Wirral University Teaching Hospital NHS
NHS Foundation Trust

Board of Directors Meeting

27 May 2015

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MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 27 MAY 2015
COMMENCING AT 9.00AM IN THE
BOARD ROOM
EDUCATION CENTRE, ARROWE PARK HOSPITAL

AGENDA

1.	**Apologies for Absence** Chairman	0900	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	0910	d
6. Performance and Improvement			
6.1	**Integrated Performance Report**	0930	
	6.1.1 Integrated Dashboard and Exception Reports Director of Infrastructure and Informatics		d
	6.1.2 Month 1 Finance Report Director of Finance		d
7. Quality			
7.1	**CQC Compliance** Medical Director	1015	d
7.2	**Risk Management Strategy** Medical Director		d
7.3	**Chair of Quality and Safety Committee Report** • **13 May 2015** Chair of the Quality & Safety Committee		d
8. Governance			
8.1	**Annual Report & Accounts 2014/2015, Annual Governance Statement and Quality Report** Director of Finance / Associate Director of Governance	1045	d
8.2	**Chair of Audit Committee Report 21 May 2015 including Annual Audit Committee Report** Chair of the Audit Committee	1115	d

8.3	**External Assessment** • **Board Declaration – General Condition G6** Associate Director of Governance	1125	d
8.4	**Health & Safety Annual Report** Director of Workforce	1135	d
8.5	**Board of Directors**	1140	d
	8.5.1 Minutes of the Previous Meeting • **29 April 2015 and 13 May 2015**		
	8.5.2 Board Action Log Associate Director of Governance		

9. Standing Items

9.1	**Items for BAF/Risk Register** Chairman	v
9.2	**Any Other Business** Chairman	v
9.3	**Date and Time of Next Meeting** **Wednesday 24 June 2015 at 9am**	v

Board of Directors	
Agenda Item	5
Title of Report	Chief Executive's Report
Date of Meeting	27 May 2015
Author	David Allison, Chief Executive
Accountable Executive	David Allison, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	1, 4, 5, 6, 7 1B, 4A, 5A, 6A, 7C 1908, 1909, 2328
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

Discussions with the CCG have been dominated by the 2015/16 contract negotiations and New Models of Care. Whilst the broad principles, as previously shared with and described to the Board of Directors are agreed, the application of these principles by the Trust and CCG varies such that the contract is yet to be finalised as the details are concluded. It is anticipated that these discussions will conclude by the end of May. The variation in

contract is driven through different assumptions on future volumes of activity (both unplanned and planned) and the potential for the Better Care Fund or QiPP schemes to reduce these volumes of activity, different assumptions on the future availability of Winter Pressure funding and the application of BCF resource into secondary care and planned improvements in recording of the care delivered to patients. Discussions continue to ensure gaps are closed between the organisations and risks identified managed and mitigated across the economy where possible.

Five Year Forward View – New Models of Care

The Executive Director of Strategic and Organisational Development has circulated to Board members feedback on the visit led by NHS England together with Monitor, the Trust Development Authority, CQC, Health Education England and Public Health England which took place on 5/6 May. The objective of the visit was to both gain a better understanding of our proposals but also to test the levels of collaboration across health economies and to enable those health economies to put on the table their 'asks' from the national bodies in relation to their proposals.

The format of the 2 days was largely dictated by the national team with the first morning being a session with the key health and social care leaders, the afternoon consisting of a series of workshops looking at issues like workforce, informatics, contracting models and engagement.

The second day was a multi stakeholder event with c100 attendees from different statutory organisations, intended to introduce and explore the outline model, followed by an afternoon feedback session.

The feedback on our proposals was as below -

- They sensed a clear enthusiasm, motivation at leadership level and delivery level. Opportunities to make difference quickly / challenging silos not preserving organisational forms.
- They gained a clear vision in respect of where want to be - whole system of care provision – health and care not just health.
- Our challenge is to articulate more clearly where we want to go from September 2015 to 2018. We need to lay out steps for change in order to get where we want to – a strong plan with clear milestones.
- We need to have a clearer picture on what cohorts of patients we want to 'start' with.
- Areas to work on are technology enablers / workforce change / social involvement / financial modelling – recognised that all of these areas will require support (local and national)
- They expected a short form business case by the end of June (how would activity change / what is benefit / financial modelling of benefits)
- Then need transformation plan to inform longer term change including a base case position and trajectory for medium and then longer term change
- We asked for less central constraint and more local support to enable us to do what we want to do to deliver.
- They saw lots of opportunities with workforce and offered that workforce expertise needs to be in the room to deliver a systematic approach to workforce, particularly with support from Health Education England.
- They observed on informatics – that investment is currently going on at each organisation and that we needed to get this more into a system based approach – needing to recognise there will be disinvestment in some systems.

- They demanded that engagement with community groups will be key and we will need to be innovative with this

We expect formal feedback in the next few weeks.

Since the session, the Senior Leaders Group has met and agreed a number of actions including the rapid development of a short business case to access initial 'pump prime' funding, some whole system external support to be externally facilitated on the 'big strategic issues' facing Wirral in context of the New Model of Care proposals and commitment from each organisation to offer capacity to the establishment of an enhanced Programme Management Office for New Models of Care.

Monitor

As advised in the last report, the investigation meeting with Monitor has been set for 18 June 2015. In preparation for this, Monitor will also be on site in the Trust on the 9 and 10 June 2015.

On 19 May 2015, the Trust was also advised by Monitor that it intends to include A & E performance as part of the investigation process. The Trust awaits the formal notification of this.

CQC

The Trust received an unannounced inspection from the CQC on Monday 18 May at approximately 7pm. Four inspectors attended for an hour and visited Surgical Assessment Unit, Acute Medical Unit, Theatre recovery, escalation ward 25 and wards 37 and 38.

The inspection was in response to whistle blowing concerns raised with them by staff regarding using theatre recovery as an escalation area, and nurse staff shortages on some wards. The formal position is that the Trust will receive a written report with the outcomes of the inspection within 51 days.

2. Internal Activities

Infection Prevention & Control

Against the objective of no more than 29 cases for 2015/16, the Trust reported 4 avoidable cases of Clostridium Difficile during April. There were no MRSA bacteraemias reported during April.

The outbreak of Carbapenamase Producing Enterobacteriaceae (CPE) has continued throughout April, however ensuring that positive and high risk contacts are transferred to the CPE cohort ward 14 at the earliest opportunity has supported the reduction in the number of cases with only 7 new cases identified. With a focus on Vancomycin Resistent Enterococcus (VRE) within high risk areas, this remains a challenge within orthopaedics. Norovirus continued to effect several wards during April.

Ebola Update

The Ebola outbreak is ongoing and the Trust remains vigilant in the event of a returned traveller from affected areas. Staff awareness and training has continued led by Emergency Department Staff. There have been no suspected or confirmed cases presenting at WUTH.

A letter of thanks was received from NHS England's Director of NHS Operations & Delivery regarding the work that Trusts have done to ensure that we are prepared to manage both suspected and confirmed cases of Ebola and is appended for information *(appendix i)*.

Recovery Plan

Good progress has been made in developing the Recovery plan for submission to Monitor by the end of May. In addition to the scrutiny around the 2015/16 submission an additional Board challenge on 22 May will focus on 2016/17 and the wider five year context associated with New Models of Care. Detailed granular plans for 2015/16 delivery have been developed to enable weekly monitoring through Transformation Steering Group. Changes have been made to the Programme Management Office (PMO) to facilitate timely delivery of plans.

A&E Update

The A & E escalation meeting was held on 14 May where Monitor and NHS England were updated on progress and advised of the trajectory that the economy will achieve in Quarters 3 and 4 of this year. The recovery plan is being refreshed to take into account recommendations from the Emergency Intensive Support Team (ECIST) walkthrough and "breaking the cycle". Internal systems and processes are also currently being reviewed with the assistance of the Interim Deputy Chief Executive who has extensive experience in this area.

Wirral Millenium – Remote Hosting

Over the weekend of 8 May the Trust's Millenium system was successfully moved to Cerner's data centre in Slough. As part of the move all of the servers the system runs on were replaced. Feedback is that the system is quicker for end users.

The wards, A&E and support services such as Pathology, Pharmacy and radiology pulled together during the downtime to ensure that Patient care wasn't compromised as a team of Informatics staff from the trust and specialists from Cerner (many of whom had flown in from the States especially) worked throughout the night to ensure that the transfer was seamless.

With the transfer complete, the Informatics team are now working on a range of enhancements to the current functionality that have been requested by end users as well as the roll out of a range of new capabilities including linking our vital sign monitors into the system (saving nursing time), uploading ECGs as well as rolling out the use of electronic prescribing into A&E.

Although mainly a technical project that was invisible to end users, the transfer is a major step forward for the Trust and underlines our position as the most technologically enabled hospital in the UK.

Workforce & Organisational Development

Leadership and Management Development

The Leadership and Management Development Framework has been approved. The overarching aim is to enable the Trust to create a transformational leadership culture and behaviour styles that are required to enable us to meet our key organisational challenges and staff satisfaction and engagement priorities.

The Trust was successful in its bid from the NW Leadership Academy for funding to support the delivery of a two day Coaching for Clinicians programme that took place in March 2015. The programme allows the Trust to further develop Coaching skills as a resource within the Organisation to support transformational leadership styles.

The Trust has developed a new Consultant Development Programme in order to support Consultants during their first 12 months with the Trust. The focus is to strengthen Clinical Leadership, values and behaviours whilst offering support and guidance to Consultants using a variety of methods. The overall programme evaluation has been very successful so far.

The Clinical Leaders Development Programme 2014 - 2016 has been established in collaboration with Mid Cheshire Hospitals and the Countess of Chester Hospital. The Trust has 14 Consultant participants on the programme with an overall total of 44 Consultants attending the programme from across the three organisations.

Staff Engagement / Listening into Action / Values

The trust-wide staff satisfaction and engagement action plan is progressing well in advance of the next staff survey. Highlights to date include:

- 100 day Challenge.
- 42 Listening into Action (LiA) mini huddles since 1 April.
- Senior leaders pledges of personal commitments to improve staff satisfaction.
- Executive members of the Trust Board have partnered with in patient wards and key clinical areas which they are visiting to offer support.
- Communications campaign highlighting what our staff say they are proud of.
- Re launched Monthly Team Brief.
- Team Brief meeting promoted to all staff, dates on the intranet.
- Raising Concerns process revised further, Staff Guardians introduced (Sharon Landrum, HROD; Carol Skillen, Midwife and Staff Side representative; and Cathy Maddaford, Non Executive Director).
- Staff Charter introduced which sets out what staff can expect from the Trust and what the Trust can expect from staff, aligned to our core values.
- New handbook for Leaders "The PROUD Way" introduced.

In addition to the above, Divisions are addressing key priorities for their areas identified from the staff survey as well as supporting actions from the LiA Huddles.

The Trust will be using the Quarterly Staff Friends and Family Test results in 2015 as an indicator of how staff satisfaction and engagement is improving and have added additional questions to this to provide more comprehensive information to directorate level. Q4 results were received recently and have already shown improvement from the previous quarter as detailed below:

- Q1 Recommending the Trust as a place for treatment and care = 70% (52% Q3)
- Q2 Recommending the Trust as a place to work = 51% (41% Q3)

Health & Wellbeing / Attendance

The Health & Wellbeing Plan 2015-2018 continues to be enacted. A successful 'Well Being Event' was held on 24th April with many staff attending to receive advice on staying

healthy including: advice on mindfulness, cycle to work scheme, weight management, physiotherapy, gym membership, the live well programme, smoking cessation and cholesterol testing for staff.

The introduction of the new Attendance Capability Policy, the formal re-training of over 400 managers, the implementation of the Health and Well Being Strategy, the continued sickness action plans for poor attenders, recognition of good attenders and the very strong focus on supporting those off long term sick have all come together this month to give an improved sickness absence figure in April 2015 of 4.17%. This has improved substantially from last month (4.59%, March 2015) and represents a large improvement on the same period last year (4.75%, April 2014).

Priority actions continue to be discussed in full at the Quality & Safety Committee.

Celebrating Success

The Trust was pleased to announce recently the first winner of the new PROUD Team of the Quarter as the Endoscopy Unit and the winner of the 100% attendance recognition scheme as Michelle Rhodes (Domestic). The team of the quarter is open again and we are hoping we will receive more and more nominations in recognition of the hard work, commitment and dedicated of our colleagues.

We have been shortlisted for the HPMA (Healthcare People Management Association) Appreciate Champion Award 2015 for staff engagement, in recognition of the significant improvements we have made across the organisation by engaging with our staff, primarily through Listening into Action. We are extremely proud of getting this far and look forward to the winner being announced on 18th June.

The Trust has also been shortlisted for the Value and Improvement in Training and Development category of the HSJ Healthcare awards for our work on Strategic Approach to Youth Employment.

This award is open to NHS organisations, and independent organisations providing services to the NHS, who are able to demonstrate innovative use of the training resource to improve efficiency and effectiveness, for example by enabling staff to take on extended roles, reducing adverse events, or using new delivery models to increase the amount of training and development available to staff.

Our submission encompasses all our work with 16-23yr olds including apprenticeships, Traineeships and Supported Internships with support from Wirral Met College (WMC)as our strategic partner.

Recruitment

The Trust welcomes Jon Scott, Interim Deputy Chief Executive, to his first Board meeting.

David Allison
Chief Executive

May 2015

Dr Sarah Pinto-Duschinsky
Director of NHS Operations & Delivery
NHS England
Skipton House
80 London Road
London SE1 6LH

To: Trust Chief Executive Officers

Publications Gateway reference: **03398**

30 April 2015

Dear Colleague

Ebola response

I am writing to express my thanks for the work that has been done to ensure that the NHS is prepared for and able to manage both suspected and confirmed cases of Ebola (a Viral Haemorrhagic Fever). Since the start of the outbreak the NHS has successfully managed 3 confirmed cases and many more suspected cases. It is clear that this outbreak, which we have been aware of since April 2014, is likely to continue for some months to come with new cases still presenting in West Africa (39 new cases week ending 15th April 20151). In view of this, it is vitally important that your staff remain vigilant and continue to follow the established procedure should a suspected case present. I would ask you to ensure that Ebola remains a priority for your organisation.

Our initial round of training sessions to support 'train the trainer' in the use of Personal Protective Equipment had a high uptake, although not every Trust accessed the training. We are running further sessions in May for Trusts that would like to take part and your emergency planning lead will have received details.

On 7th November 2014, NHS England assumed strategic command and control of the NHS for our Ebola response under the Health and Social Care Act (2012) section 46 and I took up the role of national incident director.

We now propose that these arrangements should be stood down and Ebola operational response and legacy arrangements will be managed through NHS England's business as usual EPRR processes.

In view of the unprecedented nature of this outbreak and its impact on the NHS, there is an opportunity for the wider NHS Emergency planning and resilience

[1] World Health Organisation

community to benefit from its legacy. We are therefore planning to run a legacy conference in the autumn and will send details in due course.

Yours sincerely

Dr Sarah Pinto-Duschinsky

Director of NHS Operations & Delivery

Board of Directors	
Agenda Item	6.1.1
Title of Report	Integrated Dashboard and Exception Reports
Date of Meeting	27 May 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)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To note
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

1. Executive Summary

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 April 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 April are Friends & Family, Staff Satisfaction, Demand, A&E 4-hours, Attendance, Qualified Nurse Vacancies, Contract Performance, 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. For the annual Staff Satisfaction metric, the intention is to use the Friends and Family Staff Satisfaction results on a quarterly basis in 2015-16 to track progress. Commentary on the financial performance metrics is contained within the separate finance report to the Board of Directors.

Under Monitor's Risk Assessment Framework for 2016-16 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 April 2015.

WUTH Integrated Performance Dashboard - April 2015

Meeting Our Vision

Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period
Satisfaction Rates					
Patient Satisfaction - F&F "Recommend" Rate			JG	93.0%	April 2015
Patient Satisfaction - F&F "Not Recommend" Rate			JG	3.0%	April 2015
Staff Satisfaction (engagement)			AH	3.48	2014
First Choice Locally & Regionally					
Market Share Wirral			AH	83.7%	April to Dec 2014
Demand Referral Rates			AH	-2.8%	Fin Yr-on-Yr to April 2015
Market Share Non-Wirral			AH	8.3%	April to Dec 2014
Organisational Risk Issues					
Key Performance Indicators					
A&E 4 Hour Standard			SG	83.8%	April 2015
RTT 18 Weeks Standards			SG	All met	April 2015
Cancer Waiting Time Standards			SG	On track for qtr	Q1 to April 2015
Strategic Objectives					
Delayed Transfers of Care			SG	4	12-mth ave to April 2015
Readmissions			EM	8.3%	February 2015
Harm Free Care			EM	96.0%	April 2015
HIMMs Level			MB	5	April 2015
NIHR KPIs			EM	tbc	

A Healthy Organisation

Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period
Clinical Outcomes					
Never Events			EM	0	April 2015
Complaints			JG	40.5	12-mth ave to April 2015
Infection Control			JG	0 MRSA; 4 C diff	April 2015
Productivity					
Bed Occupancy			SG	94.99%	April 2015
Theatre Utilisation			SG	66.6%	April 2015
DNA Rate			SG	8.7%	April 2015
Workforce					
Attendance			AH	95.1%	12-mth ave to April 2015
Qualified Nurse Vacancies			JG	5.55%	April 2015
Mandatory Training			AH	97.3%	April 2015
Appraisal			AH	87.6%	April 2015
Turnover			AH	11.0%	April 2015
Finance					
Contract Performance			AM	-2.1%	To M1 April 2015
Expenditure Performance			AM	1.4%	To M1 April 2015
CIP Performance			AM	-46.1%	To M1 April 2015
Capital Programme			AM	-14.7%	To M1 April 2015
Non-Core Spend			AM	9.7%	To M1 April 2015

External Validation

Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period
National Comparators					
Advancing Quality			EM	4 areas below target	February 2015
Mortality: HSMR			EM	88.6 (low ci 83.0)	April to Dec 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 M1 April 2015
Monitor Risk Rating - Governance			SG	Not Green or Red	To M1 April 2015
CQC			EM	5	April 2015
Local View					
Commissioning - Contract KPIs			SG	3	April 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 April 2015

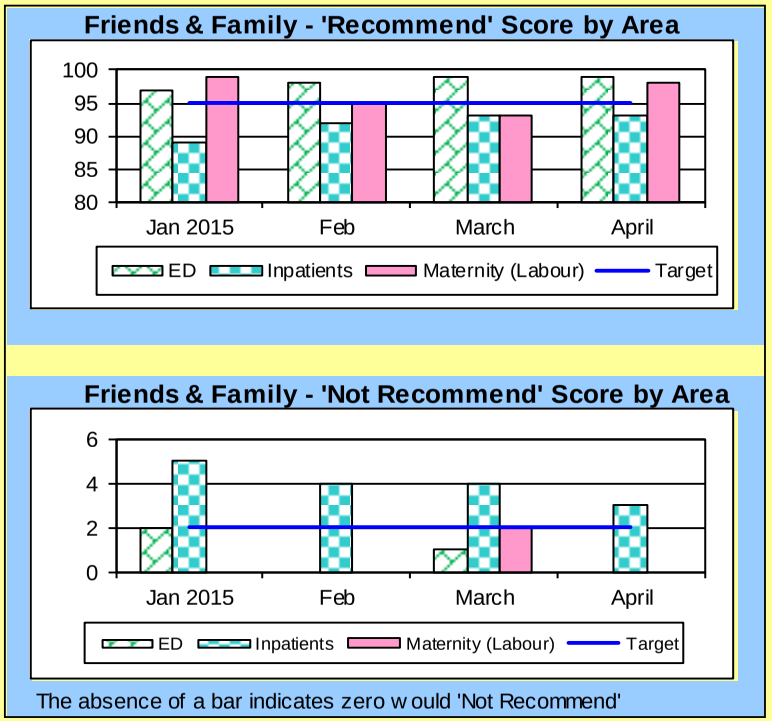
Indicator :
Friends & Family - Recommend / Not Recommend

Rating	Target	Actual	Period
Red	>95% and <2%	93% and 3%	April 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 April the performance was 93.0% for Recommend, and 3.0% for Not Recommend - so both measures did not achieve the standards.

Historic data:



Proposed Actions:

FFT performance is managed at both Clinical Governance Group and at Divisional Reviews. 3 wards/units are consistenly underperforming which is resulting in the Trust not progressing beyond the 95% threshold. These are:

Surgical Assessment Unit - Subject to ongoing actions and under CGG assurance process, Emergency Surgical Consultants have commenced duties and this is improving flow and avoidable delays. It is expected that this Unit will be achieving within 3 months.

AAMU/AMSSW - both units have improved in the last month but require focused effort to improve flow and environment. A meeting is scheduled to determine next stage actions. **Ward 36 (Gastro)** - the patient case mix on ward is resulting in underperformance, with the Division asked to progess a review on options.

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 April 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 presented the results and management recommendations on the 27th March to invitees including the Trust board, CEO forum members, PSG, JLNC, and Staff Governors. Employee Engagement Event with 100 Senior Leaders and Managers held on the 12th May, with a 100-day Pledge from all those attending.

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. Quarterly Friends and Family surveys have been amended to incorporate staff engagement scores, and these will be reported to the BoD on a quarterly basis commencing in July 2015 on Q1.

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

April 2015

Indicator :

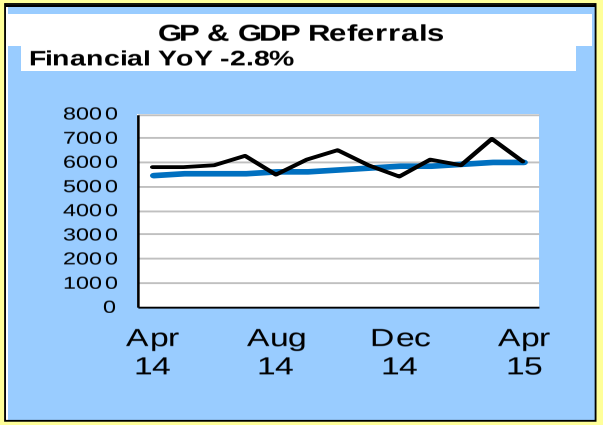
Demand Referral Rates

Rating	Target	Actual	Period
Red	>= 3% YoY	-2.8%	April 2015

Issue:

The internal standard is set at 3% growth in General Practice referrals year-on-year. April 2015 referrals are 2.8% lower than April 2014 referrals.

