Wirral University Teaching Hospital NHS
NHS Foundation Trust

Board of Directors
Public Board

7th February 2018

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MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 7th FEBRUARY 2018

COMMENCING AT 9.30AM IN THE

BOARD ROOM
EDUCATION CENTRE, ARROWE PARK HOSPITAL

AGENDA

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

5. Quality and Safety

5.1	**Bi Monthly Nurse Staffing Report** Chief Operating Officer / Interim Director of Nursing & Midwifery	d
5.2	**Mortality Dashboard** Medical Director	d
5.3	**Annual Infection Prevention and Control Report** Chief Operating Officer / Interim Director of Nursing & Midwifery	d

6. Performance and Improvement

6.1	**Integrated Performance Report**	
	6.1.1 Integrated Dashboard and Exception Reports Director Of Operations	d
	6.1.2 Month 9 Finance Report Acting Director of Finance	d
6.2	**NHS Improvement Quarterly Return** Acting Director of Finance	d

7. Governance

7.1	**Report of Finance Business Performance and Assurance Committee** Chair of Finance and Business Performance Assurance Committee	d
7.2	**Chair of the Audit Committee Report** Chair of the Audit Committee	d
7.3	**Report of the Quality and Safety Assurance Committee** Chair of Quality and Safety Assurance Committee	v

7.4 Board of Directors

7.4.1 Minutes of the Previous Meeting – 29th November 2017 d

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Director of Corporate Affairs

8. Standing Items

8.1 Items for BAF/Risk Register v
Chairman

8.2 Items to be considered by Assurance Committees v
Chairman

8.3 Any Other Business v
Chairman

8.4 Date and Time of Next Meeting v
Wednesday 28TH February 2018

Board of Directors	
Agenda Item	4
Title of Report	Chief Executive's Report
Date of Meeting	31st January 2018
Author	David Jago, Acting Chief Executive
Accountable Executive	David Jago, Acting Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	ALL
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To Note
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

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

- **NHSI Investigation**

NHSI have requested a formal investigation be carried out led by an independent investigator Carole Taylor Brown. The terms of reference for the investigation are set out below;

(i) investigate concerns raised by members of Trust staff in late 2017 with NHS Improvement regarding cultural, behavioural and governance issues at the Trust;

(ii) review the Trust's handling of a recent disciplinary case involving allegations of sexual misconduct;and

(iii) consider NHS Improvements' response to the concerns raised with it per (i) above

The Board of Directors welcome this investigation and will work with NHS Improvement and the independent investigator.

Wirral & West Cheshire Acute Care Alliance

The joint executive steering group between both organisations met on 15th January and took the opportunity to do a "look back" on the alliance work and activities so far with a view to reset and agree the work programme for 2018 onwards including agreement on a number of principles of how we will work together.

Healthy Wirral

As reported previously to the Board of Directors over the last few months Wirral as a system has been working to address the financial and performance challenges it faces through a number of 'lock-in' sessions with senior leaders across health and social care with the common goal of developing a 3 year system financial and clinical sustainability plan.

We continue to make progress with Healthy Wirral partners. The Independent Chair role, agreed by all as crucial to resetting both governance and decision making frameworks and for then holding to account those who need to take forward the agreed decisions and actions, is out to advert. The intention is to complete this recruitment quickly and then confirm arrangements for Programme Director.

The CCG have circulated their draft Commissioning and Transformation Strategy, which outlines the commissioning intentions for Wirral Integrated Commissioning. The Strategy shares high level detail of the commissioning plans to move towards a place based care system (PBCS) by 2020/21. Before the Strategy is formally adopted by the CCG and the Local Authority they have invited views on their intentions and in particular the stepped changes towards PBCS and the high level outcomes included within the Strategy. Once they have reviewed comments the CCG and LA will develop a document that is more suitable for the public and ask for their comments on our future health and care commissioning plans. After this the document will be amended as appropriate following comments from stakeholders and public and then discussed with a view to formal adoption by the Local Authority and CCG.

The last session was held on the 23rd January where I am pleased to report that as a system we are increasingly 'acting as one' working alongside our NHS England and NHS Improvement colleagues to drive forward meaningful and sustainable change for our population.

Health & Care Partnership for Cheshire & Merseyside

A System Management Board has been established with the main purpose being to drive the co-created, shared vision across organisational and professional boundaries using a collaborative leadership approach. The Board will hold to account the programmes it commissions, additionally it will seek out and identify further opportunities where a system-wide solution can be brought to C&M health and care functions. It will consist of:

- The Executive Team with STP Lead(chair)
- 3 x commissioners
- 3 x providers
- 3 x local authority

A Transformation Fund is to be established in 2018/19 via a levy to Commissioners totalling £7.0m with and additional £0.9m coming from providers. The funds will only be used to support the agreed STP programme. The majority of funds will be re-invested into Place –based Care footprints. “Eligibility” criteria will include;

- Voluntary participation in Capped Expenditure programme “lite”
- Clear and credible Place-based model of care
- Realistic but challenging Place implementation plans ,timescale and clinical /financial outcomes
- Evidence that allocated funding will increase the pace of change.

Health & Care Partnership for Cheshire & Merseyside
This is a key strategic programme running across Cheshire & Merseyside with Tracy Bullock CEO at Mid Cheshire NHS Trust as the programme SRO. The programme has recently undergone a Readiness Assessment with a methodology;

- Designed to test the Programme’s readiness to develop and deliver a proposal for sustainable acute services in Cheshire & Merseyside.

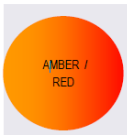
- Based on the NHS Gateway Review methodology previously used for high risk programmes / prior to public consultations.

- Peer review process – final assessment based on judgement not science

Key stakeholders were interviewed by the NHS Transformation Unit and KPMG ith the following topics being covered;

- General views on the Acute Sustainability Programme;
- Involvement and engagement of service users;
- Communications;
- Decision Making and Governance;
- Finance;
- Leadership/Involvement and Ownership of proposals by key system stakeholders, and;
- NHS England Assurance

The overall assessment based on the interviews was:



Successful delivery of the Project/Programme is in doubt with major risks or issues apparent in a number of key areas.

Urgent action is needed to ensure these are addressed.

2018/19 Planning
Currently there has been no planning guidance issued, but it is anticipated that planning guidance will be issued before the end of January; this is likely to request final planning submissions by 4th April with an initial draft submission some weeks before. This will be a refresh of the 2 year plan already submitted but noting agreement reached in regard to the Trusts’ 2017/18 control total. We continue to work up our aims & objectives for 2018/19 to frame a prioritised set of initiatives with a focus on delivering as part of clinical and financial sustainability challenge. We are working with colleagues to encourage “bold thinking” about the kind of work we need to do that is transformative within our organisation and in collaboration with Wirral partners and beyond. A first view on this will be brought to the Board of Directors for consideration in February.

Influenza Update
Flu is currently prevalent within the Wirral community with a number of confirmed inpatient cases within the Trust. On average there are currently c 40 patients in hospital at any given time. In response extra vaccination sessions have been put on at times to suit all shifts and the dial a jab service has been in operation, 80% of our staff have been vaccinated and the remaining staff are being encouraged to contact Occupational Health to be vaccinated to protect themselves and our patients.

National Emergency Pressures Panel
Shortly before Christmas the Trust received recommendations from the national lead for Urgent and Emergency Care following a meeting of the National Emergency Pressures Panel. Amongst the recommendations were:

- The expectation that non-urgent inpatient elective care should be deferred until mid-January to ensure beds and staff are available for the sickest patients. By acting early Trusts can avoid last minute cancellations that can be costly and inconvenient for patients.
- Day-case facilities should be used flexibly. Many could be used to provide inpatient care to help with the expected surge. Where this is not possible, day case procedures should be ramped up to take pressure off in-patient beds.
- Routine follow-up clinics could be converted into 'hot clinics' providing specialist care to patients referred by GPs to take pressure off of A&E units, for example, for respiratory conditions which peak in winter.
- Individual organisations should move as quickly as possible to use the additional money from the Budget and allocated last Friday to open extra beds and services.

The Trust has implemented the above recommendations and notes the NEPP would expect to review the situation in mid-January and make further recommendations on elective activity as needed. As no further update has been provided and given continuing high levels of urgent and emergency activity the Trust will continue deferral of non-urgent inpatient elective care and will review this situation on a weekly basis.

Published Urgent Care Pathways
From November 2017 the NHS has been publishing urgent care 4 hour performance at a health economy level, as well as at individual organisational level. For the Wirral economy this means the aggregation of both Wirral University Hospitals NHS Trust and Wirral Community Trust. This in no way affects the overall national performance level as it is purely a presentational issue, but rather a move to ensure consistency when different economies are compared. There has been a long standing national debate that some economies have traditionally included community services in acute trust submissions and comparisons are therefore inequitable, but also that it creates a perverse barrier to service model change which could be at the detriment on one organsations published performance.

More recently communication has been received from NHSI regarding the recognition of newly developed urgent care services which to date have gone unrecorded. There are two such services on the Wirral, namely the Parkfield and Miriam health centres which offer urgent care access and the economy is working with NHSI to see whether they should now be included.

David Jago
Acting Chief Executive
January 2018

Board of Directors	
Agenda Item	5.1
Title of Report	Nurse Staffing Report November / December
Date of Meeting	31/01/18
Author	Naomi Holder, Associate Director of Nursing , Surgical Division Denise Price, Interim Director of Nursing and Midwifery Johanna Ashworth-Jones, Senior Analyst Tracey Lewis, Head of Clinical Excellence & Organisational Development, Paul Kavanagh-Fields, Head of Clinical Practice and Improvement.
Accountable Executive	Janelle Holmes Interim Director of Nursing and Midwifery
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	1, 3
Level of Assurance **Positive** **Gap(s)**	Gaps
Purpose of the Paper **Discussion** **Approval** **To Note**	For information and discussion.
Reviewed by Executive Committee	No
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken **Yes** **No**	No

1 Executive Summary

This report provides the Board of Directors with information on Registered Nurse / Midwives and Clinical Support Workers, drawn from a range of staffing data and information including vacancy rates and staffing related incidents for November & December 2017.

2 Recruitment

At present there is an absence of a credible and robust nursing and midwifery workforce strategy; however with the appointment of the Head of Clinical Practice and Improvement this work will be prioritised and presented back to Board for approval in March 2018.

Table 1: Trust Band 5 Registered Nurse data

		Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Trust	Establishment	676.00	676.00	676.00	676.00	676.00	676.00
	Actual WTE	591.82	580.86	575.12	581.8	590.86	590.77
	Vacancies WTE	84.18	95.14	100.88	94.2	85.14	85.23
	Vacancies %	12.45%	14.07%	14.92%	13.93%	12.59%	12.61%
Medicine and Acute	Establishment	457.81	457.81	457.81	457.81	457.81	457.81
	Actual WTE	398.21	396.04	389.86	392.57	394.33	400.35
	Vacancies WTE	59.6	61.77	67.95	65.24	63.48	57.46
	Vacancies %	13.02%	13.49%	14.84%	14.25%	13.87%	12.55%
Surgery	Establishment	154.85	154.85	154.85	154.85	154.85	154.85
	Actual WTE	134.89	130.32	131.56	133.97	138.51	134.27
	Vacancies WTE	19.96	24.53	23.29	20.88	16.34	20.58
	Vacancies %	12.89%	15.84%	15.04%	13.48%	10.55%	13.29%
W&C	Establishment	63.34	63.34	63.34	63.34	63.34	63.34
	Actual WTE	58.72	54.50	53.70	55.26	58.02	56.15
	Vacancies WTE	4.62	8.84	9.64	8.08	5.32	7.19
	Vacancies %	7.29%	13.96%	15.22%	12.76%	8.40%	11.35%

The trust vacancy rate for Band 5 Registered Nurses overall is <13% and has remained broadly static against a deepening national shortage of registered nurses. It is imperative that as part of the overarching work on the development of a nursing and midwifery workforce strategy, a strong retention plan is included to retain the current workforce and bring about positive and swift impact on the vacancy rate. This will be reported back to Board in March 2018.

Table 2: Trust Care Support Worker Data

Division		Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Trust	Establishment	513.76	513.76	513.76	513.76	513.76	513.76
	Actual Numbers	508.66	505.36	496.97	511.95	516.83	519.43
	Vacancies	5.1	8.4	16.79	1.81	-3.07	-5.67
	Vacancies %	0.99%	1.64%	3.27%	0.35%	-0.60%	-1.10%
Medical and Acute	Establishment	363.73	363.73	363.73	363.73	363.73	363.73
	Actual Numbers	358.04	354.68	351.45	364.6	367.89	366.73
	Vacancies	5.69	9.05	12.28	-0.87	-4.16	-3
	Vacancies %	1.56%	2.49%	3.38%	-0.24%	-1.14%	-0.82%
Surgery	Establishment	121.20	121.20	121.20	121.20	121.20	121.20
	Actual Numbers	116.49	117.55	112.39	113.08	114.48	117.93
	Vacancies	4.71	3.65	8.81	8.12	6.72	3.27
	Vacancies %	3.89%	3.01%	7.27%	6.70%	5.54%	2.70%
W&C	Establishment	28.83	28.83	28.83	28.83	28.83	28.83
	Actual Numbers	34.13	33.13	33.13	34.27	34.46	34.77
	Vacancies	-5.3	-4.3	-4.3	-5.44	-5.63	-5.94
	Vacancies %	-18.38%	-14.92%	-14.92%	-18.87%	-19.53%	-20.60%

The Trust overall does not have vacancies for the Care Support Worker (CSW) role. However it is imperative that as part of the overarching work on the development of a nursing and midwifery workforce strategy that a deeper understanding of the skill set associated with Band 1-4 CSW roles is fully understood in relation to the bigger skill mix discussion. This will be reported back to Board in March 2018.

Within the local community there is a ready supply of people wishing to start their careers in health. The responses to advertisements for substantive Care Support Workers (CSW) and apprenticeships often result in recruitment campaigns being closed early due to the high volume of applications. The Trust has minimised pressure on our nursing workforce by ensuring there are no vacancies at CSW level. As part of the overall nursing and midwifery workforce strategy, the Trust will be carrying out a skill mix review, this will include the feasibility of a backfilling hard to fill Band 5 registered nursing posts with suitably qualified CSW roles (Bands 1-4). This will be reported back to Board in March 2018.

3. Retention

During November / December, 15 Registered Nurses left the Trust, none of which completed an exit questionnaire or face to face interview. Trust policy states that it is the responsibility of the line manger to ensure that leavers are provided with an exit questionnaire after they receive their resignation but the responsibility for completion and return sits with the employee.

As part of the Nursing and Midwifery Staffing Sub Group work, there will be a focus on the development of a robust proactive approach to retention and completion of exit interviews.

4. Career Planning and development of new roles

Advanced Nursing and Midwifery Roles

A high-level gap analysis was undertaken with the support of the Director of Medical Workforce in 2012 that identified by 2017 WUTH will require a minimum of 46 ANPs who are fully qualified (MSc and non-medical prescribing) competent and confident to support current and future anticipated gaps in rota's using a multidisciplinary approach to provide safe and effective patient care. Since the strategy was agreed there has been a requirement to increase our medical workforce to support 24/7 working and meet the increasing demand from our patients and commissioners. 24/7 working has required an increase in the medical workforce to ensure safe staffing levels are achieved during the night and at weekends as well as in hours.

Following the evaluation of our Advanced Nurse Practitioner strategy 2012-17 the Trust will continue to invest and support this role in identified areas to support gaps in medical rotas at foundation level and above. It was recognised that the Trust has reached optimum level of Advanced Practitioners in all divisions with the exception of the emergency department. This work will be incorporated in to overarching work on the development of a nursing and midwifery workforce strategy and presented back to Board for approval in March 2018.

Nursing Associate

WUTH currently has six trainee nursing associates who commenced January 2017 and will support a further six trainees March 2018. The NMC are currently developing standards and discussions are underway regarding an apprenticeship opportunity from 2018 to support workforce development.

Work has commenced around the administration of medications within the Trust. We are awaiting further information from the NMC with regards to how the role will function upon qualification of the Nurse Associate.

The Trust will incorporate this role in to the wider nursing and midwifery workforce strategy. When the NMC has confirmed registration status for this new role, it will have clear benefits for registered nurses, providing additional support and releasing time to provide the assessment and care they are trained to do, as well as undertake more advanced tasks. This will ensure we use the right skills in the right place and at the right time. As part of the nursing and midwifery workforce strategy a decision will be made as to how these posts are substantially funded going forward within the available financial resource.

Registered Nurse apprenticeships

As part of the wider nursing and midwifery workforce strategy the Trust will support nursing degree apprenticeships to enable people to train to become a graduate registered nurse through an apprentice route.

Apprentices will study part-time in a higher education institution, for example Chester University and will train in a range of practice placement settings. These courses will be delivered by Nursing and Midwifery Council (NMC) approved local education providers and will be expected to achieve the same standards as other student nurses.

Senior clinical support worker - Advanced level apprenticeships

The Trust will continue to support current CSWs though advanced level apprentices to support staff to take on additional responsibilities such as supervising junior team members, taking physiological measurements and carrying out more complex clinical procedures (e.g. wound care). This will release NMC registrants to provide the assessment and care they are trained to give.

This role development will need to be evidence based and the outcomes evaluated to assure continuation of the delivery of high quality patient care on an ongoing basis. Again this role will be part of overarching nursing and midwifery workforce strategy.

5. Use of Existing Staff

Rostering

A project plan has been developed and commenced to ensure the Trust maximises the benefits of E Roster. The policy has been reviewed. As wards go live with their new updated rosters the managers will receive appropriate training and education on the KPI reports which will be commenced.

The E roster project group have written a project plan and all actions within that plan are in date. This work will be monitored through the newly established Nursing and Midwifery Staffing Sub Group (NMSSG) which will report in to the Workforce and Communication Group which reports to the Quality and Safety Committee.

As part of the overarching nursing and midwifery workforce strategy work will focus on the operationalisation of the E Roster process ensuring that all key stakeholders are involved in the governance and performance of this tool to ensure safer staffing levels are maintained within the resources available and that any issues can be escalated as required. Key stakeholders include Nursing, Midwifery, HR, Finance and temporary staffing.

To ensure that E Roster is a functioning and fit for purpose system, it is essential that it has the ability to interface with our temporary staffing partners (NHSp). By having an approved prospective roster (4weeks) in advance (8 weeks) on a rolling basis enables control measures (rules) to be adhered to. It also enables temporary staffing to fill any identified

staffing shortfall more successfully. Work on the interface is currently underway; however the Trust will also have to ensure that:

1. ESR and Finance ledger are reconciled.
2. Evidence based Ward Staffing Templates are agreed.
3. Nurse Staffing Establishment review panels are completed.
4. Agreed Ward Staffing Templates are built on E-Roster with consistent rules.
5. Training and Development programme for Ward Staff is delivered.

To enable robust quality and financial governance is maintained a Nurse Staffing Resource Panel will need to establish at a Divisional level. This work will be taken forward by the Head of Clinical Practice and Improvement and feedback to Trust Board in March 2018.

Temporary Staffing (NHS Professionals)

Overall demand for RNs in December 2017 was responded to by a fill rate of 39.1% by NHS Professionals (NHSp). This was a reduction of nearly 10% on the short fall fill rate of November 2017 (48.8%).

Reasons that have been offered for this dip in performance have attributed to late cancellations of shifts that have been booked through NHSp. This is further compounded by the reduced ability to fill RN shift requests in the out of hour's period.

The project to interface the NHSp system with the E-roster system has commenced and is being led by the Assistant Director of Workforce. This will assist in increased controls and strengthened quality of information.

The ability of NHSp being able to meet the temporary staffing requirements is under scrutiny and the contractual indicators will be reviewed by the Head of Clinical Practice and Improvement as part of the overarching nursing and midwifery workforce strategy, an update will be provided to Board in March 2018.

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 one for fill rates by clinical area for November and December 2017.

The Trust has developed a locally agreed RAG rating for staff fill rates. Ward M2 Ortho and Ward 12 fill rates whilst RAG rated as Red had safe staffing in place, fill rates are lower due to reduced elective activity and redeployment of staff to other clinical areas. CHPPD remains in line with previous data and are higher than general acute wards.

ITU and HDU have been RAG rated as Red during November for their fill rate however CHPPD remained at the appropriate levels required for these specialities. Safe staffing was in place at all times and in line with patient acuity. Staff were redeployed to support other areas of the Trust due to operational demand. This was recorded on a daily basis.

Ward 25 are RAG rated as Red for their fill rates during November and December however on review the establishment for the ward had been reduced to reflect the staffing required for safe patient care and will be captured on the January staffing data.

Ward 37's staffing was significantly influenced by a reduced fill rate for the RN day shift. However the ward had only 9 patients and was supported by ward 38 when required. Divisional assurance has been given that safe staffing was in place at all times.

Whilst staffing remained safe during November and December there is a reduction in the CHPPD in several areas month on month and a decline in the number of areas RAG rated as Green (above 95%). There were 15 wards in November with an additional 9 areas over 100%, compared with 11 areas in green and an additional 2 areas over 100% in December. This will be monitored closely alongside nurse sensitive indicators to ensure that quality care and positive patient and staff experience isn't compromised.

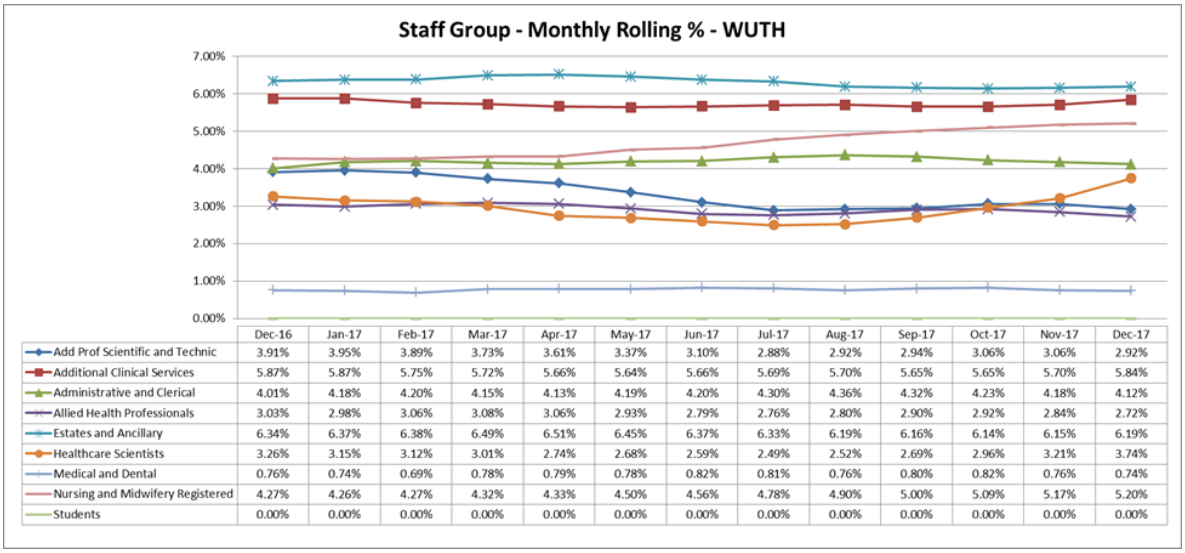
The fill rates are being closely monitored throughout January by the Associate Directors of Nursing and Midwifery within the Divisions as the challenges reported will be further compounded by additional escalation areas over and above those agreed for winter pressures (circa 40 beds).

Sickness

Sickness absence rates have demonstrated a month on month rise in the Registered Nursing/ Midwifery cohort of staff. The rolling 12 month absence data shows that performance is significantly above the trust target of 4% (5.20% for December17). Understandably this level of absence places further pressure on the workforce.

Work is progressing in HR in the form of a monthly drill down report that goes to the senior nursing team to increase understanding and visibility of the areas that are experiencing absence rates consistently above the trust target. This is further compounded by the lack of administration time available to Ward Managers as they are routinely included in the clinical numbers. This will be included as part of the overarching workforce strategy. It is anticipated there may well be a further rise in sickness absence in the nursing cohort to the impact of the current flu situation.

Table 3: Staff Sickness Levels



	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Add Prof Scientific and Technic	3.91%	3.95%	3.89%	3.73%	3.61%	3.37%	3.10%	2.88%	2.92%	2.94%	3.06%	3.06%	2.92%
Additional Clinical Services	5.87%	5.87%	5.75%	5.72%	5.66%	5.64%	5.66%	5.69%	5.70%	5.65%	5.65%	5.70%	5.84%
Administrative and Clerical	4.01%	4.18%	4.20%	4.15%	4.13%	4.19%	4.20%	4.30%	4.36%	4.32%	4.23%	4.18%	4.12%
Allied Health Professionals	3.03%	2.98%	3.06%	3.08%	3.06%	2.93%	2.79%	2.76%	2.80%	2.90%	2.92%	2.84%	2.72%
Estates and Ancillary	6.34%	6.37%	6.38%	6.49%	6.51%	6.45%	6.37%	6.33%	6.19%	6.16%	6.14%	6.15%	6.19%
Healthcare Scientists	3.26%	3.15%	3.12%	3.01%	2.74%	2.68%	2.59%	2.49%	2.52%	2.69%	2.96%	3.21%	3.74%
Medical and Dental	0.76%	0.74%	0.69%	0.78%	0.79%	0.78%	0.82%	0.81%	0.76%	0.80%	0.82%	0.76%	0.74%
Nursing and Midwifery Registered	4.27%	4.26%	4.27%	4.32%	4.33%	4.50%	4.56%	4.78%	4.90%	5.00%	5.09%	5.17%	5.20%
Students	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Data contained within the model hospital portal (latest data April 2017) highlights WUTH as an outlier for its sickness rates within Registered Nursing and Midwifery as shown in the table 4 below.

Table 4: Model Hospital

Staff Group	WUTH	National Average	Peers based on size and spend
Registered Nurses	4.4	3.7	3.7

Midwives	6.2	4.6	4.6
Care support workers	5.2	5.6	5.7

Staffing in times of Escalation

Ensuring safe staffing during periods of escalation can be a challenge, as mentioned previously during November and December additional areas were utilised to meet operational demand. Non ward based nursing staff have been released to assist inpatient escalation areas however this approach is inconsistent with limited understanding of the service impact this creates. In addition there is no formal standardisation or agreement currently in place. An initial proposal to correct this moving forward is currently out for consultation and will be included in the updated version of the 'Trust Escalation' policy when agreed.

Dependency and Acuity

In April 2017 full dependency and acuity audits were undertaken across all main inpatient wards. The result of these audits was used in conjunction with nurse sensitive indicators, workforce indicators and professional judgment to review establishment levels. As a result of this review several areas have partaken in the acuity and dependency audits again. These updated results will be analysed and shared as part of establishment reviews which will be undertaken with the Deputy Director of Nursing March 2018.

Specials

There is further understanding to be gained at pace regarding our patients who require 1 to 1 supervision. A recent review of some high level data is displayed below and is taken from the safe staffing sheets.

Table 5: Specials

November 2017 Data taken from staffing sheets								
Area	Day				Night			
	Specials requested	Specials supplied	Variance	% fill rate	Specials requested	Specials supplied	Variance	% fill rate
Overall trust total	193	81	112	42%	286	222	64	78%

Accessing live and accurate data regarding specials is not possible within the Trust, the current temporary staffing (NHSp) request system does not interface with E roster, therefore there may be times when unfilled demand remains in the NHSp request system but is filled by other routes, such as substantive staff overtime.

There is also no clinical documentation specifically related to provision/non-provision of 1 to 1 supervision within the electronic patient record, providing no auditable trail as to how the risk for the patient has been assessed and what level of care has been provided.

There is acute awareness that depravation of liberty applications is rising throughout the organisation and that this in turn will place further stresses within the nursing workforce. It is therefore essential that a clear strategy is developed to strengthen resilience and ensure safe care for patients. This will be a key work stream of the Nursing and Midwifery workforce strategy.

Ward sisters / charge nurses

Within WUTH Ward sisters and Charge Nurses should be 100% supernumerary. This provides capacity for clinical supervision and delivery of the Trust safety and quality key performance indicators. Evidence has shown that ward sisters have to step in to the numbers to provide clinical cover within the areas to maximise safe staffing. In light of this a data capture exercise was implemented to monitor the number of clinical shifts that Ward Sisters and Charge nurses are working (see table 6). As more data becomes available the Trust will be able to identify if this is an ongoing issue and in which wards.

Table 6: Supernumery Time for Ward Managers

Ward sister / Charge nurse (November 2017)		
0% to 20% Clinical shifts worked	**21%to 50% Clinical shifts worked**	**51% to 100% Clinical shifts worked**
18 wards (46%)	5 wards (13%)	16 wards (41%)

Quality data

Given the multiple challenges discussed at all points it is imperative that links are made to the quality metrics available across the organisation to understand if there has been or will potentially be an impact on patient safety.

As part of the overarching workforce review the data available from the integrated quality dashboard will be overlaid against areas that have documented deficits in actual versus planned staffing or areas that have altered skill mix against the recommendations of acuity and dependency reviews. It is anticipated that there will be further information shared in the next report to board.

6. Benchmarking

The consistent measure of nursing provision within the model hospital portal is Care Hours per patient day CHPPD. Table 7 below is the latest data available from within the portal which is for August 2017.

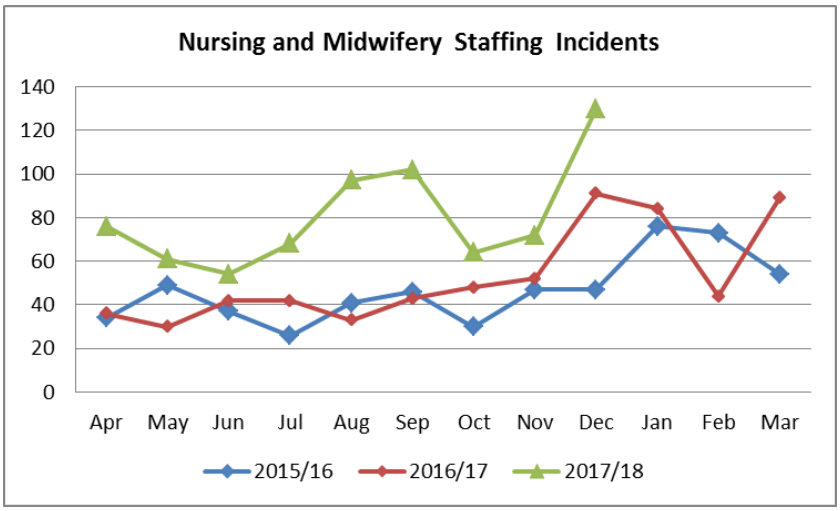
Table 7: CHPPD

	WUTH	National Average	Peers based on Trust size and spend
Total CHPPD	7.3	7.8	7.9
Registered Nurse	4.1	4.6	4.7
CSE	3.3	3.2	3.1

Work continues nationally and regionally to ensure that the data contained within the Hospital Portal is accurate and in line with Lord Carters recommendations. This will be taken forward through the nursing and midwifery strategy work.

