal | Neonatal | 24 | | | | | | | | | | | | | | | 0 | | 0 | 0 | 0 | 0 | 0.02 | 1.33 | 1 |
| Children's | childrens | 28 | 1725 | 1495.5 | 229.5 | 86.7% | 345 | 462.5 | +117.5 | 134.1% | 1380 | 1230 | 150 | 89.1% | 345 | 471.5 | +126.5 | 136.7% | 0 | 0 | 0 | 0 | 0.03 | -0.30 | 0 |
| Orthopaedics | M1 | 20 | 1387.5 | 1100.25 | 287.25 | 79.3% | 877.5 | 688.5 | 189 | 78.5% | 690 | 690 | 0 | 100.0% | 345 | 241.5 | 103.5 | 70.0% | 0 | 0 | 0 | 0 | 0.04 | 2.26 | 2 |
| General Surgery | M2 | 6 | 207 | 207 | 0 | 100.0% | 207 | 207 | 0 | 100.0% | 161 | 161 | 0 | 100.0% | 161 | 161 | 0 | 100.0% | 0 | 0 | 0 | 0 | 0 | | |
| DME | CRC | 30 | 1395 | 1277.95 | 117.05 | 91.6% | 1867.5 | 1856 | 11.5 | 99.4% | 690 | 690 | 0 | 100.0% | 1035 | 1115.5 | +80.5 | 107.8% | 1 | 2 | 0 | 0 | 0.24 | 0.11 | 0 |
| Neuro & Rehabilitation | M2 Rehab | 20 | 1303 | 1261.75 | 41.25 | 96.8% | 885 | 857 | 28 | 96.8% | 690 | 690 | 0 | 100.0% | 690 | 690 | 0 | 100.0% | 0 | 0 | 0 | 0 | 6.19 | 0.39 | -2 |
| Dermatology | Dermatology | 12 | 690 | 690 | 0 | 100.0% | 690 | 690 | 0 | 100.0% | 345 | 345 | 0 | 100.0% | 345 | 345 | 0 | 100.0% | 0 | 0 | 0 | 0 | 0.03 | 0.77 | 0 |
| Geriatric Medicine | 25 | 30 | 900 | 736 | 164 | 81.8% | 675 | 656 | 19 | 97.2% | 675 | 640.5 | 34.5 | 94.9% | 1035 | 885.5 | 149.5 | 85.6% | 0 | 2 | 0 | 0 | | 0.90 | -2 |
| Cardiology | CCU | 8 | 690 | 690 | 0 | 100.0% | 225 | 225 | 0 | 100.0% | 690 | 690 | 0 | 100.0% | 225 | 225 | 0 | 100.0% | 0 | 0 | 0 | 0 | | 0.00 | 0 |
| Respiratory | 37 | 8 | 669.5 | 669.5 | 0 | 100.0% | 345 | 345 | 0 | 100.0% | 345 | 345 | 0 | 100.0% | 345 | 345 | 0 | 100.0% | 0 | 0 | 0 | 0 | 0.01 | 0.00 | 0 |
| **Totals** | | | | | | | | | | | | | | | | | | | | | | | | | |

| Overall Staffing Hour totals (Rounded to the nearest hour) | Fill Rate | | Total Planned Hours | | Total Actual Hours | | Variance | |
|---|---|---|---|---|---|---|---|---|

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

| BOARD OF DIRECTORS | |
|---|---|
| **Agenda Item** | 7.3 |
| **Title of Report** | Nursing and Midwifery Strategy 2016-2018 Update Report |
| **Date of Meeting** | 27 January 2016 |
| **Author** | Clare Pratt, Deputy Director of Nursing<br>Julie Reid, Associate Director of Nursing M&A<br>Naomi Holder, Associate Director of Nursing SW&C |
| **Accountable Executive** | Gaynor Westray, Director of Nursing and Midwifery |
| **BAF References**<br>• **Strategic Objective**<br>• **Key Measure**<br>• **Principal Risk** | 1A, 2799, 2798<br>1B, 1908, 1909<br>3A, 2837, 2611<br>3B, 2799, 2837, 2798<br>7A, 2798 |
| **Level of Assurance**<br>• **Positive**<br>• **Gap(s)** | Positive<br>The Nursing and Midwifery Strategy is well embedded in the Trust and provides a framework for safe effective nursing and midwifery care |
| **Purpose of the Paper**<br>• **Discussion**<br>• **Approval**<br>• **To Note** | The Board of Directors are asked to discuss the report and note the update |
| **Data Quality Rating** | Bronze – qualitative data |
| **FOI status** | Document may be disclosed in full |
| **Equality Impact Assessment Undertaken** | No |

## 1. Executive Summary

In February 2016 the new Director of Nursing and midwifery delivered her revised Nursing and Midwifery Strategy 2016-2018.

This was formally launched during International Nurses Day on 12 May 2016 and has been delivered to all clinical areas and is issued to all newly appointed nurses and midwives during their induction period.

This paper updates the Board of Directors on progress made against the 5 patient focused actions contained within the strategy.

| Patient Focused Action | Developments |
|---|---|
| Patient focused values and behaviours | • Grow Your Own: The Trust has had an apprenticeship programme for 4 years and has seen this year that 3 apprentices have developed and progressed to professional roles with one entering the School of Midwifery and two going to the School of Nursing<br>• Maternity Culture Review demonstrated good overall culture. Pocket of concern is currently being addressed through engagement events<br>• Listening into Action (LiA) events with a focus on behaviours are scheduled across the Divisions |
| Patient focused population health and wellbeing | • ½ day resilience training is designed to support leaders/managers in understanding how resilient they are to challenge and change and the impact of their behaviours<br>• M-page introduced to support documentation of ongoing nurse led patient wellbeing discussions<br>• Patient helpline has been introduced to ensure that concerns re care can be actioned in a timely manner<br>• Matrons surgeries have been introduced and to support improvement in communication and patient wellbeing<br>• Planning is underway to open a Patient Information and Advice Hub to allow patients and staff to access information and advice in one central place<br>• A steering group has been established to implement "Making Every Contact Count" which is an NHS England project centered on health promotion<br>• Introduction of Text Message for Friends and Family Test (FFT) in the Emergency Department has allowed for patients to leave comments which are fed back to the department to drive improvements<br>• A review of Accessibility Standards has commenced to ensure that we make our services accessible for all through appropriate recording and relaying of information<br>• Enhanced integrated working with community partners is enabling us to develop systems that will support improvements in the Equality and Diversity agenda |
| Patient focused safe and effective nursing and midwifery care | • Corporate Matron for Patient Safety, Quality and Experience has been appointed with the remit to support clinical staff to implement service improvements to enhance patient care and to take lead responsibility for Medications Management<br>• The Ward Audit process has been reviewed to allow for a greater emphasis on supporting development through an Accreditation process. In future Wards will be rated as BRONZE, SILVER and GOLD. Where a ward scores BRONZE focused support will be provided with an expectation of an improvement within 1 month<br>• Ward 30 was rated as GOLD in their recent accreditation and received a certificate from the Chairman and Director of Nursing and Midwifery<br>• Shared learning from never event is embedded across the Divisions<br>• Close review of medication errors/near misses through Medication Safety Group<br>• Palliative and End of Life Care Strategy has been redeveloped and launched along with a newly developed record of care |

| | |
|---|---|
| Patient focused nursing and midwifery staffing | • There has been investment in maternity staffing to increase compliance with recommendations from Birthrate Plus including the introduction of the Maternity Support Worker<br>• Strengthening of the midwifery management structure has allowed for greater emphasis on ensuring good quality care is consistently delivered<br>• Increase in neonatal establishment in response to sustained increase in occupancy<br>• Full establishment reviews against national guidance and acuity data<br>• Successful bid for Trainee Assistant Practitioner roles in theatres (commencing September 2016)<br>• Successful transfer to collection of Care Hours per Patient Day to ensure staffing levels are appropriately monitored and reported |
| Patient focused nursing and midwifery management and leadership | • Two-day Middle Managers Leadership programme run every month for Band 6-7 leaders, focused on clinical staff, to enhance:<br>  • Leadership styles and behaviours<br>  • Coaching<br>  • Communication<br>  • Mindfulness<br>• One-day Coaching Skills for Leaders to embed a coaching approach to leadership with emphasis on:<br>  • Corridor coaching as a way of being<br>  • Empowering staff to problem solve<br>  • Coaching approach to all conversations<br>• Neonatal matron seconded for 1 day per week to the regional network to lead on the vanguard project<br>• A Critical Care Matron has been successfully recruited to support patient focused care<br>• #PROUDTHAT…. theme for Nurses Day 2016 helped promote best practice across all areas |

**Monitoring the Impact of the Trust Nursing & Midwifery Strategy**

The fundamental standards of nursing care are audited through the Nursing and Midwifery audit processes. The Care Quality Commission (CQC) Fundamental Standards were launched in early 2015. The Nursing & Midwifery Strategy was reviewed in February 2016 as part of the portfolio of the Deputy Director of Nursing. It was confirmed by the Senior Nurse & Midwifery Team (SNMT) that all nursing and midwifery elements of the CQC compliance requirements are covered in the Strategy and that there is a framework for evidencing this. The review by the Deputy Director of Nursing is complete and was presented to the Clinical Governance Group on 15 January 2016.The revised approach will be a “Proud to Care: Accreditation Programme.”

The outcomes for nursing and midwifery are captured in the Director of Nursing & Midwifery’s quarterly reports to the Quality & Safety Committee; monthly reports and a six monthly report on nurse staffing are presented to the Board of Directors. The report covers: Nursing & Midwifery CQUINS; pressure ulcer prevention; reduction in falls and falls with serious harm; venous thrombo-embolous assessment (VTE); urinary catheter associated infections; compliance with Modified Early Warning Score (MEWS) assessment and Malnutrition Universal Screening Tool (MUST) with associated measures such as access to a jug and glass and patient experience of eating and drinking. There is evidence of sustained improvement in all domains.

## 2. Conclusion

Substantial progress continues to be made on delivering the strategy by the nursing and midwifery workforce. Quarterly performance reports are presented to the Quality and Safety Committee that demonstrate the impact of the strategy on the nursing and midwifery workforce and on outcomes for patients and their experience. The Strategy provides a framework for nursing and midwifery care and professionalism in the Trust.

## 3. Recommendations

The Board of Directors are asked to discuss the report, and note the update.

| Trust Board | |
|---|---|
| **Agenda Item** | 7.4 |
| **Title of Report:** | Health & Safety Annual Report |
| **Date of Meeting:** | 27 July 2016 |
| **Author:** | Peter Bohan, Head of Organisational Health & Effectiveness<br>Andre Haynes Health & Safety manager |
| **Accountable Executive:** | James Mawrey Director of Workforce |
| **BAF References**<br>• **Strategic Objective**<br>• **Key Measure**<br>• **Principal Risk** | 7D. Failure to comply with health and safety legislation due to limited finances and capacity could lead to harm of both patients and staff as well as the Trust facing prosecution. |
| **Level of Assurance**<br>• **Positive**<br>• **Gap(s)** | Gaps in assurance to be added to the risk register. |
| **Purpose of the Paper**<br>• **Discussion**<br>• **Approval**<br>• **To Note** | For Noting |
| **Data Quality Rating** | Bronze - qualitative data |
| **FOI status** | Document may be disclosed in full |
| **Equality Impact Assessment Undertaken**<br>• **Yes**<br>• **No** | No |

## Executive Summary

1. The Health & Safety (H&S), 2015-16 annual report covers the period 1st April, 2015 to the 31st March 2016. The report aims to give the Trust Board an overview of how the Trust is performing against Health & Safety requirements for 2015-2016. The report shows that the Trust can be satisfied that the areas of concern identified are being effectively managed and are not unique to this organisation.

2. In 2015 / 2016 Merseyside Internal Audit undertook a comprehensive review of the Trust Health & Safety compliance. There was significant assurance that the safety management systems provide the Trust with sufficient information regarding Health & Safety performance within the Trust.

3. Of the 52 actions against the Health & Safety 2015-2016 project plan (reported to the Board), all have been completed (note comment in later section about the refreshed Asbestos Management plan).

4. The Trust has seen an increase in the numbers of staffing (Clinical) incident reported. Whilst it is positive that more cases are being reported (and therefore action taken) the Trust has pulled together a work programme to ensure that any emerging themes are quickly responded to and actions put in place. Details of this work have been reported to the Quality and Safety Committee on the 13 July 2016.

5. There were a total of 32 incidents reported to the Health & Safety Executive (HSE) in accordance with Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) in 2015 – 2016. This compares to 40 incidents that were reported to the Health & Safety Executive (HSE) in accordance with RIDDOR in 2014 – 2015. All RIDDOR reportable incidents were subject to a full Root Cause Analysis investigation and recommendations are made where failings are identified or where improvements are required

6. The Health & Safety project plan has been developed for the next 12 months to ensure that the organisation further develops in this key statutory function. This plan will be monitored at the Health & Safety Partnership Team and Workforce & Communication Group. The Quality and Safety Committee will continue to receive quarterly Health & Safety reports and progress against this plan will be included.

7. The Trust Board is asked to:

   a) Note the contents of the report
   b) Highlight and specific additional assurance requirements for Health & Safety purposes.

**Background**

1. The Health & Safety Partnership Team is established to plan, organise and monitor organisational compliance with its statutory Health & Safety obligations and duties. The role of the Health & Safety Partnership Team is to ensure compliance with external body requirements such as the Health and Safety Executive (HSE), Department of Health, Environmental Health and the Care Quality Commission (CQC).

2. The Health & Safety Partnership Team identifies and addresses matters which require action. This Group reports to the Workforce & Communication Group and then up through to the Quality & Safety Committee.

3. The overall aim and purpose of the Health and Safety Partnership Team is:

   - To ensure continued and effective Health & Safety management arrangements

- To ensure the Trust can demonstrate compliance with Health & Safety legislation and other statutory and mandatory estates related standards
- To ensure the provision of a safe environment for staff, patients, visitors and others.
- To ensure the Trust has effective Occupational Health & Safety processes and systems
- To develop procedures necessary to carry out the committees functions, taking into account the requirements of the Health and Safety at Work etc. Act 1974
- Review Health & Safety functions within the Divisions.
- Receive reports of investigations of accidents, non-clinical incidents, near miss and dangerous occurrences and occupational ill-health episodes, monitor trends and action plan compliance and make recommendations to reduce and prevent such events from re-occurrence and put in place measures for reduction and prevention.

**Key Issues**

1. In 2015 / 2016 Merseyside Internal Audit undertook a comprehensive review of the Trust Health & Safety compliance. There was significant assurance that the safety management systems provide the Trust with sufficient information regarding Health & Safety performance within the Trust.

2. The HSE has visited the Trust on two occasions this year one to review micropathology arrangements for their Containment Level 3 Laboratory and the other to investigate a lift incident at Arrowe Park Hospital. Following their visit of the Micropathology service several recommendations were made by the HSE which related to the handling and processing of hazard group 3 (HG3) biological agents. The manager of Micropathology services developed an action plan to address the issues identified by the HSE and all actions have now been completed. In terms of the lift investigation, the HSE were satisfied that the WUTH has appropriate arrangements in place as to ensure full compliance with requirements of the Lifting Operations and Lifting Equipment Regulations in relation, inspecting, servicing and maintaining of goods and passenger lifts.

3. The Trust Health & Safety Team have been made aware that a new International Health and Safety Standard is being proposed for later this year. The International Organisation for Standardisation has released it in draft form ISO 45001 and it will be the first ever internationally agreed Health & Safety standard which will apply globally. In terms of Health & Safety assurance standards this new ISO 45001 will be one of the most important new benchmarks for Health & Safety in recent times. Having reviewed the draft format of this, ISO/DIS 45001, the Team are monitoring its process and will be matching the Trusts standards with this to ensure that we are at the forefront of Health & Safety compliance and to pursue future accreditation to this standard.

4. Of the 52 actions against the Health & Safety 2015-2016 project plan (reported to the Board), all have been completed (note comment in later section about the refreshed Asbestos Management Plan for Arrowe Park Hospital).

5. The Health & Safety project plan has been developed for the next 12 months to ensure that the organisation further develops in this key statutory function. The Health & safety Project Plan 2016-17 focuses on a range of areas including the following key areas;

asbestos management, stress management, sharps safety, policy review, compliance audits, Health & Safety training for managers, and access to comprehensive Health & Safety information on the intranet. This plan which is currently ahead of schedule will be monitored at the Health & Safety Partnership Team and Workforce & Communication Group.

6. Mandatory Health and Safety training compliance in the financial year 2015-16 achieved a level of 90.49% which is below the target for compliance of 95%. All Divisions are required to develop action plans describing how their respective Divisions will ensure the KPI for 2016-17 is achieved. This is being monitored by the Workforce & Communication Group.

7. The number of staff attending Mandatory Level 2 Corporate Manslaughter training has been identified as a concern. This is being monitored by the Workforce & Communication Group.

8. The flu plan resulted in the highest percentage of frontline staff being vaccinated in the Trusts history achieving 79.2%. The target was achieved ahead of nationally determined timescales and is an extremely positive result, in particular when considering that both nationally and regionally there was a general reduction in numbers of people coming forward to be vaccinated.

9. The Occupational Health service has now achieved accreditation based on the Safe Effective Quality Occupational Health Standards (SEQOSH). These standards serve to ensure that providers, purchasers and workers understand the standards that they should expect from an OH Service. Eligibility for the award of SEQOHS Accreditation has been assessed on the basis of the collection and presentation of suitable documentary evidence which included 400 pieces of evidence and on observation with a full days assessment.

10. To support staff with all elements of wellbeing agenda a week-long event was held on the 9th - 13th of May 2016. This event included advice and guidance on mental and physical health, smoking cessation, weight management, alcohol and drug awareness, musculoskeletal disorders and keeping fit for work. A further wellbeing event was held on the 25th of Feb which focused on “mind matters” and a “mocktails on the terrace” event was held in July 2015 .

11. Mindfulness sessions are now being provided to staff out of hours with 45 staff members attending on a weekly basis; supporting staff to manage stress more effectively.

12. An in-depth analysis into injuries and near misses relating to clinical sharps was undertaken in June 2016 and a total of 8 actions were identified to assist with a reduction of these types of incidents and progress against these recommended actions will be monitored at the H&SPG and through the risk register. The findings of this analysis were discussed at the Quality and Safety Committee on the 13 July 2016.

13. A sharps awareness campaign was held on the 28th of August 2015 and 10th May 2016 in order to highlight the importance of local risk assessments for using and disposing of

sharps safely. Wherever clinically possible it is recommended to use a sharps safety device in order to eliminate or reduce the risk of injury.

**Employee Incidents**

1. There were a total of 1972 incidents reported in 2015-16 compared with a total of 1719 reported in 2014-15, equating to an increase of 253 incidents.

2. The top five non-clinical incidents reported in 2015-16 related to:-

   a. Staffing issues
   In 2015-16 there were a total of 676 Staffing clinical incidents reported compared to 417 reported in 2014-15. The main trend in the Staffing (Clinical) category related to inappropriate numbers of staff on a ward or an inappropriate level of skill mix. Often these incidents occurred due to staff on a ward being moved to another ward during a shift. Staff reported being under increased pressure, being upset as they are not able to provide appropriate care to patients and working long shifts without a break.

   b. Disruptive / aggressive behaviour incidents
   In 2015-16 there were a total of 415 disruptive / aggressive behaviour type incidents reported, compared with 365 reported in 2014-15. Of the total of 415 Disruptive / Aggressive incidents reported in 2015-16, one required reporting to the Health & Safety Executive in accordance with the Reporting of Injuries Diseases and Dangerous Occurrences Regulations; resulting in 30 days lost as a result of the assault.

   c. Security incidents
   In 2015-16 there were a total of 178 security incidents reported, compared with 166 reported in 2014-15. This represents a slight increase of 12. None of the security-related incidents were reported to the Health & Safety Executive. The main trends within this category related to patient's property being reported as lost missing or stolen and included dentures, cash, jewellery and other valuables.

   d. Slips / Trips / Falls
   In 2015-16 there were a total of 102 slips trips and falls incidents reported, compared with a total of 79 reported in 2014-15. The main trends within this category relate to incidents occurring as a result of contamination of the floor surface, falls as a result of a defect to the floor surface, falls from chairs and falls occurring on a level surface where no contamination was present on the floor surface. Of the total 102 reported in 2015-16, 14 were reported to the HSE in accordance with the Reporting of Injuries Diseases and Dangerous Occurrences Regulations in 2013 resulting in 720 days lost. It is of note that one absence alone resulted in a total 217 days lost.

e. Incidents involving clinical sharps

In 2015-16 there were a total of 100 Sharps Clinical incidents reported, compared with 84 incidents reported in 2014-15. Of the 100 reported in 2015-16, there were two clinical sharp incidents that were reported to the Health & Safety Executive in accordance with the Reporting of Injuries Diseases and Dangerous Occurrences Regulations. Neither event resulted in any absence however both were subject to a full root cause analysis. The main trends within this category involved sharps injuries to the user of the clinical sharp (37), improper disposal of a clinical sharps but no injury (46) and 6 needlestick injuries which occurred as a result of the clinical sharp being incorrectly disposed of all of which were subject to an RCA. A sharps awareness campaign was held on the 28th of August 2015 and 10th May, 2016 in order to highlight the importance of local risk assessments for using and disposing of sharps safely and wherever clinically possible to use a sharps safety device in order to eliminate or reduce the risk of injury.

3. There was an increase in the number of 223 very low graded incidents reported in 2015-16 where a total of 1604 were reported, compared with 1381 very low graded incidents reported in 2014-15.

4. There has been a decrease in the number of moderate graded incidents where in 2015-16 a total of 26 were reported compared with 28 reported in 2014-15. All 26 incidents were subject to a full Root Cause Analysis.

**Incident Reporting RIDDOR**

1. There were a total of 32 incidents reported to the Health & Safety Executive (HSE) in accordance with RIDDOR in 2015 – 2016. This compares to 40 incidents that were reported to the Health & Safety Executive (HSE) in accordance with RIDDOR in 2014 – 2015. The RIDDOR incidents have been clustered in the themes below:-

    a. 10 occurred as a result of manual handling
    b. 14 occurred as a result of a slip trip or fall
    c. 3 occurred as a result of a person being struck by a moving object
    d. 2 occurred as a result of a used clinical sharp being incorrectly disposed of
    e. 1 occurred as a result of a physical assault
    f. 1 occurred as a result of exposure to diesel fumes
    g. 1 occurred as a result of exposure to hot liquid

2. All RIDDOR reportable incidents were subject to a full Root Cause Analysis investigation and recommendations are made where failings are identified or where improvements are required

**Health and Safety Training**

1. Since the last report the Health & Safety Team have delivered a number of training lectures on subjects such as Health & Safety, Moving & Handling as well as the more

tailored training depending on the professional area and target audience. In addition to these lectures the team delivered practical training sessions on safer patient handling. These sessions supported new and existing staff including radiology students from the University of Liverpool and our new colleagues from Spain, Portugal and other areas of the European Union. See information below:

| Training description | Number of sessions | Duration of each session | Total delivery Time |
|---|---|---|---|
| Induction Presentation - Health and Safety | 20 | 0.5 hrs | 10 hrs |
| Induction Presentation – Moving & Handling | 20 | 0.5 hrs | 10 hrs |
| Induction practical-People Handling | 22 | 7.5 hrs | 165 hrs |
| Mandatory Training Presentation – Manual Handling | 37 | 0.25 hrs | 9.25 hrs |
| Mandatory Training – People Handling , practical | 68 | 1.5 hrs | 102 hrs |
| EU nurses inductions – Theory and practical | 4 | 7.5 hrs | 30 hrs |
| Theatres staff manual handling | 2 | 4 hrs | 8 hrs |
| Junior Doctors- Health & Safety and Manual Handling | 1 | 1 hr | 1 hr |
| Stress Management Training | 3 | 2 hrs | 6 hrs |
| Corporate Manslaughter Training | 3 | 2 hrs | 6 hrs |
| St Johns Hospice | 6 | 2 hrs | 12 hrs |
| **Total** | **184** | | **359.25 hrs** |

2. These figures listed represent training sessions delivered by the Health & Safety team, not necessarily the number of training sessions made available. Attendance figures and capacity of training are monitored and reported on by the Learning & Development Team.

