Wirral University Teaching Hospital NHS
NHS Foundation Trust

Board of Directors
Public Board

25th April 2018

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MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 25th APRIL 2018

COMMENCING AT 10AM IN THE BOARD ROOM
EDUCATION CENTRE, ARROWE PARK HOSPITAL

AGENDA

1	**Apologies for Absence** Chair	v
2	**Declarations of Interest** Chair	v
3	**Chair's Business** Chair	v
4	**Board of Directors**	
	4.1 Minutes of the Previous Meeting – 28th March 2018	d
	4.1.2 Board Action Log Director of Corporate Affairs	d
5	**Chief Executive's Report** Acting Chief Executive	v

6. Quality and Safety

6.1	**Patient Story** Acting Head of Patient Experience	v
6.2	**Health & Safety Report** Interim Director of Finance	d
6.3	**Nurse Staffing Report – Hard Truths Commitment** Deputy Director of Nursing & Midwifery	d
6.4	**Mortality Review and Dashboard** Medical Director	d

7. Performance and Improvement

7.1	**Management Information : Ward to Board Presentation** Director of IT and Information	p
7.2	**Integrated Performance Report**	
	7.2.1 Integrated Dashboard and Exception Reports Chief Operating Officer	d
	7.2.2 Month 12 Finance Report Acting Director of Finance	d

7.3	**Approval of Operational Plan and Financial Submission** • **Approval of Operational Plan Narrative** • **Approval of Financial Submission** Acting Director of Finance	d
7.4	**Strategic Planning Presentation** Chief Operating Officer and Interim Director of Workforce	p

8. Governance

8.1	**Report of Finance Business Performance and Assurance Committee** Chair of Finance and Business Performance Assurance Committee	d
8.2	**Report of Audit Committee** Chair of Audit Committee	d
8.3	**Review of Register of Interests** Interim Director of Workforce	d

9. Standing Items

9.1	**Items for BAF/Risk Register** Chair	v
9.2	**Items to be considered by Assurance Committees** Chair	v
9.3	**Any Other Business** Chair	v
9.4	**Date and Time of Next Meeting** Wednesday 30th May 2018	v

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF PUBLIC MEETING

28th MARCH 2018

BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL

Present

Sir David Henshaw	Chair
David Jago	Acting Chief Executive
Susan Gilby	Medical Director
Graham Hollick	Non-Executive Director
Janelle Holmes	Chief Operating Officer
Gareth Lawrence	Acting Director of Finance
Sue Lorimer	Non-Executive Director
John Sullivan	Non-Executive Director
Gaynor Westray	Director of Nursing and Midwifery

In attendance

Mike Baker	Head of Communications
Dr John Fry	Public Governor
Jayne Kearley	Member of the Public
Dr Richard Latten	Staff Governor
Helen Marks	Interim Director of Workforce
Anthony Middleton	Director of Operations and Performance
Frieda Rimmer	Public Governor
Nigel MacLeod	PA to CEO and Chairman (Minutes)

Apologies

Paul Charnley	Director of IT and Information
John Coakley	Non-Executive Director
Terry Whalley	Director of Strategy and Sustainability

*denotes attendance for part of the meeting.

Reference	Minute	Action
BM 17-18 /262	**Apologies for Absence** Noted as above.	
BM 17-18 /263	**Declarations of Interest** The Chair advised the Board he would need to leave at 11.45am to attend the funeral of Sir Ken Dodd. If the meeting had not concluded, Sue Lorimer, Non-Executive Director, was asked to take the chair.	
BM 17-18 /264	**Chair's Business** The meeting was formally opened and Board members welcomed. Whilst recognising the Board and Trust had significant progress to make, the Chair thanked members for the warm welcome he had received. The Board received an update following the visit by Mr Stephen Burrows, High Sherriff of Merseyside, who had been delighted to have met so many colleagues from across the hospital.	
BM 17-18 /265	**Chief Executive's Report** The Acting Chief Executive presented his verbal report and highlighted the following areas:	

Reference	Minute	Action
	CQC Feedback – Two unannounced visits had been undertaken. 13th – 15th March (covering Critical Care, Maternity and End of Life), 20th – 24th March (covering ED and associated areas, Medicine & Surgery, Safeguarding, Patient Experience, Complaints and the wider issue of Patient flow, with its impact on patient safety and experience). Inspectors had indicated that a report pertaining to these visits will not be received until conclusion of the Well-Led inspection. Current guidelines indicate that a report will be published no more than 56 days from conclusion of the Well-led inspection. The Acting Chief Executive apprised the Board with a summary of the two unannounced visits: • Critical Care Inspectors had noted the number of changes made since the last inspection with many of the required actions having been completed along with an acknowledgement that safety huddles were now taking place. Inspectors had noted that estate and environment issues exist in particular bed spaces. Many staff had identified a number of positive initiatives and approaches introduced by the new Matron in critical care. However, as the Matron was presently absent long-term sick, these initiatives had not been embedded. • Maternity Headline feedback from Inspectors was that culture in the department had improved significantly. Staff spoken to where positive about maternity as a place to work and the separation from Surgery had given a real sense of identity. Furthermore, the inspectors had identified that the introduction of the Practice Development Nurse had been welcomed by staff as being well supported and a positive step forward. A number of safety issues had been highlighted during the inspection; door not closing thereby being a security risk (now resolved), e-rostering and staff rostered onto two areas, out of hour's recovery staff being available and concurrent cover arrangements. • End of Life Care The Board was apprised that inspectors had been impressed with the pace of change in this area, identifying positive overall leadership of the team and consultants. Issues from the last inspection had been resolved. • Safeguarding Inspectors had found evidence of good knowledge of the principles and good use of the new system in place. • Pharmacy Whilst it had been noted there is still some further work to do pertaining to 'tidying up' the visibility check process, Inspectors had found evidence of good level of pharmacy presence across the Trust. A number of areas of concern had been identified having completed the second unannounced visit; lack of assessment in ED of long-standing patients, ward 17 general environment, use of Day Case Unit (ward 1) for overnight stays and a number of issues associated with the Discharge Lounge. Inspectors had also stated they had found evidence of variable reporting of incidents.	

Reference	Minute	Action
	There was Board consensus that the forthcoming Well Led Assessment would be critical for the Trust and agreed that an emerging plan should be agreed, in advance, that clearly demonstrated an understanding of what was required, and how plans would be developed to address emerging themes and trends. To ensure all Board members were sighted across each other's portfolios, a series of Well Led sessions would be undertaken with both Non-Executive Directors and Directors. **NHSI Plan Feedback** – The Acting Chief Executive provided the Board with an update in respect to the NHSI Plan feedback. • The Trust is to review the submission and consider further actions that can be taken to deliver an outturn position materially better than 2017/18. • The plan needs to be stretching and challenging, and one the Trust Board has confidence in delivering. To be backed by a robust CIP programme and contractual framework. It was confirmed there needed to be a stronger and more effective working relationship within the Wirral system, along with the development of a joint financial strategy. **NHSI Guidance financial/Quality Special Measures** – New guidance had been issued March 2018, updated from past framework with financial objective criteria as: 1. The trust has not agreed a control total and is planning or forecasting a deficit (or has recently delivered a significant year-end deficit). Or: 2. The trust has agreed a control total but: has a significant negative variance year to date against the control total plan and is forecasting (or has recently delivered at year-end) a significant deficit. Or: 3. The trust has an exceptional financial governance failure (e.g. significant fraud or irregularity. Having reflected on various aspects of the Chief Executives report, the Chair outlined that whilst planning was evident, internal mechanisms to deliver improvements and transformation needed greater cohesion and faster pace of implementation, supported by the Trust Service Transformation Team. The Board related to these comments and agreed a 'back to basics' approach to acknowledge current performance and culture, to agree transformational priorities for the Trust and how barriers will be overcome to succeed. By engaging with the Trust, divisions would be encouraged to undertake transactional aspects allowing the Transformational team to focus on overall strategy. The Chair discussed with the Board a radical approach to demonstrate to colleagues, stakeholders and the CQC that the Trust is driving forward and acting to control its own destiny. The Board discussed the merits of having, for example, 5 key pillars aligned to strategy, vision and goals. The Board learnt that two immediate areas of focus, that would demonstrate tangible improvements, are MSK and a dynamic bed modelling programme utilising some of the Clatterbridge bed base as step down facility for patients formally discharged, prior to returning home. Costings had already been secured via the Better Care Fund for Elder Holme staff to manage 28 beds.	**SG**

Reference	Minute	Action
	It was agreed that a formal proposal for the wrap around services, utilising the Clatterbridge bed stock as a step down facility, would be developed and presented for approval within the next two weeks. The Board also agreed to support continued progression with Partners to specialise in joint services that would benefit the wider Health Economy. Dr Gilby advised the Board that a joint Clinical Services Strategy had been launched with the Countess of Chester NHS Foundation Trust, with the support of the CCG and wider STP. In discussion with the Chair, it was agreed that an overarching Board statement would be beneficial that clearly articulates the Board priorities and strategy, to be used internally and with external stakeholders, for sustainable services across the Wirral. Mr Sullivan sought reassurance that any communication would be carefully crafted and articulated, in terms of being open and honest, but also in tandem with the CQC, local authority and CCG to ensure concise messaging pertaining to a vision that has the support of all aligned partners. In conclusion, the Board agreed a number of key actions: • A proposal for Clatterbridge Step Down to be developed over the next two weeks. • Dr Gilby to continue the work being undertaken pertaining to Clinical Sustainability. • Comms to be engaged to develop communications that provide an update from the Board. • Continue with the 'Fix It' approach; identify issues and ensure they get fixed. **NHSI Use of Resources Visit** – The Acting Chief Executive confirmed the Key Lines of Enquiry document had been submitted within deadline. The onsite visit, confirmed 5 April 2018, will review Workforce, Corporate Services, Clinical Support Services and Finance. **NHSE/NHSI working closer together** – The Board was apprised of the letter received from Simon Stevens and Ian Dalton, outlining the working arrangements to increase integration and alignment of national programmes and NHSE and NHSI regional teams. **NHSI Section 111 Undertakings** – The Acting Chief Executive sought and received Board approval to sign and return a slightly amended version of the undertakings outlined to the Board at previous meetings.	**AM** **DJ** **AM** **SG** **HM** **Board Members**
BM 17-18 /266	**Patient Story** Laura Austin, Interim Head of Patient Experience, joined the meeting to present the Patient Story. Following a period of treatment on the medical assessment unit, the Patient, who suffers with dementia, had been discharged from the Trust in November 2017, via the Discharge Lounge, into the care of his family with whom he now lives. The patient's family, having arrived to collect him upon discharge, subsequently made a complaint. His daughter in law was informed by staff on the ward that the patient would	

Reference	Minute	Action
	be discharged the next day at 2pm. The following day a further phone call was made, at around 10am, indicating that the patient would be discharged from the ward and would be going to the discharge lounge to assist in meeting the demand for inpatient beds/admissions. His daughter in law, concerned for his health and wellbeing, requested that he remain on the ward until she could collect him at 2pm, as had already been agreed. Furthermore, a telephone call with the ward sister was requested to discuss this further, as she remained unhappy with the decision. Regrettably, no call was made. At 1.30pm the patient's family arrived to find the patient was no longer on the ward. On arrival at the Discharge Lounge, they found their relative sitting in pyjamas that were not his own, with a small blanket over his knees. The patient's belongings had been placed into two plastic bags; his own overnight bag had remained on the ward in bedside locker. It transpired that the patient had been relocated to the Discharge Lounge at around 9.30am. His family explained that their family member had been in the discharge lounge for 4 hours by this time and was cold and upset. Furthermore, the family were angry that staff had not ensured he was in his own clothing. Knowing how proud the patient is of his appearance, the family were saddened and angry that staff had allowed the patient to be transferred in pyjamas that did not belong to him. Furthermore, the family did not feel that providing a thin blanket maintained his dignity. Having investigated, it was concluded that the patient had been medically fit for discharge and that the discharge lounge had been the most appropriate environment to await collection by his family. The request for telephone contact had been relayed to the hospital coordinator who regrettably had been unable to undertake the call due to existing work commitments. Appropriate contact with the family, to apologise and discuss the situation, had been undertaken. A number of key actions had subsequently been undertaken by the Trust: • A patient discharge leaflet has been developed to help prepare and assist patients for their discharge home. This has been introduced across the Trust. • A process has been implemented to ensure that any issues or concerns are escalated to the Matron rather than the hospital coordinator. • Staff have been reminded, via Ward Huddles, to appropriately assist patients in packing their belongings and ensure they are wearing day clothing upon discharge. • Teams have been reminded that soiled items of clothing should be placed in a linen bag rather than a patients wash bag, as had been the case in this situation. • The Discharge Lounge has been reviewed to ensure that the temperature remains comfortable and appropriate at all times. • The Trust will be taking part in the 'EndPJparalysis 70 Day Challenge campaign'. • Overall utilisation of the Discharge Lounge to be reviewed at the Patient Experience Group. It was also reiterated that the CQC had alluded to the environment and	

Reference	Minute	Action
	patient experience within the Discharge lounge during their recent visit. The Board took some time to review the details outlined and recognised the associated impact to patient flow across the hospital, along with a recognition that earlier discharges would be beneficial for families and the wards alike. Furthermore, the family have been invited to attend a Matrons meeting to discuss this particular case to reinforce the important aspect of maintaining patients privacy and dignity at all times.	
BM 17-18 /267	**Learning From Improvement** Dr Susan Gilby presented the 'Learning from Improvement' paper. By way of background, Dr Gilby outlined that NHSI had published 'Learning from improvement: special measures for quality a retrospective review'. The purpose to share learnings from Trusts who had been supported by NHSI in their move out of special measures. Utilising the information, the Trust had been able to undertake a self-assessment pertaining to where the Trust positions itself in relation to improvement areas identified within the document – Leadership, Engagement, Culture, Governance and Quality Improvement. In line with earlier discussions, the Board agreed to re review the initial self-assessment that had been undertaken by the Executive team and agree a precise set of next steps for the Trust to follow. In developing a high level Quality Improvement Plan for the Trust, the Board agreed it was important to the long term sustainability to review culture across the organisations across the entire team whilst also linking in with ongoing CQC Action Plans. From a communications perspective, the Board agreed the engagement of key stakeholders would be extremely important to demonstrate the Trust has led in regards to agreed activity and not reacted to circumstances as they arose.	
BM 17-18 /268	**Integrated Performance Report** • **Integrated Dashboard and Exception Reports** The Chief Operating Officer presented the integrated performance dashboard and highlighted a number of key indicators to the Board: • Increasing sickness trends had become evident. A number of hot spots have been identified with measures taken to address route course. • Band 5 Nursing vacancies had increased. The Board was advised that greater detail would be outlined pertaining to this within agenda item 7.1; Draft Nursing & Midwifery Workforce Strategy. • ED Patient flow and how differing models can be utilised to improve performance. • Increasing ambulance handover times – additional funding had been provided to provide additional resource to staff the corridors to release crews.	

Reference	Minute	Action
	• The Elective programme had recommenced. • Increased 52 weeks wait trajectory; all patients are now tracked at reaching the 30 week milestone. • Mixed Sex Breaches; linked to cohorting within the Critical Care environment. • The Chief Operating officer and Director of Nursing & Midwifery had introduced an additional threshold to support early identification of pressure ulcers, falls and infection prevention control. • Cancer standards remain on track and have been verified via Mersey Internal Audit. • Patient Nutrition and Hydration concurrently under review. • Difficulties associated with recruitment of consultants to support urology and dermatology had provided early indication of potential risk to adherence of cancer standards. Members of the Executive Management Team apprised the Board of discussions already held, to review and realign the key quality performance indicators that are required, to provide the Trust Board with a clear line of sight; Ward to Board, and the required levels of assurance. Exception reporting will then be presented to provide reassurance of activity being undertaken and who is being held accountable. A number of decisions had already been taken pertaining to realignment of performance indicators: • Finance measures to be included; a divisional led dash board, which provides granular detail aligned to finance, workforce and performance. • A greater degree of granular information that indicates who is being held to account. • Align the indicators to the Board Assurance Framework. • Engagement of the BI Leads to agree how the required information will be obtained and presented. • Existing Quality and Workforce indicators will be similarly reviewed. • Ultimately move to a risk based reporting process for 2018/2019. • Consider using Commissioners/MIAA to support in the way MIAA had been asked to support the mortality data review. The Board accepted significant progress had been made, pertaining to the current version of the dashboard, and agreed that a refresh is required to provide assurance that activity is being taken to address clearly identified trends and themes. A level of governance is also required to allow managers/divisions/departments to take action required. The Board agreed that an update will be given at the next Board meeting pertaining to agreed objectives and proposed way forward. • **M11 Finance and Cost Improvement Programme Report** The Acting Director of Finance presented the M11 Finance and Cost Improvement Report. The Board was advised that the Trust had agreed with the regional NHSI team a revised forecast of an adjusted financial performance deficit [AFPD] of £20.6M in month 10; this had shown a year end AFPD excluding STF variance of £12.5M against the control total. Assurance had been provided to	**JH** **JH**

Reference	Minute	Action
	the Finance Business Assurance Performance Committee that the revised deficit will be achieved. Confirmation was provided that funds pertaining to the sale of land at Clatterbridge had been received by the Trust, strengthening the overall cash positon. The Acting Director of Finance advised the Board that the Trust is currently reporting an YTD adverse variance (excluding STF) to plan of circa £10.7M as at the end of February. The February positon was £0.5M better than the planned AFPD due to the year-end settlement agreed with Wirral CCG. This had ensured the Trusts income positon, with regards to its main commissioner contract, and mitigated previous risks in relation to delivering CQUIN targets. There remains a residual risk of circa £1.6M on the agreed treatment of Sepsis. Board members were advised that whilst the cash positon had been strengthened, it was evident that loans would be required as the Trust progressed into the next Financial year. The Use of Resources (UoR) rating was reported at 3 in line with the plan. As in previous months, the agency spend rating was preventing the overall UoR rating from dropping to a 4. The Acting Director of Finance welcomed the discussion pertaining to the integration of Trust Finances within the Integrated Performance Dashboard and agreed to support this transition.	**GL**
BM 17-18 /269	**Strategic Planning Update** As the Director of Strategy and Transformation had tendered apologies, due to sickness, the Acting Chief Executive apprised the Board with an update pertaining to Trust Strategy. The 'Big 5 Priorities' had previously been outlined in some detail. The Board received an update associated with the creation of a 'golden thread' that linked the Trust's vision and goals with the shifting landscape in collaborating and adhering to three key publications; Wirral CCG Strategy, 2017 relaunch of Cheshire & Merseyside Health & Care Partnership and the emerging Wirral Place focus and divergence following the Healthy Wirral 'Lock Ins'. In response to a joint letter from Wirral and West Cheshire CCGs, the Board received confirmation that a joint letter from Wirral University Teaching Hospital and the Countess of Chester Hospital had been sent to the Accountable Officers agreeing to produce a joint Wirral and West Cheshire Clinical Strategy. The Medical Directors from WUTH and the Countess of Chester had agreed to determine the most beneficial approach to the commission. It was envisaged that the scope will determine the necessary adult services required for the population of West Cheshire and Wirral and how this will be undertaken in such a way as to assure services are clinically and financially sustainable.	**SG**

Reference	Minute	Action
	Having debated the detailed content of proposed strategy, vision and values, the Board agreed that the 2018 Objectives should be reviewed to develop a series of 5 – 7 key smart objectives (intrinsically linked to the '5 key pillars theme outlined earlier) that would easily communicate the direction for the organisation and articulate how the organisation aimed to become the hospital of choice for those it served. For example, Clinical Sustainability of Services was sighted as a key objective. In doing so it was key to encompass and incorporate an overarching estates programme, financial performance and plans to operationalise, and hold colleagues to account for delivery of, the agreed objectives. The Board also agreed that communication was integral to ensure Trust wide colleagues would be engaged and informed of strategy, vision and values of the Trust. The Interim Director of Workforce agreed to support the Communications team to work collaborately with the Director of Strategy and Transformation to develop Trust wide communications to support the 2018/19 strategy.	**TW** **HM**
BM 17-18 /270	**Draft Nursing & Midwifery Workforce Strategy** Having identified a material rise in sickness absence amongst the nursing and midwifery workforce, coupled with turnover amongst band 5 nurses doubling, a commitment had been given to develop a nursing and midwifery workforce strategy to support and address these particular areas of concern. The Interim Director of Workforce apprised the Board of the draft Nursing and Midwifery strategy that had been developed to address the recruitment and retention challenges facing the Trust. The Board was advised that the strategy presented a vision for the nursing and midwifery workforce, developed around four key pillars: • What our Patients can expect form our nursing and midwifery workforce • What our nursing and midwifery workforce can expect from us • What our communities can expect from the Trust • What our approach is to research Clarity was given that each pillar is supported by a number of initiatives to enhance and raise the Trust's profile in relation to recruitment of nurses. Assurance was provided that the strategy will also link collaboratively alongside actions arising from the National Staff Survey, to support progress across the Trust, and the recent cultural review. The Board welcomed the proposal and discussed the merits of utilising the strategy as a way to engage with colleagues and to open up, listen to views and encourage participation and support for the strategy. Culturally, the Board also sought and received assurance the consultation process would clarify the support and recognition staff and colleagues sought of the Board. To support further recognition and engagement, it was confirmed that a number of forums will be utilised to support consultation and engagement; Chief Executive Fora, Chief Executive Blog and the newly implemented Friday Nursing Walkarounds; a set time for the Nursing directorate to walk	**Board Members**

Reference	Minute	Action
	the wards and meet staff. Board members have an open invite to join these walkaround sessions. The Chair also suggested utilisation of the 'Listening Into Action' mechanism to support further consultation. By way of wider Board support, John Sullivan, Non-Executive Director, agreed to support the Interim Director of Workforce in regards to collaboration with the Divisional structure. Having reviewed the draft strategy, Board approval was provided to circulate the document for consultation. Agreement was reached that the final document would be submitted to the May Board of Directors for approval, ahead of a proposed nursing & midwifery conference to launch the strategy.	**JS** **HM**
BM 17-18 /271	**2017 National NHS Staff Survey** The Interim Director of Workforce provided the Board with an update from the 2017 National Staff Survey Results. Whilst the pre circulated paper provided the full set of results, the Board was provided with the key headlines: • Survey had been distributed to a random sample of 1250 members of staff across all roles and divisions. • 382 respondents - response rate of 31%. This compared to 46% in 2016. • National average response rate was 46%. As had been pre circulated, the Board was apprised of the positive areas for the Trust and those areas of concern. Positive areas are: • Staff experiencing harassment, bullying or abuse from patients, relatives and the public • Staff experiencing discrimination at work • Staff working extra hours or attending work when unwell The biggest areas of concern are, which were in the lowest 20% are: • Staff engagement • Appraisals, both quantity and quality • Lack of training and development • Lack of effective team working • Recognition and valued by managers and the organisation • Staff ability to contribute to improvements at work • Staff witnessing potentially harmful errors, near misses or incidents • Staff confidence and security in reporting unsafe clinical practice • Staff satisfaction with the quality of work and care they are able to deliver • The degree to which staff agree that their role makes a difference to patients/services users • Effective use of patient/service user feedback • Staff experiencing harassment bullying or abuse It had been agreed that the Staff engagement programme for 2018 will take a new approach and focus specifically on key themes; Culture, Leadership, Engagement, Healthy Working Environment, Learning Organisation, Valuing our Workforce and Inclusivity.	

Reference	Minute	Action
	The Board discussed the importance of ensuring that staff are engaged and aware of the culture and vision of the Trust when seeking feedback and participation within the programme. As part of the feedback process, the Board agreed the importance of assimilating why colleagues did not respond and the barriers they felt stopped them from doing so. It was also agreed that language used should be patient centric, clearly linked to the vision and values for patient care. Ahead of the 2018 survey, the Board requested that consideration be given to distribute to all staff. The Trust Board provided support pertaining to the proposed Staff Engagement Programme and requested that the each of the key themes clearly identifies what action is being taken, by when and by whom. It was agreed that progress will be monitored via the proposed Workforce Assurance Committee which in turn will provide Trust Board updates and assurance of progress. By way of wider Board support, John Sullivan, Non-Executive Director, agreed to support the Interim Director of Workforce.	**HM** **HM**
BM 17-18 /272	**Gender Pay Gap** The Gender Pay Gap report was presented to the Board by the Interim Director of Workforce outlining that gender pay gap legislation introduced April 2017 requires UK employers with 250 or more employees to publish data pertaining to their gender pay gap on an annual basis, based on a snapshot date of 31st March each year for the public sector. The report identified a mean gender pay gap of 23.9% in favour of male employees. It was also highlighted that the number of female employees (79%) outweighs the number of males (21%). Keys Themes identified were outlined as: • Low levels of male employees particularly in lower middle and upper middle quartiles, with a larger gender pay gap in pay band 1 in favour of females • Lower levels of female employees in the highest quartile positions • Bonus pay gap in favour of males and low levels of females accessing • Lower levels of female employees in Consultant positions The Board noted and acknowledged the report, along with the submission of data to the Government reporting portal and publication of the report via the Trust staff and public website. The Board requested that plans to address issues identified in the report be presented to the proposed Workforce Assurance Committee which in turn will provide Trust Board updates and assurance of progress. In collaboration, the Board also requested that the proposed Workforce Assurance Committee review the findings in line with the annual clinical excellence awards, with a view of encouraging a more to apply, noting there has been disparity in the number of male/female applicants.	**HM**
BM 17-18 /273	**Proposed Workforce Assurance Committee** In line with the pre circulated paper, the Trust Board approved both the recommendation to establish a Workforce Assurance Committee and the associated terms of reference.	

Reference	Minute	Action
BM 17-18 /274	**Board Assurance Framework** Having recently reviewed the Board Assurance Framework [BAF], the Acting Chief Executive had provided the Board with an overview of the risks and their associated scores, a profile of risks details within the BAF and a detailed analysis of each risk and associated actions to mitigate these. The Acting Chief Executive apprised the Board of a number of changes within this latest iteration. • The graph tracking scores for Current, Residual and Tolerable had been removed to avoid possible duplication of Current and Residual scores. • Risks currently included within the Corporate Risk Register (score of 15 or more) have been included to provide an overall alignment between these two documents. The Board was advised that having been reviewed at assurance committee level the top four risks for the organisation had been agreed: **Workforce** – ability to recruit and retain the workforce of the future. Undertaking OD work to enact a cultural change. **Quality and Safety** – this includes infection prevention and control and medicines management. **Access** – includes all access standards but principally the 4 hour A & E standard, noting 18/19 planning guidance re RTT and patient waiting numbers. **Finances** – includes the financial plan for 2018/19 and thereafter which includes the need for cash, shortage of capital and the current situation re our estate. Having considered the current BAF and reflected on the associated risk scores and profiles, it was agreed that a refresh and review would be undertaken to clearly articulate the top ten risks for the Trust. In agreeing this pragmatic approach, the Board concluded that a number of aspects needed to be included to drive and inform the refresh: • Review objectives from a 'Ward to Board' perspective to highlight granular detail and findings. • Utilising the acquired information, focus on a clear order of priorities to established and provide assurance that the relevant and associated risks are included. • To refresh and focus the BAF in line with the Organisation Strategic objectives and aims. • Ensure strategic objectives dovetail to support and drive the Trust Board agenda. To assist further, the Board agreed a further development session would be beneficial. Having concluded the refresh, the Board agreed that this would form part of an Away Day having determined that a review of the strategic objectives was	**Execs/ Directors** **Execs/ Directors** **Execs/ Directors**

Reference	Minute	Action
	required. Assurance was sought and received that divisional leadership would be engaged and provided with the relevant support to embed the BAF across the Trust and/or develop a version aligned to divisional aims, objectives and goals.	
BM 17- 18 /275	**Report of Finance Business Performance and assurance Committee** The Board received the update from Sue Lorimer, Chair of the Finance, Business Performance and Assurance Committee [FBPAC]. Having outlined the M11 Financial Position within the pre-circulated paper, the Board received updates pertaining to key aspects of the report. Going Concern – FBPAC had reviewed a paper which set out the rationale for the organisation being able to declare itself a Going Concern and preparing its 2017/18 accounts on that basis. The reasons were that: • The trust has not been notified of an intention for dissolution • No major losses of commissioner income are anticipated • NHSI and DH will have implicitly approved the borrowings required for 2018/19 by not rejecting the trust's plan. • The trust has not identified any risk of an inability to repay borrowings as they fall due. If required, terms may be renegotiated. The directors had identified the unapproved loans issue as a material uncertainty in line with DHSC guidance. However, this would not prevent the trust continuing to operate as a going concern for the foreseeable future. The wording for the statement proposed by the trust has been agreed with its external auditors. In concluding the verbal report, the Chair of FBPAC outlined a number of key points for the Trust Board to be aware of: • Risk that the capital receipt of £4.3m might not be available to support the 2018/19 capital programme • The Going Concern statement is reliant on the Trust's plan not being rejected by NHSI • CIP for 2018/19 still has £3.4m classed as opportunities or unidentified • The committee wished to recommend the award of the prosthetic and technician contract to Otto Bock Healthcare Ltd • Mandatory Training in Information Governance remains a concern The Trust Board agreed with the recommendation to award the prosthetic and technician contract to Otto Bock Healthcare Ltd.	
BM 17-18 /276	**Report of the Audit Committee** The Board received an update from Graham Hollick, Chair of the Quality and Safety Committee. Having pre circulated the Board report, Mr Hollick apprised members of the key aspects of the report: • The Committee had noted that the BAF required updating and review in order to give assurance to the members that the risks were being fully articulated. • The Financial Assurance report had been reviewed with further	

Reference	Minute	Action
	assurance sought pertaining to the historical VAT penalty that had been incurred in the year. • Having reviewed the NHS Improvement Licence, the Committee had agreed that the documents reflected the current position of the Trust at the end of Q3. It was still to be determined what, if any, impact the recent investigation would have on the licence. The Committee had sought and received assurance from the Acting Chief Executive that arrangements had been made to cover the Director of Finance post, Director of Workforce post and to support duties undertaken by the Corporate Secretary. The Acting Chief Executive confirmed that an appointment was imminent pertaining to the Deputy Director of Finance/Director of Finance and that Helen Marks had accepted an initial 6 month contract as Interim Director of Workforce. Options pertaining to the Corporate Secretary are concurrently being pursued with further clarity expected in the coming weeks.	
BM 17- 18 /277	**Report of the Quality and Safety Committee** The Board received an update from John Sullivan, Chair of the Quality and Safety Committee, pertaining to four key aspects of the report: • Risks associated with WUTH infrastructure condition and the future prevention of incidents as a result of losses of containment from fluid pipe work and drains. • Risks associated with delays in reaching 95% compliance with Protecting Vulnerable People Safeguarding mandatory training. In particular in the Emergency Department where compliance is 76.92% with 27 members of staff remaining non-compliant. The Board received assurance that training has now been scheduled for the 27 members of staff. • A proposal for a separate Workforce subcommittee of the Trust Board was made at the Quality & Safety Committee. Proposed terms of reference will be submitted to the Trust Board for support and approval. • The proposed Organisation Development programme (in response to recent investigation reports and the 2017 staff survey results) will be submitted to the Trust Board for discussion and agreement. The Board sought and received assurance that a Trust wide Estates Strategy, including a review/assessment of a works backlog (circa £7M), will be implemented once the findings from a recently tendered '6 Facet Survey' had been received. The Chair recorded thanks to Mr Sullivan for chairing the recent meeting at short notice.	**JS** **GL**
BM 17- 18 /278	**Board of Directors** The Minutes of the Board of Directors held 28 February 2018 were approved as an accurate record. **Action Log** The Board agreed the current Action Log and requested that closed Actions be removed to a closed Action Log one month after completion.	**NM**
BM 17- 18 /279	**Items for the Board Assurance Framework [BAF]/Risk Register** The Board agreed the BAF would be updated to reflect the discussions of agenda item BM 17-18/274.	

Reference	Minute	Action
BM 17- 18 /280	**Items to be considered by the Assurance Committees** The Chair advised the Board that two further Non-Executive Directors will be appointed. It was confirmed that Dr John Coakley will re-join the Board as Non-Executive Director. The Chair positioned his intention to ask Dr Coakley to Chair the Quality and Safety Committee. Until such time as this was confirmed, Mr John Sullivan would continue as Chair of the Quality & Safety Committee.	
BM 17- 18 /281	**Any Other Business** The Board noted Sue Lorimer will Chair the Charitable Funds Committee going forward. The Chairman sought any comments from the public on the meeting content. Having reflected on the comments and content of the meeting, Dr Latten had been pleased to hear the desire to work collaborately with colleagues pertaining to Strategy and Trust Objectives. As an employee, this was an area Dr Latten noted he would be keen to support.	
BM 17- 18 /282	**Date and Time of Next Meeting** Wednesday 25th April 2018 at 9.00am in the Boardroom, Education Centre, Arrowe Park Hospital.	