7. Incident data

As displayed in the graph below Nursing and Midwifery Staffing incidents were recorded at their highest volume during December 2017 with 130 incidents recorded. Full analysis of staffing incidents is undertaken both at senior nursing levels and within divisions. Although the number of incidents increases the associated incident scores remain low with no harm. There was one incident recorded with a risk score of 6 during November with no subsequent other higher scored incidents. There were no incidents recorded with a risk score higher than a 4 in December.



As outlined in last nurse staffing report to Board, work has commenced to ensure the safeguard incident system can further categorise staffing incident data to display themes and trends to reflect the detail within the incidents. An update on this work will be reported in the next Board nurse staffing paper.

During this peak in reporting in December the areas with the most frequently reported incidents were – Ward 18, ITU, and ESAU.

Ward 18
A review of the incidents for this ward have identified that recorded incidents related to red flag incidents such as medicine dispensed late, additional pressure due to IPC patients with co-horting CPE and staff moves to other wards.

ITU
The majority of incidents recorded for this unit were in relation to staff being moved to support other areas. Staffing remained clinically safe at all times.

ESAU
ESAU had 14 recorded incident forms, several of these were “duplicate” incidents and predominately related to the resource input required to support a specific patient with complex cognitive needs who was also at risk of falling.

8. Next Steps

A robust Nursing and Midwifery workforce strategy will be presented to Board in March 2018. It will aid recruitment, retention and career pathway development for nursing and midwifery roles.

The second phase of the acuity and dependency data needs to be analysed and the annual audits need to be prepared to commence in April. This will be an integral part of establishment reviews which will be undertaken with the Deputy Director of Nursing March 2018.

9. Conclusion

Whilst the Trust's nurse vacancy rates are better than organisations that we are benchmarked against, sickness absence rates and CHPPD are sliding. We recognize that the model hospital data suggests that the spend for nursing is an outlier when reviewed against similar organizations, however this is due in part to the length of service of a high proportion of our nursing workforce.

There are emerging early indicators such as reduced fill rates, static elevated vacancy levels at ward level, reduction in supervisory status of our ward managers, increasing sickness absence and some wards experiencing a reduction in CHPPD that suggests significant focus is required in this area moving forward.

10. Recommendations

The Board of Directors is asked to receive this report for information and discussion.

Appendix 1

Nurse Staffing Fill rates November and December 2017

Orthopaedics	Indicators	Nov	Dec
Ward 10	CHPPD	6.6	5.9
	Fill Rate	93%	90%
Ward 11	CHPPD	8.3	7.5
	Fill Rate	104%	100%
Ward 12	CHPPD	7.8	7.1
	Fill Rate	85%	76%
M2 Ortho	CHPPD	9.4	9.5
	Fill Rate	68%	73%

Surgical	Indicators	Nov	Dec
Ward 17	CHPPD	5.7	5.6
	Fill Rate	96%	94%
Ward 18	CHPPD	5.8	6.3
	Fill Rate	94%	90%
Ward 20	CHPPD	5.4	5.5
	Fill Rate	96%	90%
ESAU	CHPPD	11.2	12.3
	Fill Rate	96%	96%
M2 surgical	CHPPD	14.6	18.4
	Fill Rate	100%	100%
Dermatology	CHPPD	9.6	10.1
	Fill Rate	92%	100%

Women's & Children's	Indicators	Nov	Dec
Children's	CHPPD	8.5	12.7
	Fill Rate	113%	126%
Maternity	CHPPD	6.5	6.8
	Fill Rate	84%	81%
Delivery Suite	CHPPD	42.4	41.1
	Fill Rate	100%	96%
Ward 54	CHPPD	6.2	5.9
	Fill Rate	91%	90%
Neonatal	CHPPD	13.2	15.4
	Fill Rate	101%	94%

Acute Care	Indicators	Nov	Dec
MSSW	CHPPD	6.3	6.1
	Fill Rate	87%	85%
AMU	CHPPD	9.7	9.1
	Fill Rate	97%	96%
EDRU	CHPPD	8.7	8.7
	Fill Rate	102%	103%
ITU	CHPPD	28.9	24.6
	Fill Rate	69%	78%

HDU	CHPPD	23.3	21.1
	Fill Rate	77%	97%

DME / Rehab	Indicators	Nov	Dec
Ward 21	CHPPD	6.5	5.1
	Fill Rate	104%	98%
Ward 22	CHPPD	5.6	5.4
	Fill Rate	98%	94%
Ward 23	CHPPD	6.5	6.3
	Fill Rate	95%	94%
Ward 27 (Ward 24) 6.1	CHPPD	5.7	5.7
	Fill Rate	95%	97%
M1 Rehab	CHPPD	4.5	4.2
	Fill Rate	92%	83%
CRC	CHPPD	6.2	5.9
	Fill Rate	98%	98%
OPAU	CHPPD	7.5	7
	Fill Rate	95%	93%

Medicine	Indicators	Nov	Dec
Ward 26	CHPPD	6.2	5.6
	Fill Rate	102%	93%
Ward 30	CHPPD	6.7	6.6
	Fill Rate	92%	88%
Ward 32	CHPPD	5.9	5.8
	Fill Rate	95%	94%
CCU	CHPPD	13.9	12.4
	Fill Rate	98%	92%
Ward 33	CHPPD	6.5	5.2
	Fill Rate	102%	82%
Ward 36	CHPPD	4.7	5.3
	Fill Rate	102%	92%
LAU / Ward 37	CHPPD	7	5.4
	Fill Rate	105%	75%
Ward 38	CHPPD	5.6	5.4
	Fill Rate	91%	87%
Ward 25	CHPPD	8.3	7.9
	Fill Rate	77%	75%
Ward 24 (IPC)	CHPPD	6.7	7.2
	Fill Rate	86%	92%

Public Board	
Agenda Item	5.2
Title of Report	Mortality Review & Dashboard
Date of Meeting	31/1/18
Author	Dr M Lipton: Deputy MD
Accountable Executive	Dr S Gilby: MD
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 and describes the process all hospitals should now follow.

2. Background

The Trust remains on course to meet the requirements of the NQB.

- The Mortality Review Policy was agreed at Trust Board in September 2017.
- The mortality dashboard for Q3 is included for review, prior to public board.
- Two consultants have been trained in structured judgmental review, (sjr). They will run a further training course in February for at least 10 consultants plus ~ 4 nursing staff. This will give the Trust the necessary reviewers to perform SJRs on 10% of all deaths.
- 20 deaths in Q3 need to have second line review either by SJR, RCA or Women's and Children's processes. 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.
- Primary mortality reviews are now fully electronic for medical staff, this occurred from November and the numbers have improved. There is a delay through the system as the case notes required by the audit department, to complete the forms prior to consultant review, are first reviewed by the coding department.

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 initial Q3 dashboard has been published. Therefore second line review for avoidable deaths will not be available for a significant number of cases. The Q3 dashboard will be updated at the time of the Q4 dashboard. Further admin support would reduce some of the delay.
- Announcement for SJR trainers is shortly to be made with the running of a training program in February.

4. Next Steps

- To progress above actions
- To train consultants for SJRs
- To review our dashboard against other trusts.

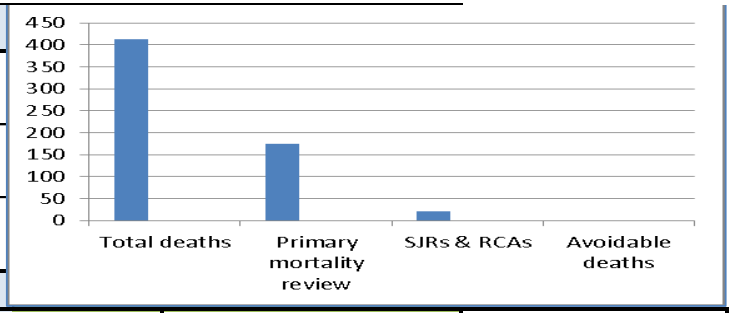
5. Recommendations

- 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		45, (49)*, (81)**		3, (17)*		0	
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, ()**-to be assigned



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	0	Q3	0	Q3	1	Q3	2
	Q4		Q4		Q4		Q4		Q4		Q4	
	This year (Q3)	0	This year (Q3)	0	This year (Q3)	0	This year (Q3)	0	This year (Q3)	1	This year (Q3)	2

Summary	Total actvity Q3 2017/18	Deaths Q3 2017/18
elective surgical patients:	18478	5
patients with severe learning disabilities	not available	0
patients with severe mental health needs	not available	0
Women's and Children's Hospital		4
Neonatal patients:	933	3
Births:	792	1
Mothers:	781	0

Avoidable deaths	0

(17 deaths still under investigation)

Narrative for "Learning from Deaths dashboard"

- At WUTH there has been 413 deaths in quarter 3, (1st of Oct – 31st of Dec 2017). This compares to 433 deaths in the same period of 2016.
- 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 Oct 16 – Sep17 is 91, (expected is 100, 2SD-86.3 to 95.6) 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 Apr16 to Mar 17 is 96, (expected is 100, 2SD-91.7 to 99.6) which means we are significantly better than what is expected by statistical analysis.
- Of the Q3 2017 deaths 45 have had a completed primary mortality review, 49 are in process and 81 need to be assigned for review. Thus it is expected that 42% of all deaths will be reviewed by the end of January. It is the Trusts aim to eventually have all deaths reviewed so areas where care could be improved are noted and acted upon. The primary mortality review has become electronic in November simplifying the process.
- 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.
- There have been, so far, 20 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 5 elective surgical deaths, 11 deaths undergoing RCAs and 4 deaths in Women's and Children's hospital.
- The Trust aims to eventually perform Strategic Judgemental Reviews on 10% of all deaths. We have 2 consultants trained at present and a program is in development to train many more including nursing staff.
- The Q3 dashboard will be updated at the time of the Q4 dashboard.

BOARD OF DIRECTORS	
Agenda Item	5.3
Title of Report	Annual Infection Prevention & Control Annual Report 2016/17
Date of Meeting	31 January 2018
Author	Lorraine Young, Infection Prevention and Control Team Leader
Accountable Executive	Janelle Holmes Chief Operating Officer / Interim Director of Nursing & Midwifery
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	1, 2, 12
Level of Assurance **Positive** **Gap(s)**	Positive
Purpose of the Paper **Discussion** **Approval** **To Note**	Approval
Reviewed by Assurance Committee	Note for Report Writers – Provide details of Assurance Committee review in the form of Committee name and date. Items which have not previously been presented to an Assurance Committee may be deferred until Assurance committee Review has taken place.
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

This is the 2016/17 Infection Prevention and Control (IPC) Annual Report. The purpose of this report is to provide an annual summary of the Trust's position and progress towards a

zero tolerance approach to Healthcare Associated Infection (HCAI) and to alert the Board of Directors to any significant problematic infection prevention and control issues within the organisation. It also outlines the progress, activities and achievements in infection prevention and control made by Wirral University Teaching Hospital NHS Foundation Trust.

The report describes progress toward the objectives to have zero avoidable Meticillin Resistant Staphylococcus aureus (MRSA) bacteraemia (table 2) and to achieve the *Clostridium difficile (C.difficile)* objective set by NHS England (graph 1).

The risk created by Carbapenemase Producing Enterobacteriaceae (CPE) has continued to threaten previous ways of working and as such, the report will demonstrate progress made with the planned CPE strategy.

In addition, the report will highlight the progress, activities and achievements made with infection prevention and control the previous year, identify areas that require further improvement and will highlight the key areas of focus for 2017/18.

2. Background

The implementation of robust, proactive IPC strategies have previously demonstrated a significant reduction in infection associated with MRSA bacteraemia and *C.difficile* and have supported the containment and management of the extremely difficult to control Norovirus. When WUTH reported the first case of CPE in May 2011, the Trust was compelled to introduce a CPE strategy to ensure patient safety.

The IPC Team (IPCT) has continued to promote and direct a proactive strategy to manage and contain this extremely difficult to treat organism, with the focus on prevention to avoid colonisation in the first instance and ultimately clinical infection and mortality.

3. Report Summary

3.1 infection Prevention and Control Team (IPCT)

- The IPCT continued to lead on the implementation of the IPC programme and provide expert advice regarding the prevention and control of infection
- There was recognition of the excellent work undertaken by the IPCT when they won the Nursing Time Awards and were shortlisted for the Health Service Journal Awards
- The Infection Prevention Operational Review Team (IPORT) met on a monthly basis to ensure that IPC remained embedded throughout the organisation; this team reported into the Hospital Infection Control Team (HICT)

3.2 Healthcare Associated Infection data

- There were 35 *C.difficile* infections apportioned to the Trust against a threshold of 29, with 13 of these deemed to be avoidable cases due to the identification of lapses in care
- There was 1 Trust apportioned MRSA bloodstream infection in 2016/17, compared with 3 the previous year

- There were 18 Trust apportioned Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections in 2016/17, demonstrating a slight reduction from the previous year
- There were 33 hospital acquired E.coli Bloodstream Infections reported in 2016/17. Due to technical and operational difficulties in submitting E.coli bloodstream infection data, it is not possible to accurately compare this with previous years
- Two categories of Surgical Site Infection (SSI) surveillance were included in the 2016/17 mandatory programme. A 1.4% surgical site infection rate was identified in total hip replacements, a reduction against the previous year. A 1.4% surgical site infection rate was reported in repair of neck of femur; an increase from the previous year when 0% was reported for this category
- There has continued to be a decrease in clinical infections due to CPE although the number of new colonisations has continued to increase
- There was one VRE bacteraemia reported during 2016/17 (haematology)
- Although Pseudomonas screening within the Neonatal Unit has continued to identify new cases of Pseudomonas aeruginosa and Pseudomonas putida, typing results have not indicated cross-transmission between babies
- During Quarters 3 and 4, a total of 16 wards were closed due to Norovirus, with 244 bed days lost. There were 195 symptomatic patients and 59 staff reported to be affected, with wards closed for an average of 8 days
- Between December 2016 and March 2017, the laboratory processed 533 flu test samples; of these, only 171 (32%) were positive
- In February 2017, following an investigation and subsequent diagnosis of an index inpatient with Norwegian Scabies in the Orthopaedic Directorate, a Scabies Outbreak was declared. No other patients developed scabies, however 21 staff required treatment due to symptoms. A total of 174 staff required prophylactic treatment and 458 patients received letters advising them of their potential exposure to Scabies

3.3 Antimicrobial Stewardship

- Audit data from throughout the year demonstrates that the proportion of WUTH patients prescribed antibiotics at any one time (averaging 33%) and adherence to, or appropriate deviation from the trust wide antimicrobial formulary (averaging at 96%) has remained fairly consistent from the previous year

3.4 Audit Activity

- Hand Hygiene compliance remained high during 2016/17, with an average compliance rate of 97% when staff were audited by the IPCT
- A trust wide audit to monitor compliance with ‘Vacation Cleaning’ was performed. This identified that only 45% staff were aware of the Standard Operating Procedure (SOP) for this process and only 8% patients had a corresponding, completed Vacation Clean SOP in their case notes (the latter providing evidence that the bed space had been decontaminated prior to their admission)

- A trust wide audit of commodes was performed and identified 44% of commodes as visibly soiled or in a poor state of repair. In addition, the audit identified that 41% of wards were not storing commodes in a clean area
- A Trust wide audit on the management of patients with diarrhoea was performed; this identified that 74% patients with unexplained diarrhoea were isolated, however for those patients not isolated, only one incident form had been completed and a review of the prioritisation for side rooms had not been undertaken in all cases
- A Trust wide Catheter Associated Urinary Tract Infection (CAUTI) audit was performed that identified a 15% prevalence of indwelling urinary catheters, with 4.5% of these patients being identified as having a CAUTI, a slight increase from the previous audit
- A Trust wide audit of hand hygiene facilities was undertaken that identified a number of issues in relation to the facilities available for current use throughout the Trust
- A Trust wide audit of water coolers and ice machines was undertaken. 33% of water coolers and 25% of ice machines were visibly soiled and staff who were questioned did not know if there was a maintenance contract for 33% of the water coolers and 55% of the ice machines
- During 2016/17, the IPCT performed 59 environmental audits, an improvement from the previous year. Only 25 (42%) of these scored 86% and over, achieving a gold status. 13 areas (53%) scored between 71% and 85% (sliver status) and 3 areas (5%) received less than 71%, a bronze status
- There was no evidence during 2016/17 that staff were monitoring High Impact Interventions (HIIs) regularly
- Mersey Internal Audit Agency (MIAA) undertook an infection prevention and control review in accordance with the requirements of the Internal Audit Plan; whilst this provided significant assurance, the review of water safety provided limited assurance

3.5 The Environment

- Hotel Services have continued to provide IPC related cleans as described in 'Which Clean do I Mean?' posters, with the exception of Vacation Cleans as there is no additional resource to support this
- The annual Patient Led Assessment of the Care Environment (PLACE) took place to assess wards, Outpatient areas, Accident and Emergency Department and internal/external common areas. For the cleanliness standard, WUTH scored 99.74% and 96.49% for condition, appearance and maintenance, scores that were above the national average
- There were several small capital schemes completed during 2016/17 which enabled bathrooms and shower rooms to receive upgrades and refurbishments as well as the first phase of refurbishment for the Wirral Neuro Rehabilitation Unit.

4. Conclusion

2016/17 was an extremely positive year for IPC, with the team receiving national and international recognition for the development of the CPE strategy, initially designed and developed to contain the outbreak that was experienced at WUTH. This has been

achieved alongside the reduction in avoidable *C.difficile* cases, however the Trust did experience one avoidable MRSA bacteraemia case against the zero tolerance standard.

New challenges are ahead in 2017/18, with the introduction of the national ambition to reduce Gram-negative Bloodstream Infections by 50% by 2021, with an initial quality premium to reduce E.coli bactereamias by 10% across the health economy.

A robust IPC surveillance system is essential in order to be able to monitor all healthcare associated infections and to identify the potential for outbreaks before they occur. To this end, it is crucial that an IT solution is secured.

5. Recommendations

The following recommendations aim to promote prevention of infection with early detection and control, as Multi Drug Resistant Organisms (MDROs) present a significant risk to patient safety, make it difficult to sustain the infection reductions already achieved, and significantly impact the day to day operations of the hospital.

- Develop surveillance systems to support effective delivery of a preventative IPC service
- Provide permanent onsite rapid testing, initially for CPE then consider extending to influenza and Norovirus
- Consider further 'compartmentalisation' of Ward 24 to release beds for step down patients
- Reinstate full ward HPV programme and compliment this with UV-C
- Re-establish the VRE strategy within the Orthopaedic Directorate
- Maintain the standard *C.difficile* strategy
- Maintain the standard MRSA strategy
- Maintain norovirus strategy
- Monitor VRE strategy
- Monitor Pseudomonas strategy
- Explore new ways of working

1. Infection Prevention and Control Arrangements

1.1 Infection Prevention and Control Team (IPCT)

The IPCT have continued to lead on the implementation of the IPC Programme and to provide expert advice about the prevention and control of infection.

There was recognition of the excellent work undertaken by the IPCT when they were shortlisted for the Nursing Times Awards and Health Service Journal Awards and went on to win the Infection Prevention and Control Nursing Times award.

The IPCT were also nominated for Team of the Quarter and were Divisional winners for Quarter 1 Team of the Quarter.

The work achieved by WUTH IPCT has been recognised world-wide with the Associate Director of Nursing for IPC invited to speak at conferences in Scotland and Hong Kong and the International CERNER conference in Kansas, USA.

Table 1: IPCT Establishment (including changes that have taken place during the year)

Post	Post Holder	WTE	Comment
Director of Infection Prevention and Control (DIPC)	Gaynor Westray		Also Director of Nursing & Midwifery
Associate Director of Nursing IPC Band 8C	Andrea Ledgerton	1.0	Also Tissue Viability Lead and Decontamination Lead
Infection Control Doctor and Consultant Microbiologist	John Cunniffe		
Senior IPC Nurse Band 7	Kerry Cotton	1.0	
Senior IPC Nurse Band 7	Sarah Deveney	1.0	
Senior IPC Nurse Band 7	Marie Bosworth	0.8	
Senior IPC Nurse Band 7	Lorraine Young	1.0	
Intravenous Access Nurse Band 7	Dave Wynne	1.0	
IPCN Band 6	Jisha Sabuji	1.0	
IPCN Band 6	Lucy Hill	1.0	Maternity leave until 13/03/17
IPCN Band 6	Ciara Ramsden	1.0	
IPC Support Band 5	Zoe Rushton	1.0	Maternity leave from 17/10/16
IP Information Analyst	Chris Hitchings	1.0	
IPC Assistant Band 3	Eileen McCutcheon	1.0	
IPC Assistant Band 3	Chris Ryan	1.0	Long-term sickness since 06/01/17 (Redeployed)
IPC Clerical Officer Band 3	Sue Arthur	1.0	

Redeployment process undertaken for one IPC Assistant (Band 3) in 2017

1.2 On call Service

The IPCNs continued to provide continuous infection prevention and control cover, available out of hours to provide information, advice and support. In addition, three Consultant Microbiologists provide continuous cover to support the IPCNs regarding clinical issues and associated advice.

2. Infection Prevention and Control Reporting Arrangements

2.1 Departmental/Divisional Infection Prevention and Control Groups

The following groups meet monthly supported by the IPCT, discussing IPC related issues and incidents whilst developing assurance reports for the Hospital Infection Control Team (HICT).

- Medicine and Acute Specialties
- Orthopaedics
- Special Surgery
- Surgery
- Theatres
- Women's and Children's

2.2 Hospital Infection Control Team (HICT)

The HICT met four times during 2016-17, receiving assurance reports from the groups identified in the last section, escalating issues that could not be rectified at the IPORT. Reports were also received from Estates and Facilities, Water Safety Group, Decontamination Group, Antimicrobial Pharmacist and HROD. If attendance at monthly IPORT improved, it was agreed that quarterly HICT meetings would be acceptable.

2.3 Infection Prevention Operational Review Team (IPORT)

The Infection Prevention Operational Team was convened to allow for a more operational meeting to take place to discuss the day to day aspects of IPC; this then allowed the HICT meetings to become more strategic.

IPORT met eight times during 2016-17 with Departmental/Divisional assurance reports submitted and discussed at each meeting. Outstanding actions from the reports, not able to be addressed by IPORT members, were escalated to HICT.

Meetings arranged for October and December 2016 and February 2017 were cancelled due to operational pressures/staff unable to be released to attend.

2.4 Clinical Governance Group (CGG)

The Associate Director of Nursing IPC provided a monthly report to the Clinical Governance Group, attending the meeting alongside the DIPC to present the IPC report to members. The Group also received the minutes from HICT.

2.5 Operational Management Team (OMT)

The Associate Director of Nursing IPC provided a monthly verbal report to the OMT, also attended by the DIPC.

2.6 DIPC Reports to the Trust Board: Summary

- MRSA bacteraemia and hospital acquired *C. difficile* were reported via the Trust's Performance dashboard
- Infection prevention and control summary reports were included in the monthly CEO report to the Board of Directors

3. Healthcare Associated Infection Data

The Trust is required to participate in the mandatory surveillance and reporting of:

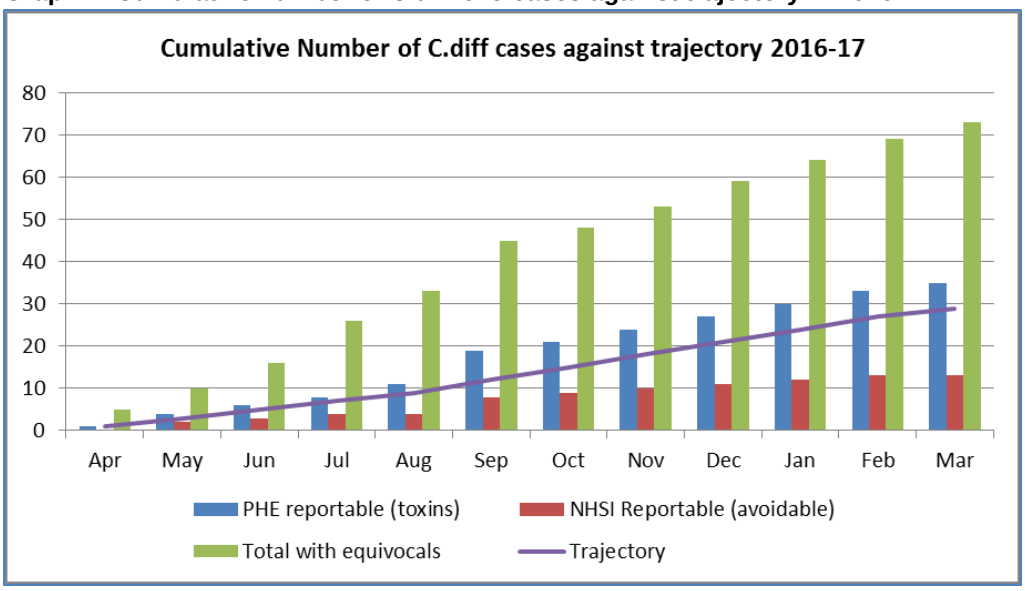
i. *Clostridium difficile*
ii. Staphylococcus aureus bacteremia, including MSSA and MRSA
iii. Escherichia coli (E-coli) bacteraemia
iv. Orthopaedic Surgical Site Infection

3.1 Clostridium difficile

Since 2014/15 all healthcare organisations have been required to assess each *C.difficile* case in order to determine whether the case is linked to a lapse in the quality of care provided to patients; consequently, commissioners were encouraged to consider sanctions for breach of *C.difficile* objectives where those cases were associated with lapses in care.

From April 2016 to end of March 2017, WUTH were working towards a *C.difficile* objective of no more than 29 toxin positive cases (the presence of toxins in a stool sample indicates *C.difficile* infection). By the end of March 2017, WUTH had reported 35 toxin positive cases, all of which were subject to a full Post Infection Review (PIR). The reviews identified that 13 of the 35 cases were avoidable. Common 'themes' included poor documentation, delayed sampling, delayed isolation and lack of assurance in relation to cleaning (both equipment and environmental).

Graph 1: Cumulative number of *C.difficile* cases against trajectory in 2016-17



The bridge of Ward 25 continued to be used for cohorting active *C.difficile* positive patients. In November 2015, refurbishment work was undertaken to improve the environment and increase the number of toilet facilities.

The Hydrogen Peroxide Vaporisation (HPV) decontamination programme was re-established in May 2016 and continued until November 2016. During this time, Ward 23 remained on the decant ward for approximately 8 weeks due to refurbishment work being undertaken. The resultant delay in the schedule meant that a total of 18 wards received full ward HPV decontamination.

Ward 27 was used as the dedicated decant ward, however this was replaced in November 2016 with Ward 19. Planning a ward decant to the new facility was challenging as the ward had only one side room. Although a second room could be utilised as a side room, it was not always considered safe to do so due to inadequate facilities. In addition, there were no doors on the bays throughout the ward.

For a HPV Decant Programme to be successful, it requires a fully equipped ward that is available to decant to. No equipment should be moved from the base ward when staff/patients make the transfer as this ensures that base ward equipment and the environment are adequately decontaminated. Although equipment had been specifically purchased for the Decant Ward, and an inventory recorded pre and post decant, essential patient equipment went missing on a regular basis, resulting in the base wards taking their own equipment with them to the decant ward, thus reducing the efficacy of the HPV Decontamination Programme.

Due to significant winter pressures, the HPV decant programme was suspended in December 2016 and replaced by a 'Deep Cleaning Programme' until March 2017, with 14 wards receiving a full deep clean during this period.

At the end of March 2017, there were 20 wards identified where environmental contamination due to *C.difficile* was likely and it was therefore recommended, by the IPCT, that the wards receive a full HPV clean to prevent patients from being unnecessarily exposed to *C.difficile* spores in the environment.

During 2016 the Glosair three hour HPV machines were replaced with a more cost effective and efficient model. The new HPV machines are less cumbersome and have a turnaround time of one hour to complete the HPV cleans.

Despite WUTH achieving the objective of no more than 29 avoidable cases of *C.difficile* in 2016-17, the number of in patients who have been *C.difficile* toxin positive or equivocal during 2016-17 has resulted in an increased bio-burden of *C.difficile* within the environment. Without an uninterrupted HPV programme, there is a risk that WUTH will not achieve the objective for 2017-18.

Action for 2017/18:

- Reestablish and maintain an uninterrupted HPV programme
- Introduce a programme for ultra violet light decontamination (UV-C) in areas where HPV is not possible

3.2 Meticillin Resistant *Stapylococcus aureus* (MRSA)

From April 2016 to end of March 2017 a Wirral wide total of 4 MRSA bacteraemias was reported. Post Infection Reviews (PIRs) that were undertaken as per the new NHS England guidance (on reporting and monitoring arrangements and post infection review process) for MRSA bloodstream infections resulted in local Commissioners assigning one of these cases to WUTH.

Table 2: MRSA bacteraemia reported since 2007- 08

MRSA Bacteraemia Reports	2007-2008	2008 - 2009	2009 - 2010	2010 - 2011	2011-2012	2012-2013	2013-2014	2014 - 2015	2015 - 2016	2016-2017
Pre 48 hours	9	11	8	9	3	1	2		2	3
Post 48 hours	12	10	8	5	1	2	2	*3*	2	1
Contaminants	5	5	1	0	0	0	0	*0*	1	0
Cumulative Total	26	26	17	14	4	3	4	*3*	5	4

The PIR identified this case to be attributable to the hospital and concluded that this could have been prevented if the patient had not become colonised with MRSA during the current admission; however, once colonised, it was considered that there was nothing that could

have been done differently in relation to the medical management to prevent the bacteraemia occurring, as this was an extremely complex patient.

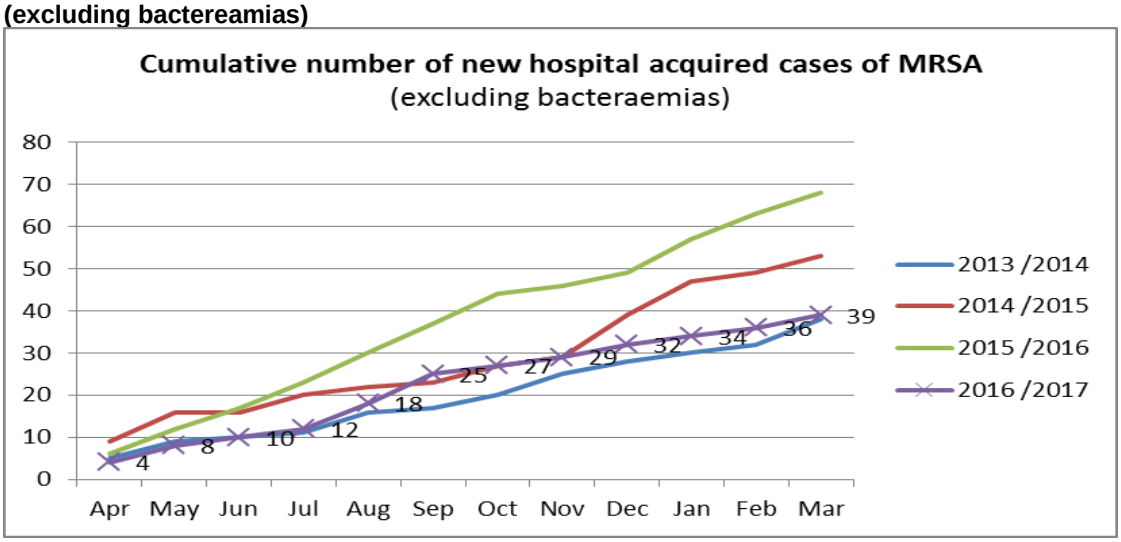
Learning outcomes identified:

- MRSA screening did not include all appropriate sites
- Sputum specimen not collected prior to commencing antibiotics
- Delay in referring problems with PICC line, therefore the patient received numerous peripheral cannulations
- Acquisition of MRSA likely occurred on a previous admission where there was lack of assurance that standard infection prevention and control precautions were being followed

It is recognised that for patients colonised with MRSA, acquiring a bacteraemia is often unavoidable; therefore, the key mitigating action is to prevent colonisation from occurring.

