Wirral University Teaching Hospital NHS
NHS Foundation Trust

Board of Directors Meeting

25 March 2015

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**MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 25 MARCH 2015
COMMENCING AT 9.00AM IN THE
BOARD ROOM
EDUCATION CENTRE, ARROWE PARK HOSPITAL**

AGENDA

1.	**Apologies for Absence** Chairman	v
2.	**Declarations of Interest** Chairman	v
3.	**Patient Story** Director of Nursing and Midwifery	v
4.	**Chairman's Business** Chairman	v
5.	**Chief Executive's Report** Chief Executive	d
6. Strategy and Development		
6.1	**New Models of Care** Director of Strategy and Organisational Development	p
7. Performance and Improvement		
7.1	**Integrated Performance Report**	
	7.1.1 Integrated Dashboard and Exception Reports Director of Infrastructure and Informatics	d
	7.1.2 Month 11 Finance Report Director of Finance	d
7.2	**Urgent Care Recovery Plan Update** Director of Operations	d
8. Quality		
8.1	**CQC – Compliance Review** Medical Director	d
8.2	**Report of the Quality and Safety Committee** • **11 March 2015** Chair of the Quality and Safety Committee	d
8.3	**Francis Report: Hard Truths Commitment: Publishing of Nurse Staffing Data: February 2015** Director of Nursing and Midwifery	d

8.4 Quality Account 2014/15 – First Draft d
Medical Director

9. Governance

9.1 External Assurance d
- **Monitor Q3 Feedback Letter**

Associate Director of Governance

9.2 Board of Directors

9.2.1 Minutes of the Previous Meeting d
- **25 February 2015**

9.2.2 Board Action Log d
Associate Director of Governance

10. Standing Items

10.1 Items for BAF/Risk Register v
Chairman

10.2 Any Other Business v
Chairman

10.3 Date and Time of Next Meeting v
Wednesday 29 April 2015 at 9am

Board of Directors	
Agenda Item	5
Title of Report	Chief Executive's Report
Date of Meeting	25 March 2015
Author	David Allison – Chief Executive
Accountable Executive	David Allison – Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	1,3, 4, 5, 6, 7 1B, 4A, 6B, 7C 1445, 2328, 2611, 2647 Financial pressures and organisational boundaries impact on the engagement of NHS and non NHS providers in active collaboration resulting in synergies and collective work not being undertaken
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

1. External Activities

CCG

The Trust continues to discuss its contractual position for 2015/16 with the CCG. These discussions are being conducted at Executive Director level with the goal being to reach a contractual resolution no later than 31 March 2015. The critical components of the contractual position which the Trust has shared with the CCG include;

- That the contract be priced at the 2015/16 Enhanced Tariff Offer;
- That the contract be based upon a Payment by Results (PbR) approach, as opposed to a block contract;
- That the CCG pay appropriately for the activities delivered to the localities residents;
- That the threshold year for marginal rate payment for non-elective over performance be raised from the 2008/09 baseline as there has been pathway, service and volume change in the years since 2008/09;
- That winter resilience resources now within the CCG core allocations are transferred to the Trust as part of the opening contract to support provision of appropriate winter resilience through 2015/16;
- That a readmission audit be undertaken to inform any future readmission penalties;
- That an appropriate volume of care be commissioned to maintain national access targets and to accommodate urgent care growth of c3% going forwards until evidence exists that alternatives to hospital attendance and admission are established in other care settings;
- That the economy recognises the scale of cost pressure within the acute sector and resources the Trust through the Better Care Fund to cover excess costs beyond those which organisations are able to internally deliver;
- That the transitional funding agreements associated with the transfer of vascular activity be honoured as proposed in 2014/15

The discussions are progressing positively although slowly and within the context of a difficult financial planning context for 2015/16 and beyond.

Five Year Forward View – New Models of Care

The Board has been briefed that the Wirral Health and Social Care Community application to the New Models of Care programme was successful. The application was driven by the Trust, in collaboration with partners from across the system and support from Cerner and a number of their national and international partners. We have been invited to host the national team in a week long visit before 1 May and to a soon to be organised national launch. Based on feedback so far, the key differentiator of our application was our proposal to use informatics and population health as a catalyst for change and reform. With partners we are considering carefully how we structure and plan our programme and will keep the Board updated on a monthly basis as we develop and implement our programme management approach. What is clear is that this is a significant national opportunity to redesign all the norms which we currently accept about our current modus operandi and offer both our population and colleagues a radical new way of working, which we hope will drive a much more integrated and sustainable system going forwards.

Monitor

Monitor announced on 6 March that it is investigating the Trust for a potential breach of its provider licence following financial governance concerns arising from the Trust reporting a Continuity of Service Risk Rating of 2 and a lower than planned Q3 surplus. Monitor recognises that the Trust has mitigations in place to allow delivery of its year end planned position; although there were risks associated with these. They were also concerned however over the medium term financial sustainability of the Trust.

The Trust has also failed to meet the A & E 4 hour wait target in Q3 for the fourth consecutive quarter, however, Monitor have taken the Trust's action in response to this and will therefore not be formally investigating this as part of the investigation. A&E performance will instead be considered through existing local escalation channels and/or Regional Tripartite escalation, as required.

As part of the investigation process, Monitor has asked the Trust to provide them additional information to enable them to determine whether further action is required. The Trust is scheduled to return this information by the 23rd March 2015.

Part of the investigation process also includes a meeting between attendees from the Board of Directors of the Trust and Monitor's Investigation Team. The date of this meeting is still to be determined.

Once Monitor has concluded its investigation it will determine what, if any, regulatory action is appropriate.

External Review

At an extraordinary Board meeting on 5 March 2015, it was agreed to appoint PriceWaterhouseCooper (PwC) to support the Trust in developing and completing a narrative turnaround plan for 2015-16 and 2016-17. PwC are in the second week of a 10 week assignment which will be of sufficient rigour and appropriately evidenced that it will withstand internal and regular scrutiny.

Internal plans are progressing across the 20 workstreams and a helpful event was held on 9 March where all workstream leads presented on their current status. There is a significant amount of work required to be completed by the end of May.

2. Internal Activities

Infection Prevention & Control

February was a busy period for the Infection Prevention & Control agenda as the Trust responded to the serious concerns raised by Public Health England.

We were able to provide assurance on progressing the actions arising from the Peer Review action plan, and these were presented to the March Quality and Safety Committee.

We continue to manage 2 outbreaks: Pseudomonas on the neonatal unit where there is a comprehensive action plan. The Executive Team have supported short and medium term improvements to the environment as well as scoping the requirements for a new unit in the context of British Association of Paediatric Medicine (BAPM) standards during 2015/16.

There have been 2 further positive cases, and these are being reviewed alongside the action plan, and our actions supported by Public Health England expertise and guidance.

The Carbapenamase Producing Enterobacteriaceae (CPE) outbreak continues with improvement in the number of new cases (13 in January, 6 in February) as a result of the isolation ward and enhanced screening. PHE are supporting the Trust on this agenda.

During February there were 2 Clostridium Difficile (C.Diff) toxin patients bringing the total reported to PHE to 26 against a target of 24; the number of patients with avoidable toxins is 18 to date and this is the Monitor reported figure. With 2 cases in review the figure may change to 19/20 during March. The threshold figure for C. Diff in 2015/16 is 28 and it is therefore important to start the year with mitigation plans in place to ensure that the Trust delivers this.

The Trust continues to respond to Ebola; there were no MRSA bacteraemias reported in February 2015 and there have been recent cases of Norovirus in the Hospital that are being monitored closely.

A&E Update

We continue to struggle with the achievement of this target as a health economy. A comprehensive update on the urgent care recovery plan is included in the papers for today's meeting which will provide detail on the pressures and action being taken. In an attempt to learn from areas of best practice we have engaged with ECIST to compliment the support we have had from the GMCSU.

Wirral Millennium Update

Work continues on the change from local hosting of the system to Cerner hosting of the system from their data centre in Slough and a formal date of 18 April has now been agreed with Cerner. Although this is a couple of weeks later than originally envisaged, it allows the teams slightly more time to test the new environment without having any significant impact on the overall programme.

The Trust had its onsite HIMMS stage 6 assessment on Friday 6 March. Overall the assessment was thorough and extremely positive. The assessors were very complimentary of what we have achieved at the Trust and were particularly impressed with the broad range of system use and particularly the engagement of clinical staff. As this is the first UK site to have an onsite assessment against the standards, the HIMMS team are currently reviewing what we have achieved against other hospitals across Europe. From this they will either be able to confirm that we have already achieved the standard, or provide us with a clear work-off plan.

The Informatics team continues to work with groups of clinical colleagues to review and prioritise requests for enhancements to the system.

Work to complete the transfer of IT services from the CSU is progressing well and the service and associated staff will transfer on 1 April.

Workforce

The Trust's annual Apprenticeship Open Day was held on 9 March 2015 and was attended by 403 young people aged 15-23 interested in a career in the health sector. The day was opened with a live interview by BBC Merseyside Radio of David Allison, Rt Hon Esther McVey MP and Rosie Jones, who has progressed from an apprentice to a permanent

administration post in Community Midwifery while completing her Access to Health course, and starts her Midwifery course in September 2015 at university. On the day we were also the first Trust in England to sign the NEW NHS Apprenticeship Promise to show our commitment to young people in the workforce; the photographs were used the next day at the launch of the initiative.

Sickness absence monthly rates continue to be in the main better than last year (with the exception of December 2014), however the rolling 12 month rate remains above the Trust target of 4% (February 2015 month only 4.83%; decreased from last month by 0.46% and decreased from previous year of 4.94%). A number of priority actions continue to be discussed in full at the Quality & Safety Committee.

Education and Development Key Performance Indicators. As at 28 February 2015:

Mandatory Training Block A has increased by 0.01% since January to 97.71%, and has consistently met the KPI since August 2014.

Mandatory Training Block B has increased by 2.05% since January to 71.93%. As this does not meet the KPI, divisional action plans are in place and are being regularly monitored by Divisional Management Teams.

Appraisal compliance has increased by 0.99% since January to 83.48%. As this does not meet the KPI, divisional action plans are in place and are being regularly monitored by Divisional Management Teams.

Our Library & Knowledge Service has been successful in a bid for £115k of funding to support a collaborative research project with Critical Care. The 12 month study will examine the role of the Clinical Librarian within the Critical Care team as a mechanism for mobilising knowledge, enhancing clinical decision-making and improving patient care. The money has been awarded from the Health Education North West (HENW) Forerunner Fund 2014/15. As a teaching hospital, our Library Service is an incredibly important part of our organisation, so it's great to see the service growing and evolving, and supporting our dementia care agenda.

Listening into Action

A Culture and Engagement Plan to support the Workforce and OD Strategy has been agreed and in process of implementation. The 2014 Staff Satisfaction Survey results were very disappointing and a high level action plan has been presented to the Executive Team that describes a series of actions supported by LiA that aim to improve staff satisfaction. This includes: 100 Day Challenge for Managers, communicating 100 positive messages in 100 days, commitments to management visibility, improving the process for raising concerns, establishing a cultural ambassador and staff guardian, re-launch of the agreed values and behaviours, improving our internal communications, focus on developing our leaders and managers in constructive and transformational styles. These actions will also support the outcome of the Cultural Survey. The staff satisfaction action plan will also include a review of stress and fairness and effectiveness of incident reporting procedures. This action plan will be monitored by the LiA Sponsor Group and assured through the Workforce and Communications Group.

Our wave 5 of LiA Teams are in progress and include Medicine and Acute Division, Partnership Working, Learning Disabilities, Energy and Sustainability, Ward LiA's and several other additional LiA work streams have been scheduled. The "Pass it On" Event for Wave 5 LiA teams will be held on 19 June where the teams will feed back to the Trust

what they have achieved and encourage others to adopt this way of working for themselves.

The last round of CEO led Big Conversations was for leaders and managers to focus on what they need to do to address cultural, quality and financial priorities. 179 attended these events and their feedback has been reviewed by the LiA Sponsor Group. Key actions arising from this link with the 100 Day Challenge, leadership and management development, addressing communications, length of stay, DNA's, inappropriate referrals, meetings, right patient /right bed and CERNER Pathways. Feedback will be fed into relevant work streams in addition to a number of schemes being set up to address these issues.

David Allison
Chief Executive

March 2015

Board of Directors	
Agenda Item	7.1.1
Title of Report	Integrated Dashboard and Exception Reports
Date of Meeting	25 March 2015
Author	John Halliday Assistant Director of Information
Accountable Executive	Mark Blakeman Director of Infrastructure and Informatics
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)**	Full
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To note
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

1. Executive Summary

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 February 2015.

2. Background

The dashboard has been developed based on the principle that the report:

- should focus the Board's attention on the issues they should be focused on, particularly those issues reserved for the Board;

- should enable the Board to monitor the delivery of external regulatory requirements as well as the Trust's longer term strategic goals and importantly to gain assurance that the right conditions are in place to continue to do so;
- should recognise and support the delegation to the Finance Business Performance & Assurance, Audit, and Quality & Safety Committees;
- sets out clear performance targets and where performance fails to meet the required level has a standardised format for providing further information.

With the monthly performance reporting cycle to the Board, the metrics and thresholds will be reviewed to ensure they provide assurance against the key targets and milestones in both the new Annual and Strategic Plans. Cognisance will also need to be taken of the reporting requirements, including frequency, to all Board Committees

3. Key Issues

Individual metrics highlighted as Red for January are Friends & Family, Staff Satisfaction, A&E 4-hours, Attendance, Qualified Nurse Vacancies, Expenditure, CIP Performance, Non-core Spend, Advancing Quality and CQC concerns. To avoid duplication, exception reports are only included in the dashboard for those metrics not covered by separate reports or updates to the Board from the relevant associated Committee.

Monitor has confirmed that under the Risk Assessment Framework for 2014-15 the Governance status for WUTH is currently considered to be neither Green nor Red, with some issues identified and described accordingly.

4. Next Steps

The list of indicators and associated thresholds will continue to be reviewed to ensure the report remains relevant and of value. Additional metrics will be incorporated to reflect any further Annual and/or Strategic Objectives not currently covered by existing indicators.

5. Conclusion

Performance across a range of metrics is provided for information

6. Recommendation

The Board of Directors is asked to note the performance to the end of February 2015.

WUTH Integrated Performance Dashboard - February 2015

Meeting Our Vision

Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period
Satisfaction Rates					
Patient Satisfaction - F&F "Recommend" Rate			JG	92.0%	February 2015
Patient Satisfaction - F&F "Not Recommend" Rate			JG	4.0%	February 2015
Staff Satisfaction (engagement)			AH	3.48	2014
First Choice Locally & Regionally					
Market Share Wirral			AH	83.5%	April to Nov 2014
Demand Referral Rates			AH	8.0%	Fin Yr-on-Yr to Feb 15
Market Share Non-Wirral			AH	8.5%	April to Nov 2014
Organisational Risk Issues					
Key Performance Indicators					
A&E 4 Hour Standard			SG	85.5%	February 2015
RTT 18 Weeks Standards			SG	All met	February 2015
Cancer Waiting Time Standards			SG	On track for qtr	Q1 to February 2015
Strategic Objectives					
Delayed Transfers of Care			SG	4	12-mth ave to Feb 2015
Readmissions			EM	9.2%	January 2015
Harm Free Care			EM	95.0%	February 2015
HIMMs Level			MB	5	February 2015
NIHR KPIs			EM	tbc	

A Healthy Organisation

Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period
Clinical Outcomes					
Never Events			EM	0	February 2015
Complaints			JG	38.3	12-mth ave to Feb 2015
Infection Control			JG	0 MRSA; 2 C diff	February 2015
Productivity					
Bed Occupancy			SG	94.9%	February 2015
Theatre Utilisation			SG	69.0%	February 2015
DNA Rate			SG	8.4%	February 2015
Workforce					
Attendance			AH	95.1%	12-mth ave to Feb 2015
Qualified Nurse Vacancies			AH	5.77%	February 2015
Mandatory Training			AH	97.7%	February 2015
Appraisal			AH	84.5%	February 2015
Turnover			AH	11.4%	February 2015
Finance					
Contract Performance			AM	1.4%	To M11 February 2015
Expenditure Performance			AM	-2.1%	To M11 February 2015
CIP Performance			AM	-27.3%	To M11 February 2015
Capital Programme			AM	-13.0%	To M11 February 2015
Non-Core Spend			AM	8.6%	To M11 February 2015

External Validation

Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period
National Comparators					
Advancing Quality			EM	3 areas below target	December 2014
Mortality: HSMR			EM	87.4 (low ci 81.3)	April to Nov 2014
Mortality: SHMI			EM	1.0 (low ci 0.89)	July 2013 to June 2014
Regulatory Bodies					
Monitor Risk Rating - Finance CoS			AM	2	To M11 February 2015
Monitor Risk Rating - Governance			SG	Not Green or Red	To M11 February 2015
CQC			EM	5	February 2015
Local View					
Commissioning - Contract KPIs			SG	3	February 2015
Education			EM	Level 2	June 13

integrated Performance Dashboard - Metric Thresholds

Meeting Our Vision

Indicator	Definition	Green	Amber	Red
Satisfaction Rates				
Patient Satisfaction - F&F "Recommend" Rate	Patient Satisfaction - Friends & Family "Recommend" Rate for Trust	>=95%	n/a	<95%
Patient Satisfaction - F&F "Not Recommend" Rate	Patient Satisfaction - Friends & Family "Not Recommend" Rate for Trust	<=2%	n/a	>2%
Staff Satisfaction (engagement)	Results from staff satisfaction survey	>=3.69	>=3.59 to <3.69	<3.59
First Choice Locally & Regionally				
Market share : Wirral	WUTH share of Wirral CCG GP Referred New OP Activity	>= 85%	>= 80% to <85%	< 80%
Demand : Referral Rates	Outpatient referrals received from all GP/GDPs - G&A specialties	>= 3% YoY variance	0% to <3% YoY	<0% YoY
Market share : Non-Wirral	WUTH share of West Cheshire GP Referred New OP activity	>=8%	>=6% to <8%	<6%

Organisational Risk Issues

Indicator	Definition	Green	Amber	Red
Key Performance Indicators				
A&E 4-hour Standard	% of patients attending ED & ADHC treated within 4 hours	>=95%	n/a	<95%
RTT '18' Week' Standard	All RTT standards met for the Trust as a whole	All met at Trust level	n/a	Not all met at Trust level
Cancer Waiting Time Standards	All Cancer Waiting Standards met for the Trust per quarter	All met at Trust level	n/a	Not all met at Trust level
Strategic Objectives				
Delayed transfers of care	Average No of patients with a delayed transfer of care at month-end	<= 4	>4 and <6	>= 7
Readmissions	% of patients readmitted non-electively within 30 days of discharge	<= 7.5%	>7.5% and <= 10%	> 10%
Harm Free Care	Compliance with Safety Thermometer definition of Harm Free Care	>= 95%	>= 93% to <95%	<93%
HIMMS Level	Current HIMMs level under Electronic Medical Record Adoption Model	5	n/a	<5
NIHR KPIs	tbc	tbc	tbc	tbc

A Healthy Organisation

Indicator	Definition	Green	Amber	Red
Clinical Outcomes				
Never Events	Number of occurences of "Never Events"	0 per month	n/a	>= 1 per month
Complaints	Number of occurences of formal complaints	<30 per month	30 to 50 per month	> 50 per month

Infection Control	MRSA Bacteremia CDIFF	0 MRSA Bacteraemia in month, and cdiff less than cumulative trajectory	0 MRSA Bacteraemia in month, and cdiff equal to cumulative trajectory	>= 1 MRSA Bacteraemia in month or cdiff cases above cumulative trajectory
Productivity				
Bed occupancy	Average % of General & Acute Beds occupied at midday	<=85%	>85% to <95%	>=95%
Theatre utilisation	Average % of scheduled operating minutes utilised	>=85%	>=65% to <85%	<65%
DNA Rate	Percentage of booked OP appointments that DNA (Med, Surg and W&C)	<=7.5%	>7.5% to <9.0%	>=9.0%
Workforce				
Attendance	Rolling 12-month staff attendance rate	>= 96%	>=95.3% to <96.0%	< 95.3%
Non Core Pay Spend	% of total spend year to date	<5%	>=5.0% to 6.5%	>=6.6%
Qualified Nurse Vacancies	% vacant posts	<=2.5%	>2.5% to 5%	>5%
Mandatory Training	Rolling 12-month staff mandatory training rate	>= 95%	>= 85% to <95%	< 84.9%
Appraisal	Rolling 12-month staff appraisal rate	>= 85%	>= 80% to <85%	<80%
Turnover	Rolling 12-month staff turnover rate	<10%	>= 10% to <12%	>=12%
Finance				
Contract Performance	Delivering both contracted volumes and values	>=3	2	1
Expenditure performance	Delivering planned levels of expenditure	>=3	2	1
CIP Performance	Delivering a recurrent CIP in-year & deliverable future proposals	>=3	2	1
Capital Programme	A sound investment programme mainatained & resourced appropriately	>=3	2	1

External Validation

Indicator	Definition	Green	Amber	Red
National Comparators				
Advancing Quality	Combined rating	All areas above target	1 area below target	> 1 area below target
Mortality : SHMI	SHMI	Lower CI < 0.90	Lower CI 0.90 to 0.99	Lower CI >= 1.0
Mortality : HSMR	HSMR	Lower CI < 90	Lower CI 90 to 99	Lower CI >= 100
Regulatory Bodies				
Monitor Risk Rating - Finance	Monitor Risk Assessment Framework - Continuity of Service rating	4	3 or 2*	2 or 1
Monitor Risk Rating - Governance	Monitor Risk Assessment Framework - Governance rating	Green	n/a	Red
CQC	Number of concerns raised by CQC following inspection	0	1 to 2	>2
Local View				
Commissioning - Contract KPIs	Number of Quality KPIs in the contract not being achieved	<=2	3 to 4	>=5
Commissioning - CQUINs	Number of CQUINs not being achieved	0	1 to 3	>=4
Education	GMC level	Level 3	Level 2	Level 1

WUTH Performance Dashboard Exception Report February 2015

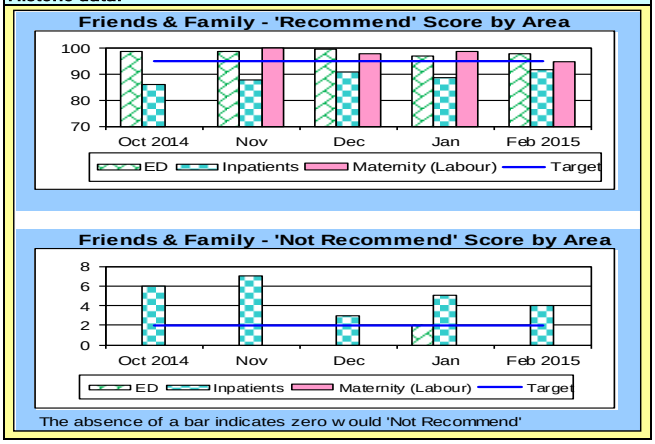
Indicator :
Friends & Family - Recommend / Not Recommend

Rating	Target	Actual	Period
Red	>95% and <2%	92% and 4%	Feb 2015

Issue:

The national measures of the Friends and Family Test have changed form the previous Net Promoter score to more simple 'Recommend' and 'Not Recommend' measures. The performance thresholds have been set at a minimum 95% for Recommend, and less than 2% for Not Recommend. For February the performance was 92.0% for Recommend, and 4.0% for Not Recommend - so both measures did not achieve the standards.

Historic data:



Proposed Actions:

FFT inpatient performance improved in February. The underlying performance is varied and split between wards/units that consistently perform well versus those where there is known quality issue with actions progressing. In addition, any wards/units that have recently emerged as underperforming have been identified through the CLIPPE analysis and are subject an assurance process at Clinical Governance Group.

Assessing Improvement:

Performance is monitored via regular reporting at department and ward level to Clinical Governance Group and at the monthly Divisional Performance Reviews, with Q&S Committee also receiving updates.

Impact:

Key measures of patient satisfaction with our clinical services. The metrics provide internal focus on areas for improvement, and are an external view available in the public domain on the perceived quality of WUTH services.

Expected date of performance delivery:

Ongoing

Director approval:

Jill Galvani, Director of Nursing and Midwifery

WUTH Performance Dashboard Exception Report February 2015

Indicator :
Staff Satisfaction (engagement)

Rating	Target	Actual	Period
Red	>= 3.69	3.48	2014

Issue:

The overall engagement score for the 2014 staff survey was 3.48, a deterioration from the 2013 score of 3.64. The national average for 2014 was 3.74, and WUTH is in the bottom 20% of trusts nationally and 4th from the bottom of 135 acute trusts.

Historic data:

Proposed Actions:

The findings have been to Trust Board with an action plan. Presentation and high level actions have been to the CoG. Q&S also have the results and will receive the action plan at the next meeting in May. Results and action plan are going to LiA Sponsor Group 23rd March, PSG 24th March, Staff Satisfaction Steering Group 25th March, and WCG 2nd April.

Quality health are presenting the results and management recommendations on the 27th March and invitees include the Trust board, CEO forum members, PSG, JLNC, and Staff Governors.

Assessing Improvement:

Improvements will be monitored via regular reporting by HR&OD to all appropriate groups including Operational Management Team, Quality & Safety, Staff Satisfaction Steering Group and Workforce and Communications groups.

Impact:

Low staff engagemant and morale will impact the Trust's ability to deliver quality services and achieve objectives.

Expected date of performance delivery:

2015 Staff Survey

Director approval:

Anthony Hassall, Director of Strategy and Partnerships.

WUTH Performance Dashboard Exception Report — January 2015

Indicator :
A&E 4-hour Standard

Rating	Target	Actual	Period
Red	>= 95%	85.1%	Q1 2014/15

Issue:

The standard is a minimum of 95% of A&E attendances being admitted, transferred or discharged within 4 hours. Performance for February was 85.5%, including the All Day Health Centre at Arrowe Park site. For WUTH alone performance was 80.9%.

Proposed Actions:

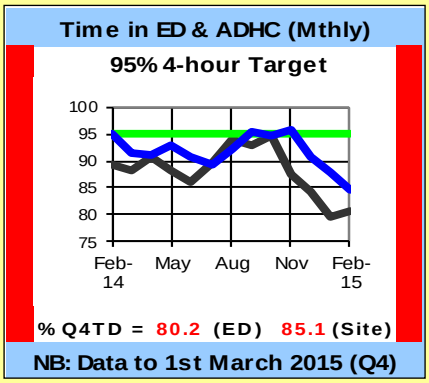
The pressures previously reported in early Quarter 4 have continued. There has been a continued increase in the number of ambulance conveyances that require direct transfer to the resuscitation area in ED (standby calls) and also an increase in MEWS emergency calls on the wards which demonstrates the level of acuity for both ED attendances and inpatients. Continued increase also in GP admissions which then reduces flow into acute assessment areas from ED.

There is also continued pressure from Infection Prevention and Control issues with numerous beds being closed over recent weeks and as it stands today (18th March), there are 18 closed beds in medicine due to Norovirus on a number of wards.

The number of medically fit patients stands at 51 with an additional 10 patients awaiting IMC or transitional care.

Work is continuing with partners across the Health and Social economy to deliver the agreed Urgent Care Recovery plan. We are also working with ECIST and partner organisations to plan a perfect week in line with the national breaking the cycle initiative to highlight blockages and implement the SAFER patient care bundle to support improved flow across the patient pathway. The intention is to carry this out on week commencing 20th April.

Historic data:



Assessing Improvement:

Current joint performance at mid-March is 85.1% for Quarter 4. The schemes in place across the economy have assisted in mitigating the impact of the previous significant spikes in admissions and acuity, and joint efforts continue with the support of the System Resilience Group. The Trust is also engaging further with ECIST to see if there are any other areas of work which can be reviewed to improve performance.

Impact:

Patients can expect to be treated within 4 hours when attending A&E or WiCs. Waiting longer is a poor patient experience and will reflect on the reputation of the Trust. As a national target, non-achievement has Governance implications with Monitor, and financial consequences under the contract with local Commissioners.

Expected date of performance delivery:

Quarter 1 in 2015/16

Executive approval:

Sharon Gilligan, Director of Operations

WUTH Performance Dashboard Exception Report — February 2015

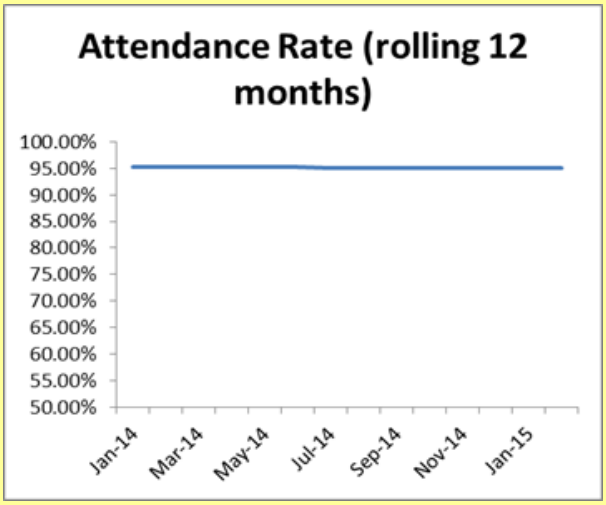
Indicator :
Attendance

Rating	Target	Actual	Period
Red	>= 96%	95.09%	Mar 14 - Feb 15

Issue:

Attendance (12 months Rolling) was 95.09% at February 2015 and therefore 0.91% below the Trust target of 96%. Urgent actions as detailed below are taking place to address this. The majority of sickness days lost are long term anfd there is a focus on this. The new Attendance Capability policy went live on 19th January 2015 and has triggers aimed at reducing long term absence.

Historic data:



Proposed Actions:

Sickness absence training was delivered to 300+ managers in January 2015. New policy went live, Validation of data, Review staff on long term sick, Audit policy compliance, Health and Wellbeing Strategy, Detailed Monthly reporting and drill down, Monthly workforce meetings (HR Managers and line managers), Individual action plans for poor attenders, Comprehensive Occupational Health Service.

Assessing Improvement:

Improvements will be monitored via regular reporting by HR&OD to all appropriate groups including Operational Management Team, Quality & Safety and Workforce and Communications groups.

Impact:

Continued high sickness absence will impact the Trust's ability to deliver quality services and achieve objectives. High sickness absence will lead to high non core spend compromising financial position and increasing CIP pressure. Temporary staffing often cannot provide the continuity of care nor local area knowledge possessed by permanent employees this can lead to quality issues.

Expected date of performance delivery:

Quarter 2 reporting

Director approval:

Anthony Hassall, Director of Strategy and Partnerships.

WUTH Performance Dashboard Exception Report February 2015

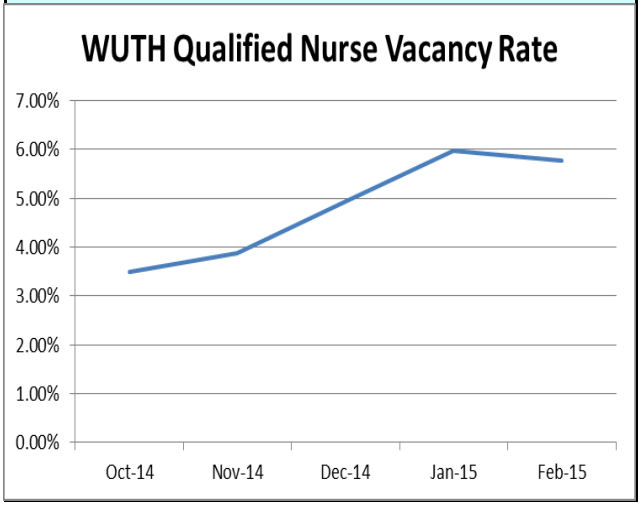
Indicator :
Qualified Nurse Vacancies

Rating	Target	Actual	Period
Red	<=2.5%	5.77%	Feb 2015

Issue:

Qualified Nurse Vacancies was 5.77% at February 2015 and although lower than last month it is 0.77% above the Trust target of 5%. Urgent actions as detailed below are taking place to address this.

Historic data:



Proposed Actions:

Exceptional generic nurse recruitment programs are running each month at present. As a result of this 26 new nurses were offered posts in January 2015. A further 50 applicants were offered posts in February. Pre employment checks, notice periods and in some cases completion of qualifications will mean there will be a necessary delay in some of these staff starting with the Trust.

Assessing Improvement:

Improvements will be monitored via regular reporting by HR&OD to all appropriate groups including Operational Management Team, Quality & Safety and Workforce and Communications groups.

Impact:

Continued high vacancy rates will impact the Trust's ability to deliver quality nursing services and achieve objectives. High vacancy rates will lead to high non core spend compromising financial position and increasing CIP pressure. Temporary staffing often cannot provide the continuity of care nor local area knowledge possessed by permanent employees this can lead to quality issues.

Expected date of performance delivery:

Quarter 1 reporting

Director approval:

Anthony Hassall, Director of Strategy and Partnerships.

WUTH Performance Dashboard Exception Report **February 2015**

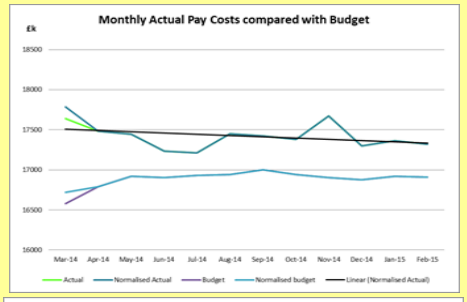
Indicator :
Expenditure

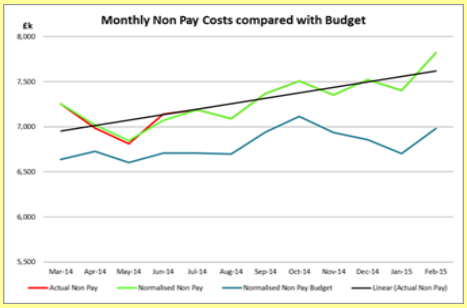
Rating	Target	Actual	Period
Red	On Plan	-2.1%	Feb 2015

Issue:

The underlying operational expenditure is £1,249k overspent in month against plan, £410k on pay and £839k on non pay. Pay costs are largely consistant with the last two months and the average for the year, although there has been a spike in the clinical supplies spend over the last two months.
The total pay spend for February was £17.3m, which is broadly consistent with previous months, however it should be noted in February the School Nursing Service transferred, this is matched by a corresponding under recovery in income. Overall the actual pay cost is continuing to run at a relatively constant £0.4m/0.5m gap to plan.
The total non pay spend is £7.8m in February compared with £7.4m last month showing a deteriation, clinical supplies continues to be overspent, partly driven by the additional non elective activity and prosthesis spend to deliver activity. Other Non Pay shows an overspend although this largely a result of catagoristion issues rather than significant spend.