Historic data:



Proposed Actions:

At the end of March 2015 GP referrals were up 8.6% for 2014-15 compared with 2013-14. As we move in to the new financial year the referral comparison for April is based on a single month. The reduction of 298 referrals compared with April 2014 is not a dramatic fall, and it will take a number of months to establish any trends. The Trust is continuing to strengthen relationships with local GP consortia, and is committed to the continuing work with local commissioners on the Vision 2018 programme wrokstreams. This is enhanced by the recent successful application to be a Vanguard site and deliver New Models of Care to our health community.

Assessing Improvement:

Demand rates are monitored monthly at Divisional Reviews, with routine reports available at Divisional, specialty and consultant team level.

Impact:

A strategic objective for WUTH is to be the hospital of choice for Wirral and other local residents. The expectation is for increased referrals and enhanced market share for those services provided by the Trust.

Expected date of performance delivery:

Revisit at end of quarter 1 in 2015/16

Executive approval:

Anthony Hassall, Director of Strategic and Organisational Development

WUTH Performance Dashboard Exception Report — April 2015

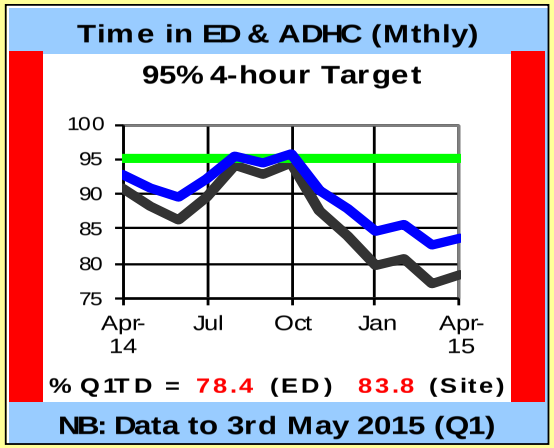
Indicator :
A&E 4-hour Standard

Rating	Target	Actual	Period
Red	>= 95%	83.1%	March 2015

Issue:

The standard is a minimum of 95% of A&E attendances being admitted, transferred or discharged within 4 hours. Performance for April was 83.8%, including the All Day Health Centre at Arrowe Park site. For WUTH alone performance was 78.4%.

Historic data:



Proposed Actions:

The pressures previously reported have continued.

The Trust has received a report from the Emergency Intensive Support Team (ECIST) based on their walkthrough of the non-elective pathway and has run a 'Breaking the Cycle' initiative. The 8 day long initiative saw some improvements in performance, an increase in the number of discharges before midday and an improvement in ambulance handover times. During this initiative the "SAFER " care bundle was piloted, ECIST describe this as "a national best practice bundle that puts 5 clear steps in that are proven to reduce hospital blockages in the system and reduce mortality". Actions from the initiative and the recommendations from the ECIST report have been added to a refreshed urgent care recovery plan (in a new format recommended by ECIST) which should be finalised in the next fortnight and signed off by the Systems Resilience Group in June. The Trust has committed to fully implement the SAFER bundle on 2 wards by the end of June and across the Trust by the end of September. The Trust is also reviewing internal systems and processes with the assistance of the Interim Deputy Chief Executive who has extensive experience in this area.

The ED escalation meeting was held on 14th May where Monitor and NHS England were updated on progress and advised of the trajectory that the economy will achieve in Quarters 3 and 4 of this year.

Assessing Improvement:

The current performance is 83.98% as an economy and given the extremely poor start the standard will not be chieved this quarter.

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:

From quarter 3 in 2015/16

Executive approval:

Sharon Gilligan, Director of Operations

WUTH Performance Dashboard Exception Report April 2015

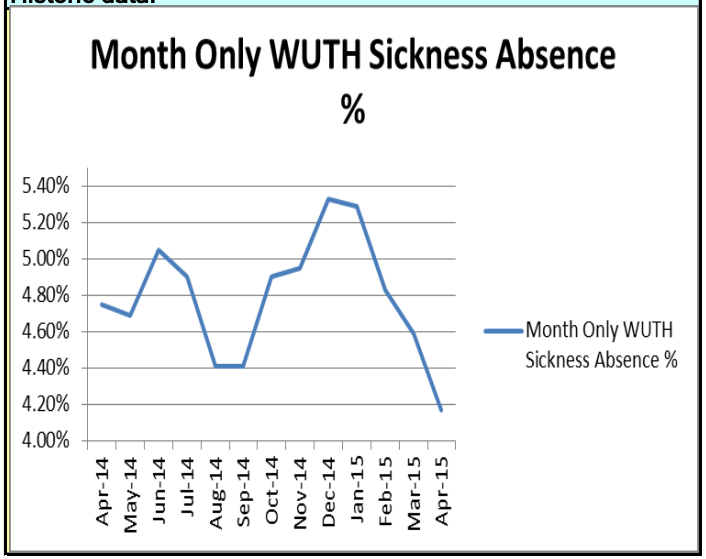
Indicator :
Attendance (month only)

Rating	Target	Actual	Period
Red	>= 96%	95.83%	April 2015

Issue:

Attendance (month only) was 95.83% at April 2015 and therefore 0.17% below the Trust target of 96%. The new Attendance Capability Policy, re-training of over 400 managers, Health and Well Being Strategy, action plans for poor attenders, recognition of good attenders and focus on supporting those off long term sick have produced reduced sickness absence in April 2015 (Month Only = 4.17%).

Historic data:



Proposed Actions:

Sickness absence training was delivered to 400+ managers in January 2015. New policy is live and sickness rates have reduced (April 2015 month only was 4.17%, previous year was 4.75% - April 2014), Strong focus on staff off long term sick has reduced numbers from 154 in December to 107 in April. Other actions include: Health and Wellbeing Strategy, Monthly reporting and drill down, Monthly workforce meetings, action plans for poor attenders, Occupational

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.
Please note the graph has been changed this month to show 'month only Sickness Percentage' as showing attendance it was more difficult to see small changes.

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:

James Mawrey, Director of Workforce

WUTH Performance Dashboard Exception Report April 2015

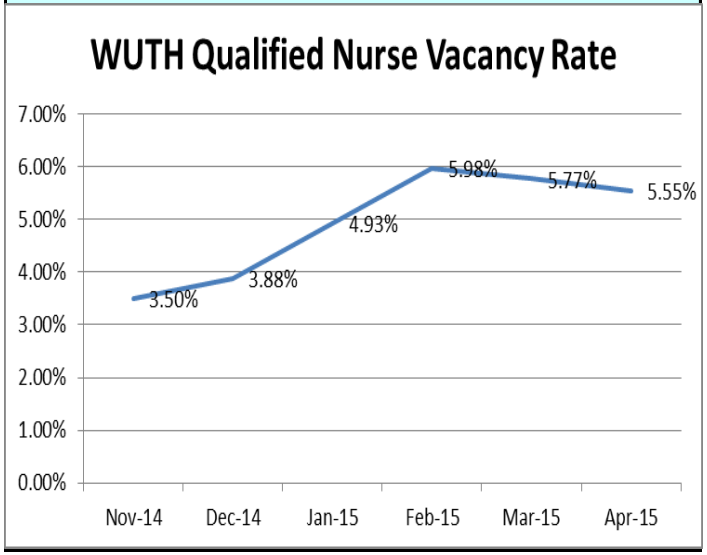
Indicator :
Qualified Nurse Vacancies

Rating	Target	Actual	Period
Red	>5%	5.55%	April 2015

Issue:

Qualified Nurse Vacancies was 5.55% at April 2015 and although this has been reducing over recent months it is still 0.55% above the Trust target of 5%. Actions as detailed below are taking place to address this. A review of Nurse Turnover metrics is taking place including benchmark data from comparator Trusts in order to establish what is a healthy level of Nurse turnover and what level requires escalation.

Historic data:



Proposed Actions:

Exceptional nurse recruitment is taking place and 75 job offers were made in early 2015 (although many of these will not start for several months due to finishing qualifications or notice periods). Further generic Nurse recruitment is taking place. A paper on international recruitment is being prepared in order that this option is fully considered.

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:

James Mawrey, Director of Workforce

WUTH Performance Dashboard Exception Report

March 2015

Indicator :
Advancing Quality

Rating	Target	Actual	Period
Red	All achieving	2 areas under target	January 2015

Issue:

The measures are composite scores, reflecting individual care to patients; the results are delayed up to 3 months and so lags behind improvement. At the end of January Acute MI, Heart Failure, Pneumonia and Stroke were all below target. Heart Failure and Pneumonia are expected to improve by year end.

Proposed Actions:

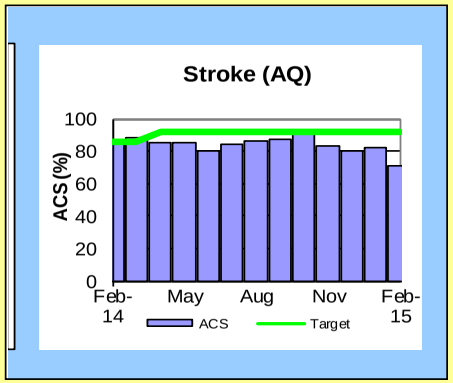
STROKE - the key measure is access to a stroke unit bed and therefore is highly dependent on the flow of patients within the hospital; ring fenced stroke beds would achieve this. We will not achieve this target for the year as bed pressures continued into March and the target is over 97%. Other organisations are facing similar issues and we are currently the highest performer in the AQ hospitals group.

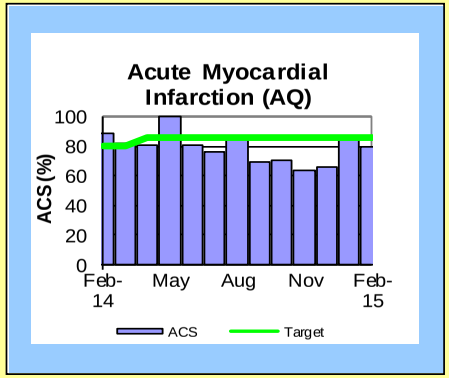
AMI - The issue remains referral to rehabilitation and the action is increased presence on the ward. For April are collecting more data real time and this supports bed side education for staff.

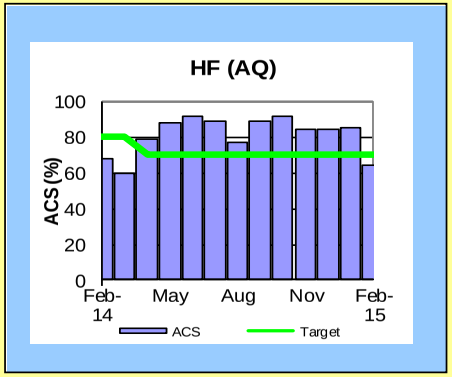
HEART FAILURE - There has been an increase in the specialist nurse resource during March; this should address the provision of specialist advice before discharge. In addition the Lead has left the Trust and currently this has no permanent lead in place until a new appointment is made.

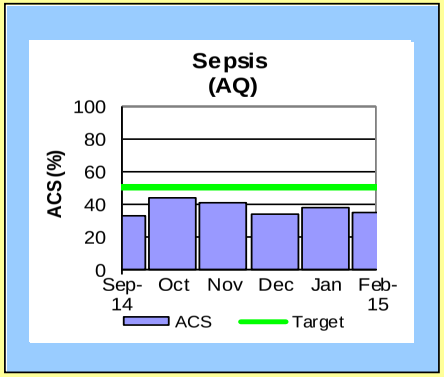
SEPSIS - This is the first time this has been reported on the dashboard. As a new area all Trusts are working to a target of 50%. The current actions are Cerner developments (expected June 2015), promoting the sepsis pathway and education and traiing for the staff. There are issues with the blood gas analysis not being available on Cerner and discussion is underway to see if this can be resolved.

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	6.1.2
Title of Report	Month 1 Finance Report
Date of Meeting	27 May 2015
Author	Shahida Mohammed, Assistant Director of Finance – Income & Commissioning Julie Clarke, Assistant Director of Finance – Operational Financial Management
Accountable Executive	Alistair Mulvey, Executive Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	7
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To note
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

1. Executive Summary

Income and Expenditure Position

The actual position for April 2015 is a deficit of £1.8m, this is £0.1m higher than the month 1 planned deficit of £1.7m.

NHS clinical income is £0.5m below plan, other income is £0.1m better than plan and the pay and non-pay expenditure position is showing a positive variance of £0.3m. There has been an application of £0.4m from reserves to support the financial position which has been necessary to mitigate the financial impact of the operational issues and to bridge the current CIP gap.

Cash Position & Continuity of Service Ratios (COS)

The cash position is £22.2m, £0.2m better than plan. There are a number of small variances to working capital balances and a £1.1m offsetting variance between trade creditors and accruals due to timing of payments.

The overall Continuity of Service rating at month 1 is a 2 which is in line with plan.

The headline EBITDA financial position is summarised as follows:

SUMMARY FINANCIAL STATEMENT MONTH 1 2015/16 (APR)							Comparative 2014/15 Position (Month 1)		
	In Month			Year to Date			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Operating Revenue	25,032	24,649	(383)	25,032	24,649	(383)	24,164	23,997	(167)
Employee Expenses	(17,140)	(17,303)	(163)	(17,140)	(17,303)	(163)	(16,789)	(17,484)	(695)
All Other Operational Expenses	(7,405)	(7,444)	(39)	(7,405)	(7,444)	(39)	(6,589)	(6,988)	(399)
Reserves	(1,053)	(622)	431	(1,053)	(622)	431	(1,045)	(176)	869
EBITDA	(566)	(720)	(154)	(566)	(720)	(154)	(259)	(651)	(392)
Post EBITDA Items	(1,152)	(1,130)	22	(1,152)	(1,130)	22	(1,109)	(1,111)	(2)
Net Surplus/(Deficit)	(1,718)	(1,850)	(132)	(1,718)	(1,850)	(132)	(1,368)	(1,762)	(394)
EBITDA %	(2.3%)	(2.9%)	(0.7%)	(2.3%)	(2.9%)	(0.7%)	(1.1%)	(2.7%)	(1.6%)

Cost Improvement Programme (CIP)

The Trusts plan incorporates a requirement to achieve £13m of in year CIP, to date detailed plans of £11.1m have been identified. The remaining £1.9m still to be identified has been extracted from budgets in a flat profile (12ths). In month 1 the planned schemes have achieved in line with expectations although there is a shortfall of £0.16m against the gap to be identified as shown in the table below.

	BY SCHEME TYPE		BY COST		TOTAL
	Income Generation (net of cost of delivery) £k	**CIP** £k	**NHS Clinical Income** £k	**Divisional Budgets** £k	£k
Month 1 Plan	30	328	103	255	**358**
Month 1 Actual	24	168	11	181	**192**
Month 1 Variance	(6)	(160)	(92)	(74)	**(166)**

Activities continue through the Programme Management Office (PMO) to identify further opportunities, both recurrent and non-recurrent, to bridge the in year gap.

2. Background

The plan position as at month 1 was a deficit of £1.7m, the actual position is showing a deficit of £1.8m. The main area of under-performance is clinical income which is £0.5m below plan.
This position provides the Trust with a risk rating of 2; although the metrics which underpin the overall rating have been weakened by the small adverse income & expenditure performance the rating of each metric remains the same.

The cash position is £22.2m, £0.2m better than plan.

3. Key Issues

The Trust has under achieved against its planned income target for month 1, delivery of the planned volumes of care is a prerequisite to the achievement of the overall financial plan. Under achievement is across both planned and unplanned care.

Surgery, Women's and Children's Division is showing the largest under recovery, which is attributed to, a combination of reduced volumes of care and reduced casemix which translates into a reduced level of income per spell of care delivered.

Within Medicine the most critical component, at this stage of the yea, relates to penalties incurred due to failure against the A & E targets of c£0.2m. Discussions, following on from the economy with A & E summit, are continuing through the localities Strategic Resilience Group (SRG) as to the appropriateness of penalizing the Trust for a position which is reliant to a significant degree on economy wide actions.

Activity plans for 2015/16 have been agreed and signed-off by Divisional leads during the planning process, it is imperative where plans have slipped remedial action plans are devised and enacted.

Divisional Analysis
The following table shows the summary Divisional position (Month 1). The senior management teams within the Divisions have provided further explanation and context to the respective positions, and this is included in further detail (attached to this document).

	Medicine & Acute £000	Surgery & W&C £000	Clinical Support £000	Corporate £000	Central £000	Total £000
NHS Clinical Income						
Planned Income	10,157	10,588	1,363	65	524	22,697
Actual Income	9,949	10,030	1,400	56	779	22,215
Variance	(207)	(558)	37	(9)	256	(482)
Net Expenditure						
Planned Expenditure	7,030	7,978	3,408	3,815	1,032	23,263
Actual Expenditure	7,153	7,948	3,317	3,919	598	22,935
Variance	(123)	30	91	(104)	434	328
Variance EBITDA	(330)	(528)	128	(113)	690	(154)
Post EBITDA						
Planned Post EBITDA					1,152	1,152
Actual Post EBITDA					1,130	1,130
Variance	0	0	0	0	22	22
Total Variance to Plan	**(330)**	**(528)**	**128**	**(113)**	**712**	**(132)**

Pay Analysis
The most significant area of expenditure for the Trust, relates to pay with pay spend in April being £17.3m, £0.2m above plan. Additional costs have been driven through additional capacity within the organisation to support patient flow and the management of infection.

The following figure provides further detail of the April pay costs analysed between permanent (core) spend and other (non-core) spend types.

Analysis of Pay Spend

Detail	14/15 Average £k	April £k
Budget	**16,916**	**17,140**
Pay Costs		
Permanent	15,875	15,605
Bank Staff	319	306
Agency Staff	518	698
Overtime	224	343
Locum	362	299
WLI (In Year)	155	52
Total	**17,451**	**17,303**
Variance	**(535)**	**(163)**

The use of flexible labour has increased relative to the average of the preceding 12 months

4. Next Steps

The Trust continues 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.

5. Conclusion

The overall I & E position for month 1 is marginally off plan with the Trusts cash position being marginally stronger than planned. The Trust has achieved its CoS rating of 2 as planned.

Whilst early in the financial year it is imperative that the Trust moves back towards delivery of its activity plans, specifically from a planned care perspective and that this is facilitated through improved patient flow across the organisation. Improvements in flow will also support a reduction in the penalties the Trust faces for non achievement of the A & E target recognising that, at an economy wide level, discussions on the application of these penalties continues. Positively the Trust has achieved its planned CIP in month albeit on an in year basis a further £1.9m of contribution is required.

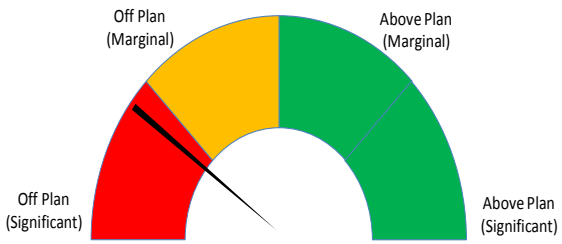
6. Recommendations

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

Alistair Mulvey
Director of Finance
May 2015

Divisional Overview (Month 1)

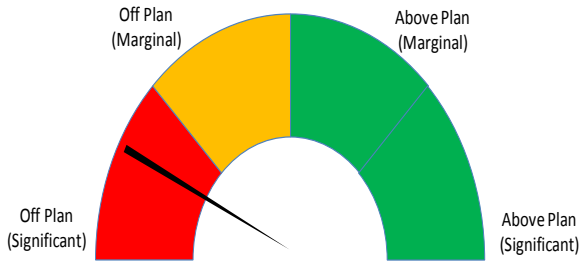
Medicine



Medicine - Key issues

- *Clinical Income behind plan by £207k.*
- *Net Expenditure exceeds budget by £123k .*
- *Overall position is £330k off plan.*

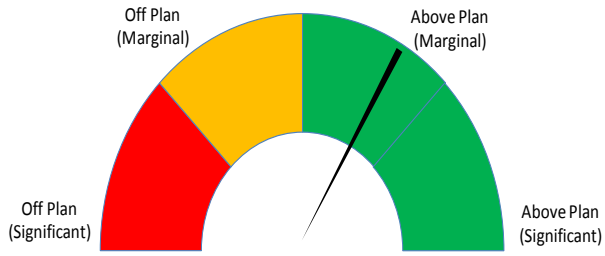
Surgery/ W&C



Surgery / W&C - Key issues

- *Clinical Income behind plan by £558k.*
- *Net Expenditure is better than plan by £28k.*
- *Overall position is £530k off plan.*

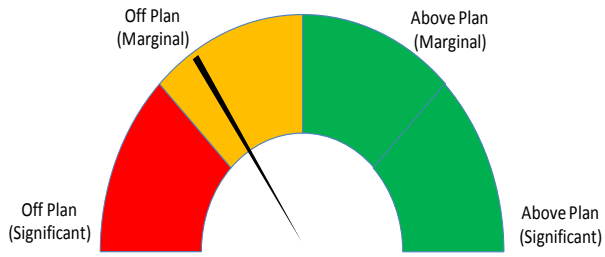
Clinical Support



Clinical Support - Key issues

- *Clinical Income marginally over plan by £37k.*
- *Net Expenditure is under plan by £91k .*
- *Overall position is £128k better than plan.*

Corporate



Corporate Services - Key issues

- *Divisional Income over plan by £50k.*
- *Expenditure over plan by £154k .*
- *Overall position is £104k off plan.*

Medicine & Acute I&E

Acute and Medical Care – The division reported a £330k deficit in month 1.