The graph below demonstrates over a 40% reduction of new hospital acquired cases of MRSA compared with the previous year. However, there is minimal assurance that all patients are screened for MRSA on admission, as per Trust policy. This is usually only identified when a new MRSA case is identified and it is found that acquisition of MRSA cannot be determined due to lack of screening.

Graph 2: Yearly comparison of cumulative number of new hospital acquired cases of MRSA (excluding bactereamias)



During April 2016 and March 2017, there were 22 patients who were identified as MRSA positive more than 48 hours post admission. As these patients were not screened on admission, it was unknown whether these were hospital acquired and as such, have not been included in the data above.

There is currently no robust surveillance system available and therefore, the IPCT are unable to monitor compliance with MRSA screening.

Due to the competing pressures for side rooms, patients colonised with MRSA are often not able to be isolated. Priority should be given to those patients with MRSA in wounds, sputum or urine (particularly if catheterised or incontinent). Consideration should be given to cohort MRSA patients together, however this is often difficult due to capacity and same sex accommodation issues.

Investigations of hospital acquired MRSA cases have often found links with other MRSA patients in the same bay. There have also been occasions when patients have been linked to the same bed space indicating that the bed space had not been cleaned effectively following vacation by the previous patient.

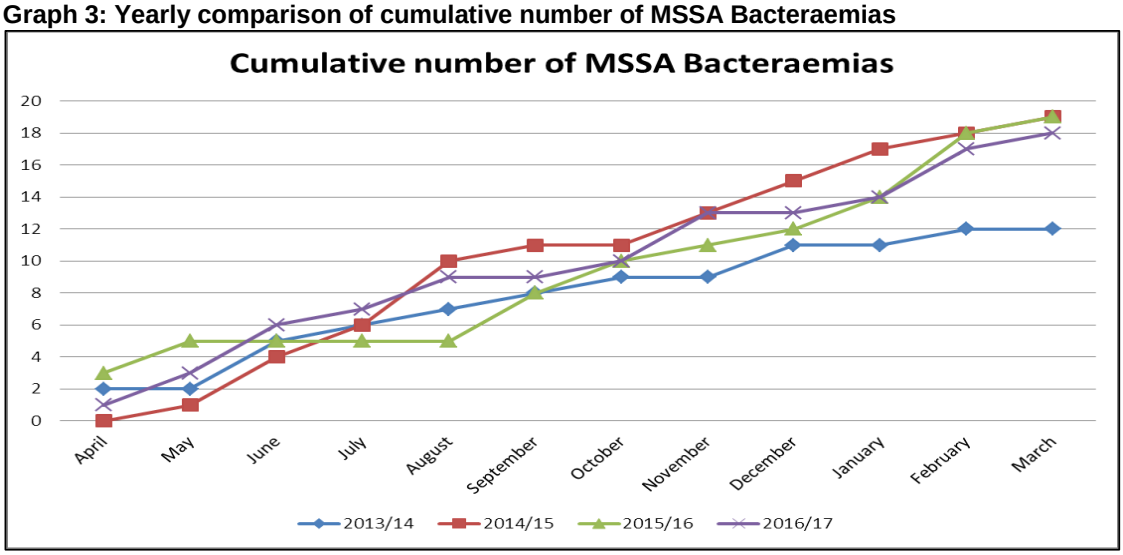
Recommendations for 2017/18

- Explore/develop IT solutions to enable the IPCT to capture screening compliance data across the trust
- Increase side room capacity as part of the Estates strategy

3.3 Meticillin Sensitive *Staphyloccus aureus* (MSSA)

MSSA is very similar to MRSA except that it is more sensitive to antibiotics including methicillin and it is more prevalent than MRSA. From January 2011, it became mandatory to report MSSA bacteraemia on a detailed basis. Objectives for the reduction of MSSA bacteraemia have not been set and it is not planned that these will be introduced in 2017/18.

Graph 3: Yearly comparison of cumulative number of MSSA Bacteraemias



During 2016/17, there was a slight decrease in the number of cases compared with the previous two years. SBARs (Situation, Background, Assessment, Recommendations) completed for these cases identified that the majority were related to invasive devices (i.e.

peripheral intravenous cannula, peripherally inserted central lines) and wounds. Despite investigations and recommendations provided, there is no assurance that these matters were discussed at Divisional Infection Control Meetings, or that actions were completed.

Recommendations for 2017/18:

- Increase engagement; Divisions to perform SBARs so that learning can be identified and ownership/change in practice can be established and embedded
- Common themes to be communicated Trust wide

3.4 E- coli Bacteraemia

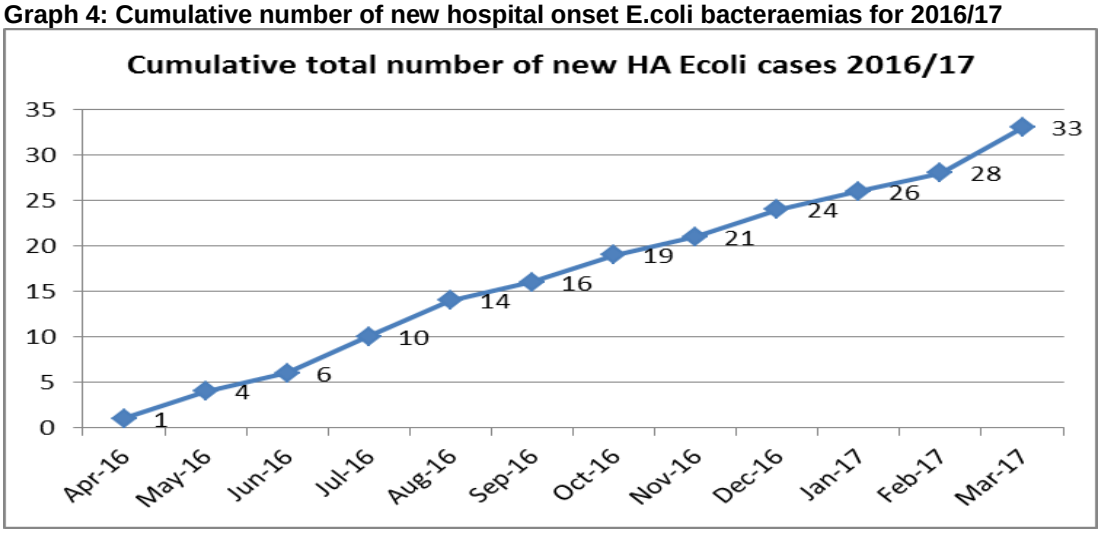
Mandatory reporting of all E.coli bacteraemia commenced in June 2011, however there have been historic issues with WUTH having technical and operational difficulties with submitting patient level data. All data from January 2016 has been locked down and signed off by the Assistant Director of Informatics, however there is a gap prior to this date.

In November 2016, the Secretary of State for Health announced a national ambition to reduce Gram-negative bacteraemia by 50% by 2021. There will be an initial quality premium for Clinical Commissioning Groups to reduce E.coli bacteraemia by 10% during 2017/18.

E.coli infections represent 65% of gram-negative infections and resulted in 5,500 deaths in the NHS in 2015; they are set to cost the NHS £2.3bn by 2018. Of note, there is a significant variation in hospital infection rates, with some having more than five times the number of cases compared to others.

This standard will pose a significant challenge and will require shared health economy colleagues to work collaboratively in order to achieve this ambition. The following graph demonstrates the number of hospital acquired E.coli bactereamias. Due to competing pressure within the IPCT, there is minimal data at this time, relating to these cases.

Graph 4: Cumulative number of new hospital onset E.coli bacteraemias for 2016/17



Recommendations 2017/18:

- The IP Information Analyst will submit data via the national HCAI data capture system
- Enhanced dataset to be submitted into the national HCAI data capture system for E.coli, Klebsiella and Pseudomonas – this will be resource intensive
- Investigation of E.coli bacteraemias to determine themes and trends and direct resource to improve practice
- E.coli rates to be visible Trust wide in exactly the same way as MRSA and *C.difficile* are currently
- Renewed focus on clinical practices particularly those associated with the insertion and ongoing management of urinary catheters

3.5 Surgical Site Infection (SSI)

Mandatory orthopaedic surgical site infection (SSI) surveillance was undertaken between October-December 2016 for total hip replacements and repaired neck of femurs.

In 2016, a 1.4% infection rate was noted in 139 hip replacement procedures with a 1.4% infection rate reported in 73 repaired neck of femurs. This indicates an improvement in total hip replacement infection rates, although the number of infections remained consistent, and a slight increase in infection rates for repaired neck of femur was noted. It is important to use trend data to identify consistently upward or downward trends in SSI incidence rates, therefore the significance of comparing the data below could be questioned when study populations and surveillance periods have varied and, as such, care should be taken to interpret these rates. To perform ongoing surgical site surveillance would provide a more accurate and significant reflection of infection rates.

Table 3: Trends on rates of SSI by surveillance period for total hip replacements

Trends in rates of SSI by surveillance period for Total Hip Replacements							
Year and period	No. of ops	Inpatient and readmission		Post discharge confirmed		All SSI*	
		No.	%	No.	%	No.	%
2012 Q1	143	2	1.4%	2	1%	4	2.8%
2013 Q1	112	2	1.8%	1	0.9%	3	2.7%
2014 Q1	190	2	1.1%	0	0.0%	6	3.2%
2015 Q4	129	1	0.8%	1	0.8%	2	1.6%
2016 Q4	139	0	0.0%	2	1.4%	2	1.4%

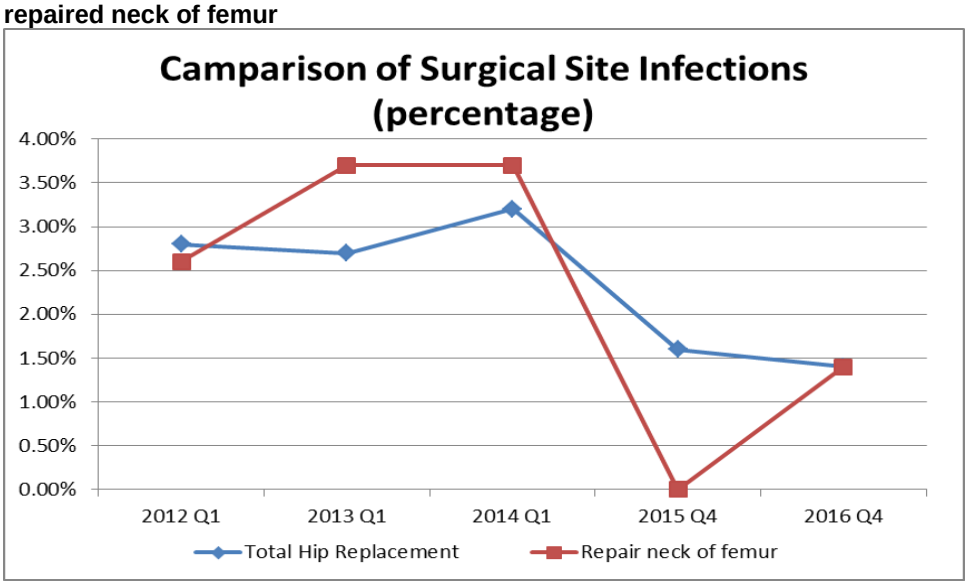
*All SSI = Inpatient & readmission, post-discharge confirmed and patient reported

Table 4: Trends in rates of SSI by surveillance period for repaired neck of femur

Trends in rates of SSI by surveillance period for repaired neck of femur							
Year and period	No. of ops	Inpatient and readmission		Post discharge confirmed		All SSI*	
		No	%	No.	%	No.	%
2012 Q1	117	3	2.6%	0	0.0%	3	2.60%
2013 Q1	123	2	1.6%	0	0.0%	2	3.7%
2014 Q1	107	4	3.7%	0	0.0%	4	3.7%
2015 Q4	65	0	0.0%	0	0.0%	0	0.0%
2016 Q4	73	1	1.4%	0	0.0%	1	1.4%

*All SSI = Inpatient & readmission, post-discharge confirmed and patient reported

Graph 5: Comparison of SSI rates by surveillance period for total hip replacements and repaired neck of femur



Recommendations 2017/18:

- The Orthopaedic Directorate, supported by the IPCT, will explore the feasibility of extending the time period when performing mandatory surveillance

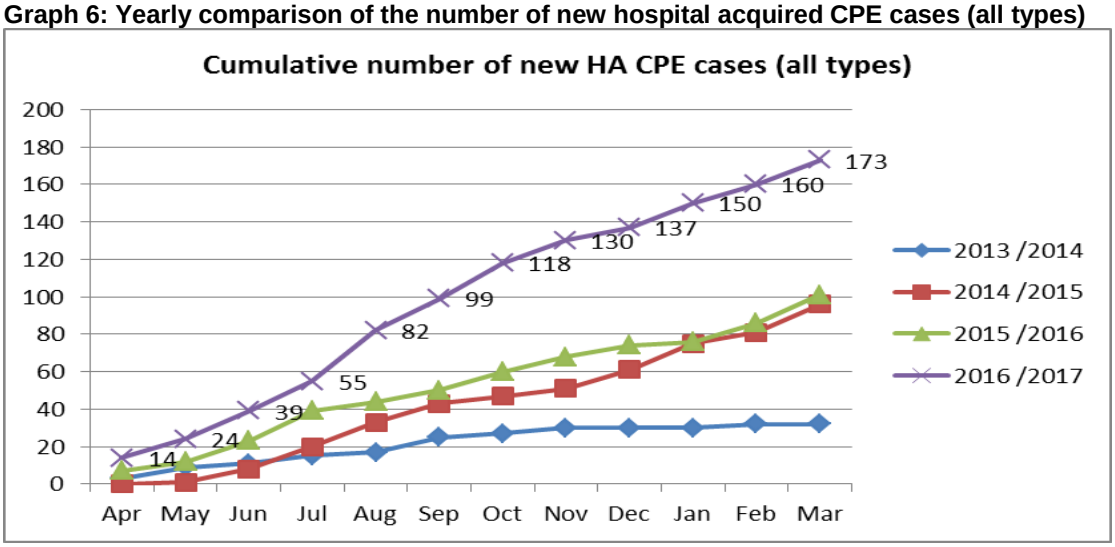
4 Non-reportable Organisms

4.1 Carbapenemase Producing Enterobacteriaceae (CPE)

Enterobacteriaceae are bacteria that usually live harmlessly in the gut of humans. Carbapenemase-producing Enterobacteriaceae (CPE) are Enterobacteriaceae that are resistant to carbapenem antibiotics (Meropenem, Ertapenem and Imipenem). CPE can cause wound infections, bacteraemia and infections of the urinary tract, with the highest risk patients being those that are immunocompromised, receive treatment in specialist units such as Critical Care, have a prolonged hospital stay or have had previous treatment with certain other antibiotics.

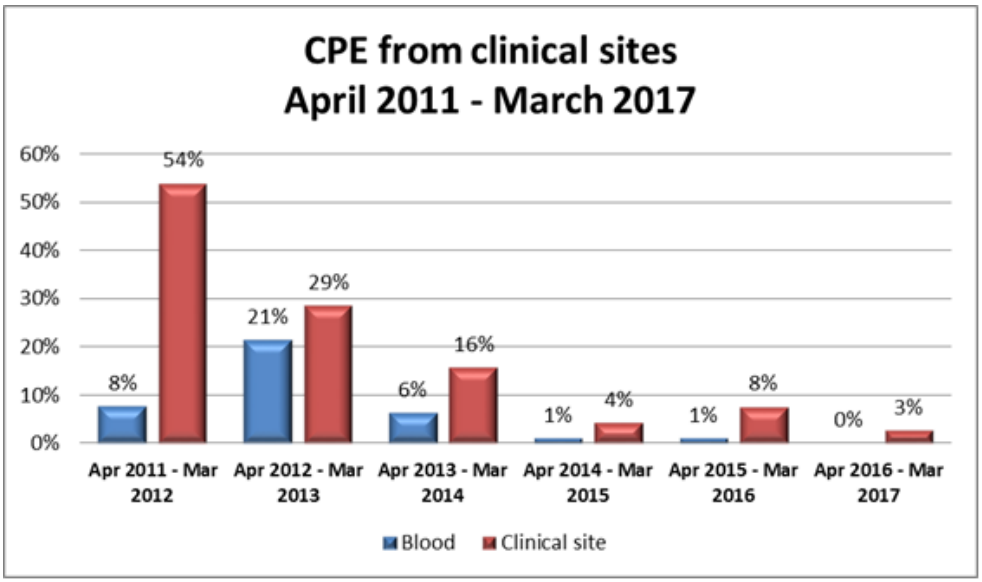
The graph below demonstrates the predicted exponential increase in the number of patients becoming colonised with CPE, with 173 new hospital acquired CPE colonisations detected during 2016-17. It is essential to optimise existing IPC measures and identify more effective ways in which to manage these difficult to treat infections.

Graph 6: Yearly comparison of the number of new hospital acquired CPE cases (all types)



Despite the increase in colonised cases, there has been a significant reduction in the number of clinical cases of CPE as demonstrated in the following graph.

Graph 6: Number of CPE cases identified from clinical sites since 2011/12



During Quarter 1, three wards were affected with an outbreak of CPE; this was exacerbated by Norovirus on one of the wards (Ward 38). Both wards were closed and close monitoring and support of practices was provided by the IPCT to prevent further transmission. Ward 22 was partially reopened due to operational pressures, however following the emergence of additional cases, the ward was fully closed again. This resulted in a protracted outbreak and the ward was closed for one month.

A further two wards were closed in Quarter 2 following the identification of 4 new CPE acquisitions on wards 36 and 33. Ward 36 was reopened without IPC advice and, following further transmission of CPE, was closed again. These outbreaks were exacerbated by the reduced capacity for CPE patients on Ward 25 as the bridge (used at the time for *C.difficile* positive patients) was closed for refurbishment to increase toilet facilities in this area.

It was not possible for Ward 33 and 38 to be fully closed due to patients still requiring the Heart Assessment Centre (HAC) and Lung Support Unit (LSU) and therefore, controlling the outbreak was more difficult as new patients continued to be admitted to these areas.

Due to the clinical specialties of Ward 33, 38 and 36 it was not always possible to transfer CPE positive patients to Ward 25 increasing the transmission opportunities on these wards, and potentially prolonging the outbreak.

In July 2016, PCR molecular (rapid) screening for all patients admitted to WUTH with a CPE exposure alert was introduced. This process was directed and closely monitored by the IPCT to prevent incorrect swabbing of patients. For patients who are more than 3 weeks post exposure and PCR screen is negative, the CPE exposure alert is removed, reducing the number of patients with a CPE exposure alert. Patients are required to be screened as soon as possible after a decision to admit is made, to ensure CPE positive patients are

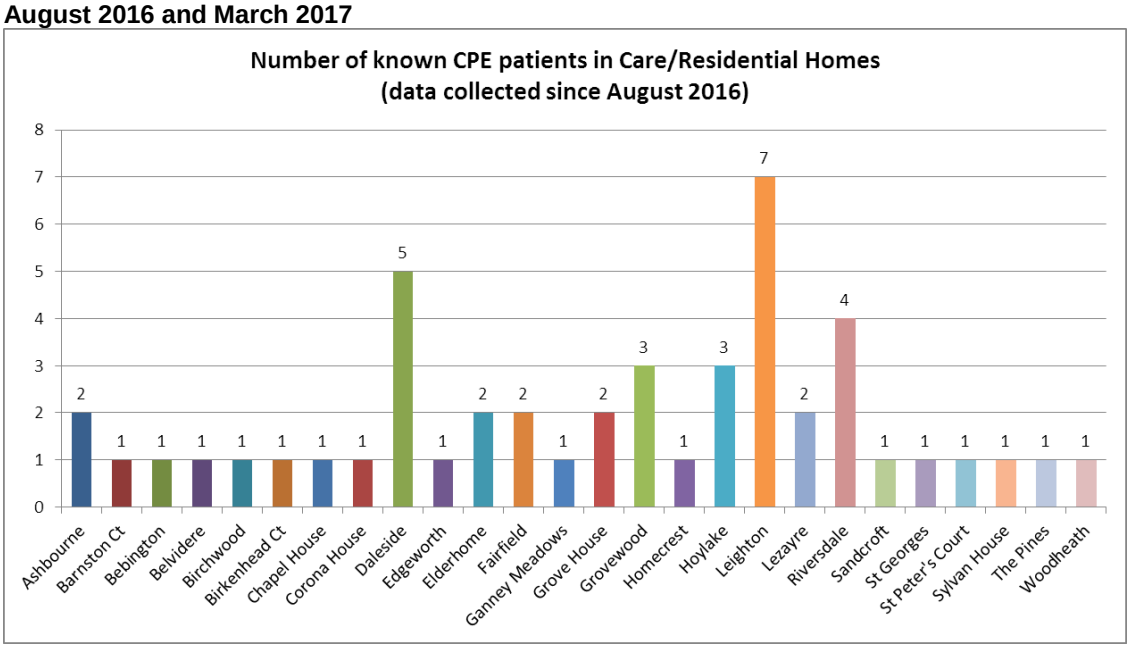
identified rapidly and located appropriately, reducing the risk to other patients, however patients are usually screened following transfer from the Emergency Department.

On site PCR molecular testing was introduced in October 2016 to increase the turnaround time of results and ensure rapid detection of new CPE positive patients. This was interrupted in November 2016 due to staffing levels, however to mitigate the time delay, additional taxi runs were provided to ensure samples were received in Microbiology at the earliest opportunity. A minimal service on site was restored in December with the ability to process approximately 10 swabs per day. The IPCT prioritised screens that would assist patient flow, particularly for patients in ED or those requiring transfer to Clatterbridge

The increase of new CPE colonisations continued during Quarter 3 and 4, although there were no further outbreaks or ward closures.

Although patients screened on admission are identified as positive, the majority of these cases are still considered to be hospital acquired if they have had any previous inpatient episodes at WUTH, which is nearly all patients. Since August 2016, the IPCT started to collate data of those patients discharged to nursing homes (see graph below).

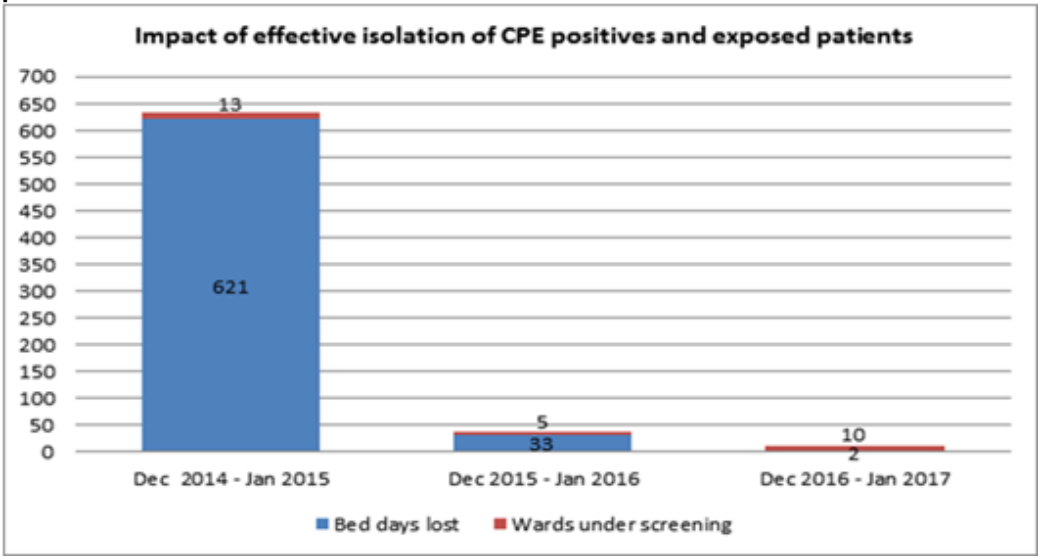
Graph 7: Number of known CPE patients discharged to care/residential homes between August 2016 and March 2017



Other residents in these homes should be considered at risk of CPE colonisation due to ongoing exposure. Whilst the risk of clinical infection in care homes is not as significant as in the hospital environment, these potential 'unknown' carriers will serve to increase the risk of colonisation and clinical infection in the hospital. Due to the number of positive patients now residing in care homes it is becoming more difficult to determine where exposure and subsequent colonisation occurred and therefore should be considered a health care associated colonisation if from any of the affected care homes.

The graph below demonstrates the impact of effective isolation of CPE positive and exposed patients. Initially the opening of Ward 25 for CPE positive patients in November 2015 saw a reduction in the number of wards under screening and the number of bed days lost. In November 2016, Ward 24 was utilised for patients exposed to CPE, reducing the number of bed days lost as bays were opened quickly following the transfer of high risk exposed patients to Ward 24. Although the number of wards on screening was still significant, this was due to various reasons including known positive patients being admitted into bays and CPE patients not being transferred to Ward 25 due to clinical need.

Graph 8: Impact of effective isolation of CPE positives and exposed patients during the same period since 2014-15



Despite Ward 25 being the dedicated Isolation Ward, due to optimum staffing levels not being maintained, there has been transmission identified, with 6 patients potentially acquiring CPE and 2 patients potentially acquiring *C.difficile*. The IPCT have maintained a presence on the ward to support staff and promote best practice.

Recommendations 2017/18:

- Introduce readmission screening (within last 12 month) for all patients not alerted as CPE exposed, using conventional screening method
- Consider refurbishment of Ward 24 (CPE cohort ward) to support flexing of the area to prevent empty beds and improve patient flow
- Explore and develop IT solutions to enable the IPCT to capture screening compliance data across the trust
- Development of IT solutions to support IPCT to manage CPE effectively
- Maintain optimum staffing levels on Ward 25

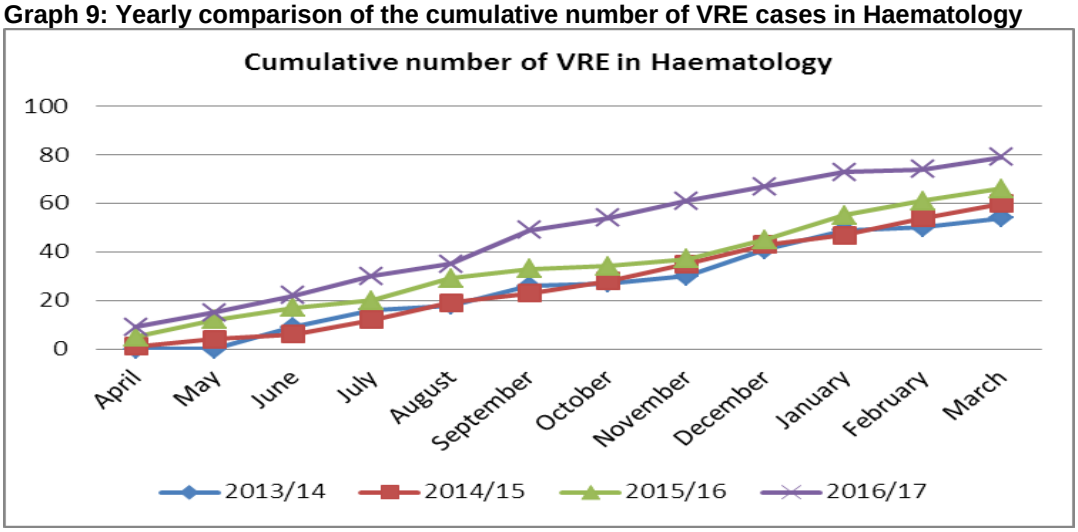
4.2 Vancomycin Resistant Enterococci

Enterococci are bacteria that are commonly found in the bowels of most humans. Vancomycin Resistant enterococci (VRE) are enterococci that are resistant to the glycopeptide group of antibiotics (Vancomycin and Teicoplanin). VRE commonly cause wound infections, bacteraemia and infections of the abdomen and pelvis, with the highest risk patients being those that are immunocompromised, receive treatment in specialist units such as Critical Care, have a prolonged hospital stay or have had previous treatment with certain other antibiotics.

Targeted screening continued in high risk areas to rapidly detect VRE in our most vulnerable patient groups i.e. haematology, critical care and orthopaedics.

The strict admission criteria and VRE cohort in haematolgy has not always been maintained which has resulted in an increase in new VRE colonisations in this area during 2016-17.

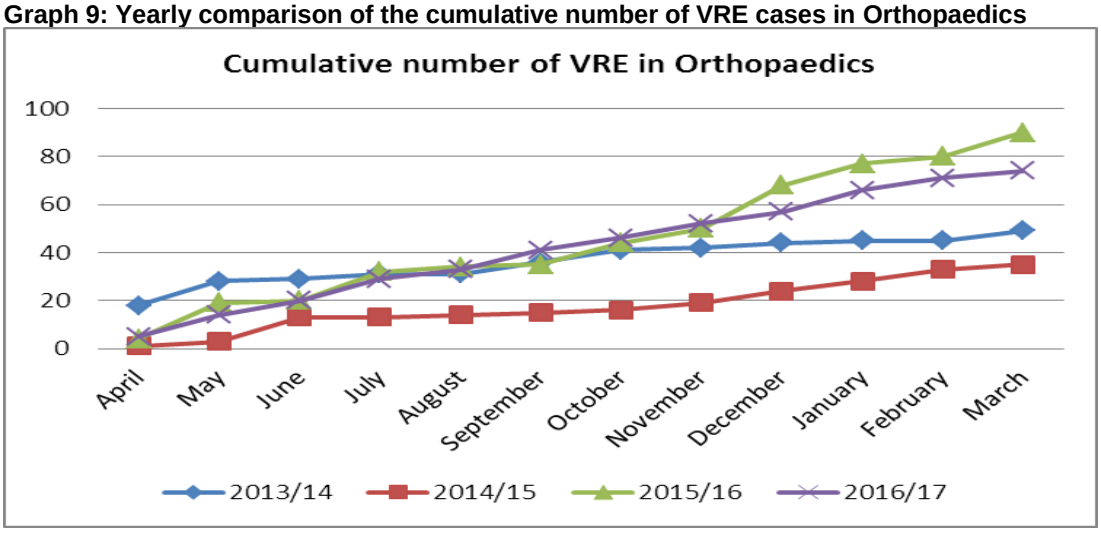
Graph 9: Yearly comparison of the cumulative number of VRE cases in Haematology



In October 2016, Haematology experienced a VRE bacteraemia thought to be related to the PICC line of a patient recently colonised with VRE. There had been a recent increase in new VRE colonisations, with 14 reported the previous month. An incident meeting was convened and an action plan was formulated to support the interruption of the outbreak. Additional training in relation to line care was supported by the IV access nurse on the ward.