……..……
Chair

……..
Date

Board of Directors Action Log
Updated – March 2018
Completed Actions moved to a Completed Action Log

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 28.3.18						
1	BM 17-18/265	CQC Well Led Preparedness Sessions to be held with Directors and Non-Executive Directors	**SG**	Non-Executive Directors have met with Howard Scott. Well Led sessions held with Directors 17.3.18.	Ongoing	
2	BM 17-18/265	Formal proposal for the wrap around services, utilising the Clatterbridge bed stock as a step down facility, to be developed and presented for approval.	**AM**	Working Group assessing scope and feasibility. Initial stakeholder communications enacted via economy.	May 2018	
3	BM 17-18/265	An overarching Board statement would be beneficial that clearly articulates the Board priorities and strategy, to be used internally and with external stakeholders, for sustainable services across the Wirral.	**DJ**		Ongoing	
4	BM 17-18/265	Dr Gilby to continue the work being undertaken pertaining to Clinical Sustainability.	**SG**	W&WC Alliance meeting held, programme support to be agreed.	Ongoing	
5	BM 17-18/265	Comms to be engaged to develop communications that provide an update from the Board.	**HM**	Message from the Board communicated Trust wide.		**Completed**
6	BM 17-18/265	Continue with the 'Fix It' approach; identify issues and ensure they get fixed.	**Exec Directors**	Top 10 in progress	Ongoing	
7	BM 17-18/268	Realign Integrated Performance Dashboard to facilitate exception report to provide reassurance of activity being undertaken and who is being held accountable. Trust Financial reporting to be incorporated within the Integrated Performance Dashboard.	**JH GL**	Ward to Board presentation (April Board) will provide update.	Ongoing	**Completed**

8	BM 17-18/269	Having agreed produce a joint Wirral and West Cheshire Clinical Strategy [WUTH/Countess of Chester], the Medical Directors from WUTH and the Countess of Chester had agreed to determine the most beneficial approach to the commission.	**SG**	See above	Ongoing	
9	BM 17-18/269	Review of Objectives pertaining to 2018 Strategic Plan; to develop 5-7 key smart objectives. Communications to be developed to engage and inform Trust wide colleagues of agreed plans/objectives.	**TW HM**		Ongoing	
10	BM 17-18/270	Draft Nursing & Midwifery Workforce Strategy: • Board members to support weekly nursing directorate walk the wards sessions. • JS to support HM in regards to collaboration with the Divisional structure, • Draft policy to be circulated for consultation	**Board members** **JS** **HM**	Details circulated – completed. Support agreed – completed. Ongoing.	Ongoing	
11	BM 17-18/271	Ahead of the 2018 National NHS Staff Survey, the Board requested that consideration be given to distribute to all staff.	**HM**		Ongoing	
12	BM 17-18/271	The Trust Board provided support pertaining to the proposed Staff Engagement Programme and requested that the each of the key themes clearly identifies what action is being taken, by when and by whom. It was agreed that progress will be monitored via the proposed Workforce Assurance Committee.	**HM**		Ongoing	
13	BM 17-18/272	Gender Pay Gap - The Board requested that plans to address issues identified in the report be presented to the proposed Workforce Assurance Committee which in turn will provide Trust Board updates and assurance of progress.	**HM**	Assumed noted & agreed		**Completed**

14	BM 17-18 / 274	BAF - Having considered the current BAF and reflected on the associated risk scores and profiles, it was agreed that a refresh and review would be undertaken to clearly articulate the top ten risks for the Trust. Further Board Development Session to be arranged.	**Directors**		Ongoing	
15	BM 17 – 18/277	Report of Quality & Safety Committee - A proposal for a separate Workforce subcommittee of the Trust Board was made at the Quality & Safety Committee. Proposed terms of reference will be submitted to the Trust Board for support and approval.	**JS**	Terms of Reference approved at March meeting. First meeting scheduled 4th May 2018		**Completed**
16	BM 17 – 18/277	A Trust wide Estates Strategy, including a review/assessment of a works backlog (circa £7M), to be implemented once the findings from a recently tendered '6 Facet Survey' are been received.	**GL**	6 Facet survey tenders received and preferred supplier selected. Report and findings will be available September 2018	September 2018	
17	BM 17-18/277	Action Log – completed Actions be removed to a closed Action Log one month after completion.	**NM**			**Completed**
Date of Meeting 28.2.18						
4	BM 17-18/243 & 245	BAF to be updated	**DJ**	Actioned and March Board agenda item. Refreshed and to return to future Board Meeting.	May 2018	
Date of meeting 7.2.18						
1	BM 17-18/210	1st review of 2018/19 Objectives to be developed for discussion at future Board meeting.	**TW**	Paper submitted to April Board Meeting.	April 2018	
2	BM 17-18/211	Bi Monthly Nurse Staffing Report – Strategy to improve sickness absence to aid recruitment, retention and career development	**JH**	Work in progress and reporting timelines to Board noted.	Ongoing	
4	BM 17-18 / 216	FBPAC - The Committee have requested that future reports of the data quality, management of information and clinical coding review provides more assurance to the Committee relating to BAF risk.	**PC**		Ongoing	

5	BM 17-18/220	BAF to be reviewed and updated. Trust Financial position to be incorporated.	**All Directors.**	Update BAF to be presented to next assurance committee meetings for review. Board review through chairs assurance committee reports.	May 2018	
Date of Meeting 29.11.17						
1	BM17-18/172	CEO Report – Strategy. The Board also agreed to include the recommendation from the Non-Executives that the aims needed to be more explicit about meeting the future changing needs of the population.	**DA TW**	Will form part of operational plan narrative submission to NHSI. Update at April Board.	April 2018	
4	BM17-18/176	Pressure Ulcers - The Board agreed that more work should be undertaken in this area and that the Safeguarding Board should review this also.	**JH/GW**	Agreed with reporting to March Quality &Safety Committee. Board review through chairs assurance committee reports.	April 2018	
5	BM17-18/176	M7 Finance and Cost Improvement Programme Report - The Board agreed and recommended that the Director of Finance and Executive colleagues articulate their forensic analysis of current performance as this would be useful ahead of any financial re-forecast required or as part of the improvement plan.	**DJ / GL**	Actioned as part of reporting on recovery plan progress and reforecast to Board. FBPAC to review at February meeting. Board review through chairs assurance committee reports and monthly finance report to Board of Directors.	March 2018	
6	BM17-18/176	M7 Finance and Cost Improvement programme Report - The Board agreed that the FBPAC should thoroughly review the Trust's progress in terms of reducing the monthly pay overspend in December in order to frame the discussion and decision making in the new year.	**DJ / GL**	Actioned. Ongoing review to link into capacity planning for 2018/19 budget setting round and use of benchmarking such as GIRFT, Model Hospital etc. Board to sign off operational plan submission including pay budgets April 2018.	March /April 2018	
7	BM17-18/178	Approval of Risk Management Strategy - The Board agreed to defer this item to the December meeting at the request of the Interim Quality Governance Consultant.	**SG**	To be agreed as part of 2018/19 Planning.	Ongoing	
8	BM17-18/182	Items for the BAF/Risk Register - The Board recommended that the recruitment of a high calibre HR replacement be included on the BAF	**CS**	Experienced interim recruited to role.	Ongoing	

9	BM17/18/183	Items to be considered by the Assurance Committees – Q & S Committee – focus on the new methodology for patient stories and the evaluation of learning from these together with the further work required in relation to exit interview analysis to inform future talent management policies. FBPAC - focus on monitoring the actions taken by the Trust to reduce the monthly pay overspend together with the developing the narrative ahead of any future financial re-forecast.	**JH/GW** **DJ/GL**	Actioned and ongoing Actioned and ongoing	March 2018 March 2018	
Date of Meeting 25.10.17						
3	BM17-18/149	Articulate in the aims and objectives how the Trust would maximise value from developing an ACO or from horizontal integration as it was not clear where the savings or where the benefits might arise	**TW**	Long list of Healthy Wirral Initiatives being reviewed in terms of quantifiable benefits	Q1 2018/19	
8	BM17-18/154	Finance Business Performance and Assurance Committee to review the potential savings/benefits from developing an ACO	**TW**		Q1 2018/19	
Date of Meeting 27.09.17						
Date of Meeting 26.07.17						
12	BM217/18/096	Undertake a review of the Board Model Hospital portal	**DJ**	To be undertaken with members as part of work programme in September – completed.	Sept 17	
Date of Meeting 28.06.17						
Date of Meeting 24.05.17						
Date of Meeting 26.04.17						
Date of Meeting 25.05.16						
20	BM16-17/037	Explore the impact of technology when reporting CHPPD in the future	**GW**	Director of IT and Information currently evaluating this work	April 17	

Board of Directors	
Agenda Item	6.2
Title of Report	Annual Health & Safety Report
Date of Meeting	25 April 2018
Author	David Sanderson - Associate Director of Estates & Facilities Andre Haynes - Health & Safety Manager
Accountable Executive	Gareth Lawrence – Acting Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	1-Quality and Safety – The Trust does not promote a culture of quality and safety resulting in patient harm, poor patient experience, poor staff engagement and failure to meet statutory fundamental standards of care
Level of Assurance • **Positive** • **Gap(s)**	• Positive - compliance • Data from reporting system
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To Note
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document includes FOI exempt information
Equality Impact Assessment Undertaken • **Yes** • **No**	No

1. Executive Summary

The report aims to give an overview of how the Trust is performing against Health & Safety requirements for the period 1 April 2017 to 30 March 2018 with the exception of the incident trends analysis which only covers the period 1st of April 2017 to 30th of September 2017 due to the reasons outlined below.

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. Background

The board should receive annual assurance on the trusts management of Health & Safety; and this paper provides an overview of our compliance

Members will note that the framework of the report has been reviewed and the report now follows the HSE (Health & Safety Executive) model for managing health and safety - 'Plan, Do, Check, Act' (PDCA) approach

3. Key Issues

- The Trusts incident reporting system Ulysses has been subject to a significant review in order to ensure it remains fit for purpose. The update to the reporting system has resulted in a range significant changes which have prevented access to non-clinical data reports which in turn has impacted on the ability to provide Health & Safety forums with comprehensive data analysis. The update commenced in October 2017 and is nearing final stages of completion. The benefits of the upgrade include immediate notifications to key stakeholders of serious untoward events, immediate investigations, improved and more accurate reporting to external agencies, improved categories for recording incident data and therefore more comprehensive analysis.

- A five year Trust Health & Safety Strategy (2018-2023) has been developed by the Health & Safety Manager which will be promoted and communicated to all appropriate forums within the Trust. The purpose of the Health & Safety strategy is to provide a key focus and direction for the WUTH on strategic health and Safety objectives over a five year period. The strategy will support existing health and safety policies and associated processes and further aid the Trust in fulfilling its statutory duties whilst achieving further improvements in health and safety management systems and organizational culture. The strategy includes 5 principle objectives covering culture, coherence, compliance, competence and continuous improvement as well as a range of targets for measuring the effectiveness of the strategy. The Health & Safety Strategy is included at the rear of this report in Appendix 2.

- The Health & Safety Executive carried out a scheduled inspection of the Radiology Services delivered at Arrowe Park Hospital on the 30 of June 2017. Three HSE inspectors were involved in assessing compliance with the Ionising Radiations Regulations 1999 and were particularly interested in the processes in place relating to the CT rooms, Fluoroscopy and the mobile C arm used within theatres. After visiting several areas of the radiology department and scrutinising local risk assessments and rules, the HSE made two verbal recommendations relating to quality assurance processes for the mobile C arm and updating the local rules to clarify the process should an unauthorised person access a room whilst x-ray equipment is in use. The HSE commented on the good quality of the risk assessments and found no material breaches of the legislation. Therefore no fee for intervention was applied and no improvement or prohibition notices were issued which is extremely encouraging.

- The asbestos resurvey was undertaken on the 23rd February 2018 by Lucian for Arrowe Park Hospitals (APH). Lucion have been requested to provide a quote for the resurvey of Clatterbridge (CGH). Three areas at Arrowe Park have been identified where work needs to be carried out to encapsulate the beading within the fire doors as soon as practicable (all three are fire door beadings on sets of doors located on the ground floor of and first floor of the Main Building of APH). The asbestos register is now available to all tradesmen within the Estates department and the risk register and will be further updated following the resurveys. This work is being managed by the Estates Department (overseen by the Executive Director Finance) with regular reports to the Health & Safety Partnership Group.

- The number of employee health and safety incidences in quarters 1 and 2 of 2017/18 totalled 1331 compared with 1025 reported in quarters 1 and 2 of 2016/17 which is a significant increase of 306 or 30%. The increase in the number of incidents reported suggests a continued improvement in reporting across most divisions. Action plans are being developed by the divisions focusing on the top 5 incident types. The top five non-clinical incidents reported in quarters 1 and 2 of 2017-18 are contained within the paper

- During quarters 1 and 2 of 2017/18 there were 21 incidents reported to the HSE in accordance with RIDDOR, compared with 11 reported in quarters 1 and 2 of 2016-17 of the previous year. This represents a significant increase of 10 equating to 47.6%. Further analysis identifies that of the total 21 incidents reported, 8 related to manual handling patients which is unusually high and the majority of these related to patients moving suddenly and unpredictably whilst being aided which is considered an unavoidable risk . A further 4 related to manual handling inanimate loads, 4 were as a result of a slip/trip/fall, 2 occurred as a result of being struck by an object, and the remaining 3 related to needle stick injuries following treating patients with known blood borne viruses. These incidents resulted in 619 days lost compared with 561 days lost in quarter 1 and 2 of 2016/17

- The Health and Safety Team will continue to support the coordination and completion of work streams which relate to statutory requirements within the estates departments function. Appendix 1 of this report includes other high risk areas and the level of compliance with the relevant statutory and mandatory requirements

- The Health & Safety team has developed their project plan for 2018-19 which will support the Health & Safety Strategy. The project plan includes the carrying out a range of audits to assess the degree of compliance with the Trust's health and safety related policies and procedures which reflect statutory requirements. The findings of the audits carried out in the full year of 2017-18 demonstrated a good degree of compliance and a positive level of interest in local health and safety management within most of the areas audited.

4. Next Steps

The Board is asked to

a) Note the contents of the report
b) Highlight any specific additional assurance requirements

Appendix 1: Statutory and Mandatory

Compliance Achieved

Compliance Achieved Outside of Required Timescale

Compliance Not Achieved

Elements	Statutory/ Mandatory	Arrowe Park Hospital	Clatterbridge General Hospital	Periodicity	Status
Fire Risk Assessment	Statutory			Annually	In progress
Asbestos Survey	Statutory			Annually	In progress
Electrical Installation Condition Testing	Statutory			5 Years – Fixed Installation Testing – annual inspection of 20% of installations	In progress
Gas Natural Annual Gas Safety Certification	Statutory			Annually	In progress
Water Quality and Legionella Risk Assessment	Statutory			2 Yearly	In progress
Lift Operations Examination Report	Statutory			Six Monthly	In progress
Generator Maintenance and Testing	Mandatory			Monthly	In progress
Pressure Vessels System of Examination	Statutory			14 months / 26 months	In progress
Lightning Protection and Lightning Conductor Certification	Mandatory			Annual	In progress

Elements	Statutory/ Mandatory	Arrowe Park Hospital	Clatterbridge General Hospital	Periodicity	Status
Restrictor Risk Assessment or Survey Report	Mandatory			2 Yearly	In progress
PAT Testing	Statutory			18 months (Annual for High Risk)	In progress
Fire Extinguisher Testing	Statutory			Annual	In progress
Emergency Lighting Testing	Statutory			Annual	In progress
Fire Smoke Detector Testing	Statutory			Weekly/Annual	In progress
Decontamination Periodic Testing	Mandatory			Weekly / Quarterly / Annual	In progress

Health and Safety Strategy

Andre Haynes, Health & Safety Manager

David Jago, Director of Finance

Executive Summary

1. The Trust recognises the importance of ensuring the health and safety of its patients, visitors and staff. In addition to its common law duty of care to protect people from injury, accidents and ill health, it has statutory obligations under the health and safety legislative framework.

2. The Trust Board is responsible for ensuring appropriate arrangements are in place to safeguard the health and safety of those who may be affected by the Trust's activities.

3. Inadequately managed health and safety has the potential to prevent the Trust from achieving its strategic intentions and objectives and may result in harm to those it cares for, employs or otherwise affects as well as incurring loss relating to assets, finance, reputation, goodwill, partnership working or public confidence.

4. Staff are the Trust's most important assets and this strategy is designed to promote the Trust's vision of providing a healthy and safe working environment, which will help to support high quality patient care and our PROUD values.

5. Health and safety is central to everything the Trust does and by working together it can ensure it provides healthcare services which are safe and secure for patients, public and its workforce.

6. The purpose of the Health & Safety strategy is to provide a key focus and direction for the WUTH on strategic health and Safety objectives over a five year period. The strategy will support existing health and safety policies and associated processes and further aid the Trust in fulfilling its statutory duties whilst achieving further improvements in health and safety management systems and organizational culture.

7. This five year strategy follows the the HSE (Health & Safety Executive) model for managing health and safety - 'Plan, Do, Check, Act' (PDCA) approach and focuses on core objectives designed to prevent harm and continually improve the health, safety and wellbeing of all staff, patients, visitors and contractors. The principle and key objectives described within this strategy address both internal organisational risks and the Health & Safety Executive's objectives within their health & work strategy.

8. This strategy is supported by a range of health & safety policies, systems and processes within the Trust so as to ensure Health and Safety is effectively managed and continually improved. The Health & Safety strategy also links in with the HR Strategy and the Health & Wellbeing strategy.

1. Purpose

1.1 The purpose of the Health & Safety strategy is to provide a key focus and direction for the WUTH on strategic health and Safety objectives over a five year period. The strategy will support existing health and safety policies and associated processes and further aid the Trust in fulfilling its statutory duties whilst achieving further improvements in health and safety management systems and organizational culture.

1.2 Effective health and safety management will reduce sickness absence, improve health and well-being, reduce financial loss, increase compliance and make the healthcare environment safe and secure and more productive. The Trust will achieve this by an on-going commitment to the health, safety and welfare of Trust staff by providing appropriate and effective advice, support and guidance on all health and safety matters in order to facilitate a healthy and safe working environment

2. Background and Context

The WUTH NHS Trust is a large organization spread across two main hospital sites employing approximately 5500 staff, providing acute care services to the population of Wirral. There are a range of varying and complex risks associated with providing these services and it is important to ensure risks are identified and managed appropriately.

The organisation must comply with the requirements of several external bodies which include the Health and Safety Executive (HSE), the Department of Health DoH), the Care Quality Commission (CQC) and the Environmental Health Agency (EHA).

There are established moral, legal and financial reasons for managing health & safety and it is important to recognise that there are benefits to the Trust in adopting a 'pro-active, good practice' approach to the management of health & safety.

Effectively Managing for Health and Safety

The HSE (Health & Safety Executive) model for managing health and safety is a simple and pragmatic 'Plan, Do, Check, Act' (PDCA) approach. This is described in detail within the HSE's 'Managing for Health and Safety Guidance' (HSG65).

The key components of the PDCA framework that is being applied within the WUTH Health & Safety strategy are summarized, as follows:

- ✓ **Plan** - determine policy; develop policy, consult and plan for implementation.
- ✓ **Do** - profile health and safety risks; organize for health and safety management; implement the plan.
- ✓ **Check** - measure performance; investigate accidents and incidents.
- ✓ **Act** - review performance; develop action plans and apply learning.

The PDCA principles achieve a balance between the systems and behavioral aspects of management and, importantly, incorporating health and safety management as an integral part of good management.

3. Plan

Strategic Aims

The key challenge for this strategy is how to embed the fundamental strategic aims into the daily activity of the Trust which has a number of high risk health and safety activities. The strategic aims will support the development of a positive health and safety **culture** with **coherent** policies and procedures which are **compliant** with all relevant health and safety regulations, implemented by a **competent** and accountable workforce and subject to regular review to ensure **continuous** improvements.

- **Culture:** to promote and develop an effective health and safety culture through the continuous improvement of attitudes, perceptions, accountability, competences and patterns of behaviour which determine the commitment to the style and efficiency of the Trust's health and safety management systems.

- **Coherence:** to embed and ensure health & safety policies, procedures, guidance and advice are understood and easily accessible to all staff, patients, visitors and contractors.

- **Compliance:** to ensure the Trust adheres to all relevant health and Safety legislative requirements and that staff follow internal policies

- **Competence:** to ensure all staff remain appropriately trained and competent to fulfil their duties and responsibilities

- **Continuous improvement**: to regularly review the health & safety management processes and systems within the Trust to support continual health and safety compliance, performance and learning outcomes when systems and processes go wrong.

The overarching aim of this five year strategy is to provide strategic direction to encourage all Trust departments to fully integrate health and safety into their operational activities and practices by clearly setting and measuring improvements in health and safety practice and performance over the next five years. In this way ensuring the Trust becomes an increasingly safer, healthier place to work and receive care.

Many departments within the Trust already proactively manage health and safety. This strategy is intended to support all departments in implementing health and safety as an integral, regular activity which positively safeguards staff, patients and other persons who may potentially be adversely affected by the Trust's undertakings.

The aim of this strategy is also to further improve general health & safety management across all departments within the organisation with a particular focus on high risk activities and the HSE's key priorities. The strategy will be supported by a range of project plans, policies and procedures, risk assessments, training and safe systems of work which will be monitored via appropriate forums and overseen by the Health & Safety Partnership Group.

Principle and Key Health & Safety Objectives

The Trust aims to establish and maintain the highest standards of health and safety management and performance that will ensure the safety and welfare of employees and others who may be affected by its activities, and to minimize the risks associated with financial and reputational losses arising from ill health and injury. The Health & Safety strategy for 2018/23 will support the Trust in achieving this and the strategic aims and principle objectives are supported by a number of key objectives contained within this strategy.

The principal health and safety objectives for the Trust over the next five years are to:

- Continue to review and improve the Trust's Health and Safety management structures and arrangements, with an emphasis on monitoring the quality and effectiveness of health & safety policies, processes and their associated outcomes.
- Support all managers and staff in achieving suitable levels of competency and improved health and safety knowledge
- Ensure all staff understands the importance of complying with Health and Safety standards, what their duties and responsibilities are and how they meet these, and what they are accountable for.
- Increase staff involvement in Health and Safety performance through line management, with a view to increased emphasis on partnership working;
- Ensure there is an identifiable top-down commitment to health and safety in order to firmly embed effective health and safety working arrangements within the Trust.
- Assess workplace risks and introduce safe systems of work for all activities with a particular focus on the high risks and the HSEs priority areas.

Each Strategic objective and their associated key objectives are summarized within the below table as follows:

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Strategic Objectives	Key Objectives
Culture	• The Trust will continue to encourage co-operation with all its employees in promoting and further developing existing measures to improve the culture within the organisation.
Compliance	• The Trust will comply with all relevant health and safety legislation by having appropriate policies in place which will be regularly reviewed ensuring all remain in date, are comprehensive so health and safety guidance and advice is available to all staff, and duties and responsibilities are clearly defined • All departments within the Trust will be subject to a rolling

Strategic Objectives	Key Objectives
	programme of inspections and audits to ensure they are compliant with the requirements of the legislative requirements and recommendations will be made to address areas of non-compliance • Introduction within the Trust of processes designed to assess safety performance and address non-compliance
Coherence	• All health & safety training including face to face theory and practical seminars, blended learning, instruction, information and polices, will be reviewed to ensure the contents are suitable and sufficient, clear, easily accessible, unambiguous and user friendly • All health & safety related policies will include a quick and user friendly reference guide outlining key points of the policy • The contents of the Health & Safety section of the intranet will be reviewed to ensure it is clear, easily accessible, unambiguous and user friendly
Competence	• The contents of all existing health and safety management training within the Trust will be reviewed to ensure managers and staff receive the appropriate level of H&S training appropriate to their respective roles. • A comprehensive training needs analysis will be carried out to identify whether further specialist health & safety training is required to be developed (DSE / COSHH / Risk Assessments) • The incident decision tree will be used for all relevant investigations in particular local reviews and RCA's and HR policies will be applied where relevant
Continuous Improvement	• Develop an annual Health & Safety Project Plan which focuses on key gaps and internal risk issues within the organisation. The Health & Safety project plan will include the HSE's priorities of stress management and mental health. It will also include sharps safety, legionella, asbestos management, sharps safety management, violence and aggression and slip trips and falls • Assist the Trust obtaining the Health & Wellbeing Sequin by supporting and promoting the Health and Well Being Programme • Develop systems to monitor safety performance of activities carried out by staff within the organisation and address non-compliance with additional training, instruction, risk assessment development and review, supervision and where necessary apply the HR disciplinary policy • Develop an annual manual handling project plan which identifies key areas for further improvement and the HSE priorities for musculoskeletal disorders associated with DSE, Manual Handling and Ergonomics. • With support from Quality and Safety department review the incident reporting arrangements and the RCA and Local Review investigations processes for RIDDOR reportable incidents and the processes in place to support divisional led non-clinical investigations. Ensure lessons are learnt following investigations and good practice is shared

Strategic Objectives	Key Objectives
	• Review the content of the health & safety audit pro-forma and investigation pro-forma to ensure they remain relevant. • Further develop risk assessments, policies and processes for the management of activities associated with slips trips and falls, sharps safely, manual handling and ergonomics, violence and aggression , work related stress, health & wellbeing • Develop a generic Health & Safety folder for clinical and non-clinical areas which can be modified so the risk assessments contained within are department specific • Review the health & safety governance arrangements and terms of reference for the various forums within the Trust to ensure appropriate forums are in place so health & safety issues are discussed, managed and escalated where appropriate • Promote health and safety through the weekly communication – at least one article per month linked with an internal key topical issue, a HSE Campaign or National day • Review the contents and layout of reports presented to the Board , Quality and Safety Committee and Health & Safety Partnership Group so they are provided with relevant information and appropriate assurance

4. Do

The arrangements for addressing the principle themes and the process for implementation of the key objectives contained within this strategy and are summarized below.

Culture

Ensuring the Health & Safety culture of all staff within the Trust is proactive and positive is a vital aspect of embedding good health and safety management systems within the organization. The safety culture of any organisation is the product of individual and group values, attitudes, competencies and patterns of behaviour. To ensure all staff promote and demonstrate a positive culture, suitable and sufficient instruction, training and supervision will be made available to staff.

The Trust will continue to encourage co-operation with all its employees in promoting and further developing existing measures to improve the culture within the organisation whilst maintaining a fair but accountable work environment.

Ensure there are clear lines of accountability from Board to ward in terms of fulfilling duties and responsibilities and apply the fair blame culture so that good practices and behavior are nurtured and encouraged and address bad practice and unacceptable behavior.

Encouraging incident and near miss reporting and ensuring managers provide appropriate feedback to staff following the reporting an event and embedding a culture where the reporting of incidents and near misses is seen as a normal and proactive duty of all staff.

Include within the audit programme departments who record the lowest number of accidents and near misses in order to identify whether good practices are responsible for the low number of reported incidents which can then be shared across all areas of the Trust. This process will also identify whether departments reporting low numbers of incidents is due to the culture within these departments, and will be addressed following in depth analysis of root causes for this behaviour which will be then be addressed.

The Health & Safety team will work closely with the Trusts Staff Engagement Team and develop health & safety specific LIA events and associated action plans which will be monitored until complete. This will ensure staff who do not attend existing health & safety forums are able to voice their concerns and contribute to solutions.

Staff side engagement in supporting the implementation of this strategy is crucial and in order to ensure staff side representatives fully support the strategy they will be involved in the consultation and development of processes aimed at further improving the culture within the organisation.

Ensure management are fully engaged and support the strategy by ensuring they understand their duties and responsibilities within the various health & safety policies. This will be achieved by ensuring they are appropriately trained to manage health & safety locally and are supported by the Health & Safety team to manage the more complex health & safety issues. Ensure where practicable health & safety systems and processes are streamlined and easy to use. This will ensure managers do not see health and safety as a paper exercise but a valuable and integral part of daily management. Managers will feel more empowered and confident to manage health & safety which will further support improving the organisational culture.

Compliance

Ensuring the Health & Safety management arrangements within the Trust are appropriate and effective is of paramount importance to the health and safety team. All organizations have statutory duties to ensure suitable arrangements are put in place to manage health and safety effectively which should form an integral part of workplace behaviors and attitudes. A comprehensive legislative framework exists within the UK, the requirements of which are reflected in the WUTH's overarching Health & Safety Policy and approximately 47 associated polices detailing specific duties and responsibilities of both the employer and employees.

The strategy will ensure these arrangements are further improved on by implementing and monitoring progress on the following:

- The Trust will comply with all relevant health and safety legislation by having appropriate policies in place which will be regularly reviewed ensuring all remain in date, are comprehensive so health and safety guidance and advice is available to all staff, and duties and responsibilities are clearly defined.

- The Health & Safety team with the support of the Associate Director of Estates and Facilities will carry out a gap analysis to identify whether further policy development is required, and introduce new and comprehensive polices where gaps are identified.

- All departments within the Trust will be subject to a rolling programme of inspections and audits to ensure they are compliant with the requirements of the legislative requirements

and recommendations will be made to address areas of non-compliance which will be monitored until actions are complete.

Coherence and Competence

Ensuring our workforce is suitable trained, competent and accountable to provide high quality patient care is our organizations priority. There is a wealth of health & safety information provided to staff, patients and others within the organization within a range of policies and processes including training seminars. It is therefore important to ensure that all health & safety training, information and instruction provided is provided is suitable and sufficient and provided in a clear and coherent way. Staff will better understand their respective duties and responsibilities, how these are complied with and fulfilled and what they are accountable for. This will ensure that all staff are competent to deliver excellent patient care and supporting services and understand what is expected from them, which will improve patient safety and their experience whilst under our care.

- The Trust will improve staff's understanding of health & safety policies and processes by reviewing policies, training seminars, and instruction and other health & safety communications so these are clear, concise and to the point, and easily understood.

- Identifying any gaps in the existing training provided by carrying out a training needs analysis to identify whether additional training seminars are required.

- All health & safety training including face to face theory and practical seminars, blended learning, instruction, information and polices, will be reviewed to ensure the contents are suitable and sufficient, clear, easily accessible, unambiguous and user friendly

- All health & safety related policies will include a quick and user friendly reference guide outlining key points of the policy

- The incident decision tree will be used for all relevant investigations in particular local reviews and RCA's and HR policies will be applied where relevant

- The contents of the Health & Safety section of the intranet will be reviewed to ensure it is clear, easily accessible, unambiguous and user friendly

Continuous Improvement

This five year Health & Safety strategy aims to build on current systems, policies and processes to increase and improve, culture, competence, accountability, coherence and the levels of compliance to allow continuous improvement and performance within the Trust. The following key objectives will support the principle objectives of this strategy;

- Develop an annual Health & Safety Project Plan which focuses on key gaps and internal risk issues within the organisation. The Health & Safety project plan will include the HSE's priorities for stress management and mental health. It will also include sharps

safety, legionella, asbestos management, sharps safety management, violence and aggression

- Assist the Trust obtaining the Health & Wellbeing Sequin by supporting and promoting the Health and Well Being Programme

- Develop systems to monitor safety performance of activities carried out by staff within the organisation and address non-compliance with additional training, instruction, risk assessment development and review, supervision and where necessary apply the HR disciplinary policy

- Develop an annual manual handling project plan which identifies key areas for further improvement and includes the HSE priorities for musculoskeletal disorders associated with DSE, Manual Handling and Ergonomics.

- Further develop risk assessments, policies and processes for the management of activities associated with slips trips and falls, sharps safely, manual handling and ergonomics, violence and aggression , work related stress, health & wellbeing

- Develop a generic Health & Safety folder for clinical and non-clinical areas which can be modified so the risk assessments contained within are department specific

- With support from the Quality and Safety department review the incident reporting arrangements and the RCA and Local Review investigations processes for RIDDOR reportable incidents and the processes in place to support divisional led non-clinical investigations. Ensure lessons are learnt following investigations

- Review the content of the health & safety audit pro-forma and investigation pro-forma's to ensure they remain relevant.

- Review the health & safety governance arrangements and terms of reference for the various forums within the Trust to ensure appropriate forums are in place so health & safety issues are discussed, managed and escalated where appropriate

- Promote health and safety through the Trusts weekly communications bulletins – at least one article per quarter linked with an internal key topical health & safety issue, a HSE Campaign or National day

- Review the contents and layout of reports presented to the Board , Quality and Safety Committee and Health & Safety Partnership Group so they are provided with relevant information and appropriate assurance

5. Check

Monitoring and Review

The five year Health & Safety Strategy will be monitored by the H&SPG and progress against the key objectives will be reported to the Board within the Annual Health & Safety Report. There are many benefits of implementing the strategy that are summarized, as follows:

The culture within the organisation will be improved, thus creating a safer environment for all, where health & safety incidents are more accurately reported on, invaluable lessons are learned from these events and shared across the organisations.

The Trust will further improve compliance with the relevant statutory provisions therefore reducing the potential of the organisation of being prosecuted by the HSE for breaches of the Health & Safety Legislation including The Corporate Manslaughter Act 2007.

The potential risk to the Trust of civil litigation due to breaches in our duty of care will also be reduced as will any associated costs with settled claims.

Staff will be guided by clear and concise policies and procedures reflective of relevant legislation therefore reducing the likelihood of breaches of legislation and accidents or incidents arising from any breach and a fair and proportional environment where all staff become accountable will be created.

Staff competence will be further improved in relation to health & safety systems and processes and good health & safety management will be built into daily work streams creating a safer and healthier environment for all. Staff will also feel more empowered to raise concerns in particular where unsafe practices are identified and will be supported by managers to change and ultimately eliminate bad and unsafe practice.

Existing health & safety management systems and processes will be regularly reviewed and audited, supporting continuous improvements and safety performance within all areas of the Trust.

6. Act

Over the course of the next five years the Health and Safety Strategy will be included with the health and safety team's work stream to ensure the key objectives are fulfilled and the principle and key objectives are met. For the strategy to be successfully implemented across all areas of the Trust engagement and commitment from all staff is required.

Communication and Understanding of Health and Safety Strategy

The Trust employs a large, multi-professional workforce of approximately 5,500 staff, across a two main hospital sites. As a consequence, line managers and their teams will be made aware of the Trust's health and safety objectives included within the strategy via a range of existing forums within the governance structure. This will be achieved by:

- Once the Board have committed to the strategy it will be included within the communications bulletin

- A PDF version of the agreed strategy will be made available to all staff on the appropriate section of the Trusts intranet
- The strategy will be referenced within the Health & Safety training and a more detailed outline will be included within health & safety training seminars aimed at managers.

Proactive Health and Safety Monitoring of the Strategy

It's important that the Trust can demonstrate it has an effective and robust process for monitoring the health and safety strategy consistent with the provisions of HSE guidance and this will be achieved by using the existing health & safety governance structure in place to monitor progress against the principle and key objectives described within the strategy. The Board and the Quality and Safety Committee will be kept informed of progress against the principle and key objectives via their respective annual reports. The Health & Safety Partnership group will monitor progress of the key objectives within this strategy.

7. Specific Targets

The Trust has a legal obligation to establish and maintain effective arrangements for the promotion and management of health and safety requirements. This Strategy outlines the principle and key objectives across a five year period. Consistent with current HSE guidance, the Trust manages health and safety using a PDCA framework, which aims to embed health and safety activity and compliance as an integral part of good management practice within all areas of the Trust.

In order to monitor the effectiveness of the strategy specific targets have been set which are considered realistic and measureable. The riddor reportable incidents have been benchmarked against Estates Returns Information Collection (ERIC) returns 2016/17 data for similar size Trusts. Values were calculated externally using the number of riddor reportable incidents divided by the number of occupied floor space per 1,000m2. The Wirral NHS Trust sits within the median quartile in comparison to other similar sized Trusts as do three of the five other Trusts highlighted in the table below. South Manchester NHS FT was assigned to the higher quartile and the only similar sized Trust assigned to the lower quartile was the Northern Lincolnshire and Goole NHS FT.

Trust	No of Employees	No of Riddor Inc	OFA in M2	Sites	Value
Wirral NHS Trust	5,500	23	108,149	2	0.21
NORTH LINCOLNSHIRE AND GOOLE NHS FT	6,500	9	151,899	3	0.06
SOUTH MANCHESTER NHS FT	5,900	44	133,748	5	0.33
CALDERDALE AND HUDDERSFIELD NHS FT	6,000	15	129,930	2	0.12
CITY HOSPITALS SUNDERLAND NHS FT	5,000	18	123,895	4	0.15
NORTH TEES AND HARTLEPOOL NHS FT	5,500	22	118,300	2	0.19

Quartiles	Value
Upper	0.2646
Median	0.1811
Lower	0.1190

It was not possible to benchmark the remaining targets contained within the Strategy against similar sized Trusts as this data is not collated nationally. The process for calculating the remaining targets contained within the strategy was to calculate the average of each incident type, settled EL/PL claims or days lost due to riddor reportable events reported over a five year period and then calculate the desired % reduction or increase as a specific and measurable target.

Specific Targets over five years (2018-2023)

- A 25% reduction in the overall number of serious accidents and dangerous occurrences reported
    - Baseline of 34 (equates to a reduction of 9)

- A 25% reduction in the overall number of incident relating specifically to manual handling including ergonomics, work related stress, slips trips and falls, workplace violence,
    - Baseline for manual handling – 83 (equates to reduction of 21)
    - Baseline for WRS – 46 (equates to reduction of 12)
    - Baseline for STF – 98 (equates to reduction of 25)

- A 50% reduction of needle-stick injuries due to improper disposal
    - Baseline of 9 (equates to a reduction of 4.5)

- A 25 % reduction of settled non- clinical claims
    - Baseline of 34 (equates to a reduction of 8.5)

- A 30% increase in the overall number of health & safety related incidents and near misses reported
    - Baseline of 1848 (equates to an increase of 554)

- A 25% reduction of number of days lost relating to workplace accidents
    - Baseline of 1500 (equates to a reduction of 375 days)

- A 100% increase in the number of H&S audits undertaken within the Trust by the H&S team
    - Baseline of 20 (Equates to an increase of 40)

- Achievement of 85% in the H&S Framework audit compliance results
    - No current baseline due to introduction of a new audit system

- 85% of all clinical sharps used within the Trust are sharps safety products by 2023
    - Baseline of 75%

The five year Health & Safety Strategy seeks to further built and improve on existing systems and processes in order to assure members that health and safety management

arrangements within the organization remain appropriate, comprehensive and are subject to regular scrutiny and review and that health & safety is recognized by most staff as being an important factor within daily work.

Effective health and safety management helps to reduce sickness absence, improves health and well-being and makes the healthcare environment safe and secure. The Trust shall achieve this by an on-going commitment to the health, safety and welfare of the Trust staff by providing appropriate and effective advice, support and guidance on all health and afety matters in order to facilitate a healthy and safe working environment.

8- References

Trust policies which underpin the Health & Safety Strategy are listed below and are accessible to all staff via the Trusts intranet;

Asbestos Management Policy

Bomb & Suspect Packages or Suspicious Mail

Condemning & Disposal of Scrap & Surplus Equipment

Confined Spaces

Control of Contractors

Control of Substances Hazardous to Health (COSHH)

Diagnostic & Therapeutic Equipment Policy & Procedure (Management of)

Display Screen Equipment Policy

Electrical Safety Policy Inc. Portable Appliance Testing (PAT)

Equipment on Loan Indemnities

Fire Safety

First Aid at Work

Food Hygiene

Gas Safety Systems Policy

Health & Safety Policy

Health and Safety (Safety Signs and Signals) Regulations Policy

Inoculations and Exposure to Bodily Fluids (including Sharps and Needlestick) Policy & Procedure

Laser Safety in Diagnosis & Treatment

Latex Allergy Sensitisation

Lifting Operations and Lifting Equipment Regulations (LOLER) Policy

Linen & Laundry Policy

Lockdown Policy & Procedure

Managing Violent & Abusive Behaviour & Therapeutic Holding (Restraint) For Adults Who Lack Capacity And Children / Young Persons (Including Lone Working)

Mobile Communications

Noise at Work

Occupational Health Policy

Pressure Safety Systems Policy

Personal Protective Equipment (PPE) at Work

Pressure Safety Systems
Provision and Use of Work Equipment (PUWER)
Provision of Cleaning Services
Provision of Pest Control Services
Radiation Safety Policy
Safe Management of Healthcare Waste
Safer Moving & Handling
Security of Patients' Cash & Valuables
Security Policy & Procedure
Slips, Trips & Falls - Prevention of
Smoke Free Policy
Uniform & Safe Dress Policy
Water Safety Policy
Working at Height
Workplace and Welfare
Young Workers Policy

BOARD OF DIRECTORS	
Agenda Item	6.3
Title of Report	Hard Truths Commitment: Publishing of Staffing Data: six monthly Update Report (September 2017 - January 2018) including bi-monthly staffing report for (November 2017 - March 2018)
Date of Meeting	25 April 2018
Author	Gaynor Westray – Director of Nursing and Midwifery Tracy Fennell, Deputy Director of Nursing Johanna Ashworth-Jones, Senior Analyst Tracey Lewis, Head Workforce Transformation
Accountable Executive	Gaynor Westray, Director of Nursing and Midwifery
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Risk Reference: 1, 2 and 3
Level of Assurance	**Positive** • The Trust continues to meet the requirements of The "Hard Truths Commitment" • A range of mechanisms have been utilised to ensure a safe nurse staffing establishment is in place, • Effective governance processes are being introduced to ensure traction is maintained against agreed work streams to ensure a safe effective workforce is maintained. • Introduction of specialty reporting of staffing fill rates and Care Hours Per Patient Day (CHPPD) allows for easier comparison of staffing data • Associate Director of Nursing (ADN) provides assurance and oversight that mitigating actions are taken, to address staffing shortfalls **Gaps** • Technology systems do not currently interface to aid easy collection of data / support effective staffing / triangulate data. • Absence of a fully developed nursing workforce strategy • National shortage of registered nurses providing additional recruitment challenges • Changes in National language test for international nurses have led to a reduction in applications to NMC register
Purpose of the Paper	For information and discussion
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 report provides the Board of Directors the six monthly update on progress within the Trust to meet the requirements of 'Hard Truths: The Journey to Putting Patients First; Expectations, Accountability and Responsibility'. Information within this report also provides the Board of Directors with an update on registered nurse / midwives and clinical support workers staffing data specifically for January, February and March 2018, including vacancy rates and staffing related incidents for January, February and March 2018. The report also includes the details of the Trust's monthly submission of Care Hours per Patient Day (CHPPD).