Historic data:





Proposed Actions:

Divisional performance reviews both with the Director of Finance and the Executive team are continuing to monitor financial performance. A clear message has been provided within the organisation, emphasising the necessity for the financial position to be improved, both in terms of delivery of activity and control of costs. The following actions are to be applied across the organisation:
-There is a cessation of all non-essential expenditure;
- Where possible necessary expenditure should be delayed;
- Increases in pay costs to be curtailed wherever possible; and
- the generation and delivery of further ideas in closing the financial gap must continue through the current year and into the new financial year.
The Trust has appointed a Turnaround Director, to assist in improving the financial performance and returning to a more financially sustainable position in the future.

Assessing Improvement:

The divisional reviews continue to assess performance on a monthly basis and any mitigation plans are constantly considered.
A Turnaround Director has been appointed to identify and implement the generation/delivery of further ideas to improve /recover the financial position and achieve financial sustainability.

Impact:

Overspending against the expenditure financial plans will put at risk the financial sustainability of the Trust for 2014/15 and beyond and have a significant impact on liquidity.

Expected date of performance delivery:

On-going

Executive approval:

Alistair Mulvey - Director of Finance

WUTH Performance Dashboard Exception Report February 2015

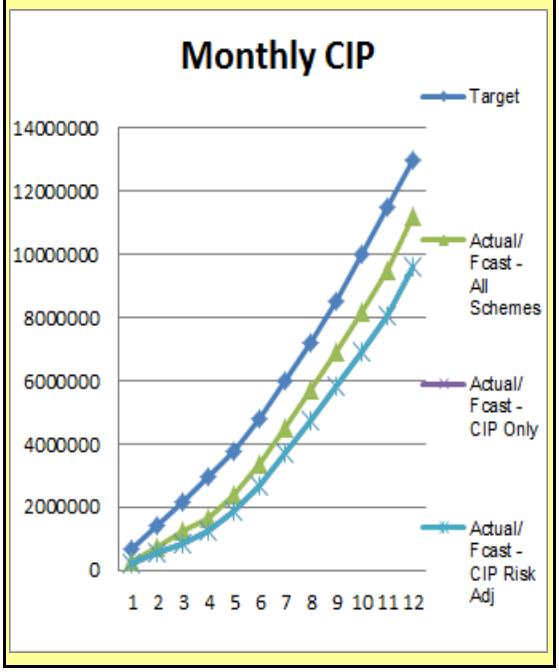
Indicator :
CIP

Rating	Target	Actual	Period
Red	On Plan	-27.3%	To Feb 15

Issue:

The in-year and year end recurrent forecast has not changed since last month. The in-year forecast remains at £3.4m behind target which is 26% less than the requirement. The full year forecast is expected to achieve the full target of £13m. The in-year position shows 16% of the total in-year delivery being forecast to achieve in Month 12. No further movements are expected in the forecast for the remaining month of this financial year.

Historic data:



Proposed Actions:

Schemes will continue to be monitored and any risks and issues reported to Transformation Steering Group (TSG). Focus is now concentrated on completing the comprehensive work stream plans for 2015/16. The part time special advisor to the Board continues on an interim basis as does the full time Recovery Director. The Interim Recovery Director continues to be supported by full time works stream leads for Length of Stay, Theatres and Outpatients as well as the PMO. Additional interim support has also be brought in from externals consultants PWC and DQIP. PWC are supporting all work stream leads to complete robust and granular level work stream plans that will ultimately be approved by the Board. PWC are also providing support to test that all CIP opportunities are identified and maximised. DQIP are a firm of consultants that are supporting the Trust to improve the quality and level of coding clinical activity.

Assessing Improvement:

The PMO is setting up a new governance structure that will be compatible with the new way of planning for CIP and will include sharp focus on KPI's and delivery of milestones and key tasks within work stream plans. TSG will continue to meet weekly with work stream leads and their teams, which will include clinical leads and finance leads, presenting on a scheduled basis.
The Interim Recovery Director is continues to lead the process and together with the full time workstream leads and external consultants aims to have all workstream plans fully drafted by 10th April.

Impact:

Failure to achieve the CIP target will put at risk the financial sustainability of the Trust for 2015/16 and beyond.

Expected date of performance delivery:

On-going

Executive approval:

Alistair Mulvey - Director of Finance

WUTH Performance Dashboard Exception Report Feb-15

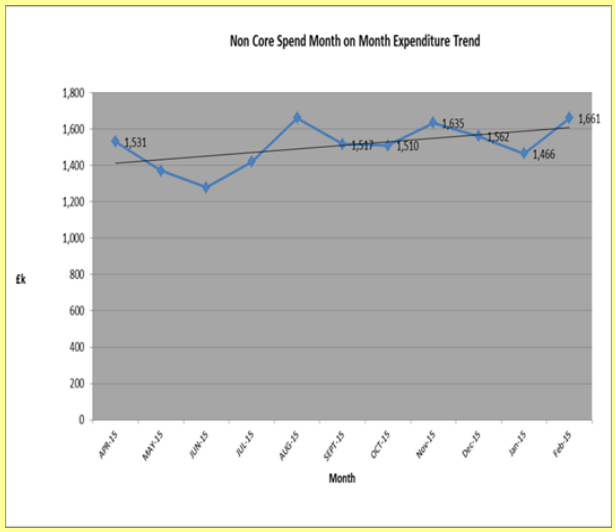
Indicator :
Non Core Pay Spend

Rating	Target	Actual	Period
Red	<5%	8.6%	Feb 15

Issue:

In February 2015 £1.7m has been spent on non core pay categories. This represents 8.6% of the total pay expenditure in February. From a divisional perspective all the divisions show relatively high spend with the Medicine and Acute division increased to 12.9%, Surgery/ Women & Childrens at 8% and Clinical Support division is at 7.4%. All three Divisions are rated as red against the target of 5%. There has been an increase in agency and overtime spend this month largely due to further vacancies in ED and additional costs for the cohort ward opening due to CPE outbreak. The main operational issues requiring non core pay categories to be utilised are largely unchanged, being, locum spend ED for target support, vacancy cover/recruitment issues, sickness cover, acuity and staffing the additional beds for unplanned capacity.

Historic data:



Proposed Actions:

The Workforce Strategy is focused on primarily using core pay spend however from a financial perspective the use of bank has a limited financial impact and allows staffing flexibility.
Continuation of tight control of Non-Core spend will continue in 2014/15 particularly around the impact of premium rates.
Targeted actions are in place to reduce sickness absence and for vacancy control to be managed effectively. WLI rates (change from procedure rates to sessional rates) have been implemented for 2014/15.

Assessing Improvement:

Associate Director of HR&OD chairs monthly meetings with Senior managers, Finance managers and HR managers to review progress on reduction of non-core spend and further actions.

Impact:

Continued high premium non-core spend will potentially compromise the Trust's financial position. Temporary staffing often cannot provide the continuity of care nor local area knowledge possessed by permenent employees. High levels of temporary staffing can also lead to quality issues.

Expected date of performance delivery:

Ongoing

Executive approval:

Alistair Mulvey, Director of Finance

WUTH Performance Dashboard Exception Report December 2014

Indicator :
Advancing Quality

Rating	Target	Actual	Period
Red	All achieving	3 areas under target	December 2014

Issue:

The measures are composite scores, refllecting individual care to patients; the measure is a cumulative score and so lags behind improvement. Acute MI, Community Acquired Pneumonia (CAP) and Stroke services all achieved the required target scores for the year 2013-14. However as stretch targets the thresholds have been raised for 2014-15. Targets set are year-to-date (YTD).

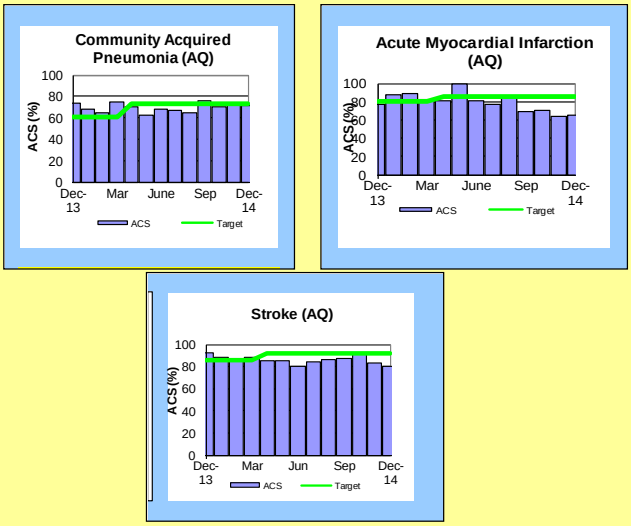
Proposed Actions:

AMI - resource issues to complete this real time and influence practice were lacking for the latter part of 2014 as previously reported. It is anticipated that from February discharges an improvement will occur but we are now unlikely to achieve this target for the year. It should be noted that the only missing measure in the December dataset was referral to cardiac rehabilitation and all other measures scored 100%; referral to cardiac rehabilitation is the key to improving this composite score and the auditor has been working to improve this.

STROKE - the key measure is access to a stroke unit bed and therefore is highly dependent on the flow of patients within the hospital. We will not achieve this target for the year as bed pressures continued into March and the target is over 97%. Other organisations are facing similar issues.

PNEUMONIA - the composite score fell just below the target in December, bringing year to date score to 70.88%. However, there were 203 patients in the population - one of the highest seen and reflects the pressure within the organisation. This ACS is still above last years end position and we expect to achieve our target overall.

Historic data:



Assessing Improvement:

Monthly reports are provided for the Clinical Governance Group. A Missing Measures meeting is held fortnightly to identify changes in performance.

Impact:

Patients are not receiving evidence-based interventions as described by Advancing Quality. These measures are not CQUINs for 2014-15

Expected date of performance delivery:

Improvement ongoing through 2014-15

Executive approval:

Evan Moore, Medical Director

Board of Directors	
Agenda Item	7.1.2
Title of Report	Month 11 Finance Report
Date of Meeting	25 March 2015
Author	Julie Clarke, Assistant Director of Finance: Operational Financial Management
Accountable Executive	Alistair Mulvey, Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	7
Level of Assurance • **Positive** • **Gap(s)**	Full
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To Note
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

1. Executive Summary

Income and Expenditure Position

The Trust delivered an in month deficit of £0.6m against a planned deficit of £0.7m, resulting in a positive in month variance of £0.1m. The cumulative variance to plan at month 11 has reduced to £0.9m, with an actual cumulative deficit of £5.6m against a planned deficit of £4.7m.

The in-month performance represents an improvement on the year to date position against the backdrop of the continued and ongoing operational pressures. The Trust has agreed a fixed year end income position with its main commissioner, which provides greater certainty for the forecast year end position, together with the planned sale of Springview (which took place on the 9th March 2015 and will be reported in month 12). On this basis the Trust forecasts a deficit of c£4.7m at year end.

With one month of the financial year remaining, there is a greater degree of certainty as to the year-end outturn position. However the Trust will continue to work towards the best possible year end outturn position, particularly considering the ongoing financial challenges facing the Trust and the NHS as a whole. Key messages delivered within the organisation continue to outline the need that;

- There is a cessation of all non-essential expenditure;
- Where possible necessary expenditure should be delayed;
- Increases in pay costs to be curtailed wherever possible; and
- The generation and delivery of further ideas to close the financial gap this year and into the new financial year

Cash Position & Continuity of Service Ratios (COS)

The cash position is £21.3m, £17.2m better than plan, this is largely due to:

- Increase in net of trade creditors and trade debtors, including specific cash management actions;
- Payments received early (ahead of terms);
- Capital spend below plan;
- Draw down of loan;

The above has been achieved through the implementation of agreed actions and an increasingly engaging and proactive approach to cash management activities.

Positive movements offset the delayed sale of Springview which was completed on 9th March and will be reported in Month 12.

The overall Continuity of Service rating at month 11 is a 2, which is in line with the planned COS rating. However the metrics which underpin the overall rating have been weakened by the adverse income & expenditure performance. The year-end CoS continues to be forecast to be a 2.

The headline financial position is summarised as follows:

SUMMARY FINANCIAL STATEMENT MONTH 11 2014/15 (FEB)							Comparative 2013/14 Position (Month 11)		
	In Month			Year to Date			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Operating Revenue	24,338	25,121	783	273,566	278,118	4,552	272,624	273,296	672
Employee Expenses	(16,909)	(17,319)	(410)	(186,041)	(191,278)	(5,237)	(177,689)	(189,006)	(11,317)
All Other Operational Expenses	(6,983)	(7,821)	(838)	(74,978)	(80,201)	(5,224)	(69,608)	(75,080)	(5,472)
Reserves	(3)	397	400	(4,613)	(213)	4,400	(11,139)	(666)	10,473
EBITDA	443	378	(65)	7,934	6,426	(1,508)	14,188	8,544	(5,644)
Post EBITDA Items	(1,189)	(1,028)	161	(12,618)	(12,005)	612	(11,660)	(11,737)	(77)
Net Surplus/(Deficit)	(746)	(650)	96	(4,683)	(5,580)	(896)	2,528	(3,193)	(5,721)
EBITDA %	1.8%	1.5%	(0.3%)	2.9%	2.3%	(0.6%)	5.2%	3.1%	(2.1%)

Cost Improvement Programme (CIP)

£13.0m of CIP was extracted from the budget at the start of the year. Identified CIP plans (c.£8.5m) were extracted according to the profile of the schemes identified (including cost avoidance), with the balance extracted in a flat profile (12 ths). At the time of the plan the balance was £4.5m so circa £0.4m was unidentified each month.

The CIP position at Month 11 (including cost avoidance and non recurrent schemes) can be summarised as follows:

	BY SCHEME TYPE		**BY COST**		**TOTAL**
	Income Generation (net of cost of delivery) £m	**CIP (including cost avoidance)** £m	**NHS Clinical Income** £m	**Divisional Budgets** £m	£m
Year to date Budget (including unidentified at time of plan)	2,129	9,358	2,779	8,708	**11,487**
Year to date Actual	2,147	7,316	3,125	6,338	**9,463**
Year to date Variance	18	(2,042)	346	(2,370)	**(2,024)**

The Trust continues to forecast an outturn delivery of £9.6m of CIP with a full year effect of c£13m moving into 2015/16. The shortfall in year of c£3.4m having been mitigated non recurrently through the use of agreed reserves and through compensating non recurrent gains.

2. Background

The Trust began the year with a deficit plan of £4.2m, which provided a risk rating of 2. The position for the first 11 months of the year translates into;

- a planned deficit of £4.7m, against which an actual deficit of £5.6m has been delivered (£0.9m adverse variance); and
- A COS rating of 2 in line with the planned COS rating of 2, although the metrics which underpin the overall rating have been weakened by the adverse income & expenditure performance.

The cash position is £21.3m, £17.2m better than plan; this is largely due to early settlement of debtors, delays in the payment of creditors, slippage in the capital programme, specific actions taken to improve cash management and the draw down of the loan. The positive variance in cash balances is offset in part by the adverse income and expenditure position, and the delayed sale of Springview which has now been concluded and which will be reported in Month 12.

3. Key Issues

The Trust has a cumulative deficit of £5.6m at Month 11 against a plan of £4.7m; this position is not sustainable going forward. The Trust has continued to work closely with both internal and external stakeholders in order to improve the financial performance and it continues to embed deeper transformational change.

Whilst the Trust will not achieve its planned financial position by the year end it is forecasting a deficit of £4.7m against the plan of £4.2m, surety of this position being provided through the agreement on clinical income levels with the localities CCG and the completed sale of Springview. In year the Trust has also significantly improved its cash position and whilst disappointing not to achieve the overall plan, within the context of the urgent care pressures seen across the economy this year the forecast outturn of within £0.5m of plan is a relatively positive performance.

Divisional Analysis

The following table shows the summary Divisional position (cumulative to Month 11). The senior management teams within the Divisions have provided narrative and context to the respective positions, and this is included in further detail (attached to this document).

	Medicine & Acute	Surgery & W&C	Clinical Support	Corporate	Central	Total
	£000	£000	£000	£000	£000	£000
NHS Clinical Income						
Planned Income	105,620	122,304	13,499	796	5,067	247,287
Actual Income	108,671	119,151	14,541	734	7,626	250,723
Variance	3,051	(3,154)	1,041	(62)	2,560	3,437
Net Expenditure						
Planned Expenditure	72,528	87,522	33,115	42,149	4,038	239,352
Actual Expenditure	76,592	91,071	34,336	42,735	(436)	244,298
Variance	(4,064)	(3,549)	(1,221)	(586)	4,474	(4,946)
Variance EBITDA	(1,013)	(6,703)	(180)	(648)	7,034	(1,509)
Post EBITDA						
Planned Post EBITDA					12,618	12,618
Actual Post EBITDA					12,005	12,005
Variance	0	0	0	0	613	613
Total Variance to Plan	**(1,013)**	**(6,703)**	**(180)**	**(648)**	**7,647**	**(896)**

Pay Analysis

The most significant area of expenditure for the Trust, relates to pay. The total pay spend for February was £17.3m, which is lower than the position for January and the average for the year – but still higher than the budgeted level of spend. Within this position it should be noted that the transfer of School Nursing staff was undertaken in month 11 which accounts for a cost reduction in pay of c£90k.

The following figure provides further detail of the monthly and cumulative position in the year to date, and also splits expenditure between permanent (core) spend and other (non-core) spend types.

Analysis of Pay Spend

Detail	April £000	May £000	June £000	July £000	August £000	September £000	October £000	November £000	December £000	January £000	February £000	YTD £000
Budget	**16,789**	**16,922**	**16,901**	**16,933**	**16,944**	**16,999**	**16,943**	**16,902**	**16,878**	**16,921**	**16,909**	**186,041**
Pay Costs												
Permanent	15,950	16,081	15,944	15,776	15,785	15,897	15,870	16,034	15,740	15,897	15,657	174,631
Bank Staff	299	326	297	355	347	342	330	350	305	258	302	3,511
Agency Staff	318	357	311	379	537	449	504	590	474	486	633	5,038
Overtime	318	208	209	162	174	229	195	203	281	187	252	2,418
Locum	418	336	301	374	435	380	339	344	381	354	327	3,989
WLI (In Year)	180	138	170	164	171	125	143	149	120	181	148	1,689
Total	**17,484**	**17,444**	**17,234**	**17,210**	**17,449**	**17,422**	**17,381**	**17,670**	**17,301**	**17,363**	**17,319**	**191,278**
Variance	**(695)**	**(522)**	**(333)**	**(277)**	**(505)**	**(423)**	**(438)**	**(768)**	**(423)**	**(442)**	**(410)**	**(5,237)**

4. Next Steps

The Trust has continued to work closely with external support partners in order to assist in improving the financial performance and in embedding deeper transformational change. The financial performances of the divisions are being closely monitored through the monthly performance review process. A clear message has been provided within the organisation, emphasing the necessity for the financial position to be improved, both in terms of delivery of activity and control of costs.

In preparing for 2015/16 the Trust has submitted its initial draft plan to Monitor as required on 27th February 2015, this plan identifies a deficit, after the delivery of CIP schemes of £13m of c£15m and the requirement for additional cash support. Within the overall position a series of material assumptions have been made including

- Assumed levels of clinical income
- Assumed levels of CIP achievement
- Pricing the contract at 14/15 values
- Delivery of national access targets both electively and non electively;
- Accommodating significant levels of inflationary cost increases driven through elements such as national pay awards and increased levels of clinical insurance premiums.

Each of the above elements will be reviewed and revised in advance of the Trusts submission of an updated annual plan of 7th April 2015, with the final iteration of the plan to be submitted on 14th May 2015.

5. Conclusion

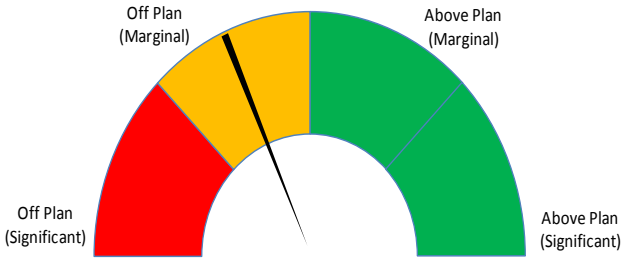
The in month position shows a deficit of £650k, against a planned deficit of £746k, resulting in a favourable variance of £96k. The year to date position shows a deficit of £5,6m, which is £0.9m worse than planned. The in-month performance represents an improvement on the year to date position against the backdrop of the continued and ongoing operational pressures. The Trust has agreed a fixed year end income position with its main commissioner, which provides greater certainty for the forecast year end position, together with the planned sale of Springview (which took place on the 9th March 2015 and will be reported in month 12). On this bass the Trust forecasts a deficit of c£4.7m at year end, which would be within £0.5m of the original plan. Despite the poorer than planned I & E position cash balances have been improved throughout the year and this provides the Trust with a greater level of headroom than initially planned with forecast year end cash balances being a minimum of £12m. Delivery of this position will deliver a minimum CoS rating of 2..

Recommendations

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

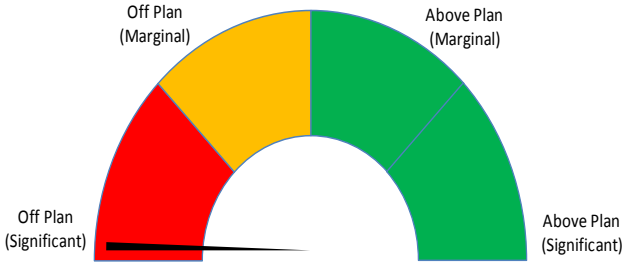
Alistair Mulvey
Director of Finance
February 2015

Divisional Overview (Month 11)



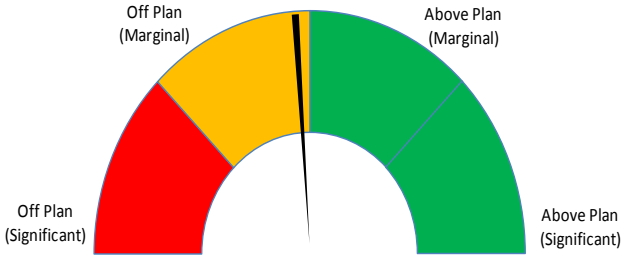
Medicine - Key issues

- ***Clinical Income over plan by £3.2m.***
- ***Net Expenditure exceeds budget by £4.1m .***
- ***Overall position is £0.9m off plan.***



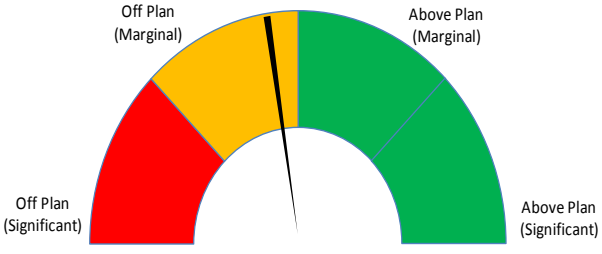
Surgery / W&C - Key issues

- ***Clinical Income behind plan by £3.2m.***
- ***Net Expenditure exceeds budget by £3.5m.***
- ***Overall position £6.7m off plan.***



Clinical Support - Key issues

- ***Clinical Income over plan by £1.0m.***
- ***Net Expenditure exceeds budget by £1.2m.***
- ***Overall position £0.2m off plan.***



Corporate - Key issues

- ***Divisional income below plan by £0.2m.***
- ***Expenditure over spent by £0.4m .***
- ***Overall position £0.6m off plan.***

Medicine & Acute I&E

The division reported a £597k deficit in month 11, and has resulted in the cumulative position having a deficit against plan of £904k. An ongoing concern is the level of acuity of patients attending A&E and the increase in referrals from GP's which has had a resulting pressure on beds. The increase in activity within the Divisional beds has also created pressure on Social Services and this has also contributed to the pressures on beds as Medical fit patients are staying longer than is required.

Clinical Income within the division is over achieving by c£3.2m, the main drivers of this include additional volumes of activity within planned care work streams both out-patients and in-patient care (£231k and £486k respectively) and increased volumes of patients from a non elective care perspective. Non elective activity (net of re-admissions) has over performed against plan by 1,397 patients equating to £2,967k. Since December the Division has had to increase its bed base due to the increased level of admissions. Emergency Department attendances in both January and February have seen a decline in the number of attendances and this combined with penalties relating to the 4-hour breaches equates in a year to date shortfall against plan to £1,352k (£874k ytd penalties). The Division has had the benefit of non recurrent Urgent Care/Winter monies of £1.6m, which has been used cover some of the additional costs to cover additional capacity requirements.

The costs of service delivery have exceeded the planned budget by £4.1m. The most significant element of pressure relates to staff costs, c£3.6m with the balance being slippage against CIP plans and over spending against clinical supplies.

From a pay perspective, the cumulative deficit relates to:-

- Emergency Department staffing, £0.8m - The excess costs which will persist at a lower rate and relates to the use of temporary/locum staff whilst awaiting substantive staff to be appointed. The department has recently lost the clinical fellows that were in post and this will create a further pressure in future months until these gaps are filled.
- Gastroenterology currently has overspending of c£0.8m as locum staff are required to fulfill vacant posts. It should be noted that the current over recovery of income within gastroenterology is c£0.3m and therefore partially off sets these costs. The Division has appointed 2 consultants who will be starting in Aug/Sep15. The over-recovery of income is not expected to continue as the specialty planned activity assumptions increase significantly in the latter part of the financial year and there will be additional gaps due to Nurse Endoscopists having recently left.
- Nursing costs – nursing budgets are currently £1.7m overspending, key areas of this are:-

    - £1.0m relates to staffing of additional beds opened and for the recent winter months additional bed pressures is offset by the additional income received via Urgent Care/Winter monies.
    - £0.3m relates to staff sickness cover. Sickness levels were at 5.6% at their height in 14/15 and through a programme of work have been reduced to under 4% in September
    - £0.4m relates to the provision of additional staff for specialling of patients as a function of their acuity needs. A revised process of agreement for the use of additional staff has been implemented and seen favourable financial results in the recent months although is likely to remain a pressure moving forwards.
    - Since February the Division is bearing the cost of the Infection Control ward which in month equated to £70k. A business case is being compiled to outline the future provision of an infection control ward.

Pressures through non pay subjective lines include variable costs associated with clinical supplies of c£0.9m which are in the main driven by over performance for activity and therefore covered by income secured. The Division continues to work with procurement to ensure optimum prices are secured.

The Division is working closely with the PMO and the Turnaround team to maximize delivery of CIP. The focus is in the main to ensure that the number of beds within the Division is in line with demand. Work is underway to look at areas where the Division may have the opportunity to reduce length of stay to ensure we are in line with the upper quartile from benchmarking exercises that have been undertaken.

Surgery, Women's & Children's I&E

The divisions overall financial position deteriorated in month 11 by £1,029k generating a cumulative year to date deficit of £6.7m. Within the overall deficit position expenditure variances are £3.55m year to date deterioration in month of £320k and income under performance is currently £3.15m of which £709k was in month.

The key cumulative drivers of the overall year to date expenditure variance of £3.55m include:-

- £273k to support additional bed capacity, of which £113k relates to the provision of the Trust CPE cohort ward and £160k due to the additional unfunded Ward (25) that has been open prior to the costs now been 100% attributed to Medicine.
- £435k relates to Non-PBR excluded devices and high cost drugs, which are pass through costs and attract additional income; £919k relates to Park Suite underperformance and operational overspends, against which there is strategic agreement to identify a different PP provision, this will be supplemented with in year price changes where available. Agreement was reached at the beginning of the year that whilst this service sat within the Surgical division any associated pressure would be centrally managed;
- £1.4m of CIP underperformance and
- £692k expenditure to deliver the additional RTT work which is funded by NHS England.

The above costs reflect the cumulative position, however Month 11 saw a significant improvement in the non-core spend position (£27k) of the Division despite 5 gaps in the deanery rotation across the Division an overall reduction in non-core spend of £27k comparing January to February. This is forecast to continue both during the rest of the financial year and also into 2015/16.

From an income perspective the division has a cumulative under performance of £3.15m of which £709k was in month 11.

The Month 11 income position is showing shortfalls in numerous areas. The Elective position under performed by £186k including the Welsh work, Ophthalmology (£97k) and Trauma & Orthoapedics (£100k) where the main 2 specialties that under performed in Month.

Within Surgery there was lost income of £80k in month due to cancellations due to bed pressures.

Non-Elective performance underachieved by £429k. Colorectal (£172k), Upper GI (£75k), Obstetrics (£91k) and Paediatrics (£64k) were the main areas of under achievement. Work has begun to be undertaken to understand this shift over the past 2 months within Surgery's Non-Elective position.

Outpatients under performed in total by £69k which was mainly in Gynaecology (£21k) & Paediatrics (£37k)

Within Non-PBR the Neonatal Unit under performed by £55k in month.

The division continues to scrutinise the detail of all of the Income postion from both a retrospective and prospective perspective increasingly focusing on a daily and weekly basis on the volume of operations booked to ensure slots are filled and resource utilisation maximised and available capacity used for alternative services where appropriate with particular emphasis on the plans for 15/16.

Whilst the overall divisional position remains significantly challenging the focus will be:

- On sub-directorates to ensure no over-spend/under-recovery is being masked.
- For areas of significant concern the division has adopted a turn-around approach, and will undertake full bottom up service reviews in the area.
- Commence monthly performance review meetings with directorate triumvirate.
- Ophthalmology will become an independent directorate away from special surgery from 1st April.
- Theatres and outpatient utlilisation.
- Reducing Non-core spend.
- Reducing Non-pay spend.
- Challenging medical staff costs to support on-call.
- Continue exploring, with success, new markets for the provision of services, specifically within North Wales and potential collaboration with Chester
- 3% devolved CIP target.

Clinical Support I&E

The Division reported an overspend of £179k year to date with an adverse movement against budget of £106k in month, £24k behind the last total Trust forecast (completed after Month 9). The in-month variance deteriorated by £95k compared to January predominantly owing to lower GP Direct Access income (lower activity particularly within MR & Ultrasound), increased Infection Control test costs (Cepheid) and backdated pay due to an agreed higher on-call allowance than currently being paid.

Cumulatively Therapies remain ahead of plan by £179k, Outpatients by £128k, Cancer Team by £17k, Patient Flow by £15k whilst Radiology and Pathology are behind plan by £74k and £654k respectively.

From an income perspective the Division is performing well being £1,041k ahead of plan YTD. This is largely driven by Radiology with cumulative unbudgeted unbundled imaging income of £216k and direct access income ahead of plan by £710k; Radiology Direct Access has experienced a 20% increase in activity and this high demand continuing in Ultrasound and Plain Film. Both AHPs and Pathology are performing slightly ahead of plan (YTD £21k and £94k respectively); again this is largely driven by direct access performance. Whilst these income gains generate a contribution there is an affordability risk across the economy if these levels of diagnostic demand continue.

The Division is reporting an overall underspend on pay of £367k YTD with only Radiology and Patient Flow over spent cumulatively. Outpatients and Therapies are underspent by £170k and £233k respectively. The Division continues to hold vacancies, where appropriate, as it progresses its staffing restructure proposals in consultation with staff side colleagues in all areas.

Non pay budgets are £1.35m overspent year to date but this is offset by £888k in associated income. Pathology non pay overspend is £668k offset by £298k additional income; the bulk of lab

costs vary with both GP & Trust activity however Pathology is experiencing a significant cost pressure in the provision of blood products to the broader organisation (£142k YTD net of income recovery) and historic over performance against the Roche MSC offset by an unbudgeted contribution on the new OPAT service. Radiology non pay overspend is £402k with income offset of £21k; the bulk of these costs being variable costs associated with direct access volumes. Outpatients non pay costs are below budget by £44k predominantly owing to the new Patient Reminder Service contract. AHPs non pay spend is over budget by £255k however a significant element of this relates to Integrated ESD and is recovered through income which is £460k ahead of plan to date.

The Division remains £1,125k behind its cumulative CIP target. Specifically Radiology is £365k behind, Therapies £280k, Outpatients £88k and Labs £392k behind plan. This is the biggest risk to delivering a balanced budget. Every service is actively in consultation/implementation to introduce new structures which will reduce cost. The division is working to identify further opportunities to bridge any remaining gaps in CIP delivery.

Corporate Services I&E

The division reported a £106k overspend in month and a cumulative net overspend of £586k. Divisional income is cumulatively £172k under-recovered and the expenditure budgets are cumulatively £414k overspent.

The table below details the financial net position for the key areas of the Corporate Services division:-

Directorate	Annual Budget	Current Month Budget	Current Month Actual	Current Month Variance	Ytd Budget	Ytd Actual	YTD Variance
CORPORATE NURSING	1,869	160	152	8	1,723	1,687	36
ESTATES	6,846	563	562	1	6,277	6,224	54
EXECUTIVE MANAGEMENT	10,557	954	963	-8	9,738	9,760	-22
FINANCE & SUPPLIES	4,125	351	339	12	3,780	3,659	121
HOTEL SERVICES	12,879	1,059	1,077	-18	11,832	12,082	-250
HR & OD	2,490	282	282	1	2,276	2,239	37
INFORMATION & IG	554	45	105	-60	510	1,063	-553
IT	6,615	496	536	-40	6,097	6,409	-313
PHARMACY	5,073	420	419	0	4,665	4,662	3
QUALITY & SAFETY	918	82	76	6	845	787	57
TRANSFORMATION TEAM	863	258	243	15	821	641	179
CORPORATE SERVICES CENTRAL	246	-50	-133	83	146	117	29
MISCELLANEOUS	-7,121	-561	-455	-107	-6,560	-6,596	35
Grand Total	45,915	4,060	4,165	-106	42,149	42,735	-586

The areas of concern this month continue to be:-

Information Governance—there continues to a pressure on Injury Cost Recovery (ICR) income. In month this budget has under-recovered by£66k with a cumulative under-recovery of ICR income of £607k.

Information Technology—continued overspends on IT due to cost pressures on maintenance and IT purchases and implementation costs.

Hotel Services budgets are under pressure from the Accommodation contract, from supporting additional beds and the impact of infection control cleans.

Pharmacy continues to be largely on plan in-month and year to date. This is in despite of the impact of activity related cost pressures that the division have continually managed to mitigate.

There are smaller overspends in some of the other directorates however they still remain cumulatively underspent. In month there have also been certain Trust wide pressures in miscellaneous.

Board of Directors	
Agenda Item	7.2
Title of Report	Urgent Care Recovery Plan (UCRP) update
Date of Meeting	25 March 2015
Author	Rob Cooper, Head of Urgent Care
Accountable Executive	Sharon Gilligan, Director of Operations
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	**2** & **7C** **2A** The Trust and its local partners fail to implement a redesigned health economy to achieve more care in the community Risk No. 2328
Level of Assurance • **Positive** • **Gap(s)**	Gap
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 Equality impact assessments to be undertaken as required for key actions relating to any service changes

1. Executive Summary

It has been recognised across the Local Health economy that achievement of the 95% target against the 4 hour standard is a shared responsibility. The standard was not achieved in any quarter of 2014-15 and a Health and Social Care Economy recovery plan is already in place (Appendix 1).