Clinical Income within the division is under achieving by £207k, the main drivers of this are A&E £114k (net of penalties of £154k) and Non Elective activity underperforming against plan by 310 cases with a resultant income underperformance of £133k net of risks. Elective activity has over performed in month by £34k with the key area of this being attributable to Gastroenterology. Outpatient activity has seen an over performance in month of £19k. Non Elective excess bed days have over performed by £74k. High cost drugs/high cost bloods have underperformed by £80k which is offset by an under spend on expenditure.

The costs of service delivery have exceeded the planned budget by £123k. The most significant element of pressure relates to unfunded bed areas relating to W26, escalation areas of W25 and W27 £206k. W14 which is the Infection Control Ward has a cost pressure of £88k due to the majority of the shifts being filled by premium costs. There has been an under spend against High cost drugs/bloods in month of £80k which is offset in income. CIP is showing an over performance in month of £88k which is due to the fact that no enabling costs have been assigned to W26 due to the underperformance for Non Elective activity associated with this CIP scheme.

At the time of writing this report W27 is closed and is now being used to support the HPV programme. W25 remains open but has averaged 10 medical inpatients for the month of May and is scheduled to close before the end of May, an element of this requirement to use W25 as an escalation area has been due to the closure of W26 for admissions week commencing 18th May due to Norovirus and C-Diff.

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

Surgery, Women's and Children's Division – The divisions overall financial position in month 1 is a deficit of £529k. Within the overall deficit position expenditure variances are underspent by £29k and Income performance is £558k behind plan in month.

The key cumulative drivers of the overall expenditure variance of £29k favourable include

- £40k Costs on Junior Medical locums/agency due to gaps in the rotation
- £46k relates to Non-PBR excluded devices and high cost drugs, which are pass through costs and attract additional income;
- £100k of favourable variances within the Division in Trauma & Orthopaedics, Theatres & Women's & Childrens

The above costs reflect the Month 1 position which shows a significant improvement for the Division from the end of the last financial year.

From an income perspective the division has an under performance of £558k in month 1. The Month 1 income position is showing shortfalls in numerous areas. The Elective position under performed by £411k, there are a number of reasons for this including case casemix loss of approximately £190k, Trauma & Orthopaedic under performance of activity equating to £85k and cancellations due to bed pressures equating to £50k.

Non-Elective performance underachieved by £73k. The main area of concern is around Colorectal (£159k) which was offset by an over performance in Trauma & Orthopaedics of £73k.

Also in Month 1 there were £142k worth of penalties relating to Readmissions, Follow up cap and 18 week penalty in Ophthalmology.

The division continues to scrutinise the detail of all of the Income position 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 maximized and available capacity used for alternative services where appropriate with particular emphasis on the plans for the rest of 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 wef 1st April
- Theatres and outpatient utilisation
- 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
- CIP delivery

Clinical Support I&E

Clinical Support Division — The Division reported a favourable movement to budget of £127k in the month. Clinical Income outperformed plan by £37k, divisional costs were underspent by £88k and CIP exceeded the monthly target by £2k.

By directorate Therapies are ahead of plan by £58k, Outpatients by £23k, Patient Flow by £16k, Divisional Management by £36k and Pathology by £36k whilst Radiology and Cancer Pathway are behind plan by £41k and £2k respectively.

From an income perspective the Division is performing well being £37k ahead of plan, driven in the main by over performance on Direct Access. In month this is largely driven by Pathology which is £29k above budget with all areas up (activity was 5.6% higher than planned). Radiology DA activity was up 2.6% generating a £7k benefit with gains on all areas bar Ultrasound. AHP DA was in line with plan although Dietetic income was slightly behind plan. Whilst there continues to be an affordability risk across the health economy if these levels of diagnostic demand continue the CCG has extended the Radiology DAD contract to March 16.

The Division is reporting an overall pay underspend of £123k YTD with all areas bar Radiology, and Patient Flow under spent. Therapies, Patient Flow and Outpatients are underspent by £61k, £16k and £17k respectively with all areas experiencing high vacancy levels; this vacancy level is currently necessitating some agency spend in Therapies. Non-core spend totalled £224k (9.7% of core spend) of which £113k relates to Medical Staffing owing to the ongoing Histopathologist shortage and reporting/on call cover issues In Radiology. The majority of the remaining costs are from a combination of agency & overtime costs to cover staff vacancies and maintain service delivery, however, as noted above the Division remains underspent on pay despite this level of non-core.
Where appropriate the Division continues to hold vacancies as it progresses its staffing restructure proposals in consultation with staff side colleagues in all areas.

Non pay budgets are £29k overspent in month with a shortfall in associated income of £5k. Pathology non pay overspend is £13k - the bulk of Lab costs vary with GP & Trust activity however in addition to this £4k of the overspend relates to Infection Control test kits. Radiology non pay overspend is £23k with much of this cost being associated with direct access volumes. Outpatients non pay costs are below budget by £7k predominantly owing to the new Patient Reminder Service contract; this underspend is expected to narrow as the service expands to other areas. The income shortfall is mainly on Private Patients as volumes are below expected levels.

The Division exceeded its CIP target by £2k mainly as a result of higher uptake on the pension opt out scheme.

Corporate Services I&E

Corporate Services Division - The division reported a £104k overspend in month Divisional income is cumulatively £50k over-recovered and the expenditure budgets are cumulatively £154k 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	1,739	144	144	-1	144	144	-1
ESTATES	6,430	528	552	-24	528	552	-24
EXECUTIVE MANAGEMENT	13,981	1,168	1,163	5	1,168	1,163	5
FINANCE & SUPPLIES	3,352	278	262	17	278	262	17
HOTEL SERVICES	13,105	1,100	1,119	-20	1,100	1,119	-20
HR & OD	2,226	186	185	1	186	185	1
INFORMATION & IG	1,587	131	157	-26	131	157	-26
IT	6,429	534	543	-9	534	543	-9
PHARMACY	5,107	422	422	0	422	422	0
QUALITY & SAFETY	921	76	71	6	76	71	6
TRANSFORMATION TEAM	528	65	57	8	65	57	8
CORPORATE SERVICES CENTRAL	-55	35	54	-19	35	54	-19
MISCELLANEOUS	-7,665	-852	-810	-42	-852	-810	-42
Grand Total	47,685	3,815	3,919	-104	3,815	3,919	-104

The areas of concern this month continue to be:-

Information Governance—there continues to a pressure on Injury Cost Recovery (ICR) income. Income levels continue to be much the same as in 2014/15 and, although there has been some pressure funding against this budget, it has under-recovered in month by £18k.

In addition there is a pressure caused by Agency staff expenditure against the Clinical Coding Department budget which moved from Finance into Information Governance from this month.

Information Technology—continued overspends on IT due to cost pressures on maintenance and IT purchases and implementation costs. This is offset in part by vacancies in EBME.

Hotel Services budgets continue to be under pressure from supporting additional beds.

Estates budgets show a pressure on Energy in month.

Pharmacy continues to be largely on plan in-month. This is in despite of the impact of activity related cost pressures that have needed to be mitigated.
There are smaller overspends in some of the other directorates however they still remain cumulatively underspent. In month there have also been certain accounting adjustments for the Trust as a whole which are reported in this Division.

BOARD OF DIRECTORS	
Agenda Item	7.1
Title of Report	CQC Compliance
Date of Meeting	27 May 2015
Author	Joe Roberts, Head of Assurance
Accountable Executive	Dr Evan Moore, Medical Director
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Strategic Objective – Supported by financial, commercial and operational expertise Key Measure – Full Compliance with our registration with CQC
Level of Assurance • **Positive** • **Gap(s)**	Full
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**	None required

1. **Executive Summary**
   The purpose of this paper is to inform the Board regarding the progress of our preparations for the CQC's comprehensive inspection which is due in September. Good progress is being made in many areas, but there are others where we need to move forward more quickly.

2. **Background**
   In March we prepared an outline project plan in the form of a Gantt chart. This listed the main actions which need to be taken by September to ensure that we are well prepared. We have revisited this plan and have reported progress in the attached table.

3. Key Issues/Gaps in Assurance

The following action points in the plan give cause for concern, or have slipped behind schedule at present:

Set up project team

It was agreed that two temporary posts would be created – a band 7 Compliance Manager, and a band 4 administrative support role. We have interviewed and selected a suitable candidate for the Band 7 role but have not yet been able to agree their secondment with their current department. We have not succeeded in recruiting to the Band 4 post. The Compliance Manager would have a key role in raising awareness among staff of the inspection process.

Mock Inspections

The inspections have been well supported, with over 100 staff agreeing to take part. So far we have visited 34 of 59 inpatient and outpatient areas. As we intend to have visited all areas by the end of July, and to focus on revisiting struggling areas thereafter, we need to accelerate the pace of this work during the next two months.

Executive Review of Standards and Key Lines of Enquiry

Although this is later than originally planned, meetings have now been scheduled to review the compliance status of each of the fundamental standards during June. In the case of the KLOEs, the self-assessment templates completed by the divisions are very large documents and will need to be condensed into a Trust-wide summary to assist the Executives in reaching a judgment.

4. Next Steps

Further rounds of mock inspection have been arranged in June and July. We are also introducing out-of-hours mock inspections, at evenings and weekends. We continue to work through our project plan.

5. Conclusion

Considerable progress has been made, reflecting the work which has been done, but we need to accelerate the mock inspection programme and ensure that the additional staffing which was agreed, can actually be delivered.

6. Recommendations

The Board is asked to note the current state of progress.

CQC Project Plan - Progress

Action	Deadline	Current Status
Set up project team	March 2015	**Partially complete** Dr Melanie Maxwell (Associate Medical Director) is leading on preparations for the inspection. We have interviewed and selected a Compliance Manager (band 7) to work on a temporary basis until the inspection, but their secondment is still to be agreed. We have been unable so far to recruit to the administrative assistant post although a part-time secretarial employee in Quality and Safety is currently working some additional hours to support the programme of work.
Site visits to other Trusts	March 2015	**Complete** In March we met with the Medical and Nursing Directors, and Head of Governance, at Mid Cheshire NHS Trust, who achieved a 'good' rating. We are hoping to meet with our opposite numbers at Tameside NHS Trust once their inspection is complete.
Deploy mock inspection programme	March 2015 onwards	**Ongoing** So far, 35 clinical areas have been inspected, out of a possible 59. 104 members of staff have either taken part in the inspection teams or are booked to do so in the near future. We have also involved 19 patient experience volunteers recruited through the League of Friends and Health Watch Wirral, and 6 Student Quality Ambassadors (nursing students from Liverpool John Moores University).
Develop inspection checklists for specialist areas	March 2015	**Partially complete** We have developed separate inspection checklists for the Children's Ward, Outpatients and Maternity. We are still drafting the checklist for Accident and Emergency, which we intend to inspect in June.
Develop data packs for core services	March 2015	**Complete** We have produced a data pack of performance information for each of the eight core services (medicine, accident and emergency, critical care, surgery, maternity, children's services, outpatients and end of life care). This has taken longer than expected but we are now confident in the data, which will be updated monthly.
Develop communication strategy	March 2015	**Partially complete** We have a number of ways of communicating with staff. For example, we have already given presentations to several staff groups, produced newsletters (awaiting printing) and included articles in Start the Week and Clinical Update. However, much of the additional work which we need to do (such as reaching more front line staff, and motivational interviewing) is dependent on obtaining additional short-term staff resources for the team (see comments for 'set up the project team'

Action	Deadline	Current Status
		above).
Develop information flow for ward assurance	April 2015	**Complete** This is set out in a flow chart which was approved by the Clinical Governance Group in May. It describes to whom the findings of ward inspections should be reported and when. It is now in use.
Review and update evidence portfolio; identify gaps	April 2015	**Complete** A portfolio of evidence has been produced for each of the Fundamental Standards, along with a Directory of Evidence (effectively a simplified and more user-friendly version of the Provider Compliance Assessment documents which were used for the former Essential Standards).
Develop CQC Audit Plan	April 2015	**Partially complete** We have identified the following topics which should be audited to provide assurance before the inspection: safeguarding (mental capacity, deprivation of liberty, and restraint); consent for children; nutrition (availability of special diets, use of parenteral nutrition, and administration of dietary supplements); and quality of record keeping on Millennium. We are also going to audit whether the action plan from the last CQC inspection has been implemented in full. However, we still need to allocate resources and program the timing of these audits.
Organise public engagement events	April 2015	**Complete** The Trust recently organised an event at Hoylake Community Centre in conjunction with the Wirral Older Peoples' Parliament to celebrate International Nursing Day. This included a question and answer session. Further public engagement events are planned.
Timetable for external partner engagement	April 2015	**Pending** This is to be discussed and agreed with Executive Directors by the end of May.
Update to Executive development day	April 2015	**Complete** A Board development session took place in April and the Associate Director of Governance has produced a summary of the discussion.
Triumvirate review of Key Lines of Enquiry	May 2015	**Complete** Each clinical division has completed a standard self-assessment template for each of their core services, based on the five key questions (caring, safe, responsive, effective and well-led) that every CQC inspection aims to answer.
Add new CQC risks	May 2015	**Pending** This will happen after the meetings with Executives to review the Fundamental Standards. Following those meetings, the Head of Assurance will draft entries for the risk register which will be agreed with them.
Executive review of Key Lines of Enquiry	May 2015	**Pending** This will be based on the self-assessments which the divisions have completed. As these are very detailed and cumbersome documents, the Head of Assurance will need to produce a summary for the Executives, in a more digestible format.

Action	Deadline	Current Status
Executive review of Fundamental Standards	June 2015	**Pending – not yet due** The Associate Director of Governance and Head of Assurance have arranged to meet individually during June with each of the Executives who have lead responsibility for CQC standards. Each will assess the compliance with those standards on which they lead.
Practical arrangements for inspectors' visit	August 2015	**Ongoing** We have arranged for the Education Centre to be made available as a headquarters for the inspection team while they are on site. Practical arrangements such as catering will be made in August.

Board of Directors	
Agenda Item	7.2
Title of Report	Risk Management Strategy
Date of Meeting	27 May 2015
Author	Tracey Bills, Risk Manager
Accountable Executive	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	Approval and recommendations
Data Quality Rating	Silver – quantitative data that has not been externally
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken	*Not Applicable*

1. Executive Summary

The Risk Management Strategy has undergone a full review which has been agreed by the Quality and Safety Review Team in February 2015. It has been sent for a 2 week consultation and further amendments have been made. It has been sent to the Clinical Governance Group (20th March) and approved.

2. Background

A full review of the Risk Management Strategy has been undertaken in line with an audit of the systems and processes within the strategy conducted by Mersey Internal Audit Agency (MIAA) in the summer of 2014. MIAA produced a report stating that the Trust could give significant assurance that it was compliant with the requirements for risk management, however a number of weaknesses were observed and therefore the report outlined key recommendations to be addressed.

In addition the review of the Risk Management Strategy included further recommendations agreed by the CQC during an inspection in September 2014, pertinent to the processes within the Strategy highlighted in the 2013/14 risk management annual report.

3. Key Issues

On review and consultation of the Risk Management Strategy overall amendments have been made. The key changes are as follows:

- Preface 1 & 2 shows the "policy on a page" clear flowcharts demonstrating the process for entering a risk on to the risk register and the monitoring and review of risks including timescales.
- Preface 3 shows the risk and incident reporting schedule providing a clear table of the monitoring committees.
- Preface 4 shows the levels of authority for managing risk clearly demonstrating from ward to board who each level of risk sits with.
- The key elements of the strategy have been moved to the appendices for ease of use.
- The new organisational structure and duties and responsibilities have been included (also showing amended organisational structure in line with the disbanding of the Risk Management Group.
- The addition of the roles and responsibilities for OMT replacing the previous responsibilities of EDT included.
- The Maternity Risk Management Strategy has been reviewed and specific roles and responsibilities have been merged, therefore negating the need for a separate strategy for Maternity.

The review of the Risk Management Strategy ensures the Trust is compliant with MIAA recommendations as follows:

- **Recommendation 1:** The Trust should continue to develop accountability for risk in the Corporate Departments as far as possible replicating the arrangements in the clinical divisions. In particular the Trust should consider:
    a. Having a nominated lead for corporate services
    b. Providing formal risk reports to the Finance, Performance and FPBDC like those provided by other committees

  Response: The Risk Management Strategy now states that the Risk Manager will support the Corporate Services Department Leads for monitoring and review of risk in their areas, liaising with them monthly to review and update risks and action plans as appropriate.
  Corporate Department DMT reports are produced by the Risk Management Team and reviewed by the Corporate Department leads. Assurance reports will be sent to Trustwide Clinical Governance Team and Operations Management Team for monitoring.

- **Recommendation 2:** The Trust should strengthen the links between the corporate objectives, the Board Assurance Framework (BAF) and the risk register.
  Response: The Associate Director of Governance recently produced a paper for CGG detailing the revised process for the Board Assurance Framework. It was agreed that the current process of risk scoring and formal approval will be adopted by the new process i.e. OMT will review and approve BAF risks over 15 and under 20.
  The Risk Management strategy now states that all risks scored 15 or above will also be reviewed by the Associate Director of Risk, the Risk Manager and recommended by the Associate Director of Governance in line with the Strategic objectives for the purpose of linking them to the Board Assurance Framework if appropriate.

- **Recommendation 3:** The Trust should review its approach to the risk scoring matrix and how it is applied in risk management and incident management with a view to assuring itself that the dual use of the matrix does not lead to inconsistency in the management of risk and incidents.

Response: The Trust is satisfied with the current risk matrix arrangements and do not want to risk making unnecessary changes that could lead to confusion at the operational level.
The Risk Management Strategy now states that all risks are scored using the Trust risk matrix. The risk matrix functionality is for incidents, complaints and claims as well as risks. Incidents are scored using a colour reference (e.g. Yellow, Green, Orange and Red) based on the actual severity of the harm caused. Risks are scored using the numerical score only based on the potential severity of the harm caused.

- **Recommendation 4:** The Trust should review its approach to how it records and monitors:
    a. The risks of non-compliance with CQC standards, in particular with regard to medicines management
    b. The results of the risk assessments undertaken as a result of new NICE guidelines being issued.

  Response: The Head of Assurance is currently undertaking a review of all risks currently on the risk register in relation to CQC. Going forward all risks relating to non-compliance with CQC standards will be collated in to one risk and will be approved and monitored in line with the risk register process detailed in the Strategy.
  NICE Guidance risks and subsequent action plans are now added to the risk register only if applicable to the Trust and have gaps identified. These will be approved and monitored in line with the risk register process detailed in the Strategy.

- **Recommendation 5:** The Trust should consider providing further guidance to risk leads with a view to ensuring that:
    a. Risk descriptions provide specific data in support of the risk evaluation
    b. Risk scores are continually re-evaluated based on competed actions

  Response: The Risk Register Entry form provides guidance on the appropriate information which should be submitted on to the form. The Risk Management Strategy states that advice can be sought from the Divisional Quality and Safety Managers, the Quality and Safety Team or the Health and Safety Team. The Risk Management Team can provide updates on request for individual wards/departments/directorates.

  The Trust will ensure that training is provided in order that the objectives of this document are met. A range of courses related to risk management are available which are relevant to the requirements of Board members (including Executive and Non-Executive Directors), senior managers, new line managers, clinicians and other staff with responsibility for risk management within the Trust. Furthermore a mandatory training session is now in place to ensure that all staff receive regular risk training.

  The Risk Management Strategy now states that the residual risk score should be reviewed and will change in line with each action completed to mitigate the risk. This is an ongoing process and will be monitored and reviewed by the appropriate Divisional Management Team/Corporate Department Meeting until completion of all actions.

The review of the Risk Management Strategy also ensures the Trust is compliant with recommendations made within the Risk Management Annual Report 2013/14 as follows:

- **Recommendation 1:** A process is needed for the closure of risks
  Response: The Risk Management Strategy now states that in order for a risk to be closed, it must first be submitted to the Divisional Management Team/Corporate Department Meeting for approval that all actions have been completed and have resulted in full mitigation of the issues raised and reduced to the target risk score, with therefore no risk remaining. Evidence that this review has taken place must be sent to the Risk Team who will then close the risk on Safeguard.

- **Recommendation 2:** A process is needed for the ongoing monitoring of high scoring risks
  Response: The Risk Management Strategy now states that risks which have a risk rating of 15 or greater require an additional level of approval prior to escalation after being submitted to the risk register. A monthly report is submitted to OMT outlining all ongoing risks with a risk rating of 15 or greater in order that the team can ensure that effective monitoring and mitigation is in place for these risks. Furthermore the lead for a 15 plus risk must be approved by the OMT and must be of at least associate director level.

- **Recommendation 3:** Guidance is needed as to the recommended level of accountability needed to lead on a high scoring risk
  Response: The Risk Management Strategy now has a section (Preface 4) detailing the level at which the risk will be managed in the organisation and where it should be escalated to.

- **Recommendation 4:** Implement and monitor new risk definitions list
  Response: The Risk definitions list as discussed in the Risk Management Annual Report 2013/14 has been in use since April 2014 and has been successful in ensuring the correct information reaches the appropriate groups of staff for review and escalation.
  The review of the Risk Management Strategy has highlighted the similarity between the Risk Types including the descriptor 'Corporate' with 'Corporate Departments', therefore these risk types have been amended to:
  - Organisational Executive Risks
  - Organisational Trustwide Risks

- **Recommendation 5:** Implement a process for reviewing the score after each closure of action
  Response: This recommendation has been covered by the MIAA recommendations above.

- **Recommendation 6:** A process is needed to review the Risk Register in its entirety by each division to ensure accuracy of score and reduce duplication.
  Response: The Risk Management Strategy now states as part of the roles and responsibilities of the DMT that a review of the risk register in its entirety should be undertaken annually to ensure all risks are accurate, there are no duplications and they remain relevant.
  For Corporate Departments the Risk Manager in liaison with the Corporate Department Leads will review the risk register in its entirety annually to ensure all risks are accurate, there are no duplications and they remain relevant.

- **Recommendation 7:** Complete an audit to ensure that 20 plus risks in 2014/15 are escalated to Trust Board.
  Response: The Risk Management Strategy specifies that this audit should be undertaken as part of the key performance indicator's. The 2014/15 audit will be undertaken and the results included in the Risk Management Annual Report 2014/15.