Key Points of Note

- The Trust continues to meet the requirements of The "Hard Truths Commitment";
- A range of mechanisms have been utilised previously to ensure a safe nurse staffing establishment is in place. Dependency and acuity reviews were last completed across a third of the inpatient areas during April / May 2017. A revised robust process has now been initiated to ensure establishments are reviewed six monthly and establishments are reviewed in line with operational requirements, acuity and dependency, workforce plans, and associated risks against a recognised staffing model.
- A variety of work streams e.g. E rostering, recruitment, NHSP, have been in place to support the safer staffing agenda however historically there has been inadequate interface between the projects, with some work streams having limited clinical involvement. The initiation of robust governance meeting "Hard truths – supporting a safer workforce" will ensure interaction, traction and seek assurance from all the agreed work streams across Human Resources, technology, nursing, and Education and Training to the Workforce Assurance Committee, Quality and Safety Committee and Board of Directors via the six Monthly Director of Nursing and Midwifery Hard Truths Report and the Bi Monthly staffing reports. The first Hard Truths – supporting a safer workforce assurance meeting is planned for May 2018.
- The Trust has mechanisms to continue to report its Safe Staffing Data openly across the Trust and to report this locally and nationally. Daily reviews are undertaken by the matrons / associate directors of nursing (ADNs) and further informal discussions regards safe staffing levels happen continually through the week, in response to operational demands, mitigation plans are initiated by ward managers, matrons and the ADN's.
- Divisions have been proactive in piloting new workforce solutions. This will now be monitored via the Hard Truths promoting a safer workforce meeting and approved by the robust six monthly establishment reviews in line with the wider workforce strategy. Solutions include innovative use of bands 2-4 clinical support workers (CSW) , associate nurses , apprenticeships, MDT working. Alternative recruitment strategies are also being considered such as desirable hybrid roles that allow ward based nursing with a compliment of a specialist nursing role.
- There is a continued trend towards an increasing nursing vacancy rates. This is in line with the national picture with more than 33,000 nurses having left the NHS last year, representing a rise of 20% since 2012 / 13 (NHS Digital). The Trust is fully engaged with this work led regionally by the Cheshire and Mersey Director of Nursing forum, supporting wider recruitment campaigns and workforce development, of which overseas recruitment is part.

2. Background

Following the Francis report, the National Quality Board (NQB) published guidance 1 that set out the expectations of commissioners and providers for safe nursing and midwifery staffing, in order to deliver high quality care and the best possible outcomes for patients. This was followed by the NICE guidance *Safe staffing for nursing in adult inpatient wards in acute*

hospital 2 (July 2014) and *Safe midwifery staffing for maternity settings* 3 (February 2015). NICE recommended that their guidance is read alongside that of the NQB guidance.

In June 2015 the Chief Nursing Officer for England, confirmed that there would be changes to the safe staffing agenda for all care settings going forward. She emphasised the importance of the NQB expectations and NICE guidance but explained that safe staffing would now be led by NHS Improvement who would work closely with NICE, CQC and Sir Robert Francis, to ensure that there is no compromise on staffing and its impact on patient safety.

The Lord Carter Review (2016) highlights the importance of ensuring that workforce and financial plans are consistent in order to optimise delivery of clinical quality and use of resources. The review described a new nursing workforce metric to be used (Care Hours per Patient Day (CHPPD) along with a model hospital dashboard. WUTH continues to report the following in line with the NQB recommendations.

Expectation	Progress
Recommendation 1 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. This will be reviewed monthly at the Hard Truths - promoting a safer workforce meeting ensuring Divisional assurance is offered around identified risks.
Recommendation 2 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 11 patients at night as per funded establishments. • The nurse staffing escalation guide has been circulated to all ward sisters / charge nurses and hospital clinical coordinators. This provides guidance and supports decision making if concerns are raised with regard to staffing. This will be reviewed periodically to reflect changes that are tracked via the work streams reporting to Hard Truths – promoting a safer workforce meeting. • Daily staffing meetings are held, (chaired by the ADNs) to determine whether or not planned staffing requirements are met. Meetings are attended by ward sisters/ charge nurses and matrons where a cross organisational review and realignment of staff takes place for the following 24 hours / weekend period / holiday periods. • Staffing plan with agreed potential moves is prepared for out of hour's periods. • Close workings with NHS Professionals (NHSP) to ensure improvement in fill rates for temporary staffing is ongoing. • The Trust is currently exploring the implementation of an IT interface between NHSP and eroster which will allow for contemporaneous review of staffing and NHSP fill rates. This will be tracked via the Hard Truths – promoting a safer workforce meeting.
Recommendation 3 Evidence based tools are used to inform nursing, midwifery and care staffing and capability	• A Dependency and Acuity (Patient Dependency / Acuity Specialty Specific Tool TM) audit was undertaken in some inpatient areas over a consecutive 21 day period during April / May 2017. A revised robust process has

	now been initiated to ensure establishments are reviewed six monthly and establishments are reviewed in line with operational requirements, acuity and dependency, workforce plans, and associated risks against recommended staffing models. The initial establishment reviews will be completed in April 2018. A full acuity / dependency is planned in line with the scheduled six monthly establishment reviews moving forward. Acuity and dependency reviews will be evidence based, IT solutions will be considered as part of the IT work stream that will report to the Hard Truths promoting a safer workforce meeting. • The Emergency Department staffing is 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. A review was planned to take place in Quarter 1 2017 however the revised national tool has not yet been released. This has been placed on the Divisional risk register establishment and reviews will continue as scheduled benchmarked against previous guidance in the absence of the revised publication. • Critical Care Unit adheres to Cheshire and Merseyside Critical Care Network (CMCCN) service specification guidance. The Critical Care Network specification meeting has identified several staffing and activity parameters and benchmarked these against other Trusts. The Trust currently uses, and is compliant with, RCN Guidance on staffing. • Neonatal Unit utilise British Association of Perinatal Medicine (BAPM) standards to inform staffing levels. BAPM levels continue to be monitored on a shift by shift basis. This remains a challenge, particularly as there has been demand for the unit to be occupied above 80% on a regular basis, this will be reviewed as part of the forthcoming establishment review. Staffing is supported through additional hours, bank and agency where possible. There is on-going work to review the possibility of integrating the maternity unit transitional care team with the neonatal team to increase flexibility of the workforce and also progress the functionality of transitional care. This will be assessed as part of a transition plan / proposal.
Recommendation 4 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. However the current technology does not aid easy extracting of "Red Flags" (Appendix 1) reporting this will be a future work stream monitored via the Hard truths - promoting a safer workforce meeting. • One incident of whistleblowing regarding safe staffing has been reported to the CQC in Quarter 3. This has been thoughroughly investigated and assurance given regarding safe staffing levels and practices. A follow up listening event is scheduled with the staff on the ward and the Deputy Director of Nursing to ensure issues have been addressed and staff feel safe and supported.

	• Freedom to Speak Up Staff guardian numbers have been increased to allow for greater visibility across the wards and departments. There has been a reduction in the number of concerns raised to Freedom to speak up guardians in relation to staffing, only one concern has been escalated , this has been addressed locally.
	• The Trust has made a commitment to develop a nursing and midwifery workforce strategy that will address areas of concern. The draft strategy has been shaped around the following key areas:
	  • What our patients can expect from our nursing and midwifery workforce
	  • What our nursing and midwifery workforce can expect from us
	  • What our communities can expect from the Trust
	  • What our approach is to research
	This will include consultation with the nursing and midwifery workforce on the document during April 2018, with the intention of the Board approving the final document in May.

Recommendation 5 A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments	• A revised robust process has now been initiated to ensure establishments are reviewed six monthly and establishments are reviewed in line with operational requirements, acuity and dependency, workforce plans, and associated risks against recommended staffing models. The initial establishment reviews will be undertaken during March / April 2018. A full acuity / dependency is planned in line with the Quarter 2 six monthly establishment reviews. Outcomes of reviews will be reported to the Workforce Assurance Committee, Quality and Safety Committee and Trust Board via the six monthly Director of Nursing and Midwifery Hard Truths report and the Bi monthly staffing reports. The First Hard Truths – supporting a safer workforce assurance meeting is planned for May 18.
Recommendation 6 Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties	• The Trust has a robust process for recording and reporting Care Hours per Patient Day (CHPPD). The Board of Directors receives a bi-monthly report containing key themes from a comparison of data of CHPPD across all wards and specialties as well as regional and national comparison data. • A downward trend in incident reporting in relation to safe staffing levels has been noted. Analysis of reported incidents indicates that the majority of reports relate to staff moves rather than patient related “red flag” (patients not receiving the fundamentals of care) events. The harms key performance indicators do not demonstrate any increase in patient harms due to poor staffing issues during the report time frame. • In 2014 Ward Managers at WUTH were afforded supervisory status and as such are not included in funded establishment. In response to the increased level of acuity and bed base during the winter 2017 / 2018 WUTH have been monitoring on a shift by shift basis the number of clinical shifts worked by ward sisters during

	November 2017, December 2017 and January 2018. Analysis shows that over 60% of ward sisters / charge nurses are regularly working between 20% to 100% of their working week clinically to ensure safe staffing. This has impacted on their ability to fulfill their leadership and quality assurance role; (Appendix 2). This is a national challenge and WUTH results reflect those of peer organisations. This will be monitored monthly and results shared within divisions and with the senior nursing team, forming part of establishment reviews. • Matrons are increasingly involved in managing operational patient flow on a daily basis, as part of the nursing review a matrons job plan is proposed to ensure all elements of the matrons role are achievable.
Recommendation 7 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. • Monthly staffing reports include information on vacancies and number of occurrences of patient harm during the month. • The Board of Directors receives formal bi-monthly reports • Monthly workforce information presented as part of integrated Board Dashboard.
Recommendation 8 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. This will be encompassed in the ward accreditation scheme moving forward. Current compliance is variable this will be monitored via the Divisional reports that report to the Hard Truths promoting a safer workforce meeting • Monthly staffing data is displayed on ward viswalls.
Recommendation 9 Providers of NHS services take an active role in securing staff in line with their workforce requirements	• The workforce forward plan will be reviewed six monthly in line with the scheduled establishment reviews ensuring full stakeholder involvement. • The Workforce and Organisational Strategy is performance managed on a quarterly basis through Workforce Assurance Committee – Board Level support. • Recruitment strategies are in place including attendance at regional events and an international nursing recruitment campaign. Overall nurse vacancy rate is 6.8% in March 2018 (105 WTE) compared to a national average of 11.9% (approximately 40,000 overall nurse vacancies). This has improved from a Trust overall nurse vacancy of 8.0% in August 2017 (122 WTE). • A review of retention strategies is required to ensure they are fit for purpose; this will be undertaken via the Hard truths – promoting a safer workforce meeting. • WUTH is working with local Higher Education Institutes (HEIs) to secure future clinical workforce requirements through participation in the nursing associate pilot, apprentice pathways, hybrid care support worker / therapist apprenticeships and pharmacy technician presence to support safe medicines administration this again will be monitored via the Hard truths – promoting a safer workforce meeting.
Recommendation 10 Commissioners actively seek assurance that the right people, with the right skills, are in the right	• A copy of this six monthly staffing report is presented to the Wirral Clinical Commissioning Quality and Risk meeting for review.

place at the right time within the providers with whom they contract	

3. Governance

A variety of work streams e.g. E rostering, recruitment, NHSP, have been in place to support the safer staffing agenda however historically there has been variable interface between the projects, with some work streams having limited clinical involvement. The initiation of robust governance meeting "Hard truths – supporting a safer workforce" will ensure interaction, traction and assurance from all the agreed work streams across Human Resources, technology, nursing, and Education and Training to the Workforce Assurance Committee, Quality and Safety Committee and Trust Board via the six Monthly Director of Nursing and Midwifery Hard Truths Report and the Bi Monthly Staffing reports. The first Hard Truths – supporting a safer workforce assurance meeting is planned for May 2018.

4. Establishment Reviews / Acuity and Dependency Reviews

Dependency and acuity reviews were last completed across a third of the inpatient areas during April / May 2017. A further review was completed across some areas in Quarter 3 2017. A new process has now been agreed to ensure all areas have an acuity and dependency review six monthly. To supplement this a revised robust process has now been initiated to ensure establishments are also reviewed six monthly in line with operational requirements, acuity and dependency, workforce plans, and associated risks against a recognised staffing model. The initial establishment reviews commenced in February 2018 concluding in April 2018. A full report will be presented to Quality and Safety Committee in July 2018. As part of the Quarter 4 2018 establishment reviews deep dives have been requested by the deputy director of nursing in the following areas to ensure effective clinical judgement is being made in relation to staffing models that will ensure patient safety due to the increased complexity / highlighted risks within the areas.

- Ambulatory Care Unit (ACU)
- Medical Short Stay Ward (MSSU)
- Acute Medical Unit
- Emergency Department
- Ward 38-Respiratory/ Lung Support Unit
- Ward 25- Isolation ward
- Ward 32- Coronary Care Unit / Heart Assessment Centre

The first full acuity / dependency review is planned in line with the scheduled Quarter 3, six monthly establishment reviews.

5. Recruitment Strategy

A key priority for the Trust is to ensure appropriate nurse staffing levels are established and maintained. The previous investments in nurse staffing, as well as a robust recruitment plan, has ensured that the Trust has had a stable nursing and midwifery workforce. In view of the national issues surrounding nurse recruitment, the organisation has endeavoured to be more creative around supporting nurse's personal development at ward level through the facilitation of planned rotational posts.

Other strategies are also being explored such as hybrid roles that offer within 1.0 WTE 30 hours ward based duties and one day within a specialist nursing function. There are very desirable but offer the added gain of ensuring specialist skills such as tissue viability, infection control, safeguarding, and falls management are infiltrated into the ward areas. WUTH Human Resources Department are also working with national recommendations to look at recruitment initiatives that allow nurses to move easily from appointment to appointment similar to medical colleagues.

The Trust has made a commitment to develop a nursing and midwifery workforce strategy that will address areas of concern. The draft strategy has been shaped around the following key areas:

- What our patients can expect from our nursing and midwifery workforce
- What our nursing and midwifery workforce can expect from us
- What our communities can expect from the Trust
- What our approach is to research

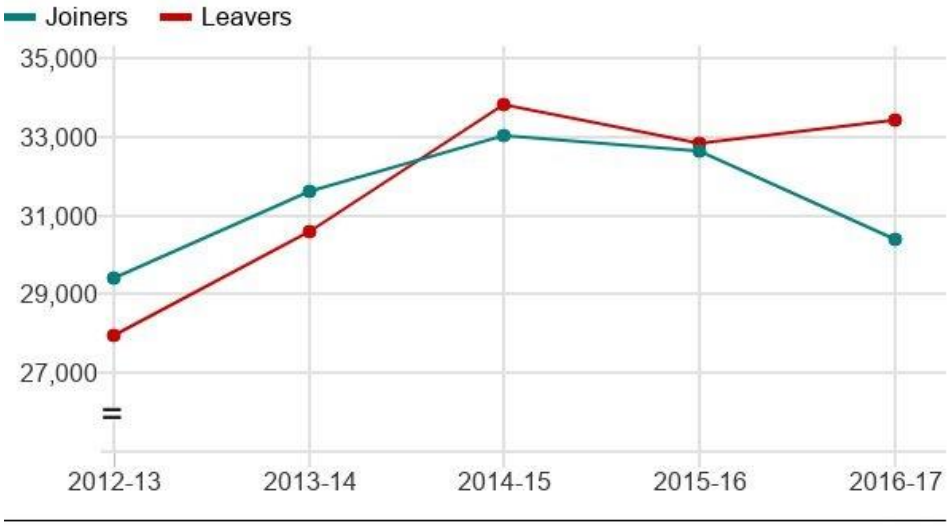
This will include consultation with the nursing and midwifery workforce on the document during April 2018, with the intention of the Board approving the final document in May

6. Vacancies

Nationally more than 33,000 nurses left the NHS last year, representing a rise of 20% since 2012 / 13 (NHS Digital) see Table 1. In Northern Ireland and Scotland, the leaver rates are also rising. In the most recent years, 7.5% of nurse's left NHS employment in Northern Ireland and 7.2% left NHS employment in Scotland. But in both nations, the number of joiners was outnumbered by leavers. This pressure is increased by NHS demand - from GP referrals and diagnostic tests to emergency admissions and A&E visits - the increase reported between 10% and 20% dependent on demographical area. The regulator, NHS Improvement, is rolling out a retention programme to help the health service reduce the number of leavers. The Trust it is fully engaged with this work led regionally by the Cheshire and Mersey Director of Nursing forum, supporting wider recruitment campaigns and workforce development, of which overseas recruitment is part

Table 1

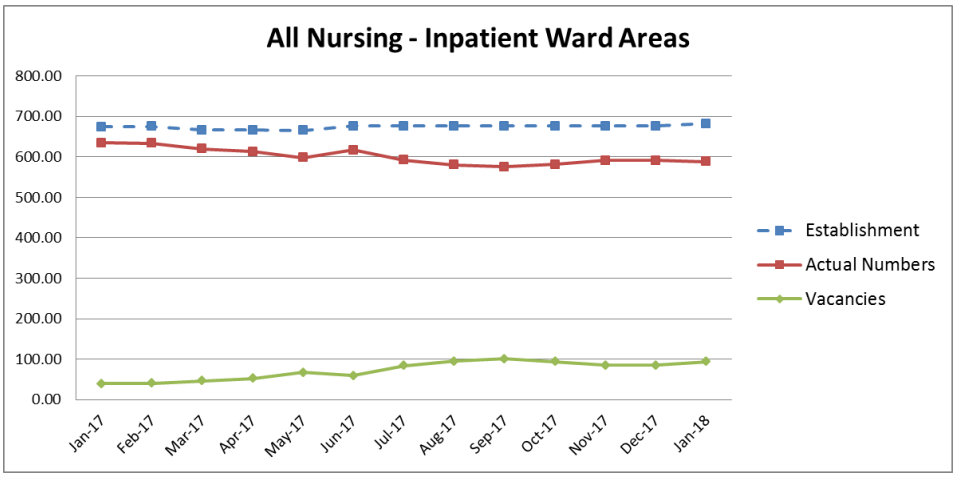
More nurses are leaving than joining the NHS in England

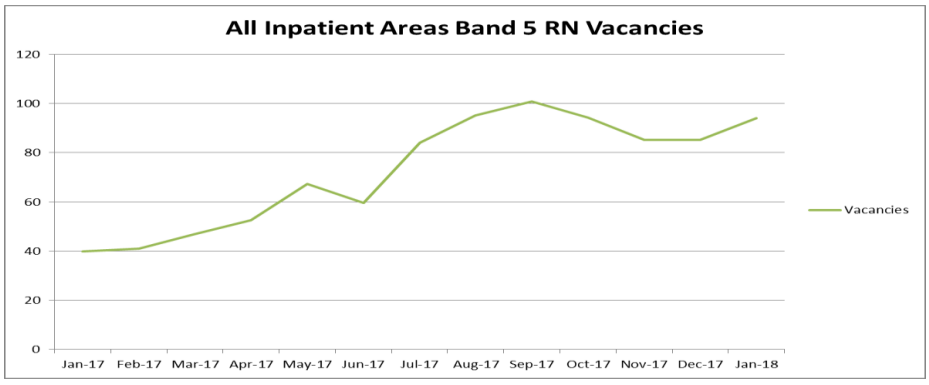


Source: NHS Digital

In addition NHS training bursaries have stopped, nurses are now required to apply for a £9,000 per annum student loan to cover their tuition fees, which has resulted in applications particularly by mature students in England to nursing and midwifery courses at British universities falling by 23%. Evidence is growing nationally of direct recruitment of students to Trust employment, for the term of the 3 year programme and a period beyond. This helps offset the longer term attrition rates of student nurses and the overall bank / agency bill over a 3 year foot print. This however adds a further pressure to an already financially challenged climate.

The Trust had been experiencing a continued trend towards an increasing nursing vacancy rates with a peak of 8% total nurse vacancy's reported in August 2017 have now improved to 6.8% in March 2018. However, this is expected to increase further in May 2018 due to the additional funded establishment on the extra capacity wards. Additional strategies have been implemented to improve the vacancy rate and leaver rate. To mitigate the above HR / OD have restructured their team to ensure dedicated time and expertise is available to support the development of a comprehensive Nursing and Midwifery workforce strategy.





As reported in previous reports the majority of vacancies occur in the Medical and Acute Division, data for band 5 posts identified a vacancy rate of 9.8% in April 2017 increasing to 14% in January 2018 which equates to 44 WTE and 65 WTE vacancies respectively (drawn from the Trust's electronic staff records). Currently initiatives are ongoing to support band 6 career progression / retention with the use of development band 6 posts. In addition highly desirable hybrid roles are being considered that allow 30 hours ward based working and 7 hours per week working within a specialist role.

Medicine and Acute Division continue to look at innovative ways to review the ward establishment and implement a variety of support roles across Band 3 and 4 however this needs to be implemented with caution as reducing the skill mix can have a detrimental effect on quality and safety. These areas will be monitored by triangulating a range of validated metrics at the Hard Truths – promoting a safer workforce meeting to ensure quality and safety of care is not compromised.

7. Retention

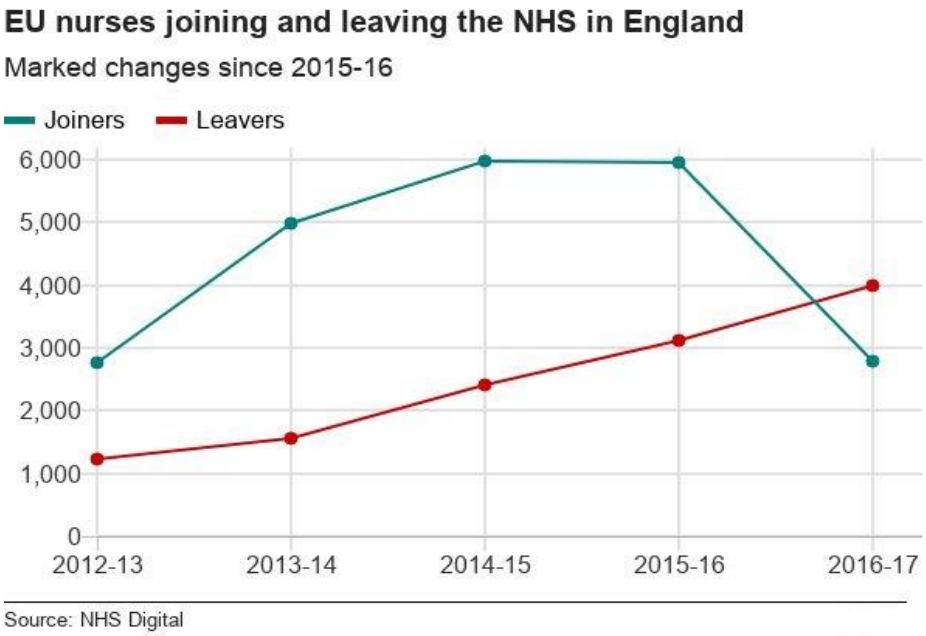
Concerns were raised in the previous September 2017 Hard Truths Commitments report in relation to staff moves and the potential impact on leaver figures. A review has concluded currently there is a lack of compliance with the exit policy and completion of exit Interviews. Although it is understood some exit interviews are undertaken recording of this is inconsistent. This metric will be measured and outcomes be addressed via the Hard Truths supporting a safer workforce meeting. A review of the current evidence however does not suggest staff moves are contributing to the number of staff leaving the Trust. Factors such as acuity, promotional offers, and traveling are known contributors to staff making the decision to leave. It is understood staff moves do have a detrimental effect on staff well-being hence advanced rota planning, block bookings and rotational contracts are being studied to reduce the necessity to move staff, however some on the day moves will always be inevitable due to on day sickness. There is a clear link between staff wellbeing feeling valued and retention plans are currently underway for the senior Nursing team to increase visibility on the wards collating themes from frontline nurses to ensure frontline views are embodied in the Nursing and Midwifery Workforce Strategy that is aimed to increase engagement, promoting the voice of the nursing workforce and the direction of nursing practice moving forward. This has been further supported with a restructure of nursing meetings to include a Professional Nurse Forum, Ward managers / Sisters meeting, Specialist Nursing meeting and Matrons meeting.

8 Nursing Associates

The new role is being introduced across health and social care settings in England only following the Shape of Caring review in 2015. Health Education England has been developing the new role to fit into the existing workforce to bridge the gap in care provision that was identified between the roles of health care assistants and registered nurses. Nurse leaders in England have been clear that the intention is for nursing associates to support and not substitute registered nurses. Having more highly educated and skilled support staff should enable better use to be made of graduate nurse resources. Substantial evidence from studies in the USA, Europe and other countries relates lower nurse staffing skill mix and higher nurse workloads to adverse patient outcomes such as mortality, infections, falls and longer lengths of stay (British Medical Journal, 2017, Appendix 4). The review of safe skill mix / strategic workforce plan for roles band 2 - 4 will be closely monitored via the six monthly establishment reviews and the Hard Truths – promoting a safer workforce meeting. WUTH has six trainee nursing associates (January 2017 cohort) that are progressing through the second year of the programme and an additional cohort of six trainee associates commenced in March 2018.

9 EU Recruitment Programme

The Trust has commenced phase 2 of its International recruitment programme with Placement Group, there is evidence that 69% of UK Trusts are actively recruiting for nurses overseas. 5977 nurses are reported to have joined the NMC register in 2014 / 15 this has dropped to 2761 in 2016 / 17. The number of EU nurses leaving the register also rose by 69% in the same period.



In addition to Brexit the fall in EU nursing numbers coincided with the introduction of the Internal English Language test (IELTS) introduced by the NMC following concerns of patient safety due to poor understanding of English language, this also has had a significant impact on the Trust's ability to secure this group of staff. Currently the Trust is enrolling EU nurses onto foundations of nursing practice that includes IELTS preparation particularly for the written element but recognises some nurses are still requiring additional English tuition at a cost of £400 per nurse to enable successful completion of IELTS.

The table below highlights current EU recruitment activity.

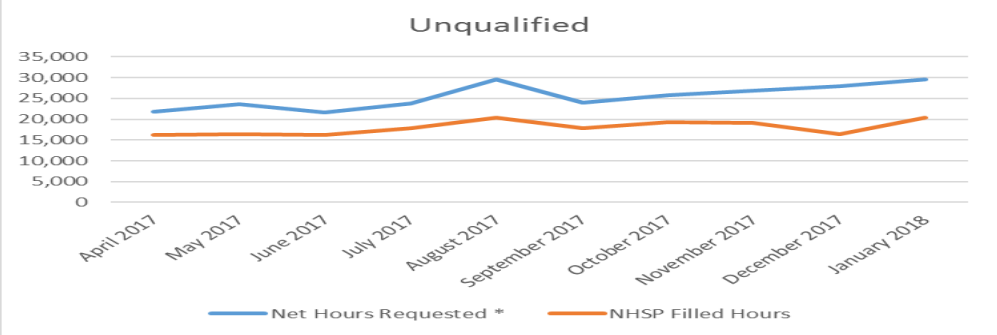
Offered posts during 2017	Commenced in post	Placement areas	Comments
25	12	Ward:10,11,20,22,23,25, 27,30 31,32. Theatres	13 nurses did not commence in post due to difficulty achieving IELTs 6.5 Of the 12 nurses who commenced ,2 have achieved NMC registration the remainder are continuing their English language classes to support IELTs exams March 2018

10. Temporary Staffing

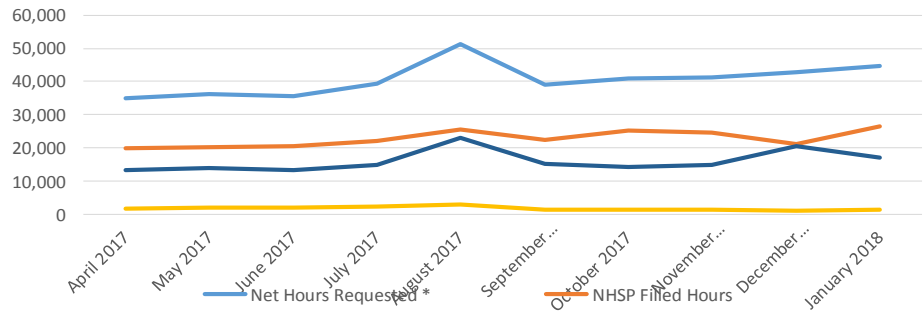
The NHSP contract / service provision is reviewed monthly and has demonstrated a productive and collaborative partnership. February 2018 review highlights the key points:

- Overall NHSP requests increased by 4.4% in January in line with operational demand / opening of additional capacity beds.

- Agency use also increased in January 2018 to 2.9%. However national and regional benchmarking identified WUTH having the lowest nursing agency usage rate at 4.3% (April 2017- January 2018) against a national average of 20.8% fill rate.
- Bank only staff are working on average 7.5 shifts, multi post holders 3.6 shifts per month. Substantive staff are requested to book additional duties via NHSP thus reducing the pressure on overtime payments. This will be monitored via the Hard Truths – promoting a safer workforce meeting.
- There has been a significant steady increase in the number of unqualified hours requested over the previous year from 21,874 in April 2017 increasing to 29,558 in January 2108 despite CSW vacancy numbers remaining less than 15. This rise is largely attributed to the use of special / 1:1 supervision for patients and the requirement to downgrade shifts to CSW skill level due to the shortage of registered nurses available. A workstream will be formed to ensure appropriate governance and appropriate requesting is assured that will report to the Hard Truths – promoting a safer workforce meeting.



- There has been an overall increase noted in the number of registered nurse shifts requested from 34,837 in April 2017 to 44,743 in January 2018, despite increased requests NHSP have only seen a 1.4% rise in unfilled shifts from 38% April to 39.4% January 2018.



11. Safe Staffing Fill Rates

It is a requirement of the Trust to provide to NHS England monthly nurse and midwifery staffing fill rates broken done by clinical area for day and night shifts. These rates include registered and unregistered staff and are used to calculate Care Hours Per Patient Day (CHPPD). Please see Appendix 3 for fill rates by clinical area for January to March 2018.

The Trust has developed a locally agreed RAG rating for staff fill rates. The following areas have been RAG rated as red during January, February and March 2018 for their overall fill rate.

Ward 38 with an overall fill rate of 76% (January 2018): The ward is carrying RN vacancies and was affected by Flu. Agency and critical care staff were used to support the reduced numbers on the ward.

Ward 37 with an overall fill rate of 75% (January 2018): Ward configuration changed to low acuity patients with 8 / 9 beds – safe staffing in place.

Dermatology with an overall fill rate 79% (February 2018: Whilst the fill rate was lower than 100% the correct nurse to patient ratio was in place at all times to maintain safe staffing).

Ward 38 with an overall fill rate of 79% (February 2018): The ward is carrying RN vacancies and was affected by Flu. Agency and critical care staff were used to support the reduced numbers on the ward. It is anticipated that this should improve in April as 5 RN's have been appointed and a new ward sister commenced in post in March 2018.

March 2018 saw an increase in the number of wards (five wards) that had an overall fill rating within the Red RAG rated status.

Ward 32 had an overall fill rate of 73% (March 2018). Ward 32's establishment covers four areas and therefore uses its workforce flexibly to provide safe staffing dependent upon patient acuity and dependency. Critical staff are used to support where staffing allows and patient need requires. There were no patient harms or significant staffing incidents for this period. Ward 32 have been identified as an area where a deep dive will be undertaken .

Ward 37's overall fill rate was 74% (March 2018). Ward 37 works alongside Ward 38 which incorporates lung assessment unit (LAU) the ward has over the past few months reconfigured bed allocation dependent upon acuity. The funded establishment will be changed to mirror this as ward 37 has 8 beds and safe staffing was in place to support this.

Ward M2 elective orthopaedics had a fill rate of 74% (March 2018) The ward was closed for cleaning for part of the month in preparation for the return of use back to orthopaedic elective inpatients as this area had temporarily been used to support medical patients due to operational pressures. In order to close the ward, the number of patients was reduced over a period of time and staffing reduced to reflect the occupancy and acuity.

Ward M2 Surgical had a fill rate of 74% (March 2018) due to the elective day case acuity during this month the ward was not required to stay open overnight on all occasions and therefore staff were used to support the organisation where required.

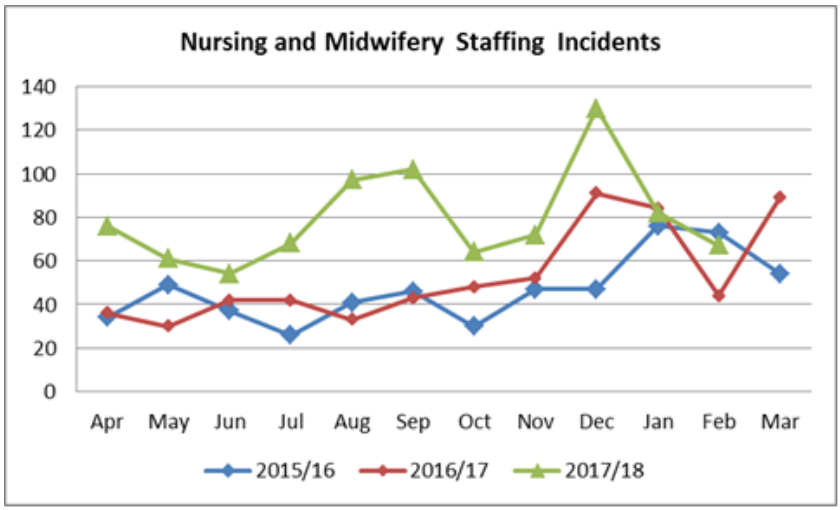
Ward 10 had a fill rate of 66% (March 2018) however this is a reflection of the change in required establishment due to a reduction in beds with the opening of Wirral Acute Femoral Fracture Unit (WAFFU). The funded establishment will be changed to reflect this moving forward. Safe staffing was in place at all times.

Dermatology had an overall fill rate of 66% (March 2018). This was significantly impacted by the CSW day shift which was not required during the month due to reduced inpatient numbers. The RN day shift had a 100% fill rate and staffing was safe at all times.
Whilst analysis is provided as overall fill rates the shift by shift analysis shows a significant number of RN shifts as red. There is assurance from Associate Directors of Nursing in the monthly assurance reports demonstrating mitigating actions such as appropriate grade changes and ward sisters working clinical shifts that staffing remained safe during January, February and March 2018 however this is reflective of the increasing challenges regarding the provision of registered nurses.

12. Reported Staffing Incidents

The Trust is proud to have a positive culture of incident reporting and whilst there has been an increase in the number of staffing incidents reported these did not result in any patient harms. There has been a downward trend in the number of staffing incidents relating to

nursing and midwifery during January and February 2018 as demonstrated in the line graph below.



A monthly analysis report of all Nursing and Midwifery incidents is provided for review and monitoring of themes and actions to the Senior Nursing Team. A review of these incidents indicate that many are based on staff perception of staff shortages and on investigation by the senior nursing team, staffing levels were safe or mitigating actions had been put in place.

During January 2018 the areas where there was increased frequency of incident reporting were:

ITU - Critical care is always staffed to RCN and Cheshire and Mersey network guidance. In periods of low patient numbers and acuity, staff are moved to support level 2 ward areas for example Coronary Care Unit or Lung Support Unit The staff are encouraged to complete incident forms for all staff moves. There is always enough staff left to safely support critical care patients. Staff who move have to return should the demand for critical care increase. No Patient was refused a bed in critical care due to staff moves in January, February or March 2018.

Ward 18: During December there was a CQC enquiry relating to staffing levels on the ward. A report was provided to the CQC and a number of mitigating actions put in place to assist ward 18 who were experiencing reduced staffing levels due an accumulation of a number of unfortunate, unforeseeable circumstances. In January 2018 a number of staff returned from sickness absence and the removal of cohort nursing has resulted in improved fill rates moving into February 2018. There were no incidents recorded resulting in patient harm. Follow up listening events have been planned with the Deputy Director of Nursing to ensure mitigations have been sustained and staff feel safe and supported.

AMU High numbers of staff were reported as moved in January 2018 despite AMU also not having full established numbers on shift. This was compounded by a higher than average number of ED. Ambulatory Care attendees (an additional 220 reported in January 2018) created additional pressure across the Acute Directorate this led to an increasing number of reported incidents and staff reportedly missing breaks. A temporary uplift of an additional Associate Director of Nursing for the Acute Directorate in medicine is allowing for greater daily scrutiny ensuring staff are able to care for patients safely. A deep dive has been commissioned by the Deputy Director of Nursing to assure quality and safe recommended standards of care are being maintained.

In February 2018 there was just one area with a significant number of staffing incidents reported which was Ward 11. Incidents for Ward 11 have all been reviewed by the matron and require down grading. Late short term sickness has been the main reason for reduced

levels and harm is monitored including hospital acquired infection. There was a reduction in **Vancomycin**-resistant enterococci (VRE) hospital acquisition for February 2018. Staffing incidents / mitigations and harms will monitored through the Hard truths – promoting a safer workforce meeting.