**Health & Safety Audits**

1. A recently reviewed Health & Safety Framework audit tool has been developed by the Health & Safety team which reflects HSE guidance. The audit process involves splitting key areas of risk into the following four categories:-

   - Health and Safety Management to include:- Risk Assessments, Workplace Inspections, Fire Safety Management, Incident Reporting, Contingency Plans, Host Employer Premises, CDM

   - Premises Management to include:- Asbestos, Legionella, Gas Safety, Security Management

   - People Management to include:- New and Expectant Mothers, First Aid, Young People, Inoculation Incidents, Control of Visitors and Contractors, lone worker, Stress, Health and Safety Induction, Slips, Trips and Falls

   - Activity to include:- COSHH, DSE, Work at Height, Provision and Use of Work Equipment, Lifting Equipment, Radiation, Manual Handling, Personal Protective Equipment, Electricity and Confined Spaces.

2. The Health & Safety team have recently developed two further audit tools which focus specifically on manual handling and stress management. Key services areas identified as high risk through trends analysis are targeted with recommendations made following the audit process monitored by the Health & Safety Partnership Team meetings until all recommendations are completed.

3. The overall results of the audits carried out in 2015-16 have indicated positive results and where systems require improving a specific action plan is developed for the service area. The areas of non-compliance are addressed with recommendations made following the audit. This is monitored at the Health & Safety Partnership Group.

**Health & Safety Key Issues / Update**

1. The main regulatory updates in 2015-16 arose out of several consultations and audits that commenced during the reporting period. These are:

   a) The workplace transport risks particularly in the delivery area at Arrowe Park Hospital have now been reviewed. All actions in relation to this risk have been completed.

   b) The Trust is fully aware of its responsibilities as a Duty Holder, under the Control of Asbestos at Work Regulations, 2012 (CAW) and the Trust policy reflects key stakeholders duties, responsibilities, arrangements and processes for ensuring asbestos is managed appropriately within our organisation. The regulations require all areas of the Trust to have a survey undertaken to assess the condition of an asbestos containing material (ACM), clearly define a process to manage the asbestos, train staff to identify different types of asbestos, advice staff and inform contractors of the location and condition of ACM's. The following matters should be noted:-

- A comprehensive survey was undertaken at the Clatterbridge site in December 2013, the high risk asbestos identified through the survey has been removed. A rolling plan is in place to remove, or make safe all residual low risk asbestos at the Clatterbridge site.

- Based on the findings of the work at Clatterbridge, the advice of our competent contractor and a proactive desktop asbestos review of the asbestos register, it has been identified that there is risk that the current Arrowe Park Hospital asbestos register may not fully comply with the 2012 Asbestos Regulations. On this basis the competent contractor has recommended a re-survey of the site. This work has been prioritised in the 2016/17 backlog maintenance programme and tenders for this survey were dispatched early July with a return date of 1st August 2016, once assessed the contract will be awarded no later than 1st September 2016. The Arrowe Park Asbestos Management Plan is being led by the Estates Department (risk noted on risk register) which will be reviewed at the Health & Safety Partnership Team and matters will of course be escalated to the Trust Senior Management Team as appropriate. The Health & Safety Manager has recently completed the P405 Management of Asbestos in Buildings Course so as to assist Estates further with advice and support to manage asbestos safely and appropriately within the Trust.

c) The Water Safety Policy is being reviewed to provide assurance that suitable controls are in place for legionella and pseudomonas meeting the Department of Health's HTM 04-01 guidelines. The Policy is being monitored via the trust water safety group and escalated through the risk register system. Resources and funding were made available following an external review by Clearwater have assisted with the pro-active management of legionella and pseudomonas within the Trust with high risk areas being addressed by the removal of known dead legs, proactive management processes and implementation of new software to record and monitor the regular flushing and temperature testing of water outlets.

d) Stress is still a concern with a significant number of stress related absences being evidenced in attendance data. The 2015 NHS Staff Survey does note though that the Trust benchmark's positively in this area. The Trust has developed a stress task and finish group to monitor trends, analyse audit findings and other indicators including sickness absence data. This involves close working with HR/OD, Health & Safety Team and the Occupational health Team and other key stakeholders to identify root cases and action required to reduce the sickness absence due to stress and other work related absences. Audits of areas highlighted as hotspots for stress are undertaken and the Health & Safety team have supported the development of several departmental stress risk assessments. The Health & Safety team have recently developed a non-work related stress management risk assessment proforma which will assist managers to support staff who are dealing with external stressors which impact on their work activities.

## Conclusion & Summary

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

## Recommendations

1. The Trust Board is asked to:

    - Note the details of the Report
    - Highlight any specific additional assurance / information required

| BOARD OF DIRECTORS | |
|---|---|
| **Agenda Item** | 7.5 |
| **Title of Report** | Safeguarding Annual Report 2015-2016 |
| **Date of Meeting** | 27 July 2016 |
| **Author** | Susan Fogarty, Head of Safeguarding/Named Nurse |
| **Accountable Executive** | Gaynor Westray, Director of Nursing and Midwifery |
| **BAF References**<br>**Strategic Objective**<br>**Key Measure**<br>**Principal Risk** | 1<br>1b<br>7d |
| **Level of Assurance**<br>**Positive**<br>**Gap(s)** | Positive – Safeguarding Strategy; Compliance with C.C.G. self-assessment framework, Merseyside Internal Audit Assessment<br>Gaps: Update of safeguarding training to ensure compliance with RPCH (2014) |
| **Purpose of the Paper**<br>**Discussion**<br>**Approval**<br>**To Note** | Discussion and approval |
| **Data Quality Rating** | Silver |
| **FOI status** | Document may be disclosed in full |
| **Equality Impact Assessment Undertaken**<br>**Yes**<br>**No** | No |

## 1. Executive Summary

The purpose of this report is to provide the Board of Directors with an annual review of the work undertaken in 2015-2016 and provide assurance in relation to safeguarding children and young people (including Looked After Children) and adults at risk.

The report will focus on how the responsibilities of the Trust have been met, an overview of the work undertaken and identify key objectives for 2016-2017. In particular it provides assurance on how the organisation has fulfilled its statutory duties and responsibilities to ensure its functions are discharged and account has been taken of below legislation:

- Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (NHS England July 2015)
- Working Together to Safeguard Children (HM Government March 2015)
- Promoting the health and well-being of looked-after children Statutory guidance for local authorities, clinical commissioning groups and NHS England (March 2015)
- Section 11 Children Act 1989 (2004)
- The Care Act 2014 (DOH 2014)
- Mental Capacity Act 2005: Code of Practice (Department for Constitutional Affairs 2007) Department of Health Guidance: Response to the Supreme Court Judgment/ Deprivation of Liberty Safeguards (October 2015)
- The NHS Outcomes Framework 2015/16 (December 2014)
- The policies and procedures of the Local Safeguarding Children Board (LSCB) and the Local Safeguarding Adults Board (LSAB).
- Compassion In Practice (NHS England 2013)
- Regulation 5: Fit and proper persons: directors and Regulation 20: Duty of candour Guidance for NHS bodies (Care Quality Commission, November 2014)
- RPCPH:Safeguarding children and young people: roles and competencies for health care staff. Intercollegiate Document (2014)
- Safeguarding Adults: roles and competencies for health care staff – Intercollegiate Document (2016)

This annual report provides assurance that Wirral University Teaching Hospital is committed to provision of the highest standards and effective patient care which in relation to safeguarding requires the Trust to provide a safe environment and be protected from harm.

Safeguarding is a shared responsibility with the need for effective joint working between partner agencies and professionals that have different roles. In order to achieve effective joint working there must be constructive relationships at all levels, promoted and supported by:

- The commitment of senior managers and board members to safeguarding children and adults at risk
- Clear lines of accountability within the organisation for work on safeguarding
- Service developments that take account of the need to safeguard all service users, and is informed, where appropriate, by the views of service users
- Safeguarding training and continuing professional development so that staff have an understanding of their roles and responsibilities, and those of other professionals and organisations in relation to children, adults and looked after children
- Safe working practices including recruitment and vetting procedures
- Effective interagency working, including effective information sharing

## 2. Introduction

Safeguarding children and adults at risk is core to the business of Wirral University Teaching Hospital and is embedded in the Trust Nursing and Midwifery Strategy 2013-2018.

As outlined in the Safeguarding Strategy 2015-2017 launched in July 2015 “Safeguarding is everyone’s responsibility” and reflects the “One chance Rule is embedded in all divisions across the Trust.

The key priorities and objectives are:

- Mainstreaming Safeguarding to support excellence
- Effective safeguarding, leadership, structure and processes
- Learning and improvement through experience and partnership

- Continuing the development of a caring, safe and effective workforce
- Engaging with service users and external agencies

A copy of the strategy is uploaded onto the Safeguarding web page for all Trust staff. The strategy summarised the key priorities and objectives for the Safeguarding Team and these actions are taken forward as part of an action plan which is being monitored by the Safeguarding Strategic Team.

The appointment of a new Director of Nursing & Midwifery at Wirral University Teaching Hospital following the predecessor's retirement in February 2016 is also the Executive Lead for Safeguarding.

The structure provides clear lines of accountability and governance within the Trust. In addition the Safeguarding Strategic Team, which reports into the Clinical Governance Group, provides external scrutiny from the Designated Professionals to whom the Trust provides evidence of compliance within the statutory and contractual framework. This provides assurance for Safeguarding Children and Adults at Risk.

As part of Commissioned Services Standards for Safeguarding Children and Adults at Risk, the requirements upon health are enshrined in statute within the children's services. The Children Act (2004) provides the legislative framework for safeguarding children. Section 11 and 13 of the Children Act (2004) states that the Trust has a duty to safeguard and promote the welfare of children and to be members of the Local Safeguarding Children Board. This is supported by Working Together to Safeguard Children (2015) which provides the guidance for the roles and responsibilities of all agencies, including Health, in ensuring their functions are fulfilled with regard to the need to safeguard and promote the welfare of children and young people.

The legislative framework for Safeguarding Adults is enshrined in the Care Act (2014). The Care Act puts adult safeguarding on a legal platform and came into force on the 1st April 2015.

The Section 11 audit and Safeguarding Assurance Framework are submitted to the Local Authority and Designated Nurses within the Wirral Clinical Commissioning Group. The Trust has to provide the following evidence:

- Demonstrate that they are meeting regulatory requirements in order to register with Care Quality Commission and then continue to deliver regulated services, inclusive of the Fundamental Standards on Safeguarding from Abuse : fit and proper Staff: and Duty of Candour

- Demonstrate that they have safeguarding leadership and commitment at all levels of their organisation. Demonstrate engagement in the local accountability and assurance structures, in particular via the Local Safeguarding Children Boards & Safeguarding Adults Board and NHS Wirral Clinical Commissioning Group

- Demonstrate they have effective arrangements in place to safeguard vulnerable children and adults and to assure themselves, regulators and their commissioners that these are working

- Demonstrate they promote provision of high quality care

- Demonstrate they treat and care for children, young people and adults at risk in a safe environment protecting them from avoidable harm

- Demonstrate they ensure effective responses where harm or abuse occurs through inter agency safeguarding policies and procedures within the provider organisation

- Demonstrate that they support the responsible local authority to fulfil their corporate parenting role when treating and caring for a child looked after

The Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework was updated and published in June 2015 replacing previous 2013 guidance. The framework clearly states safeguarding roles, duties and responsibilities particularly recognising the responsibilities of the Care Act 2014 that came into force in April 2015.

The framework aims to provide guidance and minimum standards to ensure effective arrangements are provided to protect individuals from harm caused by abuse or neglect regardless of their circumstances. The wider context of safeguarding continues to change in response to findings, such as the Francis Report and Lampard Report which was directed following Lessons Learned - Saville investigation.

Nationally and locally Child Sexual Exploitation (CSE) is a growing concern. The Trust alongside other strategic partners has a clear determination and ambition to prevent child sexual exploitation. The approach of the partnership, co-ordinated by the LSCB, has been to focus on preventative work and awareness raising, which has resulted in a comprehensive range of training. The Trust has guidance in relation to CSE on the Trust intranet with key local policies, referral pathways and e-learning guidance.

Further to the Independent Inquiry into Child Sexual Exploitation by Justice Goddard and Lessons Learned from the Bradbury Investigation, the Trust is currently ensuring that it meets the required standard in relation to storage of health records, policies and procedures are robust as recommended by NHS England.

In 2011 the Government published the third version of the United Kingdom's Counter-terrorism strategy - CONTEST. Health is involved in the fourth aspect PREVENT, which looks at identifying and supporting individuals who may be vulnerable and at risk of radicalisation before they become radicalised. The Trust have two PREVENT leads who have undertaken training and a completed training needs analysis and have added the PREVENT to mandatory training within the Trust.

The professional awareness in relation to Domestic Abuse and changes in legislation has resulted in an increase in high risk cases discussed at the Multi Agency Risk Assessment Committee (MARAC).

The Mental Capacity Act (MCA) and the Deprivation of Liberty (DOLS) agenda have also come under the spotlight in line with the Care Act.

The safeguarding agenda is no longer divided into Children and Adults; therefore this requires the Safeguarding Teams to work in a more integrated way. Safeguarding continues to be addressed under one combined agenda following a 'Think Family' approach, underpinned by the principles of the 6 C's. Within WUTH we have adopted this approach of "Think Family" specifically in regard to training.

During this past year, the Trust has seen many challenges and change across other partner agencies. Safeguarding activity continues to highlight a year on year increase. For example, in the complexity of referrals to social care for both adults and children; a greater number of children are subject to a Child Protection Plan or Care Proceedings.

Maintaining the consistency and quality of all aspects of safeguarding practice across the Trust has been essential during this challenging period. Over the past year the safeguarding arrangements within all areas of the Trust have continued to be strengthened, with a particular focus on ensuring our staff receive an appropriate level of safeguarding training and are competent to undertake their safeguarding roles.

The report will cover how the Trust has responded to safeguarding agenda at a Trust Wide level and then focus on how the Trust has implemented its statutory functions.

## 2.0 Trust Wide Response

### 2.1 Safeguarding Leadership and Accountability

Section 11 of the Children Act 2004 outlines the requirement for a clear line of accountability within NHS organisations in respect of safeguarding and promoting the welfare of children and young people. The NHS Safeguarding and Accountability Assurance Framework support this requirement and extend it to include adults at Risk.

The Board has an identified Executive Director who leads on Safeguarding for the Trust. This is the Director of Nursing and Midwifery who champions safeguarding throughout the organisation and represents the organisation on both the Local Safeguarding Children Board and Local Safeguarding Adult Partnership Board.

The Trust has a Safeguarding Team consisting of:

- Head of Safeguarding/Named Nurse for Safeguarding Children and Young People
- Named Midwife 0.4WTE
- Named Nurse for Adults at Risk
- Specialist Nurse for Domestic Abuse, Female Genital Mutilation (FGM), Forced Marriage (FM), Honor Based Violence (HBV)
- Safeguarding Practitioner for Children and Young People
- Safeguarding practitioner for Adults at Risk

Following a Care Quality Commission inspection in September 2015 it was highlighted that the Team was not supported by a Registered Paediatric Nurse. The proposal to strengthen the governance arrangements and provide clear lines of accountability is now in place. The existing Paediatric Liaison Nurse has been the Safeguarding Emergency Department Link Nurse for the past two years and is now recognised across the Trust as the Children and Young People Safeguarding Liaison Manager.

The Team is managed by the Head of Safeguarding/Named Nurse for Safeguarding and is supported by an administrator. The Trust also has a Named Doctor for Safeguarding Children, Designated Doctor for Safeguarding Children and Designated Doctor for Children Looked After.

### 2.2 Safeguarding Governance Arrangements and Assurance

The Safeguarding Strategic Team (SST) is chaired by the Director of Nursing and Midwifery. Terms of reference include:

- To ensure that safeguarding is at the forefront of service planning
- To provide assurance in respect of safeguarding all vulnerable people
- To ensure that the agreed systems, standards, protocols are in place to effectively work together within a clear framework of managerial supervision and multi-agency procedures
- To ensure that concerns related to safeguarding are escalated appropriately and in a timely manner
- Contracts and service specifications, including safeguarding audit tool which has a red, amber, green rated audit tool is completed and subsequent action plan formulated

- To monitor and review action plans, and audit tools

- To monitor compliance in safeguarding and MCA training

The SST reports into Clinical Governance Group and is responsible for overseeing the Trust's responsibilities to the adult and children safeguarding agenda (including Children Looked After and Domestic Abuse).

The Safeguarding Team complete the Safeguarding Assurance Framework for the Wirral Clinical Commissioning Group (WCCG) on a quarterly basis and co-ordinate the completion of the Self-Assessment Standards for Safeguarding Children and Adults for the WCCG who commission the services of the Trust. In addition, the Designated Nurses are receiving quarterly Safeguarding Dashboard figures. A Safeguarding Performance Report is presented quarterly to Clinical Governance Group and the Wirral Clinical Commissioning Group Quality and Risk Group.

## 2.3 Safeguarding Incident Reporting

Safeguarding incident referrals are now integrated into the Trust Safeguard database to record all safeguarding incidents. The system automatically raises the issue of an incident. Once incident documentation is received by the Safeguarding Team, it is recorded in Millennium system. The system then automatically reports relevant safeguarding incidents to the National Reporting and Learning System (NRLS).

## 2.4 Merseyside Internal Audit Agency (MIAA)

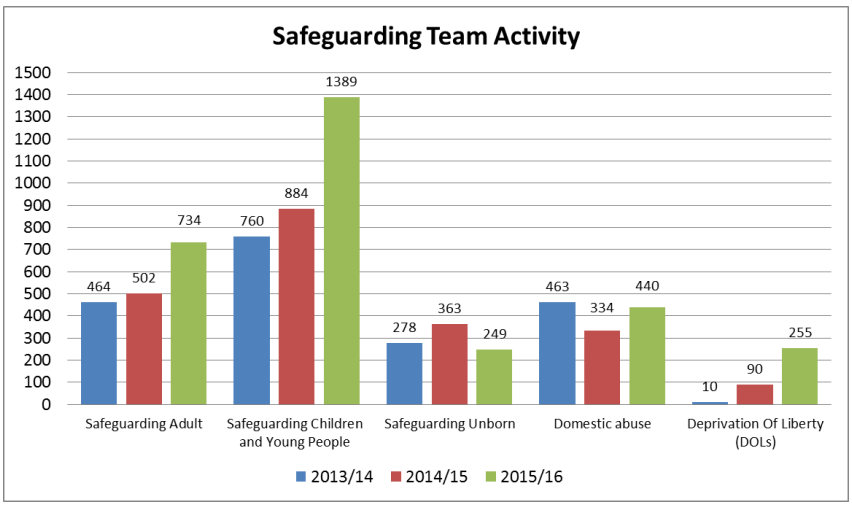
As part of the 2016/17 audit plan, MIAA have undertaken a review of the arrangements for Safeguarding Children and Adults within the Trust. The outcome of this report is of **Significant Assurance**. This level of assurance reflects the improvements made to the safeguarding service since previous review carried out in 2014/15.

Recommendations and action plan will be monitored via the Safeguarding Strategic Team.

## 2.5 Safeguarding Team Activity

During April 2015 to March 2016, the Safeguarding Team has seen an overall general increase in activity and complexity.

Table 1 below details the activities and compares this with the activity of previous years.



The above table illustrates there has been a significant increase by **57%** increase in Safeguarding Children and Young People referrals. This is due to increase in safeguarding training compliance and to the training regarding the 16-18 year age group following the Serious Case Review of a seventeen year old Wirral young person and subsequent actions that were implemented throughout the Trust.

Safeguarding Adults at Risk referrals have a **46%** increase; with a significant rise in DoLs referrals ie: from 10 referrals in 2013-14, 90 referrals in 2014-15. The current figure of 225 referrals is a significant **180%** increase. The significant rise in DoLS applications is also a national trend and the Department of Health are current in consultation to review the Deprivation of Liberty process.

Out of the 225 Deprivation of Liberty Urgent and Standard applications that were made to the Supervisory Body (Local Authority) by the Managing Authority (WUTH), 49 of these applications resulted in an authorised Deprivation of Liberty by the supervisory body. 5 were not authorised and 30 applications the Trust, as the managing authority did not receive a decision from the supervisory body prior to discharge. This has been added to the Trust register.

The remaining 141 were either found to have capacity, managed under the Mental Health Act, discharged or deceased.

There has been a decrease in unborn referrals **31%** - this may be attributed to midwives receiving specific training in relation to thresholds, making appropriate referrals and utilising the Common Assessment Framework/Team around the Family Process (CAF/TAF).

Domestic abuse referrals have had a 31% increase. The roll out of transfer of responsibility to key clinical staff in the completion of the Domestic Abuse Risk Assessments across the Trust will possibly have had an impact on the number of referrals. As part of the "Wirral 2020" pledge in relation to an Independent Domestic Abuse Advisor being deployed by the Trust, ongoing discussions are taking place with Local Authority and Designated Nurse in CCG.

The Trust has had its first case of Human Trafficking identified. This was managed with the support of the Human Trafficking Police Department. This has identified a further area to include in safeguarding training.

The increase in referrals can also be attributed to rise in awareness of safeguarding since the implementation of the Safeguarding Strategy which states that safeguarding is "Everybody's Business" and promotes the "One Chance Rule". Staff are becoming more autonomous in acknowledging their roles and responsibilities in the safeguarding arena and have a greater awareness of their training responsibility.

### 2.5 Safeguarding Training

Following Care Quality Commission inspection in September 2015 and subsequent recommendations provided in the CQC quality report published in March 2016, Wirral University Teaching Hospital commenced a review of its Safeguarding programmes to ensure that the Trust and its staff are fully equipped with the skills and competencies to protect all users from harm and abuse and to ensure it is meeting the required legislation standards.

This review has led to the Trust identifying that a number of changes are required to the current safeguarding training competencies.

To achieve this and to give the Board assurance around safeguarding training standards, a 12 month project implementation plan, owned by the Safeguarding Team, has been developed which details key activities/milestones required to implement a revised training programme for level 1, 2 and 3 safeguarding training and to move towards achieving a KPI of 90% compliance in all levels of training by August 2017.