There has been a reduction in the number of new colonisations identified in Orthopaedics compared with the previous year. The prompt isolation of VRE positive patients on Park Suite and the cohorting of high risk exposed patients on Ward 11 have supported this reduction.

Graph 9: Yearly comparison of the cumulative number of VRE cases in Orthopaedics

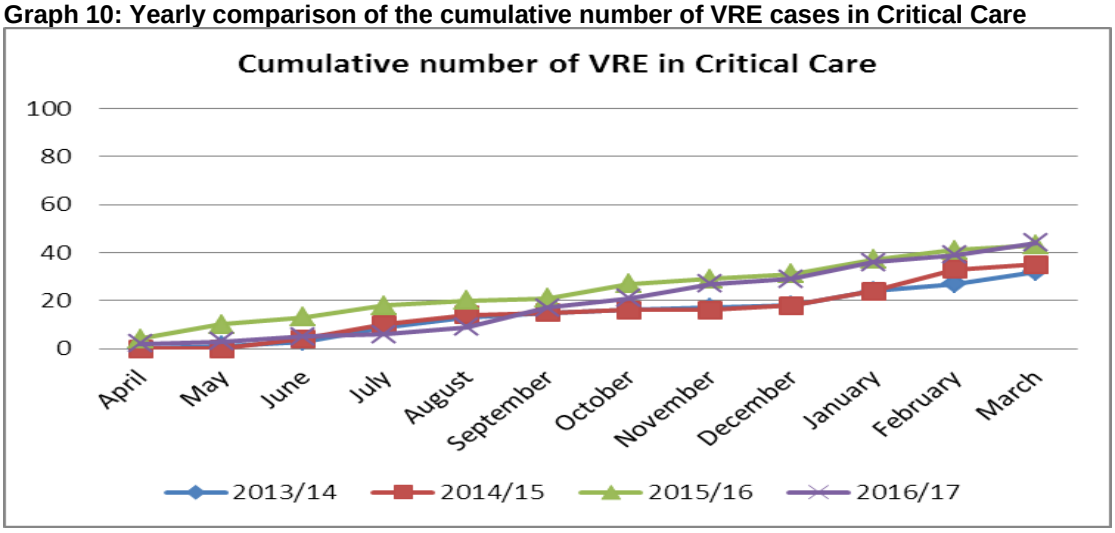


During October 2016, the planned work on Ward 11 to create a third sluice and support three separate cohort areas was undertaken. On completion of this work, Park Suite was closed and VRE positive patients were transferred to the first cohort area on Ward 11. The second cohort area was used for high risk exposed patients and the third cohort for non-exposed patients. This relied on adequate staffing to support the three separate cohort areas in order to prevent transmission.

Due to operational pressures and staffing concerns, the three cohort areas were not able to be maintained. By January 2016, VRE positive and high risk exposed patients were nursed in the same cohort area. There is a risk that if the three separate cohorts are not reinstated on Ward 11, there will be an increase in new VRE colonisations.

Despite having to prioritise side room demands within critical care, increased staffing ratios compared to those within orthopaedics and haematology will serve to reduce the risk of transmission and clinical infection from occurring within critical care. The likely reason for an increase in new colonisations during Quarter 3 and 4 is probably due to competing demands for side rooms due to influenza and norovirus.

Graph 10: Yearly comparison of the cumulative number of VRE cases in Critical Care



Recommendations 2017/18:

- Prepare a case to improve screening effectiveness and efficiency within orthopaedics and maintain three separate cohort areas
- Strive to adhere to the VRE cohort and admission criteria to heamatology

4.3 Pseudomonas aeruginosa

The IPCT have continued to provide representation at the Water Safety Group meetings and at extraordinary meetings held at the request of the IPCT during 2015/16.

The IPCT have continued to promote the guidance on controlling/minimising the risk of morbidity and mortality due to Pseudomonas aeruginosa associated with water outlets (DOH 2013) in all augmented care areas.

The team has continued to perform monthly pseudomonas inspections in these areas with the higher risk areas audited bi-weekly (neonatal unit and critical care unit).

Screening for Pseudomonas on admission, and weekly, has continued on the neonatal unit which identified 13 babies with Pseudomonas between March 2016 and December 2017. Seven cases had been identified more than four days after admission to the neonatal unit and as such, considered to be hospital acquired. Two of these cases were identified as Pseudomonas putida and did not appear to have any links with any other cases. All other cases were identified as Pseudomonas aeruginosa, with one from an eye swab. All samples were sent for typing which did not identify any cross-transmission between babies.

Filters on the taps continue to be used and are changed every 28 days as per manufacturer's guidance.

The neonatal unit have developed an infection control group for all staff with an interest in infection prevention and control, led by the Advanced Neonatal Practitioner, and they have

worked together to develop solutions to improve practice on the unit, including developing a video demonstrating the correct removal of personal protective equipment.

Monitoring of clinical cases on critical care has continued by the IPCT with no significant issues identified.

Mersey Internal Audit Agency conducted a review of Water Safety during 2016/17 which provided limited assurance overall. The Neonatal unit, required to flush daily for Pseudomonas, and Ward 17, required to flush twice weekly for Legionella, were identified as areas of good practice as a review of the L8guard confirmed that these flushes had been completed. However Critical Care had no assurance on L8guard that daily flushing had been done and there were concerns on Ward 32 that the correct process for ensuring flushing had been competed was not followed. This was rated as a high risk.

The second high risk rating was in relation to concerns that water safety checks, performed by Estates, may not be undertaken in line with policy. Estates have reviewed the job descriptions to ensure the process for the water safety checks is clear and provided increased supervision to ensure they are signed off accordingly.

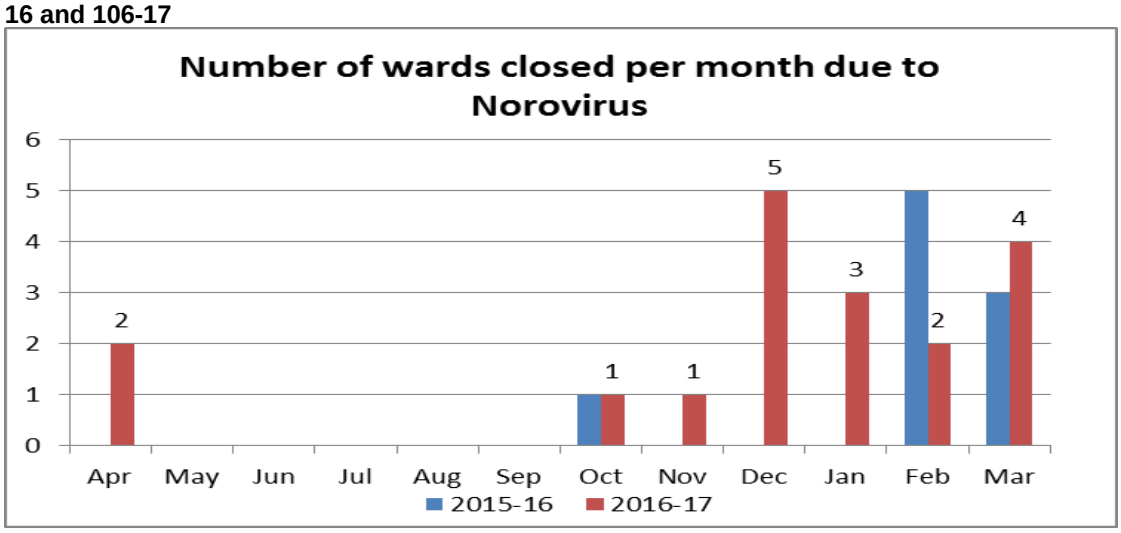
Action 2017/18:

- Support the Estates Team to develop a trust Water Safety Plan
- Embed the correct process for use of L8guard to provide assurance that flushing has been performed in accordance with policy
- Terms of reference for Water Safety Group to be reviewed

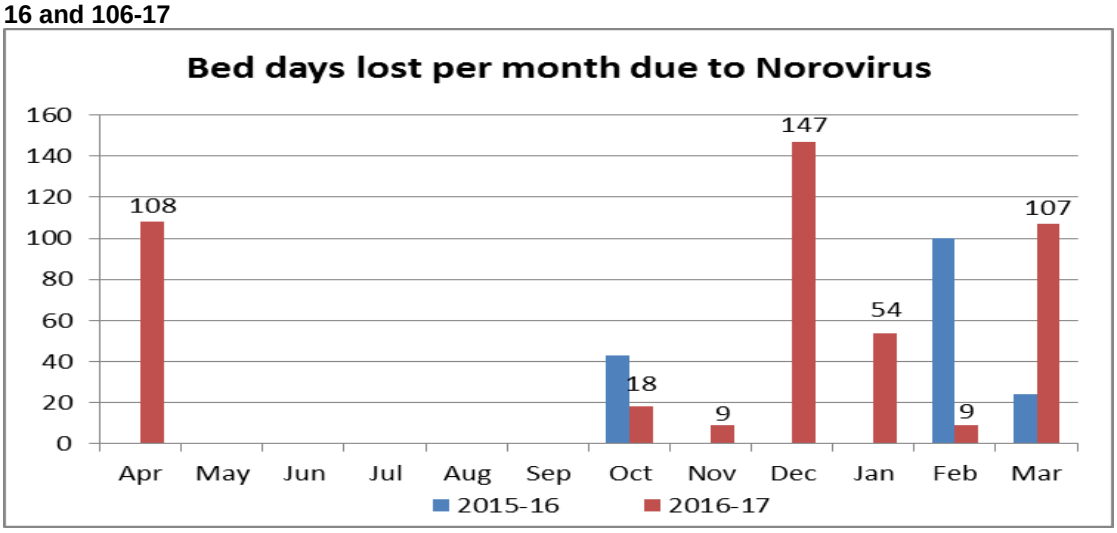
4.4 Norovirus

The graphs below compare the Norovirus season 2016-17 with the previous season 2015-16.

Graph 11: Comparison of number of wards closed per month due to Norovirus during 2015-16 and 106-17



Graph 12: Comparison of number of bed days lost per month due to Norovirus during 2015-16 and 106-17



In Quarter 1, two wards were closed due to Norovirus with 108 beds lost. This may have been impacted due to the late influenza peak in March 2016 as there were competing demands for side rooms.

During Quarters 3 and 4, a total of 16 wards were closed due to Norovirus with 344 bed days lost. There were 195 patients symptomatic and 59 staff reported to be affected. Wards were closed for a period ranging from 2 to 19 days, with an average of 8 days.

Most outbreaks originated from patients being admitted to hospital with symptoms, however it is suspected that some originated from visitors. The difficult decision to suspend visiting was made in early January 2017 by the Director of Infection Prevention and Control, which helped to control the outbreaks and reduce the number of wards (and patients) affected with Norovirus.

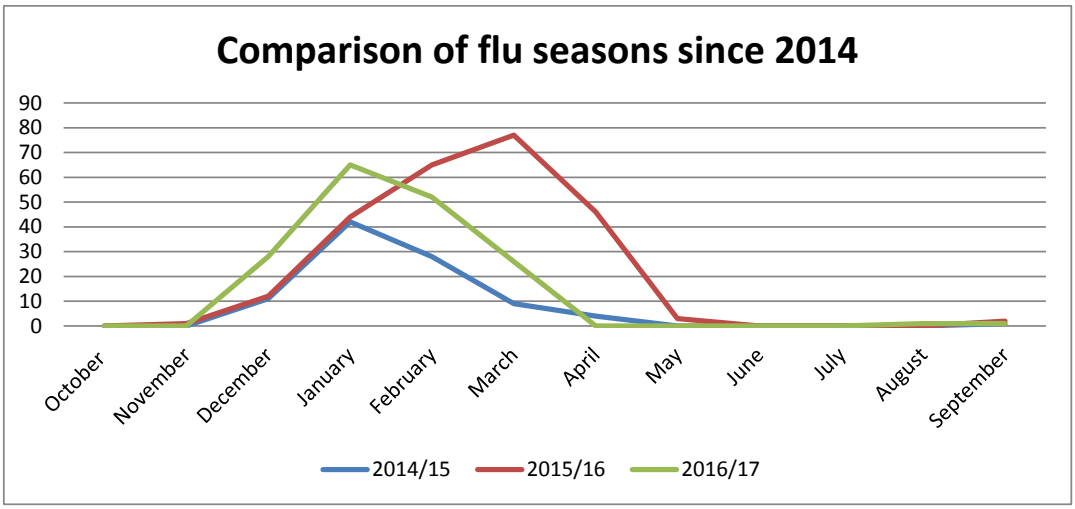
Recommendations 2017/18:

- Standardise the recording of bowel activity in Wirral Millennium to aid prompt action and detection of Norovirus
- Work in collaboration with the Community Trust IPCT to develop Norovirus protocols to support both providers in preventing spread between institutions
- Explore the feasibility of performing on site PCR testing for Norovirus

4.5 Seasonal Influenza

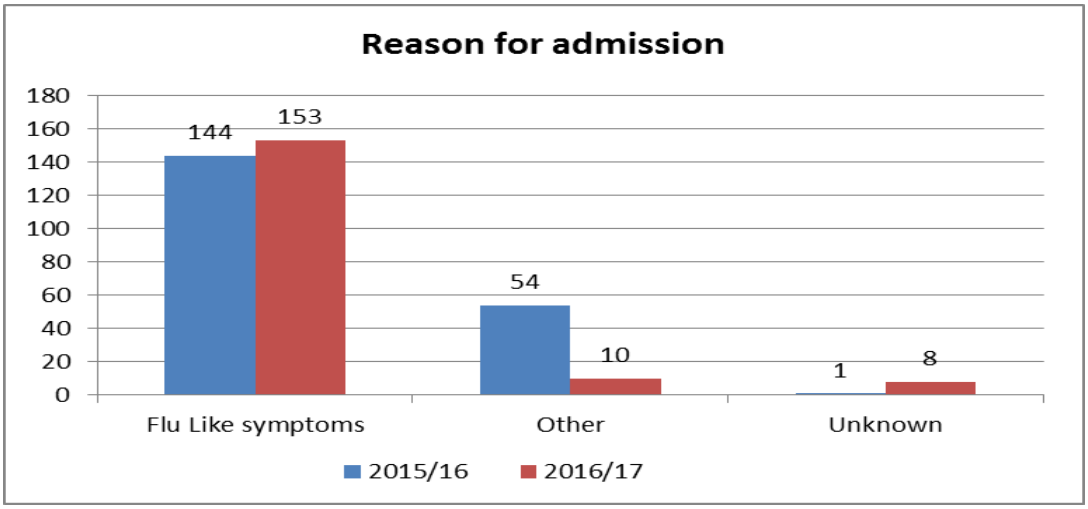
The 'flu' season in 2015-16 continued until May 2016 with 49 cases of confirmed flu identified during April and May 2016; 19 of these were strain A and 30 strain B. The following graph demonstrates that the peak of flu cases during the 2015-16 season was in March compared with the previous and subsequent seasons when the peak was in January.

Graph 13: Yearly comparison of number of flu cases per month



Between December 2016 and March 2017, WUTH reported 171 cases of confirmed flu with 161 'type A' and 10 'type B'.

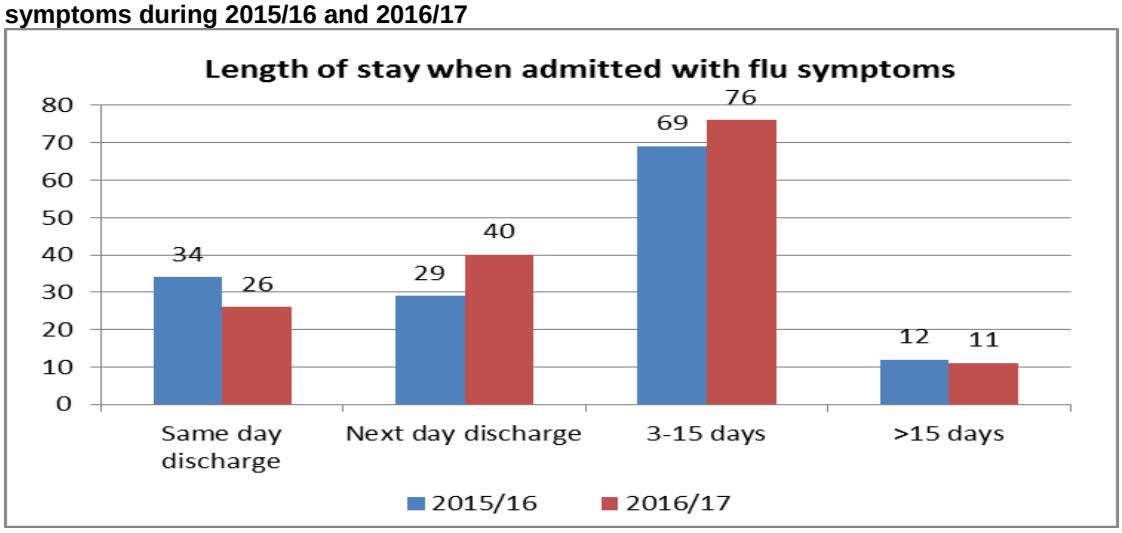
Graph 14: Comparison of reason for admission of flu positive patients during 2015/16 and 2016/17



Of the 171 confirmed cases, 153 of these were admitted with flu like symptoms, although 9 were not swabbed for flu within 72 hours of admission, therefore it is difficult to determine whether these cases were actually community or hospital acquired and if droplet precautions and isolation were not being followed, this would increase the risk of spread to other patients and staff. Of the remaining 18 cases, 7 were not swabbed within 72 hours of admission and, as they were not admitted with flu like symptoms, are considered to be hospital acquired.

The graph below demonstrates the length of stay for those patients admitted with flu-like symptoms. Despite 106 of these patients not having any underlying conditions recorded, 54 of these patients remained in hospital for 3 days or more increasing the risk of transmission to other patients.

Graph 15: Comparison of length of stay for flu positive patients when admitted with flu like symptoms during 2015/16 and 2016/17



The total number of flu swabs processed during December to March was 533 with 171 (32%) testing positive; this is a significant reduction from the previous year when 839 samples were processed with 199 (24%) testing positive.

At the point that flu is suspected, patients should be isolated and droplet precautions followed to prevent spread to other patients, staff and visitors. It is therefore essential that only patients fulfilling the criteria for suspected flu should be swabbed to ensure that side rooms are used for the most high risk patients to prevent further spread of flu.

During the peak of the flu season in January, when 64 confirmed flu cases were identified, patients suspected of having flu were not being isolated due to competing operational pressures, and this may have contributed to further cases of flu.

If a patient with confirmed, or suspected, flu is requiring an aerosol generating procedure (AGP), staff performing these procedures must wear an FFP3 respirator to protect themselves from inhaling the aerosols generated. There was minimal evidence that staff within areas likely to perform AGP were fit tested for appropriate FFP3 respirators.

Recommendations 2016/17:

- Provide fit test training for key individuals within each Division to ensure staff in high risk areas are fit tested for appropriate FFP3 respirators
- Explore the feasibility of performing onsite PCR testing for flu; as many of these will be negative, it will help to improve flow through winter months

4.6 Scabies Outbreak

In February 2017, a Scabies Outbreak was declared in the Orthopaedic Directorate following several staff on Wards 10 and 11 displaying symptoms of Scabies following contact with a microbiologically confirmed case. The index patient had recently been diagnosed with Norwegian Scabies; this is differentiated from classical scabies due to the patient's immune system. Whereby with classical scabies there may be 5-15 mites present, in Norwegian scabies the load is much higher with possibly a million mites present resulting in transmission following even transient contact with the patient or their immediate surroundings.

Staff displaying symptoms of Scabies were immediately excluded from work and referred to their GP; the first outbreak meeting was held on 28th February 2017. Following review of the index case, it was likely that the patient had had scabies for some time which had been undiagnosed and therefore is was likely that more staff may develop symptoms.

Actions implemented:

- Symptomatic staff excluded from work until received first course of treatment with Permethrin, second course required 7 days later
- Patient was commenced on treatment: Permethrin on days 1,2,3, and 8, Ivermectin weekly and a Kerototic to break down plagues
- Collated list of all staff contacts to identify staff requiring prophylaxis treatment
- Identify patient contacts who have been discharged to advise them to look out or signs and symptoms of scabies
- All current inpatients on Ward 10 and 11 received a full skin assessment and were prophylactically treated with Permethrin prior to discharge until mass prophylaxis on the ward was arranged
- Ward 11 was initially closed to admissions
- It was recommended that staff from Wards 10 and 11 should not be moved to other wards to prevent further transmission of Scabies
- An appropriate date was set to ensure that all staff and patients were prophylactically treated at the same time to prevent possible re-infection
- CCG and PHE were informed and kept updated of progress

Overall, 21 staff were treated for symptoms of Scabies, 174 staff received prophylactic treatment and 458 patients were sent letters advising them of the potential exposure to Scabies. No further patients developed symptoms of Scabies.

5 Antimicrobial Stewardship

Antimicrobial stewardship practices are based on the PHE guidance 'Start Smart then Focus'. Six month point prevalence audit data indicates that 33% of inpatients remain on antibiotics. The Antibiotic Safe Prescribing Indicator Audits were performed each month on each ward, identifying an overall average of 96% compliance with the Trust antibiotic formulary. This is an improvement on 2015-16 data (93%). The annual de-escalation audit and quarterly data return for the 2016-17 CQUIN 'Antimicrobial Resistance and

Antimicrobial Stewardship' indicated that clinical review of antibiotics within 72 hours of initiation was undertaken in >95% of audited antibiotic courses.

The national milestones of the CQUIN relating to antimicrobial consumption were not met but an annual report demonstrating appropriate antibiotic use throughout the year, specifically use of carbapenems and Tazocin® and good stewardship practices, was submitted to Wirral CCG which provided assurance that standards agreed between the Trust and WCCG for a local variance to the national CQUIN were being met.

Ward based antimicrobial stewardship ward rounds have continued to be rolled out and now occur weekly in DME (ward 27) and the 3 orthopaedic wards (wards 10, 11 and 12) in addition to the previously existent ward rounds on gastroenterology (ward 36), acute care (MSSW and AMU) and all blood culture positive patients throughout the Trust.

Recommendations 2017/18:

- Progress functionality in Wirral Millennium to further support stewardship practices, particularly around antibiotic review

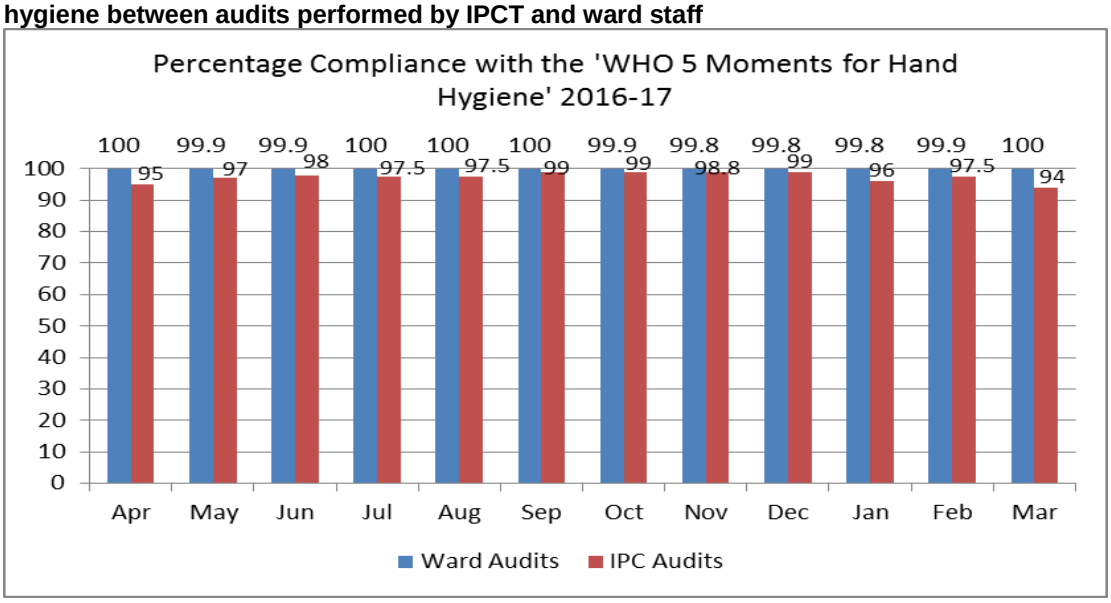
6. Audit Activity

6.1 Hand Hygiene

Adherence to hand hygiene is measured by direct observation of health care workers in clinical settings.

The following graph demonstrates Trust compliance against the WHO 5 Moments for Hand Hygiene. Hand hygiene audits are performed weekly by ward staff within their own areas, whilst the IPCT perform ongoing random audits as they visit clinical areas. Ward level audits are collated weekly by the IPCT and sent out to a wide circulation the following week. The IPCT audit results are circulated monthly in the monthly IPCT data report.

Graph 17: Comparison of the percentage compliance against the WHO 5 moments for hand hygiene between audits performed by IPCT and ward staff



The IPC Team have continued to promote hand hygiene and bare below the elbow, particularly during the awareness campaigns for World Hand Hygiene Day, Infection Prevention and Control week and Nurses day.

A report of the names of staff who do not comply with hand hygiene is submitted to the Triumvirates and Medical Director who will write to the individuals concerned to endorse the importance of complying with hand hygiene.

Recommendations 2017/18:

- Review feasibility of electronic hand hygiene audit tool to promote ownership within Divisions

6.2 Vacation Cleaning Audit

A Trust wide audit to monitor compliance with Vacation Cleaning was performed during May 2016 by the IPCT. Only 45% of staff were aware of the standard operating procedure (SOP) for a vacation clean and only 8% of patients had a completed vacation clean SOP in their case notes providing evidence that their bed space had been decontaminated following the vacation of the previous patient.

6.3 Commode Audit

A trust wide audit of commodes was performed during July 2016 by the IPCT to identify if commodes were clean, in a good state of repair and stored appropriately. 44% of commodes throughout the Trust were found to be visibly soiled or in a poor state of repair

and therefore deemed to be an infection risk. 41% of wards were not storing commodes in a clean area as per DH recommendations.

Commodes are a potential source of transmission of *C.difficile*, CPE and VRE and therefore ward level leadership supported by the Matrons is required to ensure that all staff are aware of their responsibilities in relation to commode cleaning and storage.

6.3 Management of Patients with Diarrhoea

A Trust wide audit was undertaken in October 2016 to identify the number of patients with unexplained diarrhoea and whether these patients were being managed in accordance with Trust policy. The audit identified that 74% of patients with unexplained diarrhoea were isolated, however for those patients not isolated, only one incident form had been completed and a review of the prioritisation for side rooms had not been undertaken in all cases.

Staff were also questioned on their knowledge of the management of diarrhoea guidance with only 19% of staff demonstrating awareness.

Prompt isolation of patients with unexplained diarrhoea is necessary to prevent potential transmission of infection such as *C.difficile*, CPE and norovirus and therefore ward level leadership supported by the Matrons is required to ensure that all staff are aware of their responsibilities in relation to the management of these patients.

6.4 Catheter Associated Urinary Tract Infections (CAUTIs)

A Trust wide audit was performed in December 2016 to identify the prevalence of indwelling urinary catheters, the number of patients diagnosed or being treated for a catheter associated urinary tract infection and to determine compliance with the management of urinary catheters. 15% of patients were found to have a urinary indwelling catheter at the time of the audit which demonstrates a reduction in catheter prevalence, with 4.5% of these patients being identified as having a CAUTI, which is slight increase from the previous audit in February 2016. Although 96% of patients had a catheter care pathway commenced, only 67% of these were up to date.

Audit results with recommendations were shared with the divisions for dissemination and action plans were devised within the Divisions and monitored through the Divisional IC meetings.

6.5 Hand Hygiene Facilities

A Trust wide audit on hand hygiene facilities was performed during January and February 2017 by the IPCT. The Audit identified that there are a number of issues in relation to the hand hygiene facilities available for current use in the Trust. Issues were evident in relation to the cleaning of the hand washing sinks, the state of the hand hygiene facilities and a lack of patient information for hand hygiene.

Audit results with recommendations were shared with the Divisions for dissemination, and in addition, shared with members of the Water safety Group for discussion at the Water Safety meeting/implementation of recommendations.

6.6 Water Cooler and Ice Machine Audit

A Trust wide audit of water coolers and ice machines was performed during February 2017 to identify if water coolers and ice machines were clean, in a good state of repair and maintained regularly. 33% of water coolers and 25% of ice machines were visibly soiled and staff questioned did not know if there was a maintenance contract for 33% of the water coolers and 55% of the ice machines.

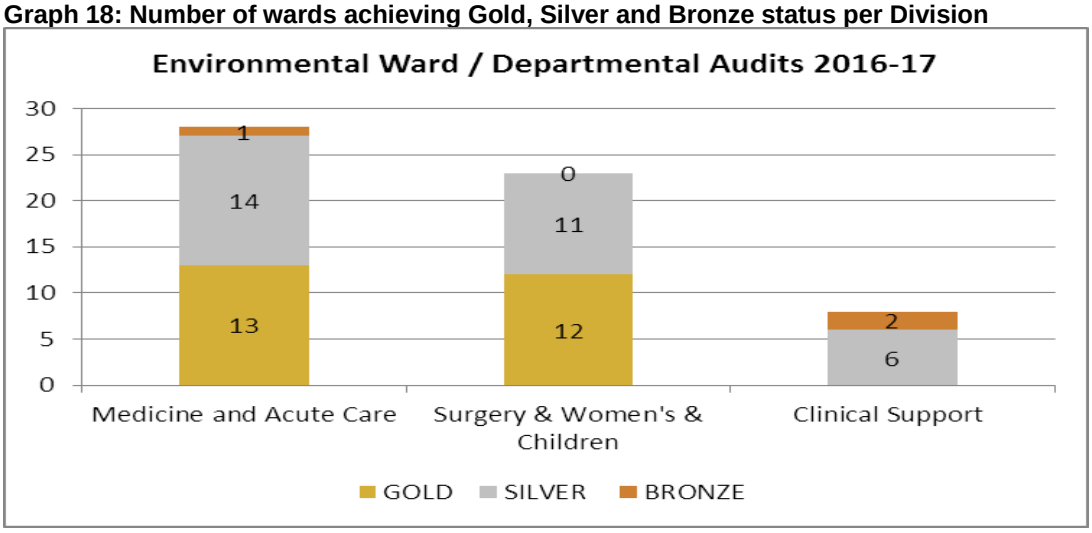
Audit results with recommendations were shared with the Divisions for dissemination, and also shared with members of the Water safety Group for discussion at the Water Safety meeting and implementation of recommendations.