13. Conclusion and Recommendations

Whilst progress has been made to meet the recommendations of 'Hard Truths: The Journey to Putting Patients First' Expectations, Accountability and Responsibility there are some emerging concerns in relation inadequate interface between the projects that support safer staffing , with some work streams having limited clinical involvement. The initiation of robust governance meeting "Hard truths – supporting a safer workforce" will ensure interaction, traction and assurance from all the agreed work streams across Human Resources, technology, nursing, and Education and Training to the Workforce Committee, Quality and Safety Committee and Board of Directors via the six Monthly Director of Nursing Hard Truths report and the bi monthly staffing report.

Historically there has been variability in the way establishment reviews have been performed and decisions relating to staffing models have been taken divisionally with limited consideration to the overall workforce strategy. These decisions have led to a reduction in skill mix in some areas that is greater than NICE safer staffing recommendations would advise. Triangulation of data suggests these areas remain safe however there is no validated data to confirm the impact on the quality of care or patient experience. The implementation of a robust six monthly establishment review / acuity and dependency score and continued review of validated metrics via the Hard Truths – promoting a safer workforce meeting will provide the board the assurance wards continue to be staffed appropriately and safely.

Benchmarking the Trust's performance for Care Hours Per Patient Day (CHPPD) with other acute hospitals via the model hospital portal, allows us to further assure ourselves that safe staffing levels are in place and this can be used to address staff perception that staffing levels are low.

The Trust will continue with monthly Trust wide recruitment for registered nurses in conjunction with other initiatives outlined in this report.

14. Recommendation

The Board of Directors are asked to receive this report.

Gaynor Westray
Director of Nursing & Midwifery
25 April 2018

Appendix 1

NICE Guidance for safe staffing describes red flag events. These are:

- Unplanned omission in providing patient medications
- Delay of more than 30 minutes in providing pain relief
- Patient vital signs not assessed or recorded as outlined in the care plan
- Regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. This is often referred to as 'intentional rounding' and involves checks on aspects of care such as the following:
    - Pain: asking patients to describe their level of pain level using the local pain assessment tool
    - Personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration
    - Placement: making sure that the items a patient needs are within easy reach
    - Positioning: making sure that the patient is comfortable and the risk of pressure ulcers is assessed and minimised
    - Less than 2 registered nurses present on a ward during any shift
    - A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. For example:

      If a shift requires 40 hours of registered nurse time, a red flag event would occur if less than 32 hours of registered nurse time is available for that shift

      If a shift requires 15 hours of registered nurse time, a red flag event would occur if 11 hours or less of registered nurse time is available for that shift (which is the loss of more than 25% of the required registered nurse time)

Appendix 2

Overview of Supervisory Ward Mangers Percentage of Clinical Shifts Worked on ward

	November	December	January
Ward	Percentage of time worked on the ward clinically	Percentage of time worked on the ward clinically	Percentage of time worked on the ward clinically
AMU	14%	14%	0%
ACU	5%	10%	4%
AMSSW	9%	0%	0%
EDRU	0%	0%	0%
ITU	0%	0%	0%
HDU	0%	0%	0%
CRC	32%	0%	35%
M1 Rehab	64%	76%	65%
M2 Ortho	45%	0%	0%
OPAU	45%	38%	65%
21	91%	38%	48%
22	82%	71%	65%
23	45%	52%	57%
27	55%	48%	61%
CCU	0%	0%	0%
D1	0%	100%	0%
ESAU	0%	38%	26%
17	41%	57%	43%
18	0%	33%	35%
20	82%	76%	87%
37	0%	0%	0%
24	82%	71%	100%
25	100%	76%	74%
26	91%	0%	0%
30	59%	69%	57%
32	91%	71%	78%
33	59%	62%	65%
36	82%	52%	61%
38	100%	38%	100%
10	86%	86%	78%
M2	0%	25%	0%
11	68%	33%	74%
12	73%	89%	91%
Children's	14%	24%	4%
Neonatal	0%	95%	57%
54	0%	10%	0%
Postnatal	5%	14%	0%
Del Suite	0%	10%	0%

Appendix 3

Orthopaedics	Indicators	Nov	Dec	Jan	Feb	Mar
Ward 10	CHPPD	6.6	5.9	6.9	6.2	6.1
	Fill Rate	93%	90%	90%	85%	66%
Ward 11	CHPPD	8.3	7.5	7.9	8.3	8.1
	Fill Rate	104%	100%	100%	101%	102%
Ward 12	CHPPD	7.8	7.1	5.9	7.8	9.4
	Fill Rate	85%	76%	116%	121%	182%
M2 Ortho	CHPPD	9.4	9.5	7.1	6.2	8
	Fill Rate	68%	73%	107%	117%	74%

During January and February Ward 12 and M2 Ortho have been used as medical wards

Acute Care	Indicators	Nov	Dec	Jan	Feb	Mar
MSSW	CHPPD	6.3	6.1	6.1	5.8	5.6
	Fill Rate	87%	85%	85%	82%	85%
AMU	CHPPD	9.7	9.1	9.3	9.9	9.6
	Fill Rate	97%	96%	98%	100%	101%
EDRU	CHPPD	8.7	8.7	8.2	8.7	7.5
	Fill Rate	102%	103%	109%	114%	106%
ITU	CHPPD	28.9	24.6	26.9	28.6	25.5
	Fill Rate	69%	78%	88%	89%	85%
HDU	CHPPD	23.3	21.1	20.4	21.9	19.7
	Fill Rate	77%	97%	92%	93%	84%

Women's & Childrens	Indicators	Nov	Dec	Jan	Feb	Mar
Children's	CHPPD	8.5	12.7	13	10.8	11.3
	Fill Rate	113%	126%	118%	101%	124%
Maternity	CHPPD	6.5	6.8	6.5	7.5	8.2
	Fill Rate	84%	81%	80%	89%	87%
Delivery Suite	CHPPD	42.4	41.1	35.5	42.6	44.6
	Fill Rate	100%	96%	100%	100%	100%
Ward 54	CHPPD	6.2	5.9	5.7	5.7	5.9
	Fill Rate	91%	90%	95%	96%	99%
Neonatal	CHPPD	13.2	15.4	16.2	14.3	12.1
	Fill Rate	101%	94%	91%	91%	92%

Surgical	Indicators	Nov	Dec	Jan	Feb	Mar
Ward 17	CHPPD	5.7	5.6	5.6	6.2	5.6
	Fill Rate	96%	94%	95%	95%	95%
Ward 18	CHPPD	5.8	6.3	6	6.3	5.9
	Fill Rate	94%	90%	88%	88%	93%
Ward 20	CHPPD	5.4	5.5	5.8	6.2	5.4
	Fill Rate	96%	90%	100%	100%	100%
ESAU	CHPPD	11.2	12.3	11.4	10.5	10.2
	Fill Rate	96%	96%	94%	92%	95%
M2 surgical	CHPPD	14.6	18.4	128.8	20.4	205.6
	Fill Rate	100%	100%	100%	100%	74%
Dermatology	CHPPD	9.6	10.1	11.5	38.3	6.6
	Fill Rate	92%	100%	85%	79%	66%

DME / Rehab	Indicators	Nov	Dec	Jan	Feb	Mar
Ward 21	CHPPD	6.5	5.1	6	5.9	5.4
	Fill Rate	104%	98%	100%	98%	92%
Ward 22	CHPPD	5.6	5.4	5.4	5..4	5.4
	Fill Rate	98%	94%	95%	96%	93%
Ward 23	CHPPD	6.5	6.3	5.9	6.4	6
	Fill Rate	95%	94%	93%	97%	90%
Ward 27 (Ward 24)	CHPPD	5.7	5.7	6.1	6	5.7
	Fill Rate	95%	97%	100%	103%	97%
M1 Rehab	CHPPD	4.5	4.2	4.5	4.5	4.4
	Fill Rate	92%	83%	91%	93%	91%
CRC	CHPPD	6.2	5.9	5.6	5.7	5.8
	Fill Rate	98%	98%	99%	98%	99%
OPAU	CHPPD	7.5	7	6.9	7.8	7.3
	Fill Rate	95%	93%	91%	91%	95%

Appendix 4

Medicine	Indicators	Nov	Dec	Jan	Feb	Mar
Ward 26	CHPPD	6.2	5.6	5.7	5.7	6
	Fill Rate	102%	93%	95%	96%	98%
Ward 30	CHPPD	6.7	6.6	6	6.1	5.8
	Fill Rate	92%	88%	88%	87%	84%
Ward 32	CHPPD	5.9	5.8	5.9	6	5.3
	Fill Rate	95%	94%	81%	80%	73%
CCU	CHPPD	13.9	12.4	12.5	12.5	12.4
	Fill Rate	98%	92%	90%	96%	96%
Ward 33	CHPPD	6.5	5.2	5.6	5.8	5.5
	Fill Rate	102%	82%	87%	90%	86%
Ward 36	CHPPD	4.7	5.3	5.3	5.5	5.4
	Fill Rate	102%	92%	91%	95%	93%
Ward 37	CHPPD	7	5.4	5.3	5.2	5.2
	Fill Rate	105%	75%	75%	100%	74%
Ward 38	CHPPD	5.6	5.4	4.6	4.8	5
	Fill Rate	91%	87%	76%	79%	81%
Ward 25	CHPPD	8.3	7.9	8.3	7.9	7.8
	Fill Rate	77%	75%	84%	83%	83%
Ward 24 (IPC)	CHPPD	6.7	7.2	6.7	6.9	6.6
	Fill Rate	86%	92%	82%	84%	82%

Reference

Aiken LH, Sloane D, Griffiths P For the RN4CAST Consortium, *et al*
Nursing skill mix in European hospitals: cross-sectional study of the association with mortality, patient ratings, and quality of care
BMJ Qual Saf 2017;26:559-568.

Public Board	
Agenda Item	6.4
Title of Report	Mortality Review & Dashboard
Date of Meeting	25 April 2018
Author	Dr Mark Lipton: Deputy Medical Director
Accountable Executive	Dr Susan Gilby, Medical Director
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	4
Level of Assurance **Positive** **Gap(s)**	N/A
Purpose of the Paper **Discussion** **Approval** **To Note**	To Note and Support
Reviewed by Executive Committee	N/A
Data Quality Rating	Bronze – qualitative data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken **Yes** **No**	N/A

1. Executive Summary

In 2016, the CQC published 'Learning, candour and accountability – a review of the way NHS trusts review and investigate the deaths of patients in England', It found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more we can do to engage families and carers and to recognize their insights as a vital source of learning.

In March 2017, the National Quality Board, NQB, published 'National Guidance on Learning from Deaths – A framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigation and Learning from Deaths in Care'; this report is in response to the CQC document.

2. Background

- The Mortality Review Policy was agreed at Trust Board in September 2017.
- The Trust's second mortality dashboard is included being for the period of Q4 17/18 as well as an update to Q3 17/18.
- 9 consultants and two senior nurses have been trained in the structured judgmental review, (SJR). A further 5 consultants also undertake these and will undertake formal training in the future. These numbers should give the Trust the necessary reviewers to perform SJRs on 10% of all deaths.
- 27 deaths in Q4 at present need to have a second line review by SJR, RCA or Women's and Children's review. These have been raised from primary mortality review, elective deaths and serious incident meetings. No secondary review has been raised from the bereavement Service or junior doctors at death certification.
- 20 deaths in Q3 needed to have second line review either by SJR, RCA or Women's and Children's review, 5 of these are still outstanding.
- There has been a significant increase in the Primary Mortality Reviews in Q4 to 63%.
- The next problem to tackle is the delay through the system which is being progressed.

3. Key Issues/Gaps in Assurance

- There is a significant lag through our system so most of the PMRs will only be completed after the respective Quarterly dashboard has been published. Therefore second line review for avoidable deaths will not be available for a significant number of cases. At the time of the quarterly dashboards subsequent dashboards will be updated.
- With trained staff in SJRs more mortality will go directly to SJR review.
- To confirm in the bereavement office relatives and carers are happy with the care of the deceased as no reviews have been raised from here.

4. Next Steps

- To progress above actions
- To progress SJRs
- To continue to review our dashboard against other trusts.
- To verify relatives and carers are happy with the care of the deceased.

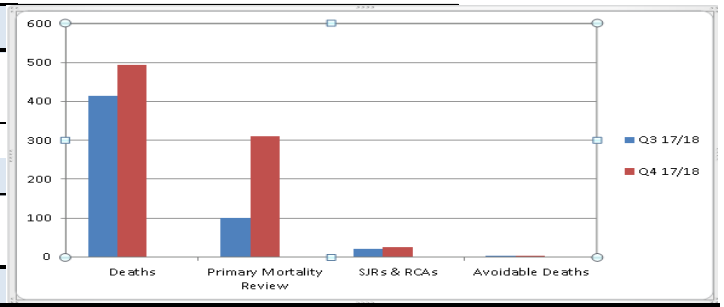
5. Recommendations

- To note and support report

Wirral University Teaching Hospital: Learning from Deaths Dashboard

Total Number of deaths		Primary Mortality reviews		SJRs, RCAs & formal Reviews		Total deaths considered potentially avoidable	
Q3 17/18	Q4 17/18	Q3 17/18	Q4 17/18	Q3 17/18	Q4 17/18	Q3 17/18	Q4 17/18
413	494	100, (24%)	310, (190)*	20, (5)*	29, (24)*	2	1
Q1 18/19	Q2 18/19	Q1 18/19	Q2 18/19	Q1 18/19	Q2 18/19	Q1 18/19	Q2 18/19

()*-in process,



Avoidable Death Assessment Score	Score 1 Definitely avoidable		Score 2 Strong evidence avoidable		Score 3 Possibly avoidable >50:50		score 4 Probably avoidable but not very likely		Score 5 Slight evidence of avoidability		Score 6 Definitely not avoidable	
	Q3	0	Q3	0	Q3	2	Q3	0	Q3	1	Q3	12
	Q4		Q4	1	Q4		Q4		Q4		Q4	4
	17/18 Q3&4	0	17/18 Q3&4	1	17/18 Q3&4	2	17/18 Q3&4	0	17/18 Q3&4	1	17/18 Q3&4	16

Summary	Total actvity Q4 2017/18	Deaths Q4 2017/18
elective surgical patients:	17,370	1
patients with severe learning disabilities	not available	0
patients with severe mental health needs	not available	0
Women's and Children's Hospital		9
Neonatal patients:	933	4
Births:	792	3
Mothers:	781	2

	17/18 Q3	17/18 Q4
Avoidable deaths	2	1
Still under investigation	5	23

Narrative for "Learning from Deaths dashboard"

Q4 17/18 Dashboard

- At WUTH there have been 496 deaths in quarter 4, (1st of Jan – 31st of Mar 2018). This compares to 438 deaths in the same period of 2017.
- There are two national mortality indexes for the hospital: Firstly HSMR-hospital standardised mortality ratio - this measures 85% of in-patient deaths adjusted for palliative care, social deprivation and admission history. It is a more timely mortality index.
  HSMR for WUTH Jan 17 to Dec 17 is 89, (expected is 100, 2SD-84.4 to 93.7) which means we are significantly better than what is expected by statistical analysis.
- Secondly SHMI – Standardised Hospital Mortality Index – this measures all deaths in the hospital and those occurring within 30 days of discharge.
  SHMI for WUTH Jul 16 to Jun 17 is 97, (expected is 100, 2SD-93.0 to 101.0) which means we are within the expected range by statistical analysis.
- Of the Q4 2017/18 deaths 120 have had a completed primary mortality review, 190 are in process. Thus 63% of all deaths will be reviewed by the end of April.
- There have been, so far, 28 deaths which now require a more detailed review. These reviews will take place using 1) Strategic Judgemental Review, – a specifically trained process to assess the death for any lapses in care, with an assessment as to whether the death was avoidable; 2) Root Cause Analysis for those deaths where a serious incident has been raised – eg: in-patient fall; 3) Deaths in Women's and Children's hospital – specific national processes are followed for these deaths.
- At the present notification there have been 1 elective surgical death, 11 deaths undergoing RCAs, 8 deaths undergoing SJRs and 9 deaths in Women's and Children's hospital.
- The Trust aims to eventually perform Strategic Judgemental Reviews on 10% of all deaths. We have 11 senior staff trained with a faculty of 16 in total.
- From the second line review of Q4 deaths an important learning point is the need to be aware of red flags, (important warning signs and symptoms), for Abdominal Aortic Aneurysm, a swelling of the main artery from the heart to the legs in the abdomen. The red flags are: male, age greater than 50, evidence of atherosclerosis and abdominal pain.
- The Q4 17/18 dashboard will be updated at the time of the Q1 18/19 dashboard.

Q3 17/18 Dashboard

- Of the Q3 2017/18 deaths 100 have had a completed primary mortality review. This was 24% of total deaths in the quarter. This was below expectation due to the severe demand within the hospital.
- There have been identified 20 deaths for more detailed review of which 5 are outstanding. These included 5 elective surgical deaths and 4 deaths in Women's and Children's hospital.
- From the second line review of Q3 deaths, important learning points are: 1) to treat in-patient falls as if they present from outside the hospital to ED, thus national protocols are followed regarding CT head scans and the reversal of anti-coagulation. 2) for all patients admitted to the hospital they are assessed as to the likelihood of having a fall. 3) for deteriorating patients without the prospect of recovery a discussion regarding not

performing cardio-pulmonary resuscitation is undertaken with the patient and relatives, furthermore this decision is documented within the patient's electronic patient health record.

- The final Q3 dashboard will be updated at the time of the Q1 18/19 dashboard.
- WUTH has had a mortality review process before the recent guidance from the National Quality Board where the divisions of Medicine and Surgery reviewed approximately 50% of all deaths within the Trust. This process along with quality improvement developments which include 1) Advancing Quality program for Heart disease, hip fractures, large joint replacements, sepsis, alcoholic liver disease, pneumonia, COPD; 2) Developments in palliative care; 3) Improving care of the deteriorating patient – mMEWS, (new modified early warning score); 4) Improving clinical handover and reducing delayed care; 5) Listening into action program have led to the improvement in our national mortality scores over the past few years.

Board of Directors	
Agenda Item	**7.2.1**
Title of Report	**Integrated Performance Dashboard**
Date of Meeting	**25th April 2018**
Author	**Anthony Middleton, Director of Ops / Deputy COO** **John Halliday, Assistant Director of Information**
Accountable Executive	**Janelle Holmes** **Chief Operating Officer**
FOI status	**Document may be disclosed in full**
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	**All Strategic Objectives (1 through 7)** **All Key Measures (1A through 7D)** **All Principal Risks**
Level of Assurance • **Positive** • **Gap(s)**	**Partial with gaps**
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	**Discussion**
Data Quality Rating	**Silver – quantitative data that has not been externally validated**
FOI status	**Document may be disclosed in full**
Equality Impact Assessment Undertaken • **Yes** • **No**	**No**

1. Executive Summary

The report provides a summary of the Trust's performance against agreed key quality and performance indicators. The Board of Directors is asked to note performance to the end of March 2018.

2. Background

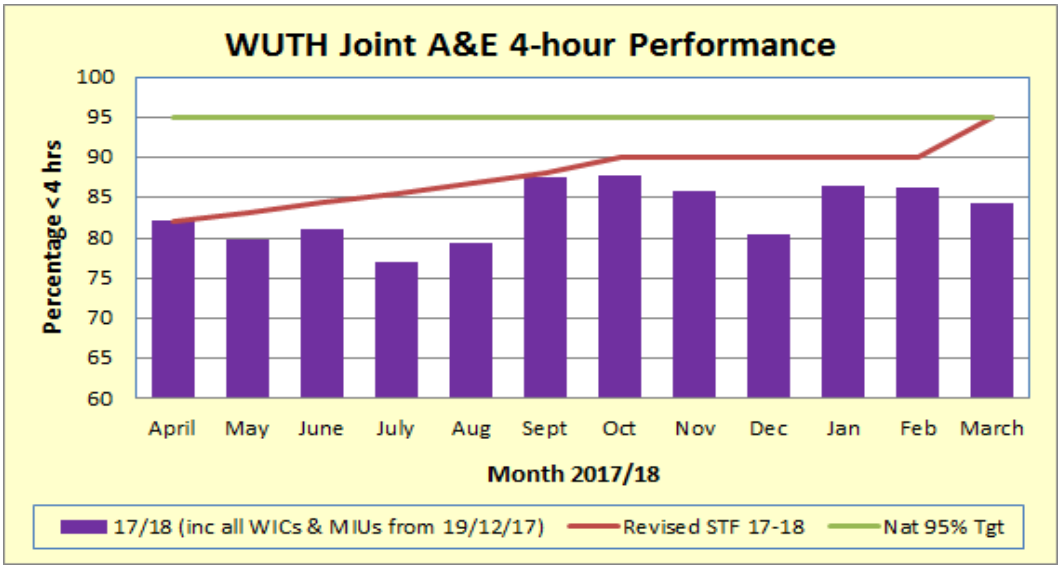
The key national priorities are the A&E four hour target and the financial position. Other key targets by exception are covered in the opening section of the dashboard. An overview of performance against the access standards is provided below.

3. Key Issues

Access Standards

A&E 4 Hours

Key Access Standards : A&E 4 Hours	Target	Jan '18	Feb	March	Trend
A&E 4 Hour Standard *(Wirral wide including all WICs/MIUs)*	>=95%	86.49%	86.34%	84.29%	
A&E 4 Hour Standard *(APH site inc ADHC)*	>=95%	78.45%	78.33%	74.39%	
A&E 4 Hour Standard *(APH site : ED only)*	>=95%	70.86%	70.49%	63.22%	



Against the A&E standard of a minimum 95% of patients to be admitted, transferred or discharged within four hours, the month of March was 84.29% as measured across the combined Wirral WUTH ED, WCT Walk-in Centres and MIUs. This is the external view of Wirral performance by NHS England. Performance for ED with the All Day Health Centre on the Arrowe Park site was 74.39%, with ED alone at 63.22%. The pressure on urgent care services continued into March.

Wirral wide capacity and demand modelling is now complete and there is a clear understanding of how demand, complexity and system configuration results in “overflow” into acute beds. The Trust has taken the decision to recruit substantively to previously tagged “unfunded” beds on 3 wards across both Arrowe Park and Clatterbridge sites. The focus remains on both SAFER work programmes as well as Stranded patients reviews which have now been extended to the Clatterbridge site on a weekly basis. During March the elective beds used since January for winter demands have now been de-escalated.

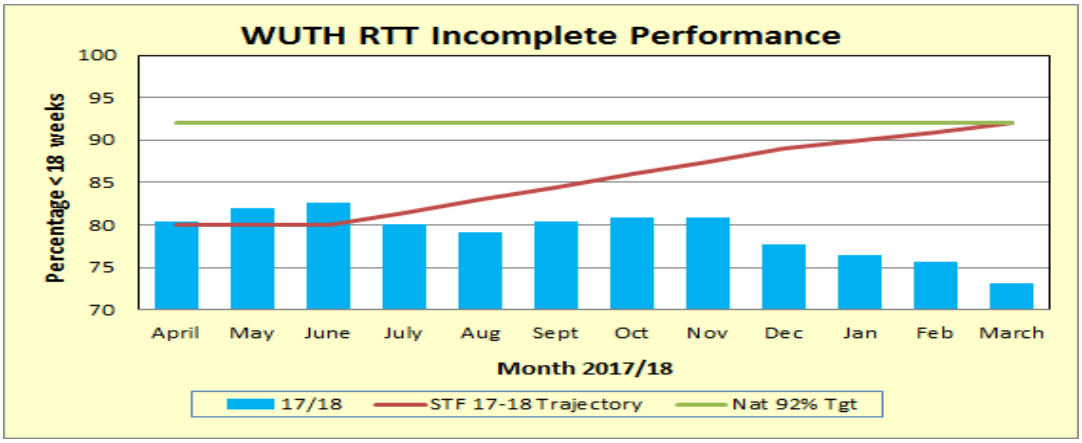
Referral to Treatment

Key Access Standards : RTT	*Target*	Jan '18	Feb	March	Trend
RTT Incompletes : 18 Weeks Position	*>=92%*	76.43%	75.60%	73.07%	
RTT Incompletes : 52 weeks waiters	*0 per month*	30	51	69	
RTT Incompletes : Total waiters	*n/a*	23189	23957	24736	
RTT Incompletes : 39 weeks waiters	*n/a*	517	611	812	
Diagnostics 6 Weeks Standard *	*>99%*	98.82%	99.20%	99.23%	

Key Access Standards : RTT (latest month)	*Target*	Acute & Med	Surgery	W&C	Clin Support
RTT Incompletes : 18 Weeks Position	*>=92%*	83.25%	67.28%	86.15%	25.17%
RTT Incompletes : 52 weeks waiters	*0 per month*	0	69	0	0
RTT Incompletes : Total waiters	*n/a*	6139	15709	2737	151
RTT Incompletes : 39 weeks waiters	*n/a*	-	-	-	-
Diagnostics 6 Weeks Standard *	*>99%*	97.31%	98.47%	-	99.74%

The focus of RTT is 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 calculated under the contract for individual specialties that do not achieve.

The position for the end of March was 73.07%. The elective programme was not back up to full capacity in March following the nationally mandated cancellations to assist with the pressure on beds from urgent care. This has a further consequential impact on waiting times and therefore RTT performance.



There were 69 patients waiting over 52 weeks at the end of March, an increase from February and reflecting the general lengthening waiting times.

The Diagnostic 6 Weeks Standard is a supportive measure for RTT performance, as they can be a 'hidden' wait in the middle of pathways. The position for the end of March was 99.23% so better than the national minimum standard of 99%.

Cancer Waiting Times

The management of individual patient pathways and validation of waiting times is continuing, and as a result the Trust is maintaining a strong record of delivery against all cancer standards in aggregate. Where individual tumour pathways are experiencing high demand management teams are taking actions to address. All standards are expected to be met for Q4, with a summary across the months shown below.

Cancer Waiting Times *	*Target*	Jan '18	Feb	March	Trend
Cancer : Two Week Wait	>=93%	96.96%	96.95%	94.74%	
Cancer : Two Week Wait Breast Symptoms	>=93%	100.00%	94.12%	94.74%	
Cancer : 31 days to First Treatment	>=96%	96.95%	99.10%	96.46%	
Cancer : 31 days to Subsequent Treatment (Surgery)	>=94%	100.00%	100.00%	95.45%	
Cancer : 31 days to Subsequent Treatment (Drugs)	>=98%	100.00%	100.00%	100.00%	
Cancer : 62 days Urgent Referral to Treatment	>=85%	85.79%	86.40%	88.70%	
Cancer : 62 days NHS Screening to First Treatment	>=90%	100.00%	90.00%	90.91%	
Cancer : 62 days Consultant Upgrade to First Treatment	>=85%	87.62%	93.33%	92.98%	
*Note : Performance figures not yet finalised					

Cancer Waiting Times * (latest month)	*Target*	Acute & Med	Surgery	W&C	Clin Support
Cancer : Two Week Wait	>=93%	97.87%	91.41%	98.45%	-
Cancer : Two Week Wait Breast Symptoms	>=93%	-	-	94.74%	-
Cancer : 31 days to First Treatment	>=96%	100.00%	94.37%	100.00%	-
Cancer : 31 days to Subsequent Treatment (Surgery)	>=94%	-	90.91%	100.00%	-
Cancer : 31 days to Subsequent Treatment (Drugs)	>=98%	100.00%	-	100.00%	-
Cancer : 62 days Urgent Referral to Treatment	>=85%	94.12%	84.71%	100.00%	-
Cancer : 62 days NHS Screening to First Treatment	>=90%	-	50.00%	100.00%	-
Cancer : 62 days Consultant Upgrade to First Treatment	>=85%	100.00%	90.48%	50.00%	-
*Note : Performance figures not yet finalised					

4. Next Steps

WUTH remains committed to attaining standards through 2018-19.

5. Conclusion

The key operational challenge has remained managing the very high pressures on urgent care and Arrowe Park Hospital in particular. For 2018-19 those continuing urgent care needs will need to be balanced against the expected return to improved elective waiting times.

6. Recommendation

The Board of Directors are asked to note the Trust's current performance to the end of March 2018.

WUTH Metrics Summary
Performance for March 2018

Metrics	✓	!	×	Not rated
	16	11	15	3

Headline Commentary

The key focus remains on the financial position and A&E 4-hour performance, followed by elective access standard performance (RTT and Cancer).

The winter pressures on urgent care services continued into March, with a corresponding impact on performance against the A&E 4 hour standard. This was also reflected regionally and nationally.

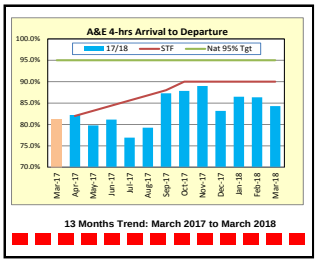
The enforced cancellation of elective activity continued into March, with a further detrimental effect on the RTT position. Very long waiters are being actively managed on an individual basis, and reviewed for possible harm.

Cancer standards remain on track to be delivered for Q4. The financial position is detailed separately.

A&E : 4 Hours Arrival to Discharge ✗

Actual: 84.29% **Accountibility:** J Holmes / A Middleton

Threshold: 95% (minimum) **Committee:** FPBAC



Metric
The total time spent in A&E, measured from the time the patient arrives in A&E to the time the patient leaves the A&E Department, by discharge home, transfer to anther hospital or admission to a ward.

Key Issues
The Trust had agreed a trajectory to deliver the standard by March 2018, but this has now been superseded by a blanket national expectation of 90% for October through to February, with 95% to be delivered in March 2018.

Performance is now reported for Wirral at various levels :

Wirral-wide including all Walk-in-Centres & MIUs	84.29%
WUTH APH site including the ADHC	74.39%
WUTH APH ED only	63.22%

This performance reflects the pressure on urgent care services through Winter and that continued into March.

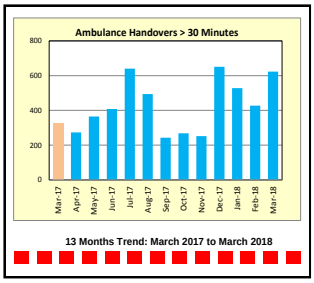
Inputs
Wirral wide capacity and demand modelling is now complete and there is a clear understanding of how demand, complexity and system configuration results in "overflow" into acute beds. The Trust has taken the decision to recruit substantively to previously tagged "unfunded" beds on 3 wards across both Arrowe Park and Clatterbridge sites. The focus remains on both SAFER work programmes as well as Stranded patients reviews which have now been extended to the Clatterbridge site on a weekly basis.

Progress
During March the elective beds used since January for winter demands were de-escalated.

Ambulance Turnaround 30 Mins ✗

Actual: 623 **Accountibility:** J Holmes / A Middleton

Threshold: 0 > 30mins **Committee:** FPBAC



Metric
The standard is a maximum 30 minutes from the arrival of an ambulance to the handover of the patient to Trust staff in the Emergency Department (ED).

Key Issues
In the month of March there were 623 arrivals by ambulance that took longer than 30 minutes to handover.

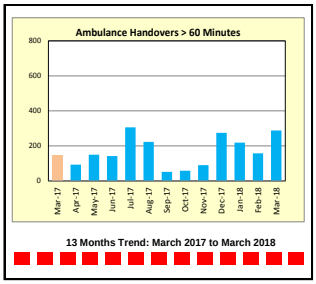
Inputs
The Trust is investing in additional nursing staff to aid in rapid handover, and when pressures increase ensure crews are not managing patients on "corridor queues". A programme of improvement in conjunction with NWAS continues and will be updated at the next A&E delivery board.

Progress
The programme which saw improvement over the autumn period but which was not resilient enough throughout winter will draw upon the lessons learnt and will adapt.

Ambulance Turnaround 60 Mins ✗

Actual: 288 **Accountibility:** J Holmes / A Middleton

Threshold: 0 > 60mins **Committee:** FPBAC



Metric
The guideline is that all handovers between ambulance and A&E must take place within 30 minutes - it is recoginsed that 60 minute handover waits are identified as a significant issue

Key Issues
In the month of March there were 288 arrivals by ambulance that took longer than 60 minutes to handover.

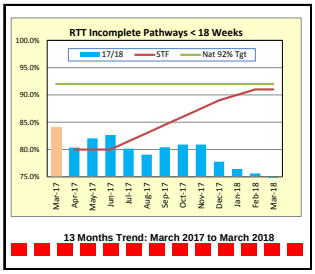
Inputs
The Trust is investing in additional nursing staff to aid in rapid handover, and when pressures increase ensure crews are not managing patients on "corridor queues". A programme of improvement in conjunction with NWAS continues and will be updated at the next A&E delivery board.

Progress
As part of the overall economy winter debriefs there will be specific inclusion of 60 min + handovers. Moving forward the national drive is to treat all breaches as formal incidents.

RTT - Incomplete ✗

Actual: 73.07% **Accountibility:** J Holmes / A Middleton

Threshold: 92% (minimum) **Committee:** FPBAC



Metric
The percentage of patients that have been referred to a consultant-led service and have not commenced treatment within 18 weeks from that referral, as measured at month-end.

Key Issues
The Trust agreed a trajectory back to compliance across 2017/18 with NHS Improvement. This trajectory has not been acheved since June 2017. Performance for the end of March 2018 was 73.07%.

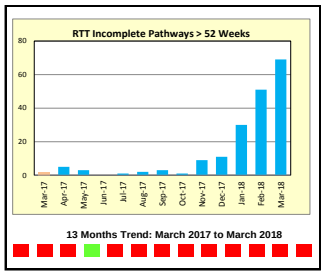
Inputs
The position continued to be affected by the partial cessation of elective activities during March. Following the de-escalation of elective wards used for medical outliers the Trust has subsequently been able to fully restart its programme. The Trust is moving to centralising all the booking and administration of RTT.

Progress
As part of the 2018/19 planning round the Trust has developed a plan to improve the position to 80% compliance by March 2019 and is discussing the phasing of the plan with commissioners. It should be noted that the national 2018/19 planning guidance moves away from 18 weeks as the key measure, rather focusing on total waiting list size.

RTT - 52 Week Waiters

Actual: 69 **Accountibility:** J Holmes / A Middleton

Threshold: 0 **Committee:** FPBAC



Metric
In conjunction with the 92% standard for incomplete RTT pathways, there is the national expectation that all patients will commence treatment within 52 weeks of referral, as measured at month-end.

Key Issues
There were 69 patients at the end of March that had waited longer than 52 weeks for treatment to commence.

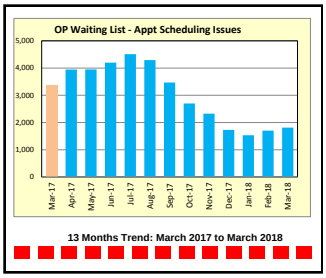
Inputs
Long waiting patients are being actively managed alongside the general waiting list and waiting time improvement actions. Any patients confirmed as having waited 52 weeks at month-end are reviewed to ensure no clincal harm has resulted from the long wait, and to understand the causes of the excessive waiting time.

Progress
Numbers have risen sharply during quarter 4 as the elective programme was impacted by emergency pressure. Plans to address have been developed within the overall RTT plan for 2018/19. National guidance for 2018/19 expects at least a 50% reduction in breaches by March 2019.

Outpatient Waiting List - Appointment Scheduling Issues (ASI)

Actual: 1812 **Accountibility:** J Holmes / A Middleton

Threshold: Zero **Committee:** FPBAC



Metric
Number of eRS referrals on the Appointment Scheduling Issues (ASI) list at month-end

Key Issues
Direct bookings from GPs via the national eRS are unable to find an available appointment for the patient if there is limited capacity at the Trust. These referrals are then logged as an ASI, preveting the referal letter reaching the Trust, and the patient does not receive an appointment until capacity becomes available.

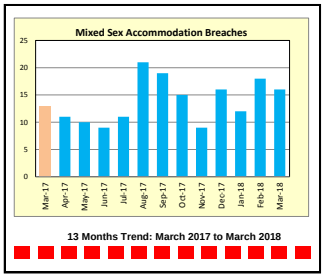
Inputs
The size of the ASI backlog increased slightly in March. Divisions are working through plans to reduce and minimise the number of ASI.

Progress
The overall RTT plan for 2018/19 includes additional outpatient activity, which should reduce the ASI numbers if demand does not increase unduly.

Mixed Sex Accommodation Breaches

Actual: 16 **Accountibility:** J Holmes / A Middleton

Threshold: Zero **Committee:** FPBAC



Metric
Patients have a right to single-sex accommodation, to respect their privacy and dignity in an inpatient setting.

Key Issues
There were 16 breaches of the same sex accommodation standard in March, relating to patients waiting beyond the 24 hours allowed for patients transferring out of critical care areas.

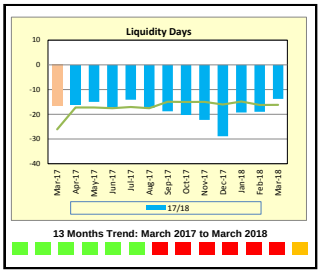
Inputs
The delays in transferring out are discussed at all bed meetings and given high priority. The patients' privacy and dignity is maintained in the critical care areas, in a side room if possible, and all care given that would be provided on their destination ward. The delays are explained to the patients, and they are moved as soon as a bed becomes available in the right ward. The increased urgent care pressure on beds in recent months exacerbates the delays.

Progress
Options to increase the side rooms in critical areas are being assessed. Improving patient flow across the Trust will allow easier and more timely transfer back to general wards for those patients that no longer need augmented care.Additional support on managing critical care patients back to general wards will be facilitated by the transfer of those areas to the responsibility of the Clinical Support Division.