The revised training model will be launched in August 2016 by the Executive lead for Safeguarding and will give staff within the Trust a 12 month window to complete the required training competencies for their role.

The revised programmes cover all the requirements of the intercollegiate documents for both Adults and Children and identify operational practices and procedures for safeguarding at the Trust.

Although the revised programs will be launched to all staff, priority and targeted action will be given to that staffs that are currently non-compliant for any form safeguarding training and those staff identified as having 'critical' roles linked to safeguarding.

The Trust's Learning and Development function are currently developing trajectories for compliance over the 12 month period. These trajectories will be monitored monthly and reported to the Trust's Workforce and Communication Group.

**Key achievements to date:**

- Competency requirements mapped into a revised TNA for all roles
- Development of Safeguarding Training Strategy (for approval at Workforce and Communications Group in August 2016)
- Development of a level 1 and 2 bespoke training package – this programme is currently undergoing user acceptance testing prior to deployment with the intention of moving to e-learning format
- Revised level 3 teaching programme

**Future Key Milestones**

- Monthly trajectories to be approved at Workforce and Communications Group – August 2016
- Safeguarding Training Strategy and revised training programmes to be launched - end of August 2016
- Monthly compliance monitoring against trajectories – September 2016
- Achievement of KPI - September 2017

**Table 2 Level of Safeguarding Training Compliance 31/3/2016**

| Specialty & Level | Compliance (%) |
|---|---|
| Safeguarding Level 1(*All areas inc MCA*) | **92.33** |
| Child Protection Level 2 | **79.29** |
| Child Protection Level 3 | **78.52** |
| Child Protection Level 4 | **100** |
| Mental Capacity Act Level 2 | **47.15** |
| Mental Capacity Act Level 3 | **13.51** |

Members of the Board of Directors must have a level of knowledge equivalent to all staff within the healthcare setting (Level 1) as well as outlined based competencies by virtue of their Board membership to ensure that the role and responsibilities of Trust in relation to safeguarding are met. The non-Executive Board member will provide overall scrutiny of the organisation's safeguarding performance.

## 2.6 Safeguarding Supervision and Support

The Trust is required to provide safeguarding supervision to all health practitioners who case load safeguarding cases. The Safeguarding Supervision Policy which was ratified during 2014-2015, states that safeguarding supervision is offered to all professionals who hold a caseload with safeguarding children concerns, and staff/departments that have direct involvement with safeguarding children and young people cases. Following recommendations from the Care Act 2014, the policy has been amended to include practitioners who support adults. Safeguarding Supervision is provided by members of the Safeguarding Team who have undertaken the accredited NSPCC Safeguarding Supervisors course.

A further twelve staff, nine from midwifery service and three from the Safeguarding Team received Safeguarding Supervision Training from the NSPCC in February 2016. Following this specialised training the Safeguarding Supervision Policy for the Trust is currently being updated. As part of the Safeguarding Assurance Framework, a KPI is that staff who require safeguarding supervision are receiving supervision in accordance with policy and national guidance. This data is collated quarterly and is provided to the CCG.

As nine midwives have received the NSPCC safeguarding supervision training, plans are in place to transfer the supervision of the safeguarding case loading midwives. The Named Midwife, Specialist Lead for Domestic Abuse will then supervise the nine midwives in accordance with guidance.

The Named Nurse for Safeguarding Children has previously provided group supervision for all Emergency Department (ED) staff and this will now be undertaken by the Children and Young People Safeguarding Liaison Manager.

A plan to expand this service to staff on the paediatric ward is currently being scoped by the safeguarding practitioner for children.

The Named Nurse, Named Midwife, Named Nurse for Adults at Risk, and Named Doctors all access safeguarding supervision from Designated Nurses and Doctor.

## 2.7 Serious Case Reviews/Domestic Homicide Reviews/Learning Reviews for Children and Adults

Currently, there is a case in Wirral that has met the threshold for Serious Case Review involving a young person. The Local Authority is currently in the process of procuring an independent author to undertake the review.

A further three cases are being considered by the panel. A Critical Case Review is currently being undertaken on a further case.

Three further cases have been identified and are to be considered at the next Serious Case Review meeting to review if they meet the criteria for serious case review or critical case review.

There have been no Serious Case Reviews for adults in this period; however three cases were discussed for consideration at Serious Case Review sub group: two of these have subsequently been escalated to LSAB for consideration.

WUTH has attended a Learning Review of a young person and the outcome of the review highlighted the excellent commitment and challenge to partner agencies in respect of this young person by the Named Nurse for Safeguarding Children.

There have been no Domestic Homicide Reviews or OFSTED inspections during 2015-2016.

### 2.8 Inspections/Reviews

The Care Quality Commission inspection was completed in September 2015. It was highlighted that the Trust did not meet the Royal College of Paediatrics and Child Health (RPCH) guidelines 2014 in relation to safeguarding training. Subsequently, in February 2016, Safeguarding Adults: Roles and Competences for health staff- Intercollegiate Document was published and the Safeguarding Team alongside Learning and Development have completed training needs analysis to incorporate both child and adults. This is part of a Trustwide CQC action plan.

Best practice is that a Paediatric Nurse is part of the Safeguarding Team. This has been actioned.

### 2.9 Partnership Working

In supporting partnership working the Trust participates in various multi-agency forums and delegates from the Trust attend.

| Forum | Responsibility |
|---|---|
| WSCB | Director of Nursing & Midwifery |
| LSAB | Director of Nursing & Midwifery |
| Serious Case Review | Named Nurse Adults at Risk |
| Staying Safe | Head of Safeguarding/Named Nurse for Safeguarding Children & Young People |
| Learning & Development | Named Nurse Safeguarding Children , Named Nurse Adults at Risk |
| Performance | Named Midwife |
| CSE | Head of Safeguarding/Named Nurse |
| Communications | Named Nurse Adults at Risk |
| Domestic Abuse | Specialist for Domestic Abuse |
| Wirral MARAC Steering Group | Head of Safeguarding |
| Wirral Health Safeguarding Children Forum | Head of Safeguarding/Named Midwife and Specialist in Domestic Abuse |

### 2.10 Children and Young People Safeguarding Liaison Manager role in relation to Child Death Overview Panel (CEDOP)

In accordance with Safeguarding Vulnerable People in the Reformed NHS – Accountability Assurance Framework (NHS Commissioning Board 2015), states that all child deaths (excluding neonatal deaths) that occur for Wirral children are reported to the specialist nurse for Child Death. Within WUTH, this has been embedded into the role of the Children and Young People Safeguarding Liaison Manager. This role is accountable for gathering, coordinating and sharing this sensitive information surrounding the death of the child. The role is responsible for liaising with Wirral Safeguarding Children Board Death Coordinator and managing the health response in accordance with the Children Act (2004) and Working Together (2015). This is in place to improve the understanding of how and why local children die. These findings aim to identify subsequent actions to prevent future death and improve the health and safety of children.

There have been thirty one child deaths in Wirral during 2015-2016. Seven of these were Sudden Unexpected Death of Child (SUDiC's). All of the deaths were reviewed at the Merseyside Child Death Overview Panel.

**2.11 Safe Recruitment and Vetting Procedures**

The Trust adheres to the standards in accordance produced by HM Government Disclosure and Barring Service. The Trust undertakes DBS for all staff, new recruits and volunteers and has robust policies and procedures

**3. Key objectives for 2016-2017**

**3.1 Next step**

- The Trust is scoping the deployment of Independent Domestic Abuse Advisor within the Trust as detailed in The Wirral Plan: A 2020 Vision – Zero Tolerance to Domestic Abuse
- To further develop the Wirral Millennium function to ensure all safeguarding information is kept in one location and accessible by all Trust staff. Currently in phase three. A safeguarding alert is currently visible on Wirral Millennium when a safeguarding concern is known
- To ensure safeguarding training becomes mandatory at all levels appropriate to post and monitor compliance in line with RCPCH 2014 – child and adult intercollegiate documents
- To support the transfer of responsibility to clinical staff for the completing of referrals to the Local Authority when concern or abuse is identified for adults at risk
- To support the transfer of responsibility to key clinical staff in the completion of the Domestic Abuse Risk Assessments
- As the Trust is part of the Early Intervention Strategy for Wirral, further training in relation to Common Assessment Framework (CAF) and Graded Care Profile will be provided to all key staff appropriate to grade
- Roll out the PREVENT strategy to all key areas within the Trust
- Due to significant increase in DoL's referrals, a training programme for Matrons and senior ward managers in key areas will be trained to support the Safeguarding Team in completing applications for DoL's

**4 Conclusion and Recommendations**

The Trust has worked in partnership with the WSCB and SAPB and other partners to improve the safeguarding element of the service it provides, and to ensure compliance with the statutory and contractual responsibilities of the Trust.

This report has detailed how the Trust has fulfilled its duty to ensure its functions are completed with regard to the need to safeguard and promote the wellbeing of children, young people and adults in line with Section 11 of the Children Act 2004, Working Together to Safeguard Children 2015 and the Care Act 2014.

The Board are asked to receive and approve the Annual Report on Safeguarding Adults and Children 2015-2016.

| Board of Directors | |
|---|---|
| **Agenda Item** | 7.6 |
| **Title of Report** | Report of the Quality & Safety Committee 13 July 2016 |
| **Date of Meeting** | 27 July 2016 |
| **Author** | Cathy Maddaford, Chair of the Quality and Safety Committee |
| **Accountable Executive** | Evan Moore, Medical Director |
| **BAF References**<br>• **Strategic Objective**<br>• **Key Measure**<br>• **Principal Risk** | 1,3,4,5,6,7<br>1a,1b,3a,3b,4a,5b,6b,7a,7c,7d<br>1445,1908,1909,2328,2485,2611,2678 |
| **Level of Assurance**<br>• **Positive**<br>• **Gap(s)** | Gaps with mitigating action |
| **Purpose of the Paper**<br>• **Discussion**<br>• **Approval**<br>• **To Note** | Discussion |
| **Data Quality Rating** | N/A |
| **FOI status** | Document may be disclosed in full |
| **Equality Impact Assessment Undertaken**<br>• **Yes**<br>• **No** | N/A |

This report provides a summary of the work of the Quality and Safety Committee which met on the 13 July 2016. Key focus areas are those which address the gaps in assurance/control in the Board Assurance Framework.

**Board Assurance Framework (BAF)**

The Committee's agenda reflected the gaps in assurance/control on the BAF and was structured such that it allowed for greater focus on the most significant risk areas.

The Committee supported the recommendation to undertake an extensive review of the BAF to reflect the increased number of key measures which underpin the strategic aims of the Operational Plan. The Committee was pleased to note that the review would also consider the learning points identified during the risk appetite session led by Mersey Internal Audit Agency (MIAA) in May 2016, any appropriate recommendations identified as part of the Well Led Governance Review and the priorities from the Quality Improvement Strategy.

The Committee was pleased that a full review of clinical and corporate governance below Board sub-committee level was planned to improve decision making at Divisional level.

**CLIPPE Report**

The Committee received the report and was advised that a review was to be undertaken to ensure that future reports included triangulation of the data between the individual complaints, litigation, incidents and patient experience reports.

**Workforce and OD Dashboard**

Good performance was reported, the key highlights being:

- Sickness absence rates were reported as better than the Trust target of 4% at 3.58% for May 2016 which was an improvement on the same time in the previous year when this was 3.72%
- The vacancy rate for Nursing and Midwifery was reported at 4.10% which remained significantly better than the national average and the overall consultant vacancy rate was low and reported at 0.31%
- Staff satisfaction continued to show improvement with a quarter 1 figure of 3.82 which was above the national average of 3.79

The Committee received an update following the Health Education England in the North West visit on 5 July 2016. The Committee was pleased to note the overall positive initial feedback but were disappointed to hear of patient safety issues raised by clinicians during the visit. The Committee requested that the issues raised were addressed immediately and that the final report be presented at a future meeting.

The Committee was pleased to note the outcome report following the recent sharps incidents 'deep dive'. The Committee noted the resultant sharps safety action plan and confirmed that sharps incidents and progress against the action plan would be monitored via the Health and Safety Group.

**Adult Palliative and End of Life Care Strategy 2016/19**

The Committee was pleased to receive the Adult Palliative and End of Life Care Strategy which was developed in collaboration with Wirral Community Trust and Wirral Hospice St Johns.

Following the recent CQC inspection, the strategy was reviewed to reflect the enhanced focus on strong teamwork and leadership required to deliver improvements at an acceptable pace. The Committee noted the planned expansion of the Specialist Palliative Care resource within the Trust to facilitate 24/7 care in line with commissioning guidance and the work required to negotiate funding to support an enhanced team.

The Committee was pleased to note that benefits associated with the Record of Care were being realised and the external recognition of the success of the initiative to date.

The Committee noted that initial discussions were to take place with Wirral Community NHS Foundation Trust (WCT) to ensure that the Strategy is adopted by all agencies across Wirral. Further support would be sought from Wirral Clinical Commissioning Group to encourage uptake of the Strategy if required.

The Committee noted the Adult Palliative and End of Life Care update and requested a further update following discussions with WCT.

**CQC Compliance and Assurance Report**

The Committee was advised of a change to the Care Quality Inspection (CQI) process which took effect prior to the July inspections and what was required to instil greater consistency between

inspection teams in how wards/departments were rated. The Committee received an overview of the results of the CQIs undertaken in July 2016 in the Emergency Department (ED) and on Ward 22. Both areas received an overall score of "requires improvement" with identified areas for improvement to be addressed as part of the action plan.

The Committee was pleased to note that a 'deep dive' into the CQC Action Plans was to be undertaken in collaboration with the Divisions to gain assurance of progress and focus contributors on achievement of a 'good' rating following the next full inspection. The Committee agreed to receive a full update at its next meeting.

**Advancing Quality Programme of Improvement**

The Committee was concerned with the number of standards not being met and agreed that the work on removing clinical variation and performance management in the Divisions incorporate Advancing Quality (AQ) to ensure improvement and accountability and as such, the Committee requested that, as part of the current Service Review, the Divisions would be apportioned accountability to support achievement of the Advancing Quality clinical focus areas.

The Committee requested a more detailed, focused report be presented to the Committee in September.

**Never Event Root Cause Analysis – Process Changes**

The Committee noted the improvements made to Never Event reporting processes and was looking forward to the benefits being realised as a consequence of the refreshed training programme.

The Committee emphasised the importance of Divisions and individual staff assuming accountability to prevent future such occurrences and therefore requested that, as part of the current Service Review, Divisional and individual ownership of working practices be embedded to facilitate a positive culture change.

**Peer Review – Cancer of Unknown Primary (CUP) Service**

The Committee received the external review of the Trust's compliance with the Quality Surveillance Programme measures for the CUP service and was pleased that WUTH was compliant with the following measures:

- Provision of Hospital CUP Service
- Clinical Guidelines

The Committee was disappointed to note that a concern was raised during the review which resulted in failure to comply with the final measure of assessment; Malignancy of Unknown Origin/CUP Patient Investigation and Management Policy. The Committee was advised that this had been raised at network and national level and feedback had indicated that the measure itself would be amended to reflect more suitable core membership of the CUP MDT which would result in Trust compliance with the measure.

The Committee was pleased to note that as a result of the level of professionalism and quality of data produced for the review, the team had been invited to contribute to the national review programme.

**Time to Theatre for Fracture Neck of Femur Report**

The Committee reviewed the Time to Theatre for Fracture Neck of Femur (#NoF) Report and requested that further assurance was received on the actions taken to address the issues identified which included; review of policies and procedures, development of a #NoF package in Cerner and reintroduction of the Fast Track Policy which will see #NoF patients moved from ED to a specialised assessment area to improve patient flow.

The Committee requested that reporting to the Committee on #NoF was to continue on a bi-monthly basis.

**Emergency Planning and Business Continuity Annual Report**

The Committee received the Emergency Planning and Business Continuity Annual Report and associated documentation which were prepared in line with national guidance.

The Committee was pleased to note that the Trust's self-assessment against NHS England's (NHSE) Emergency Preparedness, Resilience & Response Core Standards during quarters 2 and 3 had been confirmed by NHSE as having demonstrated substantial compliance.

The Committee noted that the MIAA review carried out in relation to Emergency Planning in September 2015 received significant assurance.

The Committee recommended to the Board the approval of the:

- Emergency Planning & Business Continuity Annual Report 2015/16,
- Emergency Plans,
    - Pandemic Influenza Plan,
    - Severe Weather Plan,
    - Evacuation Plan,
- Major Incident Action Cards, and
- Exercise reports.

**Clinical Audit Annual Report**

The Committee received the Clinical Audit Annual Report and the positive outcomes achieved as a result of undertaking national and local audits.

The Committee was pleased to note that 33 out of 34 nationally prescribed audits had been completed, with the outstanding audit delayed through no fault of the Trust.

The Committee approved the Clinical Audit Annual Report but requested that the process for determining divisional clinical audits be reviewed.

**Safeguarding Annual Report**

The Committee was pleased to receive the Safeguarding Annual Report for 2015/16, which outlined how the Trust met all its safeguarding responsibilities during the period and the key objectives for 2016/17.

The Committee was pleased to note the outcome of a review of the Trust's Safeguarding Children and Adults arrangements which was undertaken by MIAA during 2016 and received significant assurance.

The Committee recommended to the Board the approval of the Safeguarding Annual Report.

**Escalation to Board**

In view of the need to progress with improvements in relation to CQC, the Committee recommended that the interim line management responsibilities be reviewed following the departure of the Medical Director. The CEO agreed to progress this action.

The Committee agreed that compliance with the AQ Standards be included in the BAF.

**Cathy Maddaford**
**Chair of Quality and Safety Committee**

| Board of Directors | |
|---|---|
| **Agenda Item** | 8.1 |
| **Title of Report** | Board Statement – Modern Slavery Act 2015 |
| **Date of Meeting** | 27th July 2016 |
| **Author** | Carole Ann Self, Director of Corporate Affairs |
| **Accountable Executive** | David Allison. Chief Executive |
| **BAF References**<br>• **Strategic Objective**<br>• **Key Measure**<br>• **Principal Risk** | 7D – compliance with legislative requirements |
| **Level of Assurance**<br>• **Positive**<br>• **Gap(s)** | Positive |
| **Purpose of the Paper**<br>• **Discussion**<br>• **Approval**<br>• **To Note** | Approval |
| **Data Quality Rating** | N/A |
| **FOI status** | Document may be disclosed in full |
| **Equality Impact Assessment Undertaken**<br>• **Yes**<br>• **No** | N/A |

**Executive Summary**

The Modern Slavery Act 2015 is designed to consolidate various offences relating to human trafficking and slavery. The provisions in the act create a requirement for an annual statement to be prepared that demonstrates transparency both in the organisation and within its supply chains. In line with all businesses with a turnover greater than £36 million per annum, the NHS is also obliged to comply with the Act.

**Summary of the Act**

The legislation addresses slavery, servitude, forced or compulsory labour and human trafficking, and links to the transparency of supply chains. Section 54 of the Act specifically addresses the point about transparency in the supply chains. It states that a commercial organisation (defined as a supplier of goods or services with a total turnover of not less than £36

million per year) shall prepare a written slavery and human trafficking statement for the financial year. The statement should include the steps an organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any part of the supply chain or its business. The statement must be approved by the Board of Directors.

The aim of the statement is to encourage transparency within organisations, although it is possible to comply with the provision by simply stating that no steps have been taken during the financial year to ensure that the business and supply chain is modern slavery free. It is worth noting that although this may be an acceptable approach for this year's statement, there is an expectation that further work will be undertaken to provide these assurances in years to come.

There are potential consequences for those organisations that do not appear to make progress in this area; especially for those that are funded wholly, or in part, by public money.

**Assurance**

The Trust will be required to review and /or prepare a similar statement on an annual basis. To support the production of the statement assurance mechanisms will be put in place, including the use of Internal Audit as appropriate.

**Recommendations**

The Board is asked to review the Annual Statement as attached and approve this for inclusion on the Trust's website.

**Modern Slavery and Human Trafficking Act 2015 Annual Statement**

Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps it has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business.

The aim of this statement is to demonstrate that the Trust follows good practice and all reasonable steps are being taken to prevent slavery and human trafficking.

Wirral University Teaching Hospital NHS Foundation Trust provides a comprehensive range of high quality acute care services, our 5,600-strong workforce serves a population of about 400,000 people across Wirral, Ellesmere Port, Neston, North Wales and the wider North West footprint. We operate across two main sites these being Arrowe Park Hospital in Upton and Clatterbridge Hospital in Bebbington. We also provide a range of outpatient services from community locations at St Catherine's Health Centre in Birkenhead and Victoria Central Health Centre in Wallasey.

The Trust acknowledges responsibility under the Modern Slavery Act and will ensure transparency within the organisation. The Trust has well established and robust recruitment and vetting procedures however at this time it cannot provide assurances that suppliers operate to the same high ethical standards and code of conduct . In August 2016 the Trust will be writing to all suppliers requesting them to affirm their compliance with the legislation. Additional provisions will be built into the Trust's procurement and tendering processes to ensure Suppliers are compliant with the requirement of the Act. Internal audit undertake an annual audit on financial control as part of their audit plan. The audit includes a statutory compliance element. In future this will include the modern slavery and human trafficking act requirements.

The Trust will raise awareness amongst its staff of slavery and trafficking and national contracts are being amended to take into account the requirements.

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

| Board of Directors | |
|---|---|
| **Agenda Item** | 8.2 |
| **Title of Report** | NHSI Quarterly monitoring return |
| **Date of Meeting** | 27th July 2016 |
| **Author** | Gareth Lawrence<br>Deputy Director of Finance |
| **Accountable Executive** | David Jago, Director of Finance |
| **BAF References**<br>• **Strategic Objective**<br>• **Key Measure**<br>• **Principal Risk** | 7 |
| **Level of Assurance**<br>• **Positive**<br>• **Gap(s)** | Positive |
| **Purpose of the Paper**<br>• **Discussion**<br>• **Approval**<br>• **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**<br>• **Yes**<br>• **No** | No |

## 1. Executive Summary

The Board is asked to approve the Q1 NHS Improvement (NHSI) returns that are detailed in appendix 2.

The Board is also asked to note the quarterly financial commentary that has been submitted to NHSI.

NHS Foundation Trusts are required to submit a report to NHSI on a quarterly basis covering targets and indicators, governance and finance. The basis of the Q1 report is described below.

## 2. Background

### Quarter 1 Governance Targets & Indicators for NHSI

Under NHSI's Risk Assessment Framework, each indicator has an equal weighting of 1 point for each standard not achieved. The overall Governance ratings are Green for no concerns (i.e. all targets met). Beyond this, the failure against targets raises Governance concerns at NHSI, with no RAG rating being assigned until such time as formal regulatory action is taken and a Red rating applied.

WUTH will remain rated as Red for Q1 with issues of note with the Risk Assessment Framework standards as detailed below.

### A&E Performance

Against the A&E standard of a minimum 95% of patients to be admitted, transferred or discharged within four hours, the month of June was 87.62% as measured across a combined ED and All Day Health Centre performance at the Arrowe Park site. ED alone was 84.06%.

The performance in June for the emergency access standard although not achieving the regulatory compliance level of 95% was above the Sustainability and Transformation Fund (STF) trajectory of 84%.