6.7 Environmental Audits

Infection Prevention and Control Ward/Department audits are performed by the IPCNs annually using a locally adapted version of an audit tool promoted by the Infection Prevention Society (IPS). The tool covers elements of policy and practice including hand hygiene, use of personal protective equipment, ward environment, care and decontamination of equipment, disinfectant and antiseptic use, waste disposal, sharps handling and disposal and linen handling and disposal. Audit results are communicated to senior staff including ward sisters and infection control leads to enable staff to address shortcomings.

The scoring system was changed from red, amber and green to bronze, silver and gold to fall in line with the Ward Accreditation Scheme. During 2016/17, the IPCT performed 59 environmental audits, an improvement from the previous year. 25 (42%) of these areas scored 86% and over achieving a gold status. 13 areas (53%) scored between 71% and 85% (sliver) and 3 areas (5%) received less than 71%, a bronze status.

Graph 18: Number of wards achieving Gold, Silver and Bronze status per Division



Following the audit, ward sisters are responsible for completing an improvement plan to be discussed at the departmental/divisional IC meetings; progress with actions are monitored by the Matrons with any outstanding actions escalated to the Infection Prevention Operational Review Team. This process requires further divisional ownership to ensure that these improvement plans are robust and that the audit cycle is closed with assurance to IPORT that the actions have been addressed.

Recommendations 2017/18:

- IPCT to work with the Corporate Nursing Matron to amalgamate the corporate nursing and IPCT audits and promote ward accreditation

6.8 High Impact Interventions (HIIs)

There was no assurance during 201/17 that staff were monitoring high impact interventions regularly. Wards are expected to report compliance with these care bundles at Divisional IC meetings as there is no electronic system to collate and report compliance.

The care bundles are designed as rapid improvement tools to ensure the right thing is done for all patients by all staff at all times. These include:

- Insertion and ongoing care of renal, central and peripheral lines
- Insertion and ongoing care of urinary catheters
- Ventilated patients
- Preventing surgical site infection
- Management of *C.difficile*
- Decontamination of equipment

Recommendations 2017/18:

- The IPCT to review electronic systems for hand hygiene audits and HIIs

6.9 Infection Prevention and Control Review

Mersey Internal Audit Agency performed a review of Infection Prevention and Control in accordance with the requirements of the Internal Audit Plan, as approved by the Audit Committee which provided significant assurance.

There were 5 medium risks identified:

- 2 IPC risks on the risk register had outstanding actions that had not been updated since 2015 – these risks were reviewed and updated immediately
- Divisional assurance reports were incomplete and the identified actions did not address the issues/gaps
- Divisional IC meetings did not exist for all divisions and attendance was poor when they did occur
- Local improvement plans following audit reports were inconsistent; some did not exist and those available did not include key issues or provide assurance that the required actions had been taken forward
- A more robust process for escalating problems with the HPV decant programme should be available and a HPV policy be produced to clearly define roles and responsibilities during the process

Action 2017/18:

- Divisions to review Divisional IC meetings, including attendance, robust monitoring of Improvement Plans and dissemination of appropriate information
- HPV policy to be developed

7. Care of the Environment

7.1 Hotel Services

Hotel Services have continued to provide IPC related cleans as described in the 'Which clean do I mean?' document, including:

- Infection Control Cleans
- Enhanced Cleans
- Hydrogen Peroxide Vaporisation (HPV) programme
- Deep Clean Programme (when not possible to follow HPV programme)

The Environmental Cleaning Team was funded to provide up to 5 enhanced cleans per day and a separate funded team is available to undertake 1 full ward HPV plus decant ward clean per week. The provision of Infection Control Cleans has been an additional cost pressure within the Hotel Services budget.

As a result of this, the routine vacation cleans, also included in the 'Which clean do I mean? document, has not be provided by Hotel Services as there has been no additional funding or agreement to transfer non-cleaning duties from domestic staff to another group of staff. This was raised in 2015 with no resolution identified. Although domestics on the ward do

support wherever possible, their priority is to ensure that all baseline cleaning and duties are undertaken.

Recommendations 2017/18:

- Review resource required for vacation cleans to provide assurance that patients are consistently admitted into a clean bed space

7.2 Patient Led Assessments in Care Environments (PLACE)

A patient-led assessment of the care environment (PLACE) is a National system for assessing the quality of the hospital environment, which replaced the Patient Environment Action Team (PEAT) inspections from April 2013.

PLACE assessments apply to all hospitals delivering NHS-funded care, including day treatment centres and hospices.

PLACE assessments put patient views at the centre of the assessment process, and use information gleaned directly from patient assessors to report how well a hospital is performing in 6 specific areas to include cleanliness and general building maintenance. From 2016 the assessment also looked at aspects of the environment in relation to those with disabilities. It focuses entirely on the care environment and does not cover clinical care provision or staff behaviours.

Most importantly, patients and their representatives make up at least 50% of the assessment team, which will give them the opportunity to drive developments in the health services they receive locally.

The IPCT supported the inspection to assess wards, outpatients, A&E departments and internal/external common areas against two of the five standards, these being cleanliness and condition, appearance & maintenance of the general environment. The other standards assessed include food and hydration; privacy, dignity and wellbeing, dementia and disability.

Table 5: WUTH PLACE results compared with the national average for 2016/17

Standard	WUTH Score	National Average
Cleanliness	99.74%	98.1%
Condition, Appearance & Maintenance	96.49%	93.4%

7.3 Environmental Improvement Programme

A 2016/17 backlog maintenance budget of £1.2m had been awarded to enhance the quality of buildings and equipment with a positive impact on patient, visitor and staff experience.

Some £300,000 was awarded to assist in providing repairs for internal fabrics, flooring and roof schemes across the Trust as well as the running repairs carried out by the Estates Maintenance Department.

Many of these repairs had been identified as possible risks to infection control with damaged flooring, doors, walls and ceilings requiring attention and repair.

There were several small capital schemes completed during 2016/17 which enabled bathrooms and shower rooms to receive upgrades and refurbishments as well as the first phase of refurbishment for Wirral Neurorehabilitation Centre.

Recommendations 2017/18:

- An increase in investment on shower facility refurbishments, wall protection systems and flooring for various areas
- Focus on reducing the risk of infection from an environmental condition perspective

8. Education and Shared Learning

Training and educational programmes have been developed and delivered by the IPCT in accordance with national policies, service requirements and local need. In addition to ad hoc training sessions and promotional campaigns, the IPCT have continued to deliver corporate induction for all groups of staff and provide mandatory infection control updates.

The IPCT have also provided educational and information sessions for doctors from F1 to Consultant level and sessions delivered to Medical Students at each year of their training.

An IPC study was arranged in September 2016 for all WUTH staff interested in IPC, especially IP Ambassadors. Topics included Pandemic Flu, Group A Streptococcus, Pseudomonas, *C.difficile*. CPE, screening and care of invasive devices. The day was very well evaluated and a plan for the return of the Daring Bugs of May in 2017 was initiated.

During October 2016, the IPCT promoted International Infection Prevention Control Week using the full week to raise awareness around the basic IPC principles including:

- Screening
- Flu and PPE
- Hand hygiene
- Norovirus and Isolation
- Cleaning

IPCNs also facilitated drop-in sessions to provide the flu vaccination to staff throughout the week.

Recommendations 2017/18:

- Re-establish the annual IPC study day ‘Daring Bugs of May’
- Promote Infection Prevention Control week and World Hand Hygiene day
- Support Infection Prevention Ambassadors to promote best IPC practice

9. Conclusion

2016/17 was an extremely positive year for IPC with recognition nationally and internationally for the development of the CPE strategy to contain the outbreak experienced. This was achieved alongside the reduction of avoidable *C.difficile* cases, however the Trust did experience one avoidable MRSA bacteraemia against a zero tolerance standard.

There are new challenges in 2017/18 with the introduction of the national ambition to reduce Gram-negative bloodstream infections by 50% by 2021 with an initial quality premium to reduce E.coli bactereamias by 10% across the health economy.

A robust IPC surveillance system is essential to be able to monitor all healthcare associated infections and identify the potential for outbreaks before they occur. To this end, it is essential that an IT solution is sourced and introduced.

10. Recommendations

The following recommendations aim to promote prevention with early control, as MDROs present a significant risk to patient safety, make it difficult to sustain the infection reductions already achieved, and greatly impact the day to day operations of the hospital:

- Develop surveillance systems to support effective delivery of a preventative IPC service
- Provide permanent onsite rapid testing initially for CPE then consider extending to flu and norovirus
- Consider benefits of further compartmentalisation of Ward 24 to release beds for step down patients
- Reinstate full ward HPV programme and compliment this with UV-C
- Re-establish VRE strategy within orthopaedics
- Maintain the standard *C.difficile* strategy
- Maintain the standard MRSA strategy
- Maintain norovirus strategy
- Monitor VRE strategy
- Monitor Pseudomonas strategy
- Explore new ways of working

Board of Directors	
Agenda Item	6.1.1
Title of Report	Integrated Performance Dashboard
Date of Meeting	31st January 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

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

2. Summary of Performance Issues

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.

3. Explanation of Performance and Actions

a. A&E 4 Hour Target

Against the A&E standard of a minimum 95% of patients to be admitted, transferred or discharged within four hours, the month of December was 83.18% as measured across the combined Wirral WUTH ED and WCT Walk-in Centres. This is the external view of Wirral performance by NHS England from November 2017 onwards. Performance for ED with the All Day Health Centre on the Arrowe Park site was 78.36%, with ED alone at 70.55%. This reflects the continued pressure on urgent care services through the winter period, and that have continued into January.

The key elements of the Wirral urgent care plan are being maintained including primary care streaming, additional community beds, and revised integrated discharge managements. The primary internal focus remains on discharges earlier in the day using the SAFER framework, real time clinical escalation and bed management.

b. Financial Position

Summary information is provided in the exception updates against the individual finance metrics in the dashboard, with further detail in the separate finance report to the Board.

4. Recommendation

The Board of Directors are asked to:

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

WUTH Metrics Summary
Performance for December 2017

Metrics	✓	!	×	Not rated
	15	7	17	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).

Performance against the A&E 4 hour standard had seen improvement, however the winter pressures have made sustaining that extremeley challenging. This is a picture that is reflected regionally and nationally.

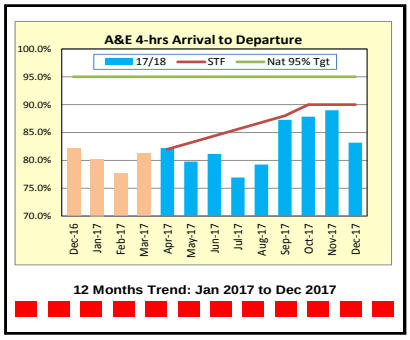
RTT incomplete validation and cleansing is complete, with increased activity now required to reduce waiting lists and times. The enforced cancellation of elective activity from December onwards has a natural detrimental effect on the RTT position. That moratorium is expected to be in place for the rest of January and potentially February. Very long waiters are being actively managed on an individual basis, and reviewed for possible harm.

Cancer standards are on track to be delivered for Q3. The financial position is detailed separately.

A&E : 4 Hours Arrival to Discharge ×

Actual: 83.18% **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	83.88%
WUTH APH site including the ADHC	78.36%
WUTH APH ED only	70.55%

Performance reflects the pressure on urgent care services through Winter, and that have continued into January.

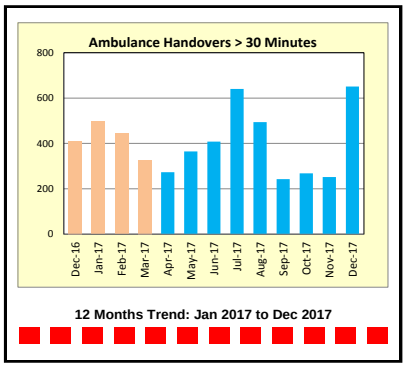
Inputs
The key elements of the Wirral urgent care plan are being maintained including primary care streaming, additional community beds, and revised integrated discharge managements. The primary internal focus remains on discharges earlier in the day using the SAFER framework, real time clinical escalation and bed management.

Progress
The Wirral system is demonstrating resilience, and still fares more comparatively on a national ranking.

Ambulance Turnaround ×

Actual: 651 **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 December there were 651 arrivals by ambulance that took longer than 30 minutes to handover.

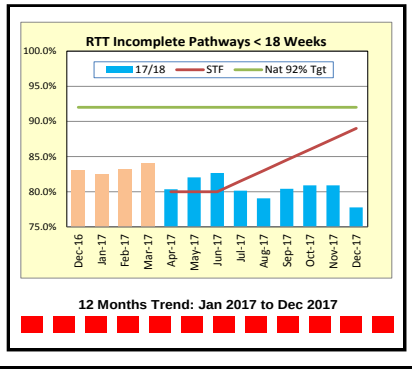
Inputs
The autumn months had seen considereable improvement in a reduced number of dealys, reflecting the overall improvement in patient flow through the Trust. However the increased pressure experienced through December and beyond is reflected in the subsequent increase in delays. This reflects the national picture.

Progress
To be monitored in conjunction with the 4-hour A&E standard and patient flow.

RTT - Incomplete ×

Actual: 77.77% **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 December 2017 was 77.77%.

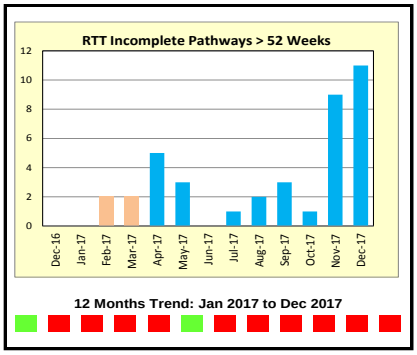
Inputs
Elective activity from December onwards has been cancelled in line with national guidance to assist with the additional pressure on beds from urgent care. This has a consequential impact on waiting times and therefore RTT performance.

Progress
The reduction in elective activity is expected to remain in place for January and February, with a corresponding detrimental effect on RTT performance.

RTT - 52 Week Waiters

Actual: 11 **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 11 patients at the end of December that had waited longer than 52 weeks for treatment to commence.

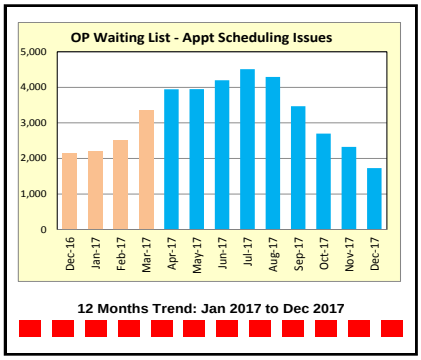
Inputs
Long waiting patients are being actively managed alongside the general waiting list and waiting time improvement actions. Any patients confirmed as having waited 52 weeks at month-end are reviewed to ensure no clincal harm has resulted from the long wait, and to understand the causes of the excessive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

Progress
The reduction in elective activity is expected to remain in place for January and February, with a corresponding detrimental effect on RTT performance. Within this long-waiting patients are still being managed as much as possible.

Outpatient Waiting List - Appointment Scheduling Issues (ASI)

Actual: 1730 **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.

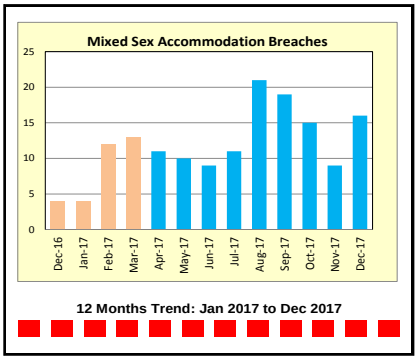
Inputs
As additional capacity comes on stream, the size of the ASI backlog is reducing. Divisions are working through plans to reduce and minimise the number of ASI. The cancellation of elective admissoin activity is allowing outpatient activity to continue largely unimpeded.

Progress
The ASI backlog is expected to continue to reduce across the remainder of 2017/18.

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 October, all relating to patients waiting beyond the 24 hours allowed for patients transferring out of critical care areas.

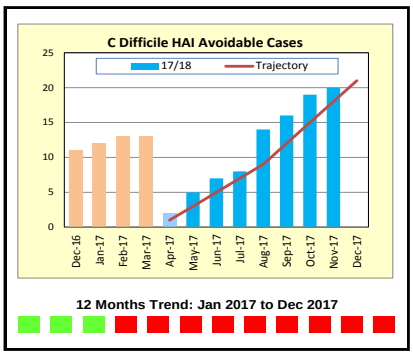
Inputs
The delays in transferring out are discussed at all bed meetings and given high priority. The patients' privacy and dignity is maintained in the critical care areas, in a side room if possible, and all care given that would be provided on their destination ward. The delays are explained to the 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.

C Difficile HAI Avoidable Cases

Actual: 20 / 26 cases **Accountibility:** D Price

Threshold: Above trajectory **Committee:** Q&S Committee



Metric
The number of clostridium difficile cases in the year to date that are hospital acquired toxin-positive, and deemed to have been avoidable

Key Issues
The Trust has a maximum trajectory of 29 toxin-positive hospital-acquired avoidable cases for 2017/18. There have been 20 cases to the end of Novemnber, and at the time of this report there have been six cases in December (subject to review). If all six are considered avoidable that would bring the cumulative total up to 26 - two cases above the expected trajectory for this point of the year.

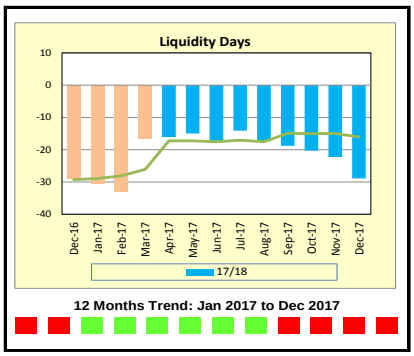
Inputs
Lack of Divisional engagement with Post Infection Reviews (PIRs) and learning outcomes although Surgical Division will be introducing weekly meeting to discuss HCAIs. Avoidability of December cases currently under review.

Progress
Effectiveness of HPV programme currently under review. Daily review of diarrhoea patients by IPCT .

Liquidity Days

Actual: -28.90 **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.

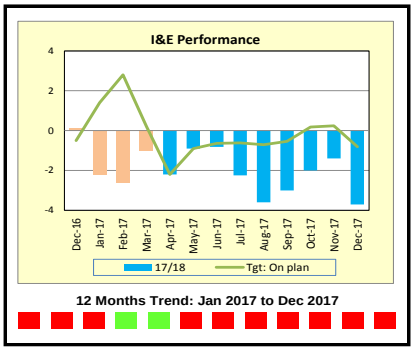
Inputs
Loan arrangements are in place with the Department of Health and NHSI, which ensure that the Trust will not run out of cash.
Such borrowings are to cover day-to-day running costs, and are not ordinarily expected to be used to improve working capital balances.
Therefore, improvement in the liquidity 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: -3.71 **Accountibility:** G Lawrence

Threshold: On plan **Committee:** FPBAC



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

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. There are issues in recruiting to medical gaps and the high levels of nursing vacancies as well as the pace of delivery on CIP schemes. This month the apprencticeship levy has been reversed back to cost c£0.6m impact; £0.5m Winter funds is assumed and there has been a c£0.3m of lost income from cancellation of planned elective work as a result of non-elective demand in the latter week of December. The non-delivery of the operational plan has resulted in not being able to access the planned Sustainability & Transformation Fund (STF) since Q1.

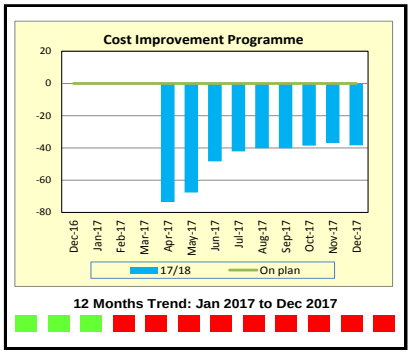
Inputs
A financial recovery plan is in place that will support the reduction of the current run-rate.

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: -38.4 **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
Pace of delivery of planned CIP schemes and the non-achievement to continue to find schemes to bridge the unidentified gap in the CIP plan.
The CIP forecast still has a potential delivery risk and the CIP mitigation risk reserve only partially offsets the current gap.

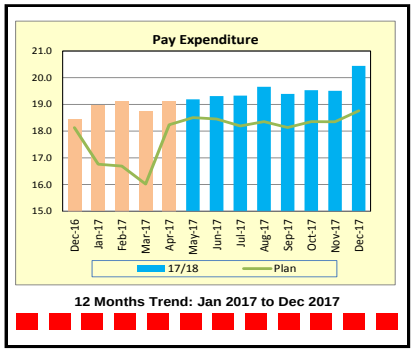
Inputs
The Transformation Steering Group (TSG) continues to review and approve new opportunities to deliver the CIP agenda and monitor plans in progress to delivery. Work is ongoing to look at the big transformational schemes for 18/19.

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: 20.44 **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. In addition the apprenticeship levy has impacted the December pay cost.

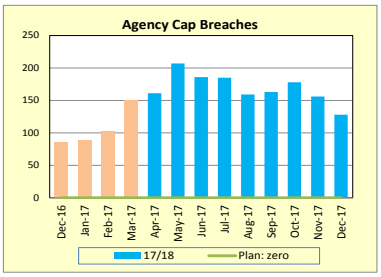
Inputs
The finance team review pay overspends and use of non-core on a regular basis with the budget managers and divisional teams.
There has been a vacancy freeze on all non-clinical posts implemented since early October and all vacancies remain under review.

Progress
As part of the financial recovery plan there are actions to look to reduce the run rate on pay expenditure.

Agency Cap Breaches

Actual: 128 **Accountibility:** J Holmes

Threshold: 0 **Committee:** FPBAC



12 Months Trend: Jan 2017 to Dec 2017

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.

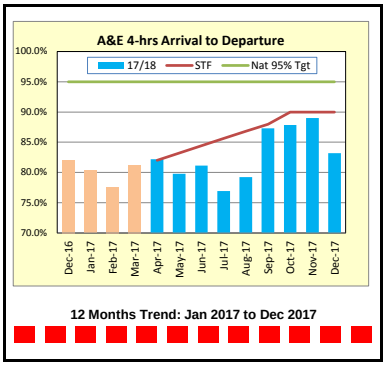
Progress
Policy amendments finalised Nov 2017. Revised workforce planning presented to WGG in Dec 2017. Collaborative agreements with other NHS organisations on agency rates are being considered for possible introduction from April 2018.

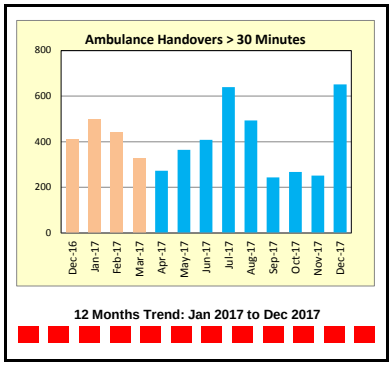
Access (Operations)

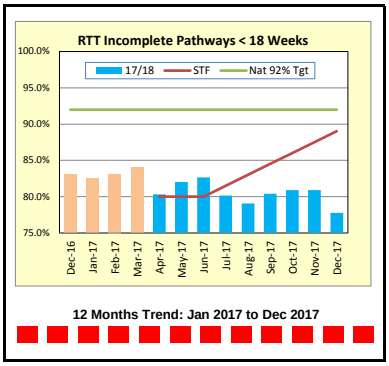
J Holmes / A Middleton

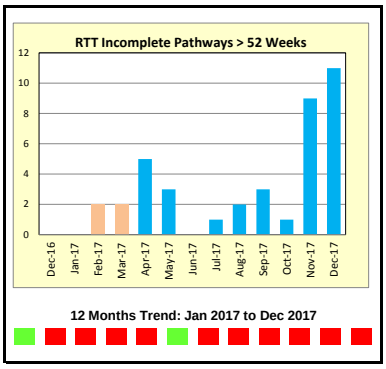
✓	!	×	Not rated
8	2	9	

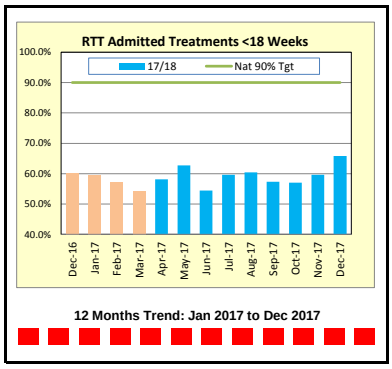
Access (Operations)

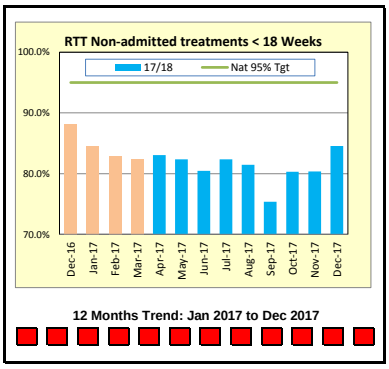


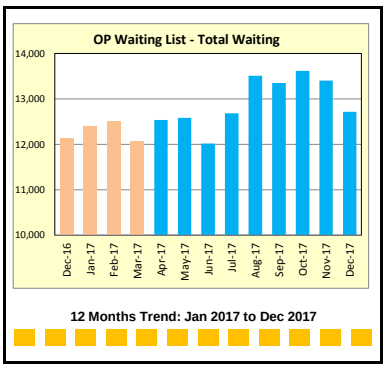


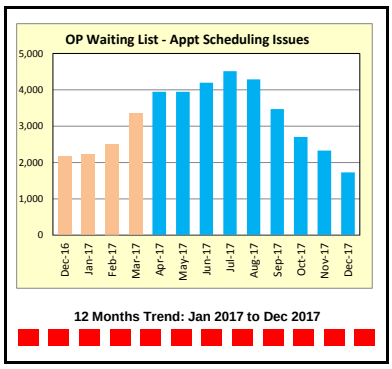


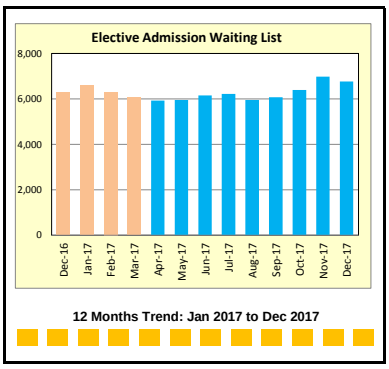


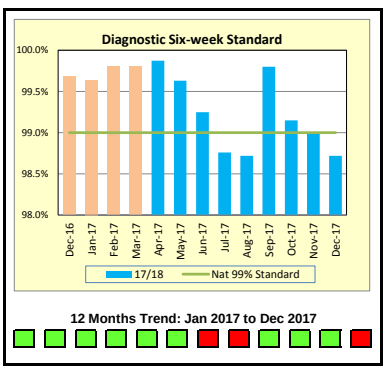


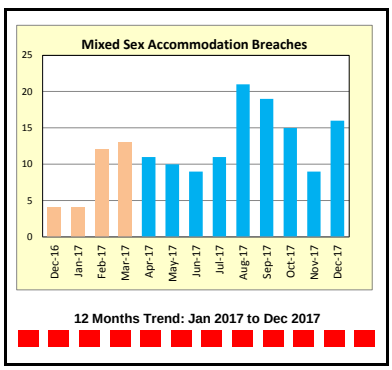




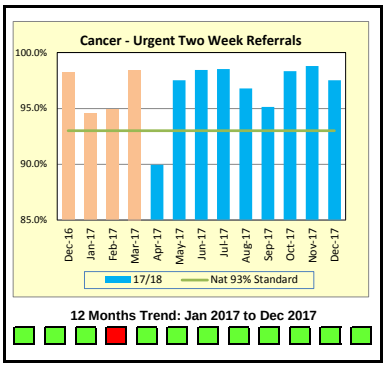


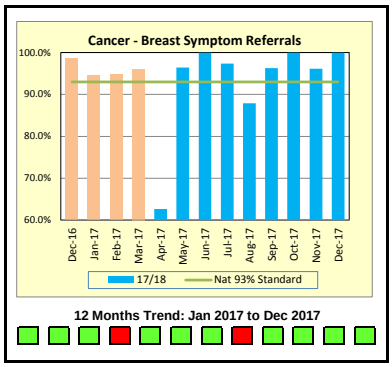


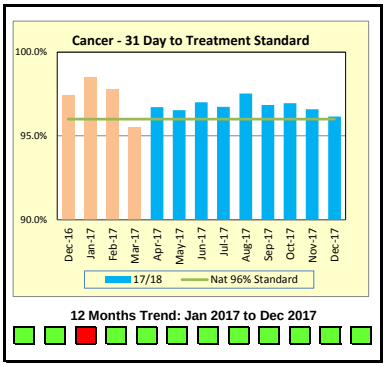


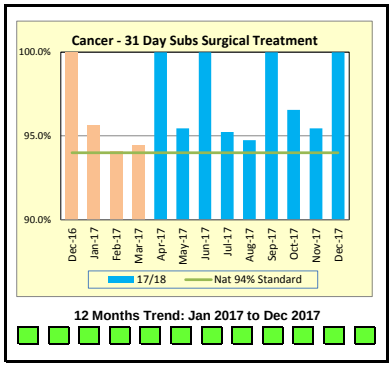


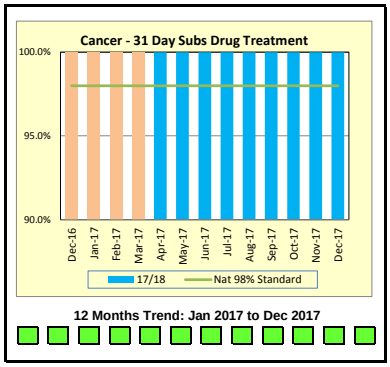
Access (Operations)