Liquidity Days

Actual: -13.80 **Accountibility:** G Lawrence

Threshold: Greater than planned liquidity **Committee:** FPBAC



Metric
Days of operating costs held in cash-equivalent forms.
2016/17 plan and actual figures (to Feb 2017) appear worse than the 2017/18 metrics because they were compiled on a different basis. Due to changing instructions from the Department of Health and NHSI, working capital facility (WCF) borrowings were previously included within working capital balances, which made the liquidity metric more negative.

Key Issues
Since 2015/16, EBITDA deficits have consistently generated net cash outflows from operating activities, which in turn have deteriorated the Trust's working capital balances. The negative 'liquidity days' metric reflects this 'negative working capital' situation – the Trust's liabilities exceed its assets, including cash. This can be seen in the Trust's Statement of Financial Position.

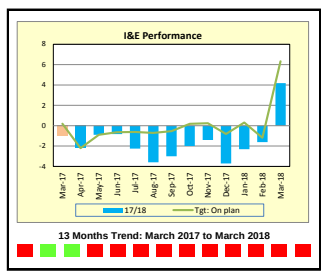
Inputs
Loan arrangements are in place with the Department of Health and NHSI, which ensure that the Trust will not run out of cash.
Such borrowings are to cover day-to-day running costs, and are not ordinarily expected to be used to improve working capital balances.
Therefore, improvement in the liquidity metric primarily depends on improvement in the Trust's underlying EBITDA performance.

Progress
Improvement in the liquidity metric primarily depends on improvement in the Trust's underlying EBITDA performance.

I&E Performance

Actual: 4.18 **Accountibility:** G Lawrence

Threshold: On plan **Committee:** FPBAC



Metric
The actual monthly Trust financial position compared to the planned financial position.

Key Issues

In line with the latest forecast to NHSI the Trust has delivered a £(20.4)m deficit. In M12 a year end settlement was agreed with the CCG and gave a £2.1m benefit. CQUIN risk was mitigated with the 'year end' settlement with the CCG. In addition the sale of clatterbridge land resulted in a £3.9m gain as part of the planned bridging items as well as the GDE benefit of £1.7m. Operational expenditure continues to be significantly above plan particularly in pay. The non-delivery of the operational plan has resulted in not being able to access £7.7m of the planned Sustainability & Transformation Fund (STF) since Q1.

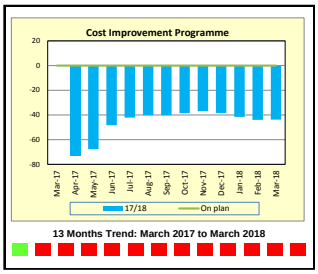
Inputs
The Trust continues to look at a sustainability challenge of c£30m plus to address the underlying deficit.

Progress
The financial recovery plan is reviewed at the Finance & Performance Group as well as the divisional finance reviews with the Director of Finance.

Cost Improvement Programme

Actual: -43.8 **Accountibility:** G Lawrence

Threshold: On Plan **Committee:** FPBAC



Metric
The percentage of non-achievement of the in year CIP forecast against the £15m plan.

Key Issues
CIP delivered £8.4m of the NHSI £15m target.

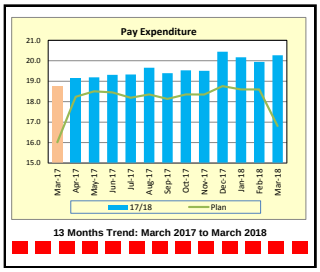
Inputs
The Transformation Steering Group (TSG) continues to review and approve new opportunities. Work is ongoing to look at the big transformational schemes for 18/19.

Progress
TSG continues to progress schemes when identified and has strong links to SSPG in order to realise benefits from proposed vertical and horizontal integration.

Pay Expenditure

Actual: 20.27 **Accountibility:** G Lawrence

Threshold: Plan **Committee:** FPBAC



Metric
The actual monthly Trust pay spend compared to the pay plan.

Key Issues
Operational expenditure in particular pay continues to be significantly above plan due to workforce pressures as a result of increased non-elective demand, issues in recruiting to medical gaps and the high levels of nursing vacancies as well as the pace of delivery on CIP schemes. Use on non-core pay is still relatively high and represents c10% of pay spend.

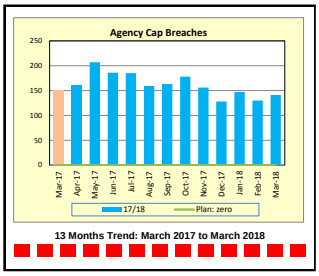
Inputs
The finance team review pay overspends and use of non-core on a regular basis with the budget managers and divisional teams.
There has been a vacancy freeze on all non-clinical posts implemented since early October and all vacancies remain under review.

Progress
Work continues to review the pay run rate.

Agency Cap Breaches

Actual: 141 **Accountibility:** J Holmes

Threshold: 0 **Committee:** FPBAC



Metric
The target is set at zero breaches of the agency cap. Divisional target to reduce agency usage by 50%.

Key Issues
Use of unfunded or unestablished escalation wards is creating increased demands for bank and agency staff. The Divisional target to reduce agency usage by 50% is proving a challenge without direct impact on patient care.

Inputs
The Effective and Efficient Workforce transformation is reviewing Medical leadership roles to free up more time for patient contact, job planning for medical and non-medical staff to increase efficiency, and policies and procedures to reduce reliance on temporary staff.

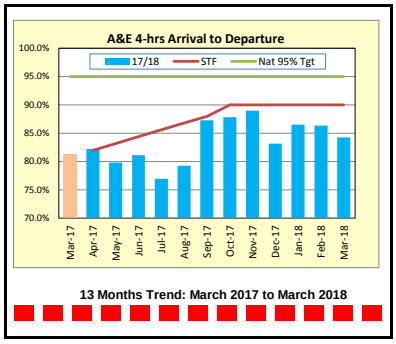
Progress
Policy amendments finalised Nov 2017. Revised workforce planning presented to WGG in Dec 2017. Collaborative agreements with other NHS organisations on agency rates are being considered for possible introduction from April 2018.

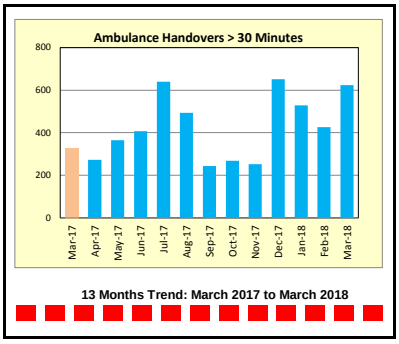
Access (Operations)

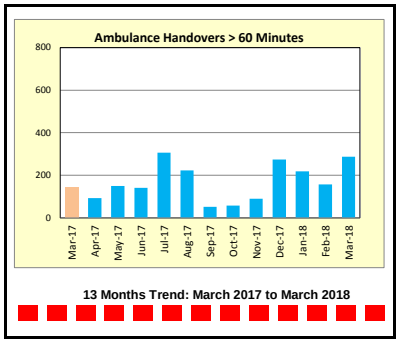
J Holmes / A Middleton

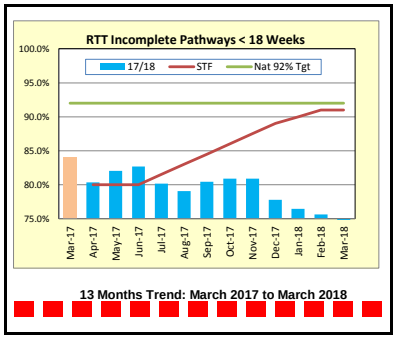
✓	!	×	Not rated
9	4	9	

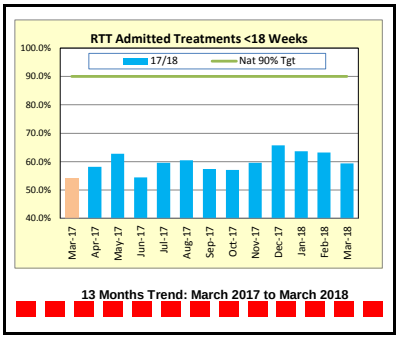
Access (Operations)

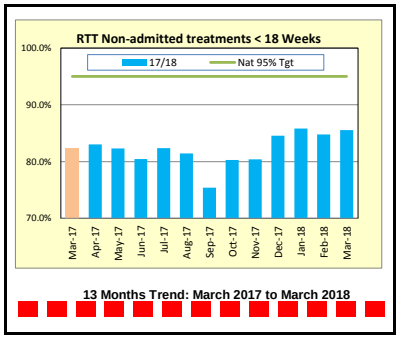


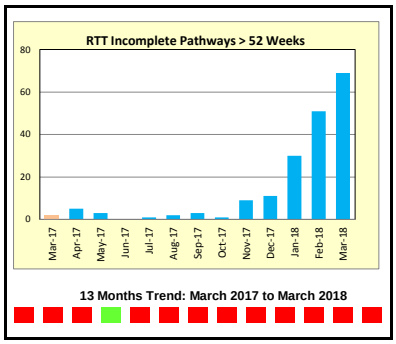


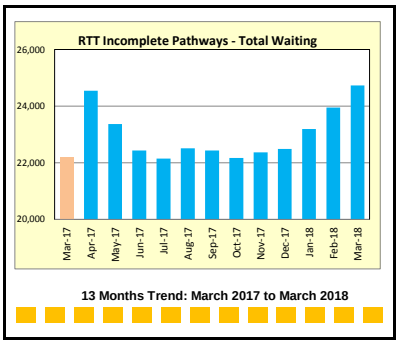


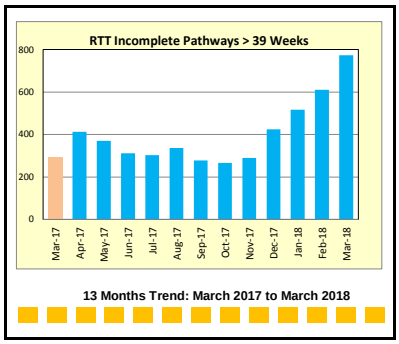


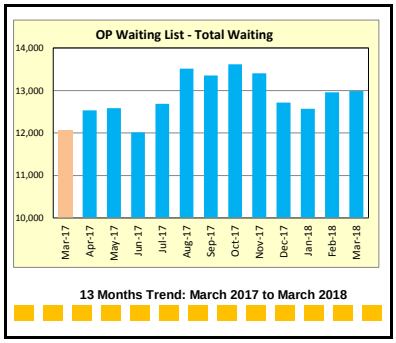


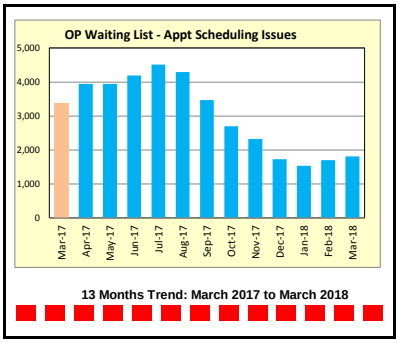


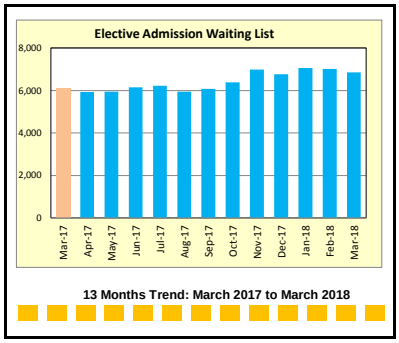


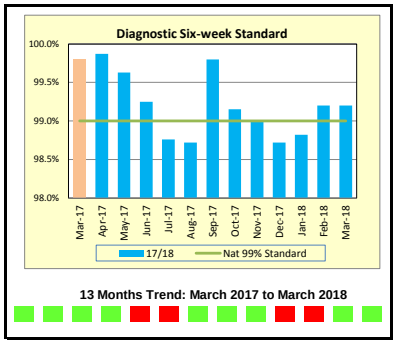


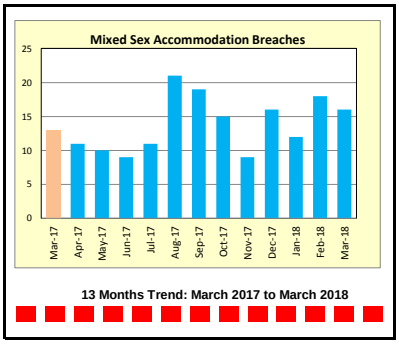




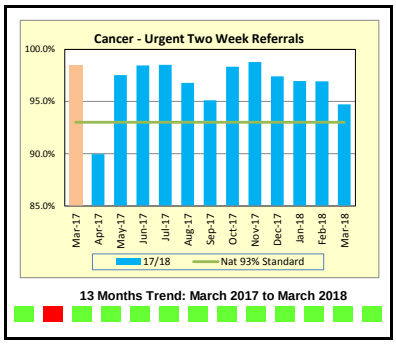


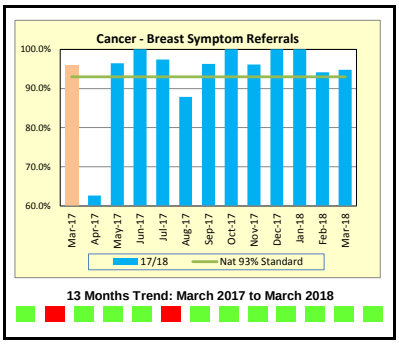


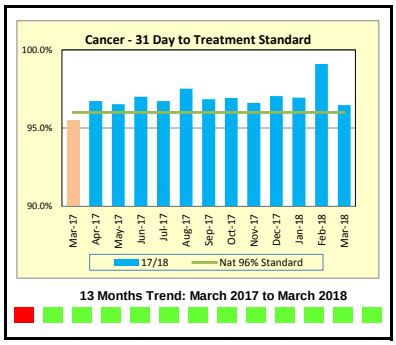


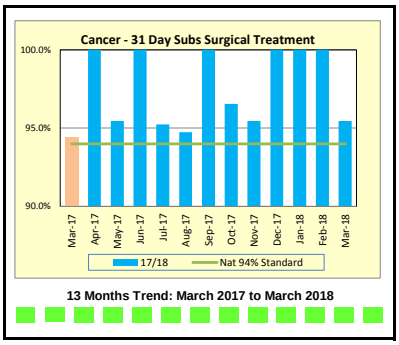


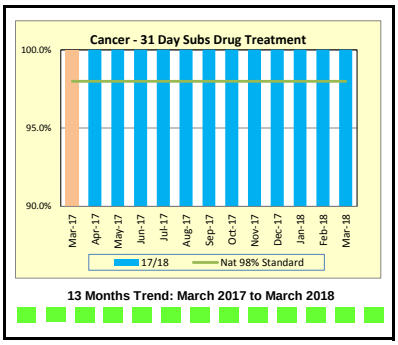
Access (Operations)

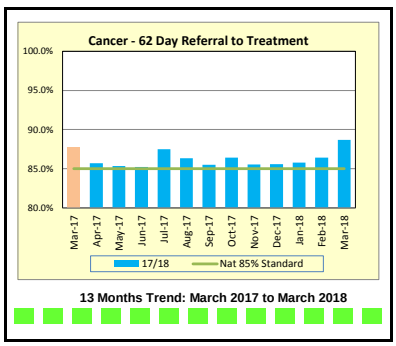


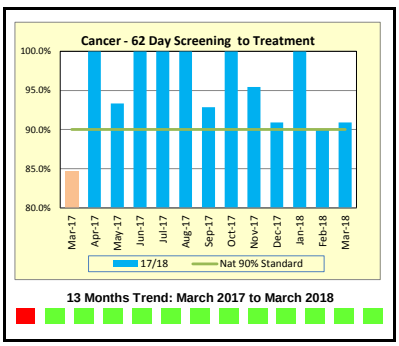


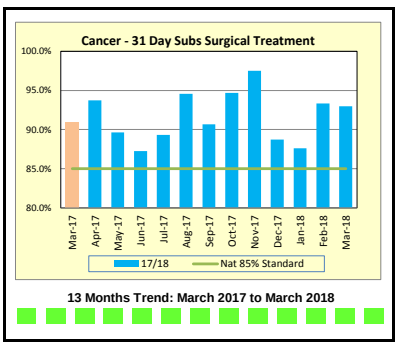










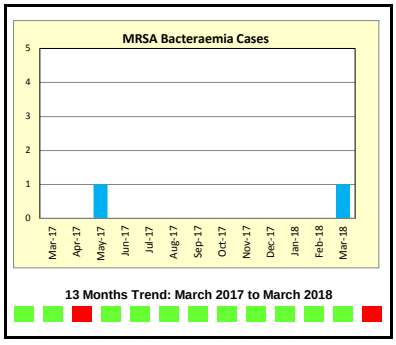


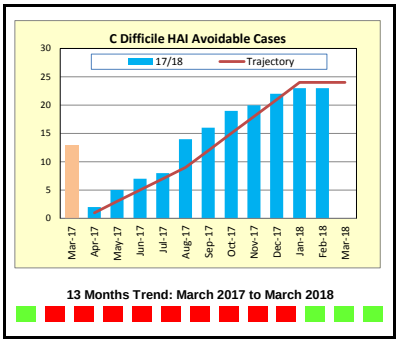
Patient Experience

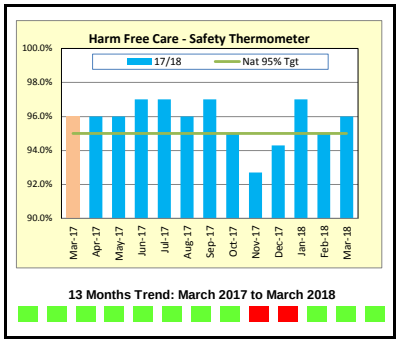
G Westray

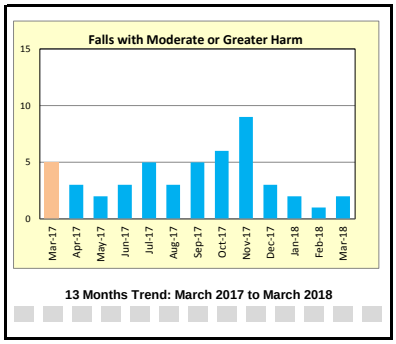
✓	!	×	Not rated
6	0	1	2

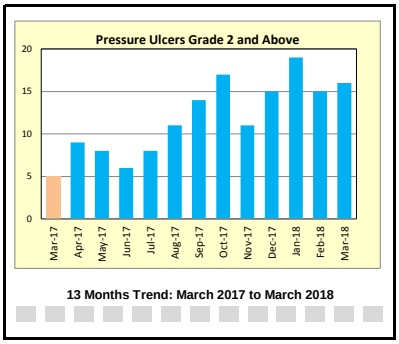
Patient Experience

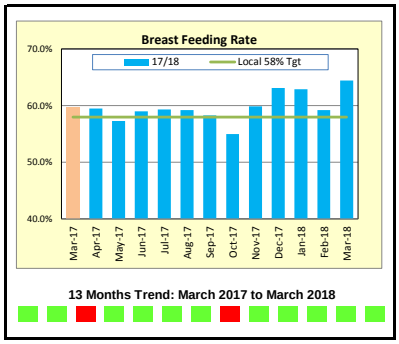


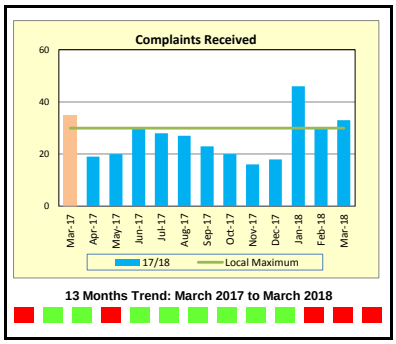


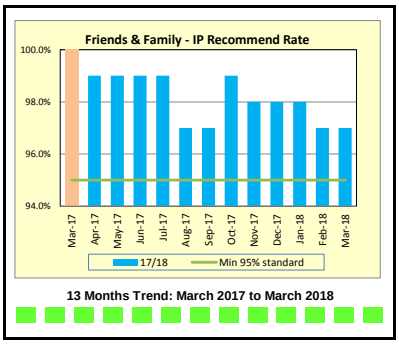


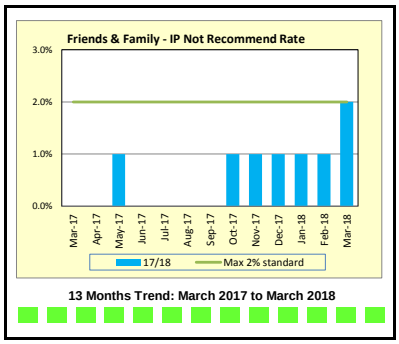










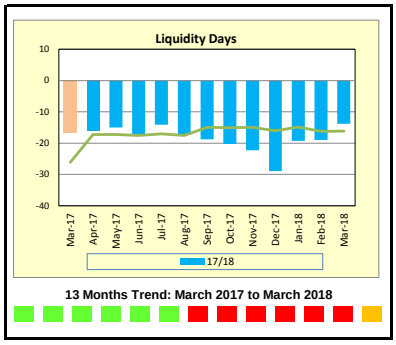


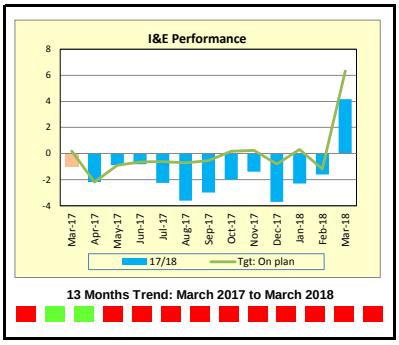
Use of Resources

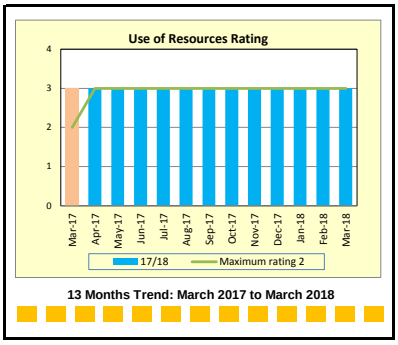
G Lawrence

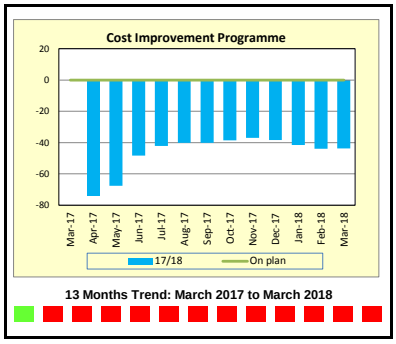
✓	!	×	Not rated
1	2	4	1

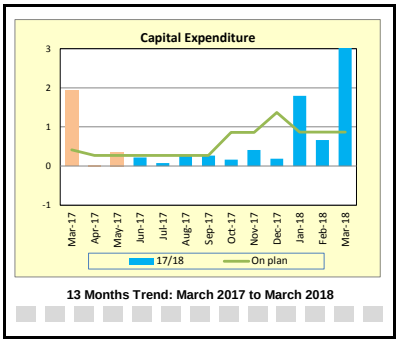
Use of Resources

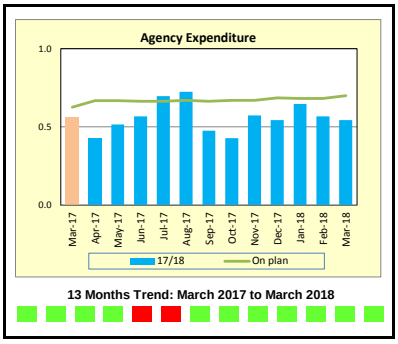


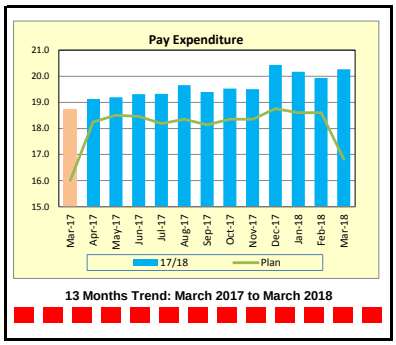


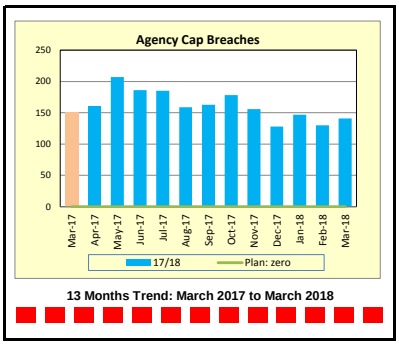










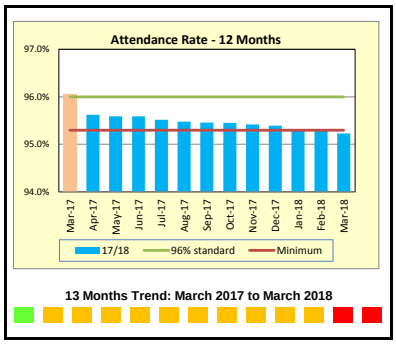


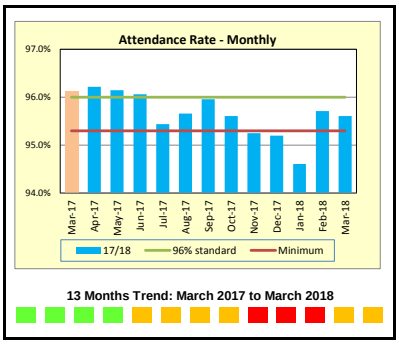
Workforce

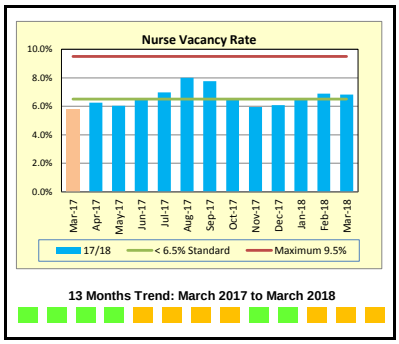
H Marks

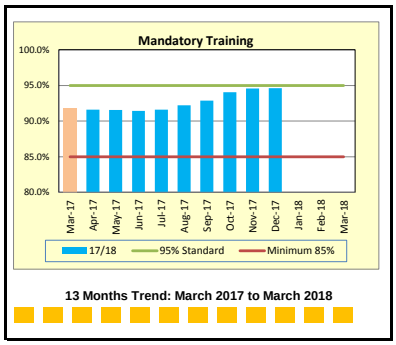
✓	!	×	Not rated
0	5	1	0

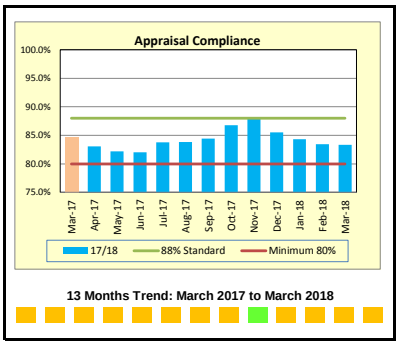
Workforce (HR)

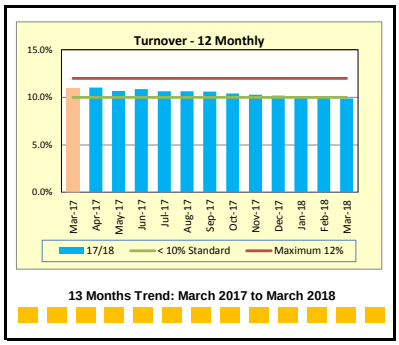












Board of Directors	
Agenda Item	7.2.2
Title of Report	Month 12 Finance Report
Date of Meeting	25th April 2018
Author	Shahida Mohammed – Assistant Director of Finance
Accountable Executive	Gareth Lawrence, Acting Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	 8 8c,8d
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To note
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

Overview

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

At the end of the financial year the Trust has reported an adjusted control deficit of (£20.4m) this is (c£20.0m) adrift from the NHSI control total. The adverse variance is being driven by:

- Non achievement of STF targets - £7.7m
- Continued Operational pressures as a result of demand in emergency care
- CIP schemes have delivered £8.4m of efficiencies in 17/18 compared to an NHSI target of £15.0m

The Trust has delivered marginally better than the forecast that was agreed as part of the forecast protocol in January 2018 of (£20.6m).

The Trust concluded the financial year with a cash balance of £8.0m, which is £5.7m above the planned closing balance (£2.3m). This positive variance mostly reflects the combined effects of the land sale, and significant borrowing, offset by adverse EBITDA performance. Although the Trust's closing cash position is strong, there is a possibility that Treasury will require repayment of borrowings in early 2018/19.

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

Capital expenditure as at 31 March 2018 was £13.6m against a total budget of £14.2m, representing an underspend of £0.6m for 2017/18. The 2017/18 budget was greater than the original planned figure (£7.3m) due to donations, grants and PDC funding.

Income and Expenditure Performance

In March 2017 the Board of Directors agreed to the control total set by NHSI that enabled access to the STF. Table 1 below details the current performance against the submitted plan and Table 2 shows the underlying financial performance

Table 1: Summary Financial Statement

Year ending 31 March 2018 Position as at 31st March 2018	Current Month			YTD		
	Plan £k	Actual £k	Variance £k	Plan £k	Actual £k	Variance £k
Clinical income	26,228	25,274	(954)	303,693	294,334	(9,359)
Non-NHS clinical income	125	30	(95)	1,566	2,335	769
Other income	7,393	5,016	(2,378)	34,288	32,290	(1,999)
Total operating income before donated asset income	**33,746**	**30,320**	**(3,426)**	**339,547**	**328,959**	**(10,588)**
Pay	(18,816)	(20,274)	(1,458)	(221,376)	(235,887)	(14,510)
Other expenditure	(7,534)	(9,716)	(2,182)	(106,045)	(107,002)	(957)
Total operating expenditure before depreciation and impairments	**(26,351)**	**(29,991)**	**(3,640)**	**(327,422)**	**(342,889)**	**(15,467)**
EBITDA	**7,395**	**329**	**(7,066)**	**12,125**	**(13,931)**	**(26,056)**
Depreciation and net impairment	(715)	(565)	150	(8,353)	(6,604)	1,749
Capital donations / grants income	0	524	524	0	965	965
OPERATING SURPLUS / (DEFICIT)	**6,680**	**288**	**(6,392)**	**3,772**	**(19,570)**	**(23,342)**
Net finance costs and gains / (losses) on disposal	(356)	3,922	4,278	(4,340)	(67)	4,273
ACTUAL SURPLUS / (DEFICIT)	**6,324**	**4,210**	**(2,114)**	**(568)**	**(19,637)**	**(19,069)**
Reverse net impairment	0	(27)	(27)	0	(27)	(27)
SURPLUS / (DEFICIT) before impairments and transfers	**6,324**	**4,183**	**(2,141)**	**(568)**	**(19,664)**	**(19,096)**
Reverse capital donations / grants I&E impact	12	(499)	(511)	142	(775)	(917)
DEL net impairments *(damage, not revaluation)*	0	(4)	(4)	0	(4)	(4)
ADJUSTED FINANCIAL PERFORMANCE SURPLUS / (DEFICIT) (AFPD)	**6,336**	**3,711**	**(2,625)**	**(426)**	**(20,412)**	**(19,986)**
AFPD excluding STF	**5,301**	**3,711**	**(1,590)**	**(8,265)**	**(21,543)**	**(13,278)**

Income:

The Trust concluded 2017/18 with clinical income showing an under performance of (£9.4m). This is largely driven by the under recovery of the STF allocation of (£7.7m) and high cost drugs which is offset by a corresponding reduction in expenditure.

The Trust's clinical income plan was supported by the year-end "agreement" with Wirral CCG for 2017/18, benefiting the position by £2.1m. The agreement also ensured risks in relation to the delivery of CQUIN schemes were also mitigated.

Expenditure:

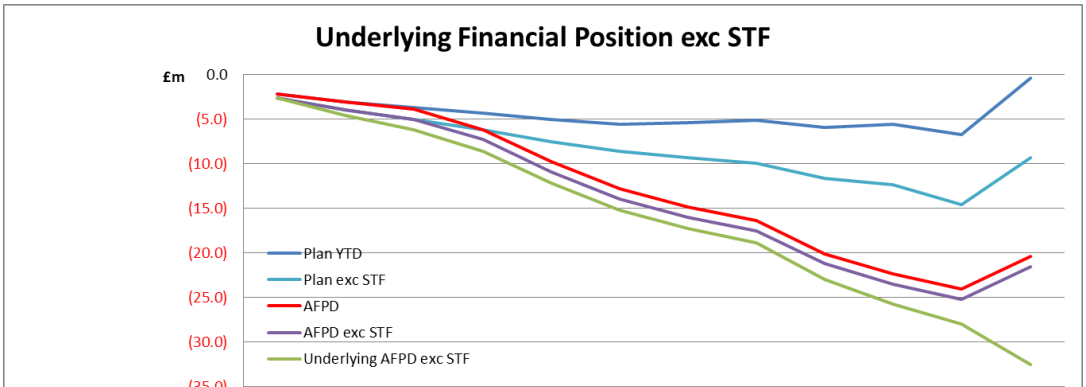
Employee costs finished the financial year above plan. This was driven by:

- Non achievement of pay CIP (£7.2m)
- Operational pressures (£7.3m)

"Non-Core" spend has averaged at c10% of the total pay bill for the year.
Agency spend outturned at £6.7m against the NHSI ceiling of £8.1m.

Non-pay cost exceeded plan by (£1.0m) predominantly relating to clinical supply costs exceeding plan.

Table 2: Underlying Financial Performance



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan YTD	(2.2)	(3.1)	(3.7)	(4.3)	(5.0)	(5.5)	(5.3)	(5.1)	(5.9)	(5.6)	(6.8)	(0.4)
Plan exc STF	(2.6)	(4.0)	(5.0)	(6.2)	(7.5)	(8.6)	(9.3)	(10.0)	(11.7)	(12.4)	(14.6)	(9.3)
AFPD	(2.2)	(3.1)	(3.9)	(6.2)	(9.8)	(12.8)	(14.9)	(16.4)	(20.1)	(22.4)	(24.1)	(20.4)
AFPD exc STF	(2.6)	(4.0)	(5.0)	(7.3)	(10.9)	(14.0)	(16.0)	(17.6)	(21.2)	(23.5)	(25.3)	(21.5)
Underlying AFPD exc STF	(2.6)	(4.6)	(6.2)	(8.6)	(12.2)	(15.3)	(17.3)	(18.9)	(23.0)	(25.8)	(28.0)	(32.6)

The normalised underlying deficit reflects the non recurrent savings and income gains that the Trust has delivered/received in year. The non recurrent nature of the savings has been reflected in the financial plan for 2018/19.

Cost Improvement Programme (CIP)

The CIP target for 2017/18 was £15m. The table below demonstrates the final CIP delivery by both division and work stream.

Table 3 – CIP Performance by Workstream and Division

Latest In Year Forecast - Divisonal & Programme		Division - In Year - £k						
Programme		Medicine and Acute	Surgery	Women and Children	Diagnostics and Clinical Support	Corporate	Central	Total
	Target	4,200	3,530	1,470	2,435	3,365		15,000
Patient Flow and Bed Reconfiguration	Fully Developed		177	93				271
Theatre Improvement Programme	Fully Developed		835					835
Outpatient Improvement Programme	Fully Developed	4	73		205			282
Clinical Variation	Fully Developed	338	254	113		170		875
Pharmacy and Meds Management	Fully Developed	215	207			95		517
Procurement and Non Pay	Fully Developed	94	534	9	217	144		998
Efficient and Effective Workforce	Fully Developed Pipeline	297	196	396	267	224		1,380
Divisional and Departmental	Fully Developed	55	450	30	437	1,692	610	3,274
	Fully Developed	1,004	2,726	641	1,126	2,326	610	8,432
Variance to Target	Fully Developed	(3,196)	(804)	(829)	(1,309)	(1,039)	610	(6,568)
%		-76%	-23%	-56%	-54%	-31%		-44%

The Trust has delivered the £8.4m of the £15m NHSI. While only £7.8m has been delivered recurrently the non-delivery has been factored into the 2017/18 agreed base plan.

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

The Trust's Balance Sheet is detailed at Appendix 2 – *Statement of Financial Position (SOFP).*

Closing capital expenditure of £13.6m exceeded plan by £6.3m, but was £0.5m below the budget of £14.2m. The underspend was partly due to projects which were initiated but not completed within 2017/18.

The Trust finished the financial year with a cash balance of £8.0m, which is £5.7m above plan. This variance comprises a number of factors.

- £3.6m brought forward cash balance over plan
- (£26.1m) EBITDA inclusive of donated asset income below plan
- £21.4m net loan funding
- (£3.3m) net working capital and capital outflows above plan
- £4.4m land sale proceeds
- £5.1m PDC drawn down
- £0.7m reduction in PDC dividend

The Trust's closing cash position is strong, although this is primarily because the land sale completed in March. There is also a possibility that Treasury will require repayment of borrowings in early 2018/19. The Trust's ongoing liquidity remains dependent on revenue borrowing. Further detail of the Trust's cash position is at Appendix 3 – *Statement of Cash Flows*.

The Trust delivered a UoR Rating of 3 at the end of the financial year, which is in line with plan. The effects of adverse operational performance are offset by strong performance on the agency metric; this is currently preventing the Trust from delivering a UoR Rating of 4 which would indicate the highest level of risk.