4. Next Steps
Once Ratified, the Risk Management Strategy will be published.

5. Conclusion
The new strategy provides clear, easy to understand processes for the management of risks and will endeavour to enhance the current systems for managing risk to ensure we are in line with national and local recommendations.

6. Recommendations
The Board of Directors considers, and if appropriate, ratifies the Risk Management Strategy.

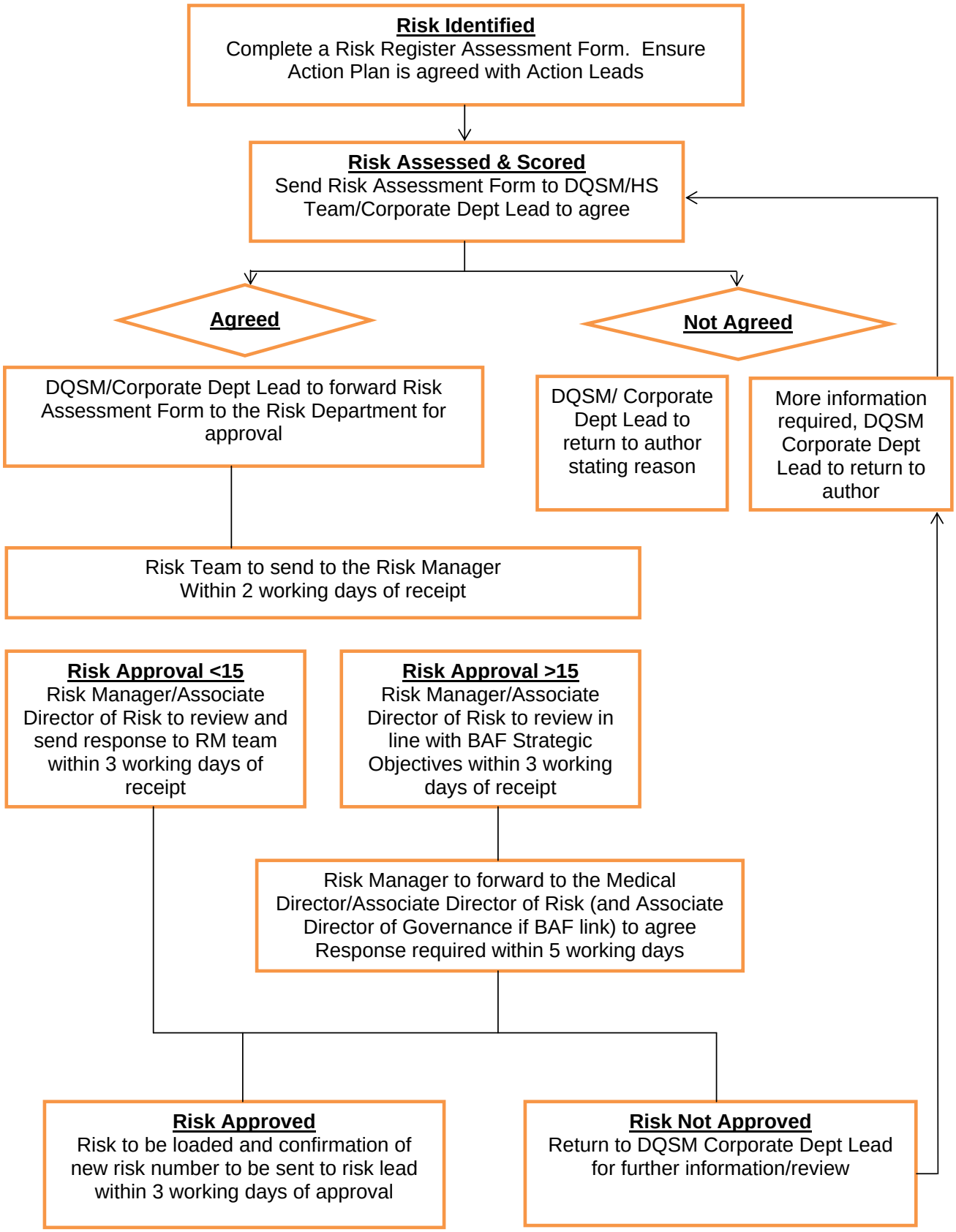
Policy Reference: 041

Risk Management Strategy and Policy

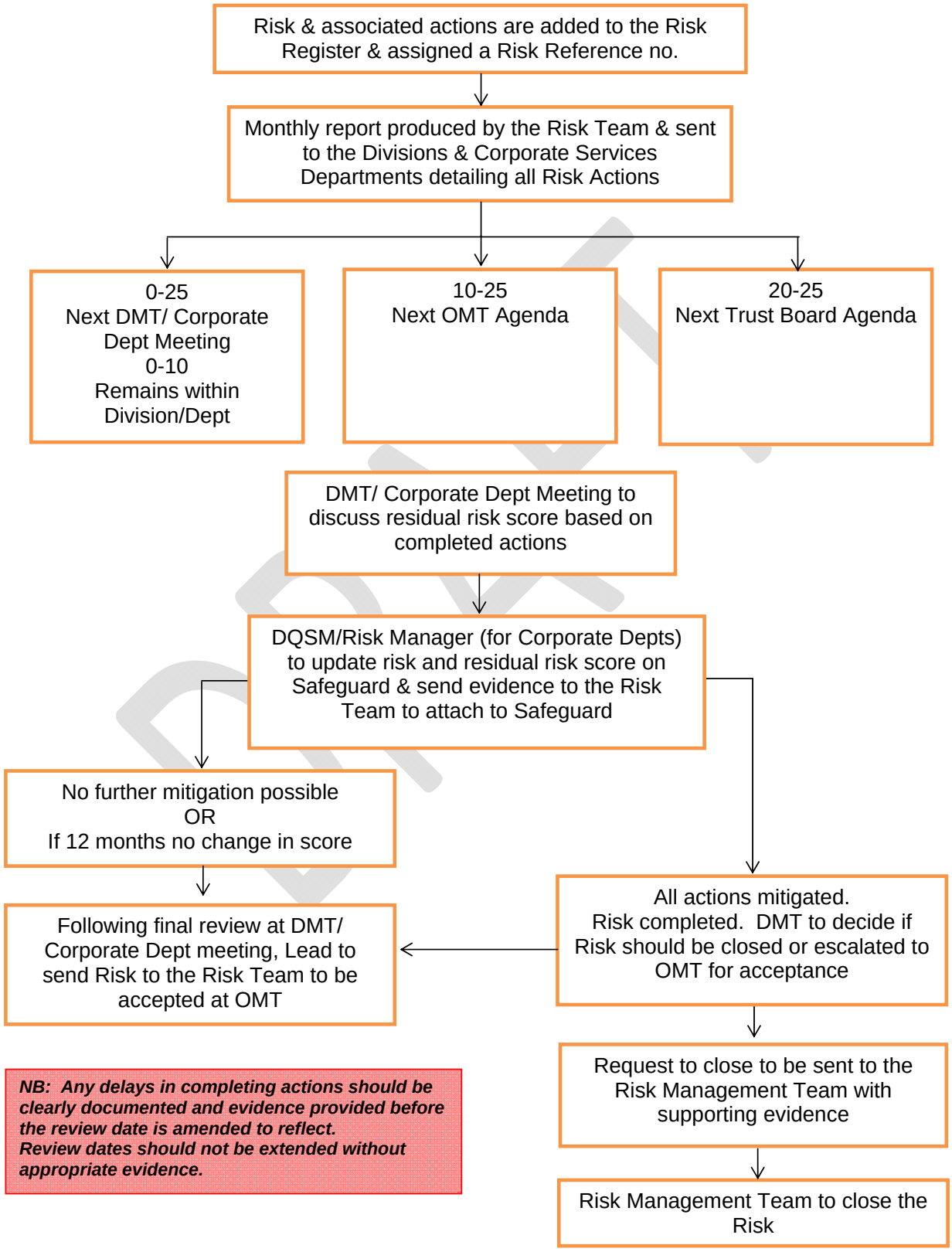
Version: 5.0

Name and Designation of Policy Author(s)	Tracey Bills, Risk Manager Dr Evan Moore, Medical Director
Ratified By (Committee / Group)	Board of Directors
Date Ratified	(Draft – not yet approved)
Date Published	(To be updated once published)
Review Date	(To be updated once published)
Target Audience	All staff
Other Associated Strategies, Policies, Procedures, etc	Trust Policy 023 – Concerns and Complaints Handling Trust Policy 041a – Incident Reporting and Management Policy & Procedure Trust Policy 041d – Learning From Experience Policy Trust Policy 108 – Claims Handling Policy & Procedure Trust Policy 118 – Health and Safety Policy Trust Policy 174 – Raising Concerns Policy Trust Policy 007 – Duty of Candour Policy

Preface 1: New Risk Register Entry



Preface 2: Risk Monitoring and Review



NB: Any delays in completing actions should be clearly documented and evidence provided before the review date is amended to reflect. Review dates should not be extended without appropriate evidence.

Preface 3: Risk and Incident Reporting Schedule / Performance Management

Frequency	Committee Meeting	Name of Report	Summary of report
Monthly	**Board of Directors**	20 plus risks	Monthly Report produced by the Risk Management Team sent for escalation and review of all new and ongoing 20 plus risks as and when the risk is loaded
Monthly	**Divisional Management Team (DMT):** • Medicine and Acute • Surgery, Women's and Children's • Clinical Support **Corporate Departments:** • Pharmacy • HR/OD • Informatics • Estates and Facilities • Corporate Nursing • Finance	DMT Report	Monthly Report produced by the Risk Management Team sent for escalation and review of: • All new risks • All ongoing 15 plus risks • All out of date risks • All risks due to expire • All incidents reported • All new and, closed and settled claims • All new and ongoing complaints • All new and ongoing PALS • All High Scoring Out of date RCAs • All High Scoring Ongoing RCAs • All INR related serious incidents
Monthly	**Clinical Governance Group**	CLIPPE	Quarterly Report including contributions from Complaints and Patient Experience, Legal Services, Risk Management, Infection Control, Falls and Pharmacy detailing a full analysis of all Complaints, Litigation, Incidents , PALS and Patient Experience to be escalated and communicated from Ward to Board and shared externally with the Clinical Commissioning Group (CCG).
		CQC Compliance Status Report	Monthly report produced by the Head of Assurance showing the current status of CCQC compliance.
		CQC Risk Register	Report produced by Risk Management Team sent for escalation and review of all new and ongoing CQC risks.
		Serious Incident trend analysis report	Quarterly Report produced by the Risk Management Team detailing all reported and completed RCAs and SBARs during the previous quarter to be escalated and communicated from Ward to Board and shared externally with the Clinical Commissioning Group (CCG).
		Contingency Business Plans	Annual plan produced by the Emergency Planning Coordinator.
		Monitor Major Incident Plan	Annual plan produced by the Emergency Planning Coordinator.
Monthly	**Operations Management Team (OMT)**	10 plus risks	Monthly Report produced by the Risk Management Team sent for escalation and review of all new 10 plus risks.

Frequency	Committee Meeting	Name of Report	Summary of report
		Accepted Risks	Monthly Report produced by the Risk Management Team after request received from Division for risks to be agreed as accepted OR If there has been no change in risk score in a 12 month period.
		Divisional/Corporate Departments quality & safety exception report Summary	Report produced by the Risk Management Team populated from the Divisional Quality and Safety Team reviews detailing any risk management exceptions to give assurance and enable any issues to be escalated through the organisation to CGG of robust risk and incident management processes including: • Policies • Risk Registers • Complaints / PALS • Claims / Inquests • RCAs External reviews
		CQC Compliance Status Report	Monthly report produced by the Head of Assurance showing the current status of CCQC compliance.
		CQC Risk Register	Report produced by Risk Management Team sent for escalation and review of all new and ongoing CQC risks.
		All Live and Out of Date policies	Monthly report produced by the Assurance Team detailing all policies which are currently live or are due for review.
		Trust Risk Management Strategy Performance /Compliance with Annual Review	Annual report produced by the Risk Management Team to **OMT with escalation to Quality & Safety Committee and Finance Business & Assurance Committee. Full review and approval reserved for the Board of Directors.**
Monthly	**Trust wide Clinical Governance Team (TWCGT)**	All Completed RCAs remaining serious	Monthly Report produced by the Risk Management Team detailing all completed RCAs which have remained serious after investigation.
		Trust Q&S assurance exception report	To include report produced by the Risk Management Team populated by the Corporate Department Leads and sent to the Risk Manager after review at specific Corporate Department monitoring meeting detailing any risk management exceptions to give assurance and enable any issues to be escalated through the organisation to CGG of robust risk and incident management processes including: • Policies • Risk Registers • Complaints / PALS • Claims / Inquests • RCAs • External reviews

Frequency	Committee Meeting	Name of Report	Summary of report
			Plus monthly Report produced by the Risk Management Team detailing: • Outstanding CAS/Internal Alerts • Out of date risks • Outstanding RCAs • Outstanding SBARs (QSRT) • NICE Guidance exceptions
		Divisional/Corporate Departments quality & safety exception report	Monthly Report produced by the Divisional Quality and Safety Team detailing any risk management exceptions to give assurance and enable any issues to be escalated through the organisation to CGG of robust risk and incident management processes including: • Policies • Risk Registers • Complaints / PALS • Claims / Inquests • RCAs • External reviews
		Serious Incident (SI) Reviews	Monthly Report produced by the Risk Management Team detailing shared learning from completed RCAs.
		Serious Incident trend analysis report	Quarterly Report produced by the Risk Management Team detailing all reported and completed RCAs and SBARs during the previous quarter to be escalated and communicated from Ward to Board and shared externally with the Clinical Commissioning Group (CCG).
		CLIPPE	Quarterly Report including contributions from Complaints and Patient Experience, Legal Services, Risk Management, Infection Control, Falls and Pharmacy detailing a full analysis of all Complaints, Litigation, Incidents , PALS and Patient Experience to be escalated and communicated from Ward to Board and shared externally with the Clinical Commissioning Group (CCG).
		Risk Annual report	Annual Report produced by the Risk Management Team providing an overview of risk management highlighted throughout the year to be escalated and communicated from Ward to Board.
		Incidents Annual report	Annual Report produced by the Risk Management Team providing an overview of all incidents reported throughout the year to be escalated and communicated from Ward to Board.
		Claims and Inquests Annual Report	Annual Report produced by the Legal Services Team providing an overview of all claims and inquests managed throughout the year to be escalated and communicated from Ward to Board.

Frequency	Committee Meeting	Name of Report	Summary of report
Bi-Monthly	**Quality and Safety Committee**	Never Events	Report produced by Risk Management Team identifying new Never Events reported.
		15 plus risks	Report produced by the Risk Management Team sent for escalation and review of all new 15 plus risks.
		Serious Incident Graph	Graph produced by Risk Management Team identifying new Serious incidents reported.
		CQC Compliance Status Report	Monthly report produced by the Head of Assurance showing the current status of CCQC compliance.
		CLIPPE	Quarterly Report including contributions from Complaints and Patient Experience, Legal Services, Risk Management, Infection Control, Falls and Pharmacy detailing a full analysis of all Complaints, Litigation, Incidents , PALS and Patient Experience to be escalated and communicated from Ward to Board and shared externally with the Clinical Commissioning Group (CCG).
		Serious Incident trend analysis report	Quarterly Report produced by the Risk Management Team detailing all reported and completed RCAs and SBARs during the previous quarter to be escalated and communicated from Ward to Board and shared externally with the Clinical Commissioning Group (CCG).
		CQC Risk Register	Report produced by Risk Management Team sent for escalation and review of all new and ongoing CQC risks.
		Trust Risk Management Strategy Performance /Compliance with Annual Review	Annual report produced by the Risk Management Team to OMT with escalation to Quality & Safety Committee and Finance Business & Assurance Committee. Full review and approval reserved for the Board of Directors.
Bi-Monthly	**Audit Committee**	Risk Management Process Dashboard	Report produced by Risk Management Team showing monitoring of all risk and incident processes.
Quarterly	**Health and Safety Partnership Group**	Health and Safety Non-Clinical Data Analysis	Report produced by the Health and Safety Team showing a full analysis of all non-clinical incidents.

Preface 4: Authority levels for managing different levels of risk

The level at which the risk will be managed in the organisation and where it should be escalated to is documented below:

Risk Score	Remedial Action	Decision to agree risk	Risk Approval	Escalated to Committee
1-10	Ward / Department Manager	DQSM	Risk Manager	DMT
10-15	Triumvirate/ Head of Corporate Department	DQSM	Risk Manager 15 plus Medical Director	10-15 OMT
15 -20	Triumvirate/ Head of Corporate Department	DQSM	Medical Director	OMT
20-25	Triumvirate/ Head of Corporate Department / Executive Director	Board of Directors	BoD	BoD

CONTENTS

1 Introduction

Wirral University Teaching Hospital NHS Foundation Trust (WUTH) recognises that risk management is an integral part of the Trust's approach to quality improvement and good governance and is a central part of the Trust's strategic and operational management. The continued delivery of high quality healthcare requires the Trust to adopt effective risk processes to ensure the identification, management and minimisation of events or activities, whether clinical, non-clinical including strategic, financial, workforce or any other which could result in unnecessary risks to patients, staff and the public and puts in place robust and effective controls to mitigate those risks.

The Trust is committed to ensuring the safety of patients, staff and the public through the integrated management of all aspects of governance and risk. Good governance, i.e. the way that the organisation is directed, controlled and held to account, is at the heart of controlling risk in any organisation. Risk management is embedded within the Trust's overall performance management framework and links with business planning and investment.

As the accountable officers, the Board of Directors have overall responsibility for corporate governance including quality and safety and risk management within the Trust. They have legal and statutory obligations, which demand that the management of risk is addressed in a strategic and organised fashion to ensure that risks are eliminated or reduced to an acceptable level. In view of the statutory duties placed on the Trust and the Accountable Officers of the Trust, the pace of change in the NHS and the growing assurance agenda, it is important that staff are empowered to manage risk at a local level wherever possible and that clear arrangements are in place to escalate risk issues when it is appropriate to do so. This will ensure that risk is managed at an appropriate level in the Trust and ensure that unreasonable delays are avoided.

This Strategy describes the systems and processes that the Trust will use to embed risk management throughout the organisation in order to provide assurance that risks are managed and an effective internal control system is in place.

This strategy is subject to annual review and approval by the Trust Board.

2 Purpose

Risk Management focuses upon proactive risk assessment and experiences and learning, in order to improve clinical outcomes, achieve Trust objectives (Appendix 1), improve the working environment, assess and where possible, anticipate risk and also eliminate or reduce risk or harm. The purpose of this document is to define the strategic direction and policy for risk management in the Trust. It describes the framework and the method that the Trust will use to identify, manage and reduce the risks (actual or potential) which exist within the Trust and its environment and provides clear direction on which to base all future risk management initiatives. The Risk Management Strategy underpins the Trust's reputation and performance and is fully endorsed by the Trust Board.

The Trust acknowledges its legal duty to safeguard patients, staff and the public and to improve safety, in turn reducing the probability of failure to meet regulatory compliance requirements or achieve strategic and operational objectives. Failure to manage risk

effectively can lead to harm, loss or damage in terms of personal injury, loss or damage to the Trust's reputation, financial loss or potential for complaints and litigation.

3 Scope

This document sets out the strategy for the continued development of risk management throughout the Trust and the policy to implement it. The strategy is a trust wide document, and is applicable to all employees working in or on behalf of the Trust in other environments, as well as non-Trust staff working in or representing the Trust in any way and seconded and sub-contracted staff at all levels of the organisation.

The Trust is committed to working in partnership with staff to make risk management a core organisational process and to ensure that it becomes an integral part of the Trust philosophy and activities. This will be achieved by building and sustaining an organisational culture, which encourages appropriate risk taking, effective internal control systems and accountability for organisational learning in order to continuously improve the quality of services. As part of this, the Trust undertakes to ensure that adequate provision of resources, including financial, personnel, training and information technology is as far as reasonably practicable made available. It is imperative that managers and clinicians ensure that the message "risk management is everybody's responsibility" is well understood and acted upon in the Trust.

4 Risk Management Policy Statement

The Trust has adopted the following risk management policy statement and it is upon this which the Risk Management Strategy and Policy is based:

"Wirral University Teaching Hospital NHS Foundation Trust is committed to the control of risks in a strategic and organised fashion, to ensure that risks can be eliminated or reduced to an acceptable level thereby improving the experience and safety of patients, visitors, staff and the public. This commitment is commensurate with the Trust's vision and values. Managing business risk is fundamental to achieving this aim."

5 Aims of the Strategy and Policy

The processes outlined within the Risk management strategy and policy aim to achieve the optimum level of quality care and treatment of patients and provision of services that are safe and free from unnecessary risks by making maximum use of available resources and reducing wasteful expenditure. The Board of Directors will continuously strive to ensure that there are effective governance and risk management arrangements in place and that these are monitored on an ongoing basis. The Trust's key strategic risk management aims are:

- To adopt an integrated approach to the management of risk and to integrate risk into the overall arrangements for clinical and corporate governance;
- To support the achievement of the Trust's strategic objectives as described in the Trust business plan;
- To comply with national standards e.g. Care Quality Commission (CQC)/Monitor regulations/standards, Information Governance standards;
- To have clearly defined roles and responsibilities for the management of risk;

- To provide high quality services to patients and to continuously strive to improve patient safety;
- To ensure the safety of its employees;
- To ensure that risks are continuously identified, assessed and minimised;
- To use risk assessments to inform overall business planning/ investment processes in the Trust;
- To encourage open and honest reporting of risk and incidents through the use of the Trust reporting systems;
- To establish clear and effective communication that enables information sharing
- To foster an open culture which supports organisation wide learning.

6 Regulatory Framework for Risk

Please see Appendix 3.

7 Risk Management Process

Risk management is having in place a corporate and systematic process for reporting and evaluating the impact of risk in a cost effective way and having staff with the appropriate skills to identify and assess the potential for risk to arise.