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

The new Acute Ambulatory Care Unit opened on 27th June, which has provided additional ambulatory capacity to assist with the 'pulling' of patients from the Emergency department and avoiding the need for GP admissions to be redirected to the Emergency department.

### Cancer Standards

All cancer waiting time standards are on track to be achieved for Q1.

**18 Week RTT**

Trust compliance against the standard at the end of June is 91.00%. This delivered compliance against the STF trajectory of 91%.

Capacity and demand models continue to be produced at speciality level utilising the Intensive Management Support tools.

**Infection Control**

For C Difficile, there have been three cases considered avoidable to the end June. This is below the maximum plan trajectory of five cases for the quarter.

**CQC Standards**
The Care Quality Commission published the final report into their comprehensive inspection of the Trust in September 2015 on Thursday 10th March 2016.
The Trust has been scored as "requires improvement" overall, with a rating of "good" for caring and effectiveness. The rating is in line with the Trust's own self-assessment undertaken prior to the inspection. The Trust submitted on the 14th April 2016 the action plan to ensure compliance with the Requirement Notices, although many of the actions have already been completed.

**Compliance Rating**
WUTH was Red for Quarter 4 (2015/16) and will remain so for Quarter 1 under NHSI Risk Assessment Framework. The Trust has ensured there has been engagement with NHSI on a regular basis in terms of the plans for improvement in A&E performance, and performance against the RTT standard.

**Governance Information**
Information relating to relevant election results will be updated to NHSI separately.

With regards to the Executive Directors Janelle Holmes commenced the post of Chief Operating Officer on the 1st April 2016, and David Jago commenced the post of Director of Finance on the 1st June 2016. There has been 1 resignation during Q1, the Medical Director resigned having been offered the role of Chief Medical Officer/Deputy Chief Executive at Betsi Cadwaladar Hospital. The Trust is undertaking a consultative exercise with the medical body to inform plans for the appointment into this vacancy.

**Finance Declaration**
The Trust has submitted an operational plan showing a marginal surplus for 2016/17 and a corresponding Financial Sustainability Risk Rating (FSRR) of 2, during Q1 the Trust has achieved its financial plan resulting in an FSRR of 2. On that basis the Board is unable to confirm the finance governance statement that "The Board anticipates that the Trust will continue to maintain a Financial Sustainability risk rating of at least 3 over the next 12 months".

The Trust's capital expenditure as at the end of the Q1 is c£1.2m below plan, however "The Board anticipates that the trust's capital expenditure for the remainder of the financial year will not materially differ from the forecast in the financial return.

**David Jago**
Director of Finance
July 2016

**Appendix 1 – Financial commentary**

## Month 3 2016/17 Financial Commentary for NHS Improvement

The following commentary details the Trust financial position as at Month 3 and cumulatively against the 2016/17 plan.

The Trust recorded an actual deficit in month 3 of (£0.2m) against a planned deficit of (£0.5m), an in month positive variance against plan of c£0.3m. The cumulative position at the end of quarter 1 is a deficit of (£2.2m), which is as planned.

The Q1 performance has been supported by the financial envelope agreed with the Trusts main commissioner Wirral CCG (WCCG). Without this agreement the Trusts income position would have deteriorated by c£1m.

The Trusts cash position at the end of Q1 is £1.7m. This is £1.8m behind plan, primarily as a result of the Trust not receiving the STF as planned within the initial cashflow. The Trust has agreed in conjunction with NHSI that an advance drawdown of the working capital facility can take place in July to mitigate this pressure.

The table below highlights the overall position in month and year to date.

| | MONTH 3 | | | YTD | | |
|---|---|---|---|---|---|---|
| | **Plan £m** | **Actual £m** | **Variance £m** | **Plan £m** | **Actual £m** | **Variance £m** |
| NHS Clinical Income | 24.662 | 25.211 | 0.549 | 73.041 | 73.664 | 0.623 |
| Non NHS Clinical Income | 0.152 | 0.155 | 0.003 | 0.456 | 0.474 | 0.018 |
| Non Clinical Income | 2.317 | 2.350 | 0.033 | 6.880 | 6.993 | 0.113 |
| **TOTAL INCOME** | **27.130** | **27.715** | **0.585** | **80.377** | **81.131** | **0.754** |
| Employee Expenses | (18.466) | (19.055) | (0.589) | (54.804) | (56.311) | (1.507) |
| Other Operational Exp. | (8.090) | (7.687) | 0.403 | (24.436) | (23.666) | 0.770 |
| **TOTAL EXPENSES** | **(26.556)** | **(26.742)** | **(0.187)** | **(74.240)** | **(79.977)** | **(0.737)** |
| | | | | | | |
| **EBITDA** | **0.575** | **0.973** | **0.398** | **1.137** | **1.154** | **0.017** |
| Post EBITDA Items | (1.101) | (1.137) | (0.037) | (3.302) | (3.319) | (0.017) |
| **Net Surplus/(Deficit)** | **(0.526)** | **(0.165)** | **0.361** | **(2.164)** | **(2.165)** | **(0.00)** |
| | | | | | | |
| EBITDA Margin % | 2.12% | 3.51% | 1.39% | 1.41% | 1.42% | 0.01% |

### NHS Clinical Revenue

Cumulatively all points of delivery (PODs) are underperforming in terms of actual activity delivered against the initial plan, with the exception of NEL and EL excess bed days, and outpatient procedures. This predominantly reflects the impact of the junior doctor industrial action during April. However, the position also reflects a richer case mix which has impacted the financial position in non-elective activity. The year to date over recovery in Non PbR areas, mainly reflects over performances in rehabilitation, neonatal and direct access pathology activity.

The overall income position as noted above is supported by the financial envelope agreed with Wirral CCG. The financial envelope agreed with the CCG is inclusive of all CQUINs payments, however schemes will be shadow monitored on a quarterly basis.

## Non NHS Clinical Income

In June (Month 3) non NHS clinical income was largely on plan and the year to date position is showing a marginal over-recovery. Cumulatively both private patients and RTA income is marginally above plan.

## Non Clinical Income

In June (Month 3) operating non clinical income also achieved plan, with the year to date position showing an over performance of £0.1m. The education and training income is higher than plan currently and reflects the anticipated additional income for SIFT for extending the cohort of students this year and will be reflected in the new 2016/17 contract soon to be issued from Health Education England.

## Operating Expenditure

In June (Month 3) operating expenditure overspent by (£0.2m) increasing the year to date overspend to (£0.7m).

Pay costs are (£0.6m) higher than plan in June and cumulatively (£1.5m) higher than plan.

A reduction in the provision of intermediate care beds within the health economy has resulted in an increased demand for non-elective beds within the Trust. As a result of this pressure escalation beds have remained open during Q1 driving adverse financial performance compared to plan. The Trust continues to work with the health economy to try to reduce this pressure going forward through the System resilience Group (SRG). These health economy changes were enacted after the submission of the performance trajectories to NHSI.

Additional gaps in Medical rota's have also increased the Trust pay bill with material increases in the Emergency Department and other medical specialties.

The Trust is currently marginally exceeding the agency ceiling within the plan by (£0.1m). Specialty reviews are currently being undertaken led by the Chief Operating Officer and Director of HR. The Trust continues to work with all agencies and Trusts within the STP footprint with the aim of formulating a single unit prices, in-line with NHSi improvement targets. Successful recruitment in some difficult to recruit specialties is anticipated to impact positively in this area towards the second half of the financial year.

Non pay costs are £0.4m lower than plan in June and cumulatively £0.8m lower than plan. The current YTD non position has been supported by the Trust receiving one off benefits relating to the conclusion of long term queries.

## EBITDA

Operating income over recovered in June by c£0.6m whilst operating expenditure over spent by (£0.2m). The combined EBITDA position is an under spend of £0.4m for June and breakeven cumulatively.

### Post EBITDA Items

Cumulatively there is a negligible favorable variance (£0.02m).

## Achievement of the 2016/17 Cost Improvement

The 2016/17 plan assumes the achievement of c£8.5m of cost improvement programmes and £2.7m revenue generation schemes through the year, delivering a combined total of £11.2m.
Plans amounting to some £9.5m have been identified and were extracted according to the profile of the schemes, with the unidentified balance of £1.7m extracted in a flat profile (12 ths).
During the month there has an under performance in the amount of efficiencies delivered of (c£0.2m), cumulatively the position is (c£0.3m) behind plan. The position has been supported by non-recurrent savings(c£0.4m).

The CIP position at Month 3 (including non-recurrent schemes) can be summarised as follows:

| Theme | YTD Plan £m | YTD Actual £m | Variance (£m) |
|---|---|---|---|
| Productivity & Efficiency | 0.7 | 0.4 | (0.3) |
| Workforce | 0.5 | 0.3 | (0.2) |
| Cost Control & management | 0.3 | 0.3 | 0 |
| Estate Management | 0.2 | 0.1 | (0.1) |
| Income | 0.3 | 0.3 | 0 |
| Other schemes | 0.1 | 0.4 | 0.3 |
| **TOTAL** | **2.1** | **1.8** | **(0.3)** |

The challenge continues to be the conversion of ideas and opportunities into expenditure releasing schemes as the Trust progresses through the financial year.

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

The Trust is mindful of the financially challenging environment and the need to maintain pace and focus in the identification of initiatives and subsequent delivery. The PMO function is working closely with the Divisions to secure the achievement of the 2016/17 CIP requirement.

## Statement of Financial Position for the period ending 30th June 2016

Total taxpayers' equity equals £137.0m.

The main variances against plan are explained below.

### a) Non-current assets

Capital assets exceed plan by £3.0m at month 3. This variance is detailed in the table below.

| Capital variances | £m |
|---|---|
| 16/17 brought forward balances above plan (revaluation) | 4.2 |
| Capex underspend | -1.2 |
| **Total variance of capital assets to plan** | **3.0** |

**b) Current assets**

Current assets are above plan by £4.9m. Current trade and other receivables exceed plan by £6.3m, this includes an accrual in relation to the delay in the receipt of STF monies £2.5m, inventories held are above plan by £0.4m. The remaining variance reflects the cash position, which is £1.8m below plan.

| Cashflow variances | £m |
|---|---|
| 16/17 brought forward cash balance exceeded plan | 1.2 |
| Working capital movements | -5.2 |
| Capital expenditure (cash basis) | 2.2 |
| **Total variance of cash to plan** | **-1.8** |

**c) Current liabilities**

Trade and other payables exceed plan by £3.0m, deferred income exceeds plan by £0.6m, and borrowings are in line with plan.

**d) Non-current liabilities**

Non-current deferred income is below plan by £1.5m, due to technical adjustments to an IFRIC 12 asset which affected 2016/17 brought forward balances.

**Financial Sustainability Risk Rating (FSRR)**

The Trust has achieved an overall FSRR of 2. This overall score, and each individual rating, are in line with plan noting liquidity being circa 1 day above plan.

**Control Total and Sustainability and Transformation Fund (STF)**

At the end of quarter 1 the Trust is forecasting achievement of the control total and the performance trajectories.

The Trusts Board of Directors will be reviewing the recent STF guidance during its July meeting.

**David Jago**
Director of Finance
July 2016

**Appendix 2 – Governance statements for Q1 2016/17**

**Introduction:**

Under its licence conditions, the Trust is required to prepare and submit a quarterly return to NHSI detailing its financial and governance risk ratings.

The quarterly submission must be made by 4 p.m. on the 29th July 2016.

The Board is asked to review the assurances received in this report, as provided by the Chief Operating Officer and Director of Finance respectively, and to self-certify four statements as set out below.

**Recommendation:**

It is recommended that the Board:

1) Does not confirm that for finance, that the Board anticipates the Trust will continue to maintain a FSRR of 3 over the next three months.

2) Does confirm that the Trusts capital plan will not materially differ from the forecast within the return.

3) Does confirm that the Board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards.

4) Does confirm that the Board confirms that there are no matters arising in the quarter requiring an exception report to NHS Improvement (per the Risk Assessment Framework, Table 3) which have not already been reported.

## In Year Governance Statement from the Board of Wirral University Teaching Hosp

| *The board are required to respond "Confirmed" or "Not confirmed" to the following statements (see notes below)* | Board Response |
|---|---|
| **For finance, that:** The board anticipates that the trust will continue to maintain a financial sustainability risk rating of at least 3 over the next 12 months. | Not Confirmed |
| The Board anticipates that the trust's capital expenditure for the remainder of the financial year will not materially differ from the amended forecast in this financial return. | Confirmed |
| **For governance, that:** The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards. | Confirmed |
| **Otherwise:** The board confirms that there are no matters arising in the quarter requiring an exception report to NHS Improvement (per the Risk Assessment Framework, Table 3) which have not already been reported. | Confirmed |
| **Consolidated subsidiaries:** Number of subsidiaries included in the finances of this return. This template should not include the results of your NHS charitable funds. | 0 |

Signed on behalf of the board of directors

| | | | |
|---|---|---|---|
| Signature | Sign Here. | Signature | Sign Here. |
| Name | David Allison | Name | Micheal Carr |
| Capacity | Chief Executive | Capacity | Chairman |
| Date | 29/06/2016 | Date | 29/06/2016 |

**Responses still to complete:** 0

*Notes:*
*NHS Improvement will accept either 1) electronic signatures pasted into this worksheet or 2) hand written signatures on a paper printout of this declaration posted to NHS Improvement to arrive by the submission deadline.*
*In the event than an NHS foundation trust is unable to confirm these statements it should NOT select 'Confirmed' in the relevant box. It must provide a response (using the section below) explaining the reasons for the absence of a full certification and the action it proposes to take to address it.*
*This may include any significant prospective risks and concerns the foundation trust has in respect of delivering quality services and effective quality governance.*
*NHS Improvement may adjust the relevant risk rating if there are significant issues arising and this may increase the frequency and intensity of monitoring for the NHS foundation trust.*

The board is unable to make one of more of the confirmations in the section above on this page and accordingly responds:

| | |
|---|---|
| A | The Trust submitted an operational plan showing a deficit for 2016/17 and has achieved a FSRR rating of 2 every month.<br>The Trust therefore cannot confirm it will maintain a FSRR of 3 over the next 12 months. |
| B | |
| C | |

| Board of Directors | |
|---|---|
| **Agenda Item** | 8.3 |
| **Title of Report** | NHS Improvement – Single Oversight Framework Consultation |
| **Date of Meeting** | 27th July 2016 |
| **Author** | Carole Ann Self, Director of Corporate Affairs |
| **Accountable Executive** | David Allison, Chief Executive |
| **BAF References**<br>• **Strategic Objective**<br>• **Key Measure**<br>• **Principal Risk** | Comply with legislative requirements |
| **Level of Assurance**<br>• **Positive**<br>• **Gap(s)** | *N/A* |
| **Purpose of the Paper**<br>• **Discussion**<br>• **Approval**<br>• **To Note** | *Discussion* |
| **Data Quality Rating** | N/A |
| **FOI status** | Document may be disclosed in full |
| **Equality Impact Assessment Undertaken**<br>• **Yes**<br>• **No** | *N/A* |

**Executive Summary**

From the 1st April 2016, NHS Improvement has incorporated the previously known organisations of Monitor and the NHS Trust Development Authority TDA and as a result has launched a consultation on how it proposes to regulate both NHS Trusts and Foundation Trusts in the future.

The Single Oversight Framework is designed to replace Monitor's Risk Assessment Framework and TDA's Accountability Framework. The new framework is also designed to be aligned with the CQC with work being developed to move to a more combined assessment of quality and use of resources.

The Five themes of the new framework are as follows:

**Quality of Care** – the intention is to use the CQC's most recent assessments of whether a provider is safe, caring, effective and responsive in combination with in-year information where available. The plan is to also include delivery of the four priority standards for 7 day hospital services.

**Finance and Use of Resources** – the intention is to oversee a provider's financial efficiency and progress in meeting its financial control total. This approach is being co-developed with the CQC.

**Operational Performance** – no change from the risk assessment framework although the metrics may be subject to variation

**Strategic Change** – the intention is to consider how well providers are working with system partners to deliver strategic changes set out in the Five Year Forward View with a particular focus on their contribution to sustainability and transformation plans STPs, new care models and, where relevant, implementation of devolution.

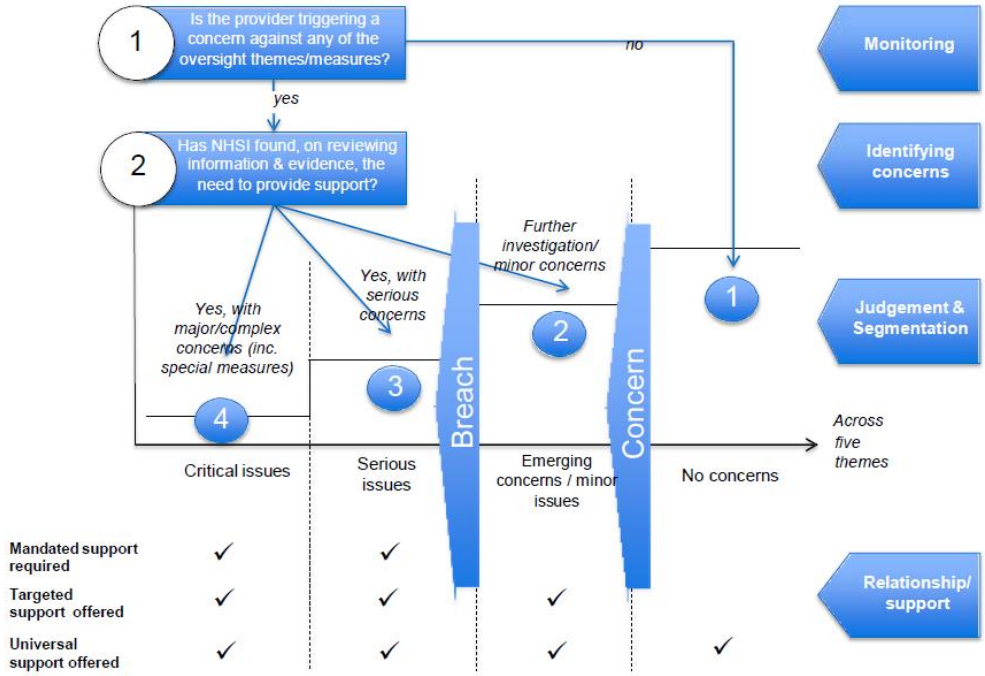
**Leadership and improvement capability** – the intention is to build on the joint CQC and Well-led framework by developing a shared system view with CQC on what good governance and leadership looks like, including organisations' ability to learn and improve.

The consultation asks nine questions as outlined in **Appendix 1** with responses required by 5pm on **4 August 2016.**

## The Framework

By having one framework NHSI intends to oversee providers in the same manner irrespective of their legal form.

NHSI propose to segment the provider sector according to the scale of issues faced by individual providers. This will be informed by data monitoring and, importantly, judgements based on an understanding of providers' circumstances. The table below sets out the proposed approach.




A Provider will only be placed in segments 3 and 4 if it's found to be in breach or suspected breach of its licence. It is of course only Foundation Trusts that are legally held to account for their Provider Licence so the commitment and aim of NHSI to treat all providers in comparable circumstances the same will need to be thought through.

## Monitoring of Providers

NHSI will collect and use information to identify where providers are triggering a potential concern in one or more of the five themes (which indicates that they are not in segment 1 and may benefit

from support) and judgement, based on consistent principles, to determine whether or not they are in breach of licence or the equivalent for NHS Trusts and if so, whether the issues are serious or very serious/complex. A summary of the information requirements for monitoring is detailed below:

| | In-year | Annual/ less frequently | Ad hoc |
|---|---|---|---|
| Quality of care | In-year quality information to identify any areas for improvement (see Appendix 2) | Annual quality information | Results of CQC inspections<br><br>CQC warning notices, fines, civil or criminal actions and information on other relevant matters |
| Finance & Use of Resources | Monthly returns | Annual plans | One-off financial events (eg sudden drops in income/ increases in costs)<br>Transactions/mergers |
| Operational performance | Monthly/quarterly(in some cases weekly) operational performance information (see Appendix 3) | | Any sudden & unforeseen factors driving a significant failure to deliver |
| Strategic change | Delivery of Sustainability and Transformation Plans (STPs)<br>Progress of any new care models, devolution plans | Sustainability and Transformation Plans (STPs) | Any sudden & unforeseen factors driving a significant failure to deliver |
| Leadership & improvement capability | Third-party information with governance implications[1]<br><br>Organisational health indicators<br>- staff absenteeism<br>- staff churn<br>- board vacancies | Staff & patient surveys<br><br>Third-party information with governance implications[1] | Findings of well-led reviews<br><br>Third-party information with governance implications[1] |

[1] eg reports from Quality Surveillance Groups (QSGs), GMC, Ombudsman, CCGs, Healthwatch England, auditors, Health & Safety Executive, Patient groups, complaints, whistleblowers, Medical Royal Colleges

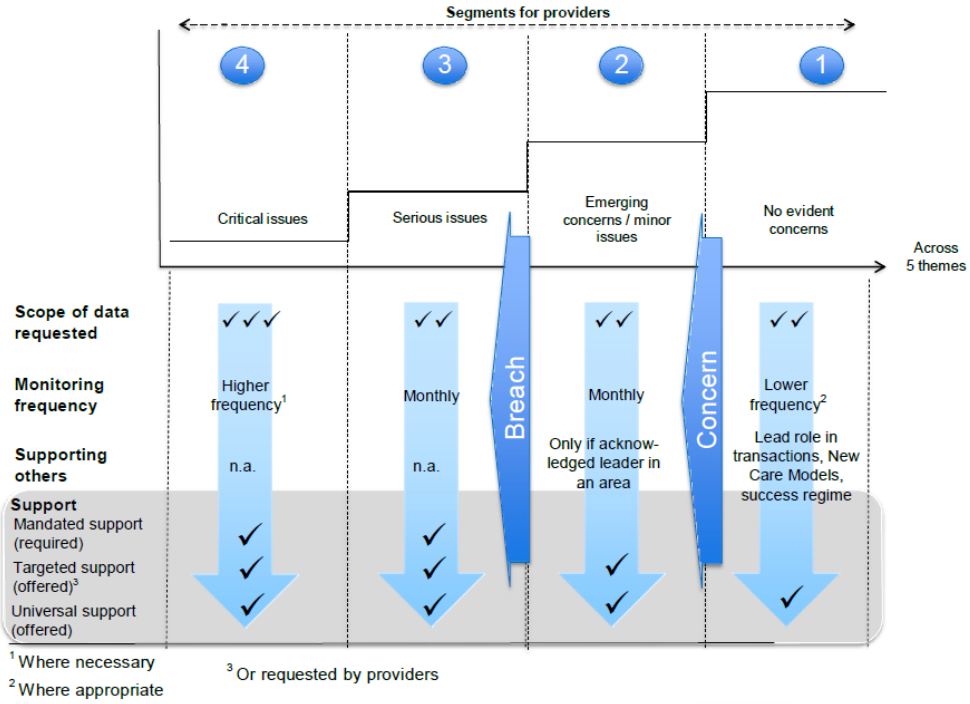
During 2016/17 NHSI will use the existing Monitor and TDA oversight templates to collect information. Notice will be given of changes to the collection as we develop our processes to gather information from providers.