Table 4 – Use of Resources (UoR) Rating

	Metric	Descriptor	Weighting %	Year to Date Plan		Year to Date Actual		Full Year Plan	
				Metric	*Rating*	*Metric*	*Rating*	*Metric*	*Rating*
Financial sustainability	**Liquidity (days)**	Days of operating costs held in cash-equivalent forms	20%	-16.2	4	-13.5	3	-16.2	4
	Capital service capacity (times)	Revenue available for capital service: the degree to which generated income covers financial obligations	20%	1.1	4	-1.3	4	1.1	4
Financial efficiency	**I&E margin (%)**	Underlying performance: I&E deficit / total revenue	20%	-0.1%	3	-6.2%	4	-0.1%	3
Financial controls	**Distance from financial plan (%)**	Shows quality of planning and financial control : YTD deficit against plan	20%	0.0%	1	-6.1%	4	0.0%	1
	Agency spend (%)	Distance of agency spend against cap	20%	-0.2%	1	-17.4%	1	-0.2%	1
	Overall NHSI UoR Rating				**3**		**3**		**3**

Conclusion

The Trust disappointingly completed the year significantly off plan. The Trust will learn from the challenges set in this year's plan in order to set a challenging, yet achievable plan for 2018/19.

Although the Trust's closing cash position was above plan, the Trust's ongoing liquidity remains dependent on revenue borrowing.

The ongoing work in controlling agency spend has resulted in the Trust maintaining a UoR Rating of 3 at the end of the financial year.

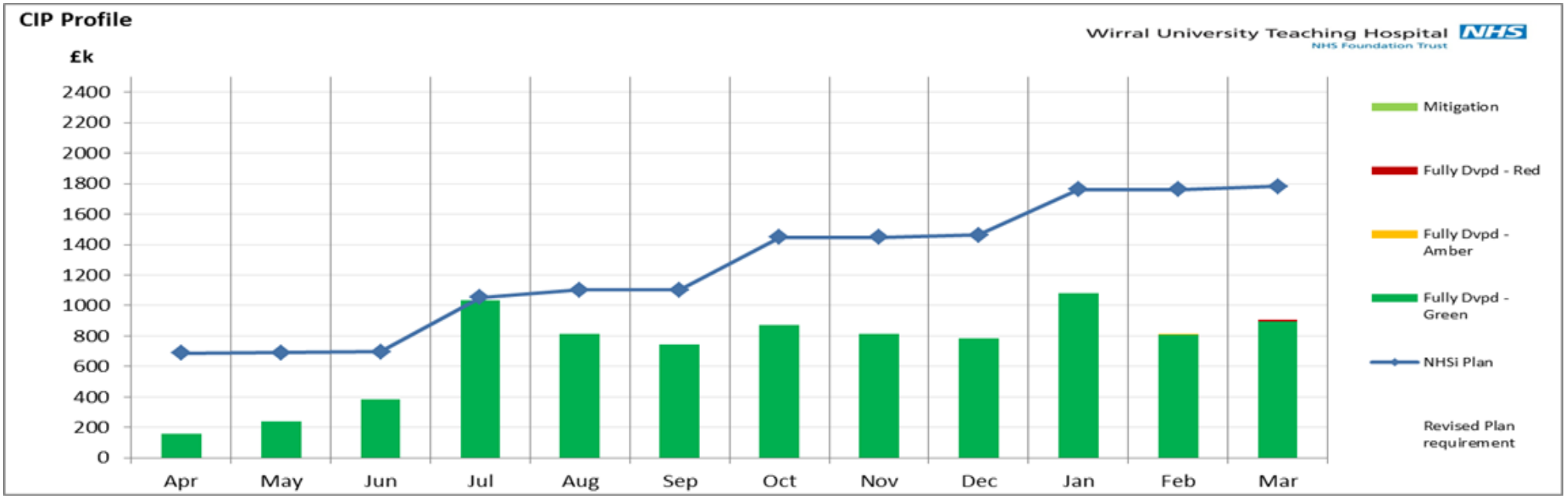
Recommendations

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

Gareth Lawrence
Acting Director of Finance
April 2018

Appendix 1: CIP Monthly Profile

The following chart highlights the CIP trajectory by NHSI category against Plan for 17/18



Appendix 2
Statement of Financial Position (SOFP)

Actual as at 01.04.17 £k		Actual as at 28.02.18 £k	Actual as at 31.03.18 £k	Variance (monthly) £k	Plan as at 31.03.18 £k	Actual as at 31.03.18 £k	Variance (to plan) £k	Forecast 31.03.18 £k	Plan 31.03.18 £k
	Non-current assets								
145,789	Property, plant and equipment	145,821	160,211	14,390	145,166	160,211	15,045	149,933	145,166
12,216	Intangibles	11,479	12,306	827	10,080	12,306	2,226	14,666	10,080
950	Trade and other non-current receivables	871	844	(27)	1,612	844	(768)	881	1,612
158,955		**158,171**	**173,361**	**15,190**	**156,858**	**173,361**	**16,503**	**165,480**	**156,858**
	Current assets								
3,881	Inventories	4,101	3,898	(203)	4,051	3,898	(153)	4,101	4,051
16,389	Trade and other receivables	30,084	15,645	(14,439)	20,760	15,645	(5,115)	24,271	20,760
0	Assets held for sale [1]	595	0	(595)	0	0	0	0	0
5,390	Cash and cash equivalents	3,458	7,950	4,492	2,257	7,950	5,693	7,884	2,257
25,660		**38,238**	**27,493**	**(10,745)**	**27,068**	**27,493**	**425**	**36,256**	**27,068**
184,615	**Total assets**	**196,409**	**200,854**	**4,445**	**183,926**	**200,854**	**16,928**	**201,736**	**183,926**
	Current liabilities								
(31,059)	Trade and other payables	(43,368)	(30,923)	12,445	(32,172)	(30,923)	1,249	(42,016)	(32,172)
(3,341)	Other liabilities	(6,187)	(4,000)	2,187	(3,696)	(4,000)	(304)	(2,783)	(3,696)
(1,015)	Borrowings	(1,074)	(1,074)	0	(1,014)	(1,074)	(60)	(1,073)	(1,014)
(668)	Provisions	(668)	(548)	120	(664)	(548)	116	(668)	(664)
(36,083)		**(51,297)**	**(36,545)**	**14,752**	**(37,546)**	**(36,545)**	**1,001**	**(46,540)**	**(37,546)**
(10,423)	**Net current assets/(liabilities)**	**(13,059)**	**(9,052)**	**4,007**	**(10,478)**	**(9,052)**	**1,426**	**(10,284)**	**(10,478)**
148,532	**Total assets less current liabilities**	**145,112**	**164,309**	**19,197**	**146,380**	**164,309**	**17,929**	**155,196**	**146,380**
	Non-current liabilities								
(9,154)	Other liabilities	(8,841)	(8,812)	29	(8,812)	(8,812)	0	(8,813)	(8,812)
(26,708)	Borrowings	(43,731)	(49,258)	(5,527)	(27,627)	(49,258)	(21,631)	(49,257)	(27,627)
(2,221)	Provisions	(2,047)	(2,318)	(271)	(1,969)	(2,318)	(349)	(2,031)	(1,969)
(38,083)		**(54,619)**	**(60,388)**	**(5,769)**	**(38,408)**	**(60,388)**	**(21,980)**	**(60,101)**	**(38,408)**
110,449	**Total assets employed**	**90,493**	**103,921**	**13,428**	**107,972**	**103,921**	**(4,051)**	**95,096**	**107,972**
	Financed by								
	Taxpayers' equity								
72,525	Public dividend capital	76,416	77,575	1,159	72,525	77,575	5,050	77,575	72,525
4,575	Income and expenditure reserve	(19,272)	(15,062)	4,210	2,779	(15,062)	(17,841)	(15,829)	2,779
33,349	Revaluation reserve	33,349	41,408	8,059	32,668	41,408	8,740	33,350	32,668
110,449	**Total taxpayers' equity**	**90,493**	**103,921**	**13,428**	**107,972**	**103,921**	**(4,051)**	**95,096**	**107,972**

[1] The Trust sold part of the Clatterbridge site in March 2018.

Appendix 3
Statement of Cash Flows

	Month			Year to date			Full Year	
	Actual	Plan	Variance	Actual	Plan	Variance	Forecast	Plan
	£k	£k	£k	£k	£k	£k	£k	£k
Opening cash	**3,458**	**2,312**	**1,146**	**5,390**	**1,752**	**3,638**	**5,390**	**1,752**
Operating activities								
Surplus / (deficit)	4,210	6,323	(2,113)	(19,637)	(567)	(19,070)	(20,404)	(568)
Net interest accrued	107	76	31	1,069	982	87	1,073	982
PDC dividend expense	(80)	277	(357)	2,967	3,326	(359)	2,924	3,326
Unwinding of discount	(3)	3	(6)	3	36	(33)	6	35
(Gain) / loss on disposal	(3,946)	0	(3,946)	(3,946)	0	(3,946)	(3,800)	0
Operating surplus / (deficit)	288	6,679	(6,391)	(19,545)	3,777	(23,321)	(20,202)	3,775
Depreciation and amortisation	592	715	(124)	6,604	8,353	(1,749)	6,578	8,353
Impairments / (impairment reversals)	(27)	0	(27)	(27)	0	(27)	0	0
Donated asset income (cash and non-cash)	(524)	0	(524)	(965)	0	(965)	(441)	0
Changes in working capital	637	1,433	(796)	(1,457)	(270)	(1,187)	(6,124)	(270)
Other movements in operating cash flows	0	0	0	0	0	0	0	0
Investing activities								
Interest received	5	7	(2)	41	82	(41)	44	82
Purchase of non-current (capital) assets [1]	(6,002)	(664)	(5,338)	(10,433)	(7,965)	(2,468)	(5,095)	(7,964)
Sales of non-current (capital) assets	4,350	0	4,350	4,350	0	4,350	4,395	0
Receipt of cash donations to purchase capital assets	306	0	306	346	0	346	40	0
Financing activities								
Public dividend capital received	1,159	0	1,159	5,050	0	5,050	5,050	0
ITFF loan principal drawdown	0	0	0	0	0	0	0	0
Support funding [2] principal drawdown	6,039	0	6,039	23,373	7,434	15,939	23,373	9,600
ITFF loan principal repaid	(508)	(508)	0	(1,015)	(1,015)	0	(1,015)	(1,014)
Support funding [2] principal repaid	0	(5,500)	5,500	0	(5,500)	5,500	0	(7,666)
Interest paid	(555)	(554)	(1)	(1,056)	(1,064)	8	(1,113)	(1,064)
PDC dividend paid	(1,262)	(1,663)	401	(2,635)	(3,326)	691	(2,924)	(3,326)
Capital element of finance lease rental payments	(5)	0	(5)	(60)	0	(60)	(59)	0
Interest element of finance lease rental payments	(1)	0	(1)	(12)	0	(12)	(12)	0
Total net cash inflow / (outflow)	**4,492**	**(55)**	**4,547**	**2,560**	**505**	**2,055**	**2,494**	**505**
Closing cash	**7,950**	**2,257**	**5,693**	**7,950**	**2,257**	**5,693**	**7,884**	**2,257**

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

[2] Support funding currently comprises a working capital facility, and 'uncommitted loans', issued by DHSC and administered by NHSI.

BOARD OF DIRECTORS	
Agenda Item	7.3
Title of Report	Approval of Operational Plan and Financial Submission
Date of Meeting	25 April
Author	Executive Team
Accountable Executive	David Jago
BAF References	Risks 13, 14, 15
Level of Assurance	N/A
Purpose of the Paper	Discussion
Reviewed by Assurance Committee	None
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken	Not required

Operational Plan Narrative 2018/19

Contents

1. Trust Summary

2017/18 was a challenging year for the Trust. While making strong progress on patient safety and quality agenda and developing closer collaborative working relationships within our health economy and the broader Cheshire & Merseyside Health & Care Partnership, the Trust's financial performance was materially adverse to plan and there were concerns raised about leadership, behavioural, governance and cultural issues at the Trust. Subsequently, both the CEO and the Chair left the Trust and the Trust now has in place an Interim Chair and Acting CEO. The Trust has agreed the timeline and processes for appointing substantively to both these posts, the first being the CEO which is set for 8th May 2018.

Following these concerns, The Trust commissioned an independent listening exercise with colleagues in our Emergency Department, and in parallel, NHSI undertook an independent review into leadership, behaviour, governance and culture which was published early March 2018, just prior to submission of this initial plan narrative.

The review, commissioned by NHS Improvement, examined issues raised about the Trust during 2017 and NHS Improvement's handling of these concerns when they were raised with NHS Improvement's regional team. The Trust has welcomed the findings of the independent investigation by NHS Improvement, and also the report into culture in our Emergency Department.

This has been a challenging period for the Trust. The Trust's immediate priority and focus going into 2018/19 is to now work through both reports so collectively an action plan can be produced on how we take any required positive steps forward. Much of this work has already started, as described in this plan narrative, and much further action will be identified as we go through these reports. The Board agreed in March 2018 to establish a new sub- committee of the Board specifically to provide assurance on all Workforce matters.

Our 2018/19 plans build on the following key elements.

Our identifier, used to underpin our external narrative, continues to be ***Wirral University Teaching Hospital, #PROUD to care for you.***

While our PROUD Values going into 2018/19 remain unchanged, our intention will be to focus on the first two in particular;

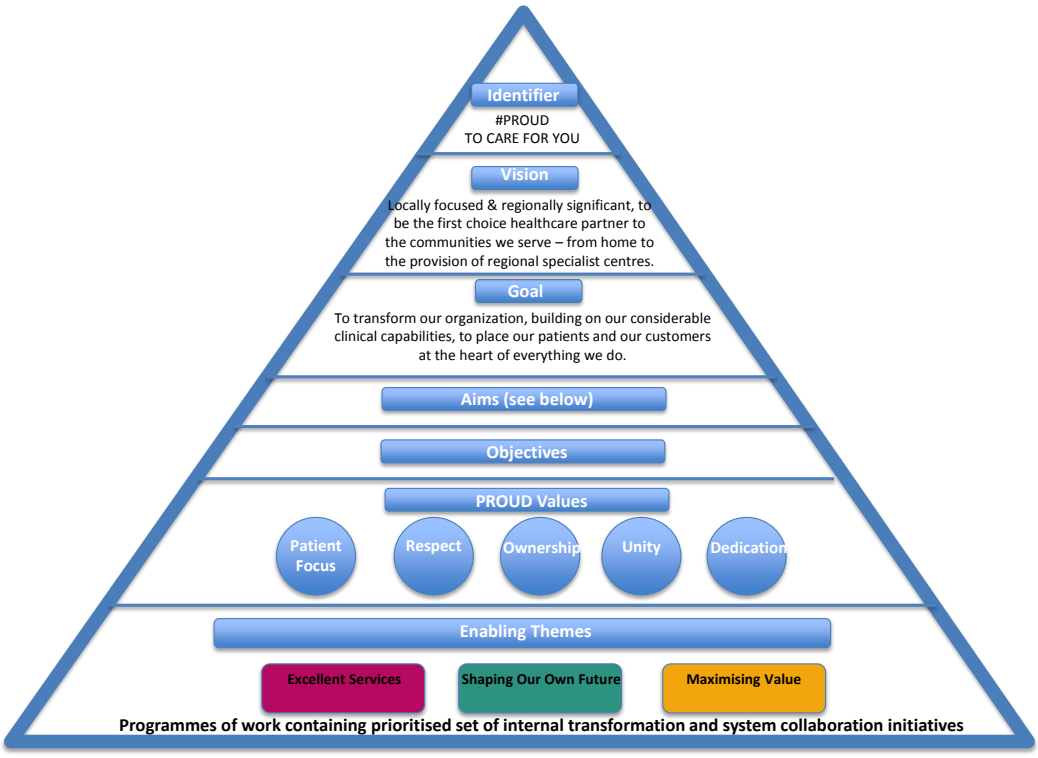
- **Patient Focus**
- **Respect**
- Ownership
- Unity
- Dedication

Our vision going into 2018/19 remains unchanged; **Our Vision is to be locally focused and regionally significant** and '**to be the first choice healthcare partner to the communities we serve – from home to the provision of regional specialist centres'**

- **Locally focused**, we are committed to our community and working with our partner organisations to provide the best possible care.
- **Regionally significant**, we aspire to be the hospital of choice for patients.

Our colleagues, and the services we provide, are helping us to achieve that Vision.

Our goal going into 2018/19 remains unchanged; 'Over the next 5 years we will work together to transform our organisation, building on our considerable clinical capabilities, to place patients and our customers at the heart of everything we do'.



While these overarching elements have not changed, we have agreed a refreshed set of strategic aims which we believe better frame our priorities going into 2018/19.

1. **We are** rated the best NHS Trust in the region, because our staff, and the patients who use our services, say we are
2. **We consistently deliver** safe, high quality, locally accessible services with health outcomes that compare with the best.
3. **We provide** safe, high quality, locally accessible services in partnership with primary, social and community care, now and in the future
4. **We put** our people first so they can put our patients first, and we **create** our workforce of tomorrow by investing in the workforce of today
5. **We excel** in a quality improvement / learning culture that allows us all to reduce unwarranted variation and constantly improve our services
6. **We are** a national exemplar for transforming care through innovation and technology
7. **We make** the best use of the public resources we have to deliver high quality, locally accessible services that are clinically & financially sustainable

We recognise that we start from a different place against some of these aims. For example, number 6, we are already recognised as a Global Digital Exemplar, and so our focus is on going further, faster enabling new care models through use of technology. Whereas for number 1, we start from a position based on 2017 staff engagement of below average so we have more work to do to achieve this aim and the journey will take more than a year.

To evidence progress, these aims connect to a series of **indicators** which we aim to provide visibility on through our integrated dashboard. They will also frame a set of **objectives** which will inform our priority work programmes sitting within the 3 areas ‘Excellent Services’, ‘Shaping Our Own Future’ and ‘Maximising Value’**.**

All of this will then provide a line of sight link between our Trust vision, aims, objectives and our prioritised programme of work to meet our clinical & financial sustainability challenge.

2. Activity Planning

The Trust recognises that a fundamental requirement of the 2018/19 planning round is for providers and commissioners to have realistic and aligned activity plans, and that these are in turn consistent with broader Cheshire & Merseyside Health & Care Partnership (formerly Cheshire & Merseyside STP) planning assumptions. Our approach this planning round has sought to support this.

2.1 Elective Planning

For elective activity planning the Trust has adopted the use of the national benchmarking data available via the Model Hospital portal, NHS Interim Management and Support (IMAS) capacity and demand tool. The use of this model has been jointly agreed with our main commissioner (NHS Wirral CCG), and identifies areas of over/under capacity and supports the divisions in maximising operational productivity. This has been assessed against 18 week trajectories to ensure capacity is in place for any contracted key performance indicators.

The approach using the IMAS tool has been:

- An initial internal validation of the IMAS tool by comparing outputs from the tool to previous annual activity outputs to ensure no major or significant discrepancies
- Using the IMAS tool to model elective capacity at individual specialty level (reflecting Consultant job planning level) with clinical and managerial engagement
- Using the IMAS tool to ensure capacity is modelled at each point of delivery, e.g. first outpatient attendance, follow up outpatient attendance, outpatient procedure and elective spell (inpatient or day case)
- Clinical and Managerial specialty “sign off” of outputs of the model
- Divisional “check and challenge” of IMAS outputs with Finance and the Service Transformation Team
- Executive “check and challenge” of IMAS outputs

Following this approach the capacity outputs have provided the Trust with realistic data in order to inform the contracting round, specifically considering additional capacity that may be required in specialty areas to support any activity backlog to deliver 18 week Referral To Treatment (RTT) compliance, adhering to national planning guidelines.

The work done on IMAS will allow more accurate planning with commissioners in order to consider any future growth, changes in referrals due to commissioning intentions (e.g. procedures of limited clinical priority) and compliance with national elective standards (18 weeks RTT and Cancer targets). This approach will allow an understanding for contracting with commissioners to deliver agreed levels of activity in line with constitutional standards.

Most of the improvements have focussed on effective theatre utilisation and productivity of theatre teams. A theatre dashboard has been developed and uses information to drive prospective planning of theatre sessions and retrospective review to inform future planning. A newly established Theatre Resource Group is the mechanism for delivering and monitoring elective care reform and improvements.

2.2 Non Elective Planning

The Trust continues to use several approaches as part of the wider health and social care economy to ensure greater success as part of non-elective planning. This will also reference the new planning guidance for elective which concentrates on zero growth in waiting list size from March 18 to 19 as opposed to achieving RTT. We will determine with our Commissioners the extent to which we maintain current performance versus closing the gap. As a current outlier on RTT, we need to ensure we get the balance right on this.

Internally as part of a wider patient flow work stream a specific bed modelling programme has been refreshed to review bed capacity related to non-elective demand. This work is supported by the Trusts Service Transformation Team and takes into account recommendations made from the Emergency Care Intensive Support Team (ECIST) and the SAFER flow bundle.

Externally the Trust continues to work in partnership with NHS Wirral CCG and the wider health and social care economy in order to better understand non elective demand and capacity on a whole system footprint via:

- Urgent Care and Elder Care Value Stream Analysis
- Health economy review of admission avoidance and discharge
- A series of strategic workshops to explore the potential for a system control total to enable system balance of the finances

2.3 Surge planning

The Trust is working with health and social care partners to align community and acute bed provision to ensure only those patients who require acute medical care remain within acute inpatient beds. As part of this work the economy will also ensure robust practice to manage any surge experienced with non-elective demand. This is in addition to our already established internal escalation plans and statutory resilience plans.

2.4 Winter Planning

Winter plans are being developed to ensure that the Trust and the broader health economy are better placed than ever to cope with anticipated demand. The Trust will ensure that planning arrangements are aligned with detailed planning guidance requirements once received to enable a robust winter planning submission by 30th June 2018.

2.5 Developing our planning capabilities further

Moving forward through 2018/19 the Trust, as a Centre for Global Digital Excellence will be seeking to develop ways of assessing and managing capacity and demand in real and predictive time in order to support elective and non-elective planning for the whole health and social care economy and be looking to share this learning system wide.

2.6 Key Operational Risks

The key operational risks to the delivery of the operational plan 2018/19 are summarized below. These would pose a risk to delivery of NHS Constitutional standards for urgent care and referral to treatment targets:

- Unplanned growth in demand (elective and non-elective). The Trust is reliant on partners implementation of demand management schemes, e.g. reducing non elective attendances and admissions in line with Right Care and Emergency Care Pathway, the failure of implementation of procedures of limited clinical value at commissioner level will impact on planned activity levels
- Managing the loss of intermediate care capacity and any further unplanned reductions
- Market vulnerability of independent sector of domiciliary care, care homes and detox provision
- Unplanned events, e.g. Junior Doctor Industrial action, Flu, Major incidents, Infection Prevention and Control issues
- Challenges with lack of system wide implementation of Better Care Fund which impacts on out of hospital care and reablement.
- Consultant workforce challenges in specific specialities and gaps in Junior Doctor rotas across Medicine as a whole.
- Bandwidth and leadership to manage internal and external system wide transformation.

The Trust hosts the Chair role of the A&E Delivery Board and as such will have opportunity to proactively manage key operational risks. Furthermore the Trust is working with health and social care partners towards the creation of an Place Based Collaboration System in order to increase operational accountability and whole system strategic planning.A number of Service Development Improvement plans (SDIPs) have been agreed with Wirral CCG including SAFER to enable a “system”based approach to improvement in 2018/19.

3. Quality planning

3.1 Approach to quality improvement

The Lead Executive for Quality Improvement is the Medical Director.

The Trust is currently implementing the GIRFT recommendations for Obstetrics and Gynaecology following from the presentation received in October 2017. Specific areas of focus include 'new to follow up' ratios and improved use of clinical techniques that reduce length of stay. In April 2018 the Trust will receive its GIRFT report for Paediatric surgery and will produce an action plan to address any issues raised. The Surgery Division has action plans in place for T&O, ENT and Urology following the most recent GIRFT visits. The actions identified have been further enhanced by a priority matrix review of clinical variation at a more granular level. The outputs of the priority matrix review are scheduled for presentation to the Divisional Triumvirate at the end of March and will inform more detailed plans for 18/19 improvement. Since the last General Surgery GIRFT visit, we have introduced an Emergency Surgical Assessment Unit employing 5 Emergency Surgeons. Improvements on performance include a reduction in length of stay, admission avoidance with patients being redirected in to the Surgical Ambulatory Service. The service is currently participating in the national Surgical Ambulatory Emergency Care Network programme.

Our Maternity services were one of the highest performing in the country in the 2017 CQC inpatient survey, and we have an action plan for areas identified for improvement. We have a programme in place to work with NHS Resolution Safer Maternity guidance to aim for a £700k reduction in CNST premium by improving quality. Our GIRFT report identified our Gynaecology service as having the lowest length of stay nationally for abdominal hysterectomy rates and we have been identified as one of the best teaching unit in northwest deanery. In line with the better births national review as members of the Cheshire and Mersey Local Maternity System partnership we are piloting in 2018 the first freestanding community midwifery lead unit in the country.

The T&O Directorate work programme includes achieving best practice tariff (BPT)for fractured neck of femur. The Directorate have established WAFFU; Wirral Acute Femoral Fracture Unit to ensure the delivery of BPT and achievement of the Advancing Quality Metrics. The Directorate of Perioperative Medicine have progressed many quality improvements this year across the operative spectrum from preoperative assessment to reducing length of stay and compliance with the basket of day case procedures. This work will continue into 18/19.

The organisation uses a number of quality improvement methodologies, and has embedded an approach to safety culture and quality improvement based on weekly safety summits. The main purpose of these events is to identify rapid learning or actions following serious incidents for the wider organisation. They also enable clinical senior leaders across the organisation to have a shared knowledge and understanding of the Trust's most serious incidents. There is an opportunity for all attendees to contribute issues to explore during the summit, and attendance is open to all. Following each summit, a 'Safety Bites' update is issued throughout the Trust summarising the topics covered together with any associated learning. Depending on the topic, items are often followed up by an evidence based research article from the Library team in an 'Evidence Bites' update.

The Trust subscribes to the Advancing Quality Alliance (AQuA) which supports our quality improvement work from ward to Board. During 2018/19, we will continue to work with AQuA to develop a training programme for quality improvement to further develop staff across the organisation and engage them in local quality improvement work. The Trust has a programme of work to develop our IT system (Cerner Millennium) that includes decision support and clinical pathways that will support safer, high quality care. As a Global Digital Exemplar (GDE) we will continue to work with our local health economy partners to develop enable new models of care underpinned by population health management, shared care records and interoperable systems.

Quality Improvement work is aligned to the specialty and divisional priorities that in turn are related to the Trust priorities as defined in the Quality Improvement Strategy, incorporating the Quality Account priorities. Projects are agreed through the relevant divisional or corporate group and are performance managed at this level. Concerns about quality improvement work are escalated to the Clinical

Governance Group who in turn provides assurance to the Quality & Safety Committee. The Quality & Safety Committee reports on levels of assurance about the Quality Improvement work to the Board. In line with recommendations from the Well Led Governance Review the Trust has enacted a revision to its governance structures to ensure that a greater degree of review and monitoring is undertaken at executive working group level. The assurance committees thereafter determine whether the assurance provided by the executive working group is sufficient to mitigate any potential risks or aid the Trust to achieve its strategic objectives. As outlined in the summary, the Board also agreed to establish a new sub-committee of the Board to focus on workforce issues going forward.

In support of the Cheshire & Merseyside Health & Care Partnership and in line with developments across the wider NHS in England, the Trust will accelerate its work on minimising clinical variation. This will be done through the Getting It Right First Time (GIRFT) and other nationally accepted quality indicators, and embedding them into our Cerner Millennium Information System in order that the Trust obtains top quartile length of stay in these conditions. A number of extant clinical pathways have now enabled digitally through Millennium (Sepsis, FNoF and Stroke pathways). These have been implemented on a risk based priority basis within the Trust, and are showing good signs of enabling a reduction in unwarranted variation. We have committed to a rolling programme to digitally enable more pathways in 18/19. The Trust has also implemented a number of Healthcare Registries as part of the roll out of Cerner's HealtheIntent, branded locally as the Wirral Care Record, and which is live in all 51 GP practices. Data coming from initial Diabetes, Asthma, COPD and Respiratory healthcare registries are showing a direct correlation between proactive self-care and primary care interventions and a reduction in emergency / unplanned attendances at A&E for cohorts with long term conditions. We plan to go further in partnership with our CCG, Primary Care and other local health economy partners rolling out further registries and enabling more proactive use by GPs.

3.2 Wirral & West Cheshire Clinical Strategy

With the development of the Cheshire & Merseyside Health and Care Partnership, and in particular, the acute sustainability programme, we plan to seek out the potential opportunities that such a programme affords. We will in 2018 examine closer workings in respect of acute services ourselves and our nearest acute neighbour, the Countess of Chester NHS Foundation Trust. From national evidence and benchmarking data we believe there is much that can be done locally to improve standards, reduce variation, and stabilise the system. Drivers such as the Model Hospital, Get it Right First Time (GIRFT), NHS Right Care, Public Health Outcome data and qualitative reports such as the AQ programme, indicate that there are significant opportunities that are beholden upon us to explore.

Whilst the focus will be on acute sustainability, we will work with commissioner and other parties to consider the whole system dependencies and impacts. There are strong interfaces with primary care, community services, and social care, and the integration of this project's work with the local system strategy as a whole will be crucial for the transformation of acute care services (Integrated Care partnerships).

The scope of work will seek to determine the necessary acute care services required for the population of West Cheshire and Wirral and how, when considering this larger population, this will be undertaken in such a way as to assure services that are clinically and financially sustainable. More specifically we consider the following questions as key lines of enquiry within which to frame our proposals. How will such an approach:

- Demonstrate improved outcomes for patients, including delivery of NHS constitutional standards and a reduction in unwarranted variation.
- Demonstrate financial sustainability, including efficient use of resources with a reduction of unnecessary duplication.
- Demonstrate the delivery of safe services within the context of a clinically sustainable workforce.
- Demonstrate the delivery of safe services within the alignment of activity and `critical mass` with the accreditation of services.
- Demonstrate the connections and integrations with other services to support demand management and the delivery of care closer to home.

This work will result in an outline framework able to demonstrate clinical engagement at the very outset and connections with key partners as a means of effectively managing pathways. In summary we expect the framework to demonstrate / consider:

- A case for change
- The delivery of clinical and patient standards
- Clinical co-dependency framework
- Gap analysis – current state
- New model of care
- Clinical support and call to action

We anticipate that our respective commissioners will support with communications, business intelligence and information as required, and that they will also provide, as required, engagement with member GP practices, scrutiny and health and well-being boards as this project matures.

The Trust aims to obtain a 'Good' CQC rating when re-inspected in 2018, albeit recognising the challenge this will present, and a rating of 'Outstanding' in 2019. The Trust has a comprehensive work programme in place in order to achieve this with a focus on:

- Implementing our Quality Strategy and complying with the recommendations of our 2015 inspection
- Continuing our Care Quality Inspections and the Ward Accreditation Programme
- Developing a programme for the minimisation of clinical variation in collaboration with other hospitals in Cheshire
- Creating a Quality Governance Team supporting Divisional clinical governance arrangements

The Trust quality objectives in support of the Trust vision are agreed in collaboration with Governors and the Board of Directors. Each Executive Director thereafter takes responsibility for these objectives.

The Trust has a robust appraisal system whereby all staff are appraised against core values and behaviours, contribution towards organizational objectives and are required to demonstrate that they have undertaken appropriate mandatory training and continuous professional development. Appraisal rates are reported formally to the Trust Board along with a range of quality measures via our Integrated Dashboard. Additionally, our Quality Dashboard is scrutinised by the Board Quality & Safety Committee on a regular basis so they can be assured we have a "grip" on quality & safety matters.

3.3 Quality Account

The Quality Account outcomes linked to the Quality Strategy are reported using the below milestones and performance indicators.

Implement the SAFER bundle to improve patient flow and ensure safe discharge • The Trust will aim for 25% of all medical discharges from base wards to be before noon • The Trust will aim to improve compliance within specialty care ('right patient right bed') so that no more than 10% of patients are admitted to the 'wrong' bed.
Ensure patients are supported with eating and drinking based on their individual needs • 85% of patients will report receiving appropriate assistance with eating, and 90% with drinking • Where appropriate, patients' nutritional and fluid input will be recorded within their electronic record of care
Reduce harm to patients, in particular from newly formed pressure ulcers • Zero tolerance of avoidable hospital-acquired pressure ulcers at grades 3 and 4 • The Trust will will aim for a 50% reduction in avoidable hospital-acquired grade 2 pressure ulcers,
Reduce the frequency of missed medication events • The Trust will aim for no more than 3% of critical medication doses to be missed, and;

• an appropriate care score of 70%
Improving End of Life Care • Launch of Wirral Palliative and End of Life Care Strategy to ensure we are clear about PEOLC outcomes that matter most to us and have a credible plan to enable those outcomes to be achieved. • The Trust has added 'Care in the Last Days of Life' to corporate induction for all new staff, to 75% of existing nurses and clinical support workers in the Acute and Medical Division, and to 75% of doctors in training Trust-wide • The Trust will roll out the 'Record of Care for Patients in the Last Days of Life' • The Trust will increase the staffing resource allocated to Specialist Palliative Care

3.4 Quality Improvement Plan

A summary of the quality improvement plan including compliance with national quality priorities is provided below, and this table contains relevant references to our Quality Improvement Plan in order to highlight the approach to key developments for 2018/19

National Clinical Audits	National audits are prioritised in the Trust to ensure the Trust has robust benchmarking data. All audit reports are reviewed in their clinical area and an action plan developed based on the findings. These are presented within the divisions and approved through the governance structure. Action plans are monitored through the divisional teams and reported in the annual audit report. In the coming year the Trust will continue to monitor completion of audits on a quarterly basis; highlighting and acting on any delays. The Audit Committee reviews the clinical audit programme and the methodology as part of its review of internal control.
Safe staffing care hours per patient day	The Trust has a robust process for recording and reporting safe staffing per patient day. The Trust uses the benchmark CHPPD with national data held on the Safer Hospitals Portal
Actions from better births review	The Trust will work collaboratively with alternative providers in order to improve the quality of care that women have said that they want by the sharing of best practice in order to improve outcomes. In addition the Trust will also implement the recommendations of NHS E "Including Safer Maternity Care" which incorporates a Board member sponsoring these recommendations.
Compliance with the 4 priorities of the 7 day standards for hospital services.	The Trust is currently delivering standards 5 and 6. Exploratory indicators and a local dashboard has shown no difference in length of stay, readmissions or risk adjusted death rates based on day of admission or discharge. The Trust is currently establishing the additional resource requirements to deliver standards 2 and 8.
Improving the quality of mortality review and Serious Incident Investigation and subsequent learning into action.	The HSMR for the Trust remains significantly below that expected for the population the Trust serves. The mortality review process has been in place for a number of years and is currently being reviewed to ensure it remains robust and current. Lessons are learnt through meetings, newsletters and also through changes to policy and guidelines. The new Executive led Serious Incident Review Group oversees the approval of root cause analysis reports and provides assurance to the Trust Board regarding the quality of reports submitted and robustness of actions to prevent recurrence. Learning is shared via weekly news bulletins as well as via divisional and corporate governance meetings. Root cause analysis training is now available for Trust staff to access; this has been very successful and the quality of investigations has improved. The Trust has implemented actions from 'Learning from Deaths'

	report, undertaking structured clinical reviews to ensure we learn from any indications of areas for improvement in delivery of care. All mortality reviews are triangulated with complaints and Serious Incident reviews.
Anti-microbial resistance	The Trust will be developing further the antimicrobial stewardship in the Trust through 2018/19 with a dedicated named consultant leading this work.
Infection Prevention and Control	Maintaining the programme of work to ensure compliance with the health and social care act is a priority. The Trust has a CPE strategy involving triple cohorting. Our C-Diff strategy includes a full ward decontamination programme involving HPV. Our MRSA strategy will continue including daily review of all MRSA patients to prevent clinical investigation. Effective use of the isolation unit is regularly assessed
Falls	The Trust has seen a reduction on falls through Ward education using our dementia matron and clear assessment on admission. The Trust continues to develop new methods of assessment e.g. sensory pads
Sepsis	For 2018 and beyond the 4 areas of focus are: Senior review of most seriously ill septic patients, IV fluid administration for septic patients, Consistency in care for septic referrals from Primary Care and sepsis screening on ambulance transfer.
Pressure Ulcers	The Trust continues to see a year on year reduction with a zero tolerance of avoidable hospital-acquired pressure ulcers at grades 3 and 4. The Trust will aim for a 50% reduction in avoidable hospital-acquired grade 2 pressure ulcers Pressure Ulcers are Part of the sign up to safety programme
End of Life Care	The Trust has in conjunction with CCG, Hospice, Primary Care, Community Trust and other key voluntary and patient stakeholders a palliative and end of life strategy and plan. This includes a record of care for patients who are in the last stages of life. The Trust has increased the capacity of the service by appointing additional consultants, 2 end of life of life educators and administrative support. The record of care will be revised through clinical audit which demonstrates substantial improvements in documented care and reduction in unnecessary interventions. The Trust intends focussed work on training, the MDT process and advanced care planning over the coming year in line with our plan to ensure a high quality, evidence based service. The Trust is also part of NHSI system change through transformational leadership programme focusing on EOL.
Patient experience	In support of the Trust aim for the best levels of patient satisfaction the Trust will continue to achieve a Friends & Family Test recommendation score above 95% and a non-recommendation score of below 2%.To achieve this the Trust will introduce new mechanisms for obtaining feedback in areas with of high volumes of patient contacts (e.g. A&E and Outpatients) and implement formal performance management arrangements for inpatient areas identified as requiring improvement. The Trust will continue to make it easier for complaints to be raised where there is a need or wish to, improving accessibility and initial response times. We don't aim to deliver a year on year reduction in the number of complaints as this may lead to suppression of complaints when we want the opportunity to learn and improve and so welcome complaints being made. Instead, we aim for a year on year improvement in response times and a reduction in the number of level 2 complaints being

	referred to Ombudsman. The Trust will introduce Matron Clinics to drive local ownership of the resolution of complaints. The Trust is opening a new communications hub providing patients, members of the general public and staff with support in the management of concerns and complaints.
National CQUINS	The Trust provides quarterly progress reports to the CCG via the joint Quality and Contract monitoring meeting. This forum allows both CCG and the Trust to propose to NHSE any local quality variations which would suit the local patient population.