The recovery plan comprises of 4 work streams that are required to support achievement of the 95% target. Each of the work streams has designated executive sponsors, management leads and clinical leads who have been selected from across the Wirral Health and Social economy, depending on their area of influence, to work in partnership to support achievement of the standard.

This paper describes the 4 work steams that make up the action plan, indicates the reasons for continued lack of compliance against the 4 hour standard and details the actions required by the Wirral wide Health and Social economy to support achievement of the standard.

2. Background

The Urgent Care recovery plan was developed in response to the continued none compliance against the 4 hour standard. This plan also recognises the fact that this is an economy wide issue and not just in relation to the Acute Trust or indeed the Emergency Department in isolation.

At its inception, the plan was developed by representatives from across the Wirral Health and Social Care economy in conjunction with the Greater Manchester Commissioning Support Unit who were commissioned by Wirral CCG to support the recovery plan. This group then continued to meet fortnightly as the Urgent Care Recovery group, led by the Head of Strategic Planning and Outcomes for Wirral CCG, in order to monitor progress and develop the action plan accordingly. This meeting reports into the System Resilience Group.

The plan also takes into account actions identified following the Perfect Day events led by WUTH

In summary the key aims/actions of the identified work streams are as follows:

Admission avoidance – This work stream aims to prevent admission by focusing on areas of high attendance such as drug and alcohol misuse as well as specific pathway work for continence, falls, frequent attenders and admission to hospital for intravenous antibiotics. The organisations involved in this work stream are tasked with developing a single front door to support signposting of patients to the most appropriate provider to prevent avoidable admissions

ED Processes – This work stream has been developed to ensure that the Emergency Department is optimising the use of its clinical ability, by ensuring that patients receive senior review at the earliest stage possible following presentation. Early senior review and requesting of appropriate diagnostic investigations will support early decision making to facilitate a timely patient journey.

Inpatient care - With the focus on care of inpatients, this work stream has been developed to ensure that once admitted, patients receive the right care at the right time with the aim of reducing waste within the patient journey. Going forward, there is further work being undertaken with NWAS to ensure that patients who are referred by GPs are transferred into hospital as soon as possible following referral to ensure that they receive early senior intervention and prevent batching of patients which causes delays in the system and increases length of stay.

Patient discharge – The key action within this work steam is, improvement of the discharge pathway out of hospital for patients requiring ongoing support/care, including patients from Cheshire. This work stream also encompasses pathways for admission into intermediate/transitional placements in the community to prevent admission, whilst ensuring integration of the Integrated Care Coordination Teams into these pathways. As a result of the work undertaken, this work stream will support commissioning of rapid community services from September 2015 and the development of effective discharge/admission avoidance pathways.

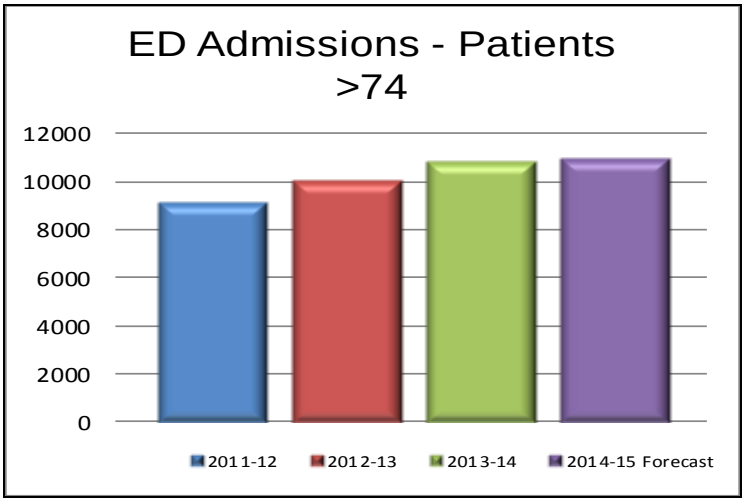
3. Key Issues/Gaps in Assurance

There have been a number of actions completed since inception of the plan in September last year, particularly in relation to the Emergency Department, which has been noted by the Greater Manchester Commissioning Support Unit. These actions include the use of the Emergency Department Review Unit to support emergency assessment not requiring admission and consistent provision of early senior review within initial assessment to reduce delays in ED.

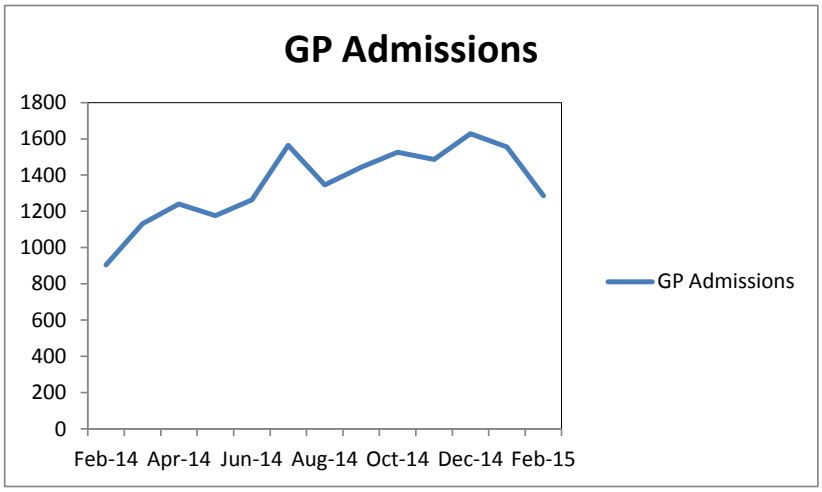
The completed actions also include provision of a social worker for Cheshire patients based with the Integrated Discharge Team on the APH site, development of improved pathways for patients who present with substance misuse issues to avoid admission from ED, which includes the employment of 5 additional substance misuse nurses and streamlining of the fast-track pathway for end of life patients.

However, despite this targeted economy wide approach, there are several key factors that continue to contribute towards the current non-compliance against the 4 hour standard namely:-

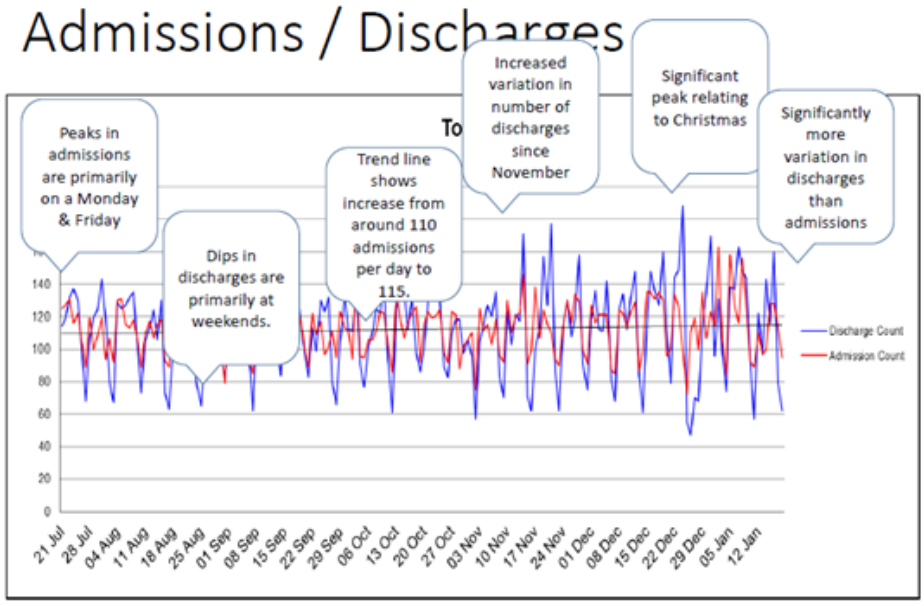
- Ageing population with increasingly complex health needs resulting in a year on year increase in emergency admissions for this group



- Significant increase in GP admissions from the same period last year 904 per month to 1,286 an increase of 42%

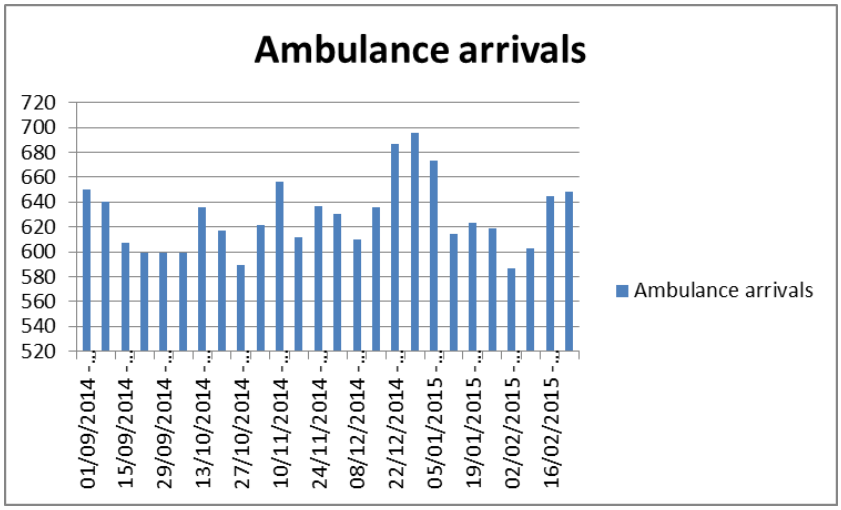


- Seasonal Trend of Admissions showing significant peak at the start of quarter 4

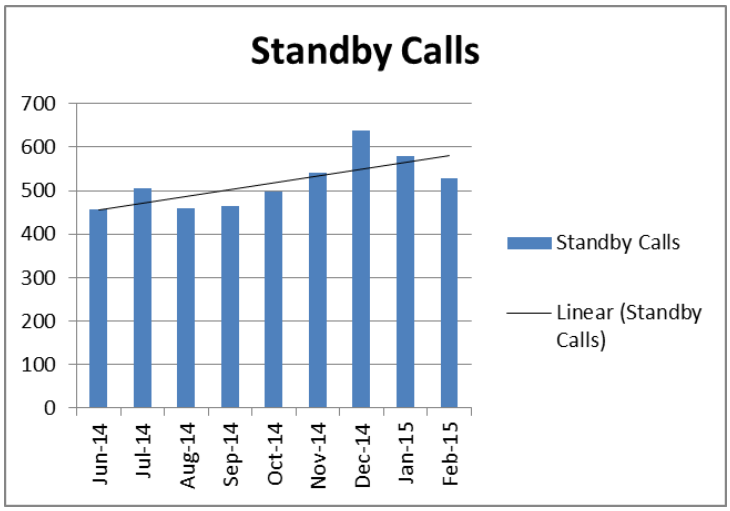


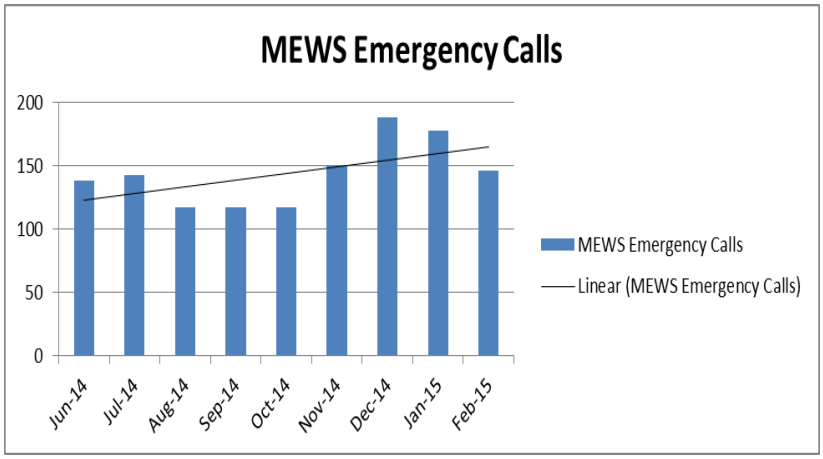
As illustrated in the data above, the trend line details an average increase of 5 admissions per day. Based on the Trust's average LoS this would equate to 3,150 bed days in quarter 4 alone.

- Ambulances conveyances per week peaked significantly at the start of quarter 4



- Increase in patient acuity demonstrated by an increase in standby calls (direct transfer from ambulance into the resuscitation area) and an increase in MEWS emergency calls (Increase in Modified Early Warning Score of inpatient triggering an immediate response from senior medical team on ward)





- Absence of discharge to assess model to support timely discharge of medically stable patients requiring formal support on discharge from hospital. For quarter 4 the Trust has on average had 51 medically fit patients within the hospital with the average turnaround from referral to discharge being 8 days. WUTH has consistently advised the economy that this number needs to be 30 patients with an average turnaround of 3 days from referral to discharge.

4. Next Steps

Whilst a number of actions have been completed, in order to ensure that compliance against the 4 hour standard is achieved, it is imperative that the outstanding actions detailed in the Urgent Care Recovery Plan are delivered as planned. These actions include:

- Development of the Single front door model on the Arrowe Park site
- Further focus on discharge to enable ongoing assessment in the community through:
  - Implementation of a consistent 4 pathway approach to discharge and admission avoidance
  - Commissioning of a 'rapid community service' for full implementation in September 2015
  - Recommission of more robust step up/down service, providing additional intermediate care beds and building in winter capacity through baseline SRG funding
- Investment in 72 hr overnight support
- GP access to rapid community intermediate care to prevent admission
- Development and implementation of a multiagency action plan in response to the crisis care concordat
- Mental health involvement in the single front door project
- Development and implementation of a 'universal access point' for mental health services

These outstanding actions have agreed timelines against them that are monitored through the Urgent Care Recovery meeting and System Resilience Group.

In addition to the Urgent Care Recovery plan, WUTH are working closely with ECIST (Emergency Care Intensive Support Team) as part of the “breaking the cycle” initiative which works on the same principle as a “perfect week,” whereby every ward will receive an increased level of clinical input over a seven day period to ensure that all patients are admitted, treated and discharged to the right place, at the right time. Managers, clinicians and admin staff during the week will be diverted from all other activities to focus on improvements at a departmental and ward level. The purpose of this initiative is to help nurses and junior doctors make correct decisions about the pathways patients follow, freeing up staff and beds across the hospitals and improving the flow through the emergency department.

Whilst acute Trusts have been tasked with completing this during the Easter period, WUTH are taking this time to effectively plan to ensure the most is gained from the exercise and as such have agreed with ECIST that this will be to carried out the week commencing 20th April 2015.

5. Conclusion

Whilst it is clear that the 4 hour standard has not been achieved for 5 consecutive quarters, it is important to note that there is a recognition that this is not an indicator of failure at the Acute Trust level but that this is an economy wide target that can only be achieved in partnership with organisations across the Health and Social care economy.

The achievement of this target requires ongoing commitment to the agreed Urgent Care recovery plan.

6. Recommendation

It is recommended that the Board of Directors support delivery of the Urgent Care recovery plan and commitment to the “breaking the cycle” initiative planned for 20 April 2015.

Wirral Health and Social Care Economy
4-hour standard
Recovery Plan

Performance Dashboard

To be completed weekly for circulation to urgent care recovery plan group

Week commencing: - 2nd March 2015

Combined Arrowe Park site compliance against 4 hour standard (Target 95%)	83.43%
WUTH compliance against 4 hour standard (Target 95%)	78.96%
Combined Arrowe Park Site Quarter 4 position	84.957%
Total number of minor breaches as percentage of overall breaches	14 (335 overall)
Total number of inappropriate medical redirects	17
ED Admission Rates	456
GP Admission Rates	269
Ambulance Turnaround Times	Awaiting NWAS update
Number of patients on the complex discharge list	36
Average length of day on complex discharge list	10 days

4 hour Standard Trajectory

Month (2014 / 2015)	Expected Achievement (as a single site)	Actual Achievement (as a single site)
October	94%	95.8%
November	96%	88.02%
December	95%	82.98%
January	94%	79.96%
February	96%	81.73%
March	95%	

Admission avoidance

Objective: To prevent unnecessary attendances and admissions to Hospital.

Executive Sponsor: Val McGee, Interim Director of Performance, Wirral Community Trust (WCT) / Sharon Gilligan, Director of Operations, Wirral University Teaching Hospital (WUTH)

Management Lead: Andrew Cooper, Head of Strategic Planning and Outcomes, Wirral Clinical Commissioning Group (WCCG) / Chris Oliver, Associate Director of Operations, Medical and
Acute Specialties Division, WUTH

Clinical Lead: Dr Hannah McKay, GP, Urgent Care Lead, WCCG /Dr Ranjeev Mehra, Clinical Head of Division, Medical and Acute Specialties Division, WUTH

No	Action	Aim	Impact / Outcome	When	Lead	Update / Actions
1	Review SPA function and admission avoidance pathways (Perfect day action)	To reduce inappropriate GP admissions	Utilisation of local directory of services to redirect patients into other appropriate care settings	October 2014	Laura Thompson Commissioning Support Manager, WCCG Dr Hannah McKay, GP, Urgent Care Lead, WCCG Val McGee, Alina McColeville, Tracey Orr, WCT	04/03/2015 • It was suggested that a task and finish group be developed to implement rapid cycle testing for new SPA models (see ED process update below) – VM suggested that as many of the people required would be present at the Single Front Door Workshop on 11/03/2015 and a plan to take this forward should therefore be developed there. • Currently links with 2x Task & Finish groups from the Value Stream Analysis – Care Navigation and Assessment and Opinion. • Laura Thompson to be involved in this; however she doesn't work Wednesdays when Single Front Door workshop meets.

2	Pathway development: • Continence • Falls • Frequent attenders • IV Antibiotics (Perfect day action)	To reduce attendances to ED and medical admissions	Reduce avoidable admissions by redesigning community focused pathways	Development in progress for completion by: • Continence – TBC • Falls – April 2015 • Frequent attenders – Completed • IV Antibiotics – service started January 2015	Sheena Hennell, Commissioning Manager, WCCG Paul McGovern, Commissioning Support Manager, WCCG Laura Thompson Commissioning Support Manager, WCCG Jacqui Evans, Head of Service, Wirral Department of Adult Social Service (WDASS)	<u>Incontinence – 04/02/2015</u> RC stated that there have only been a few cases so far, however will continue to monitor this to see if this should be a separate pathway. Trial Without Catheter (TWOC) scheme in place <u>Falls - 04/03/2015</u> • AC informed the group that this is linked to the Wirral Independence Tender • DM stated that NWAS have received numerous calls from Eldercare with falls. ➢ **DM to forward JE details of these calls.** <u>Frequent attenders</u> <u>03/12/2014 - ***completed***</u>, however, will monitor this and also links in with Action 7 – Street Triage. <u>IV Antibiotics – 04/03/2015</u> ➢ See OPAT update below

						OPAT Service – 04/03/2015 SB informed the group on the following points: • Started February 2015 – phased implementation • 2x OPAT Nurses in place • Capacity for 5x patients – capacity will increase • Working with WCT nurses who deliver the routine IV Antibiotics Service (OPAT provide specialist support and advice). • Comms have already been sent to GP's informing them that this service is due to be implemented and there has been communication to the GP Forums. However, also need to look at comms within WUTH – due to be developed / implemented this next week. ➢ **AQ will discuss in Nurse/MDT Meetings** ➢ **SB will ensure that Jen Shaw and Laura Thompson are linked in with regards to these comms.** ➢ **SB to look at referrals from GPOOHs and also provide a monthly update on the OPAT service for the UCRP.** AC thanked everyone involved for their support on IV Antibiotics.
3	Develop a single front door on the Arrowe Park site (Perfect day action)	To ensure only patients requiring ED skill set attend the ED with other patients streamed to alternative care providers	Redirect patients who could be seen in primary care or community urgent care and reduce ED attendances by agreeing and implementing joint protocols.	Mid October	Rob Cooper, Divisional Manager, Medical and Acute Specialties Division, WUTH Val McGee, Elaine McNamara, Dr Kathy Ryan, WCT Paul McGovern, Commissioning Support Manager, WCCG	04/03/2015 VM informed the group that the next meeting is scheduled for 11/03/2015, where they will also discuss SPA

4	Access to diagnostics and hot reporting of x-rays. (Perfect day action)	Rapid diagnosis to be made for patient to be directed appropriately	Reduction of GP admissions to assessment areas by providing planned access on the day	December	Amanda Farrell, WUTH Sheena Hennell, Commissioning Manager, WCCG	<u>Bloods - 04/03/2015</u> SB/AF informed the group that Andrew Bamber will provide an update for the next meeting. ➢ **AS to ensure that Agenda for next meeting is updated accordingly.** <u>Bloods (delays) – 18/02/2015</u> • AF informed the group that the contracts team have now included the cost of bottles within the contract, so this should now be progressing. ➢ **AF to check that bottles have been ordered/delivered to GP's.** <u>X-Rays hot reporting – 18/02/2015</u> • AF informed the group that only Ultrasound is currently hot reported, and would need more radiologists if wanting to hot report for x-rays. ➢ **AF will liaise with Pam Black and Simon Lee with regards to Chest Plain Film x-rays.** **Update 04/02/2015** <u>Diagnostic reporting</u> • Urgent cases can and will be reported immediately • All routine reports are normally completed within 2 weeks The department is now undertaking extra lists using external suppliers to increase baseline capacity in order to reduce the access times for routine referrals from GPs. • The waits are currently as follows;- – Ultrasound: 3wks – CT: 2wks 2 days – MRI: 3wks 3 days

5	Update the Directory of Service (Perfect day action)	Provide comprehensive document detailing full range of services available for patients in Wirral to support streaming of patients to most appropriate provider	Maximise diversion of patients to community services to avoid admission	Paper version updated by November 2014	Rob Cooper, Divisional Manager, Medical and Acute Specialties Division, WUTH Pauline Bolt, Commissioning Support Manager, WCCG Karen Milnes, WCT Sarah Alldis, Independence Manager, WDASS	<u>18/02/2015 - on-going</u> AC informed the group that work is still on-going and that this would be split into 2 separate DOS, as follows: • 111 DOS will be updated by the CSU. • Community DOS is currently with the IT Service waiting to be incorporated onto the CCG website (discussion regarding initial quote).
6	Street Triage	CPN working in partnership with the police / ambulance service to identify patients who can be diverted into community mental health services to avoid conveyance to ED	To maximise diversion of patients and reduce ED attendances (and frequent attenders)	End of March 205	Suzanne Edwards, Service Director for Wirral Mental Health, CWP. Paul McGovern, Commissioning Support Manager, WCCG	<u>04/03/2015</u> SE informed the group that this service will be fully staffed by next week.

7	NWAS 'Deep Dive' workshops	Similar to UCRP but working with CCGs and partnering providers understand reasons behind increased demand and NWAS poor 8 min performance	Impact will have same positive impact on ED as fewer patients will be conveyed to hospital. Action Plan developed to look at reducing demand for NWAS Paramedic Emergency Service and to increase capacity in order to achieve 8 min KPI	Ongoing	Debbie Mallett, Service Development Manager – Cheshire and Merseyside, NWAS Sarah Boyd-Short, Commissioning Support Manager Contracts & Delivery, Wirral CCG	04/03/2015 NWAS Deep Dive Summary Jan 2015 v2 Action Plan attached
8	Paramedic Pathfinder - schemes outlined below… GP Referral Scheme Kitemark of VCH	To stream low acuity presenting patients into See and Treat pathways and to reduce conveyance to the Emergency Department Refers patients directly into a responsive primary care service Allows NWAS clinicians to directly convey patients with minor trauma presentations to Victoria Minor	Potential of up to 40% of Emergency Ambulance Calls to be appropriately dealt with in community settings No of patients deflected: Nov 60 Dec 97 Jan 68 Numbers of patients are low but patients will be receiving most appropriate treatment in the right place and reduces need for conveyance to WUTH	Ongoing Funded with SRG winter monies until end March 2015 Ongoing	Paul Walton, Pathfinder Area Manager – Cheshire and Merseyside, NWAS Sarah Boyd-Short, Commissioning Support Manager Contracts & Delivery, Wirral CCG Tracy Orr, Wirral Community Trust Judith Roberts, Wirral Community Trust	04/03/2015 ➢ **DM to forward SBS latest data on this**

	Kitemark of All Day Health Centre on WUTH site Direct Referral Pathway to Rapid Response Team	Injuries Unit Allows NWAS clinicians to deliver low acuity patients to UDHC as opposed to ED at WUTH	Additional alternative to ED	To be agreed	Dr Kathy Ryan, Wirral Community Trust	
9	Frequent Callers and Frequent Calling locations,	To proactively identify private and public addresses that frequently call the ambulance service based on a set of pre-agreed parameters of activity. Frequent Caller Project Leads for Cheshire and attends FC meetings at WUTH	The team provide a range of interventions to patients who frequently call the ambulance service, from a basic telephone call and regular welfare check, to more intensive support and arrangement of MDT meeting and care planning. The team aim to improve patient care by providing more patient-centred support in an attempt to reduce the number of calls.	Ongoing	Angela McNally, Frequent Callers Project Implementation Lead, NWAS Fenella Foulis, Frequent Caller Specialist Paramedic – Cheshire, NWAS	04/03/2015 Nov 14 – Jan 15 report attached. February 2015.docx
10	Falls	To reduce the number of falls-related conveyances to hospital	'Falls' is the number one reason why an emergency ambulance is called on the Wirral. As many patients require assistance only, Wirral Independence Service will soon accept referrals from NWAS clinicians to directly refer into the Falls Pick-up Service to negate the need for an ambulance attendance and onward conveyance.	This is currently out to tender and will be in place in June 2015.	Pauline Bolt, Wirral CCG	04/03/2015 ➢ **DM to forward SBS latest data on this**

11	Green Car Scheme	To target low acuity calls to the ambulance service where a Senior Paramedic is required to provide face-to-face assessment to try to divert into other community based services. The car is unmarked and therefore provides a separate resource to the emergency vehicles.	To provide senior triage to proactively identify patients who can self-care or be treated by community provider to avoid conveyance to ED. SPs will target patients who have fallen or those who require additional assessment to determine the correct course of action. SP also provides more senior clinical leadership to road staff who may query need for conveyance. Green car can also be used to convey patients to their onward destination without the need to call for a second emergency ambulance for transport. Early evaluation suggests around half of all calls tended to are for patients who have fallen and around half the number of calls attended are not conveyed to hospital. The car has dealt with 395 calls between 1st Oct 2014 and 28th Feb 2015	Funded with SRG winter monies from 1st Oct 2014 – 31st March 2015	Stuart Ryall, Sector Manager, NWAS Sarah Boyd-Short, Commissioning Support Manager Contracts & Delivery, Wirral CCG	04/03/2015 ➢ **DM to forward SBS latest data on this**

ED Processes

Objective: To eliminate ED delays and ensure optimum patent flow through the ED

Executive Sponsor: Dr Evan Moore, Medical Director, WUTH

Management Lead: Rob Cooper, Divisional Manager, Medical and Acute Specialties Division, WUTH; Dr Kathy Ryan, Clinical Director & Divisional Manager, WCT.

Clinical Lead: Dr Alan Pennycook, ED Consultant, Clinical Service Lead for Emergency Medicine, WUTH:.

No	Action	Aim	Impact / Outcome	When	Lead	Update
1	Breach Analysis Pathway Review	to be shared widely with the Trust's senior managers and clinicians	To enable individual clinical directorates to take responsibility for ensuring improvement	Completed	Rob Cooper, Divisional Manager, Medical and Acute Specialties Division, WUTH	04/03/2015 AC suggested to the group that through delivery of the 'ED process' element of the plan, ED processes were now much more efficient. However, the 95% standard is not being achieved and there are still notable blockages when patients need to be moved on from ED i.e.: • Delays moving patients out of ED and in to ongoing assessment areas • Delays moving patients on to wards • SPA should be key to this i.e.: SPA assessment should incorporate sufficient challenge to the referrer to consider alternatives where appropriate – this may require GPs that have broad knowledge of available community services to work in SPA to undertake this peer-to-peer discussion / constructive challenge ➢ **RC will circulate analysis of these patients to group.** ➢ **DM will look at other SPA services available, and bring information back to the next meeting.** AC suggest a Task & Finish Group to be set up to help understand where blockages are, and the group suggested the following people: WUTH - RM, RC, Gavin Francis

						○ WCT - Dr Ryan ○ ICCT – Helen Lundy, Anne Cartwright ○ CCG – PC or AC ➢ **AS to liaise with AC to set up this Task & Finish Group.** <u>Tickets Home - 04/03/2015</u> AQ gave a quick update on the "ticket home" that is provided at WUTH for patients. • patients given an information leaflet at the time of their admission - provides information on their stay and discharge process. • Discharges are discussed at Nurse meetings, Matron/Sisters meetings and ICCT also attend these meetings. There was a discussion around the Discharge Summary, as some felt that not all fields were populated. The following feedback was received: • DM also stated that NWAS should also be linked in with the discharge summary, as this could stop patients being re-admitted if they're called out. ➢ **JE to invite DM and Cath Hanlon to next ICCT Meeting to discuss Discharge Summaries**. • SQ – would like CWP to be informed of any behavioral issues, to also deter repeat admissions. • The group agreed to pick up re-admission details from WCT / GPOOHs and WUTH, • A Single Care Plan has been discussed and remains under development but has not been rolled out as yet.

Inpatient Care

Objective: To improve patient flow within the hospital

Executive Sponsor: Sharon Gilligan, Director of Operations, WUTH

Management Lead: Amanda Farrell, WUTH

Clinical Lead: Dr Ranj Mehra, Clinical Head of Division, Medical and Acute Specialties Division, WUTH

No	Action	Aim	Impact /Outcome	When	Lead	Update
1	Ensure ambulance response times within one hour for GP admissions (Perfect day action)	To ensure patient arrive at the acute site for medical assessment earlier in the day	Enable timely diagnostics to be undertaken with the aim of increasing the likelihood of same day discharge	November 2014	Sarah Boyd Short, Commissioning Support Manager, WCCG	18/02/2015 AC stated that Sarah Boyd-Short is looking in to this, as we need to consider where investment goes in future. 04/02/2015 • Service already in place – however RC is currently doing an audit to see types of referrals and admissions. Details should be available mid-February. • DM stated that it has been difficult to do this pilot, and is currently looking at tweaking this pilot for faster turnaround times. • VM has liaised with Adrian Evans to do walk rounds on wards to chat to patients / families (frequent attenders), which then links into ICCT. • RC confirmed that Anne Cartwright and NWAS attend the Frequent Attenders meeting (not just substance misuse) which is chaired by Paul McGovern. • Ticket Home Scheme - Alison Quinn is currently looking into a "ticket home" scheme, which should also link in with NWAS.

2.	Patient flow task and finish group	To further understand the blockages in patient flow out of ED and through the hospital to the point of discharge	Following successful implementation of actions to improve ED processes and discharge, outcome of task and finish group will be to reprioritise the Urgent Care Recovery Plan to re-focus on unblocking flow issues	March / April 2015	To be agreed	

Patient Discharge

Objective: to reduce the average number of occupied bed days by minimizing delayed discharges.

Executive Sponsor: Suzanne Edwards Service Director for Wirral Mental Health, Cheshire and Wirral Partnerships NHS Trust CWP / Val McGee, Interim Deputy Director of Performance, Wirral Community Trust (WCT)

Management Lead: Jacqui Evans, Head of Service, WDASS / Karen Milnes, Divisional Manager, WCT

Clinical Lead

No	Action	Aim	Impact /Outcome	When	Leads	Update
1	Implementation of early supported discharge pathways	Reduce number of occupied bed days.	Improve utilisation of current bed base	Pilot commencing November 2014	Amanda Farrell, WUTH. Medwyn Jones, WUTH. Karen Milnes, WCT. Sarah Alldis, DASS	 18/02/2015 JE not received the ESD report from Medwyn Jones, so not able to provide any feedback to the group. 04/02/2015 Work on-going and currently going well. ➢ **MW to forward ESD reports to AS for inclusion in SRG Agenda**
2	Improve complex discharge pathway and processes: 2a) Consider CHC and nursing assessments outside hospital	• Patient assessments to be undertaken in a more appropriate setting and improve patient experience. • Reduce occupied bed days (LOS). • Encourage ability to self-care and manage condition safely.	• Reduction in permanent admissions to residential and nursing care homes • Decrease in the proportion of people discharged direct to residential care • Increase in the proportion of admissions to intermediate care beds • Increase in the number of people who are still at home 91 days after discharge from hospital	Pilot October – March 2015 Pilot Jan 2b) Pilot Dec / Jan Mainstream	Jacqui Evans, Head of Service, WDASS Adrian Evans and Jane Ralley WCT Jacqui Evans, Sarah Alldis, Jason Oxley, DASS Christine Campbell, WCCG. Alison Quinn and Karen Milnes, Jane Ralley, WCT	18/02/2015 – 2a) JE provided a draft Pathway/Criteria (including exceptions) to the group, and discussed this in more detail outlining the following points: • Launch date with GP's is 24/02/2015. • In process of planning more launch events. • Jen Shaw and Peter Tomlin are working with key links across organisations to implement this pathway - Next stage is to launch and focus on Why/where patients are being admitted.

	2b) Develop and implement rapid access element, within the Step up / Step down service. (links with wider Step up / Step down review and no. 7 on admission avoidance workplan). 2c) Review 'Home of Choice' management. 2d) Review discharge pathway and processes, including planning for discharge upon admission and support for daily board rounds, including review of 'on hold' list.	• Increased numbers of customers on a reablement plan. • Increased numbers of customers making use of assistive technologies.	• Increase in the proportion of people who are offered reablement services following discharge from hospital • Reduction in non-elective re-admission rate. • Reduced occupied bed days and LOS • Reduction in permanent admissions to residential and nursing care homes • Decrease in the proportion of people discharged direct to residential care • Increase in the proportion of admissions to intermediate care beds • Increase in the number of people who are still at home 91 days after discharge from hospital • Increase in the proportion of people who are offered reablement services following discharge from hospital • Reduction in non-elective re-admission rate. • Reduced occupied bed days and LOS	2b) April 2015. 2c) Nov 2014 2d) Nov 2014 – Jan 2015.	2 b) Jacqui Evans, Sarah Alldis, Karen Milnes, Jen Shaw. 2c) Jacqui Evans, Amanda Kelly, Sarah Alldis, Alison Quinn. 2d) Sarah Alldis, Karen Milnes.	<u>04/03/2015 – 2b) Step up/step down</u> JE informed the group that Jen Shaw is finalizing few details and will forward onto the group and would like support from people to attend the Discharge Group meetings, which are fortnightly. Currently looking at the following: • Overnight support • 7 day access to Age UK • Going to tender for 7 day offer for beds. • Currently have 70 beds at the moment with a further 30 beds by Sept. Total of 100 by Sept (25 beds in each of the 4x hubs) • MDT's scaling up to 7 days, and GP offers – will provide more details at next meeting.