### Segmentation Process

The segment a provider is placed in will reflect the seriousness and complexity of the issues it faces. Providers will be segmented as follows:

- no potential concerns identified: **segment 1**
- provider in licence breach (or equivalent for NHS trusts): **segment 3 or 4** -depending on the seriousness and/or complexity of the issues faced
- provider not in breach but still triggering a potential concern: **segment 2**.

The table below outlines how the provider section segmentation will work




## Overview of the Five Themes

### 1. Quality of Care

Where CQC's assessment identifies a provider as 'inadequate' or 'requires improvement' against any of the Safe, Caring, Effective or Responsive key questions, this will represent a potential concern and NHSI will consider what support is appropriate for the provider.

NHSI will supplement CQC's inspection findings with warning notices, any civil or criminal actions or changes to registration conditions to ensure that we use the most up to date CQC views of quality and also that their views on quality at providers yet to be inspected can be incorporated.

In a continuation of TDA's approach, NHSI will use a number of additional in-year quality-related metrics to identify emerging issues and/or scope for improvement at providers.

In addition NHSI will oversee delivery of 7 day hospital services across providers in order to identify where organisations need support. This will include assessing whether providers are delivering against an agreed trajectory to meet the four priority standards for 7 day hospital services. NHSI may, in time, extend this to monitoring other 7 day services standards and metrics where appropriate.

### 2. Finance And Use of resources

With regards to finance the objective of the new proposed oversight framework is to support providers in improving financial sustainability, delivering efficiency and controls relating to high profile policy imperatives such as agency staffing, capital expenditure and the overall improvement in financial performance of the sector. Additionally NHSI will work closely with CQC to co-develop an approach to overseeing providers' uses of resources.

NHSI reserve the right as the "Model Hospital" develops to include further efficiency metrics within the framework.

Table 1 below sets out the key metrics NHSI will take into account when assigning a risk factor to a provider.

**Table 1: Finance and Use of Resources Metrics**

| Metric | Rationale/considerations |
|---|---|
| Capital Service Capacity | Assess how much financial headroom providers have over interest or other capital charges (e.g. PFI payments). |
| Liquidity | Assess providers' short-term financial position, i.e. their ability to pay staff and suppliers in the immediate term. |
| Distance from control total or financial plan | As part of NHSIs' role in providing sector-wide financial oversight, NHSI are working with providers to agree control totals that will help the sector achieve financial balance. NHSI will track providers' positions against these through the year. |
| EBITDA margin | Assess providers' operating efficiency independent of capital structure or other factors. |
| Cost/Weighted Activity Unit - efficiency metrics<br>(to be run in shadow form in 2016/17 – NHSI will track but not incorporate in the financial rating) | NHSI are introducing a proposed efficiency metric, cost per weighted activity unit (WAU), developed as part of the Carter Review. This estimates provider efficiency by measuring the average cost of an average episode of care, taking into account different types of treatments (HRGs) and modes of delivery (e.g. elective, outpatient). The metric relates to a provider's efficiency improvement and will exclude factors that affect costs but are outside its control.<br>As reference costs are reported annually, NHSI will use different, more frequently reported, activity and cost datasets to calculate in-year costs per WAU. |
| Capital Controls<br>(as above, to be run in shadow form in 2016/17) | NHSI has a responsibility to ensure that capital expenditure remains within the system's means and will track providers' positions against their set capital limits over the year. |
| Agency spend<br>(as above, to be run in shadow form in 2016/17) | Monitor and TDA introduced controls on agency spend in 2015 in response to the sharp increases in agency costs seen since 2012. NHSI will continue to track agency spending at providers. Where NHSI have potential concerns, they will consider how best to support providers in addressing them. |

**Financial Risk Rating Metrics**

The proposed framework will aim to use financial metrics to oversee financial performance by:

- scoring providers 4 (poorest) to 1 (best) against each metric
- using provider performance average across all the metrics to arrive at an overall view of the provider.

Table 2 set out below details the key metrics and scoring levels

**Table 2 Financial Risk Ratings**

| Area | Metric | Definition | Score | | | |
|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4[1] |
| Financial sustainability | Capital service capacity | Degree to which the provider's generated income covers its financial obligations | >2.5x | 1.75-2.5x | 1.25-1.75x | <1.25x |
| | Liquidity (days) | Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown | >0 | (7)-0 | (14)-(7) | <(14) |
| Financial efficiency | EBITBA margin | EBITDA/total revenue | ≥5% | 3-5% | 0-3% | ≤0% |
| | Change in Cost per Weighted Activity Unit[2] | Assessing provider efficiency by measuring its average cost increases for an average episode of care (smaller is better) | ≤1.1% | 1.1%- 2.1% | 2.1%-3.1% | >3.1% |
| Financial controls | Capital controls[2] | Distance above capital control | <5% | 0-5% | 5-15% | ≥15% |
| | Distance from Control Total or financial plan | **Providers with control totals:** Ytd actual surplus/deficit vs. Ytd trajectory **Providers without control totals:** Ytd actual I&E surplus in comparison to the Ytd plan I&E surplus | ≥0% | (1)-0% | (2)-(1)% | ≤(2)% |
| | Agency spend[2] | Distance from provider's cap | ≤0% | 0%-25% | 25-50% | >50% |

The Board of Directors attention is brought to;

- Scoring a 4 on any metric will cap the overall rating to at most 3,triggering a concern
- Scores are rounded to the nearest whole number e.g. a score of either 2.2 or 2.5 would be rounded down to a 2

**Value for Money (VfM) considerations**

NHSI under the proposed oversight framework reserves the right to investigate whether there is, more broadly, sufficient evidence to suggest inefficient and/or uneconomical spending at a provider. Such spending may indicate that a provider is failing to operate effective systems and/or processes for financial management and control, and not operating economically, efficiently and effectively.

NHSI will use external sources of information i.e. national benchmarking to assess provider performance but will notify providers when appropriate national benchmarking information becomes available.

The Board of Directors attention is brought to NHSIs' right to in the absence of appropriate benchmarking to still consider investigating a provider if there is material evidence to suggest it is delivering poor VfM.

## 3. Operational Performance

NHSI will track providers' performance against, and support improvements in, a number of NHS Constitution standards and other metrics. Rather than require providers to make bespoke data

submissions, wherever possible NHSI will use nationally collected and evaluated datasets. NHSI will use the current metrics but may revise this list – introducing new metrics or varying the collection frequency – as necessary and appropriate, particularly as the Model Hospital work develops. NHSI will consider whether a potential concern has been triggered if:

- for a provider with one or more agreed Sustainability and Transformation Fund trajectories against any of the metrics: it fails to meet any trajectory for at least two consecutive months
- for a provider with no agreed Sustainability and Transformation Fund trajectory against any metrics: it fails to meet a relevant target or standard for at least two consecutive months
- where other factors (eg a significant deterioration in a single month, or multiple potential concerns across other standards and/or other themes) indicate NHSI need to get involved before two months have elapsed.

NHSI will then consider the nature of the issues and use this to identify the appropriate segment for the provider and develop the support offer.

## 4. Strategic Change

The 5 Year Forward View sets out the agenda for the change necessary to support a sustainable NHS. NHSI will consider the extent to which providers are working with local partners to address local challenges and improve services for patients. This will include their contribution to developing, agreeing and delivering Sustainability and Transformation Plans (STPs) as well as in some cases the implementation of new care models and implementation of devolution.

To begin with NHSI will use our forthcoming STP assurance process and associated reviews of STPs as our principal approach to oversight of this theme across providers. NHSI are working with NHS England to develop a consistent approach and are likely to consider:

- providers' relationships with local partners
- their plans (including STPs they are involved in)
- how far these plans have been implemented.

NHSI have published draft guidance on how we expect well-led providers to work with partners and collaborate locally to improve the quality and sustainability of services for patients. In this guidance we set out the expectation that providers should be engaging constructively with local partners to

- build a shared understanding of local challenges and patient needs
- design and agree solutions
- implement improvements.

NHSI have stressed that it will be important in their oversight and support offer to acknowledge the interplay between individual provider outcomes and delivery of aggregate outcome across a local health economy. As NHSI are still developing their approach under this theme, they invite input from the service on what other information they should collect and how they could identify where a provider may need support in this area. NHSI have agreed to look to hold engagement events on this theme during the consultation period.

This particular theme will be contentious as it falls outside of the current Provider Licence obligations and does not hold all partners in a health economy or STP to account.

## 5. Leadership and Improvement Capability

NHSI expect providers to demonstrate three main characteristics as part of this theme:

1. **Effective boards and governance**: NHSI will use a number of information sources to oversee provider leadership as used previously by Monitor and TDA, including:
   - information from third parties
   - staff/patient surveys
   - organisational metrics
   - information on agency spend
   - CQC 'well-led' assessments.

   NHSI will also draw on the existing well-led framework and associated tools to identify any potential concerns with the governance and leadership of a provider.

2. **Continuous improvement capability:** NHSI are working with CQC to consider how the current shared well-led framework needs to evolve to better reflect the theme of improvement.

3. **Use of data**: Effective use of information is an important element of good governance. Well-led providers should collect, use and, where required, submit robust data. Where NHSI have reason to believe this is not the case, they will consider the degree to which providers need support to do so in this area.

The approach in 2016/17

NHSI will review their approach to leadership and well-led, working with the CQC. In the meantime, NHSI propose using the same information previously collected by Monitor and TDA, augmented by other information where available, to identify potential leadership concerns at individual providers.

## Recommendations

The Board is asked to note the key elements of the proposed single oversight framework and agree that a formal response prepared by the Director of Finance and Director of Corporate Affairs is submitted for each of the consultation questions.

**Appendix 1 – Consultation Questions**

| |
|---|
| Consultation question 1:<br><br>What should we consider in seeking to ensure NHS Improvement and CQC's frameworks are as aligned as possible? |
| Consultation question 2:<br><br>(i) Do you agree with our proposed approach to the oversight of providers?<br><br>(ii) Do you consider that regular reporting should be on a weekly/ monthly or quarterly basis? Are there circumstances where oversight should be more or less frequent than these intervals?<br><br>(iii) Do you have any further comments on our overall approach? |
| Consultation question 3:<br><br>(i) Do you agree with our proposed approach to overseeing quality of care?<br><br>(ii) Given our and CQC's respective roles in the NHS, are there other approaches we could consider?<br><br>(iii) Are there other ways in which we could use this framework to identify where providers may need support to meet 7 day services requirements?<br><br>(iv) Do you have any further comments on our proposed approach to overseeing quality of care? |
| Consultation question 4:<br><br>(i) Do you agree with our proposed approach to overseeing finance and use of resources?<br><br>(ii) Do you agree with the chosen metrics?<br><br>(iii) Do you agree with the proposal to weight the metrics equally, or should some, eg distance from control totals and change in cost/WAU receive a higher weighting?<br><br>(iv) Are there any other metrics you consider we should use?<br><br>(v) Do you agree with our proposed approach to phasing in three of the metrics (change in cost/weighted activity unit, agency controls, capital expenditure controls) above?<br><br>(vi) Do you have any further comments on overseeing finance and use of resources? |

| |
|---|
| Consultation question 5 :<br>(i) Do you agree with our proposed approach to overseeing operational performance?<br>(ii) Do you agree with the metrics proposed in Appendix 3?<br>(iii) Are there other metrics or approaches we should also consider?<br>(iv) Do you have any further comments on overseeing operational performance? |
| Consultation question 6: What should we consider to identify potential issues and/or potential support needs in the area of Strategic change? |
| Consultation question 7:<br>(i) Do you agree with our proposed approach to overseeing providers' leadership and improvement capability?<br>(ii) Are there other factors we should incorporate to identify where providers may require support?<br>(iii) Do you have any further comments on overseeing leadership and Improvement capability? |
| Consultation question 8:<br>(i) Do you agree with our proposed approach to segmentation?<br>(ii) Do you have any further comments on segmentation? |
| Consultation question 9 :<br>Do you agree with our proposed approach to supporting providers? |

| Board of Directors | |
|---|---|
| **Agenda Item** | 8.4 |
| **Title of Report** | Equality & Diversity Update Report July 2016 |
| **Date of Meeting** | 27 July 2016 |
| **Author** | Alison Quinn, Head of Patient Experience |
| **Accountable Executive** | Gaynor Westray, Director of Nursing and Midwifery |
| **BAF References**<br>• **Strategic Objective**<br>• **Key Measure**<br>• **Principal Risk** | 1A Risk 2835<br>1B Risk 1908<br>4A Risk 1909 |
| **Level of Assurance** | Gaps<br>Areas to be developed around Equality Delivery System (EDS2) |
| **Purpose of the Paper** | To note |
| **Data Quality Rating** | Silver – quantitative data that has not been externally validated, next step will be for external validation |
| **FOI status** | Document may be disclosed in full |
| **Equality Impact Assessment Undertaken** | No |

## 1. Executive Summary

This report details the progress that has been made since the annual Equality and Diversity (E&D) Report was published and shared at the April 2016 Board Meeting. The report identified gaps around the 'Equality Delivery System' 2 (EDS2), a framework for self-assessment introduced across the NHS in 2015.

Overall, the self-assessment for Wirral University Teaching Hospital (WUTH) undertaken by a Focus Group including staff from several different departments/services and staff side colleagues was very positive, with staff grading WUTH as 'Achieving' in 12 of the 18 individual criteria. Where self-assessed as 'Developing' in 5 of the areas, the focus group were able to identify areas of good practice; however there was recognition that we could be in a stronger position in some areas.

The organisation is committed to ensuring that it meets its obligations to advance E&D from both a workforce perspective and in its role as a provider of healthcare services. This report therefore includes the Trust's (established) E&D Action Plan, devised in order to support successful outcomes and sustainability, and updates that include actions aimed at improving the EDS2 standards.

The EDS2 self-assessment grading was as follows:

| Goal 1 - Better Health Outcomes | | Assessment Rating (subject to verification) Undeveloped/Developing/Achieving/Excelling |
|---|---|---|
| 1.1 | Services are commissioned, procured, designed and delivered to meet the health needs of local communities. | Achieving |
| 1.2 | Individual people's health needs are assessed and met in appropriate and effective ways. | Developing |
| 1.3 | Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed. | Developing |
| 1.4 | When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse. | Achieving |
| 1.5 | Screening, vaccination and other health promotion services reach and benefit all local communities. | Achieving |
| **Goal 2 – Improved Patient Access and Experience** | | |
| 2.1 | People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds. | Achieving |
| 2.2 | People are informed and supported to be as involved as they wish to be in decisions about their care. | Achieving |
| 2.3 | People report positive experiences of the NHS. | Achieving |
| 2.4 | People's complaints about services are handled respectfully and efficiently. | Achieving |
| **Goal 3 – A representative and supported workforce** | | |
| 3.1 | Fair NHS recruitment and selection processes lead to a more representative workforce at all levels. | Achieving |
| 3.2 | The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfill their legal obligations. | Achieving |
| 3.3 | Training and development opportunities are taken up and positively evaluated by all staff. | Developing |
| 3.4 | When at work, staff are free from abuse, harassment, bullying and violence from any source. | Achieving |
| 3.5 | Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives. | Achieving |
| 3.6 | Staff report positive experiences of their membership of the workforce. | Achieving |
| **Goal 4 – Inclusive Leadership** | | |
| 4.1 | Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations. | Undeveloped |
| 4.2 | Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed. | Developing |
| 4.3 | Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination. | Developing |

The WUTH focus group acknowledged that the overall rating of 'Achieving' in Goals 1-3 reflect well on the organisation and how it has been led by the Board and senior leaders. In relation to the specific criteria for 4.1 they were unable to identify sufficient evidence to grade this criterion as 'Developing' and thus rated this component as 'Undeveloped'.

Following external verification, which consisted of the self-assessment findings being reviewed by Healthwatch and WUTH holding a focused 'E&D and Human Rights' public event 18th May 2016 in the main foyer of Arrowe Park Hospital, supported by the Chairman and Director of Nursing & Midwifery, resulted in full agreement with the self-assessment ratings as detailed in the table above. This very successful event was aimed at highlighting the excellent work being carried out in the Trust to make sure we are meeting the needs of our local community, in addition to supporting our dedicated, hardworking staff. Positive feedback was received from both staff, patients and the general public regarding its inclusivity.

The event was promoted in the recent Trust 'PROUD Magazine' which outlines the organisation's commitment to delivering continuous improvements in all that we do. As well as speaking about the commitments that the Trust currently has in place, views about any areas in which the public felt there were improvements to make were listened to and acknowledged. This information was then presented to Patient and Family Experience Group (PFEG) members.

One of the main areas identified for improvement was a request for increase in disabled parking spaces, which has now been added to the E&D Action Plan.

**2. Next Steps**

- Monitor the E&D Action Plan at PFEG as a standing item on the agenda
- Achieve the targets outlined with the 2016/17 Quality Schedule
- Monitor and escalate any gaps in progress regarding the implementation of the E&D action plan to the Board of Directors
- Benchmark performance against other NHS Organisations to identify areas for development
- Throughout 2016/17 develop quarterly stakeholder groups that reflect our population including people whose characteristics are protected by the Equality Act 2010
- Board members and senior leaders to engage in equality based initiatives
- Explore options for Board and Sub-Board Leadership Programmes for Equality & Diversity
- Workforce elements of this paper will be picked up within the Workforce Annual Report which is received by Trust Board each May (as per Workforce Equality standard)

**3. Recommendations**

The Board is asked to note the content of the Trust Equality and Diversity Action Plan and agree the specific actions identified in the 2015/16 Self-Assessment as described in Objective 10.

**Objective 1 – Ensure the Board of Directors are paying due regard to the PSED in BOD decisions and considerations**

| ACTION | Due date | Comments | Next Review Date |
|---|---|---|---|
| Complete a review of BOD papers to assess consideration of PSED | Oct 2014 | Review competed by Associate Director of Governance, BoD cover sheet revised to ensure that the requirement for an Equality Analysis is an implicit requirement (Completed) | Oct 2015 (Completed) |
| Undertake an equality analysis of Trust Recovery Plan | Aug 2015 | 1) Agree methodology (Complete) – May 2015<br>2) Undertake initial assessment of CIP schemes (Complete) – Jun 2015<br>3) Share results with work stream leads and request further evidence to support initial assessment (Complete) – July 2015<br>4) Produce summary report for Board of Directors (Complete ) – August 2015 | March 2016 or by exception if any schemes change scope (Completed) |

**Objective 2 – Deliver revised Equality & Diversity Training to all staff**

| ACTION | Due date | Comments | Next Review Date |
|---|---|---|---|
| Design revised training for all staff | Aug 2014 | Design Complete – August 2014 | Sep 2017 |
| Distribute revised training to all staff | Sep 2014 | Distribution Complete | Sep 2017 |

**Objective 3 – Develop senior capability in Equality & Diversity**

| ACTION | Due date | Comments | Next Review Date |
|---|---|---|---|
| Design and Complete Board of Directors Development Session on PSED and Unconscious Bias | May 2015 | Competed<br>Equality and Diversity Annual report presented to BOD – Inclusive leadership has been highlighted as an area for further development which will be reviewed at workforce and communications group for action planning | May 2016 (Reviewed)<br><br>Nov 2016 |
| Design and Complete development session for senior leadership teams | Oct 2015 | Outstanding | |

**Objective 4 – Develop/Improve care pathways for patients admitted with a Learning Disability**

| ACTION | Due date | Comments | Next Review Date |
|---|---|---|---|
| Establish a working group to plan LIA listening event to review care pathways | Oct 2014 | Planning completed – November 2014 | n/a |
| Deliver LIA Listening Event to include people with LD, Carers, Staff, Representative Groups and former complainants | Dec 2014 | Event completed – December 2014 | n/a |
| LIA Action – Develop link nurse role to act as subject matter expert on LD | May 2015 | 1. Senior Sister identified to specialise in LD and improve clinical capability to staff on wards – Compete - August 2015<br>2. Develop targeted training for staff in partnership with Cheshire and Wirral Partnership Trust – In progress | Complete<br><br>In progress Reviewed May 2016 and ongoing |

**Continued**
**Objective 4 – Develop/Improve care pathways for patients admitted with a Learning Disability**

| ACTION | Due date | Comments | Next Review Date |
|---|---|---|---|
| LIA action - Design and implement electronic recording of patients with LD admitted to hospital | Nov 2015 | 1) Develop electronic method for identifying LD patients on Wirral Millennium<br>2) Pre load CWP Wirral Caseload to Wirral Millennium<br>3) Develop SOP for use of electronic recording on admission to hospital<br>4) Develop Electronic Daily Record (EDR) for LD patients<br>5) Develop audit methodology utilising electronic records<br><br>Action 3 & 5 will be incorporated into the implementation of the accessibility standard | 1. Complete July 2015<br>2. Complete July 2015<br>3. Due October 2015 ongoing – review July 2016<br>4. Due October 2015 (Completed)<br>5. Due Nov 2015 ongoing – review July 2016 |

**Continued**
**Objective 4 – Develop/Improve care pathways for patients admitted with a Learning Disability**

| ACTION | Due date | Comments | Next Review Date |
|---|---|---|---|
| Develop a referral methodology for referrals from primary to secondary acute care | **Pilot Oct 2015** | **1. Agree referral methodology with CCG LD Lead and CWP**<br>**2. Design referral pro forma for review at LD Single Assessment Framework Steering Group**<br>**3. Agree governance for use of referral form with CCG GP lead**<br>**4. Identify pilot practices based on CWP patient prevalence data**<br>**5. Brief pilot GP practice managers**<br>**6. Brief Wirral Booking Office/TCI Office and Acute Assessment Areas**<br>**7. Complete pilot 1/10/15 to 31/12/15**<br>**8. Evaluate and report to LD SAF Steering Group**<br><br>**Actions 5, 6,7, 8 will be incorporated as part of the implementation of the accessibility standard** | **1) Complete April 2015**<br>**2) Complete May 2015**<br>**3) Complete July 2015**<br>**4) Complete July 2015**<br>**5) Due for completion Sep 2015 – ongoing review July 2016**<br>**6) Due for completion Sep 2015 – ongoing review July 2016**<br>**7) Dec 2015 – ongoing review July 2016**<br>**8) Feb 2016 – ongoing review July 2016** |

**Objective 5 – Review information provision for patients with protected characteristics**

| ACTION | Due date | Comments | Next Review Date |
|---|---|---|---|
| 1) Produce versions of 'Coming into hospital' and ward bedside folder in large print and most common used languages (Can be provided by exception on request at present)<br>2) Produce easy read versions of Coming into Hospital and ward bedside folder<br>3) Review access of EIDO leaflets in easy read | May 2015<br><br>Oct 2015 (revised) Nov 2015 | 1) Action in progress, tendering exercise in progress for single Interpretation and Translation provider to include provision of translated documents. New 'Communicating with pictures' booklet implemented which includes most common phrases in second languages<br>2) Easy read versions completed in partnership with Community Action Wirral and validated by CWP, Due for review by reading group in Sep 2015 prior to go live. 'Communicating with pictures' booklet implemented which includes support for patients with LD<br>3) Confirmation received that EIDO leaflets available in easy read including conformation of costs – August 2015 | 1. Sep 2015 (Completed)<br>2. Oct 2015 (Completed)<br>3. Oct 2015 (Completed) |