The Risk Management Process provides a framework by which organisational risks are identified, reviewed and monitored. This is achieved through the following stages: Risks are:

- Identified from a diverse range of sources including
    - Proactive methods such as business planning processes, including review of the Board Assurance Framework, routine risk assessments undertaken corporately and by services, identification of operational risks via Divisional Governance Groups and internal audit findings and recommendations
    - Reactive methods such as analysis of incident and near miss reporting, findings of serious untoward incident investigations, analysis of claims, complaints and concerns and recommendations following external regulator inspection reports
- Recorded on the on-line Risk Register
- Subject of robust and effective reporting and review arrangement
- Linked to the Board Assurance Framework as required
- Subject to effective monitoring

7.1 Risk Register

In the context of being open and transparent, all staff are actively encouraged to enter perceived risks onto the Risk Register. Appropriate leads will oversee divisional/corporate department operational risks with support from the Divisional Quality and Safety Managers/Risk Manager.

The Risk Register is a database that holds the main record of all identified risks to Wirral University Teaching Hospitals NHS Foundation Trust's objectives and operations. The Organisational Risk Register is a dynamic document located on Safeguard and is readily accessible.

7.2 Divisional Risk Register

The review and management of Divisional Risk Registers will be integral to the function of monthly Divisional Management Team Meetings.

New Divisional risks scoring 10 or above on the risk matrix will be escalated monthly to Operations Management Team (OMT). OMT can determine that a risk is acceptable and agree that the risk cannot be reduced or mitigated any further if applicable.

7.3 Board Assurance Framework

The Board Assurance Framework (BAF) is a high level document that records the key risks that could impact on WUTH achieving its strategic objectives. It provides a framework for reporting key information to the Board. It provides assurance about where risks are being managed effectively and objectives are delivered and will also identify which of WUTH's objectives are at risk because of gaps in controls or assurance.

Key risks cannot be considered in isolation, they will be derived from the prioritisation of risks fed up through the whole organisation and in this way the Organisational Risk Register will contribute to the Board Assurance Framework.

The current process of risk scoring and formal approval will be adopted by the new BAF process i.e. OMT will review and approve BAF risks over 15 and under 20.

7.4 Proactive Risk Identification

Proactive risk assessment enables the Trust to identify actual or potential hazards or threats that may or may not have resulted in actual incidents and ensure adequate control measures are in place to eliminate or reduce the risk of harm occurring. From this information, the Trust can assess whether or not there are sufficient precautions in place or if more needs to be done to mitigate the risk in order to prevent a particular harm or threat materialising. Proactive risk assessment also fulfils the Trust's statutory

obligations in terms of Health and Safety risk assessments. (Please refer to the Health and Safety Policy).

7.5 Completing a risk register assessment

Upon identification of an individual risk at any time a staff member can complete a risk register assessment form which is available on the Trust's intranet site. The risk will be reported to and discussed with a line manager and the Divisional DQSM and scored using the Trust risk scoring matrix. Action plans will be developed and the risk will populate the Trust's Risk Register and be escalated in line with the Trust risk escalation process. If immediate action is required this should be undertaken as quickly as possible to minimise the risk.

7.6 Initial Risk Scoring (Grading)

All risks are scored using the Trust risk matrix (Appendix 7). The risk matrix functionality is for incidents, complaints and claims as well as risks. Incidents are scored using a colour reference (e.g. Yellow, Green, Orange and Red) based on the actual severity of the harm caused. Risks are scored using the numerical score only based on the potential severity of the harm caused.

Risk scores have two main components; consequence and likelihood. Multiplying these together will give a risk score between 1 and 25.

Advice with respect to risk scoring can be sought from the Divisional Quality and Safety Managers, the Quality and Safety Team or the Health and Safety Team.

7.7 Target Risk Scoring (Grading)

The risk register assessment asks for a target risk score. This score should be the score which you aim to achieve once all actions have been completed and control measures have been implemented to mitigate the risk.

7.8 High scoring risks

Risks which have a risk rating of 15 or greater require an additional level of approval prior to escalation after being submitted to the risk register. A monthly report is submitted to OMT outlining all ongoing risks with a risk rating of 15 or greater in order that the team can ensure that effective monitoring and mitigation is in place for these risks. Furthermore the lead for a 15 plus risk must be approved by the OMT and must be of at least associate director level.

All risks scored 15 or above will also be reviewed by the Associate Director of Risk, the Risk Manager and recommended by the Associate Director of Governance in line with the Strategic objectives for the purpose of linking them to the Board Assurance Framework if appropriate.

7.9 Submitting the Risk Register Assessment Form on to the Risk Register

Please see flowchart in Preface 1 for the identification and escalation of risk.

- Once a risk is identified a Risk Register Assessment Form should be completed. The risk register assessment form should be conducted by an identified lead with responsibility for the area where the risk has been identified.

- The risk assessment must include an action plan developed by the identified lead who must engage the relevant stakeholders in the Division or Corporate Department.
- All actions must have due dates and the overall lead for an action plan must make sure that anyone who is assigned a task is aware of the action and the date by which is must be delivered.
- The completed risk assessment must then be sent to the Divisional Quality and Safety Manager, Health and Safety Team or Corporate Department Lead as applicable to agree.
- Once agreed the risk assessment form should be sent to the Risk Management Team for approval
  Approval will be given as follows:
  - Risk scored 1 to 14 – Risk Manager
  - Risk score >=15 – Medical Director then OMT
  - Risk score >=20 – Board of Directors/OMT (whichever happens first)
- Once approved the risk will be added to the Organisational risk register and will be included in the monthly reporting schedule for risks.

7.10 Residual Risk Scoring

The residual risk score should be reviewed and will change in line with each action completed to mitigate the risk. This is an ongoing process and will be monitored and reviewed by the appropriate Divisional Management Team/Corporate Department Meeting until completion of all actions.

7.11 Closure of risks

In order for a risk to be closed, it must first be submitted to the Divisional Management Team/Corporate Department Meeting for approval that all actions have been completed and have resulted in full mitigation of the issues raised and reduced to the target risk score, with therefore no risk remaining. Evidence that this review has taken place must be sent to the Risk Team who will then close the risk on Safeguard.

7.12 Acceptable Risks

The Trust recognises that eliminating all risk is not possible and that systems of control must not be so rigid that they stifle innovation, creativity, and the imaginative use of resources. In this context, the Board of Directors defines ‘acceptable’ as follows:

An acceptable risk is one where all actions have been completed as far as is reasonably practicable to ensure and a suitable and sufficient residual risk score has been reached. The risk is accepted after proper evaluation and is one where effective and appropriate controls have been implemented. The acceptance of a risk should represent an informed decision to accept the likelihood of that risk recurring. It must be:

- Identified and entered on the Risk Register;
- Quantified (Consequences and Likelihood);
- Reviewed and have been deemed acceptable by the Operations Management Team;
- Controlled and kept under review at least annually via re-submission to the Operations Management Team.

8 Monitoring of Risks / Reporting

Please refer to Flowcharts in Preface 2, 3 & 4.

9 Training and Support

The Trust will ensure that training is provided in order that the objectives of this document are met. A range of courses related to risk management are available which are relevant to the requirements of Board members (including Executive and Non-Executive Directors), senior managers, new line managers, clinicians and other staff with responsibility for risk management within the Trust. Furthermore a mandatory training session is now in place to ensure that all staff receive regular risk training.

An annual risk management training session is delivered to members of the Trust Board. The training is intended as an update and the content covers current issues in risk management. Attendance is recorded on the OLM training database. If any members are unable to attend the training session, the Quality and Safety department will contact their secretaries to arrange for them to receive the same training, delivered on a one-to-one basis by a manager from the Quality and Safety Department within three months of the original group training session.

The Risk Management Team can provide updates on request for individual wards/departments/directorates. Several specialist courses are also open to staff, details of which can be found on the Trust Staff training and development pages of the intranet.

10 Other Relevant Procedural Documentation

This document should be read in conjunction with the following:

- Incident Reporting and Management Policy & Procedure (including Serious Incidents)
- Duty of Candour Policy
- Health and Safety Policies
- Infection Control Policies
- Concerns & Complaints Handling Policy
- Claims Handling Policy & Procedure
- Information Governance Policies
- Learning from Experience Policy

11 Definitions

Please see Appendix 2.

12 Organisation Structure - Duties /Responsibilities of Committees/Individuals

Please see Appendices 4, 5 and 6.

13 References

Audit Commission (2009) Taking it on Trust: a review of how boards of NHS trusts and foundation trusts get their assurance
Department of Health (2000), An Organisation with a Memory
Department of Health (2001), Building a Safer NHS for Patients
Department of Health (2003), Building the Assurance Framework: A Practical Guide for NHS Boards, Gatelog Reference 1054
Department of Health (2006), Integrated Governance Handbook
Health and Safety Executive website (2000) *Revitalising Health and Safety*
Monitor (2015) *Quality Governance Framework*
National Patient Safety Agency (2003), Seven Steps to Patient Safety: A guide for NHS staff
National Patient Safety Agency (2006), *Safety First*
NHS Connecting for Health (2011) Information Governance Toolkit,
NHS Litigation Authority (2012), Clinical Negligence Scheme for Trusts: Acute Service Standards
Security of State directions to health bodies on measures to tackle violence and general security management (Statutory instrument 3039/2002)

Appendix 1: Our Strategic Aims

Our vision is to be the first choice healthcare partner to the communities we serve from the home to the provision of regional specialist centres.

We will achieve our strategic plan and the delivery of our organisational objectives and goals by:

- **being** the top NHS Hospital Trust in the North West for patient, customer and staff satisfaction
- **Leading** on integrated shared pathways of care with primary, social and community care
- **delivering** consistently high quality secondary care services enhanced through the provision of regional specialist centres
- **ensuring** our people are aligned with our vision
- **maximising** innovation and enabling technologies
- **building** on partnering for value
- **achieving** financial, commercial and operational excellence

Our Goal is that over the next 5 years we will work together to transform our organisation, building on our considerable clinical capabilities to place our patients and our customers at the heart of everything we do.

The focus on exceptional customer service will be delivered through integrated, seamless, continuous pathways of care enabled by innovation and leading edge technology.

Appendix 2: Definitions

Acceptable Risk	The Trust recognises that eliminating all risk is not possible and that systems of control must not be so rigid that they stifle innovation, creativity, and the imaginative use of resources. In this context, the Board of Directors defines 'acceptable' as follows: An acceptable risk is one which has been accepted after proper evaluation and is one where effective and appropriate controls have been implemented and has been reduced to the lowest level that is reasonably practicable. The acceptance of a risk should represent an informed decision to accept the likelihood of that risk recurring. It must be: • Identified and entered on the Risk Register; • Quantified (Consequences and Likelihood); • Reviewed and have been deemed acceptable by the Operations Management Team; • Controlled and kept under review at least annually via re-submission to the Operations Management Team.
Board Assurance Framework	The Board Assurance Framework sets out a list of strategic risks
Consequence	A measure of the impact that the predicted harm, loss or damage would have on the people, property or objectives affected.
Control Measures	Actions, procedures, protocols, physical controls etc. designed to eliminate, reduce or control risk presented by control of the hazard.
Harm	An injury (physical or psychological), disease, suffering, disability or death. Unexpected harm is considered to have occurred when it is not related to the natural course of the patient's illness or underlying condition (NPSA 2001).
Hazard	Anything that has the potential to cause injury, loss, damage or harm.
Incident	An incident is defined as any event or circumstance which leads to, or could potentially lead to, unintended or unexpected harm, loss, or damage to either patients, staff or the public, incur financial loss or injure the reputation of the Trust.
Likelihood	A measure of the probability that the predicted harm, loss or damage will occur.
Residual Risk	The risk that remains after identified control measures have been implemented.
Risk	The probability or likelihood that harm, damage or loss may occur, coupled with the consequence of that harm. "What can go wrong and how likely is it to go wrong".
Risk Assessment	The process by which hazards which arise out of work activities or the existing work environment, are identified and the risk rated using tools implemented by the Trust for use by all employees. Assessments will identify who may be harmed and how and then evaluate the extent of the risks those hazards pose, taking into account whatever precautions or mitigation are already in place. They can either be general or specific, but will be undertaken by

	competent persons who have received the appropriate degree of information, instruction and training.
Risk Management	Risk management is the systematic application of management policies, procedures and practices to the tasks of identifying, analysing, assessing, treating and monitoring risk. This includes the application of Health and Safety Regulations in every day working activity. Described as a five stage process, namely: 1. The identification of all risks which have potentially adverse effects on the safety of patients, staff and the public and the Trust's business. 2. The assessment, evaluation, elimination and reduction of the risks identified. 3. The creation of a system for the protection of assets and income combined with a cost effective service. 4. The creation of a management environment in which pro-active and positive action is taken to eliminate or reduce risks and ineffective or inappropriate working practices. 5. The creation of an environment in which staff are encouraged and supported to report errors, near misses and incidents so that learning and improvement is the outcome.
Risk Matrix (Appendix 7)	The tool that is used to "score" each risk and determine its place on the Trust Risk Register, levels of authority are determined through the matrix and this will provide a priority list for managers to use within their respective area of control.
Risk Register	The Trust Risk Register is a log of all risks (operational and strategic) that threaten the organisations success in achieving its objectives, managed by the Quality and Safety Department, of all of the risks which are recorded in the Trust. It includes: • Date risk entered • Source of risk • Description of the risk; • Initial risk score • Current residual risk score; • Risk action plan to mitigate the risk / Controls • Date of review The Risk Register identifies which staff member is leading on the mitigation of the risk and progress against the plans. The entire and current Risk Register is uploaded onto the intranet at the beginning of every month.
Risk type: CQC risks	Any risk which relates to the CQC outcomes.
Risk type: Corporate Department risks	Risks which affect a corporate department e.g. Informatics. The risk location will be the corporate department to ensure that the

	risk is reviewed and updated within the given department.
Risk type: Divisional risks	Risks which affect one clinical division. The risk location will be the clinical division to ensure that the risk is reviewed and updated within the given department.
Risk type: Divisional risks which affect more than one division	Risks which affect more than one division but not all divisions. The risk location will be the clinical division, and the handler will be the other area affected to ensure that the risk is reviewed and updated within both affected departments.
Risk type: Organisational Executive risks	High level organisational risks, these risks must have an Executive as the risk lead. The risk location will be the 'working area' of the risk, and this is to ensure that the risk is reviewed and updated within the given department.
Risk type: Organisational Trust wide risks	Risks which affect every division in the Trust. The risk handler will be the division in which the risk lead belongs to ensure that the risk is reviewed and updated within the given department.

Appendix 3: Regulatory Framework for Risk

Care Quality Commission

CQC is the independent regulator of health and social care services in England. Their role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety.

The CQC is currently implementing its new fundamental standards forming its regulatory framework which is based around the following five key questions about services:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they well led?
- Are they responsive to people's needs?

CQC's five year strategy 'Raising standards, putting people first', outlines their vision for developing and implementing the new regulatory framework. WUTHs Risk Strategy takes account of the revised inspection regime and aims to provide robust guidance to WUTH in ensuring that evidence of sound risk management can be provided in the event of an announced or unannounced CQC inspection.

Monitor's Risk Assessment Framework

Since 1 April 2013, all NHS Foundation Trusts require a licence for Monitor to operate stipulating specific conditions that they must adhere to in order to operate. WUTH has regularly reviewed compliance with Monitor's Quality Governance Framework (see Figure 2); a tool which enables the Trust to apply a risk based approach to evaluating the organisations rigour in relation to quality governance.

Strategy		Capabilities and culture		Processes and structures		Measurement	
1A) Does quality drives the Trust's strategy?	→	2A) Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?	→	3A) Are there clear roles and accountabilities in relation to quality governance?	→	4A) Is appropriate quality information being analysed and challenged?	→
1B) Is the Board sufficiently aware of potential risks to quality?	→	2B) Does the Board promote a quality – focused culture throughout the Trust?	→	3B) Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?	→	4B) Is the board assured of the robustness of quality information?	↓
	↑			3C) Does the Board actively engage patients, staff and other key stakeholders on quality?	→	4C) Is quality information used effectively?	→
						Overall score of 2.5	

Figure 1: Monitor's Quality Governance Framework

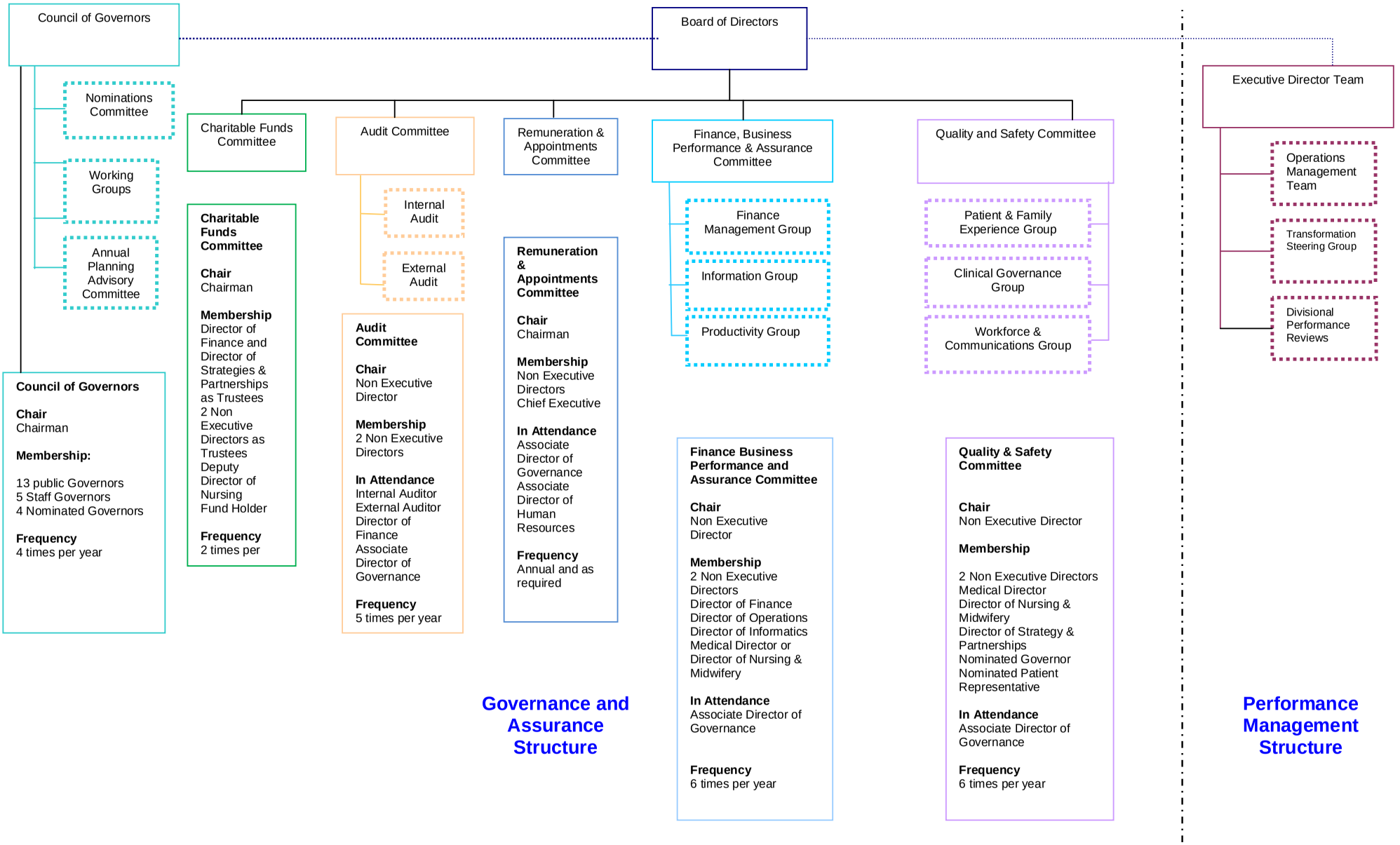
The development of this strategy supports our progress towards achieving our aspirational goals set against the Quality Governance Assurance Framework, reducing risk to patients and staff in our care and supporting sustainability of the organisation.

National Health Service Litigation Authority (NHSLA)

From April 2014, the NHSLA no longer carries out assessments relating to compliance with their risk management standards. Instead, they provide a Safety and Learning Service for members which supports improved patient and staff safety and the reduction of harm.

WUTH will actively participate in the safety and learning service provided to ensure that our risk related policies continue to be rooted in sound research and best practice.

Appendix 4: Governance, Performance Management and Assurance Structure



Appendix 5: Risk Management Organisational Structure: Duties /Responsibilities – Committees

The Board of Directors

The Board of Directors at the Trust is a unitary Board and as such each member of the Board is ultimately equally responsible for the organisation's system of integrated governance and internal control – clinical, financial and organisational. The Board of Directors is required to produce statements of assurance which declare that it is doing its 'reasonable best' to ensure that the Trust meets its objectives and protects patients, staff, the public and other stakeholders against risks of all kinds.

The Board of Directors review and are aware of the risk register in the following ways:

- The Organisational Risk Register is available on the intranet at all times for review in full by any staff member including Board members.
- Where a risk scores 20 or above using the Trust risk scoring matrix, the risk will be escalated to the Board following discussion with the Medical Director and will be escalated to the first available Operations Management Team (OMT).
- The Board of Directors defines the structure of the Board Assurance Framework (BAF) such that it meets its assurance requirements and drives the Board's agenda. The BAF is the means by which the Board holds itself to account and identifies the principal risks that would prevent achievement of the Trust's strategic goals and/or regulatory compliance. The BAF defines the control systems in place to mitigate these risks and confirms the assurances that the Board wishes to receive throughout the year to evidence the effective operation of controls and mitigation of principal risks. The Board utilises the BAF as a working document and reviews the BAF structure and content at least annually.
- Members of the Board receive the minutes of the Audit Committee, Quality and Safety Committee and the Finance, Business Performance and Assurance Committee for information. The Board of Directors also receives a Report on Key Assurances and Risks from the Chairs of the Audit Committee, Quality and Safety Committee and Finance, Business Performance and Assurance Committee.

Audit Committee

Directors and senior management are responsible for implementing the Trust policies and procedures and a key source of assurance to the Board of Directors is the Audit Committee. This is the Board Committee with overarching responsibility for the scrutiny of the risk management systems and processes and the maintenance of an effective system of internal control on behalf of the Board.