3	Care homes including: - falls pathway - appropriate community bed capacity (including IMC / TC / Respite / Short stay and bariatric beds)	a) Reduce delayed discharges to care homes for Wirral b) Reduce A+E attendances from care homes in Wirral c) Reduce emergency admissions from care homes in Wirral d) Improve quality of care in Wirral.	• Reduction in permanent admissions to residential and nursing care homes. • Decrease in the proportion of people discharged direct to residential care • Reduction in attendance at A+E • Increase in the proportion of people who are offered • reablement services • following discharge from hospital • Increase in the proportion of admissions to intermediate care beds • Increase in the number of people who are still at home 91 days after discharge from hospital • Reduction in emergency admissions and hospital LOS.	September – March 2014	Jacqui Evans, Amanda Kelly, Adrian Quinn, Boo Stone, WDASS. Pauline Bolt, Commissioning Support Manager, WCCG. Paul McGovern Commissioning Support Manager, WCCG. Christine Campbell, Head of Partnerships WCCG Jenny Shaw, Better Care Fund Project Manager WCCG Karen Milnes, WCT. Dawn Harvey, CWP	18/02/2015 Meeting next week and looking at falls, EOL work etc and will also be focusing on Diabetes work. 04/02/2015 JE updated the group on the following points: • Continuing with block resilience beds • Action on Quality, ie Falls and linking with NWAS and Care Homes. • Diabetes Care – progressing • EOL Lead required from CCG – AC stated that this would be Paul McGovern • Continue to analyse the usage of beds, to see if there is a need to change the types of beds. • Work is progressing with Dr King Sun Leong and VM who are willing to support Care Homes and the management of Diabetes (to reduce admissions).
4	Improve access and availability of equipment from the CES.	b) Reduce A+E attendances from care homes in Wirral c) Reduce emergency admissions from care homes in Wirral	• Reduction in permanent admissions to residential and nursing care homes • Decrease in the proportion of people discharged direct to residential care. • Reduce A+E attendances from care homes in Wirral • Reduce emergency admissions from care homes in Wirral	Middle June 2015	Karen Milnes, Divisional Manager, WCT Boo Stone, DASS	18/02/2015 JE stated that the tender has been completed, and outlined the following points: • contract will be available on a 7 day offer 7am to 11pm. • Bariatric not excluded in contract but more work is needed on this. • Timeline – middle of June 2015

5	Implement a Patient Questionnaire or review current patient/carer feedback from WUTH	to understand if we need to increase respite provision.	Anecdotal information from WUTH on why people were being readmitted.		Suzanne Edwards, Service Director, CWP Wirral	**04/02/2015** ➢ **CO will pick this up and feedback at next meeting.** 05/11/2014 Val McGee had conversation around anecdotal information from WUTH on why people were being readmitted. Some people are reporting that they are readmitted because their family members were not coping." They didn't want me at home.
6	ICCT In-reach				Val McGee, Interim Director of Performance, WCT.	**Val McGee to provide details of this to AS**

COMPLETED ACTIONS / MONITORING

ACTION	AIM	COMMENTS
Commence GP phone line To start Monday & Tuesday	Reduce admission, decrease pressure in ED from redirects and reduced flow.	GP phone line commenced for 2 days. Usage remained low, model reviewed and Acute Physician bleep now introduced throughout week. (Update – see entry below implement a new medical assessment model
Zero tolerance inappropriate redirects	Decrease pressure in ED	Implemented and monitored at daily teleconference
Increase capacity in assessment areas x3	Additional chaired capacity	Implemented
Managerial change within ED.	Dedicated divisional manager and matron	Implemented
Agree start date for economy teleconference	To ensure whole economy aware of NEL pressures and actions which are required to ensure timely patient flow	Implemented
CCG funded point prevalence audit to be carried by Utilisation Management Team	To review all inpatients in order to identify the number who need to be in hospital	Implemented and outcome data received. High level findings suggest majority of patients acutely ill and requiring secondary care intervention. Additional work relating to hospital flow processes underway with Karen Campion.
Provide CSW and porter for transfer team (accessible 3pm – 10pm)	Support improved flow out of the department	Implemented
Ward rounds to be commence 8am on acute assessment areas	Post take ward rounds to support flow within the assessment units	Implemented
Alter on-call junior doctor rota from 9-9 to 8-8	As above	Implemented
Medical handover to move from 9am to 8am		Implemented
Increase the senior Dr presence in ED	Approval of ED medical staffing business case	Implemented
Increase ENP cover in ED	Approval of ED medical staffing business case	Implemented
Using the data from the UMR profile medical workforce to meet times of highest demand	Sustainable workforce to ensure capacity meets demand	Implemented
Zero tolerance to minors breaches	Sustainable improvement in 4 hour performance achieved	Implemented and monitored at daily teleconference
Ensure bed management are utilising admission / discharge data on a daily basis including predictor tool	Predict number of admissions and discharges required per day to identify gap	Implemented
Implementation of 3 hour TNT	Reduce bed days - Improved utilisation of bed base in assessment areas by reducing wait for test result from 12 hours to 3 hours	Implemented
Discontinue direct admission rights for Nurse Practitioners to ensure all nurse admissions have been discussed with a GP	Reduce inappropriate admissions	22/10/2014: Pilot starting this week for 1 month. Monitor the impact and outcomes on this on a daily basis.

Increase the utilisation of the discharge lounge (Perfect day action	To release bed capacity and improve flow within the hospital	22/10/2014: Currently in consultation to consider future of Discharge Lounge.
To implement a new medical assessment model. In summary to ensure that all GP & ED admissions are reviewed by an Acute Physician. To review admissions to AMU from speciality clinics (Perfect day action)	Reduce admissions from Q1 2013/14 baseline (Health economy agreement to reduce non-elective admissions by 5% in 2015/16) Ensure patients requiring admission have had appropriate medical assessment prior to referral for admission	03/12/2014 – AMU • Completed - GF informed the group that there is now the one AMU, (combined/split sex however, separate cubicles) where they receive all the medical referrals into the hospital and patients will be seen/reviewed by a Consultant on AMU before being moved on (paramedics make their own judgment of where to take patients). • **GF will provide a list to SG/CO of things that they can and don't cover** 03/12/2014 - Bleep for GP's – on hold GF stated that he is able to take calls, however there is no dedicated person for this at the moment. Also would like it noted that if consultants are on phone to GP's, then they are not seeing patients. Therefore suggests that this Bleep number is not advertised as yet. HK will be looking into this with Glyn Thomas (who is the CSL for Orthopedics)GF and HK will look at this again in the spring.
To review the job plan of the community Geriatrician to enable the provision of a responsive service that meets patients' needs	Reduce over 74 years avoidable ED admissions	Completed
Develop a communication strategy similar to 'choose well' (Perfect day action)	Provide patients with the relevant information in order to support streaming of patients to most appropriate provider	Completed
Implement ED staffing model	Support earlier decision making/requesting of investigations to improve flow	Completed
Review patient pathways within the ED	To streamline clinical care	Completed – this is being done with Streaming
All wards to undertake daily MDT board rounds	To plan for safe patient discharges and improve flow within the hospital	Completed – ward rounds being done, and all ward sisters have been education
Pathway development for Frequent Attenders to reduce attendances to ED and medical admissions	Reduce avoidable admissions by redesigning community focused pathways.	Completed - however, will monitor this and also links in with Street Triage (Action 7).

Change EDRU to ED assessment	To increase medical workforce availability within ED	Completed -
HUB area – Rapid Initial Assessment Area	Senior Medical staff to support initial assessment, to be run as a Rapid Initial Assessment Area	Completed - (SIFT)
Redesign Trolley & Majors to become one area	To improve current environment for both patients and staff	Completed - needs Capital investment
Explore options to improve capacity and response times with Cheshire West and Chester (CWAC)	b) Reduce A+E attendances from care homes in Wirral c) Reduce emergency admissions from care homes in Wirral	
Streamline 'Fast Track' pathway for end of life patients	Improve patient journey and reduce length of stay for patient group	Completed – list going out on a daily basis
Redesign the pathway for patients who present with substance misuse issues to avoid admission from ED	To discharge patients from ED to community provision	18/02/2015 RC confirmed that everyone is now in post with the last person starting in March 2015.

Board of Directors	
Agenda Item	8.1
Title of Report	CQC - Compliance Review
Date of Meeting	25 March 2015
Author	Maryellen Dean- Associate Director of Risk Management
Accountable Executive	Dr Evan Moore – Medical Director
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	1. To be the Top NHS Hospital Trust in the North West for Patient, Customer and Staff Satisfaction
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To Note / Discussion
Data Quality Rating	Silver – quantitative data that has not been externally
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	*No*

1. **Executive Summary**
   The Board of Directors has requested an update on the progress to prepare the organisation for the CQC inspection 14 September 2015.

   The Board is asked to consider the current evidence available. Review the project plan and agree it.

2. Background

In April 2015 the Essential Standards of Quality and Safety (the sixteen regulations) will be replaced by the **new Fundamental Standards (thirteen),** which were drafted in response to the second Francis Inquiry report and by law have to be met. The new standards are more concise than the old ones, and bring together several topics under one heading. However, the supporting guidance is less detailed, in an attempt to avoid a box ticking mentality and therefore there is more room for individual judgment in assessing whether they have been met.

In addition to this the CQC will ask five questions

Is the care…

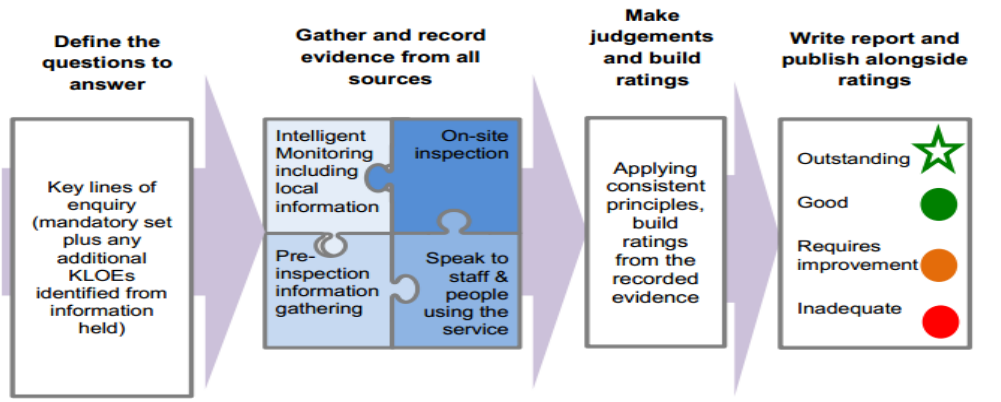
- **Safe?** Service users, staff and visitors are protected from abuse and avoidable harm.
- **Effective?** People's care, treatment and support achieves good outcomes, promotes a good quality of life and is evidence-based where possible.
- **Caring?** Staff involve and treat people with compassion, kindness, dignity and respect.
- **Responsive?** Services are organised so that they meet people's needs.
- **Well-lead?** Leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, support learning and innovation, and promotes an open and fair culture.

The CQC have developed **Key Lines of Enquiry (KLOEs)** which will be used in the inspection process to measure our organisation and they are framed under each of the five key questions.

The organisation will be judged as:

- ***Outstanding***
- ***Good***
- ***Requires improvement***
- ***Inadequate.***

Figure 2: How KLOEs and evidence build towards ratings



There are ***eight key service areas*** that will be inspected:

- A&E
- acute medical pathway (incl. frail elderly)
- acute surgical pathway (incl. frail elderly)
- critical care
- maternity
- paediatrics
- end of life care
- outpatients

CQC will hold **listening events**

- For local people to share their views and experiences of their hospital
- For staff groups

Following the inspection CQC will hold Quality Summits with local partners to discuss inspection findings/ improvement action needed.

3. Key Issues/Gaps in Assurance

Assessment
In order to meet the new CQC monitoring and inspection process the Trust has reviewed the evidence available and assessed it and categorized it in order to evaluate the **thirteen fundamental** standards.

The evidence available is:

CQC mock inspection (mapped from the KLOEs)
Audit program and assurance map
Evidence portfolios
Governance arrangements

Fundamentals assessment summary: (appendix 1)

Outstanding = 0
Good = 3 fit and proper persons directors; complaints; duty of candour
Requires improvement = 8 persons centered care; dignity and respect; need for consent; safe care and treatment; nutrition and hydration; good governance; staffing; fit and proper persons employed.
Inadequate = 2 premises and equipment; safeguarding

The next step in the evaluation of evidence is to produce data sets for the eight key services. This at present is proving difficult due to the fact that the evidence does not exist or because it is difficult to extrapolate into the key services.

A solution would be to break down the organisation into wards and departments and present the data in that format. This would allow for easier delegation of accountabilities and monitoring in divisions.

As an organisation we also need to assess ourselves against the five questions.
This should perhaps be under taken at divisional level then at executive level against the eight key services if possible and needs to be done following the review of all the thirteen fundamental standards and the CQC mock inspections.

Accountability:
The Trust has developed clear lines of responsibility from ward to board.
With executive and operational leads driving the fundamental standards agenda.
Triumvirate driving divisional progress and ward managers and clinical medical leads driving improvements at ward level.

4. Next Steps

(Success proposal appendix 2)

- Executive and operational leads review of the fundamentals with development of action plans to drive improvement by August 2015.
- Executive assessment of the five questions against the eight key services with action plan for improvement by August 2015 (appendix 3)
- Divisional assessment of the governance checklist for the division - with action plan for improvement by August 2015 (appendix 4)
- Divisional assessment of the five questions for the division - with action plan for improvement by August 2015
- Review of the evidence document management system which we have in place (s drive files) and decide if it would be of value to procure a new system to enable ward to board review of evidence and gap analysis and thus reporting.
- Assess the provision of staff and skill to manage the project of CQC proposal.(appendix 5)
- Continued implementation of the CQC project plan (appendix 6)

5. Conclusion

Much work has been done to ensure there are

- Key lines of accountability from ward to board
- The review of the fundamental standards has produced a high level understanding of areas that need further development in terms of evidence, monitoring or governance.
- Further development of the information that we have at ward level – for example nursing and midwifery audits, infection control audits
- The CQC mock inspection programme needs to be up scaled to ensure that all wards are inspected by July 2015.

6. Recommendations

The Board is asked to review the attached documents and to agree to the outline project proposal in the 'next steps and recommendations' above

Standard		Leads	Evidence folders complete?	Rating	Concerns	Actions underway / *actions required*
5	Fit and Proper Person - Directors	*Executive:* Anthony Hassall *Operational:* James Mawrey, Carole Self	✓	Good	No current concerns regarding fitness of Directors	• In January the Board approved a process for obtaining assurance when new Directors appointed, and how to ensure that existing Directors continue to meet the criteria.
9	Person centred care	*Executive:* Jill Galvani *Operational:* Gaynor Westray, Mike Chantler	✓	Requires Improvement	We need to maintain our Friends and Family Test response levels; we should also consider how to get feedback from the wider community (not just current patients / carers) in advance of the CQC planned inspection.	• Increasing response rates, for example green exit cards • *Public feedback events to be arranged during 2015 to prepare for the public forum events that CQC will hold during their inspection*
					Outdated patient information leaflets, including information which may no longer be correct or relevant	• New Patient Information Policy adopted in 2014 • Key performance indicators agreed with the Trust's print supplier • *Patient information leaflets to be managed through Covalent database in future – Quality and Safety department to facilitate* • *Leaflets to be reviewed and updated by the clinical divisions*
10	Dignity and Respect	*Executive:* Jill Galvani *Operational:* Gaynor Westray, Mike Chantler	✗	Requires Improvement	End of Life Care – adverse comments at previous CQC inspection; staffing vacancies	• Collaborative project to support identification of patients who are approaching the end of life • End of Life Care Strategy and action plan under development • Recruitment to one vacant post completed and remaining post to be recruited shortly
11	Need for Consent	*Executive:* Dr Evan Moore *Operational:* Dr Melanie Maxwell	✓	Requires Improvement	Audit results are generally positive – however, see comments for regulation 9 regarding patient information leaflets, and regulation 13 regarding Mental Capacity Act	• See comments for regulation 9 regarding patient information leaflets, and regulation 13 regarding Mental Capacity Act
12	Safe Care and Treatment	*Executive:* Jill Galvani, also Sharon Gilligan (emergency planning only)	✓	Requires Improvement	Frequency of 'Never Events' – five have been reported within the last twelve months	• External review of Theatres underway, February 2015 • *Audit to be devised against all national guidance relevant to these types of events*

Standard		Leads	Evidence folders complete?	Rating	Concerns	Actions underway / *actions required*
		Operational: Gaynor Westray, Pippa Roberts, Peter Bohan, Tracey Lewis, Maryellen Dean, Helen Nelson			Early warning system (MEWS / PEWS / MEOWS / NEWTS) observations not completed on a timely basis, or not escalated appropriately	• Laminated alert cards in use at end of patients' beds • Also monitored through Matron's Ward Rounds (weekly) and Sister's Checklists (daily) • *Cerner Millennium to flag when observations are needed*
					Medicines management – missed doses for which the reason is not valid or not documented	• Monthly auditing • Function in Cerner Millennium to flag up doses which have not been administered • Reinforcing process for protected drug rounds (red tabards) • Encouraging self-administration of medicines where appropriate
					Medicines management – secure storage of medicines	• Matrons' medicines management checklist
					Infection prevention and control, e.g. recent CPE outbreak	• Work with local Public Health team to deliver proactive strategy • 3 key themes: screening; prompt isolation; 'doing the basics brilliantly' e.g. hand hygiene and cleaning • Action plan developed in response to Public Health England report and monitored by Hospital Infection Control Team • Ward 14 designated as interim cohort facility; business case approved for permanent facility
					Supervision and preceptorship arrangements for students and newly qualified professionals – raised in previous inspection reports	• Regular audit of preceptorship framework • Database used to record preceptorship arrangements
					Emergency Planning – Major Incident and Business Continuity Plans out of date; lack of engagement with partner organisations	• New post of Emergency Planning Lead created following corporate restructure; filled January 2015 • *Update plans* • *Deliver training within the Trust* • *Attend regional meetings and develop links with counterparts at other organisations*

Standard		Leads	Evidence folders complete?	Rating	Concerns	Actions underway / *actions required*
13	Safeguarding	*Executive:* Jill Galvani *Operational:* Gaynor Westray, Sue Fogarty	✘	Inadequate	Safeguarding Team currently experiencing high levels of vacancies and sickness, hindering ability to provide advice, internal assurance and report to external agencies	• Team has been redesigned, incorporating resource for administration and assurance • *Implement new team structure* • *Programme of Safeguarding audits to be developed*
					Past audits have shown poor awareness of the Mental Capacity Act and our policy on Do Not Attempt Resuscitation	• Monthly audit of DNAR policy • *Consider developing additional, more specific training programmes, when Safeguarding team is in a position to deliver these*
14	Nutrition and Hydration	*Executive:* Jill Galvani *Operational:* Gaynor Westray, Pam Richardson, Sally-ann Connolly	✓	Requires improvement	Assistance with eating and drinking for patients who need it	• Flexible visiting, allowing relatives and carers to visit at mealtime and help their family member • Protected meal times • *Make greater use of volunteers to help vulnerable patients to eat and drink*
					Findings of previous inspection regarding patients experiencing poor nutrition and losing weight	• Implementation of new food and fluid balance chart • *Develop electronic version of the above* • *Develop more personalised version of MUST nutritional screening tool* • *Refresher training for clinical staff on use of MUST*
15	Premises and Equipment	*Executive:* Mark Blakeman *Operational:* Gary Lewis, Sally-ann Connolly, Peter Bohan	✘	Inadequate	Backlog of planned and responsive maintenance work; concerns from wards regarding time taken to complete some routine repairs	• Funding allocated for work on 6-10 priority wards • *Review overdue jobs to be completed*
					Lack of clear reporting arrangements for Estates in the corporate governance structure	• *Review reporting arrangements regarding estates performance and widen distribution*
					Security Manager post vacant for several months, interrupting normal internal and external reporting arrangements	• New Security Manager now in post, with clear line management arrangements
16	Complaints	*Executive:* Jill Galvani *Operational:* Mike Chantler, Mark McKenna	✓	Good	Complaints handling performance has improved, with a reduction of about 10% in the number of formal complaints due to the new process whereby less serious complaints are dealt with locally, and response timescales achieved for >80% of formal complaints.	• *Print and distribute new posters and leaflets about how to complain*
					More systematic approach needed for responding to anonymous complaints	• *Add information to Complaints and Concerns policy regarding anonymous complaints*

Standard		Leads	Evidence folders complete?	Rating	Concerns	Actions underway / *actions required*
17	Good Governance	*Executive:* Dr Evan Moore *Operational:* Dr Melanie Maxwell, Maryellen Dean, Joe Roberts, Mike Chantler	✓	Requires improvement	Cerner Millennium Phase 2B recently implemented – staff still familiarising selves with new system	• *Consider providing additional focused training* • *New Nurse Lead for IT issues to be appointed within Informatics team*
					Corporate Nursing Patient Focused Audit paused since November 2014	• Monitor other sources of assurance such as Matron's spot checks and Learning with Patients Questionnaire • *Develop electronic solution to monitor compliance with risk assessments and observations through Millennium without manual auditing* • *Identify resource to undertake observational aspects of audit*
					Lack of confidence of staff to raise concerns through risk reporting and internal whistleblowing procedures, leading them to contact CQC directly	• Information included in CEO Forum, Start the Week and Risk Management Training • *Consider additional options, e.g. an organisational Cultural Change Ambassador* • *Consider leadership training for managers which would enable them to respond to issues raised by staff more effectively*
18	Staffing	*Executive:* Anthony Hassall *Operational:* James Mawrey, Lynne Benstead, Peter Bohan	✓	Requires improvement	Difficulties in ensuring safe nurse staffing levels	• Nursing Establishment Review • Recruitment campaign to fill vacancies in existing establishment • Acuity Audit • New Attendance Capability Policy
					Potentially challenging results of National Staff Survey and Organisational Culture Inventory (results awaited at time of writing)	• Listening into Action • Action plan in response to 2013 Staff Survey • *Action plan in response to 2014 Staff Survey* • *Action plan in response to Organisational Culture Inventory*
19	Fit and Proper Persons Employed	*Executive:* Anthony Hassall *Operational:* James Mawrey, Lawrence	✓	Requires improvement	Recent Coroner's inquest identified shortcomings in how the process for recruiting and deploying temporary staff through Staffing Solutions (Flexibank) had operated.	• *Undertake Root Cause Analysis of the incident and implement recommendations arising from the investigation*

Standard		Leads	Evidence folders complete?	Rating	Concerns	Actions underway / *actions required*
		Osgood			Compliance with annual appraisals not reaching target percentage of 88%	• Trustwide and divisional Appraisal action plans • Training for managers • Management information for individual managers and for Divisional Management Teams • *Performance management of managers through Pay Progression Policy*
20	Duty of Candour	*Executive:* Dr Evan Moore *Operational:* Maryellen Dean	✓	Good	Limited number of breaches of the duty (approximately 6% of Root Cause Analysis investigations)	• Duty of Candour Policy revised and updated in September 2014 • Regular exception reporting both internally and to the Clinical Commissioning Group • Training – included in Level 2 Risk Management Training programme

Executive CQC success proposal

appendix 2

Outstanding/Good/Requires improvement/Inadequate.

Executives and operational leads

- Review 13 fundamentals against the evidence available:

CQC mock inspections

Audit program and assurance map

Evidence portfolios

Governance arrangements (policy, training, reporting etc)

- Action plan to improve due by August 2015
- Reviewed monthly at Execs

Executives

- Review the 5 Questions against 8 services:

Is the care…

- ***Safe?***
- ***Effective?***
- ***Caring?***
- ***Responsive to needs?***
- ***Well led?***

- Action plan to improve due by August 2015
- Reviewed monthly at Execs

Divisional CQC success proposal

appendix 2

Outstanding/Good/Requires improvement/Inadequate.

Triumvirate and operational leads

- Review ward and departmental data and CQC mock inspection findings
- Ensure Divisional governance programme is in place
- Action plan to improve due by August 2015
- Reviewed monthly at OMT by exception.

Triumvirate

- Review the 5 Questions

Is the care in your division:

- ***Safe?***
- ***Effective?***
- ***Caring?***
- ***Responsive to needs?***
- ***Well led?***

- Action plan to improve due by August 2015
- Reviewed monthly at OMT by Exception

appendix 2

Ward and departmental CQC success proposal

Outstanding/Good/Requires improvement/Inadequate.

Matrons , Ward sisters and medical leads

- Review ward and departmental data and CQC mock inspection findings
- Action plan to improve due by August 2015
- Reviewed monthly at DMT

Matrons, Ward sisters and medical leads

- Ensure ward / departmental governance programme is in place
- Action plan to improve due by August 2015
- Reviewed monthly at DMT

Wirral University Teaching Hospital NHS
NHS Foundation Trust

CQC Fundamental Standards

KLOE

The organization / division/ ward /department are judged as:

Safe? ***Outstanding /Good / Requires improvement / Inadequate.***

Effective? ***Outstanding /Good / Requires improvement / Inadequate.***

Caring? ***Outstanding /Good / Requires improvement / Inadequate.***

Responsive to needs? ***Outstanding /Good / Requires improvement / Inadequate.***

Well led? ***Outstanding /Good / Requires improvement / Inadequate.***

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There are ***eight key service areas*** that will be inspected:

- A&E
- acute medical pathway (incl frail elderly)
- acute surgical pathway (incl frail elderly)
- critical care
- maternity
- paediatrics
- end of life care
- outpatients

What will we need to demonstrate - Key lines of Enquiry for the CQC inspection team – your assessment

Safety Domain

	Key line of enquiry	Prompts	What evidence do you expect to see?	Gaps in assurance	Assessment of compliance: *Outstanding Good Requires improvement Inadequate.*
S1	What is the track record on safety?	1. What is the safety performance over time, based on internal and external information? 2. How does safety performance compare to other similar services? 3. Do staff understand their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally? 4. Have safety goals been set? How well performance against them is monitored using information from a range of sources?			
S2	Are lessons learned and improvements made when things go wrong?	1. Are people who use services told when they are affected by something that goes wrong, given an apology and informed of any actions taken as a result? 2. When things go wrong, are thorough and robust reviews or investigations carried out? Are all relevant staff and people who use services involved			

	Key line of enquiry	Prompts	What evidence do you expect to see?	Gaps in assurance	Assessment of compliance: *Outstanding Good Requires improvement Inadequate.*
		in the review or investigation? 3. How are lessons learned, and is action taken as a result of investigations when things go wrong? 1. 4. How well are lessons shared to make sure action is taken to improve safety beyond the affected team or service?			
S3	Are there reliable systems, processes and practices in place to keep people safe and safeguarded from abuse?	1. Are the systems, processes and practices that are essential to keep people safe identified, put in place and communicated to staff? 2. Do staff receive effective mandatory training in the safety systems, processes and practices? 3. Is implementation of safety systems, processes and practices monitored and improved when required? 4. Are there arrangements in place to safeguard adults and children from abuse that reflect relevant legislation and local requirements? Do staff understand their responsibilities and adhere to safeguarding policies and procedures? 5. How are standards of			

	Key line of enquiry	Prompts	What evidence do you expect to see?	Gaps in assurance	Assessment of compliance: *Outstanding Good Requires improvement Inadequate.*
		cleanliness and hygiene maintained? 6. Are reliable systems in place to prevent and protect people from a healthcare-associated infection? 7. Does the design, maintenance and use of facilities and premises keep people safe? 8. Does the maintenance and use of equipment keep people safe? 9. Do the arrangements for managing waste and clinical specimens keep people safe? (This includes classification, segregation, storage, labelling, handling and, where appropriate, treatment and disposal of waste.) 10. Do arrangements for managing medicines, medical gases and contrast media keep people safe? (This includes obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal.) 11. Are people's individual			

	Key line of enquiry	Prompts	What evidence do you expect to see?	Gaps in assurance	Assessment of compliance: *Outstanding Good Requires improvement Inadequate.*
		care records written and managed in a way that keeps people safe? (This includes ensuring people's records are accurate, complete, legible, up to date and stored securely).			
S4	How are risks to people who use services assessed, and their safety monitored and maintained?	1. How are staffing levels and skill mix planned and reviewed so that people receive safe care and treatment at all times, in line with relevant tools and guidance, where available? 2. How do actual staffing levels compare to the planned levels? 3. Do arrangements for using bank, agency and locum staff keep people safe at all times? 4. Are comprehensive risk assessments carried out for people who use services and risk management plans developed in line with national guidance? Are risks managed positively? 5. How do staff identify and respond appropriately to changing risks to people who use services, including deteriorating health and wellbeing,			

	Key line of enquiry	Prompts	What evidence do you expect to see?	Gaps in assurance	Assessment of compliance: *Outstanding Good Requires improvement Inadequate.*
		medical emergencies or behaviour that challenges? 6. How do arrangements for handovers and shift changes ensure people are safe?			
S5	How well are potential risks to the service **anticipated** and **planned** for in advance?	1. How are potential risks taken into account when planning services, for example, seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing? 2. What arrangements are in place to respond to emergencies and major incidents? How often are these practised and reviewed? 3. 3. How is the impact on safety assessed and monitored when carrying out changes to the service or the staff?			

Effective Domain

	Key line of enquiry	Prompts	What evidence do you expect to see?	Gaps in assurance	Assessment of compliance: *Outstanding Good Requires improvement Inadequate.*
E1	Are people's needs assessed and care and treatment delivered in line with legislation, standards and evidence-based guidance?	1. How are relevant and current evidence-based guidance, standards, best practice and legislation identified and used to develop how services, care and treatment are delivered? (This includes from NICE and other expert and professional bodies). 2. Do people have their needs assessed and their care planned and delivered in line with evidence-based, guidance, standards and best practice? How is this monitored to ensure compliance? 3. Is discrimination, including on grounds of age, disability, , gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation avoided when making care and treatment decisions? 4. How are people's nutrition and hydration needs assessed and met? 5. How is the pain of an individual person assessed and managed?			

	Key line of enquiry	Prompts	What evidence do you expect to see?	Gaps in assurance	Assessment of compliance: *Outstanding Good Requires improvement Inadequate.*
		6. How is technology and equipment used to enhance the delivery of effective care and treatment? 7. Are the rights of people subject to the Mental Health Act (MHA) protected and do staff have regard to the MHA Code of Practice?			
E2	How are people's care and treatment outcomes monitored and how do they compare with other services?	1. Is information about the outcomes of people's care and treatment routinely collected and monitored? 2. Does this information show that the intended outcomes for people are being achieved? 3. How do outcomes for people in this service compare to other similar services and how have they changed over time? 4. Is there participation in relevant local and national audits, benchmarking, accreditation, peer review, research and trials?			

	Key line of enquiry	Prompts	What evidence do you expect to see?	Gaps in assurance	Assessment of compliance: *Outstanding Good Requires improvement Inadequate.*
		5. How is information about people's outcomes used and what action is taken as a result to make improvements? 6. . Are staff involved in activities to monitor and improve people's outcomes?			
E4	How well do staff, teams and services work together to deliver effective care and treatment?	1. Are all necessary staff, including those in different teams and services, involved in assessing, planning and delivering people's care and treatment? 2. How is care delivered in a coordinated way when different teams or services are involved? 3. Do staff work together to assess and plan on-going care and treatment in a timely way when people are due to move between teams or services, including referral, discharge and transition? 4. When people are discharged from a service is this done at an appropriate time of day, are all relevant teams and services informed and is this only done when any on-going care is in place?			

	Key line of enquiry	Prompts	What evidence do you expect to see?	Gaps in assurance	Assessment of compliance: *Outstanding Good Requires improvement Inadequate.*
E5	Do staff have all the information they need to deliver effective care and treatment to people who use services?	1. Is all the information needed to deliver effective care and treatment available to relevant staff in a timely and accessible way? (This includes test and imaging results, care and risk assessments, care plans and case notes.) 2. When people move between teams and services, including at referral, discharge, transfer and transition, is all the information needed for their on-going care shared appropriately, in a timely way and in line with relevant protocols? 3. How well do the systems that manage information about people who use services support staff to deliver effective care and treatment? (This includes coordination between different electronic and paper-based systems and appropriate access for staff to records.)			
E6	Is people's consent to care and treatment always	1. Do staff understand the relevant consent and decision making requirements of legislation and guidance, including			

	Key line of enquiry	Prompts	What evidence do you expect to see?	Gaps in assurance	Assessment of compliance: *Outstanding Good Requires improvement Inadequate.*
	sought in line with legislation and guidance?	the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004? 2. How are people supported to make decisions? 3. How and when is a person's mental capacity to consent to care or treatment assessed and, where appropriate, recorded? 4. When people lack the mental capacity to make a decision, do staff make 'best interests' decisions in accordance with legislation? 5. How is the process for seeking consent monitored and improved to ensure it meets responsibilities within legislation and follows relevant national guidance? 6. Do staff understand the difference between lawful and unlawful restraint practices, including how to seek authorisation for a deprivation of liberty? 7. . Is the use of restraint of people who lack mental capacity clearly monitored for its necessity and proportionality in line with			

	Key line of enquiry	Prompts	What evidence do you expect to see?	Gaps in assurance	Assessment of compliance: *Outstanding Good Requires improvement* ***Inadequate.***
		legislation and is action taken to minimise its use?			

Caring Domain

	Key line of enquiry	Prompts	What evidence do you expect to see?	Gaps in assurance	Assessment of compliance: *Outstanding Good Requires improvement* ***Inadequate.***
C1	Are people treated with kindness, dignity, respect and compassion while they receive care and treatment?	1. Do staff understand and respect people's personal, cultural, social and religious needs, and do they take these into account? 2. Do staff take the time to interact with people who use the service and those close to them in a respectful and considerate way? 3. Do staff show an encouraging, sensitive and supportive attitude to people who use services and those close to them? 4. Do staff raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes? 5. How do staff make sure that people's privacy and dignity is always respected, including during physical or intimate care? 6. When people experience			

	Key line of enquiry	Prompts	What evidence do you expect to see?	Gaps in assurance	Assessment of compliance: *Outstanding Good Requires improvement Inadequate.*
		physical pain, discomfort or emotional distress do staff respond in a compassionate, timely and appropriate way? 7. Do staff respect confidentiality at all times?			
C2	Are people who use services and those close to them involved as partners in their care?	1. Do staff communicate with people so that they understand their care, treatment and condition? 2. Do staff recognise when people who use services and those close to them need additional support to help them understand and be involved in their care and treatment and enable them to access this? (This includes language interpreters, sign language interpreters, specialist advice or advocates.) 3. How do staff make sure that people who use services and those close to them are able to find further information or ask questions about their care and treatment? 4. Are people who use services and those close to them routinely involved in planning and making decisions about their care and treatment?			