**Objective 6 (New) – Review access for patients with hearing loss to hospital**

| ACTION | Due date | Comments | Next Review Date |
|---|---|---|---|
| Develop joint collaboration with Healthwatch and Merseyside Society for the Deaf | May 2015 | Joint meetings established | ongoing |
| Complete a scoping visit to the Emergency Department (identified as priority area by MSDP) | Jun 2015 | Visit compete June 2015 (awaiting resulting recommendations for action)<br>Health watch are now progressing all outcomes in partnership with MSDP | ongoing |

**Objective 7 (New) – Assess and progress action to meet the requirements of the Workforce Race Equality Standard**

| ACTION | Due date | Comments | Next Review Date |
|---|---|---|---|
| 1. Complete baseline assessment using NHS England Methodology<br>2. Report to PFEG and WCG with baseline assessment results and actions<br>3. Incorporate actions into wider E & D Action Plan<br>4. Report progress as required in SDIP | August 2015<br>Oct 2015<br><br>Oct 2015<br><br>Oct 2015/May 2016 | 1. Baseline Completed and Published<br>2. Due PFEG<br><br>Annual Equality & Diversity report presented to BOD | 1. Complete<br>2. Oct 2015 (Completed)<br>3. Oct 2015 (Completed) |

**Objective 8 (New) – Assess and progress action to meet the requirements of the NHS Accessible Information Standard**

| ACTION | Due date | Comments | Next Review Date |
|---|---|---|---|
| 1. Complete baseline assessment<br>2. Agree governance reporting<br>3. Report assessment results and actions | Sept 2015<br>Oct 2015<br>Oct 2015 | 1. Baseline assessment in progress<br><br>Corporate Lead Pam Leonard progressing implementation across the Trust | 1. 30/9/15<br><br>Ongoing – review July 2016 |

**Objective 9 (New) – Equality Delivery System (EDS) 2 - Self Assessment**

| ACTION | Due date | Comments | Next Review Date |
|---|---|---|---|
| 1. Present self assessment to Board within annual E&D Report<br>2. External verification of self-assessment<br>3. Hold public E&D event , as part of National Awareness Week<br>4. Proposed objectives/actions presented to Board | April 2016<br><br><br><br>July 2016 | 1. Presented to Board awaiting results of external verification before agreeing aligned objectives<br>2. External verification agreed with all self-assessment ratings<br>3. As part of the public event, self-assessment results were presented and areas of celebration and improvement identified from key stake holders | |

**Objective 10 – Proposed Objectives / Outcomes from 2015/16 Self Assessment**

| ACTION | Due date | Comments | Next Review Date |
|---|---|---|---|
| 1. Increase links with our British Racial Minority (BRM) Groups working in partnership with Healthwatch<br>2. Representation from hard to reach groups will be actively sought and identified; attendance at PFEG will be requested<br>3. Facilitate quarterly Stakeholder Groups that reflect our local population<br>4. Discuss provision of extra disabled car parking spaces with Facilities Dept.<br>5. Work with HROD in order that staff members feel supported and have individual health and cultural needs acknowledged/addressed | July 2016<br><br>September 2016<br><br>Quarter 2<br><br>July 2016<br><br>September 2016 | 1. Contact made with Healthwatch Leads and request made to support strengthening of links with our community groups | |

| BOARD OF DIRECTORS | |
|---|---|
| **Agenda Item** | 8.5 |
| **Title of Report** | Research Annual Report |
| **Date of Meeting** | 27th July 2016 |
| **Author** | Dr Melanie Maxwell<br>Ms. Paula Brassey |
| **Accountable Executive** | Dr Evan Moore |
| **BAF References**<br>**Strategic Objective**<br>**Key Measure**<br>**Principal Risk** | Risk 2795 participation in research studies |
| **Level of Assurance**<br>**Positive**<br>**Gap(s)** | Positive |
| **Purpose of the Paper**<br>**Discussion**<br>**Approval**<br>**To Note** | Factual report of previous 12 months activity, data around KPI and financial performance and assurance around meeting Trust strategy. |
| **Data Quality Rating** | Gold – externally validate |
| **FOI status** | Document may be disclosed in full |
| **Equality Impact Assessment Undertaken**<br>**Yes**<br>**No** | N/A |

**1. Executive Summary**

Factual report of previous 12 months activity, data around KPI and financial performance and assurance around meeting Trust strategy.

The report comes to Trust Board as part of the prescribed cycle of business; the report has been reviewed at Clinical Governance Group

**2. Next Steps**

The Board should review the report, and whilst a mixed picture in that not all KPIs have been achieved note the successes and advances through the year.

# Research Annual Report 2015/16

Paula Brassey, Research Manager

July 2016

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**Appendix**

## 1. Introduction

Research is vital in order to provide evidence to improve treatment for patients within our care. The Trust undertakes a range of clinically diverse research, from complex phase ll clinical trials of investigational medicinal products (to test a new drug or to test a licensed drug in a different way) to asking patients to complete a simple questionnaire regarding their quality of life. The research is sponsored by national charities, academic institutions or pharmaceutical companies.

The research core team consists of a Research Manager, Research Coordinator, Data Coordinator, 13 Research Nurses and a Research Midwife. The majority of these posts are funded by National Institute of Health Research and some are partially funded from commercial research or the Trust.

In 2014 a new research strategy was produced outlining the key priorities for research within the Trust until 2019. The main aim of the new strategy is to increase and improve research activity within the Trust by embedding research into everyday practice.

## 2. Research Governance

During 2015/16 the Health Research Authority (HRA) significantly changed how research is approved throughout England. HRA Approval is the new process for the NHS in England that brings together the assessment of governance and legal compliance, undertaken by dedicated HRA staff, with the independent Research Ethics Committee opinion provided through the UK Health Departments' Research Ethics Service. It replaces the need for local checks of legal compliance and related matters by each participating organisation in England. Participating organisations instead need to assess, arrange and confirm their capacity and capability with the study sponsor prior to starting recruiting. The Research Department will continue to liaise with appropriate Trust departments for all new studies prior to issuing confirmation of capacity and capability. The final roll-out of these changes was implemented 1 April 2016.

One of the changes to research within England that the HRA have introduced is for some simple, non-interventional studies not to require Trusts to even confirm capacity and capability. The Trust is just notified about the research. During 2015/16 this has applied to 7 new studies; see appendix 1 for more information.

In addition to implementing new studies the Research Department is also responsible for processing in excess of 150 amendments to on-going studies each year.

It is the responsibility of each individual member of staff to inform the Research Department about any research they wish to undertake and it is a requirement that all staff involved in research must have up-to-date Good Clinical Practice (GCP) Training. GCP is the ethical and practical standard to which all clinical research is conducted.

## 3. National Institute of Health Research

The National Institute for Health Research (NIHR) is a national organisation funded through the Department of Health. The NIHR Clinical Research Network consists of 15 Clinical Research Networks; this Trust's local network is North West Coast Clinical Research Network (NWC CRN). The NWC CRN is responsible for ensuring the effective delivery of research in the Trusts, primary care organisations and other qualified NHS providers throughout the North West Coast area.

Approximately two thirds of the research undertaken within the Trust has been adopted onto the NIHR portfolio of studies. During 2015/16 the Trust granted NHS permission (R&D approval) for 29 new NIHR adopted studies:

- 10 Clinical Trials of Investigational Medicinal Products (CTIMPs)
- 3 Clinical trials to study a novel intervention or randomised clinical trial to compare interventions in clinical practice.
- 6 Studies administering questionnaires / interviews.
- 5 Studies limited to working with human tissue samples or data only
- 4 PIC Studies (The Trust acts as a Participant Identification Centre)
- 1 Other

See appendix 2 for details of NIHR studies and appendix 3 for details of PIC studies granted NHS permission during 2015/16.

### 3.1.1 NIHR Recruitment

One of the national key performance indicators (KPIs) for research is the number of participants recruited onto NIHR portfolio studies. The Trust's recruitment target is agreed with NWC CRN and is based on the number and complexity of planned studies.

Recruitment is very dependent on the type of studies the Trust has open. Some studies are highly complex Clinical Trials of Investigational Medicinal Products (CTIMPs) and individual recruitment aims for these studies is low (typically max. 10 per study). Simpler observational or questionnaire studies by contrast are much easier to recruit to and have

much higher recruitment numbers. See appendix 4 for recruitment information by speciality.

### 3.1.2 Cancer Recruitment

During 2015/16 the Trust recruited 31 cancer patients to studies; predominately to malignant haematology studies. Cancer patients diagnosed at this Trust are frequently referred to specialist cancer centres for routine treatment. Some of these patients are subsequently recruited onto a study by the specialist cancer centre. See appendix 5 for information.

### 3.1.3 National Cancer Patient Experience Survey

The National Cancer Patient Experience Survey highlighted that few patients had seen information about cancer research around the hospital and that few patients had cancer research discussed with them. There are now specific noticeboards at various locations throughout the Trust providing information about research. In January 2016 the ADD-Aspirin study was opened across 3 specialities: colorectal, breast and prostate. In May 2016 POSNOC breast cancer study was opened and the LORIS breast cancer study is due to open shortly.

The ADD-Aspirin study is a placebo-controlled randomised trial assessing the effects of aspirin on disease reoccurrence and survival after primary therapy in common non-metastatic solid tumours. The POSNOC study is a randomised controlled trial of axillary treatment in women with early stage breast cancer who have metastases in one or two sentinel nodes. The LORIS study is a trial of surgery versus active monitoring for low risk ductal carcinoma in situ.

### 3.2 NIHR High Level Objectives

Each month the North West Coast Clinical Research Network (NWC CRN) forwards a Research Summary Report for each Trust within the Network. The Research Summary Report provides information with regard to NIHR key performance indicators; details below for information since 2013.

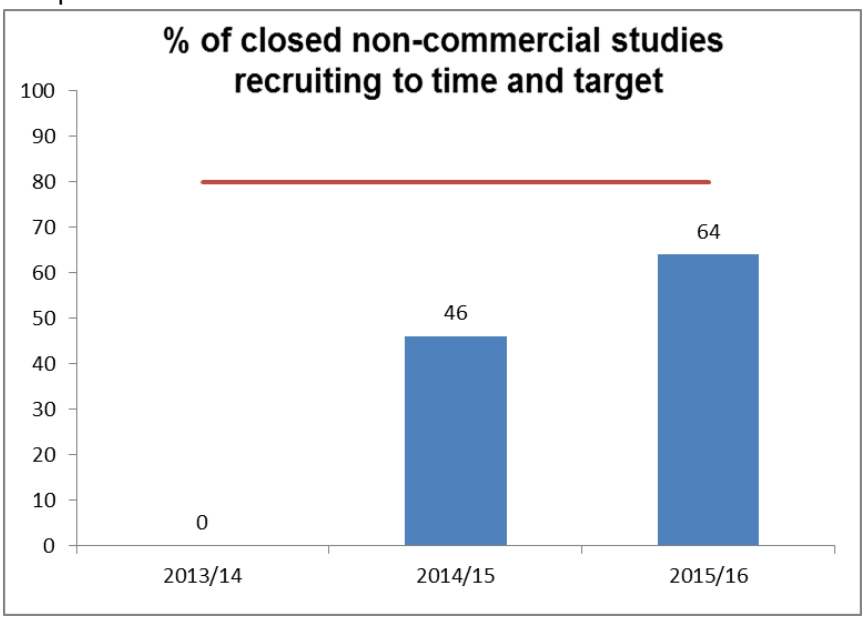
| Target Information | Target | Trust Achieved 2013/14 | Trust Achieved 2014/15 | Trust Achieved 2015/16 |
|---|---|---|---|---|
| Recruitment Target: | | | | |
| **2013/14** | 400 | 860 | 640 | 503 |
| **2014/15** | 440 | | | |

| | | | | |
|---|---|---|---|---|
| **2015/16** | 400 | | | |
| Proportion of closed **commercial** studies recruiting to time and target (achieving or surpassing recruitment target during their planned recruitment period). | 80% | 67%<br>N° of studies = 3<br>2 achieved target | 60%<br>N° of studies = 5<br>3 achieved target | 100%<br>N° of studies = 1<br>1 achieved target |
| Proportion of closed **non-commercial** studies recruiting to time and target (achieving or surpassing recruitment target during their planned recruitment period). | 80% | 0%<br>N° of studies = 6<br>0 achieved target | 46%<br>N° of studies = 13<br>6 achieved target | 64%<br>N° of studies = 11<br>7 achieved target |
| Proportion of local processes completed and NHS permission (R&D approval) issued.<br>2013/14 target = 30 days<br>2014/15 target = 15 days | 80% | 100%<br>N° of studies = 21<br>21 achieved target. | 96%<br>N° of studies = 23<br>22 achieved target | Not reported this year due to HRA changes to approval processes |
| Proportion of all studies achieving NHS permission (R&D approval) to first patient recruited within 30 calendar days. | 80% | 43%<br>N° of studies = 7<br>3 achieved target | 47%<br>N° of studies = 15<br>7 achieved target | Not reported this year due to HRA changes to approval processes |

### 3.2.1 NIHR Target Summary

A notable area of improvement for the Trust since 2013/14 is the increase in the number of non-commercial studies closing that achieved their recruitment target (see graph 1).

Graph 1




Due to the changes in the HRA approval process the metrics for 2016/17 have been amended and research departments throughout England will be required to record and report increasing amounts of information in relation to study set up times and recruitment.

### 3.3 NIHR Central Commissioning Facility (CCF) Performance in Initiating and Delivering Clinical Research (PID)

From October 2014 the Trust was required to start producing two quarterly reports to the NIHR on the performance in initiating clinical research and also delivering clinical research. This information partially duplicates the information recorded and reported by NWC CRN.

The NIHR CCF PID reports relate to clinical trials only (therefore observational / data only / questionnaire studies are excluded). The report is for both NIHR adopted and non-NIHR adopted studies. The Trust has complied with the requirement for this information to be available on the Trust public web-site.

#### 3.3.1 Q4 2015/16 NIHR Central Commissioning Facility Report

The Q4 2015/16 report produced by the NIHR confirms that this Trust belongs to League 5 (leagues are based on number of studies approved by site – similar sized research departments are 'grouped' together so sensible comparisons can be made. League 5 consists of 27 Trusts).

**VRA (valid research application) to first patient recruited**
WUTH ranked 1st on league.

**VRA to NHS Permission**
WUTH ranked 25 on league (due to one study taking 50 days to grant NHS Permission instead of 15; all other studies achieved target).

**NHS Permissions to first patient recruited**
WUTH ranked 2nd on league.

### 3.3.2 Breakdown of information provided by Trust

During 2015/16 the Trust granted NHS permission for 13 new clinical trials.

The reports provide information on:

- The length taken to grant NHS permission.
- The length taken to recruit the first patient.
- The Trust's ability to deliver to time and target (i.e., did the Trust recruit the agreed number of patients in the agreed timescales).

### 3.3.3 The length taken to grant NHS permission

The benchmark is for 80% of clinical trials to grant NHS permission within 15 days of a valid research application. The Trust achieved 92% (n=12).

### 3.3.4 The length taken to recruit the first patient

The benchmark is for 80% of clinical trials to recruit the first patient within 70 days from receipt of valid research application. The Trust achieved 15% (n=2). The reason for not achieving this benchmark is included within the reports; brief information below:

3 x delays due to study sponsor issues
5 x no patient identified
1 x patient identified but declined to participate
1 x study opened as an extension to an earlier study. Only one patient eligible and patient must have completed earlier study before becoming eligible for this study.
1 x protocol driven delay between giving patient information and ability to consent (in line with standard clinic visits)

### 3.3.5 Deliver to time and target

This benchmark relates to closed commercial studies only. The benchmark is for 80% of studies to recruit to time and target. Of the 3 commercial clinical trials closed during 2015/16 none achieved the target.

### 3.3.6 NIHR CCF PID Target Summary

It is unlikely that all the NIHR PID targets will be reached, often the reasons are external rather than Trust related issues. The NIHR are aware of this and are closely monitoring reasons provided by all Trusts.

## 4. Non NIHR Research

In addition to NIHR portfolio research the Trust undertakes non-portfolio research. This is generally single site studies led by Trust consultants, Trust staff undertaking research modules within masters or PhD qualifications or external researchers undertaking research across several sites. During 2015/16 the Trust granted NHS permission for 16 non-NIHR adopted studies.

See appendix 6 for full list of non NIHR studies.

## 5. Collaborative Working

### 5.1 Clatterbridge Cancer Centre

The Trust continues to work in conjunction with Clatterbridge Cancer Centre (CCC). Some of the commercial studies opened at CCC require this Trust to undertake some research specific activities, e.g. Ophthalmology tests that CCC is not able to perform. During 2015/16 the Trust agreed 13 new sub-contracts relating to this work. The Trust receives income for this work.

### 5.2 Research Passports

Under the NIHR Research Passport Scheme during 2015/16 the Trust issued 25 Letters of Access to allow researchers from other Trusts or universities to undertake research related activities within the Trust.

Research Passports are recommended by the Department of Health and were introduced to provide a process for handling HR arrangements for external researchers. The process,

agreed with Trust HR, provides a streamlined approach for confirming details of the pre-engagement checks of each researcher (this includes Occupational Health Check, confirmation of Disclosure Barring Service clearance, Trust Code of Confidentiality and basic mandatory training, if applicable).

### 5.3 Key-Service Support

One of the aims of the NIHR was to ensure that a broad-based infrastructure was in place to enable researcher's access to facilities and support services in order to be able to participate in studies. The Trust receives funding to support the Pharmacy, Pathology and Radiology Departments to cover costs for any research related activity for NIHR adopted studies. (Also see Finance 6.1 below).

#### 5.3.1 Pharmacy

The Trust pharmacy department continues to support clinical trials involving Investigational Medicinal Products (IMPs) and provides a dispensing and aseptic preparation service for IMPs. During 2015/2016 11 trials involving IMPs were opened and 6 closed down, leading to an increase in the total number of active trials requiring pharmacy input from 29 at the start of the year to 34 at the end. January to May 2016 the pharmacy department was unable to support the opening of any new haematology trials due to vacancies in the pharmacy haematology clinical team and the large amount of work involved in opening a haematology trial. Work is ongoing to assess current capacity and resource within the pharmacy clinical trial team.

The Trust is providing a pharmacy clinical trial service under a SLA to Cheshire and Wirral Partnership for one study and has been approached to support them with a further study.

The pharmacy clinical trials team has continued to work closely with Principal Investigators (PI's), research nurses and the Research Department to ensure trial set up and initiation is as smooth and efficient as possible. A report listing ongoing IMP trials is provided to Diagnostic & Therapies on a quarterly basis.

#### 5.3.2 Pathology

The Pathology Department supports research within the Trust by providing a wide-range of clinical services, including histopathology, cytology, blood sciences and microbiology. During 2015/16 11 of the studies granted Trust NHS permission (R&D approval) also required pathology approval. In addition to undertaking research related activity for the Trust, the Pathology Department also provides a service to Clatterbridge Cancer Centre for some of their research related activity.

### 5.3.3 Radiology

The Radiology Department supports research within the Trust by offering a full range of imaging including MRI, CT and plain films. For some studies the department provides investigations for outside review; other studies rely on diagnosis and interpretation by sub-speciality radiologists. During 2015/16 4 of the studies granted Trust NHS permission also required radiology approval. The Radiology Department occasionally provides a service to Clatterbridge Cancer Centre for some of their research related activity.

### 5.4 Non-invasive for bronchiolitis management feasibility study (NOVEMBR)

Trust Consultant Paediatric Dr David Lacy is part of the main study team for this new study. The study is sponsored by Alder Hey Children's Hospital and funded by NIHR Research for Patient Benefit. A collaboration agreement has been agreed between Alder Hey, The University of Liverpool and the Trust to support this research.

### 5.5 Junior doctors supporting research

Many doctors below consultant level contribute to research within the Trust. 14 doctors have been added to the study delegation logs of 26 studies to enable them to participate in research; they will all have undertaken NIHR Good Clinical Practice (GCP) training (4 CPD points). See Appendix 7 for a list of doctors, below consultant level, working on NIHR studies.

### 5.6 Innovation

In 2014 the Trust entered into an agreement with Trustech. Trustech provides the Trust and other North West NHS organisations throughout the region with an Innovation Service. The aim is to help NHS staff turn new ideas into products to meet the demands of future healthcare needs and spread innovative ideas across hospitals and community settings. Under the Trust's agreement with Trustech staff can access support for innovative ideas, including intellectual property advice to how to commercialise a new idea. The Research Department acts as the liaison between Trust staff and Trustech.

### 5.7 National Institute for Health Research - Collaboration for Leadership in Applied Health and Research Care - North West Coast: NIHR CLAHRC NWC

In 2015 the Trust entered into a partnership agreement with CLAHRC NWC; the other parties are:

- The NHS Liverpool Clinical Commissioning Group
- The University of Liverpool

- University of Central Lancaster
- Lancaster University

The aim of the partnership is for the parties to work collaboratively to deliver a research programme designed to decrease health inequalities and improve the health of the population of the North West Coast.

### 5.7.1 Care After Presenting with Seizure to Emergency Services (CAPS)

As part of the CLAHRC NWC partnership agreement the Trust is participating in the CAPS research study. The aim of the research is to determine whether the wide, and unacceptable, variability in care given to patients presenting with a seizure can be improved by implementation of the new care pathway and whether this can be enhanced further with implementation of a research nurse.

## 6. Funding

Funding for research within the Trust is received predominately from NWC CRN and other income is from commercial research.

### 6.1 NIHR funding

The Trust receives income from North West Coast Clinical Research Network to cover the costs of working on NIHR adopted studies; breakdown below of recent funding:

| | **2013/14 Funding from Merseyside and Cheshire Comprehensive Local Research Network** | **2014/15 Funding from North West Coast Clinical Research Network** | **2015/16 Funding from North West Coast Clinical Research Network** |
|---|---|---|---|
| Research Nurses | £313,136 | £331,329 | £297,594 |
| Pharmacy key-service support | £39,956 | £60,791 | £40,791 |
| Pathology key-service support | £20,000 | £40,000 | £20,000 |
| Radiology key-service support | £20,000 | £20,000 | £20,000 |
| Research Management & Governance | £29,700 | £20,974 | £19,147 |

| | | | |
|---|---|---|---|
| Data Support | £13,239 | £19,455 | £19,954 |
| PA Allocation | 0 | £50,000 | 0 |
| **TOTAL** | **£436,031** | **£542,549** | **£417,486** |

### 6.1.2 Consultant PA Allocation

Consultant PA allocations used to be routinely allocated to Trusts to support consultants work on NIHR adopted studies. This allocation to Trusts is unlikely to be available again. Consultant PA allocations are now paid if consultants are appointed as Speciality Research Group (SRG) Leads or take on additional roles within the NWC CRN. Currently there are no consultants within the Trust who act as an SRG Lead or who have additional roles within the NWC CRN.

- 2011/12 £62,500
- 2012/13 £18,750
- 2013/14 Nil
- 2014/15 £50,000
- 2015/16 Nil

### 6.2 Research Capability Funding

During the past few years the Department of Health have allocated £20,000 Research Capability Funding (RCF) to research active Trusts if they recruited more than 500 participants to non-commercial NIHR studies in the previous year.