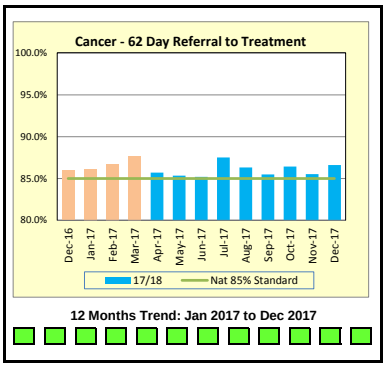


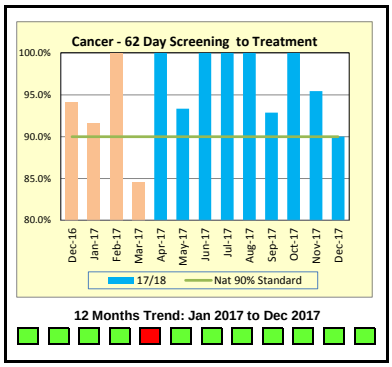


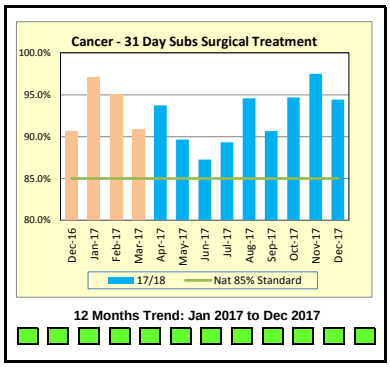










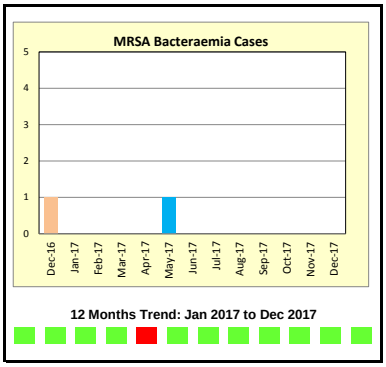


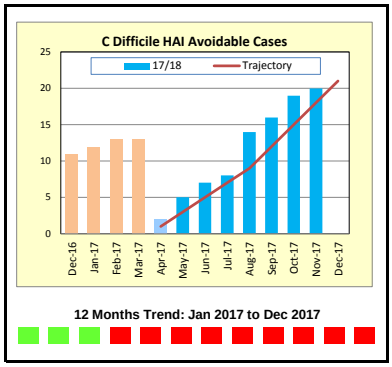
Patient Experience

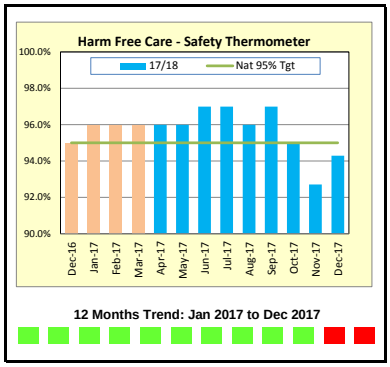
D Price

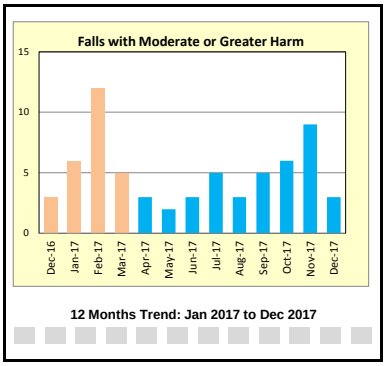
✓	!	×	Not rated
5	0	2	2

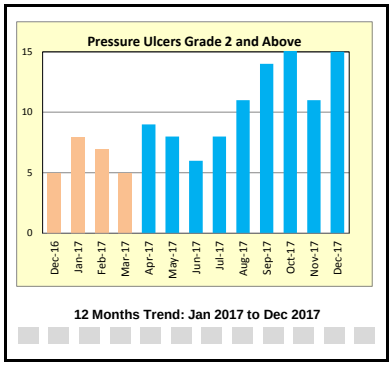
Patient Experience

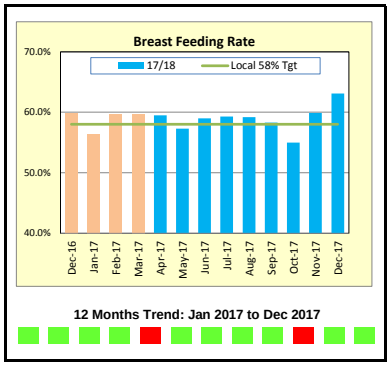


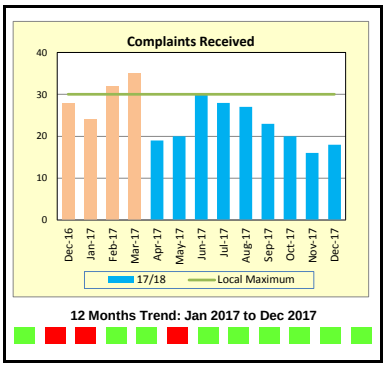


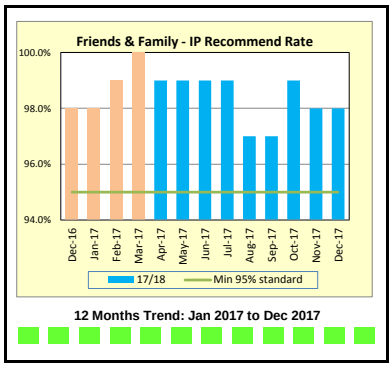


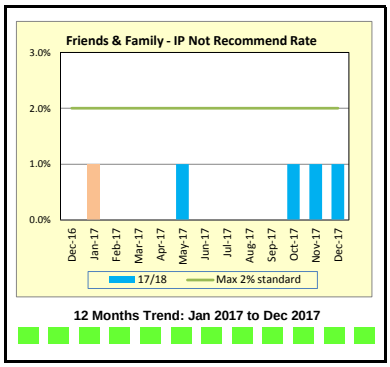












Use of Resources

D Jago

✓	!	×	Not rated
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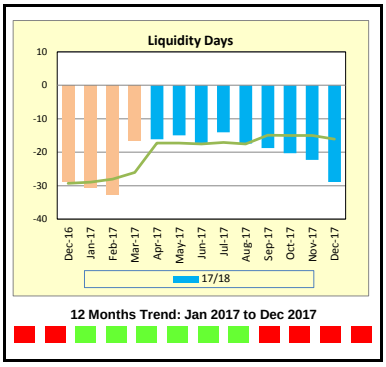
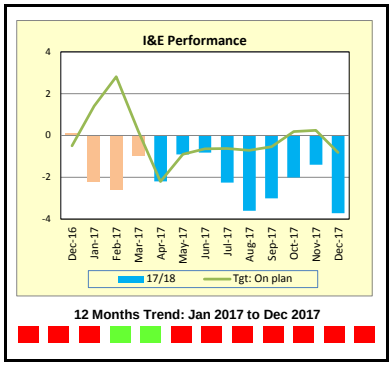
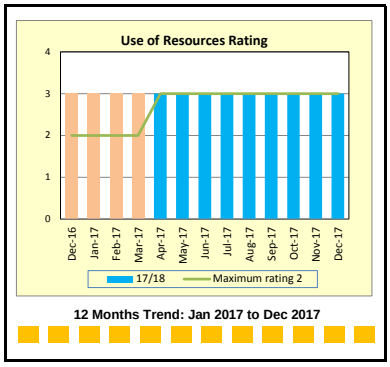
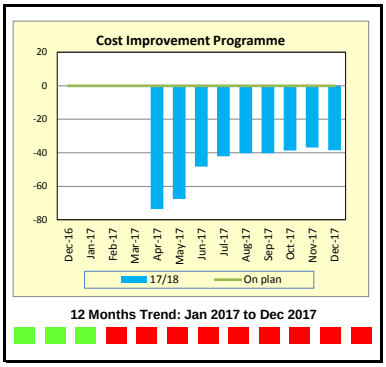
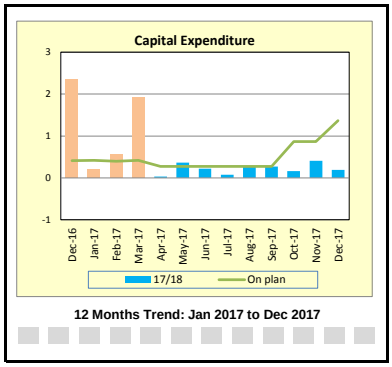
Use of Resources

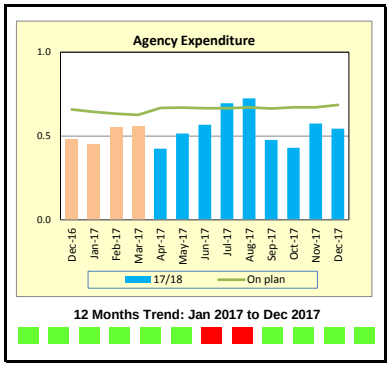


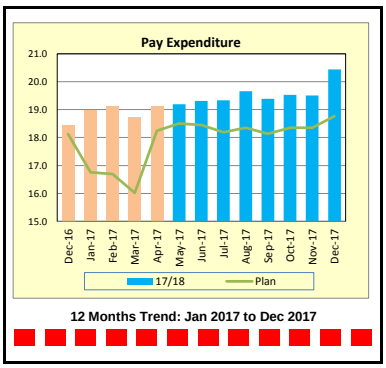


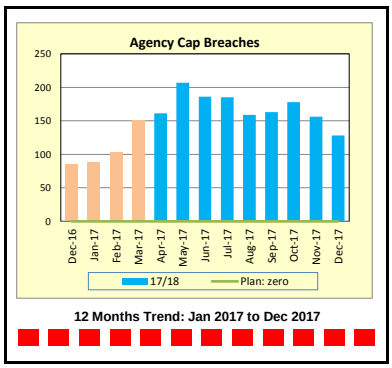










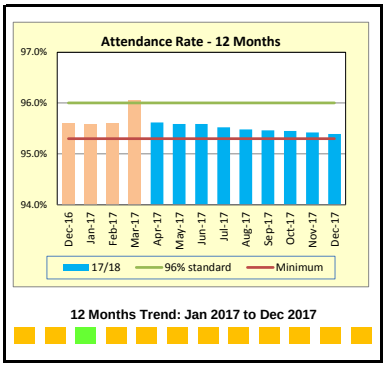


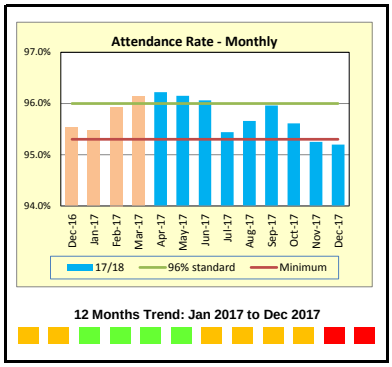
Workforce

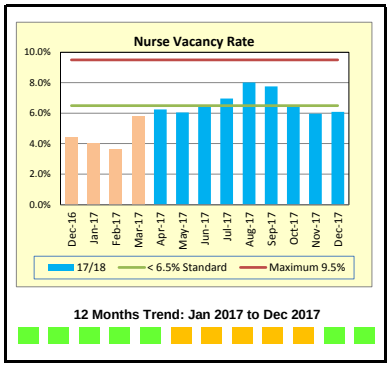
J Mawrey

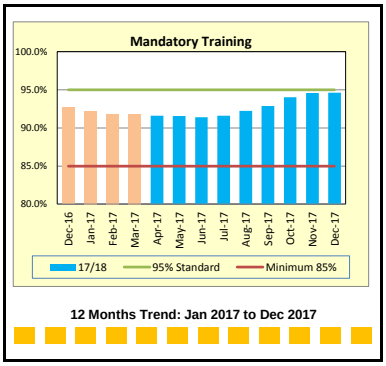
✓	!	×	Not rated
1	4	1	0

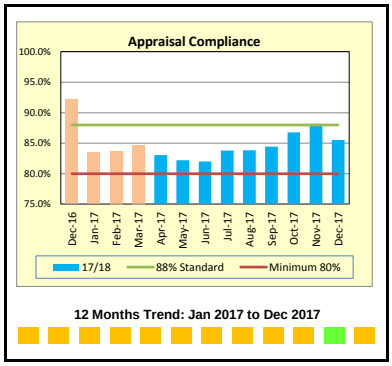
Workforce (HR)

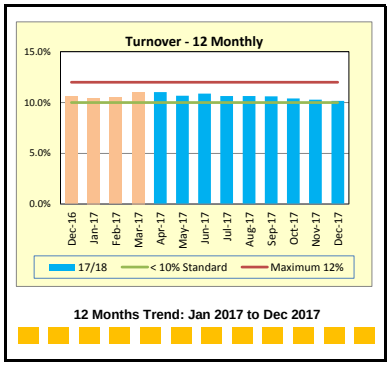












Board of Directors	
Agenda Item	6.1.2
Title of Report	Month 9 Finance Report
Date of Meeting	31st January 2018
Author	Julie Clarke, Assistant Director of Finance
Accountable Executive	Gareth Lawrence, Acting Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	8 8c,8d
Level of Assurance • **Positive** • **Gap(s)**	Gaps: Financial performance below plan with consequent non delivery of STF funding.
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To discuss and note
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

Overview

This paper provides an update to the Board of Directors on the month 9 financial performance of the Trust for the 2017/18 financial year.

The Trust submitted a revised plan to NHS Improvement (NHSI) which agreed delivery of an operational deficit of (£0.4m) in line with the control total issued and agreed at Board in March 2017. Within this plan is the requirement to deliver a Cost Improvement Programme (CIP) of £15.0m and a requirement to deliver additional initiatives identified and agreed at Board in March to deliver further savings/initiatives of £6.6m (residual risk of £5.0m) profiled to the latter part of the financial year with a key element of this reliant on working with a formally appointed SEP.

At the end of December the Trust has reported an actual deficit of (£21.2m) against a plan of (£11.7m) excluding Sustainability and Transformation Funding (STF). As a result of the non-achievement of the STF criteria the Trust has not been able to access £4.6m of the STF. In month, the Trust has delivered a (£3.7m) deficit compared to a planned deficit of (£0.8m). This is £0.7m worse than forecast and is primarily a result of reduced Elective and Outpatient activity and the reversal of the apprenticeship levy (as discussed in Decembers Board). The Trust reduced Elective and Outpatient activity in line with National guidance issued during December in response to the increased operational pressure on Health and Social care resources. The in month adverse performance relates to the non-achievement of STF, continued operational pressures as result of escalation, increased agency and locum costs as a result of vacant posts and non-delivery of the Cost Improvement Programme (CIP).

The Trust disappointingly is reporting a £4.1m adverse variance performance to the CIP having delivered £5.6m compared to the £9.7m target. The levels of savings within the plan represent c5% of Trust turnover which is c3% above the level nationally identified by NHSI in the planning guidance. Current delivery levels exceed the 2% level but fall short of the internal target required to achieve the operational plan and subsequent STF. The Trust continues to review all transformational schemes via the Transformational Steering Group (TSG) in order to support sustainable delivery of the savings target.

The cash balance at the end of December was £2.1m, which is £0.2m above plan. This primarily reflects the closing 16/17 cash position being higher than plan, additional above-plan borrowing and the additional cash received to support the Digital Wirral / Global Digital Exemplar (GDE) programme this is offset by adverse EBITDA performance. In December, additional cash support was drawn down in line with previous papers presented to the Board and FBPAC.

The Trust continues to forecast a planned deficit of c (£0.4m) at month 9, while the Trust does wish to adjust the forecast outturn, it has been agreed with NHSI that this can be done at month 10 due to the risks mentioned below and the impending land sale on the Clatterbridge site.

- Sepsis coding challenges – Discussion with the CCG and regulator have concluded that National Guidance will be issued on the treatment of Sepsis within HRG4+
- Utilisation of CQUIN risk reserve – The CCG has allocated and agreed in principle the payment to the Trust to take place in March 2018; this is reflected in the year to date position.
- CQUIN challenges on milestone delivery – CQUIN progress is being monitored through the Finance and Performance Group (FPG).
- Procedures of Low Clinical Priority (PLCP) – The Trust remains in discussion with the CCG regarding the Health Economy process and payment of activity in year.
- Winter funding allocation (Tranche 1 and Tranche 2)

The Trust has achieved an overall Use of Resources (UoR) Rating of 3 which is in line with plan. As in previous months, the Agency spend rating is preventing the overall UoR Rating from dropping to 4.

Table 1 Income and Expenditure Performance

Year ending 31 March 2018 Position as at 31 December 2017	Current Month			YTD		
	Plan £k	Actual £k	Variance £k	Plan £k	Actual £k	Variance £k
Clinical income	25,102	24,116	(986)	226,558	218,840	(7,718)
Non-NHS clinical income	131	144	13	1,179	1,841	662
Other income	2,445	2,246	(199)	22,005	21,893	(112)
Total operating income before donated asset income	**27,678**	**26,506**	**(1,172)**	**249,742**	**242,574**	**(7,168)**
Pay	(18,760)	(20,444)	(1,684)	(165,346)	(175,500)	(10,154)
Other expenditure	(8,662)	(8,837)	(175)	(80,946)	(79,140)	1,806
Total operating expenditure before depreciation and impairments	**(27,422)**	**(29,281)**	**(1,859)**	**(246,292)**	**(254,640)**	**(8,348)**
EBITDA	**256**	**(2,775)**	**(3,031)**	**3,450**	**(12,066)**	**(15,516)**
Depreciation and net impairment	(700)	(563)	137	(6,208)	(4,914)	1,294
Capital donations / grants income	0	0	0	0	325	325
OPERATING SURPLUS / (DEFICIT)	**(444)**	**(3,339)**	**(2,894)**	**(2,758)**	**(16,655)**	**(13,897)**
Net finance costs and gains / (losses) on disposal	(369)	(373)	(4)	(3,249)	(3,267)	(18)
ACTUAL SURPLUS / (DEFICIT)	**(814)**	**(3,712)**	**(2,898)**	**(6,007)**	**(19,922)**	**(13,915)**
Reverse net impairment	0	0	0	0	0	0
SURPLUS / (DEFICIT) before impairments and transfers	**(814)**	**(3,712)**	**(2,898)**	**(6,007)**	**(19,922)**	**(13,915)**
Reverse capital donations / grants I&E impact	12	16	4	107	(197)	(303)
DEL net impairments *(damage, not revaluation)*	0	0	0	0	0	0
ADJUSTED FINANCIAL PERFORMANCE SURPLUS / (DEFICIT) (AFPD)	**(802)**	**(3,696)**	**(2,894)**	**(5,900)**	**(20,118)**	**(14,218)**
AFPD excluding STF	**(1,690)**	**(3,696)**	**(2,006)**	**(11,669)**	**(21,249)**	**(9,580)**

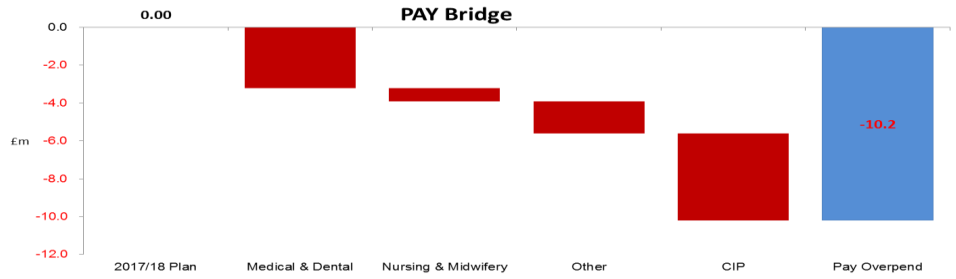
The table above details the current performance of the Trust in relation to the plan submitted to NHSI in March 2017. The detailed Income and Expenditure account can be viewed in Appendix 1.

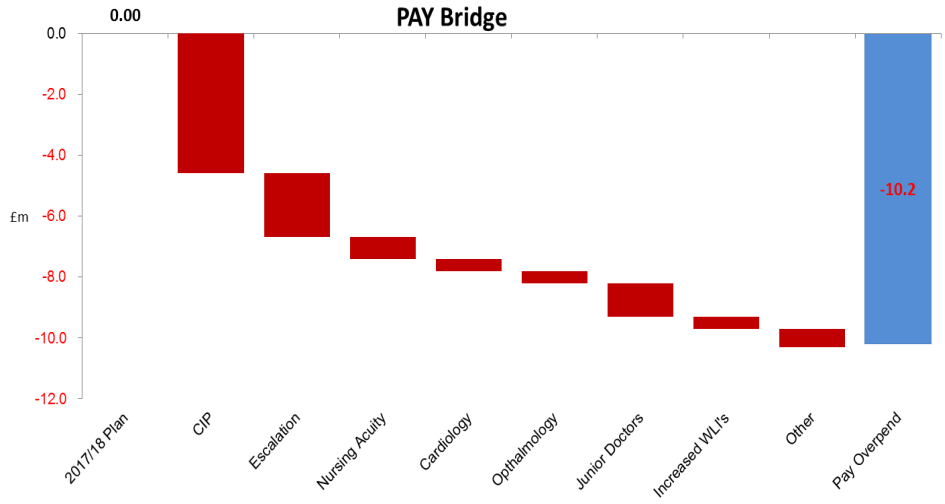
The non-achievement of the control total and A&E performance since Q1 has meant that the Trust has had (£4.6m) of the STF fund withheld further deteriorating the income position. Non PbR excluded drugs is currently below plan by (£4.4m), this is offset within expenditure.

As a result of the increased levels of NEL activity the Trust has currently been penalised by c£1.7m greater than planned for in respect of the NEL marginal rate. The Trust continues to discuss the high levels of NEL activity with Health and Social partners in order to find a more sustainable level of support.

Due to the Trust signing up to the Control Total issued by NHS Improvement, the Trust has avoided financial sanctions of c£8.6m YTD due to A&E(£1.5m)and RTT(£7.1m) adverse performance to targets.

The bridge charts overleaf demonstrate the current YTD pay pressures within the Trust.





The Trust continues to monitor the use of non-core spend and agency. The table below shows the detail by non-core category:-

Table 2 Core and Non-Core Expenditure Analysis

	15/16 Average £000's	16/17 Average £000's	17/18 Average £000's	Apr £000's	May £000's	Jun £000's	Jul £000's	Aug £000's	Sep £000's	Oct £000's	Nov £000's	Dec £000's	YTD £000's
Plan				18,241	18,506	18,455	18,190	18,352	18,134	18,357	18,351	18,760	165,346
Pay Costs													
Substantive	16,047	16,944	17,505	17,340	17,366	17,355	17,213	17,405	17,552	17,654	17,260	18,401	157,546
Bank Staff	299	336	**422**	377	374	406	418	474	428	468	472	384	3,801
Agency Staff	723	591	**550**	424	515	568	696	724	477	429	574	543	4,950
Overtime	290	255	**291**	339	266	280	272	292	281	272	315	301	2,618
Medical Bank/Locum	357	462	**576**	486	506	558	546	629	541	582	626	710	5,184
WLI (In Year)	95	103	**156**	166	164	143	186	135	113	127	262	105	1,401
Non Substantive Total	1,764	1,748	1,995	1,791	1,825	1,955	2,118	2,254	1,840	1,878	2,249	2,043	17,953
Total Pay	17,811	18,692	19,500	19,131	19,191	19,310	19,331	19,659	19,392	19,532	19,509	20,444	175,499
Variance				(890)	(685)	(855)	(1,141)	(1,307)	(1,258)	(1,175)	(1,158)	(1,684)	(10,153)
Non-Core %	9.9%	9.4%	10.2%	9.4%	9.5%	10.1%	11.0%	11.5%	9.5%	9.6%	11.5%	10.0%	10.2%

The Trust will continue to review the operational pay spend via F&PG and FBPAC with a renewed focus on actions required to reduce the pay run rate currently being experienced. The Trust agency YTD spend in M9 was £5.0m compared to the “ceiling” of £6.1m issued by NHSI however this is higher than planned levels of agency. Agency and Medical locum expenditure will continue to be closely managed given the premium adverse impact on the financial plan, alongside assessing the impact of a “freeze” imposed on non-clinical agency. The performance against the agency ceiling is ensuring that the Trust is currently delivering a UoR Rating of 3.

The YTD position includes the release of the £1.2m CQUIN risk reserve, as previously reported to the Board. While the CCG have confirmed payment the funding has not yet been released.

The YTD non recurrent support of £1.3m overall has been released in Q1. This is non recurrent mitigation and as previously reported to the Board of Directors is not available in future months to support any continuance of the current higher than planned expenditure run rate of the Trust.

The impact of the associated risks and non-recurrent adjustments to the current YTD position and the underlying position are demonstrated in the table overleaf.

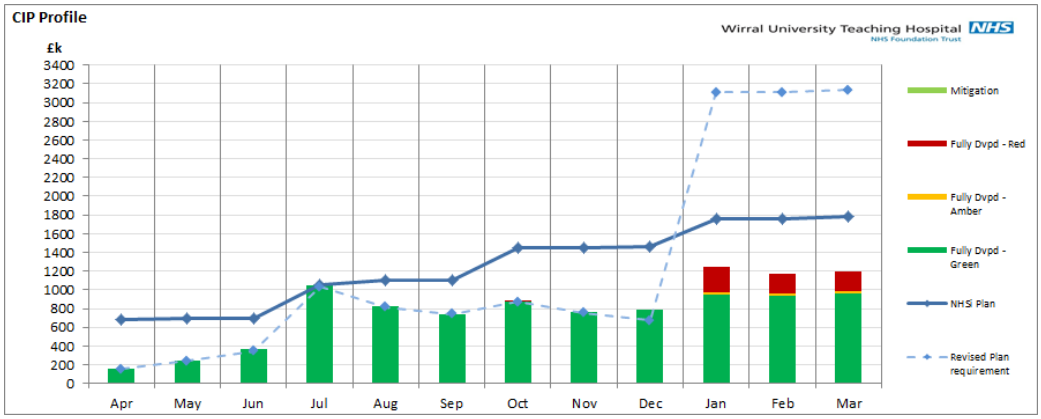
Table 3 Underlying Deficit

	YTD		
	Plan £k	Actual £k	Vaiance £k
Adjusted financial performance surplus/(deficit) (AFPD)	**(5,900)**	**(20,118)**	**(14,218)**
AFPD excluding STF	(11,669)	(21,249)	(9,580)
AFPD excluding Non-Recurrent Support inc Winter Funding	(11,669)	(23,025)	(11,356)
AFPD excluding CQUIN Risk	(11,669)	(24,225)	(12,556)
AFPD Underlying Position (exc STF & CQUIN Risk)	**(11,669)**	**(25,425)**	**(13,756)**

Cost Improvement Programme (CIP)

The CIP for 2017/18 is £15m (c5%), this is allocated as a target both divisionally and workstream led. As at the end of the Month 9 the Trust is behind the YTD target of £9.7m by £4.1m.

Table 4 CIP Performance



The table below details the month 9 position for CIP.

Summary as at Month 9	YTD		In Year		
	Actual		Forecast		Trend
NHSi Plan (Target)	£9,694k		£15,000k		
Fully Developed TSG approved schemes	£5,866k		£9,338k		
Overperformance/ (Gap) v NHSi Plan	-£3,828k	-39.5%	-£5,662k	-37.7%	
Latest Forecast performance on TSG approved schemes	£5,644k		£9,239k		↓
Over/ (Under)performance compared to TSG approved schemes	-£223k	-3.8%	-£99k	-1.1%	
Latest Forecast including mitigation	£5,644k		£9,239k		↓
Performance Variance (Latest Forecast to NHSi Plan)	-£4,050k	-41.8%	-£5,761k	-38.4%	
Latest Forecast adjusted for risk	£5,644k		£8,476k		
Performance Variance (Latest Forecast to NHSi Plan)	-£4,050k	-41.8%	-£6,524k	-43.5%	

The in-year forecast for fully developed schemes at the end of December remains at £9.3m.

The risk of delivery has also been assessed on all schemes and a provision of £0.8m in year has been made against the £9.3m. In addition the CIP mitigation reserve of £1.5m has been applied (not shown in the figures above) which increases the forecast in year CIP delivery to nearer £10m. This position is reflected in the full financial forecast.

Undoubtedly this shortfall is of concern, however considerable work has been undertaken with the divisional and programme leads to develop the plans in progress and opportunities schemes for approval at Transformational Steering Group (TSG) with all schemes having been risk assessed with a small proportion rated as red. Work will continue to assess the remaining schemes within these categories, with a view to obtain approval at TSG and have a clear understanding of the unidentified gap in order to take the appropriate actions. It is recognised that the pace of conversion of opportunities needs to be accelerated in order to reduce the gap between the plan requirement and the value of fully developed schemes. CIP performance has also been escalated to the weekly Executive Management Team meeting with particular focus on the delivery of the corporate directorate targets.

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).*

Capital variances to plan (£1.0m) are primarily due to actual brought forward balances for 2017/18 exceeding those in plan and depreciation savings, offset by the transfer of part of the Clatterbridge site to *Assets held for sale*, and a year-to-date capital underspend. Depreciation savings have been delivered by extending the asset life of the Cerner EPR system. While this has had a benefit to the Income & Expenditure position, it increases risks to the Trust's ability to fund its future capital programme without additional external support.

Capital expenditure is currently behind plan (inclusive of Digital Wirral (GDE) scheme) by £6.3m. Public dividend capital received in respect of the GDE scheme in year (£3.9m) must be spent before 31 March 2018. In order to utilise the capital expenditure available the Trust is looking to bring forward capital schemes from the 2018/19 programme.

December's working capital variances are due to controlled variations in the working capital cycle, in addition to some temporary processing delays due to an upgrade of the Trust's financial system. In month 9, movements and variances in non-current borrowings are primarily attributable to the in-month draw-down of the Trust's revenue support *uncommitted loan* facility (£7.2m).

The December closing cash balance was £2.1m, which is £0.2m above plan. This variance comprises a number of factors: 16/17 cash position being higher than plan (£3.6m), capital

underspend (£2.9m), the additional PDC cash received to support the Digital Wirral (GDE) programme (£3.9m), and above-plan loan draw-down (£6.6m), offset by working capital movements (£1.6m) and adverse EBITDA performance (£15.5m). Further detail of the Trust's cash position is at Appendix 3 – *Statement of Cash Flows*.

The Trust has achieved an overall Use of Resources (UoR) Rating of 3 which is in line with plan. As previously noted, the *Agency spend* rating is preventing the overall UoR Rating dropping to 4.

Conclusion

The Trust is currently reporting an YTD adverse variance (excluding STF) to plan of c(£9.6m) as at the end of December and as a consequence of this has not received the associated STF payments for this period. The underlying deficit position of the Trust continues to be reviewed in order to reflect the impact for 2018/19 planning.

The December position has deteriorated compared to forecast as a result of reduced Elective and Outpatient activity in order to support the increases in Non-Elective demand.

The Trust continues to liaise with the wider Health Economy and in particular its main commissioner in order to mitigate the risks identified within the current and forecast financial position.