	Key line of enquiry	Prompts	What evidence do you expect to see?	Gaps in assurance	Assessment of compliance: *Outstanding Good Requires improvement Inadequate.*
C3	Do people who use services and those close to them receive the support they need to cope emotionally with their care, treatment or condition?	1. Do staff understand the impact that a person's care, treatment or condition will have on their wellbeing and on those close to them, both emotionally and socially? 2. Are people given appropriate and timely support and information to cope emotionally with their care, treatment or condition? 3. What emotional support and information is provided to those close to people who use services, including carers and dependants? 4. Are people who use services empowered and supported to manage their own health, care and wellbeing and to maximise their independence? 5. How are people enabled to have contact with those close to them and to link with their social networks or communities?			

Responsive Domain

	Key line of enquiry	Prompts	What evidence do you expect to see?	Gaps in assurance	Assessment of compliance: ***Outstanding*** ***Good*** ***Requires improvement*** ***Inadequate.***
R1	Are services planned and delivered to meet the needs of people?	1. Is information about the needs of the local population used to inform how services are planned and delivered? 2. How are commissioners, other providers and relevant stakeholders involved in planning services? 3. Do the services provided reflect the needs of the population served and do they ensure flexibility, choice and continuity of care? 4. Where people's needs are not being met, is this identified and used to inform how services are planned and developed? 5. Are the facilities and premises appropriate for the services that are planned and delivered?			
R2	Do services take account of the needs of different people, including those in vulnerable circumstances?	1. How are services planned to take account of the needs of different people, for example, on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation? 2. How are services delivered in a way that takes account of the needs of different people on the grounds of age,			

	Key line of enquiry	Prompts	What evidence do you expect to see?	Gaps in assurance	Assessment of compliance: *Outstanding Good Requires improvement Inadequate.*
		disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation? 3. How are services planned, delivered and coordinated to take account of people with complex needs, for example those living with dementia or those with a learning disability? 4. Are reasonable adjustments made so that disabled people can access and use services on an equal basis to others? 5. How do services engage with people who are in vulnerable circumstances and what actions are taken to remove barriers when people find it hard to access or use services?			
R3	Can people access care and treatment in a timely way?	1. Do people have timely access to initial assessment, diagnosis or urgent treatment? 2. As far as possible, can people access care and treatment at a time to suit them? 3. What action is taken to minimise the time people have to wait for treatment or care? 4. Does the service prioritise			

	Key line of enquiry	Prompts	What evidence do you expect to see?	Gaps in assurance	Assessment of compliance: *Outstanding Good Requires improvement Inadequate.*
		care and treatment for people with the most urgent needs? 5. Where there is an appointments system, is it easy to use and does it support people to access appointments? 6. Is care and treatment only cancelled or delayed when absolutely necessary? Are cancellations explained to people, and are people supported to access care and treatment again as soon as possible? 7. Do services run on time, and are people kept informed about any disruption?			
R4	How are people's concerns and complaints listened and responded to and used to improve the quality of care?	1. Do people who use the service know how to make a complaint or raise concerns, are they encouraged to do so, and are they confident to speak up? 2. How easy is the system to use? Are people treated compassionately and given the help and support they need to make a complaint? 3. Are complaints handled effectively and confidentially, with a regular update for the complainant and a formal record kept?			

	Key line of enquiry	Prompts	What evidence do you expect to see?	Gaps in assurance	Assessment of compliance: *Outstanding Good Requires improvement Inadequate.*
		4. Is the outcome explained appropriately to the individual? Is there openness and transparency about how complaints and concerns are dealt with? 5. How are lessons learned from concerns and complaints and is action taken as a result to improve the quality of care? Are lessons shared with others?			

Well-led Domain

	Key line of enquiry	Prompts	What evidence do you expect to see?	Gaps in assurance	Assessment of compliance: *Outstanding Good Requires improvement Inadequate.*
W1	Is there a clear vision and a credible strategy to deliver good quality?	1. Is there a clear vision and a set of values, with quality and safety the top priority? 2. Is there are a robust, realistic strategy for achieving the priorities and delivering good quality care? 3. How have the vision, values and strategy been developed? 4. Do staff know and understand what the vision and values are? 5. Do staff know and			

	Key line of enquiry	Prompts	What evidence do you expect to see?	Gaps in assurance	Assessment of compliance: *Outstanding Good Requires improvement Inadequate.*
		understand the strategy and their role in achieving it? 6. Is progress against delivering the strategy monitored and reviewed?			
W2	Does the governance framework ensure that responsibilities are clear and that quality, performance and risks are understood and managed?	1. Is there an effective governance framework to support the delivery of the strategy and good quality care? 2. Are staff clear about their roles and do they understand what they are accountable for? 3. How are working arrangements with partners and third party providers managed? 4. Are the governance framework and management systems regularly reviewed and improved? 5. Is there a holistic understanding of performance, which integrates the views of people with safety, quality, activity and financial information? 6. Are there comprehensive assurance system and service performance measures, which are reported and monitored,			

	Key line of enquiry	Prompts	What evidence do you expect to see?	Gaps in assurance	Assessment of compliance: *Outstanding Good Requires improvement Inadequate.*
		and is action taken to improve performance? 7. Are there effective arrangements in place to ensure that the information used to monitor and manage quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are identified? 8. Is there a systematic programme of clinical and internal audit, which is used to monitor quality and systems to identify where action should be taken? 9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? 10. Is there alignment between the recorded risks and what people say is 'on their worry list'?			
W3	How does the leadership and culture reflect the vision and values, encourage openness and transparency	1. Do leaders have the skills, knowledge, experience and integrity that they need – both when they are appointed and on an ongoing basis? 2. Do leaders have the capacity, capability, and			

	Key line of enquiry	Prompts	What evidence do you expect to see?	Gaps in assurance	Assessment of compliance: *Outstanding Good Requires improvement Inadequate.*
	and promote good quality care?	experience to lead effectively? 3. Do the leaders understand the challenges to good quality care and can they identify the actions needed address them? 4. Are leaders visible and approachable? 5. Do leaders encourage appreciative, supportive relationships among staff? 6. Do staff feel respected and valued? 7. Is action taken to address behaviour and performance that is inconsistent with the vision and values, regardless of seniority? 8. Is the culture centred on the needs and experience of people who use services? 9. Does the culture encourage candour, openness and honesty? 10. Is there a strong emphasis on promoting the safety and wellbeing of staff? 11. Do staff and teams work collaboratively, resolve conflict quickly and constructively and share responsibility to deliver good quality care?			

	Key line of enquiry	Prompts	What evidence do you expect to see?	Gaps in assurance	Assessment of compliance: *Outstanding Good Requires improvement Inadequate.*
W4	How are people who use the service, the public and staff engaged and involved?	1. How are people's views and experiences gathered and acted on to shape and improve the services and culture? 2. How are people who use services, those close to them and their representatives actively engaged and involved in decision-making? 3. Do staff feel actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture? 4. How do leaders prioritise the participation and involvement of people who use services and staff? 5. Do both leaders and staff understand the value of staff raising concerns? Is appropriate action taken as a result of concerns raised?			
W5	How are services continuously improved and sustainability ensured?	1. When considering developments to services or efficiency changes, how is the impact on quality and sustainability assessed and monitored? 2. Are there examples of where financial pressures have compromised care?			

	Key line of enquiry	Prompts	What evidence do you expect to see?	Gaps in assurance	Assessment of compliance: *Outstanding Good Requires improvement Inadequate.*
		3. In what ways do leaders and staff strive for continuous learning, improvement and innovation? 4. Are staff focused on continually improving the quality of care? 5. How are improvements to quality and innovation recognised and rewarded? 6. How is information used proactively to improve care?			

appendix 4

Guidance on areas for communication, discussion and assurance in Divisional, speciality meetings.

In order to strengthen assurance and demonstrate well led governance across the organisation the attached checklist has been generated to provide clarity on areas that should be systematically included and considered in the divisional meetings, speciality team meetings and ward and department areas where appropriate the attached Draft checklist has been generated to assist.

These are core issues that we believe will be augmented with specialty requirements and specialty focus

We have not, as yet stipulate the frequency of the review and discussion has not been identified, but from a systematic perspective we believe this should as a minimum be quarterly, however some areas will require weekly or monthly review. IT is essential these are included or identifiable as agenda items even if there is nothing to report as this demonstrates that the issues have been considered. It may therefore be useful to have standardised agendas to assist this.

For speciality, ward and department use the information and discussion should of course be appropriate to the service area, but put into an organisational context.

Comments and further enchantments welcomed

Divisional Governance Checklist – What and where (Info should be appropriate to Service and area)

Topic	Divisional	Speciality	Ward/Department
Patient experience and feedback	✓	✓	✓
Complaints and PALS • Issues Reported • Investigation progress • learning	✓	✓	✓
Clinical Audits • plan versus progress • Outcome and learning • Changes in practice	✓	✓	If appropriate to area
NICE / National / Professional guidance • Baseline assessment • Compliance • Risk assessment • Outstanding assessments or guidance • Links to audit plan	✓	✓	If appropriate to area
Mortality • Feedback • Reviews • Learning and service change	✓	✓	If appropriate to area
Mandatory training compliance	✓	✓	✓
Appraisal training compliance	✓	✓	✓
Essential training and staff competency	✓	✓	✓
Incidents • Trends • Reported incidents • Investigation progress • Learning • Serious Incidents /never events	✓	✓	✓
Claims • Any received / reported • Investigation progress • Learning from investigations	✓	✓	If appropriate to area

Topic	Divisional	Speciality	Ward/Department
Inquests • Any received / reported • Investigation progress • Learning from investigations • HM Coroners Regulation 28 reports			
Risk register • New risks • Reviews of existing • Escalation • Updates of mitigation and escalation	✓	✓	✓
Central Alerting System (CAS)alerts. Device Alerts etc	✓	✓	If appropriate to area
Internal alert cascade	✓	✓	✓
Safeguarding Adult and Children updates e.g DOLS or case reviews MCA	✓	✓	✓
Infection prevention and control • Monitoring • Surveillance	✓	✓	✓
Equipment • Availability • Assurance re Competency assessments	✓	✓	✓
Service/Business developments and risks / CIP Governance issues impacting from these • Annual plan • Business case progression	✓	✓	✓
Service improvement • Improvement work streams • CQC action plan	✓	✓	✓
PLACE / Environmental; assessment	✓	✓	✓
Policies Procedures and guidelines • New and reviewed - Corporate • New and reviewed - Local	✓	✓	✓
Performance metrics • Monitoring • Recovery plan	✓	✓	✓
External service reviews • External	✓	✓	✓
Safe Staffing levels • Monitoring and exceptions	✓	✓	✓
Sickness absence Management	✓	✓	✓
Ward quality dash boards • Status • Workplan and progress	✓	✓	✓

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appendix 5

CQC compliance proposal – Project Staffing

Introduction:

In order for the Trust to secure a positive outcome from the inspection in September 2015 the Quality and Safety Department leads have evaluated the current skills and capacity of the department.

It is apparent following the significant CIP delivered in this department there is no flexibility to deliver a significant project in such a tight time scale as well as keeping abreast of the day job which is equally important in order to meet compliance in the inspection.

Therefore the Q&S department leads propose two additional posts:

Project support officer: Band 4

A project support officer provides support to the project manager and associated teams. This may include:

- setting up and maintaining project documentation
- CQC mock inspection planning and documentation
- producing regular project reports
- carrying out snap shot audits that support the development of the project
- monitor project risks and achievement of milestones
- population and monitoring of evidence folders
- admin support to support the project

Senior project manager: Band 8A

A senior project manager manages this complex project. This may include:

• planning the project
• managing and monitoring the project
• identifying and managing risks
• ensuring the project stays on track and delivers on time
• building, sustaining and facilitating relationships with project stakeholders
• securing resources for the project.

Key Responsibilities:

• Work with the Communications Team in the development and implementation of a CQC communications plan and ensure that there is regular clear organisational wide communication on the CCQ inspection regime and process;

• Develop excellent relationships with staff at all levels, including consultants, senior clinicians, senior managers;

• Ensure that there is a detailed knowledge of the fundamental standards, five questions required by the Care Quality Commission from ward to board;

• Ensure that there is a comprehensive understanding from ward to board of how the standards will be assessed by the CQC and what is required of the service;

• Ensure that Teams are fully engaged in preparing for a CQC inspection;

• Work with the key services to co-ordinate the collection and storage of key items of evidence that the standards are being consistently monitored and delivered;

- In conjunction with the Head of Assurance provide regular reports to the Trust wide Clinical Governance Team, Clinical Governance Group and Quality & Safety Committee

- In conjunction with the Head of Assurance, support the Associate Medical Director to produce reports and presentations to Board and the Executive team regarding the process and outcome of the 'mock' internal CQC inspections, assessments of the fundamental standards and assessment of the organization against the 5 key questions.

Recommendation:

The Executive team are asked to consider this paper and approve the 6month placement of a Project Support Officer and a Project Manager as described above. Or make recommendations.

Gantt Chart: Preparation for introducing new standards and the CQC visit - 14th Sept 2015

appendix 6

Action	Lead	March				April					May				June				July					Aug				Sep	
		###	###	###	###	###	###	###	###	###	###	###	###	###	###	###	###	###	###	###	###	###	###	###	###	###	###	###	###
Set up Project team	MM		x																										
Site visits	MM/EM				x								x																
Identify additional resource requirements	MM					x	x																						
Review Evidence Portfolios / update to reflect new fundamentals	JR					x																							
Identify gaps in evidence and develop action plans	JR with Exec & Op Leads					x	x	x																					
Review current CQC risk register entries and update	JR					x																							
Add new CQC risks	JR								x	x																			
Review data packs developed and agree foreward plan	MED/MM	x	x	x	x																								
Develop a Communication Strategy	MM			x	x																								
Deploy Mock CQC Inspection Programme	JR			x						x		x					x			x	x	x	x	x	x	x	x	x	x
Develop specialist areas inspection check lists	JR	x	x	x	x																								
CQC Newsletters /Lessons Learnt	JR		x				x				x				x				x		x		x		x		x		x
Develop information flow for ward for board assurance	GH			x	x	x	x	x																					
Roll out of ward to Board assurance process; report to DMTs & Board monthly	DQSMs										x	x	x	x				x					x				x		
Timetable for Staff Engagement Events	JM	tbc																											
Timetable for patient engagement events	MC									x																			
Timetable for external partner engagement	EM/MM	tbc																											
Develop CQC audit plan (additional assurance)	MM							x	x																				
Deploy CQC audit plan													x				x					x				x		
CQC file maintenance	JR														x					x					x			x	x
Progress reports to CGG/QSC/OMT	JR/MM									x			x				x					x				x		
Update to Executive development day	EM									x																			

Board of Directors	
Agenda Item	8.2
Title of Report	Report of the Quality and Safety Committee – 11 March 2015
Date of Meeting	25 March 2015
Author	Dr Jean Quinn - Chair of the Quality and Safety Committee
Accountable Executive	Dr Evan Moore - Medical Director
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	1, 2, 3, 4, 7 1A, 1B, 2A, 3A, 3B, 4A, 7A, 7C 1908, 1909, 1927, 2550, 2611
Level of Assurance • **Positive** • **Gap(s)**	Gaps with mitigating actions
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 a summary of the work of the Quality and Safety Committee which met on 11 March 2015.

Patient Story

The patient story highlighted some inconsistencies with the care the Trust delivers to patients with learning disabilities evidenced through several episodes of seizures. The Trust through working

with the family has now been able to put in place a plan for when this patient requires our care which is supplemented with the health passport.

Complaint, Litigation, Incidents, PALS & Patient Experience (CLIPPE) Q3 2014-15 Summary Report

The Committee reviewed the main issues in the report and in particular the following areas:

- The use of Ward 25 as an escalation area and the concerns raised as a result of this. The review of the escalation policy is underway
- The reduction in pressure ulcer reporting due to limited information on Cerner which has now been resolved. The Committee was assured that the use of spot checks and point prevalence audits ensured that there had been no impact on the numbers.
- The action plan in response to infection control issues raised by Public Health England which was progressing well.

Workforce Dashboard

The Committee reviewed the key points highlighted in the report which included:

- The number of vacancies in key staff groups which was being addressed through the exceptional recruitment activity
- The prioritisation of requests for bank shifts
- The reduction in sickness absence rates month on month albeit still above the target of 4%
- Mandatory training compliance at 97.70% and the plans to review this training following the inconsistencies highlighted as part of the NHS staff survey results
- The plans to achieve the appraisal target of 85% by staggering these amongst clinical and non-clinical staff groups.
- Dementia training now included as part of the essential training programme

Clinical Quality Dashboard

Positive areas of reporting included:

- HSMR data 88.86 in November 2014 and SHMI data at 100.2 as at June 2014
- Advancing quality (pneumonia) on target
- No grade 4 pressure ulcers reported
- Substantial reduction in the numbers of readmissions in November and December 2014
- Improvements in the patient experience scores for confidence in staff; patient comfort and assistance with eating and drinking

Further improvement required in the following areas:

- Advancing quality (heart failure) additional resource now in place which will help with achievement of the target
- Advancing quality (acute myocardial infarction) an improvement in the target would not be reported until the February data was available
- Increase in falls in January associated with the number of ward moves

CQC compliance against the fundamental standards and action plans

The Committee received a report which provided assurance that the Trust was now fully conversant with the requirements of the new standards together with the expectations of a full inspection. The baseline assessment, together with the outcomes from the Mock Inspections, now provide the Trust with some valuable insight into the areas for improvements and thus the actions required.

Key areas for discussion included the issues being reported in relation to Cerner and the actions to address these; the estates issues which are being reviewed by the Director of Infrastructure and

Informatics; nurse staffing which was debated at length at various points in the meeting and the work required to improve patient information.

Quality Account Report Q3 2014/15

The Committee reviewed progress against the key priorities as outlined elsewhere in this report.

Board Assurance Framework Update

The Committee reviewed the new risk associated with the Monitor investigation and approved the inclusion of a further risk associated with the outbreak of pseudomonas. A full review of the gaps in assurance/key issues was undertaken, again as demonstrated by the findings in this report.

Review of the Risk Management Group

The Committee supported the proposal in principle to disband this group as a review of its work had highlighted a high level of duplication following a revision to the governance reporting. The final decision will be made once the approval had been sought from the Finance Business Performance and Assurance Committee.

Director of Nursing and Midwifery Q3 Performance Report

The Committee reviewed the steps being taken to address the issues associated with resourcing for the patient focussed nursing and midwifery care audits; the improvements in MEWS compliance and the plans to launch a Safe Care web page in March which would contain quality data.

Public Health England Response

The Committee reviewed the suite of reports provided as part of this agenda item to ensure that the concerns and work being undertaken was reported in an open and transparent manner.

An update on the CPE outbreak was provided which included the reduction in numbers following the establishment of the cohort ward; an update on the pseudomonas outbreak which was being reviewed with a view to stepping this down and the plans for further mitigating this risk in the medium and long term and finally the plans to improve capacity in the infection control team over the next 2/3 weeks.

Health and Safety Report Q3 2014/15

The review of the report included an update on the further identification of asbestos at the Clatterbridge site and the actions to reduce the risk of exposure and in turn its removal. The report also highlighted concerns with legionella which had not been previously raised by the external consultant and the plans to address this.

Dementia Strategy Update

The Committee was updated on the plans to launch the dementia strategy on the 31st March 2015 together with the work being undertaken on training and awareness; creating a dementia friendly environment and supporting carers of people with dementia.

Falls Report Q3 2014-15

The Committee received an update on the number of falls reported as clinical incidents during the quarter which was 222 and the plans to reduce this which included the establishment of the falls improvement group to spread the learning; the development of a falls prevention leaflet; the purchase of bed bumpers and the review by ward sisters and matrons of patients who are at risk of falling which was now included in their daily/weekly audits.

The Clinical Governance Group

The revised terms of reference for this group were approved by the Committee. The changes were minor and related to the membership.

Recommendations to the Board of Directors

The Committee agreed to escalate the concerns expressed around the Trust's capacity and capability to provide adequate safeguarding provision. The risk was raised as a result of a review of the risk no. 2678 which was rated above 15. The concerns were associated with staffing levels; the plans with commissioners for training; the revised structure which was out for consultation and the need to undertake further work on deprivation of liberties and the mental capacity act. The Committee triangulated concerns with the CQC "inadequate" self-assessment rating on safeguarding and requested that a further update on this risk be provided at the next Committee together with timescales for reducing the risk.

Dr Jean Quinn
Quality and Safety Committee Chair

Board of Directors	
Agenda Item	8.3
Title of Report	Francis Report: Hard Truths Commitment: Publishing of Nurse Staffing Data: February 2015
Date of Meeting	25 March 2015
Author	Jill Galvani, Director of Nursing and Midwifery
Accountable Executive	Jill Galvani, Director of Nursing and Midwifery
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Strategic objectives: To be the top NHS Hospital in the North West; Delivering consistently high quality secondary care services; Supported by financial, commercial and operational excellence. 1A: Improve our Patient Experience to deliver the Friends & Family score of 95% or better *; 1B: Create a strong culture of empowered employees, delivering a staff engagement score of 3.59 or better, through implementation of our nursing, midwifery and customer service strategy (risk number 1908 & 1909); 3A: Implementation of a quality improvement strategy to reduce mortality to 85 HSMR (risk number 2611); 3B: Ensure that our harm free care score is no lower than 93% & no lower than 95% for 3 months*; 7A: Full compliance with our registration with CQC*. *risks to be scored.
Level of Assurance • **Positive** • **Gap(s)**	Concerned: Gaps in nurse staffing continue to be mitigated through Matrons and other nurses supplementing Ward establishments; Ward Sisters have reduced their supernumerary status; a weekly review of nurse vacancies; monthly Trust-wide recruitment; adoption of the Trust attendance policy; February 2015 Audit of acuity & dependency completed with assessment of NICE Guidance Red Flags; responded to the draft Mersey Internal Audit (MIA) report on Safer Staffing. NHS England published initial position of Trust during February: Trust 'green' for all indicators.
Purpose of the Paper	Discussion
Data Quality Rating	Gold – quantitative data that has been externally validated (MIA & NHS England) Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken	No

1. Executive Summary

This paper provides the nurse staffing data for February 2015. Data was prepared to determine performance against the Trust's own targets of 90% and 95% of shifts that met the planned requirement. No target fill rate has been set nationally; therefore the Trust applies these percentages as a test, given that 100% is optimum. Appendices 1 and 2 show the average fill rates for February 2015 at 90% and 95%.

There continues to be concerns with regard to the provision of minimum staffing levels of registered nurses during this reporting period. Table 1 shows the overarching performance where there is significant decrease in the numbers of areas reporting less than 95% and 90% fill rate of staff to establishment. The table also highlights that the majority of wards failing to meet the % fill rates are due to a lack of registered staff, and that where possible, non-registered staff back fill registered staffing numbers to increase the overall fill rate. However, there are concerns regarding data accuracy that are being addressed through implementation of version 10 E-roster.

Additional wards remained in place to manage patient demand and cohort nursing is in place to control infections of Carbapenamase Producing Enterobacteriaceae (CPE) and Vancomycin Resistant Enterococcus (VRE). Whilst it is challenging to provide cohort nursing, there is evidence to demonstrate that this approach is reducing the number of cases of CPE from 13 in January to 6 in February 2015.

An escalation policy for nurse staffing concerns has been developed and implemented designating an absolute minimum of 2 registered nurses per ward at times of pressure. Matrons have been working clinically on the additional wards and there is a system of Ward Sisters who attend these wards to ensure that patients have received the appropriate assessments. The Patient Experience Team have increased their visibility in these areas. Short term agency nurse use has been supported to enable teams to meet the needs of additional areas and cohort nursing.

Registered nurse vacancies are being reviewed weekly by the Director of Nursing & Midwifery and the Senior Nurse team. There is a Registered Nurse recruitment strategy with further successful recruitment in February 2015. There are currently 3 registered nurse vacancies in Adult surgical wards and 10 in the Medical and Acute areas with plans to pursue recruitment from the Open University and from nurses retiring from the military sector. Turnover at 10.7% in February was higher than usual and there is a need to recruit an average of 8 registered nurses each month. Neonatal and paediatric nurse recruitment is underway. Recruitment to the additional uplift for ward-based nursing that was agreed at the Board meeting in January 2015 is also underway. The implementation of the new Attendance Capability policy which went live on 19 January 2015 is a key part of managing nurse and midwifery sickness levels.

Table 1 Percentage and number of all wards reporting less than 95% and 90% average fill rate per month, rounded up/down to nearest total

Month	% (number) of all wards reporting less than 95% average fill rate for all staff, day and night	% (number) of all Wards reporting less than 95% average fill rate for registered Staff, day or night	% (number) of all wards with less than 90% fill rate for all Staff, day and night	% (number) of all Wards reporting less than 90% fill rate for registered Staff, day and night
October	52% (19) n=36	40% (14) n =36	6% (2) n=36	3% (1) n = 36
November	57% (20) n =35	57% (20) n =35	17% (6) n =35	17% (6) n =35
December	57% (20) n =35	51% (18) n =35	28% (10) n =35	23% (8) n =35
January	54% (19) n =35	54% (19) n =35	31% (11) n =35	29 % (10) n =35
February	26% (9) n =35	26% (9) n = 35	3% (1) n=35	9% (3) n=35

During the previous quarter the majority of Wards achieved 90% of planned staffing levels however, the previously reported effect of increasing numbers of patients with higher patient dependency (acuity), additional wards to care for emergency patients and the need to cohort nurse to address infection controls continued during February 2015. This meant that more than the minimum staffing levels were essential to provide the level of care that these patients needed. Set against nursing vacancies and staff sickness during February 2015, close nurse management of the movement of nurses to support patient acuity continues and remains challenging. The acuity and dependency audit was completed in February and a report is being prepared for the Quality & Safety Committee. The opportunity was taken to review the Trust's performance against the NICE guidance 'red flags' for nurse staffing (patient falls and missed breaks are examples of these) and to review the impact of Cerner Millennium in terms of how this data may be captured electronically. As previously mentioned data capture has been a particular challenge during February; it is expected that the introduction of Version 10 of E Roster during the latter part of March will enable electronic recording of staffing data.

The revised Code of Professional Standards of Practice and Behaviour for Nurses and Midwives is effective from 31 March 2015. The revised Code has 4 sections:

Prioritise People
Practise Effectively
Preserve Safety
Promote Professionalism and Trust

In this context of safe staffing raising concerns about staff and patient safety will be actively encouraged.

In addition, the Trust has begun preparation for the re-validation of nurses and midwives (due late 2015 into 2016), linked with appraisal.

2. Background

Following the publication of the Francis report in February 2013, the Government made a number of commitments in 'Hard Truths: The Journey to Putting Patients First' to make this information more publically available. This report forms part of the Trusts' obligation to publish staffing levels on hospital wards.

Processes continue to enable staffing establishments to be met on a shift-to-shift basis. Daily staffing meetings determine whether or not planned staffing requirements are met and to take action where there may be a shortfall. The outcomes of these meetings are recorded and contribute to the monthly staffing report. Further work is in progress to enhance assurance on processes following receipt of the draft report on Nurse Staffing by Mersey Internal Assessment and Audit (MIAA). The nurse staffing escalation policy is part of improving assurance.

Safe nurse staffing levels were a feature of the Francis, Keogh and Berwick Reports published in 2013. Research demonstrates that staffing levels are linked to the safety of care and that staff shortfalls increase the risks of patient harm and poor quality care. The National Quality Board issued guidance in November 2013: 'How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability'. This document informs this paper and is augmented with the July 2014 publication of the National Institute for Care and Healthcare Excellence (NICE) guidance: Safe Staffing for Nursing in Adult In Patient Wards in Acute Hospitals.

On 17 February 2015, Trusts received an update from NHS England on the Safer Staffing Performance Indicator Development (reported verbally to the Board in January 2015). This communication indicates the development of a process of publication of nursing safer staffing indicators with an intended date of publication on MyNHS – NHS Choices in the Spring of 2015. A verbal update will be provided to the Board of Directors on 25 March 2015 if there is further information.

3. Key Issues/Gaps in assurance

The Director of Nursing and Midwifery has taken steps to ensure that the Trust has responded to meet the Hard Truths milestones set out in the guidance published on 31 March 2014 and this has been presented to the Board of Directors in detail previously. The Trust's response will be further enhanced as the action plan in response to the MIA review is progressed.

February 2015, saw some improvement in the reporting of the achievement of meeting the 90% and 95% staffing fill rates. Three Wards (12, 18 & 30) were unable to achieve 95% fill rate against 3 reporting sections; no wards reported being unable to achieve against 4 sections as in last month's report. Against the 90% fill rate, Ward 30 reported red against three sections. The data is being reviewed as improvement is significant, but is not reflected in day to day staff management.

Vacancies, sickness and releasing staff for contingency areas were the main reasons for not achieving 95%.

February 2015 has seen a significant decrease in staffing reportable incidents as shown below:

Month	Number of staffing incidents reported
November 2014	41
December 2014	80
January 2015	102
February 2015	46 (7 in delivery suite) incidents to be reviewed

The 7 incidents in the Delivery suite will be reviewed. The main reason for reporting a staffing incident relates to moving of staff to cover other wards or sickness which leaves the ward with fewer than the planned number of staff. With the introduction of the revised Nursing & Midwifery Code during March 2015, there will probably be an increase in incident reporting about safe staffing and the ability to deliver safe care to patients.

The number of staffing incidents reflects an open reporting culture and also concerns by staff. Each incident is reviewed at the time of raising it by the local manager and an overview is undertaken by the Strategic Nursing & Midwifery Team.

Increasing the bed base in the Trust whether as a result of activity pressures or infection control has a direct impact on the role of the Ward Sister/Charge Nurse and Matron and the ability of the Trust to monitor and improve standards of nursing care for compliance. This has been added to the Board Assurance Framework and measures have been described in this paper to mitigate the risk to patients and staff.

As reported previously, the nursing role in planning for discharge has been consolidated into an action plan with key performance indicators during January 2015. This is described in the Ward Sister performance objectives that are linked with the Care Quality Commission Action Plan. The Ward Sister objectives are now finalized and have been shared with the Ward Sisters on 12th March 2015.

During February 2015, Ward Sisters and Charge Nurses have continued to be required to work some shifts clinically to ensure minimum staffing levels are achieved. Given the scope of the Ward Sister/Charge Nurse role it is essential that they are able to resume their supernumerary / supervisory status to enable them to monitor and improve nursing care standards. Similarly, the Matron role is to oversee nursing care standards, to hold the Ward Sisters and Charge Nurses to account, and to actively support improvements in nursing care.

Matrons are currently required to work clinically and to support bed management. This detracts greatly in terms of their ability to continue to implement improvement schemes; Matrons are required to focus on care standards and delivery of discharge schemes to reduce the length of stay as key strategies to avoid opening additional beds; however there is a primary need to provide excellent nursing care at the bedside. This position is being reviewed as beds close during March 2015.

4. Next steps

At the recruitment day on 25 February 2015, newly qualified registrants were recruited in advance of qualifying in March and September 2015. In addition, registered nurses were recruited and their applications are being processed to enable them to commence work as soon as possible.

Plans are in place to pursue overseas nurse recruitment if this is required. Matching nurse staffing with bed requirements is essential and this is being assessed in the context of seasonal variation during March and April 2015 to inform planning processes for next Winter.

Senior Nurses have continued with the actions to mitigate risks that were described in the report to the February Board of Directors, with an update on the following activities:

- Matrons and Sisters to be part of the ward numbers augmented by review rounds for assessment compliance.
- Increased visibility of the Patient Experience Team.
- A programme of Monthly Trust wide recruitment for Registered Nurses; in February a total of 49 nurses were offered posts (10 nurses immediate start dates, 3 due to graduate March , 36 due to graduate Sept 2015).
- Recruitment event March has 32 applicants due to be interviewed on 25 March 2015.
- Return to Practice: uptake aim of 7 – 8 per year by the end of 2015, on track for delivery.
- Continue to review the use of flexi bank but reduce the number of agency nurses as additional wards begin to close to enable consistent cohort nursing.
- Deliver version 10 of E-roster with training during March 2015 that brings the benefit of having a 3 month rolling view of nurse staffing thereby enabling the identification of potential staffing shortfalls and taking mitigating action, although there will always be some need to respond to variance in patient acuity, infection control and unexpected capacity demand. Upgrade begins late March with a planned phased implementation programme.

5. Conclusion

Strategies to recruit registered nurses are proving to be successful and will continue. There continue to be serious concerns with regard to the provision of minimum staffing levels of registered nurses during this reporting period, although the data demonstrates a slight improvement on January's performance. Whilst the Trust did not meet the 95% staffing level across all Wards during February 2015, but there was an improvement in the numbers that were non-compliant across the sections and a significant decrease in the number of staffing incidents reported. All mitigating actions are in place to ensure that patients and staff are safe.