As part of a refresh of our quality strategy through 2018/19 the Trust will factor in the direction of travel from the Cheshire and Mersey Partnership Health & Care Partnership.

3.5 Quality impact assessment process

Both Cost Improvement Plans (CIP) and Service Improvement Plans are developed with clinical teams at speciality, divisional and corporate levels. Programme and plans are reviewed and signed off at Transformation Steering Group with Executive representation. Individual projects are subjected to Quality Impact Assessment (QIA) using a standard form incorporating national guidance. Building on work from 2017/18 the QIA process for 2018/19 and beyond will incorporate the wider five CQC domains (safe, effective, responsive, caring and well led), allowing insight into staff impact.

Completed forms are scrutinised, challenged as appropriate and approved by the Medical Director (MD) and the Director of Nursing & Midwifery(DoN). If a project requires an Equality Impact Assessment, this is supported by the Divisional Associate Directors of Nursing. The Trust's Service Transformation Team (STT) is responsible for warehousing QIAs. The overall process is overseen by the Clinical Governance Group which reports to the Quality & Safety Committee (QSC) of the Board. QSC's work programme is designed to receive assurance on patient safety, clinical outcomes, and patient experience and workforce indicators. This is signed off by MD and DoN with option to review at 3, 6, 9 months as required.

In addition for 2018-19 an agreement has been reached with NHS Wirral CCG Clinical Senate representing the whole health economy whereby individual organizations share proposed efficiency plans to allow for impact analysis across the whole health economy.

3.6 Triangulation of quality with workforce and finance

We have developed and implemented a monthly Integrated Quality Governance Report (Dashboard) aligned to the five CQC domains – Safe, Caring, Responsive, Effective and Well Led. The purpose of this dashboard is to provide 'one version of the truth' that is used to support internal and external quality meetings. Within the Trust the Dashboard is reviewed and scrutinised monthly by the Clinical Governance Group and bi-monthly at the Board Quality & Safety Committee. Externally it supports the monthly Wirral Clinical Commissioning Group's Quality & Clinical Risk Meeting. Divisional integrated quality dashboards are currently in production and will be rolled out in 2018.

Specifically for workforce building on existing work from 2017/18 the Trust Board will receive monthly information relating to safe staffing and care hours per patient day for all inpatient areas. On a six monthly basis a robust analysis of funded establishment, patient acuity and dependency and nurse sensitive indicators is produced to ensure that funded establishments enable delivery of high quality safe care.

The key indicators uses in this process are:

- Professional Judgement model
- Shelford Group Safer staffing tool
- Use of nurse sensitive indicators such as pressure ulcers, falls and medication errors.

The Trust Board will use this information to inform decisions relating to future workforce models, skill mix and funded establishment.

4. Workforce

The Trust is facing some significant challenges in relation to the culture across the Trust. The issues of bullying and harassment, lack of engagement and the questioning of the Trust's values and behaviours have surfaced following independent reviews, as mentioned in the summary. Therefore, over the coming 12 months the Workforce and OD strategy will significantly focus on the following areas:

- Culture – redefining the Trust's values and behaviours and shaping a compassionate organisational culture from board to ward.
- Leadership – developing compassionate leaders at every level of the organisation.
- Healthy working environments – creating healthy working environments for all our workforce which are free from bullying and harassment and promotes the health and wellbeing of our employees
- Learning organisation – supporting our workforce to grow and learn that are based on quality conversations about individuals development needs and aspirations.
- Engagement – ensuring our workforce have a voice and our actively engaged in the business of the Trust and its direction of travel
- Valuing our staff – that we recognise the contributions that are staff make to theTrust on daily basis and celebrate their successes
- Inclusivity - securing a diverse workforce enables us to deliver a more inclusive service and improve patient care.

The Trust will be reviewing its Workforce and Organisational Development strategy over the coming months to ensure that it underpins the strategic direction of the organisation. The strategy will focus on shaping the culture of the Trust and in particular detailing the required behaviours that will create a compassionate organisation from board to ward. In addition the Trust will be securing compassionate leaders at every level of the organisation particularly focusing on the newly established clinical leadership teams.

The Board responded to the very disappointing outcome of the Medical Engagement Survey undertaken in the summer of 2017 by developing and implementing a clinical engagement plan supported by the implementation of a new clinical leadership mode.

Conversations will be cultivated across the organisation to engage the workforce in shaping discussions on quality ideas that may subsequently positively impact on the Trust finances. As well as introducing recruitment and retention activities that incorporate the development of career pathways, supporting newly qualified members of staff from education to profession.

The Trust will commit to ensure that we have the right numbers of staff in the right place with the right skills at the right time. Trust leaders will maintain a strategic forward view, anticipating and managing required organisational change. In the period 2017–19 workforce numbers and structures at WUTH will be impacted by increased cross working with the Countess of Chester Hospital (COCH) and closer co-operation with primary and social care in a move towards an Integrated Care System.

IT developments will increase the effectiveness of the workforce. The outcomes of these changes on staffing levels will inevitably be impacted by increased demand, increased acuity and a drive for improved quality (e.g. ensuring safe staffing levels through management of KPIs such as Care Hours per Patient Day, meeting waiting time targets etc.).

The Trust currently has a 4.69% sickness rate, over a rolling 12 month period. Reductions in sickness allows extra staff days for the care of our patients as well as reducing the reliance on bank and agency staff. The organisation is committed to creating a health and wellbeing framework with a view to supporting the health and wellbeing of our workforce, our patients and our communities. As a minimum the Trust ensures a very high number of our staff receives the Flu Vaccination; this year 81.3% employees were vaccinated.

The Trust has a total vacancy rate of 4.9%. For our nursing staff it is 6.09% and for our medical and dental workforce 4.98%. However, for consultant medical staff we have a vacancy rate of 7.71%. The Trust is committed to reduce vacancy rates part of which will be nurturing new talent. The Trust has plans to expand the numbers participating in its already successful apprenticeship program (in line with national guidance). Further progress will be made in our multidisciplinary workforce planning including a particular focus on the integration of new roles. New roles, job planning and skills development particularly in key groups such as our Advanced Nurse Practitioners and Associate Physician will assist in maintaining a stable workforce.

Key to the delivery of workforce efficiency savings and to maintaining high quality services will be a reduction in reliance on and cost of non-core staffing. Progress has been made in ensuring that the skill mix of substantive staff is optimised to reduce the need for agency and bank staffing. The further development of e-Roster, currently underway, will also support this.

5. Finance

The Trust's draft financial plan has been developed in line with the annual planning timetable set out by NHS Improvement. The underlying financial position of the Trust has been reported throughout the year to the Finance Business Performance & Assurance Committee (FBPAC) and Trust Board with initial draft plan being discussed by the Board of Directors at the February Board Meeting. The overarching financial strategy principles agreed by the Board of Directors is to create a long-term financially stable organisation with the:

- Ability to invest in patient care and facilities, delivering maximum value from the deployment of the Trust's estate with a longer term estates strategy based on a more joined up approach to care on the Wirral and between hospitals.
- Capacity to secure internally a transition from delivering transactional efficiencies to a focus on delivering sustainable service transformation through our newly established Service Transformation Team supported by enhanced governance structures and processes.
- Ability to survive structural changes in the financial flows in the NHS and wider health and social care economy.
- Capacity to cope with short term financial shocks.
- Deployment of the Wirral Millennium platform and Global Digital exemplar status to transform the delivery of care to patients on the Wirral. Patients will benefit from evidence based electronic care pathways. These pathways will be continuous across all health and social care settings.

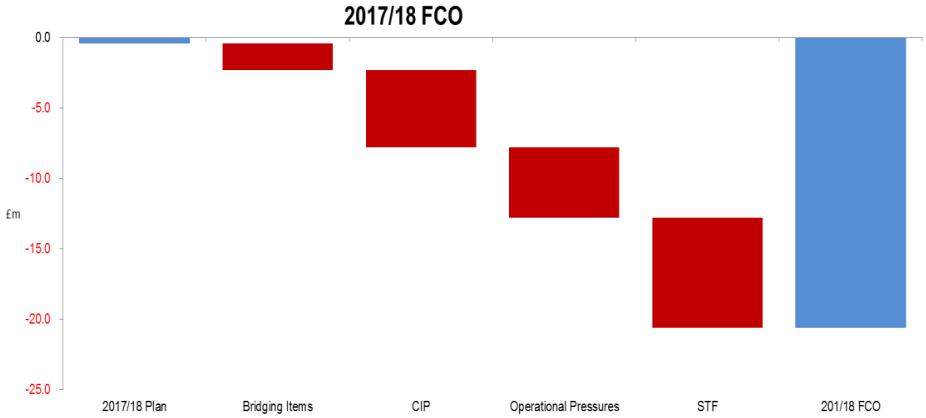
In the short term;

- Maintain a Use of Resources rating of level 3
- Balanced approach to delivering on the money, safety and quality in 2018/19
- A requirement for cash support going into 2018/19

The Trust whilst cognisant of the historical financial challenges it has faced (and recognises the continuing challenge in the short term) is of the belief that opportunities exist to significantly re-shape and transform the provision of health and social care on the Wirral through some form of Integrated Care Partnership (ICP), this is consistent with the intent set out within our CCG's draft commissioning strategy to more toward a Place Based Collaboration System (PBCS), although the timeframe for this journey is a live discussion as we continue to respond to the CCG consultation on this strategy.

5.2 2016/17 Financial Plan Performance

The Trust is currently forecasting to finish the 2017/18 financial year with an actual deficit of £19.6m which converts into an Adjusted Financial Performance Deficit of £20.4m which is comparable to the Control Total issued by NHSI. This is worse than the planned control total of a £0.4m deficit. The key drivers behind the Trusts normalised forecast outturn deficit is set out in the bridge chart below;



As set out in correspondence with NHSI/NHSE and the Wirral Health and Social care system the main drivers of the adverse plan are;

- While the Trust will deliver a CIP of 3% in 2017/18 which is 1%more than the National target it will fall below the 5% target included within the plan.
- Loss of STF funding as a result of non-achievement of the control total since Q1 - £7.8m
- Operational pressures as a result of continued escalation beds opened throughout the year, loss of Elective activity due to National directions around winter pressures and increased costs as a result of National intervention around A&E performance - £5m
- Non achievement of bridging items set in plan to enable acceptance of control total - £1.9m

As can be seen the failure to deliver the financial plan is not as a consequence of loss of "financial grip", the Trust has embedded robust governance processes and structures ensuring a focussed approach on controlling the cost base and managing delivery of financial and non-financial key performance indicators during the course of 2017/18.

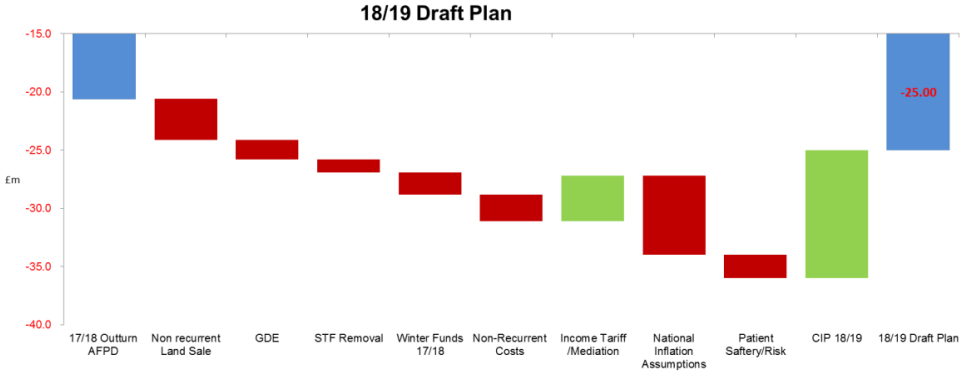
The 2017/18 position has been supported by non-recurrent benefits of c£7.5m that will not be available to support the Trust during 2018/19. These non-recurrent benefits have been reported throughout the year to the FBPAC and Board as part of the underlying position.

5.3 Key Planning Assumptions

WUTH is facing a considerable challenge in the second year of this planning cycle. The Trust continues to see significant growth in Non-Elective Activity and is currently having c£5.8m withheld by Wirral CCG under marginal rate rules. Despite the Health economy investing in excess of the mandated requirement in the Better Care Fund, the Trust continues to have significant pressures around Non-Elective activity. Following mediation it has been agreed to review baseline levels to during the year and agree where marginal rate is invested . The Trust has allocated resource for a 1% pay award although no confirmation has yet been received on how the lift on public pay awards will be allocated for 2018/19. We've also made assumptions around the level of CIP that is achievable, and how our GDE programme will use resources during the period.

The Trust's overarching financial strategy is to maintain a minimum level 3 Use of Resources rating throughout the planning period under the current Single Oversight Framework. To deliver upon this objective, the Board of Directors at WUTH recognises the need to robustly plan and secure delivery of increasingly challenging efficiency requirements moving from an historical transactional delivery to one which delivers truly transformational programmes of efficiency both within the acute hospital setting but increasingly aligned to the Cheshire & Merseyside Health & Care Partnership, Place Based Collaboration System (Healthy Wirral) and our Wirral & West Cheshire Acute Care Alliance. We are though dependent upon collaboration from the CCG and other Wirral partners, and our current planning assumptions are based on the current realistic prospect of change in partnership with those parties.

The movement from the 2017/18 outturn position to the operational plan for 2018/19 is demonstrated in the bridge graph below.



Agency Rules: WUTH will continue with the range of measures introduced in 2017/18 that will see successful delivery of the agency cap to ensure on going compliance with the £7.5m cap from April 2018. The Trust will continue to build upon its robust approach to workforce planning to minimise the use of agency staffing in 2018/19 reflecting on its forecast outturn for 2017/18 of circa £7m.

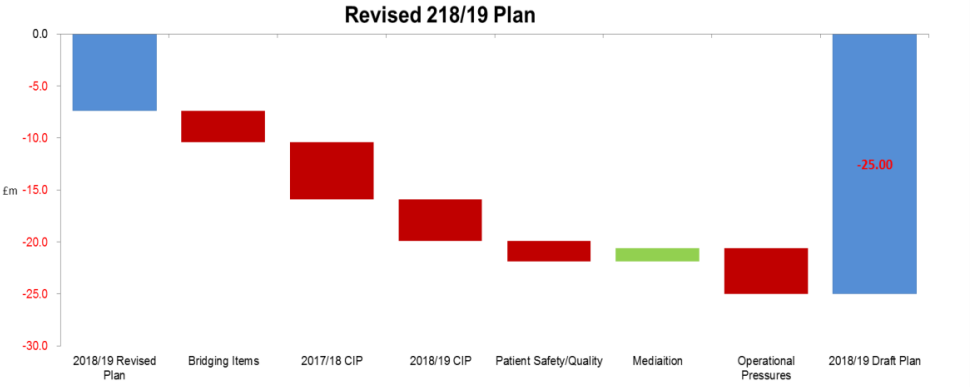
Procurement: The Trust is actively engaged with Countess of Chester NHS Foundation Trust on moving toward a shared Procurement function and aligning / harmonising contract arrangements to enable increased purchasing power and other synergies. The Trust actively reviews the opportunities available to it from the Purchasing Price Index Benchmarking (PPIB) tool. We continue also to work with other trusts across Cheshire & Merseyside to explore opportunities to buy better together and achieve some of the Carter at Scale benefits that may be available.

Movement from Initial Plan

The Trust did not accept the control total for 2018/19 as a result of the non-recurrent elements including in the bridging items for 2017/18 and the significant stretch that would be required to deliver a £6.1m surplus from a £0.4m deficit. As a result of the not accepting the control total the subsequent STF was removed for the 2nd year of the plan as were the non-recurrent bridging items.

Due to the significant challenges that the Trust has encountered during 2017/18 some of the initial assumptions included in the 2nd year plan are no longer viable. The bridge below demonstrates the movement from the plan submitted last March to the current draft plan.

The Trust does not believe that a 5% CIP is deliverable given the national historical challenge in delivering this level of saving through 2017/18 and in all previous years. The Trust has reduced the savings target to 3% which is still 1% more than the National target as per the guidance.



5.4 Transformation Agenda & Sustainability Programme

The indicative requirement for achieving overall financial sustainability is circa £30 million. As noted previously, planning guidance assumes 2% efficiency is realistic and so a challenge in the region of 9% is wholly unrealistic based on traditional CIP approach.

However, given the challenges in getting anywhere near close to 5% in the 17/18 year and with little visible prospect of a fundamental shift in health economy collaboration at this stage, we believe that 9% is not achievable for the 18/19 year, and the risk to quality and safety of attempting to do so would be highly undesirable and not aligned to the Board of Directors view that while we challenge ourselves to make best use of resources and deliver financial sustainability, this cannot be at the expense of patient safety and quality.

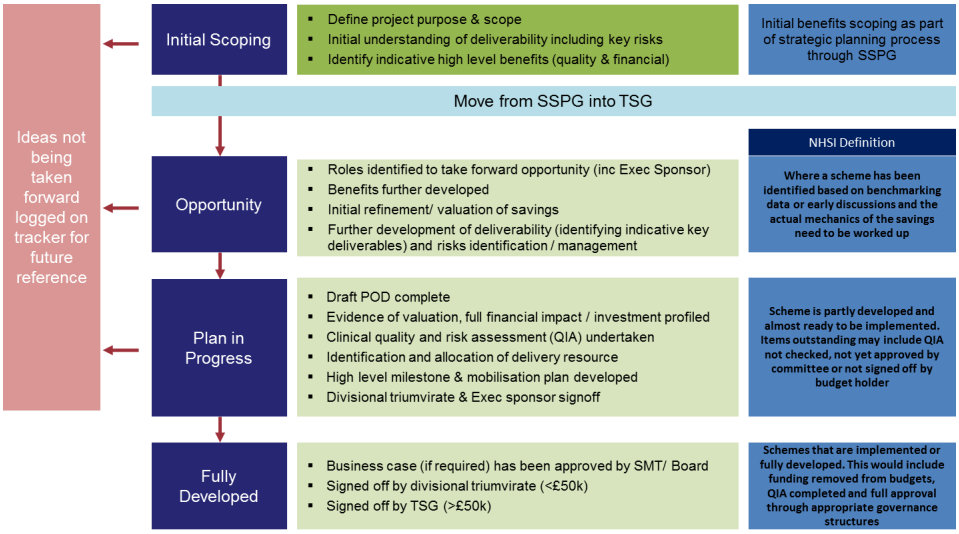
We have taken the view that rather than a traditional CIP, which frankly is a barrier to real clinical engagement and tired approach which colleagues have become weary of, we will identify opportunities to enable long term financial (and clinical) sustainability in each of the three areas described below.

- **Tactical & Transactional** – the result of operational grip, low level cash releasing efficiencies and short term decisions that will enable us to achieve a baseline efficiency saving in the region of 2% per planning guidelines. In other words, '*doing the things we do today more efficiently tomorrow*.'
- **Operational Step Change** – additional more fundamental changes to what we do and / or how we do it within our operations. In other words, *'doing different things and/or doing things differently, where it is within the Trust's gift to do so'*. These items will enable us to stretch beyond 2% and get to the 3% plus target we have set as described above, potentially even a little beyond.
- **Strategic Transformation** – these rely heavily and wholly on collaboration outside the hospital walls. New models of care, either as part of place based collaboration within Wirral (vertical) or as part of acute care alliance working (horizontal). In other words, *'doing different things and/or doing things differently, where it is NOT within the Trust's gift to do so'*. These items will enable us to stretch beyond 3% and start to close the gap on the kind of 9-10% challenge we are facing.

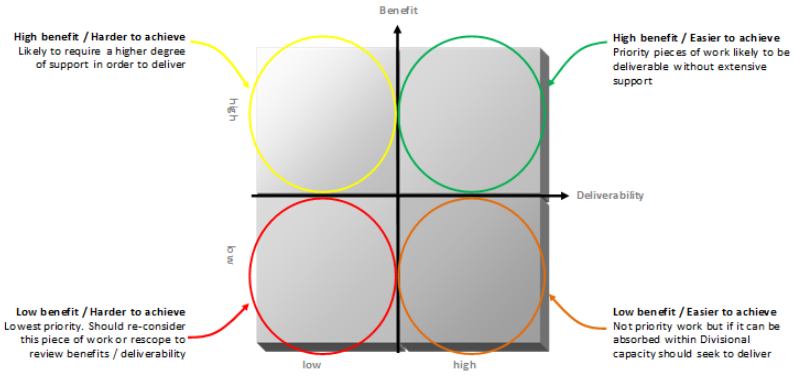
Current modelling assumes that the Trust will deliver the CIP through the first two categories, which translate into traditional CIP; i.e. c3% of turnover and 1% higher than the planning guidance target of 2%. The Trust had, when submitting plans a year ago, assumed a further 5% CIP target within the 2018/19 plan.

Against the 2018/19 efficiency target of £11m planning work undertaken by the Trust's Service Transformation Team have identified work streams to support the delivery of £7.2m of the overall requirement with a further £3.5m identified as opportunities.

To enable us to influence and take a leading role in identifying strategic transformation opportunities, we have established a Strategy & Sustainability Planning Group (SSPG). Chaired by the Director of Strategy & Sustainability, this senior leader group representing all divisions and corporate services and including clinical, nursing and operational / management colleagues, this group provides the capacity & capability to identify and 'shape' opportunities and determine actions to progress within and without the Trust. The table below shows how 'ideas' move from this SSPG into well-defined pieces of work which then become managed through our extant Transformation Steering Group and associated governance. This also shows how schemes translate into NHSI definitions for purposes of reporting 'CIP'.

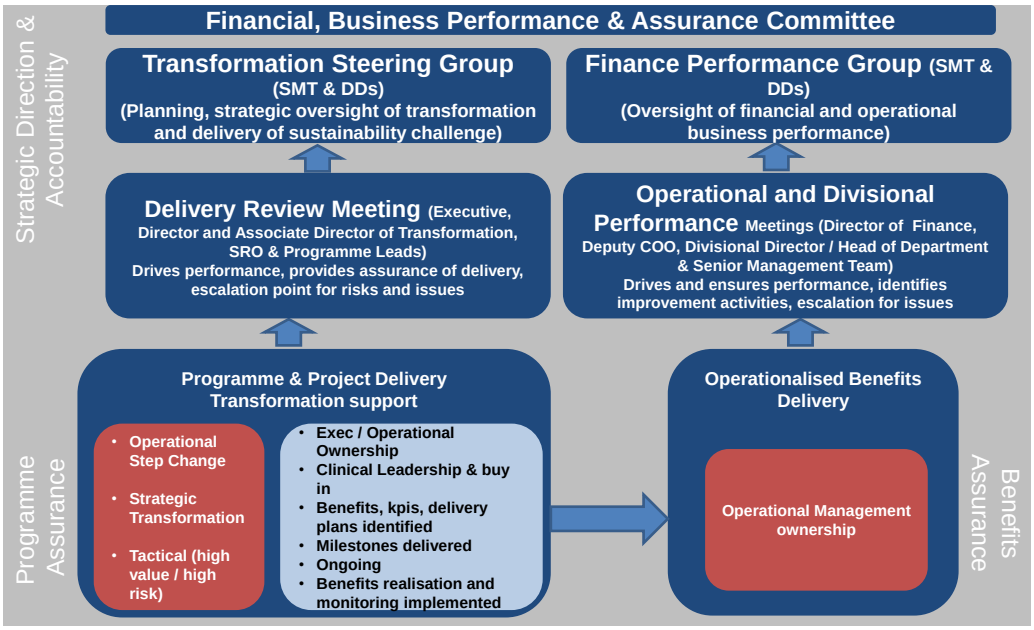


Recognising that there is limited bandwidth for change given the hot and busy nature of acute hospital environments in 2018, we have developed an approach to prioritising ideas based on quantum of benefit (better health, better care and better value) and on practical consideration of deliverability.



The diagram below demonstrates the governance arrangements for the Transformation agenda:

Portfolio Governance Assurance Arrangements

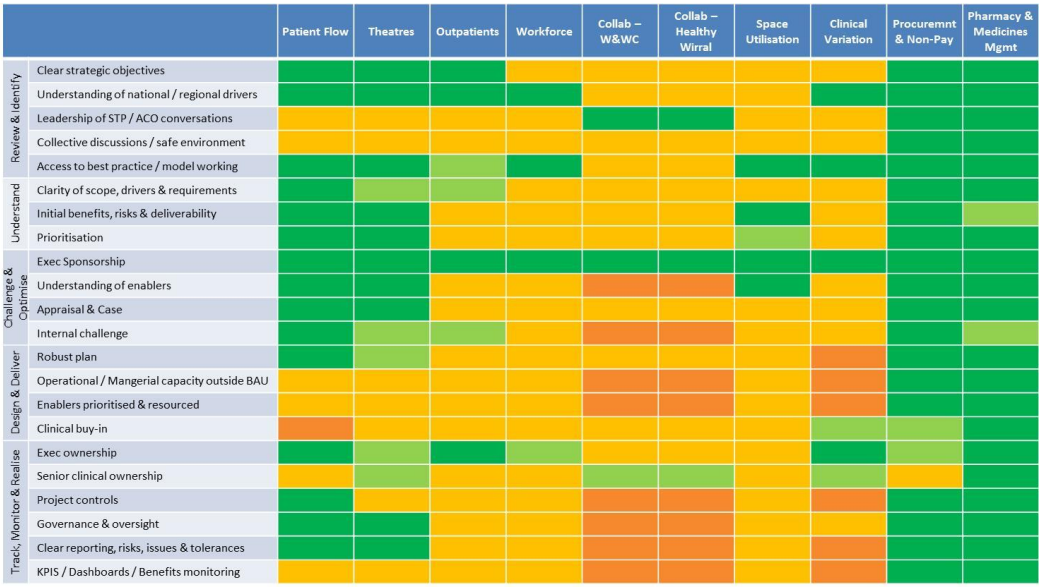


The Transformation Steering Group (TSG) operates as a strategic group and is chaired by the Chief Operating Officer and reports into the Finance, Business, Performance and Assurance Committee (FBPAC). The group oversees all significant change and improvement projects within the Trust, and each programme has an Executive lead and the appropriate meeting structure to support delivery. The group have a holistic view at a portfolio level to ensure that all interdependences are highlighted; approved programmes/projects align with the Trust's vision, and deliver the specified benefits such as achieving value for money and whilst sustaining quality and safety. The diagram below shows the current portfolio of work within scope of TSG.

Quality Healthcare, Sustainable Future Transformation Portfolio		
Programme & Aim	**Ownership & Accountability**	**Service Transformation Programmes & Projects**
Operational Step Change		
Patient Flow and Bed Reconfiguration To free up beds in the hospital and community by ensuring that we have the right patients in the right beds at the right time supported by the most appropriate staff to ensure patients receive the best care	SRO: Anthony Middleton Programme Lead: Shaun Brown	Achievement of internal ED targets Redesign of ACU pathways Primary Care Streaming Embed SAFER Assessment Area flow and reconfiguration Transformation of discharge services
Theatre Productivity To improve theatre efficiency to enable us to reduce waste and treat more patients in a timely way	SRO: Gareth Lawrence Programme Lead: Jo Keogh	Theatre utilisation Pre-op pathway
Outpatient Improvement Programme To improve our outpatient services to enable us to see more patients in a timely way and improve patient experience	SRO: Anthony Middleton Programme Lead: Nicola Davidson	Clinic Productivity Nursing skills mix Clinic supoport staff including IT enablers
Workforce Transformation To reduce our total workforce costs by continuously improving our ways of working	SRO: Janelle Holmes/ Helen Marks Programme Lead: Ann Lucas	Medical Staffing Nursing Corporate Clinical A&C
Clinical Variation To reduce variation in patient outcomes, care and experience, and reduce variation in costs of delivery through implementation of consistent care practices	SRO: Susan Gilby Programme Leads: Various	Clincial pathways GIRFT Demand management
Strategic Transformation		
Collaboration - Healthy Wirral To reshape health & social care services to ensure quality patient care is delivered in the appropriate setting, enhancing the experience of our patients whilst offering best value for money	SRO: Terry Whalley Programme Leads: Various	Collaboration - Women's & Children's Place Based MSK Urgent Care
Collaboration - Wirral & West Cheshire To reshape acute healthcare services enhancing the experience of our patients whilst offering best value for money	SRO: Terry Whalley Programme Leads: Various	Collaboration - Urology Collaboration - Women & Children Acute Services
Other Strategic - IT To provide our patients with the best care supported by world leading technology	SRO: Paul Charnley Programme Lead: Sheila Stewart	GDE
Other Strategic - Site Strategy To ensure our space is fully utilised and enhances the experience of our patients, whilst offering the best value for money	SRO: Gareth Lawrence Programme Lead: Dave Sanderson	Site utilisation
Tactical and Transactional		
Procurement and Non Pay To provide high quality, clinically appropriate products and services at the best possible prices and reduce waste and inefficiencies in the supply chain	SRO: Gareth Lawrence Programme Lead: Jane Christopher	Comprehensive spend analysis Contract review Product standardisation
Pharmacy and Meds Management To safely reduce our drug and prescribing spend and ensure efficient use of our pharmacy services	SRO: Pippa Roberts Programme Lead: Sue Robinson	Comprehensive spend analysis Reduced medicines waste Pharmacy collaboration
Divisional and Departmental	Programme Leads: Divisional Directors	Tactical schemes

In addition, it ensures that any new projects are assessed to the agreed methodology and makes recommendations as appropriate to the Senior Management Team (SMT) or Finance, Business, Performance and Assurance Committee (FBPAC).

To ensure visibility of progress and provide assurance on ability to deliver against plan, we have developed a heat map approach to inform TSG view of where to seek further detail, early snapshot below.



5.5 Capital Planning

The capital allocation for 2018/19 is based on receipts from the Clatterbridge Land Sale received during March 2018, nationally funded Global Digital Exemplar and on internally generated resources. The Trust has a rigorous, fair and risk adjusted process in selecting agreed capital developments but recognises the challenges it faces in meeting all of its needs in respect of capital expenditure. The financial plan caters for capital expenditure with the following key areas of planned expenditure;

- GDE
- Medical Equipment
- Backlog Maintenance

The above planned investments represent a risk based approach to capital investment within the Trust predicated on eliminating backlog risk and risk re medical equipment obsolescence to ensure delivery of safe and sustainable services within an appropriate environment.

5.6 Cash

The Trust has had a challenging year in 2017/18 in respect of cash as a result of the operational performance. The Trust will require continued cash support throughout 2018/19 as a result of the deficit plan.

6. Digital

During 2018/19 the Digital Wirral programme, funded in part with NHS Digital Global Digital Exemplar funding, will deliver new developments within the Trust in the areas of;

- Medicines management – extending into maternity and neonates, chemotherapy trials, antimicrobial stewardship, and the more complex areas of prescribing and administration. We will be aiming to improve safety when administering drugs so that we do the "closed loop" checks of the rights (Right patient, right medication, right dose, right route, right time, right documentation, and right situation) easily on the system. We will also introduce prescribing in the outpatient setting.
- Device Integration – of a range of equipment from vital signs, and ECGs to infusion pumps will be integrated making it easier to add information to the patient record.
- Incorporating digital images - from medical photography and "oscopies" so they can be found as part of the overall record
- Clinical Pathways - The introduction of electronic support for a range of clinical pathways which will help to manage unwarranted variation
- Patient Flow - The development of a capacity management capability to be included as part of the introduction of a command centre to assist with patient flows into, through and beyond Wirral Hospital
- Pathology Services - The migration of microbiology system from an externally managed system to be part of our integrated Laboratory Information System in Wirral Millennium. We are also in discussion with the Countess of Chester Hospital about this being the first part of bringing the pathology services in both hospitals together onto the one system
- Patient portal – We will be enhancing and expanding the patient portal which has been piloted to develop a range for digital services for patient to provide them with more convenient access to services
- Becoming paperless – ultimately the combination of all these things along with digital dictation and voice to text technologies deployed in the outpatient setting should allow us to reduce and eventually eliminate the cost of paper consumption, printing, storage and the people required to move paper around the system

Informatics is working with the Transformation Team and the Divisions to establish plans for the systematic and methodical realisation of benefits from these new features which will contribute to quality improvement and in some cases cost reductions. We will also aim to ensure that governance for developments within the current programme and beyond is led by clinicians and the divisions.

Of course the majority of what is done in Information and IT and Information governance and Medical Records is business as usual and will be the subject of continuous improvement and cost management attention during the course of the year. Under the heading of Information Governance the main focus will be on ensuring that the Trust is compliant with the General Data Protection Regulations which come into effect in May 2018.

The information management team has also been working on new interactive, self-service website with dashboard of information collated for the divisions and executive management to modernise reporting and access to data for operational management. This will be rolled-out and continue to develop throughout the year.

Behind the scenes the Digital Wirral programme is helping to develop infrastructure improvements including continuing the ongoing process of ensuring cyber security against evolving threats. We have also been able to expand our workforce and skill sets to ensure we can support our systems in future years.

In the wider system digital services will be expanded and linked both "vertically" in Wirral and "horizontally" with the Countess of Chester Hospital

- Communication between organisations - Move to electronic data flows between our organisations within Wirral and further afield speeding up communications and reducing printing and postal costs.
- Building the Wirral Care Record and Registries - Wirral has a unique opportunity as the first place outside the USA to adopt a system which allows the combination of records from different systems into one which will support new care models and population health management. All 51 GP practices are providing data to be merged with the hospital data and Wirral community will be adding more data over time. 5 registries have been developed in Diabetes and respiratory care and there are 6 more in development Cardiovascular Disease: AF, HF; Substance Misuse; Wellness; Mental health; Frailty and End of Life. We also aim to have social care connected into our shared systems during 2018/19.
- Linking systems - we are also enabling the visibility of the patient records from each of the main providers in Wirral to clinicians regardless of which organisation they work for
- Digital Partners - We are also working with Countess of Chester who will become digital partners in our hospital system (a Fast Follower in NHS Digital terms). The plan is for them to be live on the same instance as Wirral towards the end of 2019 so much of the planning and technical work will begin and we will be in full flow by the end of 2018/19. Work will also begin to bring the two Trust's informatics and IT functions together as they begin to work on the one system
- Cheshire and Merseyside health and care partners - in line with wanting to be part of the wider health and care system we are also fully involved with the digital plans in Cheshire and Merseyside to review services and share work in areas such as interoperability, cyber security, shared infrastructure and support for urgent care and patient flow.

7. Collaboration beyond WUTH

7.1 Links to the Cheshire and Merseyside Health & Care Partnership (formerly C&M STP)

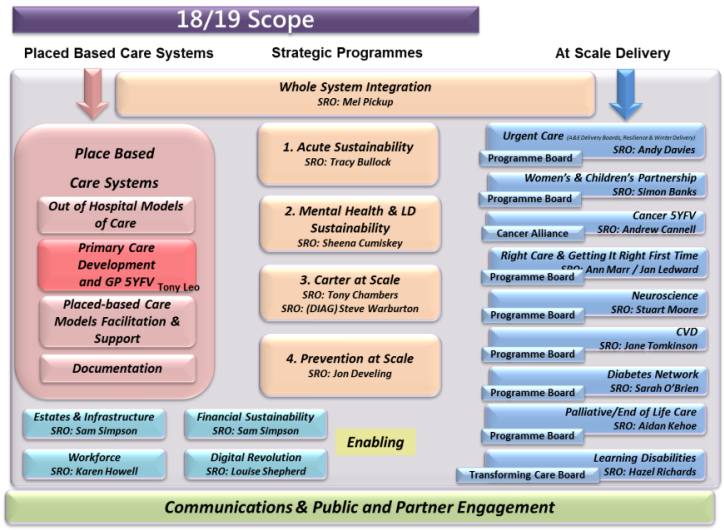
The Cheshire & Merseyside (STP) submitted to NHS England in October 2016 was based on three 'Local Delivery System Plans' (LDSP). WUTH was included within the LDSP for Cheshire & Wirral. The STP represented "the design stage of a programme [of change]". The underpinning vision – improving the health of the Cheshire & Merseyside population, improving the quality of care in hospital settings, optimising direct patient care – remains clear and compelling. But the way in which the STP and LDSPs were progressed did not work.

In the summer of 2017 the STP recruited a new Chair and SRO (Andrew Gibson and Mel Pickup), and 'reset' the STP. Relaunched as **Cheshire & Merseyside Health & Care Partnership**, there is much more emphasis and focus on Place Based Care, and a recognition that the majority of 'work' to deliver sustainable services will need to happen through 'Place', building on ever increasing Integrated Care Systems. This is a welcome approach, and is consistent with the content of the recently published CCG Strategy, and the aspiration that underpins Healthy Wirral Partnership.

It follows from this that a key objective for 2018/19 is to work with Cheshire & Merseyside Health & Care Partners and Healthy Wirral partners to develop the work streams and projects to a position where a detailed change programme is in place and can be delivered. WUTH has committed to play a material role in the development of both. Project management and governance arrangements are currently being put in place. The Trust will continue to provide resources to support implementation and to invest in the development of closer relations with partners.