Recommendations

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

Gareth Lawrence
Acting Director of Finance
January 2018

Appendix 1
Income & Expenditure

Year ending 31 March 2018 Position as at 31 December 2017	December Plan £k	 Actual £k	 Variance £k	YTD Plan £k	 Actual £k	 Variance £k
NHS clinical income						
Elective	1,721	1,769	48	16,812	17,270	458
Daycase	2,056	1,830	(226)	20,037	19,844	(194)
Elective excess bed days	81	183	102	792	756	(36)
Non-elective	8,027	8,761	734	67,776	72,110	4,334
Non-elective excess bed days	195	219	24	1,640	1,871	231
A&E	1,015	1,105	90	9,323	9,751	429
Outpatient	2,582	2,380	(202)	25,439	24,668	(770)
Diagnostic imaging	191	254	63	1,843	1,836	(7)
Maternity	478	380	(98)	4,236	3,929	(307)
Non PbR	5,709	5,553	(156)	52,249	49,586	(2,663)
HCD	1,707	1,236	(471)	15,364	10,961	(4,403)
CQUINs	433	442	9	5,099	4,969	(130)
Other income	20	4	(16)	180	158	(22)
STF	888	0	(888)	5,769	1,131	(4,638)
Total clinical income	**25,103**	**24,116**	**(987)**	**226,558**	**218,840**	**(7,718)**
Non-NHS clinical income						
Private patients	54	4	(50)	486	305	(181)
Other non-NHS clinical income	77	140	63	693	1,535	842
Total non-NHS clinical income	**131**	**144**	**13**	**1,179**	**1,841**	**662**
Other income						
Education & training	815	800	(15)	7,335	7,375	40
R&D	34	52	18	306	401	95
Non-patient services to other bodies	773	594	(179)	6,957	6,388	(569)
Other income	823	799	(24)	7,407	8,055	648
Total other income	**2,445**	**2,246**	**(199)**	**22,005**	**22,218**	**213**
Total operating income	**27,679**	**26,506**	**(1,173)**	**249,742**	**242,899**	**(6,843)**
Pay costs	(18,760)	(20,444)	(1,684)	(165,346)	(175,500)	(10,154)
Drug costs	(2,552)	(2,026)	526	(21,366)	(18,068)	3,298
Clinical supplies	(2,505)	(3,001)	(496)	(23,119)	(26,440)	(3,321)
Other costs	(3,605)	(3,810)	(205)	(36,461)	(34,631)	1,830
Depreciation and net impairment	(700)	(563)	137	(6,208)	(4,914)	1,294
Total operating costs	**(28,122)**	**(29,844)**	**(1,722)**	**(252,500)**	**(259,553)**	**(7,054)**
Operating surplus / (deficit)	**(444)**	**(3,338)**	**(2,894)**	**(2,758)**	**(16,655)**	**(13,897)**
Operating surplus / (deficit) %	**-1.60%**	**-12.59%**		**-1.10%**	**-6.86%**	
Net finance costs and gains / (losses) on disposal	(369)	(373)	(4)	(3,249)	(3,267)	(18)
Actual surplus / (deficit) per annual accounts	**(813)**	**(3,712)**	**(2,898)**	**(6,007)**	**(19,922)**	**(13,915)**
Reverse net impairment	0	0	0	0	0	0
Surplus / (deficit) before impairments and transfers	**(813)**	**(3,712)**	**(2,898)**	**(6,007)**	**(19,922)**	**(13,915)**
Reverse capital donations/grants I&E impact	12	16	4	107	(197)	(303)
DEL net impairments *(damage, not revaluation)*	0	0	0	0	0	0
Adjusted financial performance surplus / (deficit) (AFPD)	**(802)**	**(3,696)**	**(2,894)**	**(5,900)**	**(20,118)**	**(14,218)**
AFPD excluding STF	**(1,690)**	**(3,696)**	**(2,006)**	**(11,669)**	**(21,250)**	**(9,580)**

The variance on AFPD measures the Trust's performance against its control total.

Appendix 2
Statement of Financial Position (SOFP)

Actual as at 01.04.17 £k		Actual as at 30.11.17 £k	Actual as at 31.12.17 £k	Variance (monthly) £k	Plan as at 31.12.17 £k	Actual as at 31.12.17 £k	Variance (to plan) £k	Forecast 31.03.18 £k	Plan 31.03.18 £k
	Non-current assets								
145,789	Property, plant and equipment	143,434	143,134	(300)	143,997	143,134	(863)	146,842	145,166
12,216	Intangibles	11,668	11,597	(71)	10,803	11,597	794	16,367	10,080
950	Trade and other non-current receivables	887	874	(13)	1,612	874	(738)	874	1,612
158,955		**155,989**	**155,605**	**(384)**	**156,412**	**155,605**	**(807)**	**164,083**	**156,858**
	Current assets								
3,881	Inventories	4,169	3,664	(505)	4,051	3,664	(387)	3,664	4,051
16,389	Trade and other receivables	23,876	27,043	3,167	22,500	27,043	4,543	17,981	20,760
0	Assets held for sale [1]	1,805	1,805	0	0	1,805	1,805	1,805	0
5,390	Cash and cash equivalents	2,090	2,143	53	1,991	2,143	152	3,989	2,257
25,660		**31,940**	**34,655**	**2,715**	**28,542**	**34,655**	**6,113**	**27,439**	**27,068**
184,615	**Total assets**	**187,929**	**190,260**	**2,331**	**184,954**	**190,260**	**5,306**	**191,522**	**183,926**
	Current liabilities								
(31,059)	Trade and other payables	(40,928)	(39,239)	1,689	(33,509)	(39,239)	(5,730)	(37,907)	(32,172)
(3,341)	Other liabilities	(3,863)	(4,443)	(580)	(3,696)	(4,443)	(747)	(2,783)	(3,696)
(1,015)	Borrowings	(1,074)	(1,074)	0	(1,015)	(1,074)	(59)	(1,073)	(1,014)
(668)	Provisions	(668)	(668)	0	(664)	(668)	(4)	(668)	(664)
(36,083)		**(46,533)**	**(45,424)**	**1,109**	**(38,884)**	**(45,424)**	**(6,540)**	**(42,431)**	**(37,546)**
(10,423)	**Net current assets/(liabilities)**	**(14,593)**	**(10,769)**	**3,824**	**(10,342)**	**(10,769)**	**(427)**	**(14,993)**	**(10,478)**
148,532	**Total assets less current liabilities**	**141,396**	**144,836**	**3,440**	**146,070**	**144,836**	**(1,234)**	**149,090**	**146,380**
	Non-current liabilities								
(9,154)	Other liabilities	(8,926)	(8,898)	28	(8,898)	(8,898)	0	(8,813)	(8,812)
(26,708)	Borrowings	(32,246)	(39,441)	(7,195)	(32,634)	(39,441)	(6,807)	(49,484)	(27,627)
(2,221)	Provisions	(2,094)	(2,079)	15	(2,009)	(2,079)	(70)	(2,032)	(1,969)
(38,083)		**(43,266)**	**(50,418)**	**(7,152)**	**(43,541)**	**(50,418)**	**(6,877)**	**(60,329)**	**(38,408)**
110,449	**Total assets employed**	**98,130**	**94,418**	**(3,712)**	**102,529**	**94,418**	**(8,111)**	**88,761**	**107,972**
	Financed by Taxpayers' equity								
72,525	Public dividend capital	76,416	76,416	0	72,525	76,416	3,891	77,511	72,525
4,575	Income and expenditure reserve	(11,635)	(15,347)	(3,712)	(2,664)	(15,347)	(12,683)	(22,100)	2,779
33,349	Revaluation reserve	33,349	33,349	0	32,668	33,349	681	33,350	32,668
110,449	**Total taxpayers' equity**	**98,130**	**94,418**	**(3,712)**	**102,529**	**94,418**	**(8,111)**	**88,761**	**107,972**

[1] The Trust is actively pursuing options related to the sale of part of the Clatterbridge site.

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	**2,090**	**2,990**	**(900)**	**5,390**	**1,752**	**3,638**	**5,390**	**1,752**
Operating activities								
Surplus / (deficit)	*(3,712)*	*(815)*	*(2,897)*	*(19,922)*	*(6,010)*	*(13,912)*	*(26,675)*	*(568)*
Net interest accrued	*96*	*89*	*6*	*769*	*731*	*38*	*1,079*	*982*
PDC dividend expense	*277*	*277*	*(0)*	*2,493*	*2,495*	*(2)*	*3,324*	*3,326*
Unwinding of discount	*1*	*3*	*(2)*	*5*	*27*	*(22)*	*6*	*35*
(Gain) / loss on disposal	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Operating surplus / (deficit)	(3,339)	(445)	(2,894)	(16,656)	(2,758)	(13,899)	(22,266)	3,775
Depreciation and amortisation	563	701	(137)	4,914	6,208	(1,294)	6,578	8,353
Impairments / (impairment reversals)	0	0	0	0	0	0	0	0
Donated asset income (cash and non-cash)	0	0	0	(325)	0	(325)	(325)	0
Changes in working capital	(4,346)	(774)	(3,571)	(2,890)	(1,252)	(1,638)	3,452	(270)
Other movements in operating cash flows	0	0	0	0	0	0	0	0
Investing activities								
Interest received	5	7	(2)	24	61	(37)	21	82
Purchase of non-current (capital) assets [1]	(25)	(1,087)	1,062	(2,842)	(5,773)	2,931	(11,937)	(7,964)
Sales of non-current (capital) assets	0	0	0	0	0	0	0	0
Receipt of cash donations to purchase capital assets	0	0	0	40	0	40	17	0
Financing activities								
Public dividend capital received	0	0	0	3,891	0	3,891	4,986	0
ITFF loan principal drawdown	0	0	0	0	0	0	0	0
Support funding [2] principal drawdown	7,200	600	6,600	15,200	8,600	6,600	25,766	9,600
ITFF loan principal repaid	0	0	0	(508)	(508)	0	(1,015)	(1,014)
Support funding [2] principal repaid	0	0	0	(2,166)	(2,166)	0	(2,166)	(7,666)
Interest paid	0	0	0	(502)	(510)	8	(1,117)	(1,064)
PDC dividend paid	0	0	0	(1,373)	(1,663)	290	(3,324)	(3,326)
Capital element of finance lease rental payments	(5)	0	(5)	(45)	0	(45)	(59)	0
Interest element of finance lease rental payments	(1)	0	(1)	(9)	0	(9)	(12)	0
Total net cash inflow / (outflow)	**53**	**(999)**	**1,052**	**(3,247)**	**239**	**(3,486)**	**(1,401)**	**505**
Closing cash	**2,143**	**1,991**	**152**	**2,143**	**1,991**	**152**	**3,989**	**2,257**

[1] Outflows due to the purchase of non-current assets are not the same as capital expenditure due to movements in capital creditors.
[2] Support funding currently comprises a working capital facility, issued by DH and administered by NHSI.

Board of Directors	
Agenda Item	6.2
Title of Report	Month 9 – NHSI Commentary
Date of Meeting	31st January 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)**	Gaps: Financial performance below plan with consequent non delivery of STF funding.
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To discuss and note
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

Month 9 2017/18 Financial Commentary for NHS Improvement

The following commentary details the Trust's financial performance during December (Month 9) and the cumulative outturn position for FY18 against plan.

The year to date performance excluding STF results in the Trust reporting an actual deficit of (£21.2m) against a plan of (£11.7m). The Trust continues to experience year on year increases in demand for its non- elective services with A&E activity higher than the same period in 2016/17. This in turn has led to continued operational costs in delivering this increase in demand which has resulted in an adverse financial performance to plan.

The Trust continues to forecast a planned deficit of c. £0.4m at Mth 9, although this was due to be adjusted in-line with NHSI protocol at quarter 3. Following the December monthly meeting with NHSI it was agreed that a revised forecast will be submitted in Mth 10, reflecting the continuing discussions on land sale and economy wide interventions which have not yet been finalised and will affect the Trust outturn position materially.

Pay costs exceed plan by c. (£10.2m) as at the end of December, reflecting operational pressures in supporting non- elective activity levels, significant pressures in medical staffing in the Emergency Department of c(£0.8m), and non-delivery of CIP c(£4.6m). In addition other operational pay pressures due to further gaps in key medical specialties, high levels of nursing vacancies continue and the subsequent use of non-core pay spend to deliver services have also adversely impacted upon pay plan performance. A vacancy freeze on non-clinical posts has been implemented by the Trust in October and remains under review. In order to maintain patient safety the Trust has had to increase internal escalation areas as a result of higher than planned demand for non-elective services within the system. This is also in line with the direction issued by the NHS England TSAR of A&E, who visited the Trust during July. The Trust still has significantly high numbers of "medically optimised" patients within the bed base, reflecting a lack of alternative support within the health and social care system and consequent adverse to plan financial performance.

The Trust has utilised the 0.5% CQUIN risk reserve within the YTD position (c£1.2m), although this is yet to be paid over, the CCG have agreed to release the resource. Also included within the YTD position is £1.3m of non-recurrent support, this will affect the overall run-rate of the Trust going forward and the underlying position for 2018/19 all of which continues to be monitored through internal governance and assurance structures.

The Trust continues to perform well in terms of GP streaming in line with National timeframes and has plans in place to utilise the National Capital Funding that has been allocated to improve A&E flow and performance.

Cash balances at the end of December were £2.1m, exceeding plan by £0.2m. This primarily reflects factors such as the closing 16/17 cash position being higher than plan (£3.6m), movements in working capital (£1.6m), capital underspend (£2.9m) and the additional PDC cash received to support the Digital Wirral (GDE) programme (£3.9m), additional revenue support loan funding offset by EBITDA performance (£15.5m).
As the financial position has become more challenging the Trust as noted above has entered into an internal "recovery plan" mode to support the delivery of the financial plan. Discussions have taken place within the Health Economy around any potential support that could be provided to the Trust with the Finance, Business Planning and Assurance Committee and Board of Directors having received the first draft of the internal recovery plan this will be updated further at the February meetings at which the revised forecast outturn will also be shared.

The table overleaf details the year to date performance against the Trusts' control total.

Year ending 31 March 2018 Position as at 31st December 2017	Current Month			YTD		
	Plan £k	Actual £k	Variance £k	Plan £k	Actual £k	Variance £k
Income from patient care activities (exc STF)	24,345	24,161	(184)	221,968	218,693	(3,274)
Other income (inc STF)	3,333	2,345	(988)	27,774	23,880	(3,894)
Total operating income before donated asset income	**27,678**	**26,506**	**(1,172)**	**249,742**	**242,574**	**(7,168)**
Pay	(18,748)	(20,431)	(1,683)	(165,232)	(175,388)	(10,156)
Other expenditure	(8,674)	(8,850)	(176)	(81,060)	(79,252)	1,808
Total operating expenditure before depreciation and impairments	**(27,422)**	**(29,281)**	**(1,859)**	**(246,292)**	**(254,640)**	**(8,348)**
EBITDA	**256**	**(2,775)**	**(3,031)**	**3,450**	**(12,066)**	**(15,516)**
Depreciation and net impairment	(700)	(563)	137	(6,209)	(4,914)	1,295
Capital donations / grants income	0	0	0	0	325	325
OPERATING SURPLUS / (DEFICIT)	**(444)**	**(3,339)**	**(2,894)**	**(2,759)**	**(16,655)**	**(13,896)**
Net finance costs and gains / (losses) on disposal	(369)	(373)	(4)	(3,249)	(3,267)	(18)
ACTUAL SURPLUS / (DEFICIT)	**(814)**	**(3,712)**	**(2,898)**	**(6,008)**	**(19,922)**	**(13,914)**
Reverse net impairment	0	0	0	0	0	0
SURPLUS / (DEFICIT) before impairments and transfers	**(814)**	**(3,712)**	**(2,898)**	**(6,008)**	**(19,922)**	**(13,914)**
Reverse capital donations / grants I&E impact	12	16	4	107	(197)	(303)
DEL net impairments *(damage, not revaluation)*	0	0	0	0	0	0
ADJUSTED FINANCIAL PERFORMANCE SURPLUS / (DEFICIT) (AFPD)	**(802)**	**(3,696)**	**(2,894)**	**(5,901)**	**(20,118)**	**(14,217)**
AFPD excluding STF	**(1,690)**	**(3,696)**	**(2,006)**	**(11,669)**	**(21,249)**	**(9,579)**

NHS Clinical Revenue

Cumulatively, non-elective (2.36%) and A&E attendances (1.33%) are over performing in terms of actual activity delivered against the initial plan, with all other areas under performing. During the period PbR activity under achieved from an activity perspective reflecting cancellations due to operational pressures, actual income exceeded plan by c£0.5m. During December non-elective activity was 9% higher than plan. Cumulatively the income position was further supported by increases in complexity.

The main NEL areas seeing an increase in complexity are, Diabetic Medicine £1.1m. Geriatric Medicine £2.0m, Respiratory, £1.4m and Upper GI, £1.1m, however acute care has seen a significant increase in activity however the case-mix has been less complex. Non PbR areas broadly delivered plan with the exception of neonatal bed days, adult critical care and direct access physio. High Cost Drugs income is below plan albeit this is offset by a reduction in drug expenditure.

The Trust continues to be penalised for NEL activity above the MRET baseline with c£1.8m being returned to the CCG above planned levels. The Trust is in discussions with the CCG in relation to the possible re-investment of this resource to support the increasing demand in emergency care.

Performance against Wirral CCG is c£1.2m ahead of plan, reflecting the year to date position and the in month over performance in NEL and elective activity. The Trust has been informed that the CCG's plan for the remaining part of the year is less than the Trusts as a result of planned reductions in activity due to Rightcare savings. The Trust has not yet noticed any reduction on its services and has requested updates from the CCG on the respective delivery.

During Q3 the Trust has not achieved c£0.1m of CQUIN. Plans continue to be reviewed within internal governance structures to ensure that CQUIN targets are achieved for the remainder of the year. As a result of the increased pressures on affordability within the Health and Social care economy the Trust is aware that there may be strict adherence to all CQUIN targets.

NHS England specialised commissioning below plan performance reflecting the under recovery in drug "pass through" costs.

Other Operating Income

In December (Month 9) other operating income (excl. donated assets income) is below plan by a further (£1.0m), this largely reflects the non-delivery of the financial control total and the subsequent STF monies withheld again this month of (£0.9m). YTD the impact of the STF not achieved is a (£4.6m) pressure for the Trust. During Q1 non-recurrent income of £0.3m has supported the financial position in other operating income.

Operating Expenditure

In December (Month 9) operating expenditure (excluding depreciation) is (£1.9m) above plan with a YTD overspend of (£8.3m).

Pay costs exceeded plan in December by (£1.7m) and are showing a cumulative overspend of (£10.2m). The Trust is reviewing the level of pay costs and continues to review the use of agency, recruitment issues and vacancy fill. The material issues driving the current cumulative adverse performance in pay continue to be:

- Escalation pressures c(£1.8m) continue to drive costs significantly above plan as a result of the high level of medically fit patients ready for discharge and the increasing demand on Non-Elective services. The Trust has worked with external partners via the A&E Board and the System Wide Recovery group to access additional winter funds and there is £0.5m in the December income position. Continued medical staffing gaps in the Emergency Department (ED) are resulting in a (£0.8m) pressure YTD. Emergency Department streaming has been implemented since October but there remains significant challenges in delivering the A&E performance target due to demand pressures and flow challenges. There has been cancellation of planned activity to accommodate the non-elective demand in December and this will continue in January as per the national picture.

- Non–delivery of cost improvement plans in relation to pay work-streams of c(£4.6m) ytd. Work continues to review pace of delivery and focus.

- Other operational pressures have adversely impacted the position, further costs for medical staffing, high levels of qualified nurse vacancies and patient acuity have resulted in the use of non-core spend of c(£3.8m) on non-medical bank staff, (£5.2m) on medical locums and a further (£2.6m) on overtime to cover the gaps and vacancies in clinical staff. In addition approximately (£1.4m) has been utilised in the use of WLIs to support delivery of the current income plan. The Trust continues to pursue opportunities to improve list and theatre utilisation in order to reduce the requirement for premium rate payments.

This month in line with the guidance of the accounting treatment of the apprentice levy there has been a £0.5m write-back to pay that was a benefit last month.

Agency spend was £4.9m as at the end of December which remains c£1.1m lower than the agency cap. The Trust has issued an agency staff freeze across all non-clinical staff but undertakes a quality impact assessment and continues to review all agency spend.

Other operating expenditure (excl. depreciation) is above plan by (£0.2m) in December however is cumulatively below plan by £1.8m.

Non-recurrent savings arising from accrual reviews have supported the financial position by £0.8m YTD. The underlying impact of this is being factored into plans for 2018/19. High Cost pass through drugs is a further £4.4m underspent ytd and £0.5m in-month this is offset in NHS Clinical income. Significant overspends on clinical supplies is reducing this underspend and is under review in theatres and other clinical areas. The financial variance in relation to both drugs and clinical supplies reflects non-delivery of the assumed plan CIP that has been delivered in other operating costs. The purchase of healthcare from non-NHS bodies is above plan again this month reflecting outsourced activity to third party providers due to capacity constraints. Again reviews are underway to recruit to vacancies and utilize core capacity. A £0.3m pressure on VAT was incurred in Q2.

The CQUIN risk reserve has been fully utilised within the YTD position supporting the underlying position by £1.2m.

Achievement of the 2017/18 Cost Improvement Programme

The 2017/18 plan assumed the achievement of £14.0m of cost improvement programmes and £1.0m revenue generation schemes through the year, delivering a combined total of £15.0m.
The Trust currently has c£9.0m of fully built up schemes with opportunities and plans continually explored and reviewed at the TSG monthly meeting to realise the remaining target.

The CIP position for 2017/18 (including non-recurrent schemes) can be summarised in the table below:

Summary as at Month 9	YTD		In Year	
	Actual		Forecast	
NHSi Plan (Target)	£9,694k		£15,000k	
Fully Developed TSG approved schemes	£5,866k		£9,338k	
Overperformance/ (Gap) v NHSi Plan	-£3,828k	-39.5%	-£5,662k	-37.7%
Latest Forecast performance on TSG approved schemes	£5,644k		£9,239k	
Over/ (Under)performance compared to TSG approved schemes	-£223k	-3.8%	-£99k	-1.1%
Latest Forecast including mitigation	£5,644k		£9,239k	
Performance Variance (Latest Forecast to NHSi Plan)	-£4,050k	-41.8%	-£5,761k	-38.4%
Latest Forecast adjusted for risk	£5,644k		£8,476k	
Performance Variance (Latest Forecast to NHSi Plan)	-£4,050k	-41.8%	-£6,524k	-43.5%

The in-year forecast on fully developed schemes is c£9.3m, £5.7m behind the NHSI requirement.

Undoubtedly this shortfall is of concern, however considerable work has been undertaken with the divisional and programme leads to develop the plans in progress and opportunities schemes for approval at Transformational Steering Group (TSG) with all schemes having been risk assessed with a small proportion rated as red. Work will continue to assess the remaining schemes within these categories, with a view to obtain approval at TSG and have a clear understanding of the unidentified gap in order to take the appropriate actions. It is recognised that the pace of conversion of opportunities needs to be accelerated in order to reduce the gap between the plan requirement and the value of fully developed schemes. CIP performance has also been escalated to the weekly Executive Management Team meeting with particular focus on the delivery of the corporate directorate targets.

It has to be noted that the lead time in terms of benefits realisation associated with many of the transformational and STP programmes will necessitate an increased focus on tactical in-year schemes.

The Trust is mindful of the financially challenging environment and the need to maintain pace and focus in the identification of initiatives and subsequent delivery. The Service Transformation team continues to work closely with the Divisions to secure progress in 17/18, and provide support in the subsequent delivery, and also commence planning for 18/19.

Post EBITDA Items

For month 9, the favourable year-to-date variance to plan for ITDA items totals £1.6m, due to depreciation savings (£1.3m) and capital donations (£0.3m).

Statement of Financial Position for the period ending 31 December 2017

Total taxpayers' equity equals £94.4m. The main variances for actual balances against plan are explained below.

a) Non-current assets

Total capital assets are above plan by £0.1m at month 9. This variance is detailed in the table below.

Capital variances	£m
17/18 brought forward balances above plan	1.7
Capex underspend, not including finance lease recognition	-2.6
Depreciation below plan	1.3
Donations above plan	0.3
Finance lease recognition / derecognition	0.9
Transfer to *Assets held for sale*	-1.8
Total variance of capital assets to plan	**-0.1**

b) Current assets

Current assets are above plan by £6.1m. Current trade and other receivables are above plan by £4.5m, and inventories are below plan by a further £0.4m. The Trust has recognised *Assets held for sale* (£1.8m), which were not in the plan. The remaining variance is due to cash balances being above plan by £0.2m. The cash variance is detailed in the table below.

Cashflow variances	£m
17/18 brought forward cash balance exceeded plan	3.6
EBITDA and donations below plan	-15.5
Working capital movements	-1.6
Capital expenditure (cash basis) behind plan	2.9
Additional revenue support loan funding	6.6
PDC received	3.9
Other minor variances	0.2
Total variance of cash to plan	**0.2**

c) Current liabilities

Current liabilities are above plan by £6.9m. This is attributable to cash preservation measures preceding the month 9 drawdown of *revenue uncommitted loan facility.*

d) Non-current liabilities

Non-current liabilities exceed plan by £6.9m, primarily due to the month 9 draw-down, which was not included in the plan.

Use of Resource (UoR) Rating

The Trust has achieved an overall UoR Rating of 3, which is in line with plan.

	Planned Rating	Actual Rating
Liquidity	4	4
Capital service capacity	4	4
I&E margin	4	4
Distance from financial plan	1	4
Agency spend	1	1
Overall UoR Rating	**3**	**3**

Control Total and Sustainability and Transformation Fund (STF)

The Trust has delivered £1.1m of the £5.8m available via the STF reflecting the achievement of the financial plan in quarter 1, and the GP streaming element of the A&E performance standards. Since month 4 the Trust has been unable to deliver the financial plan due to the continued pressures of escalation costs in emergency areas. The Trust continues to work with the Health Economy to improve this position and has also brought in external support to aid improvement in A&E performance.

Conclusion

The Trust continues to work through the Recovery plan presented to Trust Board in September (and shared with NHSI colleagues) and will be further updated at the January Board, at which the revised forecast outturn will also be discussed and the likelihood of planned schemes delivering as expected.

Further discussions have taken place with the Wirral Health Economy around agreement to a system control total and to voluntarily enter the capped expenditure programme. This will enable system wide ownership of the financial challenge and increase the innovation across all aspects of the health and social system.

The Trust will continue to submit 13 week cash flows in line with NHSI processes to support the requirement of future cash draw downs in line with plan.

The Trust is working closely with all partners across the health economy to support the delivery of a sustainable health service within the Cheshire and Wirral LDSP.

Gareth Lawrence
Acting Director of Finance
January 2018

Board of Directors	
Agenda Item	7.1
Title of Report	Report of the Finance, Business Performance and Assurance Committee – 15th December 2017
Date of Meeting	31st January 2018
Author	Andrea Hodgson, Chair of the Finance, Business Performance and Assurance Committee
Accountable Executive	David Jago, Director of Finance (As at date of the FBPAC Meeting)
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

This report provides a summary of the work of the Finance, Business Performance and Assurance Committee (FBPAC), which met on the 15th December 2017. Key focus areas are those, which address the gaps in assurance/control in the Board Assurance Framework.

1. Board Assurance Framework

The Committee noted there were no further changes to the Board Assurance Framework (BAF) during the reporting period and that risks and risk scores remained static.
It was requested and agreed that the risk 'heat map' be updated and refreshed. Further it was agreed that it would be helpful for a clearer alignment and correlation of the organisation's 'top-4 risk' to be visible to the Board.

2. Risks at 15+

There were no risks scored at 15+ reported to the Committee this month.

3. M8 Financial Position and Financial Recovery

The Committee reviewed the current position at M6 which included a review of:

- **The year to date deficit position** which was reported at £17.6m excluding STF which was £7.6mM adverse variance to plan. Non delivery of financial and A&E 4 hour targets resulted in loss of access to STF to month 8 of some £3.8m.
- **Income** – Clinical PbR income was reported above plan at £3.6m however non-PbR was £2.5m behind plan and the STF was a further £3.8m below plan. Under performance was attributed to lower pass through of High Cost Drugs equating to £3.9m although this underperformance was offset by a corresponding underspend within drug expenditure. The Committee was advised that £5.7m of the income position related to contract penalties recognising that this would have been higher (£7.5m) if the Trust had not accepted the in year control total of £0.4M deficit.
- **Expenditure** – this was reported at £6.5mabove plan ytd with pay costs being the largest contributor at £8.5m. Within this position there were £3.3m of pressures reported associated with non-delivery of CIP, £1.3m of additional costs incurred due to above plan escalation capacity, a further £0.6m in respect of above plan nursing costs due to acuity levels. The Committee noted the adverse impact of middle grade and junior grade medical vacancy levels with premium costs being incurred to cover at c£1.0m and £0.6m of pressures in the Emergency Department. Some of the overspend had been offset by agency cost savings as a result of agency freeze on all non-clinical staffing areas; the release of the CQUIN reserve in Q1 and circa £1.3M of mitigating actions as a result of reviews undertaken on accruals and deferred income. The Committee also noted the treatment of the apprenticeship levy as a prepayment supporting the position by some £0.5m with the accounting treatment to be agreed with external audit.
- **Cash** – Balances stood at £2.1m., £0.9m below materially due to below plan EBITDA performance at £12.5m partially offset by GDE monies at £3.8m,below plan capex at £1.9m,working capital at £1.9m and higher than planned opening cash balances at £3.6m.It was noted that additional above plan borrowing had been drawn down in December in line with levels previously agreed at FBPAC and the Board of Directors.
- **Use of Resources** – this was reported as a 3 in line with the plan and supported by agency costs being delivered within the cap.
- **Cost Improvement Plan** – YTD performance is £3.3m below plan, however the in-year forecast continues to be forecast at circa £9.5m inclusive of risk reserve. The focus of attention was reported as being on improving performance with patient flow and whilst recognizing this activity is not in itself cash releasing, it would support achievement of STF funding and the quality and safety of patients. The Committee was pleased to see some key achievements such as more patients being discharged before midday and faster recovery after full capacity days. Challenges such as changing in Divisional leadership, sustainability with beds and the need for increased 'buy in' from clinical colleagues was acknowledged.

The Committee was concerned that despite improvements in the adverse to plan run rate there was a need for significant improvement in the remaining months of the year for the control total to be achieved. The Committee noted that a forecast position update would be presented to the Board of Directors at its December meeting.

4. Data Quality, Management of Information and Clinical Coding Review

The Committee reviewed the report specifically noting key issues around training targets and data quality audits which have become more difficult in the absence of paper records.

It was requested that future reports provide more assurance to the Committee around the BAF risk and are supported by delivery of date quality metrics.

The Committee noted that the informatics team are also looking at access data measures (kite marks) and are working with the Director of Operations, and requested that assurance around this is also reported on.

5. Informatics Programme Review and Update

The Committee received the report showing improvements in a number of Digital Wirral Projects and noted that further activity on supporting 'deep dives' would be needed, including granular detail of approach, outcomes and benefits.

It was requested that future reports from the Group reported specifically on the Data Quality risks, include greater detail and metric performance around risks enabling confidence and assurance to be taken from the work.

The Committee supported the recommendation to the Board of Directors to apply for an extension of the contract between WUTH and Cerner for a further 10 years. The agreement would allow the Trust to make changes in the payment level from the current year onwards in order to:

a) Reduce the cost of depreciation by circa £1.3m (noting impact on capex going forwards)
b) Reduce the amount spent with Cerner (by an average of £1m per year) in the first two years and then reducing to a recurrent £0.6m
c) The extension will also create sufficient length of time for a parallel COCH contract

Assurance was received by the Committee that the Trust can exit the contract after 5 years with 18 months written notice, and the ability to terminate the Healthy Wirral Care Record product with only 3 months' notice.