6. Recommendations

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

Appendix 1

February 2015 Nurse Staff Fill Rates at 95%

	Day		Night	
Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives	Average fill rate - care staff (%)
10	94.8%	95.9%	100.0%	98.4%
11	88.7%	90.5%	99.2%	96.8%
12	85.7%	89.0%	100.0%	93.5%
14/20	87.1%	97.0%	95.7%	98.3%
17	96.5%	91.7%	88.2%	98.4%
18	87.8%	92.2%	85.0%	98.5%
21	98.5%	98.9%	98.5%	100.0%
22	98.6%	98.6%	99.1%	100.0%
23	95.4%	99.5%	96.7%	100.0%
24 & Isolation	98.8%	99.2%	95.2%	99.2%
OPAU	98.2%	99.6%	96.8%	100.0%
30	82.8%	95.4%	83.8%	86.3%
32 & CCU	98.5%	97.0%	99.2%	98.9%
33 / HAC	97.4%	96.2%	94.6%	94.6%
36	96.8%	95.4%	92.5%	97.8%
38	89.9%	99.6%	86.2%	98.9%
26	97.4%	97.1%	98.9%	98.9%
MAAU	97.1%	99.2%	96.8%	100.0%
MSSW	97.0%	97.4%	99.3%	100.0%
EDRU	99.9%	100.0%	100.0%	100.0%
Parksuite	100.0%	100.0%	100.0%	
SAU	95.5%	95.3%	83.7%	100.0%
ITU	100.0%	100.0%	100.0%	
HDU	100.0%	100.0%	100.0%	100.0%
54	97.4%	100.0%	93.5%	
M1	89.8%	90.5%	100.0%	96.8%
M2	100.0%	100.0%	100.0%	100.0%
Delivery Suite	93.6%	100.0%	95.0%	100.0%
53	95.6%	93.8%	89.5%	100.0%
Neonatal	95.7%		93.9%	
Children's	100.0%	91.6%	98.7%	96.8%
CRC	99.5%	99.6%	100.0%	100.0%
Dermatology	100.0%	100.0%	100.0%	100.0%
36 CBH	100.0%	100.0%	100.0%	100.0%
25	99.4%	100.0%	100.0%	100.0%

Feb-15

RGN days

Ward	Fill	Reason
10	94.8%	Outstanding vacancies
11	88.7%	Outstanding vacancies & sickness
12	85.7%	Sickness and additional beds
14/20	87.1%	Out standing vacancies & sickness
18	87.8%	Out standing vacancies & sickness
30	82.8%	Sickness & contingency
38	89.9%	Out standing vacancies & contingency
M1	89.8%	Outstanding vacancies
Delivery Suite	93.6%	Bank staff unfulfilled

CSW days

11	90.5%	Outstanding vacancies
12	89.0%	Sickness and additional beds
17	91.7%	Outstanding vacancies & sickness
18	92.2%	Sickness
M1	90.5%	Outstanding vacancies & sickness
53	93.8%	Bank staff unfulfilled
Childrens	91.6%	Sickness

RGN nights

17	88.2%	Sickness & contingency
18	85.0%	Outstanding vacancies & sickness
30	83.8%	Sickness & contingency
33 / HAC	94.6%	Sickness
36	92.5%	Contingency & outstanding vacancies
38	86.2%	Outstanding vacancies
SAU	83.7%	Sickness
54	93.5%	Sickness
Delivery Suite	95.0%	Bank staff unfulfilled
53	89.5%	Bank staff unfulfilled
Neonatal	93.9%	Bank staff unfulfilled

CSW Nights

Ward	Fill	Reason
12	93.5%	Sickness and additional beds
30	86.3%	Sickness
33 / HAC	94.6%	Sickness & contingency

February 2015 Nurse Staff Fill Rates at 90%

	Day		Night	
Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives	Average fill rate - care staff (%)
10	94.8%	95.9%	100.0%	98.4%
11	88.7%	90.5%	99.2%	96.8%
12	85.7%	89.0%	100.0%	93.5%
14/20	87.1%	97.0%	95.7%	98.3%
17	96.5%	91.7%	88.2%	98.4%
18	87.8%	92.2%	85.0%	98.5%
21	98.5%	98.9%	98.5%	100.0%
22	98.6%	98.6%	99.1%	100.0%
23	95.4%	99.5%	96.7%	100.0%
24 & Isolation	98.8%	99.2%	95.2%	99.2%
OPAU	98.2%	99.6%	96.8%	100.0%
30	82.8%	95.4%	83.8%	86.3%
32 & CCU	98.5%	97.0%	99.2%	98.9%
33 / HAC	97.4%	96.2%	94.6%	94.6%
36	96.8%	95.4%	92.5%	97.8%
38	89.9%	99.6%	86.2%	98.9%
26	97.4%	97.1%	98.9%	98.9%
MAAU	97.1%	99.2%	96.8%	100.0%
MSSW	97.0%	97.4%	99.3%	100.0%
EDRU	99.9%	100.0%	100.0%	100.0%
Parksuite	100.0%	100.0%	100.0%	
SAU	95.5%	95.3%	83.7%	100.0%
ITU	100.0%	100.0%	100.0%	
HDU	100.0%	100.0%	100.0%	100.0%
54	97.4%	100.0%	93.5%	
M1	89.8%	90.5%	100.0%	96.8%
M2	100.0%	100.0%	100.0%	100.0%
Delivery Suite	93.6%	100.0%	95.0%	100.0%
53	95.6%	93.8%	89.5%	100.0%
Neonatal	95.7%		93.9%	
Children's	100.0%	91.6%	98.7%	96.8%
CRC	99.5%	99.6%	100.0%	100.0%
Dermatology	100.0%	100.0%	100.0%	100.0%
36 CBH	100.0%	100.0%	100.0%	100.0%
25	99.4%	100.0%	100.0%	100.0%

Feb-15		
RGN days		
Ward	Fill	Reason
11	88.7%	Outstanding vacancies & sickness
12	85.7%	Sickness and additional beds
14/20	87.1%	Out standing vacancies & sickness
18	87.8%	Out standing vacancies & sickness
30	82.8%	Sickness & contingency
38	89.9%	Out standing vacancies & contingency
M1	89.8%	Outstanding vacancies
CSW days		
12	89.0%	Sickness and additional beds
RGN nights		
17	88.2%	Sickness & contingency
18	85.0%	Outstanding vacancies & sickness
30	83.8%	Sickness & contingency
38	86.2%	Outstanding vacancies
SAU	83.7%	Sickness
53	89.5%	Bank staff unfulfilled
Neonatal	93.9%	Bank staff unfulfilled
CSW Nights		
30	86.3%	Sickness

BOARD OF DIRECTORS	
Agenda Item	8.4
Title of Report	Quality Account 2014/15 – First Draft
Date of Meeting	25 March 2015
Author	Joe Roberts - Head of Assurance
Accountable Executive	Dr Evan Moore - Medical Director
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	3 3a, 3b
Level of Assurance • **Positive** • **Gap(s)**	The six priorities which we set ourselves for the 2014/15 financial year have not been achieved in full, so we propose to carry them forward into the 2015/16 Quality Account.
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	This is the first draft of the annual Quality Account. It is sent to the group for discussion. As we have not yet reached the end of the financial year, members should be aware that not all data is yet available, and some of the data and conclusions may be subject to change in the final version of the report.
Data Quality Rating	Mixture of gold, silver and bronze data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	Not applicable – not proposing a service change

1. **Executive Summary**
   This is the first draft of the annual Quality Account Report for 2014/15. The report covers the twelve months from April 2014 to the end of March 2015. At the time of writing, we have not yet reached the end of the financial year so some of the data required for inclusion in the report is either incomplete or unavailable. However, this draft does provide an indicator of our direction of travel so far, and our priorities for the year ahead.

2. Background

The Quality Account is a public report which each NHS Trust in England is required to produce every year, after the end of the financial year. It is intended to provide an overview of the quality of services provided by the Trust during the year, in the same way that the annual accounts provide an overview of the Trust's financial performance. The content and presentation of the Quality Account is governed by guidance from Monitor, the regulatory body for Foundation Trusts.

3. Key Issues/Gaps in Assurance

In 2014/15 we set ourselves six priorities covering the following topics: nutrition and hydration; missed medication events; readmissions; mortality; pressure ulcers; and dementia. Although a great deal of work has been done, we have not yet achieved in full the targets which we set for ourselves and therefore we propose to include the same priority topics in next year's Quality Account, with revised targets where appropriate.

4. Next Steps

The next steps are as follows:

- Obtain Board approval for proposed priorities for 2015/16
- Update report after financial year end with complete year's data
- Submit document to one month of external consultation
- External audit by KPMG of data quality for a selection of three indicators reported in the Quality Account
- Board approval of final version of the report, and signature by Chairman and Chief Executive, by end of May
- Publication of final report to stakeholders, and on NHS Choices website

5. Conclusion

Overall the Quality Account reflects a challenging year for the Trust, which has experienced rising demand for its services amid a difficult financial climate. This has adversely affected performance in several areas and made our priorities more difficult to achieve. However, we intend to retain our priorities until we have achieved them.

6. Recommendations

The Board is asked to note the progress to date, and to approve the proposed priorities for 2015/16. At this point, the improvement targets have not yet been set for these priorities as this will depend on the position at the end of the financial year.

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Quality Account 2014/15
Draft – March 2015

Report Date: 20th March 2015

Compiled By: Joe Roberts, Head of Assurance

Name of Approving Committee:
Board of Directors

treating you well

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Part 1: Chief Executive's Statement

This has been a challenging year for our hospitals, but in the face of increasing demand for services, and financial pressures, our staff have continued to deliver compassionate and effective care to the best of their considerable abilities. We have not achieved all the targets which we set for ourselves in last year's Quality Account, but a great deal of work has been done and real progress has been made. We intend to carry that progress into the coming year, with the aim of meeting those targets by March 2016.

Our financial position has meant that we had to take difficult decisions during the year. In June 2014 we reorganised our corporate services function, and reduced the number of divisions within the organisation to make our management structures more streamlined and effective. This has allowed us to make funding available for new nursing posts, thus reinforcing our front line services. During 2015/16, we will be investing an extra £1.1 million in nurse staffing. This will help to make the commitments in our Nursing and Midwifery Strategy a reality.

Throughout the year we continued to engage with our staff, and involve them in making decisions about how to improve services. In last year's edition of this report, we mentioned the 'Listening into Action' programme. In total, more than 1,000 staff have attended one of 14 'big conversation' events to put their own ideas forward, and over 650 staff have taken part in team-led conversations to make improvements. Over 120 high impact improvement actions have been completed as well as over 200 'quick win' improvements. Our success was recognised when we won the prestigious Health Service Journal for Staff Engagement in November 2014. The judges commented that we had a "powerfully impressive, evidence based programme to bring about positive change through staff engagement".

In September 2014 we were inspected by the Care Quality Commission, and we were told that we needed to improve the standard of our record-keeping, and some aspects of the care and welfare of patients – particularly around making sure that they are given sufficient food and fluids, and are helped with eating and drinking if needed. CQC also observed the challenges that we faced to deliver safe staffing levels, and recommended improvements to how we assess and monitor the quality of our services. We have acted on their feedback by developing and delivering a robust action plan. It is encouraging that CQC still place our Trust in Band 6 – the group of Trusts judged to be at the lowest risk of delivering poor quality care. In September 2015 we will undergo a full-scale planned inspection by the CQC. We see this as a positive opportunity to demonstrate some of the good work that we are doing.

In November 2014 we reached an important milestone when we implemented phase 2B of our Cerner Millennium electronic patient records system across the inpatient areas of the hospital, enabling completely electronic nursing documentation to all the wards. Functions in the new system flag up when patients' assessments and observations need to be completed, and when medication should be administered. These should help with improving nutrition and hydration, and reducing the frequency of missed medication doses – two of our priorities for the past year, and the year ahead.

I would like to thank our patients for choosing Wirral University Teaching Hospital to care for them, and I would like to thank our staff for their hard work and determination. Together, we have achieved a great deal over the past twelve months, but there is a lot more to do.

I am pleased to confirm that the Board of Directors has reviewed the 2014/15 Quality Account and confirm that it is a true and fair reflection of our performance.

David Allison
Chief Executive

May 2015

Part 2: Priorities for Improvement and statements of Assurance

Part 2.1: Looking forward to 2015/16; what are our priorities?

We have developed our quality improvement strategy based on the views of patients, relatives and carers, governors, staff, Wirral Healthwatch, the Family and Wellbeing Policy and Performance Group and our commissioners by asking what they thought of our services and what we should focus on when improving quality. We have also analysed our patient experience feedback, the risk management systems and our existing quality improvement work such as clinical audit, to help focus our activity. The strategy sets out clear expectations about quality improvement with measurable achievements to monitor our progress. In light of this, we have reviewed our Quality Account priorities for 2015/16 to support making that vision a reality.

2.1.1 Our priorities for improvement in 2015/16 are:

We intend to maintain the same priorities which we have been working towards in 2014/15. Over the past twelve months a great deal of work has been done to improve performance in the six selected areas. However, we are not yet consistently achieving the targets which we set, and the work which we are doing will take more time to bear fruit. In the past, we have always retained priorities in the Quality Account until the targets have been achieved, and we are continuing with this approach.

We are currently in discussion with our commissioners regarding the development of an additional priority to represent a theme of 'social value'.

Therefore, in 2015/16 the priorities are:

Patient Experience

1 Improving care for patients with dementia

Rationale: We are seeing more patients with dementia across all areas of the Trust. We know our population is ageing and therefore the prevalence if dementia is increasing; evidence suggests the care received is not always as good as it could be and this influences both the patient experience of our services as well as their clinical outcomes. Delivering high quality care to these patients will be based on best practice standards as described by the National Institute for Health and Clinical Excellence (NICE). This year, we will focus on ensuring our staff are well trained across all areas of the organisation and that the information we provide to patients and their family both is appropriate to their needs at that time, robust and consistent.

Targets:

1a: People with dementia receive care from staff appropriately trained in dementia care.

During 2014 a baseline audit was undertaken to identify how many staff require training. Based on this, we developed an educational plan training pack to reinforce the NICE standards. Milestones will be set for more staff to be trained during 2015/16. This training will cover both front-line clinical staff, and non-clinical staff who may come into contact with patients suffering from dementia in the course of their work.

1b: People newly diagnosed with dementia and/or their carers receive written and verbal information about their condition, treatment and the support options in their local area.

During 2014 a baseline audit was undertaken and is now being repeated on a quarterly basis. Milestones will be set for expected improvements in the results of the audit during 2015/16.

Lead: Mrs J Galvani, Director of Nursing and Midwifery

2 Ensure patients are supported with eating and drinking based on their individual needs.

Rationale: Eating and drinking are basic needs for our patients. Some patients require support and which can be as minimal as opening a sandwich packet or ensuring drink is in reach to more complex support for those with swallowing difficulties. Poor nutrition and hydration can increase the risk of poor healing and additional complications for our patients as well as causing distress. We monitor the support we give patients and are not satisfied with the results. Therefore we think this should be a focus for improving our patients' experience.
Target:
2: tba % of patients will report receiving appropriate assistance with eating and drinking as measured by our Learning with Patients Survey.
Lead: Mrs J Galvani, Director of Nursing and Midwifery

Safety Priority

3.1 Reduce harm to patients particularly in relation to newly formed pressure ulcers

Rationale: Health care is not without risk of harm. We have been measuring harm free care using the Safety Thermometer tool. This is based on a monthly audit of a sample of patients from across the Trust noting whether they have fallen, had a blood clot, a catheter acquired urinary tract infection and/or a pressure ulcer. We believe this is a helpful monitoring tool and will continue to report it; we have progress still to make, with the baseline being between 93-95% harm free care. The key harm is pressure ulcers and therefore we will continue to focus on this and reduce new pressure ulcers further.
Targets:
3.1a: Harm free care as measured by the safety thermometer monthly will be above 95% all year

3.1b: We will achieve an xx% reduction in avoidable new pressure ulcers grade 3-4 and an xx% reduction in new grade 2 pressure ulcers compared to the 2014/15 year end position. *(percentage targets to be confirmed once final data for the year is known)*
Lead: Mrs J Galvani, Director of Nursing and Midwifery

3.2 Reduce the number of "missed medication" events

Rationale: Patients need to receive their prescribed medication in a timely way to speed recovery. During this year a pharmacy intervention monitoring audit has identified a number of missed medication doses and it is one of the main drivers for our medication error rate. Therefore we want to undertake targeted work to reduce the number of such events.
Target:
3.2: We introduce the medication safety thermometer. We will achieve a tba % reduction in missed medication events by Q4.

Lead: Mrs J Galvani, Director of Nursing and Midwifery

Clinical Effectiveness Priority

4.1 Reduce the hospital standardised mortality rate (HSMR)

Rationale: A higher than expected mortality rate can be due to a number of factors not just poor health care given within an organisation. However, it is accepted that it provides a good overall indicator of care; when high rates have been investigated various quality issues have been highlighted within hospitals. Our HSMR is currently better than the national average and we have seen significant improvement over the past two years.
Target: The HSMR will be lower than expected based on our risk assessment. With a stretch target to reduce by at least 5 points over the year from the rebased position (2014/15).
Lead: Dr E Moore, Medical Director

4.2 Reduce emergency readmissions within 30 days

Rationale: Returning to the hospital for unplanned care is a measure of failure of the healthcare system. Quality issues that can underpinning readmission include poor discharge processes, lack of communication and lack of community service provision. Some admissions will be completely unlinked. Our current readmission rate is "as expected" for the population we service; but one of the highest in the region. We believe we can reduce this to help us provide better patient experience and support acute care to deliver high quality services by freeing up time and resources to see new patients.
Target:
4.2 We will reduce our readmission rate by 1% during 2015/16 from the 2014/15 baseline.
Lead: Dr E Moore, Medical Director

2.1.2 Monitoring of our Priorities for 2015/16

We will continue to provide a quarterly report on progress with our priorities to the Board of Directors and internal committees; progress is shared with the governors biannually. The quarterly reports on progress are available to our local commissioners, Wirral Healthwatch, Wirral Borough Council Overview and Scrutiny Committee via the Families and Wellbeing Policy and Procedures Group and NHS England. Individual priorities are managed and monitored by a range of staff in the Trust. All priorities will have a work programme in place.

2.1.3 Provision of Feedback

We welcome and wish to encourage feedback on our Quality Account. If you would like to comment on this report or if you want to make suggestions for future priorities please contact Dr M Maxwell, Associate Medical Director.

Part 2.2 Statements of Assurance from the Board of Directors

The Trust uses a wide variety of information to provide the Board with assurance on the quality of our services. This information comes from a number of national and local initiatives:

2.2.1 Service reviews

During 2013/14, the Trust provided and/or subcontracted 68 NHS services (see Appendix 1). Since the previous year, the Trust has undergone a corporate restructure which reduced the number of clinical divisions from four to three; some services have moved from one division to another. The Trust has reviewed the data available to it on the quality of care in all of these services. The income generated by the NHS services reviewed in 2014/15 represents 100% of the total income generated from the provision of NHS services by the Trust for 2014/15. Information covering all services and the three dimensions of quality is brought together in an Integrated Performance Report reviewed by the Board of Directors every month. This report enables the Board to triangulate quality data and monitor the impact of target delivery. In addition a clinical quality dashboard is monitored monthly through the Quality and Safety Committee (a subcommittee of the dashboard); this monitors trends in the safety, clinical effectiveness and patient experience and main drivers underpinning them.

Each division has an internal quality and safety structure and processes that support and performance manage the quality agenda.

2.2.2 Participation in National Clinical Audit and Confidential Enquiries

Clinical audit helps improve the quality of patient care by measuring compliance with best practice standards for care we give. This identifies areas for improvement that can be acted on prior to re-audit at a later date to show improvement. During 2014/15, participation in the relevant national clinical audits increased.

During 2014/15, the Trust took part in xx national clinical audits and five national confidential enquiries covered relevant health services that the Trust provides.

During 2013/14, the Trust participated in xx% (xx/29) national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. In 2013/14, we participated in 97% of relevant national audits.

The national clinical audits which the Trust was eligible to participate in during 2013/14, for which data collection was completed during 2014/15 are listed in Appendix 2 *(note – this draft version of the report contains only partial data as at March 2015)*. This table includes the number of cases submitted to each audit as a percentage of the number of registered cases required by the terms of that audit and a summary of actions. In year, we received reports for xx national audits of which xx have not yet completed the review process, and xx did not identify any specific actions. The remainder have been discussed and action plans are either in place or development.

Examples of actions taken in response to our results in national audits include:

- National Bowel Cancer Audit – for colorectal cancer, the Multi-Disciplinary Team now discusses the patient's suitability for laparoscopic / robotic surgery, and all patients meeting the criteria are offered access to a surgeon who has been appropriately trained in this type of colorectal surgery.
- National Emergency Laparotomy Audit – emergency surgeons and designated anaesthetists have been selected to lead on the development of new protocols and pathways when the new specialty is operational.
- National Joint Registry – the 2015 edition of the report is not expected until October, but the

previous year's report showed that consent rates for inclusion in the audit were below 80%. This has been followed up by our own local audit and there has been a dramatic improvement in consent rates.

Since May 2013, the Trust has had in place a small corporate audit team who work with the clinical staff to improve the participation in the national clinical audits as one of their workstreams. During 2014/15 they have collected data for the National Chronic Obstructive Pulmonary Disease Audit, the National Heart Failure Audit, the MINAP audit of acute myocardial infarction, and the Childhood Epilepsy 12 Audit.

There were five national confidential enquiries which the Trust was eligible to participate in during 2014/15, all of which we actually participated in (see table 1 below).

National Confidential Enquiries Title	Case Requirement	Cases Audited
The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – Sepsis Study	100%	3/4
The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – Lower Limb Amputation	100%	7/7
The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Gastrointestinal Haemorrhage	100%	5/5
The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Tracheostomy Care	100%	2/2
Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries Across the UK (MBRRACE-UK) *Formally known as Centre for Maternal and Child Enquiries (CMACE)*	100%	Add at end of financial year

Table 1- National Confidential Enquiries

The reports of two national confidential enquiries were received by the Trust in 2014/15.

- *Lower Limb Amputations – Working Together*: this was published in November 2014; the report was disseminated to divisions, however following a gap analysis it was apparent that no further actions were required.
- *Trachaeostomy Care – On the Right Track:* this was published in June 2014, and following a gap analysis a Trust-wide action plan was discussed and approved by the Trust-wide Clinical Governance Team.

In addition to the national clinical audits we undertake local clinical audits, a number of which are repeat audits in order to identify the level of improvement made as a result of earlier improvement actions.

The reports of xx local clinical audits were reviewed by the provider in 2014/15 and the Trust has taken or intends to take the following actions to improve the quality of healthcare provided:

- *This information will be added after the end of the financial year – details awaited from each Division*

2.2.3 Participation in Clinical Research

In 2014/15 592 patients receiving NHS services provided or sub-contracted by the Trust were recruited to participate in research approved by a research ethics committee. This demonstrates the Trust's continued commitment to research in order to provide evidence to improve treatment and the quality of care for our patients.

The Trust recruited participants to 44 National Institute for Health Research (NIHR) adopted studies; 45% of studies were Clinical Trials of Investigational Medicinal Products or Clinical Trials to study interventions in clinical practice. The research portfolio continues to be clinically diverse including: cancer, cardiovascular, critical care, dermatology, dementia, haematology, ophthalmology, paediatric, reproductive health, respiratory, rheumatology, stroke and surgery studies.

Research within the Trust is supported by a small administrative team (2.4 WTE) and 14 Research Nurses (9.0 WTE); due to external funding this is reduction of 0.6 WTE from the previous year. Over XX Trust clinicians are study Principal Investigators. Much of the research involves collaboration with key support services and the Research Department works closely with pharmacy, pathology and radiology to ensure that the Trust has the capacity and capability to set up and effectively run our studies.

During 2012/13 and 2013/14 the Trust achieved the national key performance indicator for granting NHS permission (research and development approval) to all new studies within the 30 day target; during 2014/15 this target was reduced to 15 days and we still achieved this target.

In addition to NIHR adopted studies the Trust approved XX new WUTH consultant-led studies and XX new WUTH student-led studies. During the last year, Trust staff were involved in XXX publications accepted in professional journals. This shows our commitment to improving outcomes for patients, staff professional development and also to making a wider contribution to healthcare on a national level.

2.2.4 Commissioning for Quality and Innovation

Commissioning for Quality and Innovation (CQUIN) is a mandated sum of money put aside by Commissioners to fund quality improvement, with providers earning the income by delivering agreed quality targets. A proportion of Trust income in 2014/15 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and local healthcare commissioners, and any person or body the Trust entered into a contract, agreement or arrangement with the provision of NHS services, through the CQUIN payment framework.

The targets for 2014/15 were developed by NHS Wirral and agreed with the Trust, and reflected areas of desired improvement identified nationally and locally. Further details of the agreed goals for 2014/15 and the following 12 month period are available at:

http://www.monitor-nhsft.gov.uk/about-nhs-foundation-trusts/nhs-foundation-trust-directory/wirral-university-teaching-hospital-nhs-f

Indicator for 2014/15	Year-end Position
1. Implementation of the Staff Friends and Family Test To demonstrate full implementation of the test across all staff groups, as outlined in the guidance	*On track to achieve* In quarter 1, the test was offered to 2,000 staff to complete, with a response rate of 28 and it is expected that all staff will have had the opportunity to take part by the end of quarter 4.

Indicator for 2014/15	Year-end Position
2. Friends and Family Test – early implementation To demonstrate full delivery of the test across all services delivered by the Trust, as outlined in the guidance	Data awaited
3. Friends and Family Test for patients – increased response rate To achieve a response rate of at least 20% for Accident and Emergency services, and at least 30% for inpatient services, by the end of quarter 4	We were on track to achieve this target in quarters 1 and 2, although performance declined in quarter 3 – in December, there was a response rate of 14% in the Emergency Department and 21% for inpatients. Performance management is in place to achieve the target by the end of quarter 4.
4. Friends and Family Test for patients – increased response rate in acute inpatient services To achieve a response rate of 40% or higher for the month of March 2015	See comments for no. 3 above – there has been a deterioration in performance during quarter 3 which we are aiming to reverse during quarter 4.
5. Dementia – Find, Assess, Investigate and Refer To achieve 90% or more for each of the following indicators: the proportion of patients aged 75 or older to whom case finding is applied following emergency admission; the proportion of those identified as potentially having dementia who are appropriately assessed; and the proportion referred on to separate services	*On track to achieve* This target has been consistently met or exceeded in quarters 1, 2 and 3.
6. Dementia – Clinical Leadership To appoint a named lead clinician for dementia and deliver an appropriate training programme for staff	*On track to achieve* We have designated a Lead Clinician – Dr Bramwell Spencer, a Consultant in Medicine for the Elderly. A training plan has been produced and was approved by Dementia Steering Group in December. By the end of quarter 3, 663 staff had received additional training.
7. Dementia – Supporting carers of people with dementia To undertake a quarterly audit to test whether carers of people with dementia feel supported, and to produce a bi-annual summary audit report for the commissioners	*On track to achieve* The audit has been completed throughout the year to date, although it has been a challenge to obtain a representative sample and we have therefore supplemented the audit with a postal survey.
8. Pressure Ulcers – Zero Tolerance Approach To establish a baseline for the number of grade 2 pressure ulcers and to set a target for improvement, with regular reporting to the commissioners of progress against this target	*On track to achieve* We agreed a baseline target for a reduction of 35% compared to the previous year's total of 466, meaning that we should report no more than 266 during the year. By the end of quarter 3, there had been 192 grade 2 pressure ulcers.

Indicator for 2014/15	Year-end Position
9. Dementia – assessment and personalised care plan To ensure that people with dementia have an assessment and an ongoing personalised care plan, agreed across health and social care, that identifies a named care co-ordinator, and addresses the patient's overall needs To establish the current level of performance against this objective and to set targets for improvement to be achieved by the end of quarter 4	We have developed a dementia care bundle which covers many of the issues in the CQUIN target. This started to be implemented in quarter 2. In only 25% of cases sampled had the 'bundle' been applied in full, although assessments had been done for the majority of patients.
10. Dementia – Dementia Friendly Hospital To improve the experience and outcome of care for people with dementia by adopting dementia-friendly best practice This will involve self-assessing our Trust using the D-Kit assessment checklist and producing an action plan. This should deliver improvements in the following: the environment in which care is given; the knowledge, skills and attitude of the workforce; support given to discharge patients with dementia back to their homes; and the use of person-centred care plans which involve families and carers	We completed the D-kit self-assessment and the results of this exercise formed the basis for the new Dementia Specialist Matron's programme of work, which is ongoing.
11. Compassion in Clinical Care – implementation of a cultural barometer To ensure a culture of patient centred care by implementing a recognised tool to assess the culture of care delivery, and producing an action plan and quarterly progress reports	*On track to achieve* The Organisational Cultural Inventory survey was circulated to a sample of 500 staff during quarter 3 and a report of the results was provided in January 2015. The existing Culture and Engagement Action Plan has been revised and supplemented to take account of this survey.
12. Integrated Care Co-ordination Teams To continue with the programme of work undertaken in 2013/14 to support implementation of these eight teams across Wirral; to agree and report key performance indicators for the teams	*On track to achieve* These teams have all now been set up. A service specification was adopted which includes key performance indicators, and we plan to use a scorecard to measure the impact on emergency admissions, readmissions, length of stay and A&E department attendances. Reporting of the KPIs commenced at the beginning of quarter 3.

Indicator for 2014/15	Year-end Position
13. Smoking Cessation To ensure that all patients are asked whether they smoke, and that those who smoke are offered a brief intervention To develop smoking cessation skills by training a group of nurses to become Level 2 intermediate smoking cessation advisers To audit against NICE public health guidance PH48 To increase the number of patients referred into the Stop Smoking Service by at least 25% compared to the 2013/14 figure To increase the number of Nicotine Replacement Therapy prescriptions by 10% compared to 2013/14	*Pending* Training programmes have been delivered for staff in the wards which we have targeted and we are undertaking regular audits, following on from a baseline audit against the NICE Guidance which was completed and reported in July 2014. We will not know until after the end of the financial year whether we have achieved our targets for increasing the take-up of nicotine replacement therapy and referrals to the stop smoking service.
14. Service Quality Dashboards for Neonatal and Renal Services To use the required clinical dashboards which were developed during 2013/14 for specialised services	*On track to achieve* Both services have submitted data for the dashboards prior to the deadlines. There have been some delays in receiving the dashboards although they have since been displayed and discussed in the departments.
15. Investment in HIV IT To develop an information system to support implementation of the anti-retroviral drugs procurement programme	*On track to achieve* Milestones have been agreed, the Telecare Mills system was been updated to capture the data in May 2014, and staff were trained to input data to the system in June 2014. Data relating to patient demographics and management regime is being input to the system.
16. Renal Dialysis To involve patients in the tasks of haemodialysis	*On track to achieve* At the end of quarter 2 we were exceeding the target for 10% of patients to participate in 5 of 14 tasks relating to their own dialysis treatment, and 95% being asked whether they would like to participate in these tasks.
17. Patient Held Records (Breast Cancer) To encourage the use of patient held records by patients with breast cancer (these records include self-care plans, care summaries and emergency contact cards)	At present, our patients do not have their own records. We developed a questionnaire to gauge patients' opinions about the introduction of the practice. A pilot project was delayed but the Trust is working to ensure that the target is achieved in full by the end of quarter 4.
18. Clinical Coding To ensure consistent coding for oral surgery and maxillofacial surgery procedures across all secondary care providers	*Not achieved* The Trust is unable to deliver information outside the nationally agreed standards and works to Secondary User Service deadlines. We code to nationally agreed standards as provided by the Health and Social Care Information Centre classification service – the guidance which all coding departments have to follow.
19. Friends and Family Test – early implementation To expand implementation of the F&FT in all areas of dental services	*Not achieved* The response rate for the dental clinic, and dental day case patients, has been consistently low (6% in October, 3% in November, and 1% in December).

Indicator for 2014/15	Year-end Position
20. Health Inequalities To undertake a baseline assessment of access and coverage for vulnerable or deprived groups such as those living in deprived neighbourhoods, people with disabilities, people suffering from mental illness, plus a number of other groups within the community who have particular needs This should cover the following services: diabetic retinopathy; breast screening; and school nursing. The Trust should produce a plan to reach those groups who fail to access the services.	*On track to achieve* Baseline assessments for all three services were completed and submitted in quarters 1 and 2. Plans have been developed to ensure that members of these groups are able to access each of these services when they need them, and we are reporting regularly against these plans.

Table 2: 2014/15 CQUINs

The amount of income in 2014/15 conditional on achieving quality improvement and innovation goals was £5,155,436 subject to the final year income for 2014/15. For the year 2012/13, the total associated payment was £6,106,823.

At the time of writing, the national CQUIN guidance has not yet been published, although the Five Year Forward View for the NHS indicates that our priorities should include sepsis and acute kidney injury. The national CQUINS are likely to include the urgent care pick list, and dementia and delirium.

The CQUINS agreed locally with the Wirral Clinical Commissioning Group are expected to include two targets relating to urgent care (integrated therapy service, and safe staffing) and standards on consultant review and the complex discharge pathway.

2.2.5 Care Quality Commission Registration and Reviews

The Trust received an unannounced inspection from the Care Quality Commission in September 2014. This was not a full-scale planned inspection, but rather was in response to specific concerns that had been raised directly with the Commission by patients or carers.

The inspectors visited six wards – 1, 20, 21, 22, 33, and Accident and Emergency. They checked against five of the Essential Standards of Quality and Safety. They found that we were not fully compliant with all five. For three, they had minor concerns (respecting and involving service users, assessing and monitoring the quality of services, and staffing). For two, they had moderate concerns (records, and care and welfare of patients).

We took corrective action in the immediate aftermath of the inspection, with the Director of Nursing and her Assistant Directors working clinically in the areas that had been inspected over the weekend. In addition to these remedial action plans, we developed a plan of medium and long-term actions to address some underlying issues which the inspection helped bring to light. This plan includes actions such as: developing a new performance management framework for Ward Sisters and Charge Nurses; reviewing our nutritional screening process to make it more personalised around the patient's needs; and implementing weekly Matrons' ward rounds. The plan has been shared with the CQC, with Monitor, and with our commissioners.

We have been notified that we will undergo a full-scale planned inspection by CQC in September 2015. We are already preparing for this inspection. As part of our preparation, we are undertaking our own mock inspections. These are carried out by Trust staff from all professions and all grades, who have volunteered for the task. We are also starting to involve some of the volunteers who work in the

hospital, and representatives from the Clinical Commissioning Group and Health Watch. We intend to have inspected all our wards by July and thereafter to focus on areas that need the greatest improvement.

2.2.6 Data Quality

The Trust submitted records during 2013/14 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

The percentages in table 4 below include the patient's valid NHS number. The results shown for GP Registration have a 'valid' GP code assigned. This includes all 'valid' codes so will include any records assigned as 'unknown'.

NHS Coverage	2011/2012	2012/2013	2013/14	2014/15
Admitted patient care	97.8	99.2	99.6	*Not available until after end of financial year*
Outpatients	98.7	99.5	99.8	
AandE	96.1	98.7	98.8	
GP Registration				
Admitted patient care	99.9	99.9	100	*Not available until after end of financial year*
Outpatients	100	100	100	
AandE	100	100	99.9	

Table 4 Data Quality

The Trust is committed to achieving and maintaining high levels of data quality across all areas of healthcare information. As part of the information governance assurance regime, a Trust-wide data quality group meets regularly to review data quality standards, reports on data quality errors, and to address any ensuing issues.

The Trust will be taking the following actions to improve data quality for 2015/16:

- Information awaited

2.2.7 Information Governance

Information Governance ensures the necessary safeguards for, and appropriate use of, patient and person identifiable information. Risks relating to Information Governance are contained within the Trust monitoring and reporting mechanisms. An Information Group ensures the Trust maintains compliance with relevant Information Governance legislation and good practice.

The Trust Information Governance assessment report overall score for 2014/15 was 74% and was graded green in the grading scheme. This is an improvement on last year's score.