The Audit Committee oversees arrangements in place relating to Counter Fraud and Corruption which are compliant with Department of Health requirements and are also subject to external audit. Its roles and responsibilities are described in the terms of reference.

The audit committee receives a risk process dashboard which provides a high-level summary of incident and risk management throughout the Trust. The dashboard submits ongoing data showing where the Trust is or is not meeting key targets from the Incident Reporting and Management Policy and the Risk Management Strategy; for example the number of risks opened and closed each month, the number of risks

accepted each month, the number of out of date risks each month and the detail of any new risks with a risk rating of 15 or greater.

Quality and Safety Committee
The Quality and Safety Committee is responsible to the Board of Directors for assuring the quality of patient care and service delivery in respect of clinical effectiveness, safety, and patient and staff experience. The Committee has specific objectives on monitoring high level risk, clinical effectiveness and safety, patient and staff experience, staff engagement and governance through a range of reports. The Committee has a role to support the integration of clinical, organisational and financial risk management and promotion of a holistic approach to management of risk.

The committee receives notification of all new 15 plus risks (both organisational and strategic) added to the risk register.

Finance, Performance and Business Development Committee
The Finance, Performance and Business Development Committee is an assurance committee of the Board of Directors.

The Committee receives direct reports from E Programme Group, Information Governance Group, Transformation Programme Group, Finance Management Group, Capital management Group and the Business Development Group. The Committee has specific objectives on monitoring high level risk from these areas and additional areas as appropriate.

Clinical Governance Group (CGG)
The Group is a strategic group led by the Medical Director. Its primary purpose is to oversee the execution of the Clinical and Quality Improvement Strategies and associate key delivery plans.

CGG objectives are:

- To be proactive to ensure that the Trust is aware of clinical governance issues.
- To ensure the Trust is aware of new developments that could impact on the quality and safety agenda.
- To oversee the development and approval of plans for the implementation of Trust wide clinical governance and patient experience issues.
- To scrutinise strategies and plans for the implementation of Trust wide clinical governance and monitor progress in implementing specific proposals.
- To escalate clinical governance and proposals with financial implications as necessary for approval by the EDT.
- To ensure clinical governance or concerns are investigated, discussed and actioned at the appropriate level in the organisation as they arise.
- To monitor compliance with the Care Quality Commission (CQC) registration and performance manage outstanding action plans.
- CGG is the key committee to oversee and develop the Quality Account prior to approval by the Board of Directors and to monitor progress via the Quarterly Quality Account Reports.
- To assess, receive and monitor risks in accordance with the Risk Management Strategy.

The CGG will support the integration of clinical, organisational and financial risk management with that of the business planning process. It will promote a holistic approach to managing risk that will encourage all staff to provide safe, effective, timely and efficient care to patients.

The CGG meets on a monthly basis with a minimum 10 meetings per year.

The Executive Director leading the CGG will take responsibility for communicating key issues between EDT, the CGG and other teams / staff to ensure that operational actions are delivered and risks managed and communicated in a timely way.

Operations Management Team (OMT)
The primary purpose of this Group is to oversee the execution of this Strategy and associated policies. It is responsible for providing assurance to the Committees' of the Board of Directors.

OMT is responsible for the monitoring and review of risks as follows:

- Any risks identified by Divisions and Corporate Departments which are scored 10 or above using the Trust risk scoring matrix are presented to the group. Group members provide a quality assurance role with respect to risk scores and mediate on risk scores where there is disagreement about consequence or likelihood.
- Any risks relating to CQC outcomes are presented to the group.
- Receive summary reports from each Divisional Management Team meeting in order to escalate any concerns or problem areas.

The OMT is also responsible for the management of operations within the Trust. Members of this Team are senior members of Trust staff with key management responsibilities. These responsibilities include risk management.

The OMT is responsible for accepting risks which cannot be mitigated any further. If the OMT considers further mitigation to be appropriate the risk will be returned to the appropriate team for further management.

Health and Safety Partnership Team (HSPT)
The Health and Safety Partnership Team is central to risk management of non-clinical risks within the organisation. This "committee" reviews risks, agrees mitigation plans and escalates risk in line with the Trust's escalation policy and procedure. Its roles and responsibilities are described in the terms of reference.

HSPT will:

- Discuss and agree mitigation plans escalated from their subcommittees;
- Discuss risk issues directly as they arise if urgent;
- Escalate risk issues which cannot be resolved to Workforce and Communication group in line with the Trust escalation process;
- Escalate risk issues which score 10 or above using the Trust risk matrix to OMT.

Divisional Management Teams (DMTs)
These team meetings are responsible for reviewing all divisional risks pertaining to their area, ensuring robust action plans are in place and monitoring action plans to ensure that they are completed on time. They will escalate risks which are outside of their control or which have financial implications which cannot be managed internally.

To support management action a Risk Summary Report is produced each month which highlights key issues for management action in relation to policies, risk, incidents, complaints and claims.

DMTs will also:

- Discuss, agree and monitor mitigation plans for all risks belonging to their Division;
- Ensure that risks are reviewed in a timely manner;
- Ensure that actions taken to mitigate risks are reflected in the residual risk score
- Ensure that risks are fully mitigated prior to closure
- Review the risk register in its entirety annually to ensure all risks are accurate, there are no duplications and they remain relevant.
- Review monthly incidents, complaints and claims which occur in the Division.

Appendix 6: Duties / Responsibilities – Individuals

Chief Executive
The Chief Executive (CEO) has overall responsibility for having an effective governance system, including risk management, in place in the Trust and for meeting all statutory requirements and adhering to guidance issued by the Department of Health in respect of governance and risk management. To fulfil this responsibility the CEO will:

- Ensure that full support and commitment is provided and maintained in risk management activities;
- Ensure an appropriate Board Assurance Framework is in place;
- Ensure that the Annual Governance Statement adequately reflects the risk management issues within the organisation.

Medical Director
The Medical Director is the responsible Executive for:

- Quality and safety including clinical governance and risk management which includes patient safety

Director of Nursing and Midwifery
The Director of Nursing and Midwifery is responsible for:

- Patient experience;
- Complaints and concerns via PALS;
- Safeguarding;
- Provision of professional leadership for nursing and midwifery including the Infection Control Nursing Team and Tissue Viability Team.
- Emergency planning

Director of Finance
The Director of Finance is responsible for:

- Systems of financial control;
- Implementing the Trust's financial policies and ensuring that they are maintained;
- Providing financial advice to the Trust and its Board of Directors;
- Standards of business conduct and Counter fraud;
- Preparing and maintaining Trust accounts.

Director of Operations
The Director of Operations is responsible for:

- Business continuity;
- Day to day operational performance;
- Performance management of the Head of facilities and the divisional structure.

Director of Strategic and Organisational Development
The Director of Strategic and Organisational Development is responsible for:

- Reputational strategy management and risk mitigation through the communications and public relations functions;
- Assessment of our strategic market risk.
- Occupational health service;
- Mandatory training provision and compliance monitoring;
- Human resource and organisational development policies;

- Ensuring that the Trust's Health & Safety management systems and processes are developed and maintained.

Director of Infrastructure and Informatics
The Director of Infrastructure and Information is responsible for the mitigation of risks relating to:
- Information technology;
- Data protection;
- Information governance;
- Data storage and security.
- Estates
- Fire

The Director of Infrastructure and Information is also the Senior Information Risk Owner (SIRO).

The SIRO is responsible for:
- Owning the Organisation's Information Risk Policy.
- Acting as champion for information risk on the Board.
- Implementing and leading the Information Governance (IG) risk assessment and management processes within the Organisation.
- Advising the Board on the effectiveness of information risk management across the organisation.

Associate Director of Estates
The Associate Director of Estates is responsible for the mitigation of environmental risk including:
- Fire safety and fire safety training;
- Water integrity (Legionellae);
- Control of asbestos, plant, machinery & equipment;
- Food safety;
- Construction, Design and Management (CDM);
- Security;

Associate Medical Director
The Associate Medical Director is the Trust Caldicott Guardian.
The Caldicott Guardian is responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing.

Associate Director of Governance
The Associate Director of Governance is providing support and facilitation of the Board of Directors, Council of Governors, Audit committee and Assurance committees in discharging their duties and responsibilities as outlined; and ensuring that the Trust's corporate governance arrangements meet best practice and are reviewed periodically for effectiveness.

Associate Director of Risk Management
The Associate Director of Risk is the organisational lead for the development, co-ordination and implementation of effective risk management strategies across the Trust. This includes ensuring an integrated approach to patient safety.

The Associate Director of Risk has lead responsibility for the Trust's Safeguard database relating to the Risk Register, incident reporting (including serious incidents), complaints, concerns, inquests and claims management. The Associate Director of risk is responsible for ensuring that Risks, Incidents, Inquests, Claims & Assurance are managed effectively throughout the trust.

Risk Manager
The Risk Manager is responsible for:

- Advising the organisation on governance and risk issues enabling the organisation to achieve Governance and Risk objectives
- Development of the Risk Strategy, Policy and relevant policies
- Lending expert opinion/advice on the risk management process.
- Supporting the development of the Board assurance Framework
- Producing risk management reports and dashboards to assist WUTH in its risk management activity

The Risk Manager is responsible for the development and maintenance of the organisation wide risk management systems and processes

The Risk Manager has responsibility for maintaining and developing the Trust's Safeguard database relating to the Risk Register and incident reporting (including serious incidents).

The Risk Manager will support the Corporate Department Leads for monitoring and review of risk in their areas, liaising with them monthly to review and update risks and action plans as appropriate.

In liaison with the Corporate Department Leads the Risk Manager will review the risk register in its entirety annually to ensure all risks are accurate, there are no duplications and they remain relevant.

Health and Safety Manager
The Health and Safety Manager will provide advice on health and safety related risk assessments and risks to be entered on to the risk register.

Head of Facilities
The Head of Facilities is responsible for the mitigation of environmental risk including:

- Food safety
- Clinical and non-clinical waste

Triumvirate for Clinical Divisions/Heads of Corporate Departments
Accountability for the Clinical Divisions lies with the Divisional Medical Director, the Associate Director of Operations and the Associate Director of Nursing and is known as the Triumvirate. Each Triumvirate/ Head of Corporate Department is accountable for the management of risk within their Division/Corporate Department. They will ensure that the risks in their risk registers are regularly reviewed. They are responsible for implementing and monitoring any identified risk management control measures needed within their designated area(s) ensuring that they are appropriate and adequate. Risks will be monitored organisationally if they score 10 or above using

the Trust risk scoring matrix. Action must be undertaken by management in the Department/Division or area where the risk has been identified.

Clinical Service Lead (Women's Services)
Working closely with the Obstetric Consultant Clinical Governance Lead and Associate Director of Midwifery and Nursing, the Clinical Service Lead (CSL) is responsible for the day to day clinical management of the Obstetric Services, providing professional leadership.

Head of Midwifery
Working closely with the CSL, they are responsible for the day to day management of maternity services in all care settings, providing professional leadership for the midwifery aspects of clinical risk management.

Consultant Clinical Governance Lead
Risk management is led by the Consultant Clinical Governance Lead. They are the professional lead who oversees clinical risk management activity.

Divisional Quality and Safety Managers
The Divisional Quality and Safety Managers work with three clinical Divisions; Medical Specialities and Acute Care, Surgery, Women and Children's and Clinical Support. They co-ordinate the risk management, governance and assurance agenda in the Divisions and provide real time information to support risk mitigation. They are responsible for the day to day direction of the risk agenda in the Divisions managing the Divisional Clinical Governance Teams and structures to ensure that the risk, governance and assurance agenda is managed, monitored and escalated appropriately.

Supervisors of Midwives (SoMs)
Supervisors of Midwives play a proactive and reactive role in the risk management systems and processes within the Maternity Service. Supervisors work alongside but separate to the management team when investigating incidents or situations involving poor practice. Where appropriate, SoMs formulate action plans and escalate concerns to the Local Supervisory Authority (LSA) via the processes outlined.

Corporate Services Departmental Leads
Due to the recent restructure of the Divisions within the organisation and the allocation of Divisional Quality and Safety Managers there is currently no Divisional Lead for the Corporate Services Division. Therefore the Manager for each department within the Corporate Services Departments is responsible for the review and monitoring of risk within their own areas with the support for monitoring and review by the Risk Manager.

Other Managers and Matrons in the Trust
All managers have a delegated responsibility for the identification and management of risk in their Departments, Wards, and any other areas. Risk management is integral to their day to day management responsibilities and managers are authorised to mitigate risks identified at a local level wherever possible.

If risks cannot be mitigated locally, issues should be escalated in the management lines of accountability and action undertaken by management in the Department, Division or area where the risk has been identified as far as possible.

In addition all Managers and Matrons have a responsibility for:

- Ensuring effective communication and distribution of all policies and guidelines to staff.
- Ensuring that staff have suitable and sufficient information, instruction, training and supervision to perform their duties in accordance with the organisation's standards.
- Monitoring compliance with their own standards and implementation of the organisation's procedures.
- Taking appropriate action in the event of significant errors or deviations to accepted practices.
- Ensuring their business plans take account of risk management issues which will be monitored through the performance review process.

All Staff

All members of staff, irrespective of profession, grade or discipline, including locums and those with honorary contracts are responsible for:

- Compliance with Trust strategies, policies, procedures and guidelines;
- Working within their own level of competence;
- Providing safe standards of clinical practice through compliance with the regulations of appropriate professional bodies.
- Identifying risks and reporting of all incidents and near misses;
- Escalation of risk, incidents and near misses as required;
- Attending risk management training as required for the post;
- Participating in risk assessment processes as necessary.
- Using any safety equipment, personal protective equipment and adopting safe working practices;
- Co-operating with management, representatives of enforcement agencies and auditors in respect of Health & Safety issues, investigation of incidents, complaints and claims.
- Taking responsible care of their own health and safety and the safety of anyone else who may be affected by what they do whilst at work.
- Being aware of emergency procedures e.g. resuscitation, evacuation and fire precaution procedures pertaining to their service area.

Appendix 7: Risk Scoring Matrix

The Risk Scoring Method should be applied to all incidents, complaints, claims and risks identified through proactive risk assessments.

1. **Consequence:** Use **Table 1** to determine the Consequence Score(s) **C**. In the case of incidents, complaints and claims, this is the **actual** consequence (i.e. what actually happened). In the case of proactive risk assessments, it is the potential consequence (i.e. what could potentially happen). All events, actual or future, may have one consequence or several consequences (e.g. affecting patient care, financial impact, adverse publicity, etc.) **The score used to calculate the overall consequence is the row from which the highest numerical score is achieved.**

2. **Likelihood:** Use **Table 2** to determine the Likelihood Score **L**. This is the chance that the consequence described above will occur (or recur) to that identified group.

3. **Risk Score:** See **Table 3**. Multiply the Consequence Score **C** with the Likelihood Score **L** to obtain the Risk Rating, which should be a score between 1 and 25.

4. **Near Miss:** Please tick the Near Miss box if applicable. All 'near miss' incidents are to be scored twice; Once for what actually happened and then for what would have happened had intervention not taken place.

5. Orange and Red incidents must be reported to Risk Management on ext. 2611 immediately

6. Root Cause Analysis (RCA) **must** be undertaken for all red/orange incidents and claims. Inform your Line Manager if you feel that an incident, complaint or claim is likely to attract media attention. RCAs **must** be completed within **25 working days (5 working days for MRSA bacteraemia cases)**.

Table 1 – Consequence

Actual Severity = Incidents / Complaints / Claims Potential Severity = Risk Assessments/Near Miss

	1	2	3	4	5
Descriptor	**No Harm / insignificant**	**Very low harm / minor**	**Low harm**	**Moderate**	**Severe/Death**
Clinical impact on the safety of patients (physical/ psychological harm)	No harm: Impact prevented- any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care. Minimal injury requiring no/minimal intervention or treatment No time off work	Impact not prevented any patient safety incident that ran to completion but no harm occurred to people receiving NHS funded care. Minor injury or illness, requiring minor intervention, will probably resolve within one month Staff injury requiring time off work or light duties for 6 days or less Hospital acquired **colonisation** affecting one or more patients, member of staff or the public	Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS funded care. Staff injury requiring time off work or light duties for 7 – 35 days Hospital acquired **infection** affecting one or more patients, members of staff/the public or where a bay closure occurs	Any patient safety incident that resulted in moderate increase in treatment and which caused significant but not permanent harm to one or more persons receiving NHS funded care Moderate increase in treatment is defined as return to surgery, an unplanned readmission, prolonged episode of care, extra time in hospital or as and outpatient , cancelling of treatment or transfer to another area such as ITU as a result of the incident Moderate/ major injuries/Dangerous Occurrences reportable under RIDDOR	Severe: any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS funded care. Death: any patient safety incident that directly resulted in the death of one or more persons receiving NHS funded care. Unexpected death or significant permanent disability where outcome is directly attributable to a safety incident All Never Events* (See list below) Part 1 of death certificate stating hospital acquired infection Hospital acquired

	1	2	3	4	5
Descriptor	**No Harm / insignificant**	**Very low harm / minor**	**Low harm**	**Moderate**	**Severe/Death**
				Requiring time off work or light duties for >36 days with eventual recovery Unexpected admission to critical care area with eventual recovery MRSA Bacteraemia with eventual recovery Hospital acquired **infection** affecting > 1 bay	**infection** affecting > 1 ward
Health & Safety / Non clinical impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment No time off work	Minor injury or illness, requiring minor intervention, will resolve in 6 days or less Staff injury requiring time off work or light duties for 6 days or less	Injury or illness, requiring intervention, is expected to resolve within one month Staff injury requiring time off work or light duties for 7-35 days	Major injuries / dangerous occurrences reportable under RIDDOR Staff injury requiring time off work or light duties for >36 days with eventual recovery	An accident at work resulting in a fatality Significant permanent disability where outcome is directly attributable to a health and safety incident
Objectives / Projects	Insignificant project slippage Barely noticeable reduction in scope or quality	Minor project slippage Minor reduction in scope or quality	Serious overrun on project Reduction in scope or quality	Project in danger of not being delivered Failure to meet secondary objectives	Unable to deliver project Failure to meet primary objectives
Service / Business Interruption Environmental Impact	Loss / Interruption of service Up to 1 hour Minimal or no impact on the environment including contamination, not directly coming into contact with patients, staff or members of the public	Loss / Interruption of service 1 to 4 hours Minor impact on the environment	Loss / Interruption of service 4 to 8 hours Moderate impact on the environment	Loss / Interruption of service 8 hours to 2 days Major impact on the environment including ward closure	Loss / Interruption of service More than 2 days Catastrophic impact on the environment including multiple ward or hospital closure
Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training on an ongoing basis
Finance including claims	No obvious / small loss < £5k	£6k - £99k	£100k to £250k	£251k to £999k	Over £1m
Statutory duty/ inspections	No or minimal impact or breach of guidance/statutory guidance	Breach of statutory legislation reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices low performance rating. Critical report	Multiple breaches in statutory duty Prosecution Complete system change required Zero performance rating. Severely critical report

	1	2	3	4	5
Descriptor	**No Harm / insignificant**	**Very low harm / minor**	**Low harm**	**Moderate**	**Severe/Death**
Adverse Publicity / Reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Element of public expectation not being met	Local media coverage – long term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the house). Total loss of public confidence
Quality/ Complaints	Unsatisfactory patient experience not directly related to patient care Locally resolved concern	Overall treatment or service suboptimal Justified formal complaint peripheral to patient care	Treatment or service has significantly reduced effectiveness Justified formal complaint involving lack of appropriate clinical care, short term effects	Non-compliance with national standards with significant risk to patients if unresolved Justified multiple formal complaints. Serious mismanagement of care, long term effects	Totally unacceptable level or quality of treatment/service Ombudsman Inquiry Legal Claim
Information Governance	Less than 5 people affected or risk assessed as low e.g. files were encrypted	Serious potential breach & risk assessed high e.g. unencrypted clinical records lost. Up to 20 people affected.	Serious breach of confidentiality e.g. up to 100 people affected.	Serious breach with either particular sensitivity e.g. sexual health details, or up to 1000 people affected.	Serious breach with potential for ID theft or over 1000

Table 2 – Likelihood

	1	2	3	4	5
Likelihood reflects how likely the consequence described will occur; either frequency or probability. % chance of recurrence of consequence in identified group.	This will probably never happen/recur Not expected to occur for years (1 - 5%)	Do not expect it to happen/recur but it is possible it may do so Expected to occur at least annually (6 - 25%)	Might happen or recur occasionally Expected to occur at least monthly (26 – 50%)	Will probably happen/recur, but it is not a persisting issue/ circumstances Expected to occur at least weekly (51 – 75%)	Will undoubtedly happen/recur, possibly frequently Expected to occur at least daily (76 - 100%)

Consequence	**Likelihood**				
	1	**2**	**3**	**4**	**5**
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

Consultation, Communication and Implementation

Consultation Required	Authorised By	Date Authorised	Comments
Equality Analysis	Tracey Bills	24th February 2015	Full Equality Analysis not required
Expert Committee/ Policy Reader	QSRT, Maryellen Dean	24th February 2015	Checked for workforce / development, medicines, finance or wider corporate implications.
Other Stakeholders / Groups Consulted as Part of Development	Clinical Governance Group, Audit Committee Members, Hospital Management Board members, All Divisional Quality and Safety Managers, Health and Safety Manager, Risk Management Team		
Trust Staff Consultation via Intranet	24th February to 10th March 2015		

Date notice posted in the News Bulletin.	To be completed by the Assurance Team	**Date notice posted on the intranet**	To be completed by the Assurance Team

Describe the Implementation Plan for the Policy / Procedure / Strategy (Considerations include; launch event, awareness sessions, communication / training via DMTs and other management structures, etc.)	**By Whom will this be Delivered?**
▪ Inform Division/Corporate Quality and Safety Management teams ▪ Incorporate into Quality and Safety based training ▪ Build on the risk tools, systems and processes used and further embed in the organisation ▪ Promote a culture of openness in terms of reporting and learning from incidents for both staff and patients ▪ Ensure that the lessons learnt from incidents, complaints and claims are shared and disseminated across the Trust to foster Trust-wide learning ▪ Use the Trust intranet to publicise and improve access to risk management information including risk management tools	All Trust staff groups named in the document.