In March 2015 the NIHR announced that it was rewarding all Trusts additional Network Research Capability Funding (nCRF) funding for commercial studies that had recruited to time and target. The allocation allowance per qualifying study has changed and reduced since its introduction.

| | **2013/14** | **2014/15** | **2015/16** | **2016/17** |
|---|---|---|---|---|
| Research Capability Funding | £20,000 | £20,000 | 0 | Information not yet available |
| Network Research Capability Funding | Payments first made in 2015/16 | | £31,000 (based on 2013/14 | £12,056 (based on 2014/15 |

| | | | |
|---|---|---|---|
| | | performance – 4 qualifying studies) | performance - 4 qualifying studies) |

### 6.3 Commercial Income

The Trust receives income from commercial sponsored research; the majority of which goes directly to the speciality undertaking the research though the Research Department does keep a proportion to cover costs and also for capacity building. Breakdown below of current and previous year's commercial income:

| | 2013/14 | 2014/15 | 2015/16 |
|---|---|---|---|
| Divisions | £85,025 | £93,229 | £95,108 |
| Research Department | £40,971 | £39,769 | £32,612 |

Commercial budgets for NIHR adopted studies are based on the nationally agreed NIHR Industry Costing Template; budgets for new studies are negotiated and agreed by the Research Department.

In April 2015 the NIHR introduced new guidelines regarding the allocation of income from commercial studies and a new Research Commercial Income Policy has been ratified to ensure the Trust complies with these new requirements.

### 6.4 Contracts

Most of the Trusts collaborative research requires the Trust to enter into a contract with the study sponsor; these contracts are based on a suite of model agreements and are completed and agreed by the Research Department.

## 7. Library

### 7.1 Publications

Since June 2012 the Trust Library and Knowledge Service (LKS) has been recording all publications that have been publicised via the Library Blog. The criteria for inclusion are that the articles have been listed on PubMed, Medline or EMBASE and have been written by members of WUTH staff. The Research Department have display space within the library

including a list of these articles. See appendix 8 for list of articles added to the blog from 1 April 2015 to 31 March 2016.

The LKS achieved a compliance score of 96% in their external quality assessment, the Library Quality Assurance Framework (LQAF) for health libraries, which includes an assessment of how well they support research activity within the Trust.

To encourage publication and help develop research skills the LKS invested in BMJ Case Reports to enable WUTH staff to publish case reports (avoiding the usual publication fee).

### 7.2 HEE Funding Bid

The Library and Knowledge Service was successfully awarded £115,000 from the Health Education North West Forerunner Fund for a study entitled "Measuring the Contribution of a Clinical Librarian in Critical Care." This is a 12 month research study to establish the knowledge requirements of critical care staff and patients, then pilot and evaluate a model of LKS support.

## 8. Additional Information

### 8.1 Advice and support

The Research Department continues to provide a wide range of advice and support to Trust and external researchers wishing to either undertake their own research project or be part of a collaborative multi-centre research project.

### 8.2 Future Research Annual Reports

Please offer comments, and suggestions for improvement of future Research Annual Reports to:

Paula Brassey — Research Manager
Ex 5246
Paula.Brassey@nhs.net

Dr Melanie Maxwell — Associate Medical Director
Ex 2212
Melanie.Maxwell@nhs.net

APPENDIX 1

List of studies not requiring Trust Confirmation of Capacity and Capability

| **Study Title** | **Type of Study** | **Study Sponsor** |
|---|---|---|
| A survey to provide baseline activity in relation to ward sister/charge nurse supervisory roles | Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology | University of Warwick |
| Use and Usefulness of Patient Experience Data: National Survey of patient experience leads in NHS acute Trusts | Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology | University of Oxford |
| What are the current models of care, and the resources needed to support them, for the management of HIV in primary care in the UK to inform optimal model development for people living with HIV | Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology | University College London |
| Perspectives on functional disturbance following rectal cancer surgery | Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology | Imperial College London |
| WEB-RADR | Study limited to working with data (specific project only) | UCL Institute of Child Health |
| INTERACT: Therapist Survey and Delphi study | Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology | University of Bristol |
| Consultants perceptions on the determinants of adoption and diffusion of innovation in cancer treatment | Study involving qualitative methods only | Imperial College London |

APPENDIX 2

**List of NIHR adopted studies granted NHS permission (R&D Approval) 01/04/15 – 31/03/16**

| **Study Title** | **Type of Study** | **Principal Investigator / Speciality** |
|---|---|---|
| Review of current preceptorship programmes in North West NHS Trusts | Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology | No local investigator |
| Epidemiology, management, outcomes and pathophysiology of SCAD | Study limited to working with human tissue samples and data | Dr Saravanan Palaniappan, Cardiology |
| **MCL Biobank** – Establishing a biobank and database as a national resource for characterising indolent and aggressive forms of mantle cell lymphoma | Study limited to working with human tissue samples and data | Dr Barbara Hammer, Haematology |
| **CRASH-3 -** Tranexamic Acid for the treatment of significant traumatic brain injury: an international, randomised, double blind, placebo controlled trial | Clinical trial of an investigational medicinal product | Dr Andrea Wootten, A&E |
| **BEST –** The Bedside Evaluation of sensitive troponin | Other clinical trial to study a novel intervention or randomised clinical trial to | Dr Andrea Wootten, A&E |
| **AML 18 –** A Trial for older patients with acute myeloid leukaemia and high risk myelodysplastic syndrome | Clinical trial of an investigational medicinal product | Dr Ranjit Dasgupta, Haematology |
| Phase 2 of a Longitudinal National Evaluation of Schwartz Centre Rounds | Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology | Dr Juline Smit, Health Services |

| | | |
|---|---|---|
| **PUMA -** Paediatric early warning systems: Utility and Mortality Avoidance | Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology | Dr David Lacy, Paediatrics |
| **AML 19 -** Adults with acute myeloid leukaemia or high-risk myelodysplastic syndrome | Clinical trial of an investigational medicinal product | Dr Ranjit Dasgupta, Haematology |
| A phase 3 randomised, double blind study assessing the efficacy and safety of pf06410293 and Adalimumab in combination with Methotrexate in subjects with moderately to severely active Rheumatoid arthritis who have had an inadequate response to Methotrexate. | Clinical trial of an investigational medicinal product | Dr Emmanuel George, Rheumatology |
| **CHEMO T –** Cyclophosphamide, Doxorubicin, Vincristine and Prednisolone (CHOP) versus Gemcitabine, Cisplatin and Methylprednisolone (GEM-P) in the first line treatment Of T-Cell Lymphoma, a multicentre, randomised, Phase II study. | Clinical trial of an investigational medicinal product | Dr Barbara Hammer, Haematology |
| Improving clinical practice for babies with hearing loss | Basic science study involving procedures with human participants | No Local Investigator |
| **COMMANDER HF –** A Randomized, Double blind,Event driven,Multicenter Study Comparing the Efficacy and Safety of Rivaroxaban with Placebo for Reducing the Risk of Death, Myocardial Infarction or Stroke in Subjects with Heart Failure and Significant Coronary Artery Disease Following an Episode of Decompensated Heart Failure | Clinical trial of an investigational medicinal product | Dr Palaniappan Saravanan, Cardiology |

| | | |
|---|---|---|
| **MUNROS** – Health Care Reform: the impact on practice, outcomes and costs of New roles for health professionals | Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology | Dr Melanie Maxwell, Health Services |
| **Baby Oscar** – Outcome After Selective Early Treatment for Closure of Patent Ductus Arteriosus in Preterm Babies | Clinical trial of an investigational medicinal product | No Local Investigator |
| **RAPSODY ROLLOVER** – An OpenLabel Safety Extension Study (OLSES) Evaluating the Long term Safety and Durability of Response of CHS0214 (CHS 021405) | Clinical trial of an investigational medicinal product | Dr Emmanuel George, Rheumatology |
| **SAFE -** Seizure first aid training for people with epilepsy who attend emergency departments, and their family and friends intervention development and pilot. | Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice | Dr Mark Buchannan, A&E |
| **ADOPTS -** Accelerating Delivery Of Psychological Therapies after Stroke | Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice | Dr Ruth Davies, Stroke |
| **MAPLE -** Molecular profiling for lymphoma | Study limited to working with human tissue samples and data | Dr Barbara Hammer, Haematology |
| **GEM** - The Genetic Environmental Microbial Project. A Multidisciplinary Human Study on the Genetic, Environmental and Microbial Interactions that Cause Inflammatory Bowel Disease | Other | Dr Paul Flanagan, Gastroenterology |

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|---|---|---|
| **ADD-ASPIRIN -** A phase III double blind placebo controlled randomised trial assessing the effects of aspirin on disease recurrence and survival after primary therapy in common non-metastatic solid tumours | Clinical trial of an investigational medicinal product | Principal Investigator: Mr Liviu Titu, Colorectal. Sub-investigators: Mr Nigel Parr, Urology. Mr Raman Vinayagam, Breast. |
| A Multicenter, Randomized, Double Blind, Placebo Controlled,Parallel Group Study to Evaluate the Efficacy and Safety of Sirukumab in the Treatment of Patients with Giant Cell Arteritis | Clinical trial of an investigational medicinal product | Dr Emmanuel George, Rheumatology |
| Decision-making for intensive care unit admissions: Work Package 2 | Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology | Mr P Prashast, Anaesthetics |
| National Registry of Rare Kidney Diseases | Research Database | Dr Thomas Ledson, Renal |
| **PRE-EMPT -** Preventing Recurrence of Endometriosis by Means of long acting Protestogen Therapy | Clinical trial of an investigational medicinal product | Mr Tom Aust, Reproductive Health |

APPENDIX 3

**List of NIHR adopted studies granted NHS permission (R&D Approval) for the Trust to become Participant Identification Centres (PICs)**
**01/04/15 – 31/03/16**

| Study Title | Type of Study | Trust Lead / Local Collaborator |
|---|---|---|
| **RESPONSE:** A randomised, double blind, multicentre Placebo controlled study to evaluate the efficacy, safety, and tolerability of NT100 in pregnant women with a history of unexplained recurrent pregnancy loss (RPL) | Clinical trial of an investigational medicinal product | Mr Mike Ellard, Reproductive Health |
| The impact of creative interventions on symptoms of postnatal depression | Basic science study involving procedures with human participants | No local investigator |
| **VIOLET** - Video assisted thoracoscopic lobectomy versus conventional Open Lobectomy for lung cancer, a multi-centre randomised controlled trial with an internal pilot | Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice | Mr Mike Shackcloth, Consultant, Liverpool Heart and Chest |
| Understanding elective colorectal practice national questionnaire | Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology | No local investigator |

APPENDIX 4

**Total NIHR Recruitment Data since 2013/14**

| Speciality | No of participants recruited 2013/14 | No of participants recruited 2014/15 | No of participants recruited 2015/16 |
|---|---|---|---|
| A&E | 0 | 0 | 42 |
| Anaesthetics | 0 | 126 | 0 |
| Cancer | 36 | 35 | 31 |
| Cardiovascular | 19 | 10 | 0 |
| Critical Care | 546 | 164 | 0 |
| Dementia | 21 | 22 | 1 |
| Dermatology | 15 | 10 | 4 |
| Diabetes | 0 | 7 | 0 |
| Gastroenterology | 0 | 0 | 8 |
| Health Services | 0 | 0 | 128 |
| Microbiology | 17 | 47 | 19 |
| No Local Investigators | 10 | 0 | 0 |
| Ophthalmology | 21 | 3 | 0 |
| Paediatrics | 95 | 88 | 75 |
| Renal | 0 | 2 | 7 |
| Reproductive Health | 48 | 93 | 111 |
| Respiratory | 4 | 10 | 7 |
| Rheumatology | 22 | 10 | 20 |
| Stroke | 3 | 13 | 47 |
| Surgery | 3 | 0 | 3 |
| **TOTAL** | **860** | **640** | **503** |

APPENDIX 5

**Referring Cancer Data**

Many of this Trust's patients diagnosed with Cancer are referred to specialist cancer centres for routine treatment. Some of these patients were subsequently recruited onto a study by the specialist cancer centre. Information below:

| | 2012/13 | 2013/14 | 2014/15 | 2015/16 |
|---|---|---|---|---|
| **Aintree University Hospitals NHS Foundation Trust** | | | | |
| Head and Neck Cancer Group | 16 | 24 | 1 | 1 |
| Upper Gastrointestinal | 0 | 0 | 0 | 1 |
| **TOTAL** | **16** | **24** | **1** | **2** |
| **Royal Liverpool and Broadgreen University** | | | | |
| Children's Cancer and Leukaemia | 0 | 1 | 0 | 0 |
| Genetics | 0 | 1 | 0 | 0 |
| Haematology | 4 | 1 | 1 | 1 |
| Upper Gastrointestinal | 0 | 0 | 0 | 1 |
| **TOTAL** | **4** | **3** | **1** | **2** |
| **Clatterbridge Cancer Centre NHS Foundation Trust** | | | | |
| Bladder | 2 | 1 | 2 | 1 |
| Breast | 3 | 12 | 4 | 3 |
| Colorectal | 14 | 0 | 0 | 0 |
| Genetics | 1 | 1 | 0 | 0 |
| Gynaecological | 5 | 3 | 3 | 2 |
| Lung | 2 | 2 | 5 | 10 |
| Melanoma | 2 | 0 | 1 | 0 |
| Prostate | 22 | 37 | 28 | 9 |
| Renal | 11 | 1 | 0 | 2 |
| Gastrointestinal | 6 | 5 | 2 | 3 |
| Palliative | 0 | 0 | 1 | 0 |
| Teenage & Young Adults | 0 | 0 | 1 | 0 |
| Urology | 0 | 0 | 0 | 1 |
| Multiple | 28 | 3 | 0 | 9 |
| **TOTAL** | **96** | **65** | **47** | **40** |
| **GRAND TOTAL** | **116** | **92** | **49** | **44** |

APPENDIX 6

**List of non-NIHR adopted studies granted NHS permission (R&D Approval) 01/04/15 – 31/03/16**

| **Study Title** | **Type of Study** | **Principal Investigator / Name of University if applicable** |
|---|---|---|
| Home birth and the NHS: Exploring the dynamics of organisational change in the context of care | Study involving qualitative methods only | Lisa Common, University of Nottingham |
| Attitudes and perceptions of the medical ANP role. | Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology | Emma Williams, University of Chester |
| Does an increased baseline MEWS score increase the LOS of patients admitted with an exacerbation of COPD | Study limited to working with data | Sarah Williams, University of Chester |
| Has the introduction of the Nurse Prescriber altered the professional dynamics between nurses and the medical profession | Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology | Mike Pritchard, University of Chester |
| Report on electronic prescribing systems and the training offered to newly employed prescribers | Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology | Clare Brown, Durham University |

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|---|---|---|
| The response from radiology services to changes in population habitus particularly with regard to obesity: A pilot study | Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology | Catherine Williams, Gemma McPate-Webb, University of Liverpool |
| Retrospective cohort study of Type 1 Diabetes Mellitus (T1DMM) in the Wirral Peninsular | Study limited to working with data | Akata Eloho, University of Chester |
| An exploratory study: Views, experiences and perceptions specialist respiratory Nurses working in the community regarding unplanned re-hospitalization of COPD patients within 30 days of previous admission. | Study involving qualitative methods only | Gilbert Ngatia, University of Chester |
| An Exploration of the Perceptions of Non-Medical Prescribers on Acute Medical Units (AMUs) in the United Kingdom (UK) regarding their Self- Efficacy in Prescribing. | Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology | Louise Cope, University of Manchester |
| Does having a prescribed Pharmacist in the pre-operative setting of an acute hospital reduce the number of missed and delayed doses for patients? | Study limited to working with data | Nicole Copping, University of Chester |
| An Exploration of the Construction and Use of Prescribing Documentation in Secondary Care | Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology | Dr Kate Shemilt, Liverpool John Moores University |
| An investigation into the perspectives of mentors | Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology | Dr Gillian Peiser, Liverpool John Moores University |

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|---|---|---|
| **CAPS** - Care After Presenting with Seizure to Emergency Services<br><br>CLAHRC Project.<br>See section 5.7.1 for more information about this study. | Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology | Mark Buchannan, A&E |
| In the Neonatal Population, has there been successful Implementation of the Rotavirus Vaccine? | Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology | Dr Tricia Radia, Institute of Child Health |
| Does supersensitive PSA add additional prognostic benefit to predicting biochemical recurrence in post radical prostatectomy patients at medium term follow up | Study limited to working with data | Dr Kaylie Hughes, Wirral University Teaching Hospital |
| The librarian as knowledge mobiliser in critical care<br><br>See also section 7.2 for more information about this study. | Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology | Dr Girendra Sadera, Wirral University Teaching Hospital |

APPENDIX 7

Junior doctors supporting research

| Name | Position | Research Title |
|---|---|---|
| Dr Lamees Salaman | F1, Gastroenterology | **GEM** - The Genetic Environmental Microbial Project. A Multidisciplinary Human Study on the Genetic, Environmental and Microbial Interactions that Cause Inflammatory Bowel Disease |
| Dr Gavin Lewis | Registrar, Cardiology | **COMMANDER HF** - A Randomized, Double blind, event driven, Multi-centre study Comparing the Efficacy and Safety of Rivaroxaban with Placebo for Reducing the Risk of Death, Myocardial Infarction or Stroke in Subjects with Heart Failure and Significant Coronary Artery Disease Following an Episode of Decompensated Heart Failure |
| Dr McCaffrey | Registrar, Rheumatology | A long-term, open-label, follow-up study of tofacitinib (CP-690,550) for treatment fo Rehumatoid Arthritis |
| Dr Bhadauria | Registrar, Rheumatology | A phase 3 randomised, double blind study assessing the efficacy and safety of pf06410293 and Adalimumab in combination with Methotrexate in subjects with moderately to severely active Rheumatoid arthritis who have had an inadequate response to Methotrexate |
| | | An Open label Safety extension Study(OLES) evaluating the long term safety and durability or response CHS-0214(CHS-0214-05) |
| | | A Double-Blind, Randomized, Parallel-Group, Active-Control Study to Compare the Efficacy and Safety of CHS-0214 Versus Enbrel® in Subjects With Rheumatoid Arthritis and Inadequate Response to Treatment With Methotrexate |
| | | A long-term, open-label, follow-up study of tofacitinib (CP-690,550) for treatment fo Rehumatoid Arthritis |
| | | A Phase 3, Randomized, Double-Blind, Placebo-Controlled Study Of The Efficacy And Safety Of 2 Doses Of Tofacitinib (CP-690,550) |

| | | |
|---|---|---|
| | | Or Adalimumab In Subjects With Active Psoriatic Arthritis |
| Katherine Cooper | Neonatal Registrar | **PLANET 2** - Platelets for Neonatal Transfusion study 2 |
| Kostas Kakleas | ST5 Neonatal Registrar | |
| Shakir Saeed | ST8 Neonatal Registrar | |
| Kostas Kakleas | ST5 Neonatal Registrar | **SIFT** - Speed of Increasing milk Feeds Trial |
| Shakir Saeed | ST8 Neonatal Registrar | |
| Subajini Kaviethasan | ST5 Paediatric Registrar | |
| Maire-Claire Longworth | ST7 Registrar, Obs & Gynae | **SIMS** - Adjustable Anchored SingleIncision MiniSlings Versus Standard TensionFree MidUrethral Slings in the Surgical Management Of Female Stress Urinary Incontinence; A Pragmatic Multicentre Non–Inferiority Randomised Controlled Trial |
| Khadija Ashraf | Trust Grade, Obs & Gynae | **HEALTH** - A multicentre randomised controlled trial comparing laparoscopic supracervical hysterectomy with second generation endometrial ablation for the treatment of heavy menstrual bleeding |
| | | **PRE-EMPT** - Preventing Recurrence of Endometriosis by Means of long acting Protestogen Therapy |
| Sean McGoldrick | Registrar, Haematology | **AML 17** - A Programme of Treatment Development for Younger Patients with Acute Myeloid Leukaemia and High Risk Myelodysplastic Syndrome |
| Sean McGoldrick | Registrar, Haematology | **AML 18** – A trial for older patients with acute myeloid leukaemia and high risk myelodysplastic syndrome |
| Indrani Karpha | Registrar, Haematology | |
| Sean McGoldrick | Registrar, Haematology | **AML 19 Pilot** – A phase 2 randomised study to evaluate the feasibility of sequential administration of the inhibitor ponatinib given sequentially with standard chemotherapy in younger patients aged 18 – 60 years with acute myeloid leukaemia |
| Sean | Registrar, | **AML LI1 –** A programme of development for |

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|---|---|---|
| McGoldrick | Haematology | older patients with acute myeloid leukaemia and high risk myelodysplastic syndrome |
| Sean McGoldrick | Registrar, Haematology | **CHEMO – T** - Cyclophosphamide, Doxorubicin, Vincristine and Prednisolone (CHOP) versus Gemcitabine, Cisplatin and Methylprednisolone (GEM-P) in the first line treatment Of T-Cell Lymphoma, a multicentre, randomised, Phase II study |
| Vandan Arora | Registrar, Haematology | |
| Sean McGoldrick | Registrar, Haematology | **MAJIC** - A RandoMised study of best Available therapy versus JAK Inhibition in patients with high risk Polycythaemia Vera or Essential Thrombocythaemia who are resistant or intolerant to HydroxyCarbamide |
| Indrani Karpha | Registrar, Haematology | |
| Sean McGoldrick | Registrar, Haematology | **MYELOMA XI** – Randomised comparisons in myeloma patients of all ages, of thalidomide, lenalidomide and bortezomib induction combinations and of lenalidomide and combination lenalidomide vorinostat as maintenance |
| Indrani Karpha | Registrar, Haematology | |
| Sean McGoldrick | Registrar, Haematology | **PACIFICO** - Purine-Alkylator combination in follicular lymphoma imunon-chemotherapy for older patients: a phase III comparison of first line R-CVP versus R_FC |
| Indrani Karpha | Registrar, Haematology | |
| Vandan Arora | Registrar, Haematology | |
| Sean McGoldrick | Registrar, Haematology | **REMOBL-B** – A randomised evaluation of molecular guided therapy for diffuse large B cell lymphoma with bortezomib |
| Indrani Karpha | Registrar, Haematology | |
| Vandan Arora | Registrar, Haematology | |
| Sean McGoldrick | Registrar, Haematology | **RIALTO** - A Randomised Investigation of Alternative Of atumumab containing regimens in less fit patients with CLL |
| Indrani Karpha | Registrar, Haematology | |
| Sean McGoldrick | Registrar, Haematology | **SPIRIT 2** – A phase 3 prospective randomised comparison of imatinib v dasatinib in patients with newly diagnosed chronic phase chronic myeloid leukaemia |
| Sean McGoldrick | Registrar, Haematology | **UKALL 14** - A randomised trial for adults with newly diagnosed acute lymphoblastic leukaemia |
| Indrani Karpha | Registrar, Haematology | |

| | | |
|---|---|---|
| David Taylor | Registrar, Haematology | |
| Sean McGoldrick | Registrar, Haematology | **UKALL 60+** - A Phase 2 study for older adults with Acute Lymphoblastic Leukaemia |
| Indrani Karpha | Registrar, Haematology | |
| David Taylor | Registrar, Haematology | |