Information risks are managed in the same way as all other risks identified in the Trust; they are reviewed by the Information Group, which reports to the Finance, Business Assurance and Assurance committee. The Information Group also continues to report to the Audit Committee to increase the level of assurance on Information Governance systems.

Highlights from the work programme for this year will include reviews of the Corporate records register and data flows in and out of the Trust, a plan to integrate IG thinking into working practices through privacy audits making the IG team more accessible and the completion of information asset management documentation for level 3 information assets.

2.2.8 Clinical Coding

Accurate clinical coding is essential to the provision of effective healthcare at local and national level. It drives financial flows, informs payments and is critical to intelligent commissioning through the provision of epidemiology data which truly reflects the health and care needs of the nation. The Trust commissioned an external audit programme from the Clinical Coding Academy at Merseyside internal audit agency (MIAA). Four audits have been conducted across the year. Specialties audited this year included cardiology, respiratory medicine, orthopaedics, urology and deceased patients. Following these audits individual and team feedback has been given to enhance performance. These external audits were supplemented with additional internal audit.

The Trust was not subject to the Payment by Results clinical coding audit during 2014/15.

The Trust will be taking the following actions to improve data quality:

- Continue to commission external clinical coding audits
- Continue to undertake internal audits
- Ensure coding staff receive feedback at individual and team level as appropriate
- Provide education and training to all staff involved in the coding process

In 2015/16, the Trust is planning to review the whole coding process to ensure it is as cost effective as possible.

Part 3: Review of Quality Performance

This section of the report tells you how we performed against the six priorities that we set ourselves in 2014/15.

3.1.1 Patient Experience Priorities

1. Improve care for patients with dementia

The target for 2014/15 is:

- People with dementia receive care from staff appropriately trained in dementia care.
- People newly diagnosed with dementia and/or their carers receive written and verbal information about their condition, treatment and the support options in their local area.

Lead: Mrs J Galvani, Director of Nursing and Midwifery

During the past year, we have completed a great deal of work to ensure that patients suffering from dementia and their carers get the care and support they need, and to train our staff to provide that support.

Over 600 staff have received training on dementia care, which has taken a variety of forms including attendance at conferences and the Dementia Forum, online learning and one-to-one training provided by the Dementia Specialist Nurse. We have been undertaking a quarterly audit of carers' views which asks about whether they were involved in decision-making, whether they were kept informed, and whether they were told about support available outside the hospital in the community. While this audit provides a baseline against which to measure performance, the results have been inconsistent and we have not been able to reach as many carers as we would have liked. As a result, this priority will remain in the Quality Account for the coming year. *Quarter 3 and 4 results of audit to be added to report when available*

A summary of the actions which the Trust has taken is given below:

- We appointed a Specialist Matron for Dementia who works across the Trust and leads on this stream of work. She took up her post in September 2014.
- We have adopted a Dementia Strategy covering the four years from 2014 to 2018. It includes thirty separate actions covering training, clinical leadership, support for carers, assessment and care planning, and a dementia-friendly environment. A launch event for the strategy is being held in March 2015.
- We have established a Dementia Steering Group and an operational group which will monitor the implementation of the strategy across the Trust.
- We have made a training DVD on the subject of dementia care available via the intranet, and will monitor how often it is accessed on our corporate learning and development database. We are also training a range of staff who may come into contact with dementia patients – including staff who are in non-clinical roles – to act as 'Dementia Friends'.
- We are supplementing our audit questionnaire with a postal survey in order to reach more carers, such as those who may not come into the hospital so often.

2. Ensure patients are supported with eating and drinking based on their individual needs

The target for 2014/15 is:

- 75% of patients will report receiving appropriate assistance with eating and drinking as measured by our Learning with Patients Survey.

Lead: Mrs J Galvani, Director of Nursing and Midwifery

During the year, we have consistently met our target for assistance with drinking, although the target for assistance with eating was met in quarter 2, and also in January 2015. *Note: data for February and March 2015 not available at time of draft report – quarterly table to be added to report when data ready.* The times when performance has dropped generally coincide with those periods when the level of activity in the hospital, and staffing pressures, have been most acute.

We have reinforced a number of existing measures which we have in place to make it easier for patients to eat and drink, such as the red tray system, and the availability of specially adapted cutlery. We have also taken a number of simple, practical measures such as opening sandwich packets for patients and cutting the sandwiches into small triangles, and providing soft fruits which are easier to eat, for example bananas in place of apples.

We now have flexible visiting times in the hospital. Although this initiative was not developed with the issue of nutrition primarily in mind, it means that relatives and carers can visit at meal times and can help their family member to eat and drink if needed. They can also bring in food, although they must avoid certain foods which can prevent an infection control risk.

We are implementing patient-focused rounding on our wards. This involves nurses maintaining regular communication with their patients to identify their needs proactively. It should have many benefits, not least identifying those patients who are struggling to eat or drink on their own.

In response to the CQC inspection which took place in September, we are overhauling our food and fluid balance charts, reviewing our nutritional screening assessment process to make it more personalised around the patient's individual needs, and developing a flag on our new electronic patient record status which will alert staff to patients who are at risk of malnutrition.

Looking forward, we intend to deliver refresher training for our staff on nutritional issues, and to make greater use of our hospital volunteers to support patients with eating and drinking.

3.1.2: Safer Care Priorities:

3. Reduce harm to patients particularly in relation to newly formed pressure ulcers

The targets for 2014/15 are:

- Harm free care as measured by the safety thermometer monthly will be no lower than 93%, and above 95% for at least 6 months of the year.
- We will achieve an 80% reduction in avoidable new pressure ulcers grade 3-4 and a 30% reduction in new grade 2 pressure ulcers.

Lead: Mrs J Galvani, Director of Nursing and Midwifery

During the year, we have made very substantial progress, but we have not achieved our own ambitious target of reducing the number of avoidable grade 3 pressure ulcers by 80%. *Note: at time of first draft edition of this report, data available to end of quarter 3 only.*

The actions that we have taken during the past year include:

- Holding a Pressure Ulcer Summit, and organising a 'Listening into Action' service improvement event, jointly with colleagues from Wirral Community NHS Trust and the Wirral Clinical Commissioning Group
- Daily review of patients with a grade 1 pressure ulcer to ensure that the ulcer does not worsen to become a grade 2 or 3
- Completing a Root Cause Analysis investigation to ascertain the cause of every grade 3 pressure ulcer, and a simpler 'Situation Background Assessment Recommendation' investigation for grade 2 pressure ulcers
- Monitoring against a set of 29 key performance indicators; compliance is generally high, and improving, but there is scope to improve the completion of pressure ulcer care plans, and the moving and handling of patients, and wider use should be made of slide sheets.

Going forward, we have planned the following actions:

- Providing additional training in the form of four competency-based programmes
- Designating a member of staff on each ward and community team to act as a 'Pressure Ulcer Champion'

We have applied for funding from the Department of Health's 'Sign up to Safety' programme, which aims to reduce avoidable harm by 50% over three years. One of the three priority areas in our bid is pressure ulcers – we are seeking funding to create an additional post for a Specialist Tissue Viability Nurse, to provide improved information leaflets for patients, to improve how our IT system records assessments and treatment, and to implement 'Pressure Ulcer Passports'. These would accompany the patient as they move between different services and would allow better information sharing with our colleagues in the community.

4. Reduce the number of 'missed medication' events

The target for 2014/15 is to achieve a 50% reduction in missed medication events by Q4. The rate reduction will be based on the outcome of a monthly audit during quarter 1.

Lead: Mrs J Galvani, Director of Nursing and Midwifery

We completed a baseline audit in July 2014, which we are now repeating every month. The initial audit showed that approximately 20% of doses were missed, and that for 28% of the missed doses, no reason was recorded for the dose not being administered. The most common reason for missed doses was that the patient had refused the medication, and the second most common was a lack of stock on the ward.

The audit results have not shown a significant improvement since then – the proportion of doses missed had reduced to 15% by October 2014, but this was reversed in November and December, presumably because staff were still getting to grips with the new Millennium patient information database which was implemented in November.

Going forward, the Millennium system should actually contribute to a reduction in missed doses. The system has a task list which flags the tasks that need to be completed for each patient, including administering medicines. It also allows us to monitor when medicine supplies have been ordered and by whom, which makes it possible to scrutinise ordering patterns and adapt them to reduce the risk of ward supplies running out.

Among the actions we have taken during the year:

- Monitoring the existing controls over medicines administration, for example wearing of red tabards that indicate that a nurse is doing a drug round and should not be disturbed, through Matron's spot checks and our CQC mock inspections
- Regular meetings of a multi-disciplinary Medicines Optimisation Group, chaired by the Clinical Director of Pharmacy
- Completing a project to promote self-administration of medicines by patients who are competent to do so
- Encouraging patients to bring their own regular medicines to hospital with them, thus placing less pressure on our own supplies

3.1.2: Clinical Effectiveness Priorities:

5. Reduce emergency readmissions within 30 days

The target is to reduce our readmission rate by 1% during 2014/15 from the 2013/14 baseline.

Lead: Dr Evan Moore, Medical Director

The readmission rate for 2013/14 was 9.25% and therefore this year's target was 8.25% based on 2013/14 this would equate to about 700 fewer admissions. Whilst the data are not yet available for the whole year we are not likely to achieve this target. The year to date rate is 9.49 % (April – Jan 2014; unverified monitoring data). This follows unprecedented demand over the winter period reported nationally.

The actions undertaken this year include:

- A 'Listening into Action' event on the subject of readmissions; this was cross organisational including partners from the rest of the Wirral health economy, such as Age UK.
    - This led to additional support to ensure our staff are educated about alternatives to hospital admission with the redevelopment of a Directory of Services for our staff to ensure that know about alternatives to admission both provided by the Trust and also other agencies across Wirral..
    - We have set up secure data sharing with the Integrated Care Community Teams (ICCT) for patients who are readmitted. This ensures their care plans are comprehensive and appropriate community based services are available. There are numerous advantages for the patient, including having a single care co-ordinator to keep in touch with, not having to be re-assessed and answer the same questions from different organisations, and being supported to understand their condition better and to take some control over their own care. The ICCT's form part of Vision 2018. This is a plan formed by local GP's, NHS organisations, and Wirral Borough Council to re-shape health and social care in Wirral by delivering more services in the community rather than in hospital and enabling people to take more responsibility for their own health.
    - A multiagency group is reviewing individual care plans of those more complex patients who have multiple admissions to ensure they are receiving appropriate support to minimise their need for admission; whilst relatively new they are already showing some signs of success in managing some of the more challenging patients. There was a commitment from all parties to remove barriers to progress.

- We have also introduced increased specialist and senior review with a Consultant Geriatrician present on the Acute Medical Unit seven days per week, to support the management of older patients – the group who are most likely to experience repeat hospital admissions.

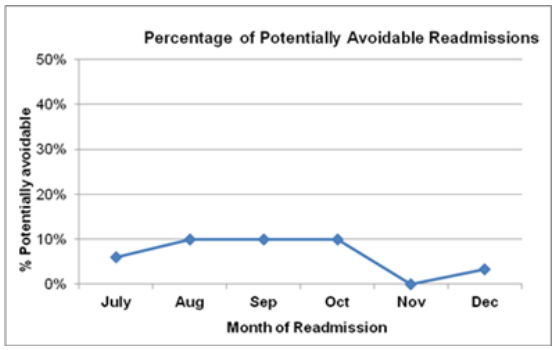
- We have a standard operating process in place that is triggered on readmission so that patients are reviewed by the team they were discharged by to determine whether they need admission or can be managed in an alternative way within Medicine. This is not fully embedded because we are waiting for a readmissions flag in Cerner Millenium so that we can quickly identify the readmissions.

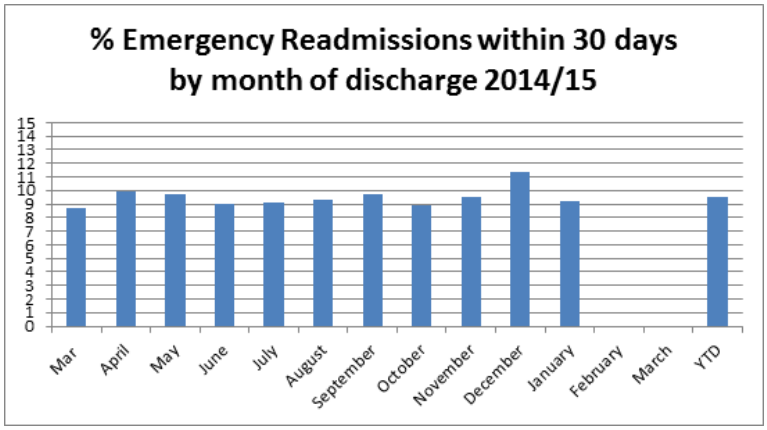
- The patient focussed discharge process is being rolled out across the organisation with one to one training with every ward sister. This includes an amended "ticket home"; this will help reduce readmissions by ensuring a safe discharge with patients and their carers fully involved in the process. It is supported by the Integrated Discharge Team from the Local Authority, whose hours, roles and responsibilities have been extended.

- We have invested in additional surgeons to support an Emergency Surgeon presence on our Surgical Assessment Unit seven days a week to provide rapid assessment of potential admissions and where possible manage them safely without admission. Whilst these posts have been appointed the service will not commence until later in 2015.

- We continue to audit a sample of 30 readmissions each month as surveillance for potentially avoidable admissions. We identify why the patient needs admission on that day, for example the commonest findings are a requirement for an IV infusion, and new ECG changes. We did find around 10% are inappropriate each month; this reduced over November and December and so it may be that whilst the readmission rate has not reduced in year the potentially

avoidable readmissions have:





6. Reduce the hospital standardised mortality rate (HSMR)

The target is for the HSMR to reduce by at least 10 points over the year from the rebased position (2013/14).

Lead: Dr Evan Moore, Medical Director

We have largely continued with the initiatives which have delivered success in recent years, for example the Clinical Divisions undertake mortality reviews of patients who have died, and take action to deal with common themes arising from these reviews. We are able to analyse data to a high level of detail and we investigate services, specialties, diagnoses or procedures whose HSMR is rising. During the year it was apparent that the level of risk-adjusted mortality in our hospitals was higher at weekends than during the week; this remains the case but it has reduced to the point that it is within the nationally expected statistical range.

New actions taken during the year include:

- Participating in a Mortality Network Collaborative project with the Advancing Quality Alliance, which aims to improve the care of patients with sepsis, which is the single most

common cause of death in intensive care units in the UK
- Taking part in another collaborative project, aimed at early identification of patients who are approaching the end of life so that their needs can be met, and their symptoms better controlled.

3.2 External reviews

During the year the Trust has had a number of external reviews of its services, examples of which are set out below.

National Peer Review for Trauma

The National Peer Review for Trauma and the Network Trauma Unit reaccreditation took place during January 2015. Although we have not yet received the official report, a feedback session took place at the end of the visit and the comments made were very positive.

The first observation that was of great importance to us and the review team, was the commitment of the organisation as a whole to the care of trauma patients, which was demonstrated by the presence and support from various teams during the review process.

The review team also identified various other areas of good practice which they thought were commendable and as such should be shared throughout the network. In summary they were:

- the injury prevention programme
- the trauma team activation protocol
- the role and commitment of the Trauma Coordinator
- excellent Radiology services in particular the enhanced 8 – 8 service, weekend cover, CT hotline and the MR service
- the trauma documentation
- the commitment of the therapy services including completion of the rehabilitation prescription

Although the review team identified the need to commission additional rehabilitation beds in the network, it is important to note that the team found no areas of concern that related to the Hospital or any of our teams.

Endoscopy

Our Endoscopy Unit has recently been awarded Joint Advisory Group (JAG) accredited status for the first time. JAG accreditation provides formal recognition that the service has demonstrated that it has the competence to deliver against best practice endoscopy standards and provide a high quality service.

Over the past 12 months there has been a sustained effort to ensure the Unit can demonstrate and evidence achievement of numerous key standards required for JAG accreditation. The service has striven to reduce and maintain short waiting times for endoscopy and now patients referred to the unit will be seen within best practice waiting times (< 2weeks for urgent and <6 weeks for routine).

A significant factor in the successful bid for JAG accreditation was our £1.7 million investment into refurbishing, redesigning and expanding the Unit. This work ensures that quality and safety standards are met, specifically around increased procedure room and recovery area capacity, and improved single sex waiting areas.

JAG accreditation is of significant strategic importance as it is a requirement for developing and expanding other services. As a result of receiving JAG accreditation, the unit will now participate

from January 2015 as the local provider for Wirral patients in the national Bowel Scope Screening Programme.

Baby Friendly Accreditation
The Trust has recently received Baby Friendly accreditation at level 3 – the highest level possible. This is a global accreditation programme which encourages health services to improve the care provided for all mothers and babies. In the UK, the initiative works with the NHS and other public services to protect, promote, and support breastfeeding, and to strengthen mother-baby and family relationships.

Accreditation is given after a strict assessment takes place by a UNICEF team against best practice standards. It includes interviewing mothers about the care they have received and reviewing policies, guidance and internal audits.

3.3 Listening into Action

In 2014/15, we continued to implement Listening into Action (LiA) as a way of working as a Beacon Trust within the National Pioneers Programme, aiming to achieve a fundamental shift in the way we work and lead, putting clinicians and staff at the centre of change for the benefit of our patients, our staff and the Trust as a whole.

Our focus in 2014/15 was on improving quality and safety and patient experience, along with improvements that need to be made to enable staff to deliver the best possible care and service.

Some of the achievements through LiA in 2014/15 include:

- Held four excellent "Pass it On" Events in 2013 and 2014 where our LiA teams fed back to the Trust what they have achieved in response to what matters to staff and patients
- Introduced staff engagement through Listening into Action annual awards as part of the Trust annual awards programme
- £2.5 million major refurbishment of our A/E department
- Improved infection prevention through better facilities and promotion
- Speedier availability of take home medications and introduced "ticket home" process
- Reduction in length of stay from 12 to 5 days in the older peoples short stay unit
- Opened Older People's Assessment Unit to support patients back to the community
- Introduction of a breast cancer wellbeing and survivorship programme
- Introduction of core values and behaviours for all staff developed with staff and patients. These are now embedded into HR processes (recruitment, induction, appraisal and training)
- New, easier appraisal system and achieved 87% compliance
- Improved dementia care for patients through the introduction of a memories café and improved staff training
- Established a staff social group and held first staff talent show
- Introduced multi-professional ward leadership to improve performance now being rolled out following a successful pilot
- IT enabled healthcare – 4G connectivity achieved, community staff able to access electronic records, system enhancements and increased staff confidence
- Improved alcohol support service by working in partnership with primary care, police, housing and social services
- Streamlined the induction and Initial mandatory training programme for new recruits, getting them into the workplace quicker and putting 3000 hours back into front line care

- Improved patient experience through introduction of flexible visiting, standardised staff behaviours, tackling smoking and improved communications with relatives and carers
- Reduction in frequent readmissions through better discharge planning, improved standard operating procedures for board rounds and improved cross health economy working
- Introduction of better working across specialties in paediatrics and recruitment to specialist nursing posts
- Reduction in stress by 8% in 2014 through variety of health and wellbeing interventions
- Reduction in Grade 1 pressure ulcers from 7 to 4 as a result of standardization of practice, information and champions

The progress and outcomes of the Listening into Action is monitored regularly by the Listening into Action Sponsor Group chaired by the Chief Executive. We have now developed an integrated approach to culture and engagement through a strategic plan that brings together Listening into Action, National Staff Survey, Cultural Barometer and the Staff Friends and Family Test with comprehensive and integrated action planning and progress monitoring and assurance.

2014 saw the Trust achieve national recognition for staff engagement primarily through the excellent achievements made through Listening into Action by becoming winners of the prestigious Health Service Journal Award.

We have recently stepped away from Optimise Consultancy, having developed the foundations to work this way whilst still remaining part of the national LiA network. Given our challenges around finance, quality, safety and performance, we are clear that we need further culture change to transform our services and meet these important agendas. There is no greater time than now for staff to be engaged in service transformation and as such we are committed to continuing working closely with our staff to improve year on year in staff satisfaction, engagement and organisational performance so that we become the best we can be.

3.4 Local and National Quality Indicators

3.4.1 Locally used Indicators

The indicators in this section have been identified by the Board in consultation with stakeholders or are a national requirement and are monitored throughout the year.
In comparison to the published Quality Account for 2012/13 some of the indicator values have changed:

- HSMR updated to the year end position for 2012/13
- SHMI updated for the year end position for 2012/13
- Friends and Family test from national staff survey for 2012/13 refreshed to reflect CQC reported outcome.

Safety measures reported	2010/11	2011/12	2012/13	2013/14	2014/15
"Never events" that occurred in the Trust *These are a national list of 25 applicable incidents that should never occur (March 2010).*	0	1	2	3	5
Serious Incidents reported, investigated and remain serious (as of 31/03/2013)	94	88	96	69*	101
Reports made to the National Patient Safety Agency by the Trust and percentage of incidents reported that resulted in serious harm or death. (as of 31/03/2013)	8,280 0.1%	9,610 0.1%	13,120 0.2%	10,005 0.2%*	8957 0.4%*
National Patient Safety Agency *Rate of patient safety incidents (per 100 admissions) and % resulting in severe harm.* NB: Data released in 2013/14 relates to Oct – Mar 2012/13	7.8 <1%	9.7 <1%	12.6 <1%	11.9 <1%	Not yet available
Clinical outcome measures reported –					
Hospital Standardised Mortality Ratio (HSMR) - an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect *(Dr Foster data*) NB: Data for 2013/14 relates to Apr –Feb 2014.	102.8	108.4 (range 102.6 – 114.4)	105 (range 99 – 110)	85 range (80-90)	88
88Summary Hospital-Level Mortality Indicator *SHMI value and banding (National Information Centre data)* NB: Data released in 2013/14 relates to June 12-July 13 % of Admissions with palliative care coding % of Deaths with palliative care coding *(Dr Foster data)*		105.0 (range 89-112) Band = 2 as expected 0.59% 12.70%	107 (range 89 - 112) Band 2 as expected 0.94% 19.02%	104 (range 89 – 112) Band 2 as expected 1.0% 19.96%	101.4 (as expected) Xx% 27.7%
% of admitted patients risk assessed for VTE	45.6%	95.4%	95.0%	95.5%	94.1%
% of admitted patients who had risk assessment for malnutrition (MUST)			82.4%	86.15%	Data awaited

Clinical outcome measures reported	2010/11	2011/12	2012/13	2013/14	2014/15
% Emergency Readmissions within 28 days *(Dr Foster data)* NB: Data for 2013/14 relates to Apr -Nov 2013 admissions.		7.7%	8.0%	9.0%	Data awaited
Average length of stay (days) *(Dr Foster data)* NB: Data for 2013/14 relates to Apr -Feb 2014.		4.4	4.6	4.5	Data awaited
Patient experience measures reported -					
Number of complaints received by the Trust	401	422	515	482	412 (to end of Feb)
% complaints responded to within agreed timescale	80%	59%	38%	69.6%	84% (to end of Feb)
% patients who felt they were treated with courtesy and respect (from Learning with Patients survey) **NB dignity replaced by courtesy in 2013/14**	98%	99%	98%	95%	Data awaited
Responsiveness to inpatients personal needs (from National Patient Survey)	65.1%	67.4%	71.2%	67.2%	68.0%
Staff respondents who would recommend the Trust to friends or family needing care (from National Staff Survey: CQC)		58%	58%	60%	52%

Table 8 Local and National Quality Indicators
NB* this figure correct as of 4th April 2014 but may change as investigations are completed.

Never events
It is of great concern that the Trust has reported five never events reported during this financial year; and of greater concern is that similar incidents have been reported before.

The details of these incidents are as follows:

1. Reported August 2014: Unexpected Death of Inpatient (not in receipt) (NEVER EVENT: Misplaced Naso-gastric tubes)

The RCA has been completed for this incident and concluded that the Nasogastric feeding tube pathway was not being implemented and no audits are undertaken regarding compliance with the pathway. An internal alert was sent to all Medical staff with an action to read the policy and to respond stating that they had done so. The action for this alert is still ongoing to date.

2. Reported September 2014: 2 X Surgical Error (NEVER EVENT: Wrong prosthesis -Knee)

These both related to patients undergoing a right total knee replacement with an incorrect sided implant being implanted. A left sided implant was used instead of a right sided. The root cause of this incident was lack of a standardised process. This then led to either:
i. The surgeon calling out the incorrect laterality
ii. The runner retrieving the incorrectly sided implant from the trolley

A further root cause of this incident that was considered as part of the investigation was the possibility that the manufacturer had packaged a batch of implants incorrectly, however the MHRA have now responded stating that the manufacturer had reviewed the device history records which were found conforming to requirements at the time of manufacture. A product history search identified no other complaints for the specified part and lot combination. Surgical notes were not provided. X-rays were

not provided. Package labelling for this lot was reviewed and clearly indicates that this is a left femoral component. Both of these incidents were identified during routine inputting in to the National Joint Registry (NJR) Database. It was also observed that there was a delay in reporting these incidents due to miscommunication and there being no formal process of escalation for occasions where inconsistencies were identified by the NJR.

Reported December 2014: Surgical Error (NEVER EVENT: retained needle)
This Never Event related to a Retained needle in Gynaecology theatre. The RCA has been completed for this incident and concluded that following an uncomplicated robotic laparoscopic hysterectomy staff failed to identify that a needle/suture had been left within the abdominal cavity. This resulted in the patient having an abdominal x-ray and return to theatre for the removal of the retained needle/suture. This incident seems to have occurred due to staff failing to visually check the grasper on removal from the ports and the timing and order of the instrument/needle/swab count. The RCA panel identified a number of factors that affected the performance of staff during the procedure these included issues regarding communication within the team and the pressure created by meeting the demands of a heavy theatre list within the planned time frame.

Reported January 2015: Surgical Error (NEVER EVENT - Retained Swab)
This Never Event related to a small radio opaque swab being left within the vagina following a perineal repair which was identified 7 weeks postnatal. The swab count at the time of the perineal repair was flawed and documentation did not follow unit guidelines.
The RCA Panel acknowledged that the patient experienced undue additional symptoms and treatment as result of this error. However, it is unlikely that this incident will result in any long term implications to the patient.

The findings of all Never Event RCAs are shared at the Trust wide Clinical Governance Group (TWCGT) and have been distributed to all Divisions for learning.

Serious Incidents
The number of incidents which have been investigated and remained as serious has increased since the last financial year.

During the period 1st April 2014 to 28th February 2015 there were a total of 101 serious incidents which were completed and have remained at a serious risk rating following investigation. These RCAs have been examined to identify the key learning points which have been investigated following these incidents to prevent recurrence.

National Patient Safety Agency (NPSA)
The number of incidents reported to the NPSA via National Reporting and Learning System (NRLS) has reduced in the last financial year. There are two factors which have contributed to this; firstly incident reporting in the Trust overall has declined in the last financial year due to the implementation of web incident reporting and difficulties within the divisions with the uptake of the new system. In addition when incidents are reported on the web incident system these incidents are not submitted to NRLS until a web managers form has been completed, currently there is a Trustwide issue with the time taken for incidents to be managed on the web system; thus there has been a delay in the reporting of clinical incidents to NRLS.
This dialogue still remains.

The monthly point prevalence medicines near miss reporting days ceased during Q2 2014/15 and as a result the overall medication incident numbers reported have decreased. There was also a large

decrease seen in 'Dispensing in a Pharmacy' incidents explained by the change to the categorisation of the Pharmacy Robot incidents, which are now only reported as one incident per day with the number of times the robot fails included on the form.

Mortality
Our mortality continues to improve (see section 3.1). The SHMI is reducing at a similar rate to HSMR; however, reporting lags six months behind HSMR.

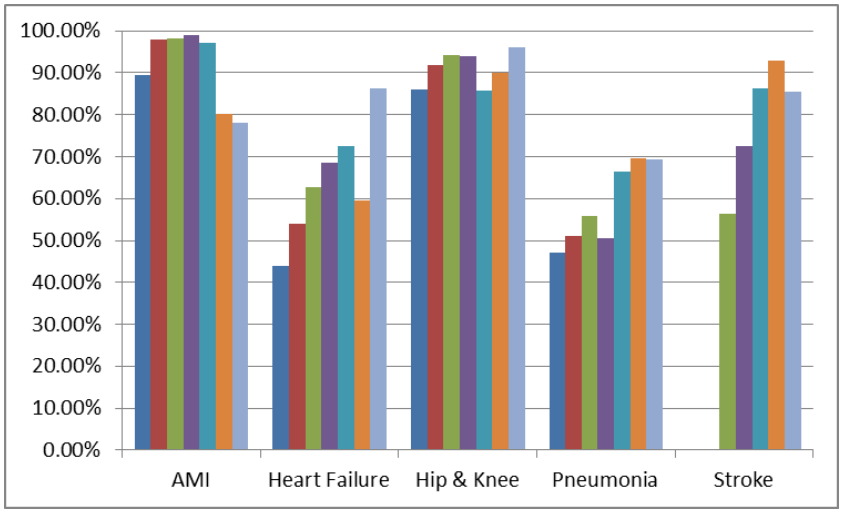
Complaints
In previous years, complaints handling was one of the priorities for improvement in the Quality Account. We comprehensively overhauled our process for handling concerns and complaints and this work has borne fruit, with a reduction in the number of formal complaints, and a greater proportion of complaints concluded within agreed timescales.

3.4.2 Advancing Quality

Advancing quality is about ensuring consistent evidence based care in specific focus areas. The table below shows our current position based on the appropriate care score. Appropriate care scores reflect the care given to individual patients. If the score was 100% then everyone received perfect care as defined by the focus area measures. Often we find there is one intervention in the measure set we are struggling to deliver consistently, for example smoking cessation advice to smokers with pneumonia or referring patients with a heart attack to cardiac rehabilitation before they leave hospital.

During Year 6, some indicators were added for patients with heart failure, hip & knee replacement and heart attacks; these changes led to a reduction in performance in some areas as we adjusted our systems to ensure consistent care. However, we have improved in most areas during the current year. From 2015, some new areas have been introduced and these will be reported in the next Quality Account.

		Appropriate Care Score (ACS)				
		Heart Attacks	Heart Failure	Hip & Knee	Pneumonia	Stroke
Y1	Oct 08 - Sept 09	89.46%	43.97%	86.09%	47.13%	
Y2	Oct 09- March 10	97.79%	53.89%	91.87%	51.20%	
Y3	April 10 - March 11	98.23%	62.72%	94.16%	55.74%	56.43%
Y4	April 11 - March 12	99.04%	68.41%	93.92%	50.62%	72.43%
Y5	April 12- March13	97.22%	72.57%	85.66%	66.39%	86.38%
Y6	April 13 - Mar 2014	80.12%	59.57%	90.02%	69.63%	92.90%
Y7	April 14 - Nov 14 *Final data to be added after end of financial year*	78.12%	86.20%	96.00%	69.20%	85.50%



3.4.3 Reducing Hospital Acquired Infection

The Trust has continued to follow a proactive focussed improvement programme to reduce hospital acquired infections. The key actions undertaken this year to prevent hospital acquired infections have been:

- The Hydrogen Peroxide Vaporiser (HPV) programme has continued, although a shortage of equipment to decontaminate the wards caused delays at certain points in the year.
- An Infection Prevention Steering Group has been established in the Trust. This is overseeing two separate workstreams: facilities and services; which focuses heavily on cleaning; and 'detect and isolate' which focuses on working practices in the clinical areas and the Infection Control team.
- A new strain of resistant organism known as Carbapenemase Producing Enterobacteriaceae (CPE) started to be identified in the Trust during 2013/14 and we have experienced 72 confirmed cases during 2014/15 *(note – data to end of January only)*. We have been using molecular testing to achieve rapid detection of CPE; this has had a positive impact in improving diagnostic accuracy, the quality of epidemiological information, and reducing the time of measures during the quarantine period.
- We have continued to undertake Root Cause Analysis or post infection reviews following cases of MRSA and Clostridium Difficile respectively. These have identified learning points about a range of issues which can contribute to healthcare-acquired infections such as cleaning regimes, staffing issues, ineffective auditing of clinical practice, failure to isolate patients with diarrhoea quickly enough, and delays in discharging patients.
- Ward 11 has been compartmentalised to allow patients with CPE or Vancomycin Resistant Enterococcus to be cohorted (accommodated separately to prevent transmission to other patients). This should also have the effect of making more side rooms available for patients suffering from MRSA.

Period	MRSA Bacteraemia Cases	Target	Clostridium difficile cases	Target
2009/10	8	18*	187	260
2010/11	5	6	120	190

2011/12	1	5	68	120
2012/13	2	0	27	50
2013/14	2	0	28	33
2014/15	3	0	24 (to end of January)	24

Table 9 Infection Control Maximum Targets for MRSA and Clostridium difficile cases

Whilst aiming to remain focussed in leading proactive strategies to reduce hospital acquired infection, this has been a challenging year. We have experienced three cases of MRSA, against a target of nil, and 24 cases of Clostridium difficile. It should be noted that these figures for C-Diff, which are those reported internally, are higher than those reported externally to Monitor, which are shown in the 'performance against national targets' section of this report. This is because Monitor only require us to report those cases which are clearly the result of deficient care being provided in the hospital.

In order to meet the challenge, we will need to take forward a number of actions including: ensuring that the Infection Prevention and Control team is fully staffed; developing information technology systems to support the team in its work; introducing permanent rapid detection using the Cepheid platform; and making available a permanent cohort / isolation area with fixed, appropriate staffing levels. We are also stressing the role of nursing staff at the front line, and the Associate Directors of Nursing have been asked to provide regular assurance that hand hygiene audits are being completed in their areas.

Period	Tolerance for 2013/14	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
MRSA Bacteraemia Cases	0	0	0	0	0	0	1	0	1	1	0		
C Difficile cases	24	4	3	0	3	1	3	0	4	0	6		

Table 10: Hospital Acquired Infections reported in 2013/14

3.4.4 National Targets

The Trust's performance against the national targets has generally been strong, although we missed the referral to treatment time of 18 weeks for admitted patients in quarters 2 and 3, and we have failed the target for a maximum four-hour wait in Accident and Emergency in all three quarters.