Version History

Date	Ver	Author Name and Designation	Summary of Main Changes
Dec 2011	01	Pam Lees, Head of Quality and Safety	Integration of Proactive Risk Assessment Procedure and Risk Identification, Management and Escalation Policy into the Risk Management Strategy and Policy. Reflects approved changes in committee structure. Adjusted risk grading matrix to reflect NPSA matrix and order of matrix adjusted to reflect that consequence is considered prior to likelihood.
May 2012	02	Pam Lees, Head of Quality and Safety	Further detail/clarification on role of committees, insertion of links, revised Trust Wide Governance Structure to reflect reporting changes.
June 2012	03	Pam Lees, Head of Quality and Safety	Updated to provide clarity in section 9.1.7
February 2013	04	Evan Moore, Medical Director	Revised Governance structure and reporting mechanisms incorporated. Changes checked for NHSLA compliance Circulated to EDT members for comments
March 2013	4.1	Sarah Mattocks, Risk Manager	Addition of “Chemotherapy Prescribing” to the Risk Scoring Matrix.
May 2013	4.2	Melanie Maxwell, Associate Medical Director	Clarification of reporting. Update structures
September 2013	4.3	Joe Roberts, Head of Assurance	Additional information regarding Board risk training in section 9.6 to provide clarification for NHSLA Standard 3.6, and corresponding KPI; change in information reported to Risk Management Group

November 2013	4.4	Sarah Mattocks, Risk Manager	Information governance descriptor added to risk scoring matrix
March 2014	4.5	Sarah Mattocks, Risk Manager	Updated risk scoring matrix added to policy
June 2014	4.6	Maryellen Dean; Associate Director of Risk Management	Review of the strategy to reflect current processes
February 2015	5.0	Tracey Bills, Risk Manager	Review Strategy processes in line with MIAA recommendations, annual report recommendations and CQC advice.
March 2015	5.0	Tracey Bills, Risk Manager	Risk Management Group disbanded and therefore all reference omitted from strategy.

Monitoring Compliance with the Policy

Describe Key Performance Indicators (KPIs)	Target	How will the KPI be Monitored?	Which Committee will Monitor this KPI?	Frequency of Review	Lead
In date risk management strategy in place with risk management structures described	Approved	Risk Management Annual Report	OMT	Annual	Risk Manager
Risk Register (New *Risks scored 10 or above)* escalated to OMT	On agenda	OMT agenda and minutes Annual Review of OMT against Terms of Reference Risk Management Annual Report	OMT	Monthly (min 10 per year) Annual	Risk Manager
New Risks scored 15 or above reviewed for BAF Link	100%	Risk Management Annual Report	OMT	Annual	Risk Manager
Review of the Board Assurance Framework Quarterly by the Board of Directors	100%	Board minutes Risk Management Annual Report	Board of Directors (BOD) OMT	Annual	Associate Director of Governance
Risks (to be accepted) escalated to OMT	On OMT agenda	OMT agenda and minutes Risk Management Annual Report	OMT OMT	As they occur Annual	Risk Manager
Risk Register (*Risks scored 20 or above)* escalated to Board of Directors	100%	Risk Management Annual Report	BOD	Monthly (min 10 per year)	Risk Manager
All members of the Trust Board complete the annual Board risk training update, or are followed up and receive the training on a one to one basis if they cannot attend	100%	Risk Management Annual Report	OMT	Annual	Risk Manager
Divisional Annual Review of Risk Register	100%	Risk Management Annual Report	OMT	Annual	Risk Manager

Performance Management of the Policy

Who is Responsible for Co-ordinating Action Plans if KPIs are Not Met?	Which Committee Will Monitor These Action Plans?	Frequency of Review (To be agreed by Committee)
Associate Director of Risk	OMT	12 monthly

Equality Analysis

Title	Risk Management Strategy and Policy
Agenda Item/Policy Reference	Version 5.0
Completed by	Tracey Bills, Risk Manager
Date Completed	24th February 2015

Description *(provide a short overview of the principle aims/objectives of what is being analysed)*

The document sets out the strategy for the continued development of risk management throughout the Trust and the policy to implement it. Risk management aims to achieve the optimum level of quality care and treatment of patients and provision of services that are safe and free from unnecessary risks by making maximum use of available resources and reducing wasteful expenditure. The Board of Directors will continuously strive to ensure that there are effective governance and risk management arrangements in place and that these are monitored on an ongoing basis. This document sets out the systems and processes within the Trust to manage risk appropriately.

The objective of the strategy and policy are:
To adopt an integrated approach to the management of risk and to integrate risk into the overall arrangements for clinical and corporate governance;
To support the achievement of the Trust's strategic objectives as described in the Trust business plan;
To comply with national standards e.g. CQC regulations/standards, Information Governance standards;
To have clearly defined roles and responsibilities for the management of risk;
To provide high quality services to patients and to continuously strive to improve patient safety;
To ensure that risks are continuously identified, assessed and minimised;
To use risk assessments to inform overall business planning/ investment processes in the Trust;
To encourage open and honest reporting of risk and incidents through the use of the Trust reporting systems;
To ensure appropriate links to the Board Assurance Framework;
To establish clear and effective communication that enables information sharing
To foster an open culture which supports organisation wide learning.

Who will be affected *(Staff, patients, wider community?)*

The document applies to all staff working in or on behalf of the Trust in other environments. It also applies to non Trust staff working in or representing the Trust in any way and contractors employed by others who work on Trust premises.

The Equality Analysis template should be completed in the following circumstances:

- **All new policies**
- **All policies subject to renewal**
- **Business cases submitted for approval to Hospital Management Board impacting on service users or staff**
- **Papers submitted to Hospital Management Board detailing service redesign/reviews impacting on service users or staff**

Equality Analysis

- **Papers submitted to Board of Directors for approval that have any impact on service users or staff**

Please note the results of this Equality Analysis will be published on the Trust website in accordance with the Equality Act 2010 duties for public sector organisations

Section 1 should be completed to analyse whether any aspect of your paper/policy has any impact (positive, negative or neutral) on groups from any of the protected characteristics listed below.

When considering any potential impact you should use available data to inform your analysis such as PALS/Complaints data, Patient or Staff satisfaction surveys, local consultations or direct engagement activity. You should also consult available published research to support your analysis.

You should also refer to the NHS North West Health Equality Library Portal for any relevant information that may assist in your analysis.

Section 1 – Initial analysis

Equality Group	**Any potential impact? Positive, negative or neutral**	**Evidence** *(For any positive or negative impact please provide a short commentary on how you have reached this conclusion)*
Disability *(Consider any impact on attitudinal, physical and social barriers)*	Positive	The strategy aims to identify those areas that may impact on disability and manage any associated risks.
Age *(Consider and barriers across age ranges. This can include safeguarding consent, care of the elderly and child welfare)*	Positive	The strategy aims to identify those areas that may impact on age barriers and manage any associated risks.
Race *(Consider any barriers impacting on ethnic groups including language)*	Positive	The strategy aims to identify those areas that may impact on racial barriers and manage any associated risks.
Religion or belief *(Consider any barriers effecting people of different religions, belief or no belief)*	Positive	The strategy aims to identify those areas that may impact on religious / beliefs and manage any associated risks.
Sexual Orientation *(Consider any barriers affecting heterosexual people as well as Lesbian, Gay or Bisexual)*	Positive	The strategy aims to identify those areas that may impact on sexual orientation and manage any associated risks.
Pregnancy & Maternity *(Consider any impact on working arrangements, part time or flexible working)*	Positive	The strategy aims to identify those areas that may impact on pregnancy and manage any associated risks.
Gender *(Consider any barriers relating to men and women eg: same sex accommodation)*	Positive	The strategy aims to identify those areas that may impact on gender and manage any associated risks.
Carers *(Consider any impact on part time working, shift patterns and general caring responsibilities)*	Positive	The strategy aims to identify those areas that may impact on carers and manage any associated risks.

Equality Analysis

Gender Reassignment *(Consider any any impact on transgender or transsexual people. This can include issues relating to privacy of data)*	Positive	The strategy aims to identify those areas that may impact on gender and manage any associated risks.

If you have identified any **positive** or **neutral** impact then no further action is required, you should submit this document with your paper/policy in accordance with the governance structure.

You should also send a copy of this document to wih-tr.equalityWUTH@nhs.net

If you have identified any **negative** impact you should consider whether you can make any changes immediately to minimise any risk. This should be clearly documented on your paper cover sheet/policy document detailing what the negative impact is and what has changes have been made.

If you have identified any **negative** impact that has a high risk of adversely affecting any groups defined as having a protected characteristic then please continue to section 2.

Section 2 – Full analysis

If you have identified that there are potentially detrimental effects on certain protected groups, you need to consult with staff, representative bodies, local interest groups and customers that belong to these groups to analyse the effect of this impact and how it can be negated or minimised. There may also be published information available which will help with your analysis.

Is what you are proposing subject to the requirements of the Code of Practice on Consultation
No
Who and how have you engaged to gather evidence to complete your full analysis? (List)
What are the main outcomes of your engagement activity?
What is your overall analysis based on your engagement activity?

Section 3 – Action Plan

You should detail any actions arising from your full analysis in the following table; all actions should be added to the Risk Register for monitoring.

Action required	Lead name	Target date for completion	How will you measure outcomes

Equality Analysis

Following completion of the full analysis you should submit this document with your paper/policy in accordance with the governance structure.

You should also send a copy of this document to wih.tr.equalityWUTH@nhs.net

Committee Ratification of Trust-wide Policies & Procedures

Policy Number & Title:	041 – Risk Management Strategy
Author:	Tracey Bills
Version:	5

Status: New □ **Review** **X**

Ratification minutes: **Included** □ **To follow** □

Confirmation of Ratification

Trust Committee	Date of meeting	Name of Chair	Signature
Board of Directors			

On completion, this document is to be forwarded to Quality & Safety

Once received, the ratified policy will be uploaded to the Intranet.

Board of Directors	
Agenda Item	7.3
Title of Report	Chair of Quality and Safety Committee Report 13 May 2015
Date of Meeting	27 May 2015
Author	Dr Jean Quinn Chair of the Audit Committee
Accountable Executive	Evan Moore, Medical Director
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	 1,3,4,5,6,7 1a,1b,3a,3b,4a,5b,6b,7a,7c,7d 1445,1908,1909,2328,2485,2611,2678
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

This report provides a summary of the work of the Quality and Safety Committee which met on the 13 May 2015

Chairs Business

The Committee discussed the recent Theatre Review and the action plan developed in response to this. The Committee were informed that the Review and the action plan would be circulated across the Trust in the near future. It was agreed to receive a further update in 6 months' time.

Quality Governance Framework

The Committee reviewed the latest self-assessment undertaken by the Medical Director and the Associate Director of Governance highlighting in particular areas where the Trust had rated its performance other than GREEN. The section on assurance about quality information was downgraded from green to amber. In addition the Committee agreed a series of actions to further improve the focus on quality and safety throughout the organisation.

Assurance Reports

The Committee received assurance reports in relation to Safeguarding, Business Continuity and Emergency Preparedness and End of Life Care. The Committee agreed to a follow up report on safeguarding training to ensure compliance with Levels 1 and 2 and for End of Life Care to be included in CQC Mock Inspections in the future in view of the operational issues highlighted. The Committee expressed concern about the level of Medical Leadership for End of Life Care and the fact that there is currently no End of Life Care Strategy in place.

Diagnostics and Clinical Support Divisional Presentation

The Committee were updated on their work programme which included as an example the following:

- Pathology serious incidents – a visit by the Human Tissue Authority is due to take place on the 11th June 2015
- Cervical Cytology – working with Public Health England to reduce risks in this area
- Breast Screening – Wirral is now the lead unit in the Wirral and Chester Breast Screening Programme
- Quality of Care – Friends and Family Test results for Breast Care reported at 99%
- Bed usage – further plans in place to streamline processes and introduce criteria led discharge
- National Patient Access and Care Targets – compliant with 6 week target
- CIP Impact – good plans in relation to Outpatients noted
- It was of particular note that the concerns expressed last time about inability to recruit histopathologists were well on the way to being addressed with appropriate appointments having been made or about to be made

The Committee agreed that the issues raised in relation to Cervical Cytology would be included on the risk register.

CQC Mock Inspection Report – March 2015

Five inpatient wards were visited together with the main out patients departments at both Arrowe Park and Clatterbridge Hospitals. One of the issues identified during the inspection was the out of date complaint leaflets which was being reviewed by the Patient Experience Team.

Concerns about staffing levels and environmental and infrastructure issues were again noted.

The Committee was disappointed that storage of medicines was inadequate in some areas given the amount of work that had been done previously.

It was reported that a plan was in place to visit all wards and outpatient areas in the hospital by July 2015 and to focus on areas that require further improvement thereafter.

National Accident and Emergency Survey 2014 – Summary Report

The National Accident and Emergency Survey was conducted in the summer of 2014 and sampled patients who had attended Accident and Emergency during January, February and March 2014. The results indicated that the Trust's position in terms of other Trusts was comparable. There were a number of questions which showed a significant change from the previous survey in 2012 which was encouraging and reflected the major environmental changes made to the department and also the positive effect of initiatives such as patient focused rounding on the experience of patients in the department.

Workforce Annual Report

The Workforce Annual Report was received which highlighted progress in the following areas:

- Reduction in overall staffing numbers

- Achievement of the flu vaccination target ahead of schedule
- Achievement of the Appraisal compliance target
- Reduction in the number of formal employee relations cases

The Committee agreed that areas of focus would be Whistleblowing and streamlining and improving mandatory training.

Clinical Quality Dashboard

Areas of Good or Improving performance highlighted were HSMR which continues to be below the national average at 88; Sepsis which is improving month on month and Friends and Family Test results for inpatients.

Areas for improvement highlighted were harm from falls; the number of ward moves which had increased; the increase in medication allergies which is being closely monitored; and the response rates to the friends and family test for the emergency department and maternity.

Incidents Analysis

The Committee reviewed the analysis of incident reporting for the period 1 March 2014 – 28 February 2015. The review highlighted the reduction in incident reporting since the implementation of web based reporting although the Trust remains in the top 25% of reporters and the positive reporting culture with high numbers of incidents being reported with low or no harm.

Review and Gap Analysis (relating to Maternity Services at Women and Children's Hospital following publication of Morecombe Bay Report (Kirkup Report) in March 2015

The Committee reviewed the gap analysis undertaken by the Women's Directorate Governance Leads against the 44 recommendations identified in the Morecombe Bay Report (Kirkup Report) to identify any gaps or risks within the current maternity service. The report identified a number of key actions which will be addressed within the next two months in preparation for the CQC inspection in September and are included in the local CQC Action Plan.

Director of Nursing & Midwifery Performance Report Q4 2014-15

The Committee reviewed the performance report for Q4 which highlighted the increased attendance to the Emergency Department and an increase in hospital admissions, additional wards open and an outbreak of Norovirus; the need to undertake the patient focussed nursing and midwifery care audits by the end of quarter following a period of suspension; the reduction in grade 2 pressure ulcers although there had been an increase in Grade 3 pressures ulcers and the improvement in three of the MEWS standards during quarter 4 although there was still room for improvement.

Dr Jean Quinn
Chair of Quality and Safety Committee

Board of Directors	
Agenda Item	8.1
Title of Report	Annual Report & Accounts 2014/2015, Annual Governance Statement and Quality Report
Date of Meeting	27th May 2015
Author	Emma Pridgeon, Assistant Director of Finance – Corporate Financial Services Carole Self, Associate Director of Governance
Accountable Executive	David Allison, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	All BAF references apply
Level of Assurance • **Positive** • **Gap(s)**	Full
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Approval
Data Quality Rating	Gold – externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	*N/A*

1. Executive Summary

The purpose of this paper is to ask the Board to approve the 2014/15 Annual Report and Accounts for submission to Monitor by the national deadline of 29th May 2015.

The Annual Report and Annual Accounts are contained in a separate document sent to Board members with the Board agenda and papers. The Annual Governance Statement and Quality Report are also included in the Annual Report.

The Annual Report and Accounts have been audited and were also reviewed in detail by the Audit Committee on the 21st May 2015. In reviewing the Annual Report and Accounts, the Audit Committee received the External Auditors' report (ISA 260 Memorandum 2014/15) and Letters of Representation for the financial statements and Quality Report along with the Director of Internal Audit's Opinion (Appendix A).

Both internal and external auditors were present at the Audit Committee meeting to report on their findings.

Key amendments as a result of the review by Audit Committee have been highlighted in the documents

It is the recommendation of the Audit Committee that, subject to these amendments, the Annual Report and Accounts 2014/15 are to be approved by the Board for submission to Monitor.

The Audit Committee also recommended that the letters of representation relating to the engagement of KPMG be approved by the Trust Board:

i) on the Financial Statements, to be signed by the Director of Finance and the Chief Executive
ii) on the Quality Accounts, to be signed by the Medical Director and Chief Executive

The Annual Report and Accounts must then be submitted to be laid before Parliament on or before 25th June 2015 before being received by Governors and presented at the Annual Members' Meeting on 1st October 2015.
The Quality Report must be published on the NHS Choices website by 30th June 2015
Thereafter, the documents will be made available via the Trust's website.

2. Introduction/Background

The Foundation Trust submitted its Accounts to the Auditor on the 22nd April 2015 in advance of the required timetable. The external Audit has been completed and the auditor's Annual Governance Report (prepared in accordance with International Standard on Auditing (ISA) 260) is included within the Annual Report.

Enclosed are the Annual Report and Audited Accounts of the Foundation Trust for the twelve months 1st April 2014 to 31st March 2015 which include any changes agreed with the Auditor.

Unless otherwise stated, any reference to 2014/15 refers to this twelve month period.

3. Annual Report

The Annual Report has been produced in accordance with the requirements of Monitor and includes:

- a Strategic Report
- a Directors Report
- the disclosures set out in the NHS Foundation Trust Code of Governance
- an Annual Governance Statement
- a Quality Report
- a Remuneration Report
- non-financial reporting covering the Trust's performance, improving excellence in clinical quality, patient experience and safety; sustainability/climate change, regulatory ratings, equality and diversity, and staff survey
- other disclosures in the public interest
- a statement of Directors' Responsibility
- a statement of Accounting Officer's Responsibilities

4. Production of the Accounts

The Accounts have been prepared under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 which states that in preparing its annual accounts an NHS Foundation Trust shall comply with any directions given by Monitor with the approval of the Treasury as to:

a. the methods and principles according to which accounts are to be prepared; and
b. the information to be given in the accounts.

The detailed guidance on the accounts composition is provided in the NHS Foundation Trusts' Annual Reporting Manual (ARM) which is reviewed and revised annually by Monitor.

The statement of the Accounts with regard to the Foundation Trust's performance of its functions is to give a true and fair view of the income and expenditure and cash flow of the year, and of the state of affairs at the end of the financial year.

The Accounts comprise the following four statements which are preceded by a brief foreword:

- statement of comprehensive income
- statement of financial position
- statement of changes in taxpayers equity
- statement of cash flows.

All the above are supported by notes to the accounts.

These statements form the published accounts of the Foundation Trust. In addition, to facilitate the collection and collation of information for consolidating whole of government accounts, the Accounts are required to be presented in a standard form, (i.e. the Consolidation Report known as the FTC forms) which is forwarded to Monitor following the audit.

The FTC Forms also include a statement of Losses and Special Payments (FTC35). This form summarises the entries made in the Trust's Losses and Compensation Register. A narrative summary of this information is included in the Annual Accounts (Note 31).

The Chief Executive, as Accounting Officer, is required to sign on behalf of the Board a Statement of Directors' Responsibilities in respect of Internal Control. He is also required to sign the Statement of the Accounting Officer's Responsibilities (as presented in the Financial Statements section of the Annual Report and Accounts).

The Annual Governance Statement covers the assurance process, the capacity to handle risk, the risk and control framework and its effectiveness in respect of the achievement of the organisation's objectives and to manage them efficiently, effectively and economically.

5. Approval process for the Annual Report and Accounts

The Board is required to approve the Annual Report and Audited Accounts before they are submitted to Monitor by the 29th May 2015. The Annual Report and Accounts of foundation trusts must be laid before Parliament in an approved format. The final version must be submitted to the Parliamentary Clerk at the Department of Health by 25th June 2015.

The Accounts are required to be audited by auditors appointed by the Council of Governors, in the Foundation Trust's case, KPMG.

The Auditor is required, under ISA 260 (as included at Appendix A) to present a summary of their findings to "those charged with governance", prior to the approval of the Accounts by the Board of Directors.

6. Financial Performance

The Trust's financial performance is summarised as follows:

	Actuals £'000
Operating income	306,325
Operating expenses	(306,519)
	(194)
Finance costs and PDC payable	(4,487)
Retained loss for the year	**(4,681)**

A foundation trust's financial performance is measured against the risk rating metrics set by Monitor in the Foundation Trust Compliance Framework. The Foundation Trust's performance is detailed below.

Financial Criteria	Weight % age	Metric to be scored	2014/15 ratings - Actual		2014/15 ratings - Plan	
Liquidity Ratio (Days)	50%	Liquidity Ratio (Days)	-4.94	**3**	-12.53	**2**
Capital Servicing Capacity (Times)	50%	Capital Servicing Capacity (Times)	1.38	**2**	1.75	**2**
		Weighted average risk rating		**2.50**		**2.00**
		Overall Risk Rating		**3**		**2**

The deterioration in financial performance against plan was due to the poor operational position.

7. Other Significant Issues on the Accounts

Cash

Cash and bank balances increased significantly in the period by £12.9m from £10.0m to £22.9m. £7.5m of the increase related to the receipt of a loan from the Foundation Trust Financing Facility, the remaining increase was due in part to cash management actions and high levels of creditors at year end.

Losses and Special Payments

As referred to above, Losses and Special Payments are reported on Form FTC35 and summarised in Note 31 to the Accounts.