APPENDIX 8

**Trust Publications** (see inclusion criteria in Library section 7)

| Title of article | Citation | Author |
|---|---|---|
| A retrospective study of seven-day consultant working: reductions in mortality and length of stay | The Journal of the Royal College of Physicians of Edinburgh. 2015, 45(4), 261-7 | Leong KS, Titman A, Brown M, Powell R, Moore E, Bowen-Jones D |
| A simple technique to achieve parallel transverse cuts in the scarf osteotomy | Annals of the Royal College of Surgeons of England. 2015, 97(3), 238-9 | Brookes-Fazakerley SD, Platt SR, Jackson GE |
| A UK wide survey on attitudes to point of care ultrasound training amongst clinicians working on the Acute Medical Unit | Acute Medicine. 2015, 14(4), 159-164 | Smallwood N, Matsa R, Lawrenson P, Messenger J, Walden A |
| Absence of extensor indicis tendon complicating reconstruction of the extensor pollicis longus | The Journal of Hand Surgery (European volume). 2016 Mar 2 | Taylor J, Casaletto JA |
| Altered Cortical Processing of Observed Pain in Patients With Fibromyalgia Syndrome | The journal of pain : official journal of the American Pain Society, Aug 2015, vol. 16, no. 8, p. 717-726 (August 2015) | Fallon, Nicholas; Li, Xiaoyun; Chiu, Yee; Nurmikko, Turo; Stancak, Andrej |
| Amnioinfusion in preterm premature rupture of membranes (AMIPROM): a randomised | Health technology assessment (Winchester, England), | Roberts, Devender, Vause, Sarah, Martin, William, Green, |

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|---|---|---|
| controlled trial of amnioinfusion versus expectant management in very early preterm premature rupture of membranes--a pilot study. | Apr 2014, vol. 18, no. 21, p. 1-135 (April 2014) | Pauline, Walkinshaw, Stephen, Bricker, Leanne, Beardsmore, Caroline, Shaw, Ben N J, McKay, Andrew, Skotny, Gaynor, Williamson, Paula, Alfirevic, Zarko |
| An additional middle cuneiform? | J Surg Case Rep. 2015;2015(7) | Brookes-Fazakerley SD, Jackson GE, Platt SR |
| An Alternative Technique for External Fixation of Traumatic Intra-articular Fractures of Proximal and Middle Phalanx. | Techniques in hand & upper extremity surgery. 2015, 19(4), 163-167 | Kapur, Benjamin; Paniker, Jayanath; Casaletto, John |
| An interesting case of an antihypertensive causing post-prostatectomy incontinence | BMJ Case Rep. 2015;2015 | |
| An unusual presentation of a retroperitoneal cyst | BMJ Case Rep. 2014;2014 | Sarkar D, Gulur D, Patel S, Nambirajan T |
| ANNALS EXPRESS: Validation of Serum Free Light Chain Reference Ranges in Primary Care Patients | Annals of Clinical Biochemistry. 2015 Nov 13 | Galvani L, Flanagan J, Sargazi M, Neithercut WD |
| Are we failing our trainees in providing opportunities to attain procedural confidence? | Br J Hosp Med (Lond). 2015 Feb;76(2):105-8 | Lagan J, Cutts L, Zaidi S, Benton I, Rylance J |
| Arthroscopic Evaluation of Impingement and Osteochondral Lesions in Chronic Lateral Ankle Instability. | Foot Ankle Int. 2015 Jun 1; | Odak S, Ahluwalia R, Shivarhatre DG, Mahmood A, Blucher N, Hennessy M, Platt S |
| Atrial fibrillation during pregnancy: cardioversion with flecainide | British Journal of Hospital Medicine. 2015, 76(12), 720-1 | Lewis G, Currie P |
| Changes to the law on consent following Montgomery vs Lanarkshire Health Board | British Journal of Hospital Medicine. 2016, 77(6), 355-7 | Clearkin L |
| Comment on 'Herpes zoster ophthalmicus reduction: implementation of shingles vaccination in the UK'. | Eye (Lond). 2014 Dec;28(12):1522-3 | Clearkin L |
| Conversion of abdominal hysterectomy to laparoscopic hysterectomy-the reverse paradigm. 5 year experience of a | Gynecological Surgery. 2015, 12(1) SUPPL. 1(S471), 1613-2076 | Rowlands D.; Gul N.; Minas V.; King S. |

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|---|---|---|
| large UK district teaching hospital between 2010/11 and 2014/15 | | |
| Critical care in the emergency department: acute kidney injury. | Emerg Med J. 2015 May 12; | Nee PA, Bailey DJ, Todd V, Lewington AJ, Wootten AE, Sim KJ |
| Documentation of Focal Neurology on Patients with Suspected Cauda Equina Syndrome and the Development of an Assessment Proforma | Open Orthop J. 2015 Aug 31;9:390-4 | Mehta N, Garbera D, Kaye J, Ramakrishnan M |
| Early triaging using the Modified Early Warning Score (MEWS) and dedicated emergency teams leads to improved clinical outcomes in acute emergencies. | Clin Med. 2015 Jun 1;15(Suppl 3):s3 | Patel A, Hassan S, Ullah A, Hamid T, Kirk H |
| Ebola virus disease in Africa: epidemiology and nosocomial transmission | The Journal of Hospital Infection. 2015, 90(1), 1-9 | Shears P, O'Dempsey TJ |
| Endometriosis of the liver | British Journal of Hospital Medicine. 2016, 77(5), 310-1 | Adishesh M, Hawarden A, Rowlands D |
| Epithelioid haemangioma: a rare cause of painful erections and sleep deprivation. | Int Urol Nephrol. 2014 Sep;46(9):1747-50 | Lucky MA, McGuinness LA, Floyd MS, Azhar U, Shanks JH, Li C, Shenjere P, Nonaka D, Robinson LQ, Parr NJ |
| Improving the handover and care of acute urological admissions | BMJ Quality Improvement Reports. 2015, 4(1) | Bass E, Patel S |
| Inpatients' expectations and experiences of hospital pharmacy services: qualitative study | Health Expectations. 2015, 18(5), 1009-17 | Morecroft, Charles W; Thornton, David; Caldwell, Neil A |
| Life-threatening Petersen's hernia following open Beger's procedure | Journal of Surgical Case Reports. 2016, 3 | Goh YL, Haworth A, Wilson J, Magee CJ |
| Localised amyloidosis of the glans penis presenting as a painless lump with progression after 10 years. | Int Urol Nephrol. 2014 Sep;46(9):1737-9 | Floyd MS, Glendinning J, Hiew K, Avram AM, Seneviratne R, Parr NJ |
| Longitudinal studies are required | J R Soc Med. 2015 Jun;108(6):210 | Ahmad N, Thomas GN, Gill P, Chan C, Torella F |
| Management of hyperglycaemia in patients with acute coronary syndrome | Diabetic Medicine, March 2014, vol./is. 31/(77), | Hegde P.; Ormsby N.; Kaivani F.M.; Bowen-Jones D. |

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|---|---|---|
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**BOARD OF DIRECTORS**

**UNAPPROVED MINUTES OF MEETING**

**29 JUNE 2016**

**BOARDROOM**
**EDUCATION CENTRE**
**ARROWE PARK HOSPITAL**

**Present**

| | |
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| 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 |
| Cathy Maddaford | Non-Executive Director |
| Evan Moore | Medical Director |
| Jean Quinn | Non-Executive Director |
| John Sullivan | Non-Executive Director |
| Gaynor Westray | Director of Nursing and Midwifery |

**In attendance**

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| Carole Self | Director of Corporate Affairs |
| Mike Coupe | Director of Strategy* |
| James Mawrey | Director of Workforce* |
| Pippa Roberts | Director of Medicines Management & Pharmacy |
| Jane Kearley | Member of the Public |

**Apologies**

*denotes attendance for part of the meeting

| Reference | Minute | Action |
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| **BM 16-17/062** | **Apologies for Absence**<br>Noted as above | |
| **BM 16-17063** | **Declarations of Interest**<br>None | |
| **BM 16-17/064** | **Patient Story**<br>The Director of Nursing and Midwifery conveyed thanks passed on to the Trust for an act of kindness and compassion demonstrated by an off duty Nurse who helped a lady following a fall. The Nurse alleviated the lady's fears and in her own time took the lady to hospital and stayed with her to ensure she was well cared for. | |
| **BM 16-17/065** | **Chairman's Business**<br>The Chairman updated the Board on the recent consultant appointments as follows:<br>Critical Care – Dr Paul Jeanrenau<br>Anaesthesia – Dr Jessica Griffith<br>Anaesthesia – Dr Andrew Prenter | |

| Reference | Minute | Action |
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| | Cardiology – Dr Kanella – Eleni Karamani<br><br>The Board recorded their congratulations to Mr Blakeman, Director of Infrastructure and Informatics following his recent appointment to the Director of Information Services and Infrastructure at NHS England. The Board also welcomed Mr David Jago, Director of Finance to his first meeting of the Board following his appointment. | |
| **BM 16-17/066** | **Chief Executive's Report**<br><br>The Chief Executive presented the report and highlighted the following areas for discussion:<br><br>**Medical Director Appointment Process** – the Chief Executive updated the Board on the engagement undertaken on this process with a Clinical Advisory Group which was part of the wider clinical engagement agenda.<br><br>**Director of Infrastructure and Informatics** – the Chief Executive confirmed that he was currently in discussion with NHSE and Cerner with regards to future potential candidates for this specialist position in order that a shortlist could be established.<br><br>**All Day Health Centre** – the Board was updated on the CCGs plans to close the All Day Health Centre without apparent regard to the impact on the emergency department. In view of concerns the Chief Operating Officer confirmed that she had outlined these in a letter to the Chief Accountable Officer of the CCG and was currently awaiting a response. The role of the System Resilience Group was called into question.<br><br>**CNST Premiums** – the Board was reminded of the significant increase in premiums as a result of historical factors and advised that following a focussed drive by the Medical Director and his team to reduce the level of claims in the previous year that these had in fact reduced in number by 9% and in value by 27%. The amount now being paid out in claims was lower than the actual premium paid by the Trust which would begin to impact on future premiums.<br><br>The Board sought to understand whether the contract with specialist commissioners was a "block" or "payment by results". The Director of Finance confirmed that this was a "payment by results" contact and as such he was not anticipating any risk as a result of this. | |
| **BM 16-17/067** | **Integrated Performance Report**<br><br>The Chief Operating Officer presented the Integrated Performance Report and highlighted the following:<br><br>**A & E 4 Hour Standard** – the Board was advised that the Trust had met the Sustainability and Transformation Fund STF trajectory for May and was currently at 87% for June which was above the STF trajectory. The performance for the Emergency Department alone was reported as 83.2% for June. Performance over the last 2 weeks was reported at 91% this | |

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| | being as a result of the following:<br>• Rapid senior decision making as close to the "front door" as possible<br>• Focus in the daily "huddles"<br>• Appropriate utilisation of the organisational assessment unit<br>• The opening of the new ambulatory care unit<br>• Tracking and monitoring of patients to reduce lengths of stay and expedite discharge<br><br>The Board was updated on the impact of delayed discharges which equated to approx. 60 patients on average this being 2.5 wards of patients at any one time in the hospital. The Chief Operating Officer outlined initial plans, following the approval of capital expenditure, to provide a "step down" facility at Clatterbridge which would allow the Trust to nurse patients differently and expedite discharge. The Chief Executive advised that the Trust was exploring options with partners on future staffing models for such a ward, recognising that the Trust could not fully staff an additional ward. The Board sought to establish where the responsibility for these patients fell recognising that the Trust was operating within a strict financial envelope. The Chief Operating Officer acknowledged the concerns and confirmed that the proposals were designed to use its current bed base in a more efficient way as opposed to enhancing this. The Board sought clarity on the impact of the closure of the All Day Health Centre and was advised that this related to those patients that the Trust deflected to a GP in hours as the out of hours provision remained unchanged. The Chief Operating Officer confirmed that she had requested access to a GP appointment in each practice every day to ensure no impact on patient flow. She also confirmed that the Emergency Department was continuing to deflect patients through triage despite the loss of the single front door initiative and that the funding for the All Day Health Centre was being used to implement 7 day access to primary care which was a NHSE decision. The Board expressed concern that it was hard to reconcile these actions with a health economy that was working together. The Chief Executive agreed to provide the Board with a full briefing at its next meeting on the proposal for the step down facility which included how this fits with the work of the health economy.<br><br>**Referral to Treatment Times RTT –** despite some issues in gastroenterology the Chief Operating Officer confirmed that the Divisions were forecasting compliance from July onwards. The Board was updated on the work being undertaken to cleanse the data on the patient list which would address the data quality issues recently identified. The Board sought and received an update on the initiative in trauma and orthopaedics which was designed to address the case mix issues. The Board sought further information on the issues in gastroenterology and colorectal and was advised that demand was high and therefore the focus of work was on moving capacity from the first appointment to further down the pathway to reduce the waiting list. The Medical Director provided an example of how this focus had led to achievements in the bowel screening process by moving from 3 appointments to 1 in delivering the necessary care.<br><br>**C difficile** – the Director of Nursing and Midwifery confirmed that the Trust | **DA/JH** |

| Reference | Minute | Action |
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| | had reported 2 avoidable cases up until May and 1 case in June taking the total number to 3 and well below the trajectory. She confirmed that the plans continued to work well and outline the plans to incorporate a C difficile unit in the isolation ward. The Board was pleased that this work had been recognised by the Nursing Times.<br><br>**Cancer** – no specific issues were reported.<br><br>**Advancing Quality –** the Board expressed concerns at the number of areas not achieving which had increased and whilst it recognised that the number of areas covered by Advancing Quality together with the standards had increased, it still sought to establish the reasons for this. The Medical Director confirmed that this was in part due to staff shortages and sickness and some of the interfaces with Cerner. The Chief Operating Officer advised that there was greater focus on filling posts as well as increased accountability and holding to account at the Operational Performance Team Meetings which was leading to some early signs of improvement.<br><br>The Board sought to establish how much of the problem was in relation to data capture as opposed to not providing care. The Medical Director provided an example of where the Trust was not meeting the AQ standard for sepsis despite the mortality rates from sepsis improving which means that there was not always a direct correlation. He also advised that the figures had a 3 month time lag so any real improvement would not be visible until October 2016. | |
| **BM 16-17/068** | **Month 2 Finance Report**<br><br>The Director of Finance reported the position at Month 2. During the month of May it was reported that the Trust delivered a £0.7M deficit compared to the plan of £0.5M with expenditure being above plan by £356K and cumulatively by £550K. The main driver of the additional pay expenditure was attributed to the continued utilisation of the escalation areas which had resulted in increased nursing, medical and support costs.<br><br>The cash position at the end of May was reported as positive at £21.2M this being £18.7M above plan although this reflected the advance payment from Wirral CCG in relation to June's contract payments.<br><br>The Director of Finance reported that the Trust had delivered £1.2M of savings against the plan of £1.4M. The non-recurrent savings that had supported the year to date position were reported at £352K.<br><br>The financial sustainability risk rating FSRR was reported at 2 in line with plan albeit with variance to individual metrics and very limited overall headroom.<br><br>The Board sought to understand the current cash position and the impact of any delay of the sustainable and transformation funding (STF)or the cessation of the advance payments by the CCG. The Director of Finance advised that cash was a challenge as the £2.2M from the STF expected in June would not now be available until July at least. He advised that a range of options were being explored to improve the cash position which | |

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| | included a review of the payments to suppliers in 30 days which was strong and the review of stock which was currently £250K above plan. The Board was aware that the cash position was tight particularly if the advanced payment was removed. The Board sought to understand how confident the Director of Finance was that the STF funding would be forthcoming in July. The Director of Finance advised that he was confident that the funding would be forthcoming as the delay was between NHSI and NHSE and therefore a system fault as opposed to a local issue.<br><br>The Board sought clarity on the impact should the FSRR rating fall to 1 and was advised that the Trust would not be meeting its plan and therefore this could impact on future STF funding although it was acknowledged that the guidance on tolerances in relation to this funding had not yet been received.<br><br>The Director of Medicines Management and Pharmacy provided some reassurance to the Board on the work being undertaken to achieve the savings plan. She confirmed that a new Director of Transformation was now in place, and there had been a change in reporting arrangements as it was recognised that previous arrangements were not as the Trust would have hoped. The Chief Executive provided a summary of the performance against savings plans which was that the Trust was broadly on track although it was recognised that the profiling gradient grew steeper over the coming months and the need for delivery was urgent. He confirmed that the Trust was balancing the need to close the gap in savings plans whilst delivering the £8.7M of plans. He clarified that the profile did not include the £5M of health economy savings plans which was still required. | |
| **BM 16-17/069** | **External Assurance**<br>• **Board Declaration – Corporate Governance Statement**<br><br>The Director of Corporate Affairs presented the draft corporate governance statement in preparation for submission to NHSI by 30th June 2016. As in previous years, she confirmed that the draft statements were supported by evidence or commentary to aid the decision making process. The Board agreed to focus on the areas that were marked as "not confirmed" and debated the reasons for this which were associated with the CQC comprehensive inspection; the non-compliance with A & E and RTT statutory targets and the qualified audit on the Quality Report.<br><br>The Board agreed with the statements as drafted and agreed that a further review should take place by December 2016 to enable the work to be undertaken on the statutory targets, data quality and the action plan from the CQC. | **CS** |
| **BM 16-17/070** | **External Assurance**<br>• **NHS Improvement Quarter 4 Feedback Letter**<br><br>The Board noted the contents of the NHS Improvement Q4 feedback letter which was unchanged from the previous quarter. | |

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| **BM 16-17/071** | **Approval of Risk Management Strategy**<br><br>The Medical Director presented the Risk Management Strategy confirming that this had been completely re-written to take account of the changes in the Trust. He confirmed that the two most important changes were in relation to the separation of the strategy from the practical process and the revised risk scoring system to ensure this was in line with NHSE guidance, the impact of which would be in a reduction in some of the scores.<br><br>The Board thanked the Medical Director for the report and sought and received clarity on where key performance indicators were being monitored. The Board debated the role of the Operational Management Team in the risk management process and the lack of visibility for the Board on this work and how this could be improved. The Board agreed that the report to Audit Committee on the risk management process needed to be reviewed and that internal audit should review the system as a whole to provide the assurance required.<br><br>The Board requested that the Accountable Officer for Controlled Drugs role be included.<br><br>The Board approved the Strategy subject to the changes identified. | **EM/CB**<br><br>**EM** |
| **BM 16-17/072** | **Report of the Finance Business Performance and Assurance Committee**<br><br>Mr Hollick reported on key areas of work undertaken by the Committee not covered by the Finance Report, this included the capital expenditure work being undertaken; the agency spend which was slightly above plan and the recommendation to the Board by the Committee for the reference cost submission. The Board approved the process for the submission of the reference costs. | |
| **BM 16-17/073** | **Board of Directors**<br><br>The Minutes of the Board of Directors Meetings held on 25th May 2016 were confirmed as an accurate record subject to Dr Moore being included as present.<br><br>**Board Action Log**<br><br>The Board action log was updated as recorded. The Director of Corporate Affairs reported that the amended G6 Compliance Statement had been submitted to NHSI as per previous correspondence. For the public record statement 2 of the declaration was submitted as compliant. | |
| **BM 16-17/074** | **Items for BAF/Risk Register**<br><br>The Board requested that the wider health economy risk be reviewed to reflect the concerns raised at the meeting. | **CS** |
| **BM16-17/075** | **Items to be considered by Assurance Committees**<br><br>The Board agreed the following: | |

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| | • Finance Business Performance and Assurance Committee – Cash forecasting and activity<br>• Quality and Safety Committee – a deep dive in the Advancing Quality standards to aid improvement<br>• Audit Committee – the risk process | |
| **BM 16-17/076** | **Any Other Business**<br>None | |
| **BM 16-17/077** | **Date and Time of Next Meeting**<br><br>Wednesday 27 July 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 – July 2016

| No. | Minute Ref | Action | By Whom | Progress | BoD Review | Note |
|---|---|---|---|---|---|---|
| **Date of Meeting 29.06.16** | | | | | | |
| 1 | BM16-17/067 | Provide the Board with a briefing on the step down facility proposal at the meeting in July | JH | **This is included on the private part of the agenda for July 16** | July 16 | |
| 2 | BM16-17/069 | Review the corporate governance statements in relation to the CQC action plan; data quality and compliance with statutory access targets | CS | | Dec 16 | |
| 3 | 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 | | Sept 16 | |
| 4 | BM16-17//71 | Include the accountable officer for controlled drugs in the roles and responsibilities for the Risk Management Strategy | EM | | Sept 16 | |
| 5 | BM16-17/074 | Review the wider health economy risk on the BAF to reflect the concerns raised at the Board in June 16 | CS | | Sept16 | |
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| **Date of Meeting 25.05.16** | | | | | | |
| 6 | 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 September in light of current position** | July 16 | |

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| 7 | 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** | | |
| 8 | BM16-17/037 | Explore the impact of technology when reporting CHPPD in the future | GW | | | |
| 9 | BM16-17/040 | Board to continue to receive CQC updates until the next inspection on a quarterly basis | EM | | September 16 | |
| 10 | BM16-17/046 | Include the CIP £5M gap in the Board Assurance Framework | CS | | July 16 | |
| **Date of Meeting 27.04.16** | | | | | | |
| 11 | BM16-17/007 | Include attendance and appraisal performance in the achievement of 2015/16 objectives | MC | **Completed** | | |
| 12 | BM16-17/012 | Update the Board on the improvements being made to the Equality and Diversity Agenda through the Chair of Q & S report | GW/JM | **Included on the agenda for July 2016** | July 16 | |
| 13 | BM16-17/016 | FBP&AC to focus on demand, capacity and achievement of access targets; achievement of financial targets and review of thresholds | CS | | June 16 | |
| **Date of Meeting 30.03.16** | | | | | | |
| 14 | BM15-16/297 | Present the Medical Engagement Strategy | EM/JM | **This work is underway** | May16 | |
| 15 | BM15-16/299 | Update on the number of discharges before noon as a result of the SAFER roll out | CO | | April 16 | |
| 16 | BM15-16/300 | Circulate to members the impact of the nursing investment from a financial perspective in order to complete the evaluation process. | GW | | April 16 | |
| **Date of Meeting 27.01.16** | | | | | | |
| 17 | BM15-16/243 | Provide a weekly progress report on A & E in light of current performance | CO | **ongoing** | | |

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| 18 | BM15-16/244 | Further work recommended on the performance report to ensure that the anticipated impact of planned action was captured, together with the risks, which would aid with future evaluation and analysis | MB | **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** | | | | | | |
| 19 | BM 15-16/163 | Surgical Activity -The Board asked for consideration to be given to reporting routinely how and where beds were being protected as well as where these had been absorbed hence impacting on performance. | MB/SG | **This work will be undertaken as part of the action plan from the well led Governance review** | November 2015 | |
| 20 | BM 15-16/163 | RTT - The Board requested that further consideration be given to implementing an "early warning system" thus using the technology the Trust has. | MB/SG | **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** | | | | | | |
| 21 | BM 15-16/132 | The Board requested that the actions being taken to address areas of under performance in the performance report ranked in terms of desired impact, where possible, to aid with review. | MB | **This work will be undertaken as part of the action plan from the well led Governance review** | October 2015 | |