6. Performance Report ending 30th November 2017

The Committee reviewed performance for the period ending 30th November 2017 focusing in particular on the following:

The improvement in performance against the 4 hour Urgent Care standard and the changes in STF which now required the Trust to achieve 90% compliance from October to February and 95% from March 2018. It was noted that performance had significantly improved at c 88% since August but December was proving challenging with compliance at closet to 80%.

The position with regards to RTT compliance continues to remain of concern with performance between 79% and 80%. The Committee noted the co-production of an RTT paper between the Trust and Wirral CCG noting that RTT compliance levels could not be slipped further but from the last "lock in " session neither would compliance rates be improved putting at risk the RTT element of the recovery plan.

Diagnostics six week compliance was noted and the plans in place to mitigate the high level of radiologist vacancies were acknowledged by the Committee. Work was noted as ongoing looking at GP Direct access, and the need to establish the right quantum of demand.

Cancer targets were reported as on track to month 8. The Committee noted the very marginal underperformance against the 31 days to first treatment' standard in month 8 and sought assurance on returning to compliance in December.

Above trajectory C Difficile performance was noted with the Committee requesting confirmation of the continuation of the HPV programme.

7. Workforce Report

The Committee reviewed the workforce update report noting the current pressures and mitigating actions. Since the production of the report the Workforce Director confirmed that there has been some improvement in the vacancy rate during November.

The sickness rate was recognized as an increasing concern, particularly within the Outpatients department, this will require a more in depth piece of work to understand reasoning behind this. The Quality & Safety Committee was requested to follow up interventions around this.

8. **Assurance Reporting**

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

- Finance and Performance Group.
- Digital Wirral Programme Board.
- Information, Information Governance and Coding Group.
- The Strategy and Sustainability Planning Group

9. Escalation to the Board/Inclusion on the Board Assurance Framework

The Committee recommend to the Board the VEAT providing for a 10 year extension of the contract with Cerner. The contracts includes an 18 month notice period from 5 years should the Trust wish to exit and 3 months' notice to exit the Healthy Wirral Care Record system. It was also clarified that the Trust will not be liable for any costs if CoCH do not sign a parallel contract.

Andrea Hodgson
Chair of Finance, Business Performance and Assurance Committee

BOARD OF DIRECTORS	
Agenda Item	7.2
Title of Report	Chair of Audit Committee Report
Date of Meeting	31st January 2018
Author	Graham Hollick, Chair of the Audit Committee
Accountable Executive	David Jago, Director of Finance (As at date of Audit Committee Meeting)
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

A) Terms of Reference:

The committee reviewed the Committee's terms of reference in line with best practice including HFMA NHS Audit Committee handbook and recommended to the Board for adoption the following inclusions:

1) 3.2.5 The Committee members shall conduct annual private meetings with Internal audit in line with the Committee Work Plan and if required, by ad – hoc private meetings can be requested by either party at any time.

2) 3.3.8 The Committee members shall conduct annual private meetings with External Audit in line with the Committee Work Plan and if required, by ad-hoc private meetings can be requested by either party at any time.

B) Board Assurance Framework (BAF)

1) The Committee reviewed the Board Assurance Framework and supported the actions of the Quality and Safety Committee's decision that note risk 1 should include seven day working and general clinical outcomes and thereby remove risk 4. The Committee

also noted and agreed with the FPBAC and Q & S's decision to increase the risk to 20 to reflect the current context and that SMT will review this increased risk rating at its meeting in December.

2) The Committee agreed with the methodology of updating, reviewing and escalation to provide adequate assurance for their purposes.

C) Financial Assurances Report

The Committee discussed the Financial Assurance Report noting:

1) The losses and special payments recorded up to 31 October 2017.

2) The current debtors position – over six months old and over £5K and overseas patients. A comprehensive report on the debtors report was given satisfying the Committees concerns over the debtors build up and ex gratia payments.

3) Capital and single tender actions and the compliance with SFIs and the 12 single tender actions since the last audit report.

D) Clinical Audit Up Date

The Committee received the Clinical Audit up date from the Interim Head of Quality and Patient Safety noting the Audit Forward Plan has been affected by staff vacancies and sickness in the Quality and Safety Department and the divisional governance teams. Despite this the Quality and Safety complied with the annual audit report requirements and setting out the policy framework. Discussion on aligning the policies to the work force and consultants engagements was confirmed and the Committee accepted that the draft Clinical Audit Strategy will provide a framework on which to ensure that Clinical Audit is embedded into a robust integrated process to move forward when a new Quality Governance structure is in place. In this respect the Committee also sought confirmation that appropriate KPIs were in place and monitored on the trust's dashboard providing actual and trend analysis for all committees and the Board, this was given.

E) Risk Management Strategy

Members discussed the draft strategy and noted the progress being made in its development. Further feedback and views were invited for those that had not had the opportunity to be involved.

F) Internal Audit Progress report and Limited Assurance reports:

The Committee discussed in detail the Internal Audit Progress report and in particular the areas of 'Limited Assurance' surrounding IM&T; Critical Application- JAC Pharmacy System and Activity Data Capture; 62 day Cancer wait and the Critical Application Review -JAC-Pharmacy. The Director of IM&T was asked to explain and clarify the situation to give appropriate assurance to the Committee that concerns expressed in the internal audit report were being managed to expectations and remedial action concluded by the stipulated date of 31 March 2018. This was confirmed by the Director of IT&M and deputy Director of Operations.

In view of the impact that RTT times had on the Trust's performance and concerns over data validation, the Committee was reminded that RTT list had been 'cleansed' and that the trust had experienced a deterioration in performance in the short term although improvement could be expected once the Director of Operations had completed a full analysis. Whilst this had occurred, concerns still remained about data capture and the accuracy of figures being submitted to the Board. Accordingly the Committee directed that Internal Audit include this as a prerequisite in the annual programme to provide assurance as to the accuracy of the figures being submitted.

G) Internal Audit Actions

The Committee accepted the report on actions by Internal Audit and that appropriate timely action is being taken in areas of concern to address risks posed in the report.

H) Anti-Fraud Progress Report

The Committee received the Anti-Fraud Progress Report, noted and discussed the actions being taken and the assurance provided.

I) Audit Progress Report

The Committee noted the Audit Progress and Sector Report Update received from the external Auditors.

J) External Audit Extension of Contract Recommendation

Following due processes on reviewing the External Auditor's performance the Committee recommend the extension of Grant Thornton's contract as External Auditors to the Trust for another two years to the Board.

Graham Hollick
Audit Committee Chair

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF PUBLIC MEETING

29 NOVEMBER 2017

**BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL**

Present

Michael Carr	Chairman
David Allison	Chief Executive
John Coakley	Non-Executive Director
Dr Susan Gilby	Medical Director
Andrea Hodgson	Non-Executive Director
Graham Hollick	Non-Executive Director
David Jago	Director of Finance
Sue Lorimer	Non-Executive Director
Cathy Maddaford	Non-Executive Director
Anthony Middleton	Director of Operations and Performance
Jean Quinn	Non-Executive Director
Denise Price*	Interim Director of Nursing & Midwifery
John Sullivan	Non-Executive Director

In attendance

Carole Self	Director of Corporate Affairs
Jayne Kearley	Member of the Public
Dr John Fry	Public Governor
Ian Linford	Public Governor
Steve Evans	Public Governor
Tom Tasker	Chair of Salford CCG - Observer

Apologies

Janelle Holmes	Chief Operating Officer
Gaynor Westray	Director of Nursing and Midwifery

*denotes attendance for part of the meeting

Reference	Minute	Action
BM 17-18/169	**Apologies for Absence** Noted as above	
BM 17-18/170	**Declarations of Interest** None	
BM 17-18/171	**Chairman's Business** Nothing to report	
BM 17-18/172	**Chief Executive's Report** The Chief Executive presented the report and highlighted the following areas: **Director of Workforce** – the Board extended congratulations to James Mawrey on his appointment as Executive Director of HR at Bolton NHS Foundation Trust. The Chief Executive advised that plans were in place to secure interim support and a permanent replacement.	

Reference	Minute	Action
	Deputy Director of Nursing – the Board extended its congratulations to Tracy Fennell from Whiston who would join the Trust in February as the new Deputy Director of Nursing. **Infection Prevention Control (IPC) Improvements** – the Board was pleased to note the joint appointment of a Senior IPC Lead Nurse from the Countess of Chester, **Flu Vaccinations** – the Chief Executive reported vaccination rates of 80% to date **PROUD Team of the Quarter Awards** – the Board was pleased to note the work in the Orthotic Service had been recognised and welcomed the introduction of Employee of the Year as part of the refreshed reward and recognition methodology. **Petition** – the Board formally accepted the petition established on the Wirral Globe website which was presented to the Chief Executive on the 27th October by Frank Field MP. The petition title was – "Arrowe Park Hospital bosses must stop charging nurses £10 to park". The Chief Executive advised that the meeting with Frank Field MP was very positive in that it afforded the MP the opportunity to raise concerns with parking and equally to hear the challenges with balancing the needs of patients in relation to parking with those of staff on what is a limited site. The Trust had agreed to establish a Travel Working Group to review car parking in general as well as its green travel policies including car sharing. The Board formally accepted the petition and the work being undertaken to address the concerns raised. **Strategy** – the Chief Executive highlighted the refreshed aims and sought approval to these. The Board debated the difference between aims and objectives as part of this process and the wording of the first aim which began with the words "we are". The Board agreed that its aims should remain aspirational despite the challenging environment. 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**
BM17-18/173	**Learning from Patient Experience Paper** The Medical Director presented the Learning from Patient Experience Paper in the absence of the interim Director of Nursing and Midwifery. She reported that the proposal was an attempt to take the practice of learning to the next level with a view to informing the work the Trust undertakes and set the context for this. The Board was advised that the Trust at present had limited resource to undertake this work as well as support patients who may feel able to present at meetings. The Proposal included identifying a group of volunteers who could be trained to support patients to share their stories, not just on the day but thereafter. The ultimate aim would be to have a thematic approach to sharing patient stories in the Trust, details for the first year of which were outlined in the paper. The Board was asked to support the methodology which would include stories from both staff and patients. The Board sought to understand whether patients would physically attend meetings and it was advised that in some cases where this was appropriate this would be the case, although other times this may be through video or other electronic means. The Board supported the methodology and the presence of the patient although it acknowledged that this would not always	

Reference	Minute	Action
	be appropriate. The Medical Director advised that the plan would be that at every meeting, members would consider the impact and value of the story. The Board agreed that there was a genuine need to disseminate these stories and welcomed staff having the opportunity to present as well. The Board was keen to ensure that the impact of this learning was monitored throughout all quality improvement projects which the Medical Director acknowledged. The Board formally approved the new methodology.	
BM17-18/174	**Report of the Quality and Safety Committee** **T**he Chair of the Quality and Safety Committee reported on the work of the Committee meeting held on 08 November 2017. The Board was advised of the changes to the Board Assurance Framework and the recommendation to merge risks 1 and 4; increase the risk score in relation to quality and safety; the workforce and access to reflect the current concerns raised in nurse staffing and performance reports. The Committee also reported its support as to the top 4 risks in the organisation as raised by the Senior Management Team and the Finance Business and Performance Committee. The Board was pleased that quality impact assessments would remain a key focus of attention for the Committee as the Trust progresses with its Financial Recovery Plan. The Committee also reported that it had sought and received assurance that there was no freeze on agency spending for front line staffing. The Committee reported continued concerns with nurse vacancies particular the increasing numbers of band 5 nurse vacancies and sought to establish the steps being taken to address this. The Board was advised that because of the concerns with the PLACE survey in relation to nutrition and hydration and compliance with the MUST tool that it had recommended that a "deep dive" be undertaken in this area at pace. The Committee also reported concerns with the deteriorating staff friends and family test scores and response rates. The Chair of the Quality and Safety Committee assured the Board that the Committee had formally received the Infection Prevention Control Improvement Plan and that it would continue to monitor progress as agreed previously. The Board was advised that the Deputy Medical Director had provided an update on mortality reviews following approval of the policy in September. He had confirmed that training was ongoing and that deaths requiring a structured judgement review were being monitored by the Trust's Serious Incident Meeting. The Committee was advised that primary mortality reviews were below expected levels and that change to the process were being put in place to address this. The Medical Director took the opportunity to assure the Board that there was a 100% review of all deaths, multi-disciplinary reviews were part of the serious incident review process and that these were taking place in all cases. The Board supported the recommendation in relation to the merging of risks 1 and 4 and the increase in risk ratings for workforce, quality and safety and access. Furthermore it agreed to discuss the action being taken in relation to these areas as part of the Nursing staffing Report and Performance Report to	

Reference	Minute	Action
	be discussed later in the meeting. The Board formally supported the top 4 risks identified as Workforce; Quality and Safety; Access and Finance.	
BM17-18/175	**Bi Monthly Nurse Staffing Report** The Interim Director of Nursing and Midwifery presented the latest staffing report for the period September/October 2017. The key highlights included the increase in band 5 nurse vacancy rates; the work required on E-Roster and the change in recruitment adopted. The Board was advised that recruitment was now focused on attracting year 2 students as opposed to year 3 which had begun to have a positive impact; the evidence of effective E-Rostering on CHPPD performance and how this might explain the disparity in figures locally and nationally and the reduction in staffing incidents as a result of a changes to approval for staff moves. The Board was interested to learn that the Escalation Policy currently allowed for a degree of local interpretation by staff, work however was underway to ensure that it was clear when staff moves needed to be enacted in the best interests of patient care. The Board sought and received clarity from the interim Director of Nursing and Midwifery the reasons for the disparity in the CHPPD and the apparent deterioration against peers. The Board also sought assurance as to how the Trust would ensure that staff were more engaged in meeting the needs of its patients and therefore understand the reasons for the need to move at specific times of great need. The Director of Nursing and Midwifery agreed that the process for staff moves needed to be fair and equitable, she also addressed the concerns with regards to increased band 5 nurse vacancy levels through the development of a retention and career progression plan although many of the issues associated with the transient nature of this part of the workforce was something that was being experienced nationally. The Board raised concerns as to the age profile of the nursing workforce as evidenced in the report and sought to understand what plans the Trust had for retaining these individuals. The Interim Director of Nursing and Midwifery agreed with the concern as the numbers were high and expected to increase further over the next 5 years, she confirmed that the key would be to be flexible and creative in the development of roles for this cohort as many do not want to leave but equally do not want to work at the current frantic pace. The Chief Executive advised the Board of the discussions he had had with organisations who had moved to a 100% request model for this cohort of staff, accepting that this required a lot of thought. The Board agreed that this was worthy of exploration not just for this cohort of staff but maybe for junior doctors. The Board requested further information on the outcome of exit interviews which could inform the Trust's future talent management programme. The Interim Director of Nursing and Midwifery advised that the systems were not in place at the moment to provide this robustly although the themes were in the main in relation to career development and staff moves. The Board noted all aspects of the report and the work being undertaken to improve sustainable staffing levels for the future.	

Reference	Minute	Action
BM 17-18/176	**Integrated Performance Report** • **Integrated Dashboard and Exception Reports** The Chairman commented ahead of formal presentation that you only had to turn the first few pages of this report to see the challenges the Trust was facing. The Director of Operations and Performance presented the newly designed integrated performance dashboard and advised the Board as follows: **A & E 4 Hour Standard** – The Board was reminded of the national focus in this area particularly as this was an indicator as to how the NHS as a whole functioned. The Director of Operations and Performance advised the Board to be cognisant of the 3% deterioration in performance nationally when viewing the Trust's position. The Chief Executive reported that the Trust's performance was in the 85%-89% range in the main putting the Trust routinely in the middle of national rankings, and significantly out-performing many category 3 organisations. The Board sought to establish whether the reporting numbers included the wider definition in relation to walk in centres discussed in the previous month following the letter from NHS Improvement. The Board was advised that although the Trust had undertaken the steps outlined in the NHSI letter and secured approval through the A & E Delivery Board, nationally it was now being reported that the Chief Executive of NHSI had acted too quickly and therefore no agreement on this new methodology had been secured. If this was the case the Trust would be reporting at 89.9%. The Board was disappointed to note that Trusts were not being treated equally, if the Trust was integrated with the Community, all performance figures could be included as in other health economies, and reported Trust positions. The Board sought to understand how involved all the Divisions were particularly as it was reported that a key issue was bed availability ie not an ED specific issue. The Director of Operations and Performance assured the Board that Divisions were involved and that the focus was on compliance with inter professional standards; response times and timely initial contact. The Board drew on learning from the Kings Fund that if you shifted the pathway to an hour the whole approach would be different and sought to understand whether the Trust was considering this. The Director of Operations and Performance agreed with that approach and confirmed that the Trust was looking at the standard being 1 hour to senior consultant review but in the context of the plan for the whole day. The Board sought to understand the levels of confidence by Executives of meeting the 95% standard by March 2018. The Director of Operations and Performance advised that this posed a significant risk as the Trust's own internal assessment showed performance to be more routinely around 88% with further effort required to move to 90%. Compliance at 95% was deemed to be a significant step. The Board sought clarity on the impact on receipt of Sustainability and Transformation Funding (STF) in the future. The Director of Finance confirmed that this was now linked to the Financial plan, in that if the Trust was to achieve the A & E Standard it would receive the credit for the performance but without achievement of the financial plan there would be no STF funding. Furthermore he advised that the Trust was focussing on	

Reference	Minute	Action
	doing the right thing by its patients, even if that means recovering costs in other ways as part of a system wide approach. For clarity the Board was advised that originally £2.7M of the £8.9M STF funding was associated with A & E performance and the trajectory of improvement submitted assumed this. The Director of Finance confirmed that the Trust had incurred costs of £1.2M in relation to escalation beds in order to keep patients safe. The Board sought an update on the external support being provided by Ernst Young which would not only support short term achievement of the A & E standard but also maintain this on a sustainable basis. The Director of Operations and Performance agreed that Ernst and Young were providing a valuable extra set of hands although the methodology offered nothing new. **Ambulance Turnaround** – the Director of Operations and Performance linked the performance on ambulance turnaround on the Trust's ability to meet the A & E 4 hour standard. Although the Trust had been praised for improving turnaround standards, there were still too many above an hour therefore improvement needed to continue. The Board was advised that all ambulance turnovers of over 1 hour would in the future be treated as a serious incident. The Board sought and received clarification as to where the duty of care resided between ambulance and hospital staff. The Board further requested that all transfers over 1 hour be included in the report in the future. **Referral to Treatment Times** – performance was reported as static with support from the independent sector not being forthcoming as expected although some support was now being received from Spire. The Board was advised that the lead of Quality and Safety concurred with the Trust's view that no further deterioration in waiting times to meet financial targets could be sustained as these were not in the best interests of patients. **C Difficile avoidable cases** – the interim Director of Nursing and Midwifery reported that the upward trajectory was concerning although this was not as a result of a lack of leadership in the team. The solution was thought to be greater ownership for good practice in all Divisions. The Board was advised that the Senior Management Team agreed paper on actions to improve isolation, screening and cleaning would have an impact provided it was kept high profile though initiatives such as CLEAN week. **Workforce Metrics** – improvements were reported in appraisal, mandatory training and nurse vacancy rates. A slight deterioration was reported in sickness absence levels which remain the subject of continued focus particularly in relation to return to work interviews. The Chair of the Finance Business Performance and Assurance Committee reminded members of the request to split out short term and long term sickness and sought an update on this. The Chief Executive confirmed that this work was ongoing and would be presented shortly. The Board sought to understand the reasons for the increase in Grade 2 and above pressure ulcers. The Interim Director of Nursing and Midwifery advised the Board that this was due to an increase in the number of cases arising from the community, and reporting as a whole did not aid the Board. She confirmed that the Trust was working with other agencies to improve care particularly in nursing homes. The Board sought to understand whether the Trust correlated performance to individual homes. The Director of Nursing and Midwifery advised that the Trust were aware of where the incidents occurred but that more work was required to monitor and improve	**AM** **JM**

Reference	Minute	Action
	this. The Chief Executive agreed that the Trust needed to undertake more work in this area, as patients were staying too long in hospital as a result of these, having developed these within days of returning to a care home. The Board asked whether each case of a pressure ulcer was classed an incident which was the position although not attributed to a particular care home where this be the case. The Board agreed that more work should be undertaken in this area and that the Safeguarding Board should review this also.	**DP**
	• **M7 Finance and Cost Improvement Programme Report** The Director of Finance presented the M7 Finance and Cost Improvement Report reporting the following: At the end of October 17, the Trust delivered an overall deficit of £16M which was £6.7M adverse to plan excluding STF funding. The Board was advised that the Trust had only achieved £1M of STF against the plan of £4M to date and despite the run rate improving; the challenge to achieve the financial plan was significant. The Director of Finance reminded members that improvement on the previous year's savings achievement of £11.2M to £15M was always going to be challenging, however the Trust had to attempt to achieve this and sign up therefore to the control total if it was going to avoid significant penalties which would have deteriorated the deficit by a further £6.5M. The variance to plan was attributed to the loss of STF of £3M; underperformance in the cost improvement programme of £2.4M; £1.1M of escalation costs above plan; staffing pressures of £600K; acuity levels of £400K and the VAT costs reported at M6. 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. Cash was reported at £600K above plan at £2.6M; this was attributed in the main to the support received from the Digital Wirral/Global Exemplar (GDE) programme. The Board was reminded that a further cash drawn down would be required in December of £7M as forecast and reviewed by the Finance Business and Performance Committee. Performance against the payment by results contract was reported as strong at £2.5M above plan although this was a result of a rise in non-elective activity with elective activity broadly in line with plan. The Chair of the Finance Business Performance and Assurance Committee suggested that the Trust present a more measured view of its ability to achieve the year end out-turn noting that to recover a further £7M would be extremely difficult. 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. The Board sought to understand what areas were driving the high agency costs. The Director of Finance outlined consultancy costs in cardiology in the main totalling £1.5M; £100K in A & E; £200K in Ophthalmology; Community	**DJ**

Reference	Minute	Action
	Paediatrics £200K and finally £300K to cover winter consultancy costs. The Board agreed that the Trust needed a revitalised workforce strategy going forward accepting that improvements would not be forthcoming in the short term. The Medical Director concurred with the Chairman in that the Trust, in comparison with peers, performed quite well. She further added that the Trust was also successful in terms of its recruitment despite a very traditional approach to care. The Board was advised that work was underway to change this approach and the work to modernise the workforce had already began. The Board noted that financial sustainability would only be achieved through transformational change which required a significant amount of resource which was not currently available as this was required to ensure operational grip. The question was how the Executive Team planned to break out of this cycle. The Director of Operations and Performance agreed with this view hence the focus on the key 3 or 4 schemes that would have the most impact as this should prove to be much more manageable. The Chief Executive further added that the focus was being re-directed into the next year to avoid effort being diverted to those very small schemes in year as well as allowing the Trust to concentrate on ensuring that those cross organisational schemes such as MSK and the prime provider contract are a success. The Board concluded that it needed to temper its forward look-ahead of the decision whether to re-forecast in January 18. The Board agreed that the Finance Business Performance and Assurance Committee should thoroughly review the Trust's progress in terms of reducing the £1M monthly pay overspend in December in order to frame the discussion and decision making in the new year.	**DJ**
BM 17-18/177	**Month 7 NHSI Compliance Report** The Board formally noted the M7 NHSI quarterly return and agreed that future submissions should reflect the discussion above.	
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**
BM17-18/179	**Procurement Transformation Plan** The Director of Finance presented the report which set out the Trust's progress against Lord Carter's recommendations for improving procurement across the NHS provider landscape. The Board was asked to note that this was not a procurement transformation plan in itself as this was yet to be completed. The Board noted that the delay was due to the Trust being involved in the drafting of a business case for a shared procurement service across the Cheshire and Wirral Local Delivery Service Partnership which was felt to deliver more value and benefits than could be achieved by acting independently. The Board was advised that NHSI were in support of this approach.	

Reference	Minute	Action
	The Board having received previous updates on the model hospital portal acknowledged that the information was not in "real time" and had in fact only been updated in 2016/17. The Board noted the strong performance in many of the areas and in particular in relation to the purchase of clinical supplies. The Board agreed that performance was strong which evidenced that the Trust was not a non-productive organisation. Members considered how it could articulate this as part of the work on financial recovery and any forthcoming financial re-forecast. This would provide the regulator with the context required and highlight issues with the shortfall in income and the increase in demand for non-elective activity.	
BM17-18/180	**Consultant Revalidation and Appraisal Annual Report** The Medical Director presented the Annual Report advising that this was designed to show how the Trust was meeting the required standards. The Board was asked to note how well the Trust benchmarked and to acknowledge the work of Dr Debra King and Amanda Branson who had undertaken this work. The Board was advised that the Trust had appointed a new lead appraiser, Dr Catherine Hayle and of the plan to revise and modernise some of the approaches in the future. The Medical Director reported that unlike other Trusts where coaching for doctors was quite innovative, at the Trust this was used for remediation so had more negative undertones. The Board questioned whether the number of interventions highlighted in the report was deemed to be high. The Medical Director advised that in her view this was not high although unusual to see in this type of report. The Board accepted the work and extended thanks to Dr King for her work in this area.	
BM17-18/181	**Board of Directors** The Minutes of the Board of Directors held on the 25th October 2017 were confirmed as an accurate record. **Action Log** The Board accepted the action log as presented.	
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**
BM 17-18/183	**Items to be considered by the Assurance Committees** The Board agreed the following focus areas for the assurance committees: • **Quality and Safety Committee** – focus on the new methodology for	

Reference	Minute	Action
	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. • **Finance Business Performance and Assurance Committee** – 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.	**DP** **DJ**
BM17-18/184	**Any Other Business** The Chairman took the opportunity to express the Board's thanks to Dr Jean Quinn at this would be her last public Board Meeting. The Board agreed that in all Dr Quinn's 7 year tenure she had never failed to put patient safety at the top of her agenda. Thanks were extended for Dr Quinn in her previous role as Chair of the Quality and Safety Committee and the Organ Donation Committee and her work on End of Life Care, the latter two of which she would hopefully remain involved in. Members agreed that Dr Quinn would not only be missed professionally but also personally although they expected to see her actively involved in the local health sector in the future. The Chairman sought any comments from the public on the meeting content. Dr Fry sought and received assurance that the pressure in the hospitals had not led to patients being discharged too earlier leading to a rise in re-admissions. The Medical Director responded by saying that although she did not have qualitative evidence, if this had been a concern clinicians would have raised and they had not. Her view was that in the current climate people were a little bit more risk adverse which might well be appropriate. Mr Linford welcomed the changes planned to learn from patient stories and asked that Governors be included in this wherever possible. He also sought to understand with the current system pressures how the Trust would manage the growing elective list and in particular how the Trust would manage the conversion from inpatient to outpatient as a consequence. The Director of Operations and Performance confirmed that this was part of the annual planning process and there were in deed a lot of follow up appointments that could be undertaken in the community in the future.	
BM 17-18/185	**Date and Time of Next Meeting** Wednesday 31st January 2018 at 9.00am in the Boardroom, Education Centre, Arrowe Park Hospital.	

……..……

Chairman

……..

Date

ACTION LOG
Board of Directors
Updated – November 2017

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
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**			
2	BM17-18/176	Ambulance Turnaround - The Board requested that all transfers over 1 hour is included in future reports.	**AM**			
3	BM17-18/176	Workforce Metrics - The Chair of FBPAC reminded members of the request to split out short term and long term sickness and sought an update on this.	**JM**			
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.	**DP**			

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**			
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**			
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**			
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**			

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.	**DP** **DJ/GL**			
Date of Meeting 25.10.17						
1	BM17-18/148	Include the pay budget in the Use of Resources section of the new performance dashboard	**DJ**	**Included in new Integrated dashboard - completed**	Nov 17	
2	BM17-18/148	Include the breach analysis in the A & E narrative	**JH**	**Included in new integrated dashboard - completed**	Nov 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	
4	BM17-18/154	Quality and Safety Committee to review the top 4 risks identified by SMT and review the risk ratings for risk 1 quality and safety and the risk for workforce	**CS**	**Review undertaken in November 17- update included in Chair's report - completed**	Nov 17	
5	BM17-18/154	Quality and Safety Committee to review the work being undertaken on E Roster	**JM**		Jan 18	

6	BM17-18/154	Quality and Safety Committee to review the infection prevention control action plan	**DP**	**Review undertaken in November 17 – update included in Chair's report - completed**	Nov 17	
7	BM17-18/154	Quality and Safety Committee and Finance Business Performance and Assurance Committee to review the development of the new performance dashboard	**JH**		Dec 17	
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						
9	BM17-18/112	Ensure future nursing reports focus on the action being taken to ensure that staff moves are appropriately managed	**DP**	**Included in the nurse staffing report – Nov 17- Completed**	Nov 17	
10	BM17-18/116	The Board requested an update on the action being taken in relation to infection prevention and control in light of the increase in reported avoidable cases of C difficile	**DP**	**Included on the agenda for October 17 - completed**	Oct 17	
11	BM17-18/119	Confirm the time commitment for Board members in undertaking the enhanced level 2 Equality, Diversity and Human Rights training	**DP**	**The Board has agreed the training session will take place in Dec 17**	Oct 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	**Deferred until October 2017**
13	BM17-18/104	Quality and Safety Committee to review research work as part of their work plan	**SG**			
14	BM17* 18/105	Provide an update on future Care Quality Inspections to the CoG in September	**SG**		September 17	

Date of Meeting 28.06.17						
15	BM17-18/068	Quality and Safety to receive assurance on CQC preparedness and overall compliance and provide regular reports on this to the Board	**SG**	**Ongoing**	July 2017	
Date of Meeting 24.05.17						
16	BM17-18/039	Provide regular reports on the A & E 9 point action plan – specifically those areas that relate to the Trust	**JH**	**Ongoing – last review June 17**	June 17	
17	BM17-18/049	Review the IT risk on the BAF in relation to cyber security	**PC**	Work is ongoing to implement further protections e.g. awaiting delivery of a new Internet circuit which is ordered but has a 90 day delivery time. Working with NHS Digital and GDE sites with Cerner to go through the Cyber Essentials plus framework funded by NHS Dgitial – dates being agreed. WUTH is leading work on Cyber for Cheshire and Mersey STP. A further update is due in December when the Audit actions will be complete. Review thereafter to be undertaken at Senior Management Team and Audit Committee	July 17	
Date of Meeting 26.04.17						
18	BM17-18/013	Ensure Equality and Diversity is covered throughout the Trust's Mandatory training programme	**GW**		June 17	
Date of Meeting 25.05.16						
19	BM16-17/036	Full review of the performance report to be undertaken to avoid this becoming unmanageable	**JH**	**New dashboard included on the agenda for Nov 17 - completed**	Sept 17	**Draft dashboard viewed in October**

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	