The Cheshire & Merseyside Health & Care Partnership sets out four key areas of work, each made up of a number of discrete programmes & projects as summarised below and in the diagram that follows:

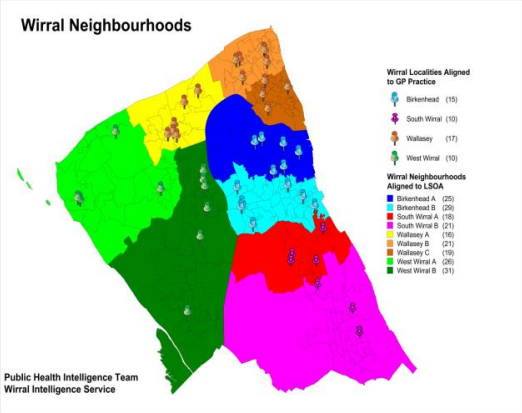
1. Place Based Care Systems, which for us is the Healthy Wirral Place Based Integrated Care System work
2. Strategic Programmes enabling Whole System Integration, including most notably Acute Sustainability for which our Medical Director is the Clinical Lead, and Carter at Scale which we actively support and influence through initiatives such as procurement, payroll, pathology and pharmacy.
3. At Scale Delivery across a number of significant areas.
4. Enabling, cross cutting themes such as workforce, digital, estates & infrastructure, communications & engagement.



We are clear, in line with C&M Health & Care Partnership thinking, that 80% of the solutions to how we ensure clinically and financially sustainable services will come from Place Based Collaboration, and how we achieve Integrated Care Systems / Partnerships. And, as described in Finance section previously, this is essential to our ability to get closer to the overall financial sustainability challenge we face. We are very committed therefore in 2018/19 to progressing Healthy Wirral in partnership with Wirral CCG, Wirral Community Trust, Cheshire & Wirral Partnership, Primary Care Federations and other public, third and voluntary organisations.

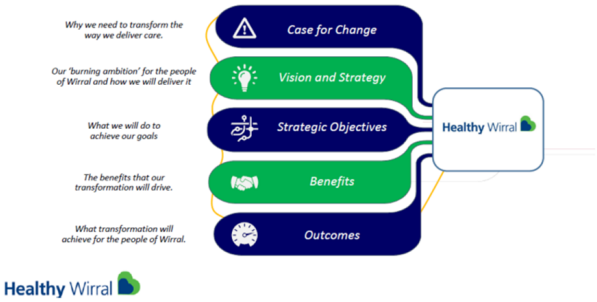
7.2 Healthy Wirral

We continue to develop asset based new models of care, building on recognition that in Wirral there are 4 localities, 9 neighbourhoods, 51 general practices and a single district centre for acute care. This '51-9-4-1' model will underpin new models of integrated care, developed within various strands of Healthy Wirral and consistent with the now published draft Wirral Integrated Commissioning (WIC) Strategy 2018-2021.

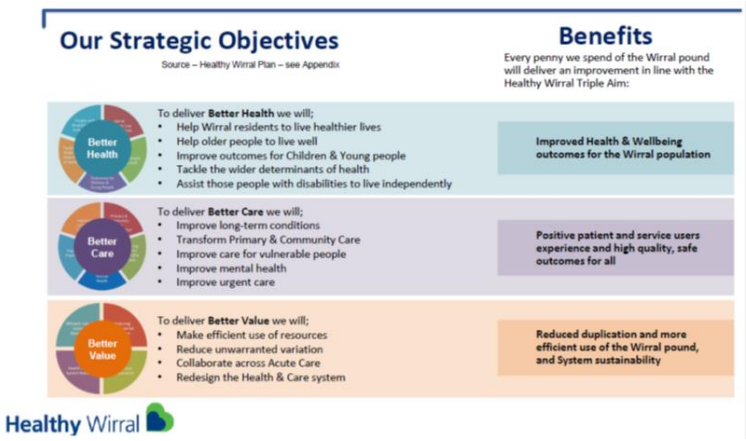


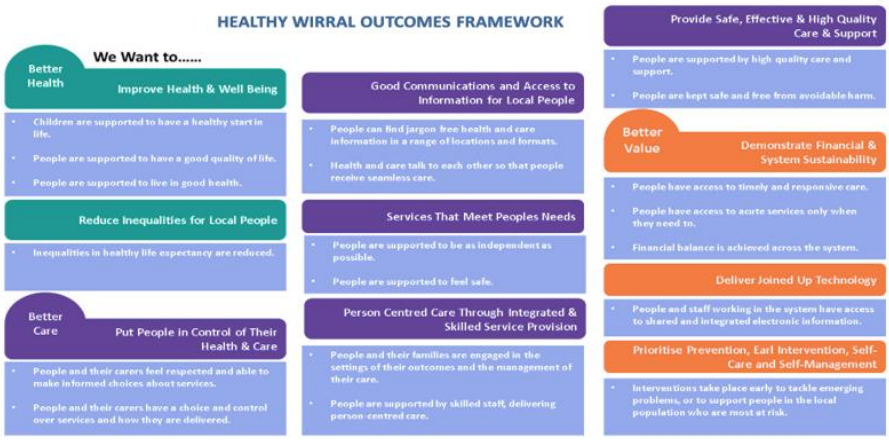
This WIC strategy document outlines intent from 2020/21 to undertake place based commissioning to improve population health outcomes in Wirral. The document outlines WIC's vision, how they will move towards the commissioning of high level population based health and care outcomes, and the timeline for achieving this change. This Commissioning & Transformation Strategy is intended by WIC to be a living document which will change and develop as the new system evolves, and we have already provided some quite detailed feedback to the commissioners as part of early consultation on the draft document.

Our Healthy Wirral Plan is built around a 'Golden Thread', one that connects our case for change to specific initiatives we plan.



The initiatives are described in the context of delivering Better Health, Better Care and Better Value, and are linked to a series of agreed outcomes against which we will measure progress.





The ambition of the WIC is to commission on a place based care basis, with a capitated budget in place by 2021. In order to achieve this goal and to ensure development of a sustainable health and care system, it is proposed that a gradual approach be adopted, as indicated below:

- 2019/20 – older people (50+)
- 2020/21 – all adults
- 2021/22 – all age population

During the next two years WIC plan to commission services in a different way and have identified opportunities to facilitate the development of a PCBS. These enablers are identified below, and they have indicated that they will seek to develop formal contracts only with Providers who are working in appropriate collaborative arrangements and are the most capable to deliver the required outcomes.

- Muscular Skeletal Services
- Drug and Alcohol Services
- Diabetes Pathway
- Respiratory Pathway
- Urgent Care Service
- Older People Living Well
- Obesity
- Mental Health – (IAPT, crisis care and integration with physical health

To support the approach described above by WIC, we will at the invitation of WIC work with all stakeholders in the period to October 2018, to co-produce a prospectus. This will include wide engagement and consultation with local people to ensure that they are involved in how services and pathways are transformed. This prospectus will define placed based commissioning requirements for the older people (50+) population and outline what is expected from providers to meet the requirements of the particular pathways to be agreed for inclusion within this segment of PBCS. The prospectus will identify populations needs and the outcomes that are important to the people we serve in their particular place, and this will include defining what success looks like. While supportive of the intent, and as previously described, the prospect of a 3 year phased approach does not directly show how we will close the financial sustainability challenge in 18/19 and we continue to seek to influence more pace.

7.3 Acute Care Alliance

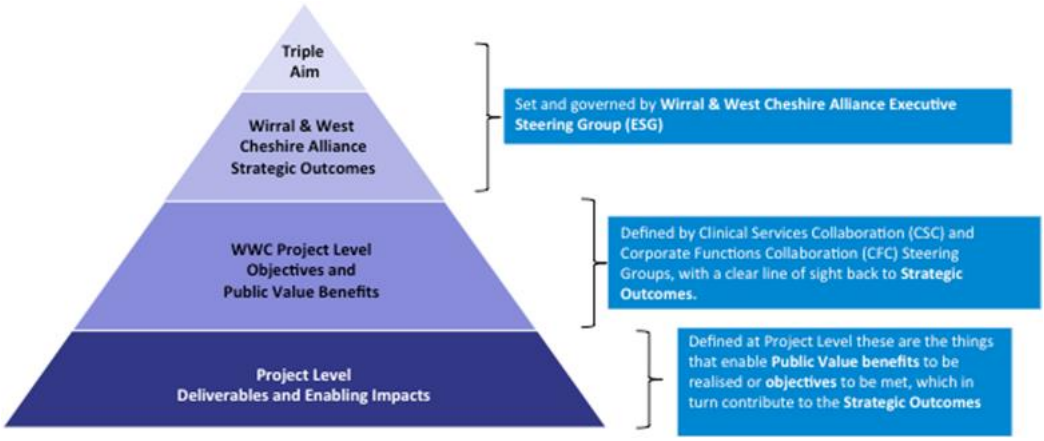
As referenced in Quality Section of this plan, we will in 2018 examine closer workings in respect of acute services between ourselves and our nearest acute neighbour, The Countess of Chester NHS Foundation Trust.

Our two organisations have a track record of successful collaboration; joint ownership of microbiology shared service, shared HR / Payroll services, clinical collaboration on a vascular hub, joint interventional radiology, human milk bank and other services to name but a few. We plan to collaborate in a number of additional areas;

- Digital enablement (Countess of Chester expect to become the first 'Fast Follower' to the WUTH / Cerner GDE model)
- Lord Carter Model Hospital collaboration, taking forward procurement and payroll opportunities in corporate functions and exploring a range of clinical opportunities as part of the clinical strategy work.
- Immediate opportunities for collaboration in areas such as Urology, Pathology and Women's and Children's Services. Pathology collaboration will build on extant shared microbiology service, meet the extant timetable for MES renewals and contribute to emerging dialog across North 4 Pathology Network which both Trusts are committed to supporting while remaining open minded about the future stave vision / target operating model options appraisal that will be required.

The WWC Alliance is in place to enable both Trusts to work together on some carefully selected things that will enhance the clinical and financial sustainability of services delivered by both Trusts. To do this and to provide a public narrative that our colleagues and the general public can get behind, the WWC Alliance has, at its heart, a 'triple aim'

1. Improve Health Outcomes for the half million or so people in the Wirral & West Cheshire path served by the two Partner Trusts
2. Improve the experience of Healthcare, not just for the people we serve but for our colleagues who deliver healthcare services
3. Better use of resources for health and care – Financial Sustainability



8. Trust Membership and Elections

The Trust holds Governor Elections each year for both public and staff seats on the Council of Governors. The Trust held an election in summer 2016 for 5 seats, both staff and public, which were all successfully filled. Elections in summer 2017 also successfully filled 5 public and staff governor seats.

In December 2017 the Trust held an additional by-election for the role of staff governor for the Medical and Dental Constituency.

The Trust continues to hold Council of Governors Workshops which includes visits to particular areas of the hospital to increase Governor Knowledge of, and insight into key areas of the Trust's operations. The majority of topics and areas for workshops are selected by Governors themselves and have recently been expanded to include the participation of Ambassadors. The Governor role in the internal Care Quality inspections will remain pivotal in 2018 and beyond as this expands upon the concept of Board Walkabouts making these more meaningful and structured for all parties. The role of Ambassadors introduced during 2015/16 was a means of retaining the knowledge of ex-Governors who have reached the end of their tenure and using this to support new Governors. This has proven to be very successful, seeing more governors at the end of their natural tenure wishing to return as Ambassadors.

The Trust has continued with its active engagement of Governors via its Strategy & Sustainability Advisory Committee, the Committee reviews strategic themes and objectives and the programme for completion of the annual plan.

The Membership Strategy was revised and updated to take into account the evolving needs of the Trust, aiming to have wider links with the community. It was developed with the involvement of the Membership and Engagement Committee and approved by the Council of Governors in July 2017.

The Trust has always worked with established groups on the Wirral such as HealthWatch and the Older Peoples Parliament as a way of engaging with members and drawing upon a limited resource. Our Governors and Ambassadors play a huge role in the promotion and execution of our Annual Members' Meeting and with the content of our joint staff and public Newsletter.

The Trust continues to have a membership that is a good representation of the population it serves.

Board of Directors	
Agenda Item	7.3
Title of Report	Financial Plans 2018/19 - Update
Date of Meeting	25th April 2018
Author	Shahida Mohammed – Assistant Director of Finance
Accountable Executive	Gareth Lawrence, Acting Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	 8 8c,8d
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To note
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

1. Executive Summary

The purpose of this paper is to update the Finance, Business, Performance and Assurance Committee on the Income and Expenditure plans and Balance Sheet assumptions for Wirral University Teaching Hospital (WUTH) for the 2018/19 financial year.

The Trust submitted its draft plan to NHSI on 8th March. This paper outlines movements between the draft plan and the final plan which will be submitted by 30th April.

The Trust has been offered Sustainability and Transformation Funds based on the acceptance of the control total set by NHSI. The Trust has been offered £12.5m, which is £3.6m more than offered last financial year, in exchange for delivering a £11.0m surplus in 2018/19 this is £11.5m higher than the plan for 2017/18 and £4.9m higher than the offer during last year's two year planning process.

The Trust agreed to a challenging financial plan for 2017/18 that included an element of non-recurrent savings. The Trust concluded the year with a deficit of (£20.4m) reflecting operational pressures and unprecedented demand. The underlying deficit for the year is (c£33.0m).

The initial plan for 2018/19, submitted in March, was for a planned deficit of £29.0m and as a result, the Trust was unable to accept the Control Total issued for 2018/19. Following further contract negotiations, mediation with Wirral CCG and baseline and CIP assumption reviews the revised plan is for a deficit of £25.0m.

Despite this improvement and taking into consideration the current underlying position of the Trust and the extremely challenging Control Total issued by NHSI it is still not possible to accept the Control Total for 2018/19.

Table 1 – Financial plan headlines

	Initial Plan 2018/19 £m	Revised Plan 2018/19 £m
Normalised Surplus/(Deficit)	(29.0)	(25.0)
Control Total	11.0	11.0
Capital Investment	10.8	7.0
Cash Balances	1.8	2.2
Loan Requirements	29.0	25.0
CIP	10.0	11.0
Use of Resources	3	3

2. Movements In Plan position

During March and April further work has been undertaken to:

- Review the assumptions underlying initial income, expenditure and CIP baselines
- Conclude contract negotiations
- Complete the mediation process with Wirral CCG (separately reported)
- Clarify GDE funding

As a result of the above, the plan deficit is now £25.0m, an improvement of £4.0m. This is outlined in the table below:

Table 2 – Financial plan movements

	£m
Readmissions	0.5
Neuro Rehab	0.8
Additional CIP	1.0
GDE Income	1.7
Total Plan Movements	**4.0**

- Readmissions: In mediation it was agreed that the CCG and Trust will, jointly, undertake a clinical audit of re-admissions within Q1. The outcome of the joint audit will be binding on each organisation and will be applied retrospectively from 1st April 2018. In the interim for planning and payment purposes, and pending the outcome of the audit, the baseline has been adjusted from 12.6% to 10%.

- Neuro Rehab: Another outcome of mediation was that the CCG will undertake a review of the Neuro Rehabilitation Service this will be concluded by the end of Q1. Initially, the CCG will include funding for 7 beds within contract plans from 1st April 2018 until 30th September 2018. Contract values will be adjusted from October 2018 onwards in accordance with the outcome of that review. Plan reflects expected full year effect

- Additional CIP: CIP target for 2018/19 has been adjusted to 3%

- GDE Income: further discussion and review has taken place and this income stream has been confirmed to offset costs included in initial plan baseline

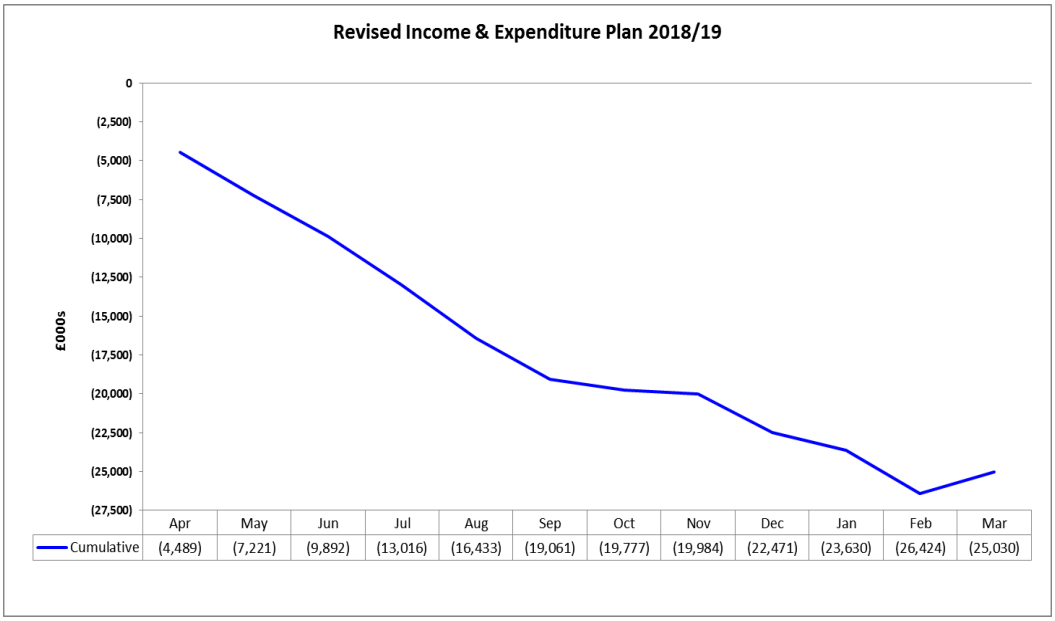
Table 3 – Summary income and expenditure

	Updated Initial Plan 2018/19 £m	Plan Adjustments £m	Revised Plan 2018/19 £m
Income From Patient Care Activities	303.9	1.3	305.2
Other Operating Income	29.5	1.7	31.2
Total Income	**333.4**	**3.0**	**336.4**
Employee Expenses	(246.6)	0.5	(246.1)
Operating Expenses	(103.8)	0.5	(103.3)
Total Operating Expenditure	**(350.4)**	**1.0**	**(349.4)**
EBITDA	**(17.0)**	**4.0**	**(13.0)**
ITDA	(12.3)	0.0	(12.3)
Surplus/(Deficit)	**(29.3)**	**4.0**	**(25.3)**
Remove Capital Donations/Grants I&E Impact	0.3	0.0	0.3
Deficit	**(29.0)**	**4.0**	**(25.0)**

The surplus/deficit profile is summarised below, these reflect divisional review of expenditure profiles and contracting review of income profiles for the year. CIP profiles are based on divisional plans

At present an indicative profile has been used which assumes low CIP delivery in Q1 and Q2 with increasing delivery thereafter as schemes are fully worked up and implemented.

Chart 1 – Income and expenditure profile



The Trust is reporting a pre-audit deficit at M12 of £20.4m, the following table summarises the key movements between this position and the revised plan.

Table 4 – 2017/18 outturn to 2018/19 plan bridge

	£m
2017/18 Outturn (Pre-Audit)	**(20.4)**
Non recurrent Land Sale	(3.9)
GDE	(3.4)
STF	(1.1)
Winter Funds	(1.9)
Non-Recurrent Items	(2.1)
2017/18 Normalised Outturn (Pre-Audit)	**(32.8)**
Income Tariff	2.6
National Inflation Assumption	(6.8)
Development Reserve	(2.0)
CIP	10.0
Initial Plan	**(29.0)**
Readmissions	0.5
Neuro Rehab FYE	0.8
GDE Income	1.7
CIP to 3%	1.0
2018/19 Plan	**(25.0)**

3. Statement of Financial Position (Balance Sheet), Cash and Borrowings

As a result of the improvement in the deficit since draft submission, the planned borrowing requirement has reduced from £29.0m to £25.0m.. All other working capital assumptions remain unchanged.

Table 5 – 2018/19 Statement of Financial Position : initial to revised plan

	Initial Plan £m	Revised Plan £m
Non Current Assets	**165.6**	**173.4**
Current Assets	22.8	19.6
Cash & Cash Equivalents	1.8	2.2
Total Current Assets	**24.6**	**21.8**
Total Assets	**190.2**	**195.2**
Current Liabilities	**(35.3)**	**(32.3)**
Net Current Assets/(Liabilities)	**(10.7)**	**(10.5)**
Total Assets Less Current Liabilities	**154.9**	**162.9**
Non-Current Liabilities	(10.3)	(10.6)
Borrowings	(77.4)	(73.2)
Total Non-Current Liabilities	**(87.7)**	**(83.8)**
Total Assets Employed	**67.2**	**79.1**
Taxpayers' Equity		
Public Dividend Capital	79.0	78.0
Income & Expenditure Reserve	(45.1)	(40.3)
Revaluation Reserve	33.4	41.4
Total Taxpayers' Equity	**67.2**	**79.1**

In cash terms, planned changes are in the level of borrowings and capital, due to the land sale adjustment.

Table 6 – 2018/19 cash summary : initial to revised plan

	Initial Plan £m	Revised Plan £m
Opening Cash	**7.9**	**8.0**
Income & Expenditure Surplus/(Deficit)	(29.2)	(25.3)
Non-Cash & Financing Items	12.0	12.3
EBITDA	(17.2)	(13.0)
Working Capital Movements	(2.1)	(0.5)
Capital Expenditure (Cash Basis)	(10.9)	(12.4)
PDC Dividends Paid	(2.1)	(2.3)
PDC Received	0.5	0.5
Interest & Finance Lease Flows	(2.3)	(1.9)
Loan Repayment	(1.0)	(1.0)
Loan Drawdown	29.0	25.0
Closing Cash	**1.8**	**2.2**

4. Risks

The table below identifies the potential risks and issues associated with delivery of the plan.

Risk
As a result of not accepting the Control Total the Trust would be liable for penalties for RTT and A&E. The plan does not include any provision for any such penalties being levied
No Winter support has been included in the plan. This means that without adequate preparation across the Health Economy there is potential for deterioration in elective plans during the winter period
Escalation wards have been funded at January 2018 run rates, further escalation could lead to increased costs at premium rates
The Capital allocation has been reduced for return of the land sale receipts. In order to meet capital investment requirements the Trust will,potentially need to apply for capital loans
No central direction has been issued regarding the National Pay Award. The plan includes a 1% allocation. If the pay award was to exceed this level without any central mitigation there may be exposure to an increased financial risk

5. Conclusion

The Trust has been set an ambitious and challenging control total for 2018/19. The respective total has been set with the assumption that the Trust has delivered the recurrent 2017/18 plan. As a result of this not being achieved the Trust is not in a position to accept the Control Total for 2018/19.

The Trust will require significant cash support during the year to pay for operational costs as a result of the planned deficit.

The current plan is underpinned by the delivery of a £11.0m CIP. The CIP represents c3% of the Trust's turnover and is 1% more than planning guidance identifies.

6. Recommendations

The Board are asked to

- Consider the revisions to the financial plan for 2018/19
- Agree the revised planned deficit at £25.0m
- Approve submission of this revised position to NHSI in line with the 30th April deadline

Gareth Lawrence
Acting Director of Finance
April 2018

Board of Directors	
Agenda Item	8.1
Title of Report	Report of the Finance, Business Performance and Assurance Committee – 20 April 2018
Date of Meeting	25 April 2018
Author	Sue Lorimer, Chair of the Finance, Business Performance and Assurance Committee
Accountable Executive	Gareth Lawrence, Acting Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	4, 7, 8 4a, 7a, 7b, 7d, 8a, 8c, 8d, 5, 6, 7, 8, 9, 16, 17, 20
Level of Assurance • **Positive** • **Gap(s)**	Gaps with mitigating action
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion
Reviewed by Assurance Committee	Not applicable
Data Quality Rating	Not applicable
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	Not applicable

Report of the Finance, Business, Performance and Assurance Committee 20th April 2018

This report provides a summary of the work of the FBPAC which met on 20th April 2018.Key focus areas are those which address the gaps in assurance in the Board Assurance Framework.

1. Chair's Business

   Sue Lorimer welcomed Tracey Fennell, Deputy Director of Nursing to her first meeting of the committee, representing Gaynor Westray. She also thanked Gareth Lawrence [GL] for his valuable input to the committee as Acting Director of Finance and wished him good luck for his new role at St Helens and Knowsley Hospital NHS Trust. The committee welcomed

the shorter pack of papers but understood that some of the reduction was due to the finance and performance reports being in a state of transition to the new format and that these would be presented to the Board of Directors on 25Th April.

It was noted that workforce assurance would now pass to the new Board subcommittee which was meeting on 4th May and that this committee's terms of reference would be reviewed as part of the review of trust governance currently under way.

2. Board Assurance Framework

There was no BAF update as the BAF is being reviewed along with the governance arrangements of the trust.

3. M12 Financial Position

The committee received a presentation from GL and noted that in general performance remains on course to achieve the revised forecast outturn deficit position. However, GL informed the committee that he had been notified by NHSI of a potential distribution of STF for 2017/18 which might improve the final outturn slightly. He commented on capital expenditure which had ended the year at £13.6m which is an underspend of £0.6m.The committee voiced concerns about the potential inefficiency of spending circa £8m capital in the last month of the year and the fact that because of the trust's cash deficit underspent capital budget can't be carried forward. The committee were assured that the executive team have now changed the capital process for 2018/19 and a mid-year review would be conducted in future with unspent capital being reallocated to other schemes.

The committee noted a cash balance of £8m at the year-end due largely to a land sale receipt of £4.5m. The trust has been informed by NHSI that this receipt must be used to reduce the 2018/19 borrowing requirement.

4. 2018/19 Contract with Wirral CCG – Post-Mediation Update

The committee reviewed a paper setting out the contract position subsequent to mediation discussions with Wirral CCG. There had been a positive outcome for the trust in readmission penalties, Neuro Rehabilitation, RTT and QIPP. In particular the contract will now include RTT performance at 80% and the elimination of 52 week waiters which will enable the trust to improve its performance in this area. The contract value had improved by £7.2m from the CCG's proposal and this would have a positive impact of £1.7m on the trust's financial plan for 2018/19. There were a number of actions agreed during the mediation process and formalised in an MOU between the two parties. The committee requested an action plan from executives setting out the actions with timescales and accountability in order that progress is visible and issues can be escalated if there are problems in implementation of the MoU. In particular, there were a bundle of actions agreed with regard to non-elective activity and tariffs with an agreement to implement the outcome retrospectively from 1st April 2018.

5. Financial Plan Update 2018/19

The committee received a presentation on the financial plan for 2018/19. The proposed deficit had reduced from £29m to £25m due to increased income from commissioners (£1.7m), an increase to the cash value of the CIP of £1m resulting in an £11m CIP equivalent to 3% of expenditure and other adjustments of £1.3m. The committee welcomed the improvement but noted there was still a considerable distance from NHSI's control total

offer of £1m deficit. The committee discussed the risks associated with not accepting the control total but agreed that currently the organisation did not have plans sufficient to close the considerable gap and that therefore savings above a 3% CIP would not be achievable.

The committee was clear that it would recommend the plan to the Board of Directors but there would have to be rigorous budgetary control in 2018/19 as there was no scope for further overspend, particularly as budgets had been funded at the expenditure run rate experienced in 2017/18. It was also agreed that any further positive outcome on income would be credited to the bottom line deficit and not used for further investment.
The committee noted that the land sale receipt of £4.5m had been taken out of the capital programme at NHSI's instruction to support the cash position and reduce borrowings.
GL agreed to provide for the Board of Directors details of the financial risks inherent in non-acceptance of the control total for 2018/19.

6. Update on Wirral Millennium Business Case – Contract between Cerner and COCH and Fast Follower arrangements

PC took the committee through the progress made on the Cerner contract by COCH and confirmed that the COCH board had agreed to sign up to the contract. The trust now needs to sign a MoU with COCH and issue a VEAT notice to extend our own contract as previously agreed by the Board in principle. The committee discussed the risks and benefits and requested that the risk mitigation scheduled was strengthened and the wording firmed up in order for the Board to review on 25th April. The committee also requested that there was a clear statement about any residual financial risk the trust would carry if COCH pulled out of the contract. PC agreed to this and on that basis the committee agreed to recommend the proposal for a contract extension to the Board.

7. CIP 2018/19

JH took the committee through a comprehensive presentation on CIP plans for 2018/19. She explained how the divisional teams had been given clear ownership of their targets and would be performance managed on achievement as part of divisional performance reviews. The committee noted that of the £11m target £3.8m was unidentified but the executive team expressed confidence on this being addressed over the next few weeks. The committee welcomed the change in process and the enhanced accountability of the new divisional management teams.

<u>Integrated Performance Dashboard</u>
The committee reviewed the performance dashboard and noted that a new format would be submitted to the next Board meeting. The committee noted that A&E performance at 84.9% and ED performance at 63.22% had continued to slip since January. JH informed the committee that she has requested a review of the key metrics agreed as part of the Ernst and Young work to ensure that trust staff were still complying with agreed processes. She also confirmed that patients waiting were reviewed regularly. RTT performance was 73.07% with 69 patients waiting over 52 weeks. This will improve as a result of the new contract agreement with Wirral CCG. The trust awaited a review of the 6 post-72 hour c-difficile cases reported in March in order to confirm how many of these were avoidable and how the trust had performed against its target at year end. The committee noted there was one MRSA case in March.

The committee noted the Diagnostics 6 week standard is expected to be achieved and the trust continues to perform well against Cancer standards.

8. Update on Reporting Format

   The committee were pleased to note that the new reporting format had been developed and a draft would come to the next Board meeting. It would enhance divisional and executive accountability in all areas and would be key part of improved governance and controls at the trust.

9. Reports from Group Meetings

   The committee received a written report from the Digital Wirral Programme Board and verbal reports from Finance and Performance Group and Information, Information Governance and Coding Group.
   PC agreed to bring a report to next FBPAC on proposed actions to improve mandatory training in Information Governance.

10. Items for the Risk Register or Internal Audit Plan

    Risks to be discussed at the Board related to:
    - non-acceptance of the financial control total for 2018/19 in terms of contract penalties and lack of access to capital
    - GDE fast follower arrangement between the trust and COCH.

11. Recommendations to the Board

    The committee agreed to recommend to the Board:
    - Approval of the 2018/19 financial plan
    - Approval of a VEAT to extend the trust's contract with Cerner and an MOU with COCH.

Sue Lorimer
Chair of Finance, Business Performance and Assurance Committee
25.4.2018

BOARD OF DIRECTORS	
Agenda Item	8.2
Title of Report	Chair of Audit Committee Report
Date of Meeting	25 April 2018
Author	John Sullivan, Acting Chair of the Audit Committee
Accountable Executive	Gareth Lawrence, Acting Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	All
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion
Reviewed by Assurance Committee	Not applicable
Data Quality Rating	Not applicable
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	Not applicable

Board Assurance Framework

The committee noted the updated Board Assurance Framework (BAF) and that it provided adequate assurance. Grant Thornton stated that of the BAFs they see, the WUTH BAF is one of the better ones. However the committee also supported greater future transparency on the updating methodology used as well as more use of summary points (less narrative text) and more critical appraisals of mitigation actions (that do not reduce risk scores).

Draft Annual Governance Statement

David Jago, Acting Chief Executive, was in attendance for part of the meeting and presented the first draft of the Annual Governance Statement. The committee recommended that the financial position feature more explicitly in the statement. David Jago took away a number of comments and suggestions on revised wording. The committee also agreed that Carole Self, Director of Corporate Affairs will meet with Grant Thornton and capture their comments on the first draft.

The subject of significant internal control issues was discussed. The committee concluded that as the NHSI have invoked conditions relating to workforce governance and resulting culture, that we now acknowledge a significant internal control issue. In response the Trust is establishing a new Workforce Assurance Committee reporting to the Trust Board.

Management responses to Grant Thornton

A schedule of responses from Management were discussed and accepted by the Committee.

Financial Assurance Report

The committee sought and received assurance on the £1million Wirral CCG debt. The committee sought and received assurance regarding the single tender waiver applied to Spire Healthcare (£400k).

Licensee Undertakings

The committee reviewed the new undertakings that took effect from 28th March 2018. An updated compliance checklist will be presented back to Audit Committee in May 2018.

Data Warehouse MIAA Review

The committee reviewed the MIAA Data Warehouse Review Assignment Report 2017/18. Paul Charnley, Director of IT and Information, was in attendance and described the management responses to the recommendations. The committee agreed that MIAA follow up work on the management actions will take place within the next 6 months.

MIAA Internal Audit Items

The 2018/19 Internal Audit Plan was discussed and approved. The committee was reassured that items arising from the new Workforce Assurance Committee could be accommodated later in the plan.
The 2017 /18 Internal Audit Progress Report was reviewed by the committee.
The Head of Internal Audit Opinion for 2017/18 was received by the committee. The overall conclusion is one of 'Substantial Assurance for 2017/18'. This opinion will inform the completion of the Trust's Annual Governance Statement.
Substantial Assurance is given because there is evidence of a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently. The committee was assured by MIAA that the Trust has a strong record of reacting positively and with action to internal audit findings when they arise.

Anti - Fraud items

The Anti-Fraud Plan for 2018/19 was reviewed and approved.
The MIAA Anti-Fraud Services Annual Report 2017/18 was reviewed. The committee were reassured to hear that the Trust's current compliance level with the 2017/18 standards were self-assessed overall as 'green' indicating a high level of compliance.

Internal Audit Follow Up Report

The committee acknowledged that the report was currently a work in progress. The committee did recommend that completion dates appear more explicitly, both 'completed by' and 'to be completed by' dates.

External Audit Progress Report

Grant Thornton (GT) verbally reported no issues to date with yearend processes and that yearend accounts are due next Tuesday (24 April 2018). However, GT also stated that they are inclined to give a 'qualified' Value for Money (VFM) conclusion for the Trust. This is a deterioration from last year and was discussed at a GT National Consistency panel last week. GT's outline position on VFM is to be further informed by more benchmarking on Family & Friends Tests data and the 2017 Employee Survey results. GT pointed out that they have not observed systemic issues but have noted isolated issues which are driving their current VFM position conclusion.
Grant Thornton were invited to the special Trust Board meeting on 25 May 2018 to explain their Value for Money conclusion and the evidence leading to their conclusion.

John Sullivan
Acting Audit Committee Chair.

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Board of Directors and Senior Managers - Register of Interests

April 2018

Name	Position	Nothing to Declare	Description of Interest
Sir David Henshaw	Chair		Chair of Alder Hey Children's NHS Foundation Trust and Chair of National Museums Liverpool.
John Coakley	Non -Executive Director	✓	
Graham Hollick	Non -Executive Director		Aston University - Private Placement Tutor and Skills Coach, two separate departments/portfolios.
Sue Lorimer	Non -Executive Director		Employed by Greater Manchester Health and Social Care Partnership until 20/05/18 for 2.5 days per week as Senior Transactions Adviser. Partner now Acting Director of Finance at Clatterbridge Cancer Centre NHSFT.
John Sullivan	Non -Executive Director		Director and co-owner of ICTAN Limited (Management Consultancy).
David Jago	Acting Chief Executive	✓	
Gaynor Westray	Director of Nursing and Midwifery		Sister is Assistant Practitioner at WUTH Sister is Therapy Assistant as part of ESD at WUTH Sister is Deputy Shop Manager in League of Friends shop
Janelle Holmes	Chief Operating Officer		Husband Anthony Holmes – Senior Manager at Salford Royal Foundation Trust

Name	Position	Nothing to Declare	Description of Interest
Susan Gilby	Medical Director	✓	
Gareth Lawrence	Acting Director of Finance	✓	
Paul Charnley	Director of IT and Informatics		Owner/MD of HI4PC Ltd previously used to work as Interim CIO. Not active, waiting for end of Company's financial year to then close down.
Helen Marks	Interim Director of Workforce	✓	
Anthony Middleton	Director of Operations and Performance	✓	
Pippa Roberts	Director of Pharmacy and Medicines Management	✓	
Carole Ann Self	Director of Corporate Affairs	✓	
Terry Whalley	Director of Strategy and Sustainability		No response provided
Dr Mark Lipton	Deputy Medical Director		Spire Murrayfield – admitting rights, but no routine lists or clinics. Society of Radiographers – wife: Professional Officer for Managers, MRI and CT.
Tracy Fennell	Deputy Director of Nursing and Midwifery	✓	
Dr Ranj Mehra	Associate Medical Director - Surgery	✓	
Jo Keogh	Divisional Director - Surgery	✓	
Naomi Holder	Associate Director of Nursing - Surgery	✓	

Name	Position	Nothing to Declare	Description of Interest
Mr Mike Ellard	Associate Medical Director – Women and Children's Services		IVI Cheshire – salaried consultant. Spire Murrayfield – private practice.
Debbie Edwards	Associate Director of Nursing – Women and Children's services		QA Assessor for Public Health England for the Antenatal and Newborn Screening Programme.
Gary Price	Divisional Director – Women and Children's Services		Governor at West Kirby Primary School Staff Governor at Ronald McDonald House Charity Royal National Lifeboat Institution Crew member
Dr Nicola Stevenson	Associate Medical Director – Medical and Acute Specialities	✓	
Julie Reid	Associate Director of Nursing - Medicine	✓	
Nicky Martin	Associate Director of Nursing - Acute	✓	
Shaun Brown	Divisional Director – Medical and Acute Specialities	✓	
Dr Simon Lea	Associate Medical Director – Diagnostics and Clinical Support		Cook Medical – employed as a Proctor with private income and travel to present training. Gore Medical – Course Leader.
Alistair Leinster	Divisional Director - Diagnostics and Clinical Support		Brother works for Allocate (system that provide e-rostering and job planning database)