National targets and regulatory requirements	Target	Q1	Q2	Q3	Q4
Referral to treatment time within 18 weeks – admitted patients	Min 90%	92.8%	88.8%	89.1%	*Not yet available*
Referral to treatment time within 18 weeks – non-admitted patients	Min 95%	97.3%	94.5%	95.4%	
Referral to treatment time within 18 weeks – incomplete pathways	Min 92%	94.7%	93.9%	94.8%	
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	Min 95%	91.2%	94.0%	92.2%	

Maximum waiting time of 62 days from urgent referral to treatment for all cancers	Min 85%	86.2%	85.3%	85.1%	
Maximum waiting time of 62 days from NHS Screening referral to treatment	Min 90%	93.8%	96.0%	100%	
Maximum waiting time of 31 days from decision to treat to start of subsequent treatment for cancer – surgery	Min 94%	97.1%	94.5%	94.1%	
Maximum waiting time of 31 days from decision to treat to start of subsequent treatment for cancer – drug treatment	Min 98%	100%	100%	100%	
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	Min 96%	97%	97.8%	96.9%	
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	Min 93%	96.8%	96.1%	94.1%	
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all breast symptom referrals	Min 93%	94.7%	96.1%	95.6%	
Clostridium Difficile cases due to a lapse in care (cumulative)	Max 24 pa	7	11	12	

Table 11 National targets and regulatory requirements

3.4.5 Core Indicators

The Health and Social Care Information Centre provides comparative benchmarking for organisations against a range of indicators. These data are not always as timely as other data reported from local sources, and may not refer to this financial year. However, it does provide some information about how the Trust has performed relative to other organisations as it compared WUTH's position with the national average, as well as the lowest and highest indicator values nationally.

Summary Hospital Mortality Indicator

The SHMI is "as expected" for the Trust for both data sets:

	April 2012 – March 2013				April 2013 – March 2014			
	National Average	**WUTH**	**Low**	**High**	**National Average**	**WUTH**	**Low**	**High**
SHMI	1.0	1.07 (as expected)	0.65	1.16	1.0	1.014 (as expected)	0.53	1.19
% Deaths coded for palliative care	19.9%	19.0%	0.2%	43.3%	23.6%	27.7%	6.4%	48.5%

Table 11: Summary Hospital Mortality Indicator

The Trust considers that this data is as described for the following reason – the data are historic and the Trust recognised the mortality indicators were higher than we would want although. We were also aware the coding for co morbidities and palliative care was not reflecting the population; this has now been rectified following a review of the clinical coding process.

The Trust has taken steps to improve this score as described in the priority area "reducing HSMR" above.

Patient Reported Outcome Measures

Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys. The data have been collected since 2009. The adjusted average health gain looks at how much better patients' health is after their surgery than before; therefore the higher the figure the better the result.

	April 2013 – March 2014				April 2014 - September 2014 *Full year data available after end of financial year*			
	National Average	**WUTH**	**Low**	**High**	**National Average**	**WUTH**	**Low**	**High**
Groin Hernia Surgery	0.085	0.063	0.008	0.139	0.081	0.009	0.009	0.125
Hip replacement surgery	0.436	0.391	0.342	0.545	0.442	*	0.35	0.501
Knee replacement surgery	0.323	0.382	0.215	0.416	0.328	0.383	0.249	0.394
Varicose Vein Surgery	0.093	0.074	0.023	0.15	0.100	*	0.054	0.142

Table 12 Patient Reported Outcome Measures
**Casemix-adjusted figures not calculated where there are fewer than 30 modelled records*

The Trust considers that these data are as described for the following reason – the data are historic and the Trust works to ensure patients receive effective care that enhances their experience.

The Trust has taken steps to improve this score by ensuring the care given is patient centred. Work is ongoing to improve the response rates.

Readmissions within 28 days

	April 2010 – March 2011				April 2011 – March 2012			
	National Average	**WUTH**	**Low**	**High**	**National Average**	**WUTH**	**Low**	**High**
Readmissions (aged 0 – 15)	10.15	13.91	3.53	25.8	10.1	13.60	6.4	14.94
Readmissions (16 and over)	11.42	12.47	2.38	22.93	11.45	11.75	9.34	13.8

Table 13 Readmissions within 28 days

The Trust considers that this data is as described for the following reason – the data are historic and the trust needs to consolidate work to reduce emergency readmissions to effect a change. The most recent data available from the Health and Social Care Information Centre is from the year ended 31st March 2012.

The Trust is taking steps to reduce this percentage. This was a priority area in the Quality Account this year and has been carried forward to 2015/16. The section of this report which reviews performance

against our six priorities provides information about the measures which we have taken and which are still underway.

Trust's responsiveness to the personal needs of its patients

Responsiveness to personal needs is a high-level indicator bringing together patients responses from the national inpatient surveys. The 2013/14 survey showed a slight decline in performance, moving from being slightly above the national average the year before, to very slightly below.

	April 2012 – March 2013				April 2013 – March 2014			
	National Average	WUTH	Low	High	National Average	WUTH	Low	High
Responsiveness to personal needs (indicator value)	68.1	71.2	57.4	84.4	68.7	68	54.4	84.2

Table 14 Trust's responsiveness to the personal needs of its patients

The Trust considers that this data is as described for the following reason – the data are historic and the trust has been working to improve this score through our Learning with Patients survey which provides more timely information for actions to take place. The introduction of intentional rounding during this period is likely to have had an impact.

The Trust has taken steps to improve this score through work on a number of initiatives developed by the divisions in response to their local patient survey results. These vary by division. At a corporate level, the "fifteen steps" programme enables additional intelligence to be captured and support change as well as the use of patient stories at our Board and high-level committee meetings to provide a patient focus. Also, some new initiatives have been introduced during 2014/15, such as weekly spot checks by Matrons on the wards in their areas, and patient focused rounding, which involves nurses maintaining regular communication with their patients so they can be more proactive in meeting their individual needs.

Recommend the Trust to Family and Friends

	Staff Survey 2013				Staff Survey 2014			
	National Average	WUTH (no's/rate per 100 patient admissions)	Low	High	National Average	WUTH (no's/rate per 100 patient admissions)	Low	High
Agree/Strongly Agree (%)	67.1	59.85	39.5	93.9	67	52	20	93

Table 15 Recommend the Trust to Family and Friends

The Trust considers that this rate is as described for the following reason – the past year has been a challenging one for our organisation, which has experienced high levels of demand, staffing pressures, and a restructuring process which was necessitated by our adverse financial position.
The Trust has taken steps to improve this score by reinforcing existing measures, such as educating

staff about the importance of a high return rate, using the LiA initiative to ensure staff are able to articulate the changes needed locally to provide better care, listening to their concerns and acting on them. In 2014/15 we have also raised awareness among staff through our regular e-mail bulletins, the Chief Executive's Forum, and risk management training, about how they can raise their own concerns about poor care through our own internal channels. We have undertaken a cultural barometer survey using the Organisational Cultural Inventory questionnaire (this was one of our CQUIN targets for the year) and have drafted a Culture and Engagement Plan covering the three years from 2015 to 2018.

VTE assessment – Based on acute trusts

The Trust continues to perform slightly lower than the national average, and there is a slight downward trend in performance.

	Quarter 1 2014/15				Quarter 2 2014/15			
	National Average	WUTH	Low	High	National Average	WUTH	Low	High
Compliance (%)	96	95.4	87.2	100	96	94.10	86.4	100

Table 16 VTE assessment – based on acute trusts

The Trust considers that this percentage is as described for the following reason – our performance is broadly consistent and, although falling short of the target, reflects the considerable effort which has been put into raising awareness of how to prevent and manage this disease. Our new electronic patient record alerts doctors of the need to assess individual patients in a different way to its predecessor, and a lack of familiarity with the new system may temporarily depress the level of compliance.

The Trust has taken steps to improve this score by reviewing our corporate policy for the prevention and management of VTE disease and reviewing our training package, with a particular focus on the importance of completing assessments on admission.

C.difficile rates

The Trust has seen an increase in its C-Difficile infection rate, although our performance remains better than the national average:

	April 2012 – March 2013				April 2013 – March 2014			
	National Average	WUTH	Low	High	National Average	WUTH	Low	High
C.difficile (rate per 100,000 bed days)	17.3	9.6	0.0	30.8	14.7	11.3	0	37.1

Table 17 C.difficile rates

The Trust considers that this rate is as described for the following reason: *to be confirmed*
The Trust has taken steps to improve this score by: *to be confirmed*

Patient Safety Incidents Reported, based on large acute trusts

We also actively encourage automated electronic reporting in some areas to ensure better coverage of incidents and support monitoring the impact of our safety work:

	April 2013 – September 2013				October 2013 – March 2014			
	National Average	**WUTH (no's/rate per 100 patient admissions)**	**Low**	**High**	**National Average**	**WUTH (no's/rate per 100 patient admissions)**	**Low**	**High**
Patient Safety Incidents	4,346	5,118 (10)	1,967	7,757	4,461	4,664 (9.1)	787	8,015
	The Trust reported 7 incidents that resulted in severe harm or death				The Trust reported 11 incidents that resulted in severe harm or death			

Table 18 Patient Safety Incidents Reported, based on large acute trusts

The Trust considers that this rate is as described for the following reason - the Trust continues to have higher than average levels of incident reporting. This is associated with low levels of harm and NPSA consider this to be a sign of an open culture. These data are historic. Whilst the national picture is of increased reporting between the periods, the Trust has reduced reporting. It is difficult to understand the reason; in part we would assume it is safer care, however during this period we introduced web based reporting and have noted a reduction in reporting as the new system embeds.

The Trust has taken steps to improve this score by educating staff about the importance of reporting incidents, and providing additional support and education with the roll out of web based reporting. Incidents leading to severe harm and death and of great concern; a full root cause analysis is undertaken and actions to ensure this does not recur are monitored to completion through our risk systems. Lessons learnt are shared across divisions and departments as appropriate. During 2014/15 we introduced a new form of initial investigation of incidents that appear to be serious - the SBAR (Situation Background Assessment Recommendation). This should be completed within three days of the incident being reported; if the incident remains serious following this initial stage, we complete an RCA. We have also relaunched the Level 2 Risk Management Training for senior clinicians and managers, and in 2015 we are launching a new Risk Management Strategy.

Annex: Statements from Third Parties

Statement from Wirral Clinical Commissioning Group

To be provided at a later date

WIRRAL

Statement from Wirral Metropolitan Borough Council

To be provided at a later date

To be provided at a later date

Glossary for Quality Account

Abbreviation / term	Definition
AKI	Acute Kidney Injury
AQ	Advancing Quality
Appropriate Care Score	A patient in the Advancing Quality Programme receives all the interventions they are entitled to.
CAUTI	Catheter Associated Urinary Tract Infection
CCG	Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease – chronic lung disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
Composite scores	Calculation derived from data in multiple variables in order to form reliable and valid measures
CPE	Carbapenemase Producing Enterobacteriaceae – new strain of resistant organism
DASS	Department of Adult Social Services
DME	Department of Medicine for the Elderly
ECIST	Emergency Care Intensive Support Team
EAU	Emergency Assessment Unit
ERP	Enhanced Recovery Programme
FCE	Finished Consultant Episode
FFT	Friends and Family Test – a question contained within the national inpatient and staff survey
HPV	Hydrogen Peroxide Vaporiser
HES	Hospital Episode Statistics
HSMR	Hospital Standardised Mortality Rate
LWPQ	Learning with Patients Questionnaire – an internal patient survey
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries
MEWS	Medical Emergency Warning Score
MUST	Malnutrition Universal Screening assessment Tool
MRSA	Meticillin Resistant Staphylococcus Aureus – bacteraemia; this is a blood stream infection
NCEPOD	National Enquiry into Patient Outcome and Death
NHSLA	NHS Litigation Authority
NICE	National Institute of Clinical Excellence
NIHR	National Institute of Health Research
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning System
OPRA	Older Persons Rapid Assessment
PEAT	Patient Environment Action Team
ROP	Retinopathy of Prematurity
RTT	Referral to Treatment – time taken from referral to treatment
Safety Express	Safety Express is a single programme which focuses on system re-design of fundamental care processes and behaviours.
SDIP	Service Development and Improvement Programme – contractual obligation to improve care in a given area. These may be national or locally defined.
SHMI	Summary Hospital-Level Mortality Indicator – a measure of death within 30 days of discharge form hospital; not adjusted for palliative care
SSKIN	SSKIN is a five step model for pressure ulcer prevention. **Surface**: make sure patients have the right support. **Skin inspection**: early inspection means early detection. **Keep** patients moving. **Incontinence/moisture**: patients need to be clean and dry. **Nutrition/**hydration: help patients have the right diet and plenty of fluids
TARN	Trauma Audit Research Network
VRE	Vancomycin Resistant Enterococci
VTE	Venous Thrombo-Embolism or blood clot in the vein
WUTH	Wirral University Teaching Hospital

Appendix 1

Services Provided by the Trust

CLINICAL SUPPORT DIVISION (11)

Pathology	Radiology
Bed Management	Therapies
Integrated Discharge Team	Theatres and Anaesthetics
Hotel Services	Sterile Services
Cancer Pathway Management	Pain Management
Booking and Outpatients	

ACUTE AND MEDICAL SPECIALTIES DIVISION (15)

Emergency Department	Respiratory
Acute Medicine	Rheumatology
Critical Care	Haematology
Department of Medicine for the Elderly	Endoscopy
Cardiology	Sexual Health
Gastroenterology	Stroke
Diabetes	Rehabilitation
Nephrology	

SURGICAL AND WOMEN'S AND CHILDREN'S DIVISION (17)

Surgical Elective Admissions Lounge	Maxillofacial
Pre-operative Assessment	Dermatology
Surgical Assessment	Park Suite
Surgical Day Case	Trauma and Orthopaedics
Colorectal	Paediatrics
Limb Centre	Obstetrics and Maternity Services
Upper Gastro-intestinal	Gynaecology
Urology	
Ear, Nose and Throat	
Ophthalmology	

CORPORATE SERVICES (25)

Corporate Governance and Foundation Trust Membership Office	Information Technology
Finance and Procurement	Informatics
Clinical Coding	Information Governance
Programme Management Office	Medical Records
Quality and Safety	Equipment Services
Corporate Nurse Management (including End of Life Care)	Switchboard
Chaplaincy	Strategy and Partnerships
Bereavement Office	Communications
Infection Prevention and Control	Human Resources
Complaints and Patient Experience	Education and Training
Safeguarding	Occupational Health
Pharmacy	Health and Safety
Estates	

Appendix 2

National Clinical Audits Participation

	Name of Audit/Confidential Enquiry	Data collection 2014/15	Participation Yes/No Number Participation %	Report received and reviewed (Y/N)	Actions taken and comments
1	Bowel cancer (NBOCAP)	Yes	Yes	Yes (2013 data)	Report published 15 December 2014 – 2013 data. Figures are at 96% for data completeness. Figures are lower than national figures for laparoscopic surgery. This has been addressed in the colorectal cancer MDT work programme - MDT discussion to formally include suitability for laparoscopic/robotic surgery & all patients meeting criteria to be offered access to a surgeon appropriately trained in laparoscopic / robotic colorectal surgery
2	Elective surgery (National PROMs Programme)	Yes	Yes 680 81% (all procedures – latest report covering April 14 – Sept 14)	Yes	Provisional report published February 2015. Participation rate is lower for Groin Hernia and Varicose Vein surgery. Forms are now given out by pre op nurses with the aim of improving the participation rate.
3	Head and neck oncology (DAHNO)	Yes	Yes	Yes (2012 – 13 data). Not reviewed.	Annual Report due June 2015.
4	National Joint Registry (NJR)	Yes	Yes 1370 98%	Yes (2013 data)	Annual Report due October 2015. Previous report showed that consent rates for inclusion in the audit were below 80%. This has been followed up with local audit and consent for participation in the audit is now taken in Joint School which has made a dramatic improvement in consent rates. Other areas demonstrated compliance.

5	National emergency laparotomy audit (NELA)	Yes	Yes	Organisational audit report received. First patient data audit report due June 2015	Emergency surgeons and designated anaesthetists will lead on the development of new protocols and pathways as recommended by the NELA when the new speciality is operational.
6	Oesophago-gastric cancer (NAOGC)	Yes	Yes	Yes (2011 – 2013 data)	Action plan is led by regional specialist centre – Aintree Hospital.
7	Prostate Cancer	Yes	Yes	Organisational audit report received. First patient data report due October 2015	Organisational audit report received. All key facilities recommended are offered on site or on referral.
8	Fitting child (care in emergency departments)	Yes	50 (100%)	No	Report not available until summer 2015
9	Mental health (care in emergency departments)	Yes	40 (100%)	No	Report not available until summer 2015
10	Older people (care in emergency departments)	Yes	50 (100%)	No	Report not available until summer 2015
11	Severe trauma (Trauma Audit & Research Network, TARN)	Yes	Awaiting verification	Sent quarterly	Continuing to improve data (98.9%). Case study folder – discussed at CG/Trauma mtgs
12	Renal replacement therapy (Renal Registry)	Yes	Awaiting verification	Awaiting verification	Last report 2014 published with 2013 data
13	Sentinel Stroke National Audit Programme (SSNAP)*	Yes	100%	Awaiting verification	Report due October 15
14	National COPD Audit (BTS)	Yes	Awaiting verification	Awaiting verification	Jan - May 2014 (data entry) Site level report Nov 14, May 15
15	Inflammatory bowel disease (IBD) programme	Yes	Awaiting verification	Awaiting verification	2013 data in June 2014 report available. Due to restart Sept 14 - Feb 16
16	Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	Awaiting verification	Awaiting verification	Report due May 15. NHFD ongoing. National Audit of Falls & Bone Health (In-patient Audit)due to re-commence May 15

17	National Clinical Audit of Rheumatoid and Early Inflammatory Arthritis	Yes	Awaiting verification	Awaiting verification	Audit ongoing until 2018
18	National Heart Failure Audit	Yes	Awaiting verification	Awaiting verification	Last report Nov 13
19	Coronary angioplasty (PCI)	Yes	Awaiting verification	Awaiting verification	2012 data published Jan 2014
20	Cardiac Rhythm Management (CRM)	Yes	Awaiting verification	Awaiting verification	Last Report published Feb 14
21	Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	Awaiting verification	Awaiting verification	2013-14 data report December 14
22	National Lung Cancer Audit	Yes	Awaiting verification	Awaiting verification	2013 data published December 14
23	Diabetes (Adult), includes National Diabetes Inpatient Audit (NADIA), diabetes care in pregnancy, diabetes footcare*	Yes	Awaiting verification	Awaiting verification	2013 report published June 14
24	Pleural Procedures Audit	Awaiting verification	Awaiting verification	Awaiting verification	Data collected June-July 14 Greyed out on latest spreadsheet
25	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	Yes All deaths 100%	Yes	Triennial Report published in December 14 – the directorate is currently reviewing this document to determine current compliance against recommendations
26	Epilepsy 12 audit (Childhood Epilepsy)	Yes	Yes 18 100%	No	Unfortunately due to a miscommunication within the Epilepsy Team only half of the audit was completed. Therefore when the final report is published the division will be unable to compare themselves against the data.
27	Fitting child (care in emergency departments)	Awaiting verification	Awaiting verification	Awaiting verification	Awaiting verification
28	Neonatal intensive and special care (NNAP)	Yes	All NNU Admissions 100%	Yes	To be discussed and presented at April 15 audit meeting
29	Paediatric intensive care (PICANet)	N/A	No	Awaiting verification	Not applicable to WUTH only to Alder Hey Children's Hospital

Appendix 3

Statement of directors' responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2014 to June 2015
    - Papers relating to Quality reported to the Board over the period April 2014 to June 2015;
    - Feedback from the commissioners dated TBC
    - Feedback from governors dated February 2015
    - Feedback from local Healthwatch; dated TBC
    - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated June 2014;
    - The latest national patient survey (2014);
    - The latest national maternity survey (2013)
    - The latest national staff survey (2014);
    - The Head of Internal Audit's annual opinion over the trust's control environment dated TBC
    - CQC intelligent monitoring reports dated June and December 2014
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review;
- and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual)).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

Chairman
Date: TBC

Chief Executive
Date: TBC

Appendix 4

To be added following completion of audit

5 March 2015

Mr David Allison
Chief Executive
Wirral University Teaching Hospital NHS Foundation Trust
Arrowe Park Hospital
Arrowe Park Road
Upton
Wirral
CH49 5PE

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Dear David

Q3 2014/15 monitoring of NHS foundation trusts

Our analysis of your Q3 submissions is now complete. Based on this work, the Trust's current ratings are:

- Continuity of services risk rating - 2
- Governance risk rating - Under Review

These ratings will be published on Monitor's website later in March.

As outlined in our letter of 3 March 2015, Monitor is investigating the Trust for a potential breach of its provider licence following financial governance concerns arising from the Trust reporting a Continuity of Service Risk Rating of 2 and a lower than planned Q3 surplus. The Trust's governance risk rating will remain Under Review with a narrative stating "Monitor is investigating financial stability and governance concerns at the trust, triggered by a continuity of services risk rating of 2" until such time as Monitor has concluded its investigation and determined what if any regulatory action may be appropriate.

Upon conclusion of the investigation, should Monitor decide not to take formal enforcement action, the Trust's governance risk rating will revert to Green. Where Monitor decides to take formal enforcement action to address its concerns, the Trust's governance risk rating will be Red. In determining whether to take such action, Monitor will take into account as appropriate its published guidance on the licence and enforcement action including its Enforcement Guidance[1] and the Risk Assessment Framework[2].

The Trust has also failed to meet the A&E 4 hour wait target in Q3 for the fourth consecutive quarter. In addition, the Trust failed to achieve the 18 weeks Referral to Treatment (admitted and non-admitted) targets for Q3, which we understand is a planned breach agreed with commissioners.

[1] www.monitor-nhsft.gov.uk/node/2622
[2] www.monitor.gov.uk/raf

We expect the Trust to address the issues leading to the target failures and achieve sustainable compliance with the targets promptly. Monitor does not intend to take any further action at this stage in relation to these operational target failures, however should these issues not be addressed promptly and effectively, or should any other relevant circumstances arise, it will consider what if any further regulatory action may be appropriate.

A report on the FT sector aggregate performance from Q3 2014/15 is now available on our website[3] which I hope you will find of interest.

We have also issued a press release[4] setting out a summary of the key findings across the FT sector from the Q3 monitoring cycle

If you have any queries relating to the above, please contact me by telephone on 02037470352 or by email (Tania.Openshaw@monitor.gov.uk).

Yours sincerely

Tania Openshaw
Senior Regional Manager

cc: Mr Michael Carr, Chairman
Mr Alistair Mulvey, Director of Finance

[3] https://www.gov.uk/government/publications/nhs-foundation-trusts-quarterly-performance-report-quarter-3-201415
[4] https://www.gov.uk/government/news/nhs-foundation-trusts-tackle-rising-patient-demand

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF MEETING

25th FEBRUARY 2015

BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL

Present

David Allison	Chief Executive
Cathy Bond	Non-Executive Director
Michael Carr	Chairman
Jill Galvani	Director of Nursing and Midwifery
Sharon Gilligan	Director of Operations
Anthony Hassall	Director of Strategic & Organisational Development
Andrea Hodgson	Non-Executive Director
Graham Hollick	Non-Executive Director
Jeff Kozer	Non-Executive Director
Cathy Maddaford	Non-Executive Director
Evan Moore	Medical Director
Alistair Mulvey	Director of Finance
Jean Quinn	Non-Executive Director

Apologies
None

In attendance

Carole Self	Associate Director of Governance (minutes)
Mark Blakeman	Director of Infrastructure & Informatics

Governors
None

Members of the Public
None

Reference	Minute	Action
BM 14-15/181	**Apologies for Absence** None	
BM 14-15/182	**Declarations of Interest** None	
BM 14-15/183	**Patient's Story** The Director of Nursing and Midwifery presented two patient stories, the first reflected inconsistent care and although there were positive elements relating to nursing care and the discharge process, the overall outcome was that the patient would not recommend the Hospital as a place to receive treatment. The second story was taken from the NHS choices and related to the care on Ward 33 where the feedback was that there was no wait and nothing was too much trouble.	

Reference	Minute	Action
BM 14-15/184	**Chairman's Business** The Chairman updated the Board on the forthcoming full inspection by CQC which had now been set as the 14th September 2015. The Board was advised of the letter received from Monitor to all Trusts which outlined the recommendations of "Freedom to Speak Up", the review commissioned by the Secretary of State and chaired by Sir Robert Francis QC. The Chief Executive confirmed that this had been circulated to all Managers in the Trust encouraging people to speak out. The Chairman confirmed the appointment of two new consultants, these being Mr Rafik Ishak and Mrs Katharine Buckley for the new Department of Emergency Surgery. The Board was reminded of the next Council of Governors meeting on the 4th March at 2.00pm.	
BM 14-15/185	**Chief Executive's Report** The Chief Executive presented the report and highlighted the following areas: The interviews for the Accountable Officer position for Wirral CCG had concluded with the appointment of Mr Jon Develing who will take up his new position in May 2015. The Board was updated on the submission of the bid for the new Models of Care confirming that this had been well received with confirmation of those Trusts progressing to the next round being made in the next couple of days. The Chief Executive confirmed that a further call with Monitor was planned for 26 February 2015, the details of which would be provided to Board members. The Chief Executive confirmed that the Single Item Quality Surveillance Group provided a good opportunity for the health economy to gain an understanding of some of the issues facing the Trust as a result of the increased demand. The outcome included a range of actions for the health economy as a whole and those specifically for the Trust. A formal report is awaited. An overview of some of the partnership working with the Countess of Chester and Wirral Community Trust was provided, with the recognition that both these relationships were becoming more transactional than strategic in nature. The ongoing discussions with the Community Trust in relation to the use of Victoria Central Health Care were reported as good although further negotiation was progressing on the level of rental payable for St	

Reference	Minute	Action
	Catherines which was likely to be more difficult. The Chief Executive confirmed that a district valuation for the use of the site was being obtained. The Director of Nursing and Midwifery provided the Board with the latest position with regards to the pseudomonas outbreak which included the likely source of the outbreak and the actions being addressed to mitigate the risk in the short term. The medium term solution might involve the removal of some of the walls to address the issue of limited space. Further information and learning is being sought from other neonatal units in relation to addressing the issue of space. The Chief Executive advised the Board of aspects of the concerns raised by Public Health England in relation to infection control which had subsequently been responded to. The action plan developed received a favourable response from Public Health England with progress being monitored through the Quality and Safety Committee.	
BM 14-15/186	**Workforce and Organisational Development Strategy** The Director of Strategic and Organisational Development presented the paper and confirmed that the strategy drew together a number of workstreams linked to the overall strategic objectives. He outlined the four priorities for action which were as follows: • A healthy organisational culture • A sustainable workforce • A capable workforce • Effective leadership and Managers The Board debated key points of concern including education and training; the need for nurses and midwives to undertake revalidation similar to the medical workforce and the cascade of communication ensuring that the appropriate level in the organisation is identified that can give information holistically and with confidence. The Board approved the strategy and agreed to review the full action plan at its meeting in May 2015.	**AH**
BM14-15/187	**Staff Survey** The Director of Organisational and Strategic Development presented the results of the staff survey which had now been published. In view of the work undertaken as part of the Listening into Action initiative the Board expressed its real disappointment with the results. The Board was advised that the findings triangulated with the findings of the staff Friends and Family Test and the cultural barometer recently undertaken.	

Reference	Minute	Action
	The significant response rate and the reasons for the general deterioration in categories were debated by the Board. The Director of Strategic and Organisational Development confirmed that he had shared the outputs in a proactive way with Staffside. The Board agreed that it needed to concentrate on action to address the concerns and that the route for this would be through the work being undertaken as part of the Workforce and Organisational Development Strategy. A report on the specific action would be forthcoming.	
BM 14-15/188	**Integrated Performance Report** **Integrated Dashboard and Exception Reports** The Director of Infrastructure and Informatics presented the integrated performance dashboard and highlighted the key areas of performance which required improvement. The Director of Nursing and Midwifery confirmed that the focus of attention as a result of the friends and family test was on the contingency wards where there was an identified need to protect patients from the effects of how staff feel as a result of having to move to these areas. Ongoing work on improving the response rates was beginning to show results. The Director of Operations outlined the continued struggle in A & E with the levels of demand. She reported that the un-validated position to date was 85.67%. The Board was advised of the key issues associated with patient flow and GP referrals. It was reported that the Trust currently had 47 medically fit patients waiting to be discharged, which although better than other Trusts was still too many. The Director of Infrastructure and Informatics confirmed that the Trust had its 4th busiest day, the day prior to the Board, since the summer of 2014. There was recognition from the Area Team of NHS England that the Trust had had to open more escalation beds than anyone else. The Board debated the need for alternatives to GP admission, the work being undertaken strategically to identify solution and the need to reforecast as a health economy the A & E performance going forward. The Board suggested that the Chief Executive might write to Cllr Phil Davies outlining the concerns to ensure a wider discussion could be had on the issues in the health economy. The Board also agreed to receive an update on the Urgent Care Recovery Plan at its meeting in March 2015. The Board sought to understand how the demands on the hospital were impacting on stroke performance and received assurance that there was still a limited number of ring fenced beds for these patients. The Board requested that specific actions be included in the narrative supporting the performance in high risk area as opposed to a descriptor of the issue. The Board also asked that Executives consider key trends and be clear about incremental change which results in movement of RAG ratings to allow for better interpretation of slight movements.	**DA** **SG** **MB**

Reference	Minute	Action
BM 14-15/189	**Month 10 Finance Report** The Director of Finance presented the Month 10 position and highlighted the following: The planned income and expenditure position for Month 10 showed an actual surplus of £286k resulting in an adverse variance of £25k in month. The Board was reminded of the planned deficit at the end of month 11 and advised of the cumulative deficit of £4,930k representing an adverse variance against plan of £992k. The Director of Finance outlined the planned forecasts for each of the remaining months until the year end and reported that with the sale of Springview, the Trust was forecasting a year end deficit of £4.8M. He confirmed that the cash position remained strong and significantly above plan; the Cos Rating remained at 2 although slightly weaker than planned and the CIP programme was progressing as planned although the Trust's inability to close beds as a result of the demand was impacting on this. The Board was advised that £300K of reserves were used in month; the Trust was still running at £900K a month in deficit which it was working hard to address. The Board agreed that the latest out-turn forecast was now £4.8M or £5.5M if Springview was not sold by the year end.	
BM 14-15/190	**Francis Report: Hard Truths Commitment: Publishing of Nurse Staffing Data: January 2015** The Director of Nursing and Midwifery presented the nurse staffing paper confirming that the data was for January 2015. She reported that there continued to concerns with the provision of minimum staffing levels of registered nurses and outlined the actions being taken to mitigate these. The Board sought to understand how the investment of £1.1M into nurse staffing was reflected in the paper. The Director of Nursing and Midwifery clarified that it did not at this stage however it would be reflected in the next paper along with a progress update on recruitment. The Board was advised that the Acuity and Dependency Audit undertaken in January and February 2015 would be presented to the Quality and Safety Committee in March 2015. The Board noted the contents of the report.	
BM 14-15/191	**Report of the Audit Committee : 11 February 2015** Mrs Bond highlighted the review of standing financial instructions and the scheme of Delegation by the Committee in February and outlined the	

Reference	Minute	Action
	reasons for the work. She confirmed that the Committee was happy to recommend these to the Board for approval. The work undertaken to tender for External Auditors was outlined which included the role of Governors and the detail of the project plan to be presented to the Council of Governors on 4th March 2015. Mrs Bond provided an overview of the considerations and approvals made by the Committee in relation to not progressing with segmental reporting and secondly the rationale for not incorporating the charitable funds accounts in this year. The Board was updated on the Cerner Impairment Review and assured that the review process was strong in light of the external assessment, the Auditors assessment leading to the conclusion that there was no impairment necessary. Mrs Bond highlighted a number of issues resulting from a review of the risk process dashboard which included late reporting and outstanding risks which had been subsequently addressed. Mrs Bond concluded her report by explaining that MIAA had confirmed that the standing financial instructions and scheme of delegation were in line with best practice guidance.	
BM 14-15/192	**Review and Approval of Standing Orders, Standing Financial Instructions and Scheme of Delegation** The Associate Director of Governance presented the review of the standing financial instructions and scheme of delegation highlighting the key revisions as per the report. She reiterated Mrs Bond's earlier recommendation and subsequently asked the Board for its approval. The Board approved the revised documents.	
BM 14-15/193	**Board of Directors** **Minutes of the meeting dated 28th January 2015** The minutes of the meeting held on 28th January 2015 were agreed as a correct record of the meeting**.** **Board Action Log** The Board reviewed the action log and concluded that this provided an up to date view of progress.	
BM 14-15/194	**Items for BAF/Risk Register** The Board agreed to include two new risks: The risk of a Monitor investigation following the Q3 performance and the	**CS**

Reference	Minute	Action
	impact on the Trust's reputation and the confidence from staff and patients. The risk associated with the hosting changes planned for Cerner from the end of March 2015 to ensure that the appropriate business continuity arrangements are in place.	**MB**
BM 14-15/195	**Any Other Business** None	
BM 14-15/196	**Date and Time of Next Meeting** Wednesday 25 March 2015 at 9.00 a.m. in the Boardroom, Education Centre, Arrowe Park Hospital.	

……..……
Chairman

……..
Date

ACTION LOG
Board of Directors

Updated – 25 March 2015

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 25.02.15						
Feb 15	BM 14-15/186	Present the full action plan to support the Workforce and Organisational Development Strategy	AH		May 15	
Feb 15	BM 14-15/188	Write to Cllr Davies outlining the concerns relating to the problems with discharging medically fit patients in order that a wider discussion can be had	DA			
Feb 15	BM 14-15/188	Present an update of the urgent care recovery plan	SG		March 15	
Feb 15	BM 14-15/188	Ensure the integrated performance dashboard provides detailed actions for all high risks and consider how the Board might more easily interpret small incremental change to determine the level of risk	MB		March 15	
Feb 15	BM 14-15/194	Develop a risk of a Monitor investigation following Q3 performance and the impact on the Trust's reputation and the confidence of staff and patients	CS	**Completed**	March 15	

Feb 15	BM 14-15/194	Develop a risk associated with the hosting changes planned for Cerner from the end of March 2015 to ensure that the appropriate business continuity arrangements are in place	MB		March 15	
Date of Meeting 28.01.15						
Jan 15	BM 14-15/165	Review the changes to Corporate Governance agreed at the Board in January 15 in 6 months time	CS		June 15	
Date of Meeting 26.11.14						
Nov 14	BM/14-15/138	Include how outpatient nurses were being utilised during period of high demand in the next nurse staffing paper	JG		Jan 15	
Date of Meeting 29.10.14						
Oct - 14	BM14-15/114	Report against a trajectory of improvement in the future in relation to the Annual Plan	AH	**Ongoing**	Jan 15	
Oct - 14	BM14-15/121	Consideration to an Annual Research and Innovation Forum	EM			
Date of Meeting 24.09.14						
Sept - 14	BM 14-15/087	Board Walkabouts to include a review of Cerner post implementation	JG	**Board requested in February for the inclusion of patient safety questions**	Oct 14	**To be included as part of programme from Dec 2014**