In summary, the reported figures were as follows:

	2014/15 £000	2013/14 £000
Losses of cash:		
- due to fraud	-	-
- other	1	-
Bad Debts written off	37	14
Damage to property/stock write-offs	6	17
Ex Gratia and Special Payments	11	35
Total	**55**	**66**

Charitable Funds

The 2014/15 Accounts must be submitted to the Charity Commission by 31st January 2016. The existing auditor (KPMG) will audit these Accounts. The Accounts will be prepared so that they will go to the Charitable Funds Committee in October 2015. As in the prior year, it was agreed at the February 2015 Audit Committee that the charitable funds would not be consolidated into the Trust accounts due to immateriality.

Going Concern

The Board is asked specifically to comment in the Annual Report as to the Trusts going concern status. Given the financial position of the Trust the following narrative has been specifically included:

Going Concern Basis

After making enquiries, the Trust's Board of Directors had a reasonable expectation that the Foundation Trust had adequate resources to continue in operational existence for the foreseeable future. For this reason, they continued to adopt the 'going concern' basis in preparing the accounts.

In considering the above position the Board of Directors has specifically noted the Trusts requirement, based upon its annual plan submission, for external financial support of £4.8m which it has assumed will be available through the national approach to distressed financial support.

The Board of Directors have also considered the development of the Trusts recovery plan in framing its view on going concern and the additional external support the Trust has secured to support the development, execution and delivery of the recovery plan.

The final material consideration the Board of Directors have reflected upon, is the overall health economy position and within that the Trusts contract for the current year. Whilst a variance between the Trust and CCG on the contractual position exists the Trust has a largely Payment by Results contract to ensure it is reimbursed for the activities volumes it delivers, has explicitly shared its assumptions with the CCG and will continue the contractual dialogue through the financial year with the CCG.

8. Internal Control

Internal Audit are required to provide an opinion on the effectiveness of the system of Internal Control. Their assessment is "significant assurance" that there is a generally sound system of control designed to meet the organisation's objectives.

This fits into Category A, the required level under the assessment process.

As referred to above, the Chief Executive has signed an Annual Governance Statement on behalf of the Board

9. Required Action to complete the approval process

The Accounts were submitted to the Auditor in accordance with Monitor's requirements.

A summary of the auditor's findings is included at Appendix A under the requirements of ISA 260.

On satisfactory completion of the audit on the basis of the amended accounts, the auditor is required to sign the certificate and opinion.

Prior to publication the Annual Report and audited Accounts must formally be approved by the Board of Directors.

The Statements of Directors' responsibilities in relation to the Accounts and Internal Control, and the auditor's opinion must be included in the published accounts.

The Letter of Representation needs to be signed off by the Director of Finance and Chief Executive.

The Statement of Accounting Officers Responsibilities needs to be signed off by the Chief Executive.

The Directors' Report and Remuneration Report need to be signed off by the Chief Executive.

The FTCs need to be signed off by the Director of Finance.

10. Recommendation

The Board is asked to approve the Annual Report and audited Accounts of the Foundation Trust for the twelve months April 2014 to March 2015.

Alistair Mulvey
Director of Finance

Carole Self
Associate Director of Governance

May 2015

KPMG

cutting through complexity

Wirral University Teaching Hospital NHS Foundation Trust

I confirm that this is the final version of our ISA 260 Audit Memorandum relating to our audit of the 2014-15 financial statements for Wirral University Teaching NHS Foundation Trust.

This document was discussed and approved by the Trust's Audit Committee on 21 May 2015.

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Timothy Cutler
Senior Statutory Auditor for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
1 St Peter's Square
Manchester
M2 3AE

29 May 2015

Our audit opinions:	
Financial Statements: Unmodified	**Use of resources: Unmodified**

ISA 260 Audit Highlights Memorandum

2014/15

DRAFT

14 May 2015

Contents

The contacts at KPMG in connection with this report are:

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This report is addressed to Wirral University Teaching Hospital ('the Trust') and has been prepared for your use only. We accept no responsibility towards any member of staff acting on their own, or to any third parties. Monitor has issued a document entitled Audit Code for NHS Foundation Trusts. This summarises where the responsibilities of auditors begin and end and what is expected from the Trust. We draw your attention to this document.

External auditors do not act as a substitute for the Trust's own responsibility for putting in place proper arrangements to ensure that public business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

Background

International Standard on Auditing (ISA) 260 requires us to provide a summary of the work we have carried out to discharge our statutory audit responsibilities to those charged with governance at the time they are considering the financial statements. ISA 550 requires us to communicate with those charged with governance, unless they are all involved in managing the entity, significant matters arising during the audit in connection with the entity's related parties. This report summarises the key issues we have identified during our audit of the financial statements and will be presented to the Audit Committee on 21 May 2015.

As auditors we have a responsibility for forming and expressing an opinion on the financial statements that have been prepared by management with the oversight of those charged with governance. The audit of the financial statements does not relieve management, those charged with management or those charged with governance of their responsibilities.

Use of Resources (UoR)	The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources and regularly reviewing their adequacy. Our responsibility is to satisfy ourselves that you have proper arrangements in place by reviewing and, where appropriate, examining relevant evidence and reporting on these arrangements. We reflect our judgements from the use of resources work in the certification of the audit. Our certificate provides assurance on the Trust's arrangements for achieving economy, efficiency and effectiveness in its use of resources. The Trust is responsible for putting into place systems of internal control to ensure the regularity and lawfulness of transactions, to maintain proper accounting records and to prepare financial statements that give a true and fair view of its financial position and its expenditure and income. It must also publish an Annual Governance Statement (AGS) within its Annual Report.
Accounts	This is the first year that we are required to provide a long-form audit report in relation to our financial statements audit opinion. This is required by the 2014/15 NHS FT Audit Code and follows the adoption of the new NHS Foundation Trust Code of Governance which is based on the revised UK Corporate Governance Code. ISA 700 (Revised) requires us to include details of materiality, risks and our response to those risks within our audit report. In addition we give an opinion as to whether the contents of the Strategic Report and the Director's Report are consistent with the financial statements and whether we have identified material inconsistencies between the knowledge acquired during our audit and the director's statement that they consider the that the annual report and accounts taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy. We also give our opinion as to whether the part of the Remuneration Report that is required to be audited has been properly prepared. We also conduct a high level review of the AGS and consider whether it is consistent with the financial statements and complies with relevant guidance.

Structure of report

This report is structured as follows:

- Section 2 summarises the headline messages.
- Section 3 outlines our findings and final conclusions on the UoR work.
- Section 4 sets out our findings on the audit of the accounts.

Headlines

The table below summarises the work we have completed throughout the year and the results of the audit.

Use of Resources and audit certification (section three)	■ Based on the findings of our work, we concluded that the Trust has adequate arrangements to secure economy, efficiency and effectiveness in its use of resources. ■ We are required to certify that we have completed the audit of the Trust financial statements in accordance with the requirements of the Code. If there are any circumstances under which we cannot issue a certificate, then we must report this to those charged with governance. There are no issues that would cause us to delay the issue of our certificate of completion of the audit.
Accounts, unadjusted audit differences and management representations (section four)	■ We intend to issue an unqualified audit opinion on the accounts following the Board adopting the accounts and receipt of the management representation letter. Our proposed audit opinion is shown within your draft financial statements, this opinion requires final sign off as part of our firm's risk management procedures. ■ We have completed our audit of the financial statements. Our key findings are: – There is one unadjusted audit difference, relating to the valuation of the Trust's land and buildings. This unadjusted audit difference is not considered to be material. – We have agreed minor presentational changes to the accounts with Finance, mainly related to compliance with the ARM. – We have not requested any specific additional management representations outside of those normally contained within our routine Management Representation Letter. Section four provides further details.
Audit and Accounting issues (section four)	ISA 260 has been revised to require the auditor of entities applying the UK Corporate Governance Code (including those applying the Code on a voluntary basis) to report to the audit committee any information that the auditor believes is relevant to understanding the auditor's rationale and supporting evidence for the exercise of the auditor's professional judgement.
Review of Annual Report and Remuneration Report (section four)	We have read the contents of the Annual Report (including the Strategic Report, Director's Report and Annual Governance Statement (AGS)) and audited the relevant parts of the Remuneration Report. Based on the work performed: ■ We have not identified any inconsistencies between the contents of the Strategic Report and the Director's Report and the financial statements. ■ We have not identified any material inconsistencies between the knowledge acquired during our audit and the director's statement that they consider that the annual report and accounts taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy. ■ The part of the Remuneration Report that is required to be audited has been properly prepared. ■ The AGS is consistent with the financial statements and complies with relevant guidance. ■ The report of the Audit Committee included in the Annual Report appropriately addresses matters communicated by us to the audit committee.

Headlines (cont.)

Recommendations (Appendix A and B)	■ We are satisfied that the Trust has addressed the recommendations we raised in our ISA260 report for 2014/15. ■ We have made two recommendation as a result of our 2014/15 audit work, relating to: – a formal impairment review of tangible assets; and – the inclusion of standard HMRC wording within 'off-payroll' contracts in order to provide appropriate assurances per HM Treasury guidance.
Whole of Government Accounts (WGA) (Appendix D)	■ For 2014/15, the National Audit Office (NAO) has changed how it requires component auditors to report their findings. For a sample of components the reporting process remains unchanged from the prior year. For non-sampled components, we are only required to report any findings relating to potential irregularity and unadjusted errors identified in the course of your audit (including nil returns). Wirral University Teaching Hospital NHS Foundation Trust is a non-sampled component for 2014/15. We have identified 3 disagreements in the agreement of balances process which will be reported to the NAO. We do not have any concerns over the accounting treatment or recognition of these balances by the Trust. See details of these variances at Appendix E.
Quality Accounts (Separately reported)	We have completed our audit of the Trust's 2014/15 Quality Accounts. Overall, based on the work performed: ■ You have achieved a limited assurance opinion on the content of your Quality Report which could be referenced to supporting information and evidence provided by the Trust. This represents an unqualified audit opinion on the Quality Report. ■ This year we have also tested the following mandated indicators: – Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period. – Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers. ■ Our detailed testing on the indicators has concluded that we are able to give a limited assurance opinion on the presentation and recording of the 62 day cancer indicator. ■ We have been unable to provide an opinion on the 18 weeks indicator due to a number of issues found with the processes and underlying data. We have not been able to gain assurance over the accuracy of the data reported within the Quality Account in relation to this indicator. ■ Our work on the local mandated indicator, the percentage of patients reported as receiving appropriate assistance with eating and drinking as measured by the Learning with Patients Survey, has indicated that, if required, we would not be able to provide a limited assurance opinion on this indicator. We have been unable to gain assurance over the completeness of the total number of responses that should be included within the indicator and the validity of the data included within the indicator. ■ Our detailed findings following the audit of the Quality Report are presented to you in a separate report; see our external assurance report on your 2014/15 Quality Report.

Headlines (cont.)

Public Interest Reporting (not discussed further in this document)	In auditing the accounts of an NHS Foundation Trust, auditors must consider: ■ whether, in the public interest, they should make a report on any matter coming to their notice in the course of the audit, in order for it to be considered by Trust members or brought to the attention of the public; and ■ whether the public interest requires any such matter to be made the subject of an immediate report rather than at the conclusion of the audit. There are no matters in the public interest that we wish to raise at this time.

Introduction

We have a responsibility to satisfy ourselves that you have put in place proper arrangements to secure economy, efficiency and effectiveness in your use of resources. In meeting this responsibility we are required to review and, where appropriate, examine evidence and report on your overall governance, corporate performance management and financial management arrangements.

The Code requires us to specifically consider three prime sources of evidence (the AGS, work of other regulators and any other work we identify as relevant) and reach a conclusion on the robustness of your arrangements in order to issue an unqualified audit certificate.

Element of Work		Key Findings
AGS	We review your AGS to confirm whether it is consistent with our understanding of your operations.	We reviewed the 2014/15 AGS and took into consideration the work of internal audit. We confirm that the AGS reflects our understanding of the Trust's operations and risk management arrangements.
Work of other regulators	We consider the work of relevant regulatory bodies (eg Monitor and the CQC), to determine if their work has an impact on our responsibilities.	We have ensured that the outcomes of any reviews by other regulatory bodies have been considered when developing the scope of our work. In September 2014 the Trust was inspected by the Care Quality Commission. The CQC reviewed the Trust against five standards and judged the Trust as needs improvement for all five standards. In response to the inspection the Trust has developed an action plan, which has been shared with the CQC, CCG, NHS England and Monitor. Many of the actions were short-term corrective actions specific to the areas that CQC visited, but others were wider in scope and had more medium-term timescales. The Trust has stated in their annual plan that most of the actions have already been completed and the remaining actions are due for completion by summer 2015. Due to the action taken we do not believe that this inspection has an impact on our responsibilities. The issues identified by the inspection appear to be related to specific wards and as a result we don't believe that the issue found are an indication of systemic issues impacting on the wider Trust. On the 3 March 2015 Monitor wrote a letter to the Trust opening a formal investigation into the Trust's compliance with its licence. This investigation has been opened due to financial governance concerns arising from the Trust's financial underperformance against plan at Q3 2014/15 and the Trust's forecast deficit into 2015/16, for which Monitor do not believe that there is yet a detailed and robust recovery plan. A previous investigation by Monitor, which concluded in March 2014, satisfied the regulator that the Trust was taking steps to improve their financial position, however the financial position has not improved as swiftly as projected and Monitor are now seeking to understand why. Following the issues in 2013/14, we have had ongoing dialogue with the Trust around their financial position and have kept up to date with the conversations and interactions between the Trust and Monitor.

Element of Work		Key Findings
Work of other regulators (cont.)	We consider the work of relevant regulatory bodies (eg Monitor and the CQC), to determine if their work has an impact on our responsibilities.	Monitor is concerned about the Trust's financial stability and governance due to an underperformance of c.£1m against its planned Q3 2014/15 financial position. The Trust initially forecast a full year deficit of £4.2m in 2014/15 however at Q3 reported a YTD deficit of £5.2m and a planned continuity of services rating (CoSRR) of 2. The Trust has ended the year with a deficit of £4.7m and a CoSRR rating of 3. This is an adverse variance of £500k from the original plan and an improvement on the Q3 position that Monitor had concerns over. The CoSRR has also moved up to an acceptable level at year end and is recorded as a 3. In addition, Monitor is concerned over the medium term financial sustainability of the Trust. Our conclusion is based on the performance in 2014/15 and therefore Monitor's concerns will be considered as part of our work in 2015/16. Monitor's final concern was that the Trust has failed the A&E four hour wait target in Q3 2014/15 for the fourth consecutive quarter. Monitor concluded that having taken into account the Trust's actions in response to the A&E target performance, they would not be formally investigating this as part of their investigation. A&E performance will instead be considered through existing local escalation channels and/or Regional Tripartite escalation. Although the Trust is persistently not meeting this target, it is recognised that action needs to be taken across the wider community including all relevant stakeholders and that the resolving of this issue is not directly under the control of the Trust. We do not believe that the issue with achieving this one target is indicative of systemic issues in governance across the wider Trust or that the Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.
Other Work	We perform other work that we regard as necessary to enable us to conclude on whether you have effectively, efficiently and economically exercised your functions.	We did not consider it was necessary to perform other work in order to conclude our opinion on the Trust's use of resources in 2014/15. Our work on the Quality Account has not highlighted any areas of concern that would impact upon our use of resources conclusion.

Conclusion on use of resources

As a result of our work, we are satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2015.

To review your financial statements we perform tasks split between those which are undertaken before, during and after the accounts production. These are summarised below:

	Accounts production stage		
Work Performed	**Before**	**During**	**After**
1. Business Understanding: review your operations.	✓	✓	–
2. Controls: assess the control framework.	✓	–	–
3. Prepared by Client Request (PBC): issue our prepared by client request.	✓	–	–
4. Accounting standards: agree the impact of any new accounting standards.	✓	✓	–
5. Accounts Production: review the accounts production process.	✓	✓	✓
6. Testing: test and confirm material or significant balances and disclosures.	–	✓	–
7. Representations and opinions: seek and provide representations before issuing our opinions.	✓	✓	✓

We have completed the first six stages of the process. We report our key findings from each stage in the remainder of this section.

Business Understanding	▪ In our 2014/15 audit plan we assessed your current operations to identify significant issues that might have a financial consequence. ▪ We have provided an update on the key accounts audit issues on page 11.
Assessment of the Control Framework	▪ We have assessed the effectiveness of your key financial system controls in place that prevent and detect material fraud and error. We found that the financial controls on which we seek to place reliance are operating effectively. We have raised one recommendation in relation to a formal impairment review of tangible assets. See Appendix A for more details
Internal audit	ISA (UK & Ireland) 610 (revised June 2013) 'Using the work of internal auditors' now prohibits the use of internal audit to provide direct assistance to external auditors and applies to all audits from 2014/15 onwards. We adapted our approach to ensure we complied with the new requirements. This meant we liaised with internal audit and reviewed the findings from their programme of work for 2014/15. There were no significant control deficiencies identified by internal audit.

Accounts (cont.)

Prepared by Client Request	■ We produced this document to summarise the working papers and evidence we asked you to collate as part of the preparation of the financial statements. ■ We discussed our request with the Assistant Director of Finance: Financial Services and the Financial Accountant and this was issued as a final document to the Finance Team. ■ As in prior years, the documentation provided by the Trust was of a high quality.
Accounting Standards	■ We work with you to understand the changes to accounting standards and other technical issues. ■ The key areas we have identified are considered in on page 11.
Accounts Production	■ We received complete draft accounts on 22 April in accordance with Monitor's deadline. There were some minor presentational amendments made to these accounts before the audit started. However, none of these amendments significantly hindered the progress of the audit. ■ The accounting policies, accounting estimates and financial statement disclosures are in line with the requirements of Monitor. – There has been no significant changes in accounting policies to the prior year. – There have been no significant estimates made during the year. ■ As in previous years, we will hold a debrief with the Finance team to share views on the final accounts audit. Hopefully this will lead to further efficiencies in the 2015/16 audit process. ■ Trust finance staff were available throughout the audit visit to answer our queries as they arose. ■ We thank the Finance Team for their co-operation throughout the visit which allowed the audit to progress smoothly and complete within the allocated timeframe.
Testing	■ During the audit we identified one issue which has not been adjusted for as it has no material effect on the financial statements. In accordance with ISA 260 we must communicate this uncorrected misstatement to the Audit Committee. We have summarised this issue at Appendix C. ■ We did not identify any issues which have been adjusted for. ■ Our findings related to areas of high audit risk are shown on page 11.

Representations and Opinions	■ You are required to provide us with representations on specific matters such as your financial standing and whether the transactions in the accounts are legal and unaffected by fraud. We provided a draft of this representation letter to the Finance Director on 12 May 2015. ■ We draw your attention to the requirement in our representation letter for you to confirm to us that you have disclosed all relevant related parties to us.
Other Accounting and Auditing Issues	■ We are required under ISA 260 to communicate to you any matters specifically required by other auditing standards to be communicated to those charged with governance; and any other audit matters of governance interest. ■ As the Trust is required to comply with elements of the UK Corporate Governance Code through the FT Code of Governance, ISA 260 (16-1) also requires us to communicate to you any information that we believe is relevant to understanding our rationale and the supporting evidence for the exercise of our professional judgement. This includes our view of: – business risks relevant to the financial reporting objectives, the application of materiality and the impact of our judgements on these areas for the overall audit strategy and audit plan; – Significant accounting policies; – Management's valuations of the Trust's material asset and liabilities and the related disclosures; – The quality of management's assessment of the effectiveness of the system of internal control included in the AGS – Any other matters identified during the course of the audit ■ We have identified the following matters to report: – We did not encounter any significant difficulties during the audit; – We did not identify any significant matters arising from the audit that were discussed, or subject to correspondence with management ; and – We did not identify any other matters, arising from the audit that, that in the auditor's professional judgment, are significant to the oversight of the financial reporting process. ■ We have not identified any other matters to specifically report.

Accounts (cont.)

During our testing we have considered the following area of significant risk affecting the Trust this year and have summarised our findings below:

Areas of significant audit risk	Summary of findings
Valuation of tangible assets Audit areas affected ■ Tangible assets ■ Income and expenditure reserve ■ Revaluation reserve	■ We do not consider the valuation of property, plant and equipment to be at high risk of significant misstatement, or to be subject to a significant level of judgement. However, due to its materiality in the context of the financial statements as a whole it is considered to be one of the areas which had the greatest effect on our overall audit strategy and allocation of resources in planning and completing our audit and therefore we consider this to be a significant audit risk. ■ For 2014/15 an interim 'desk-top' revaluation of all of the land and buildings, which did not involve the physical inspection of the assets, was undertaken by an external valuer. ■ To gain assurance over the valuation of tangible assets we: – assessed the competence, capability, objectivity and independence of the Trust's external valuer considering the terms of engagement of, and the instructions issued to, the valuer for consistency with the requirements of the NHS Foundation Trust Annual Reporting Manual (ARM). We had direct dialogue with the valuer and completed a detailed review of the valuation. We did not identify any issues in this area. – undertook work to understand the basis upon which any impairments to land and buildings had been identified and classified by the Trust. The net movement arising from the valuation was an increase in the asset values of £1,513k, which incorporates a decrease in value of £2,011k across 4 specific assets and an increase across all remaining assets of £3,524k. As discussed with external audit prior to the production of the financial statements, the Trust has not recognised this movement in the financial statements and this has been included in Appendix C as an unadjusted audit difference. Through discussion with the Finance Team we concluded that there is no formal process that takes place within the Trust to identify impairments to tangible assets. We have raised a recommendation in relation to this in Appendix A. Although there is no formal process in place, the Trust has a number of informal arrangements which mitigates the risk of significant impairments not being identified.

Accounts (cont.)

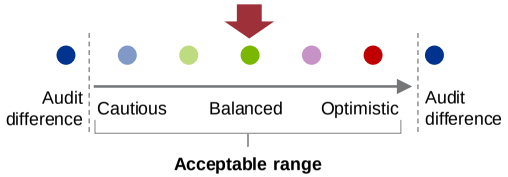
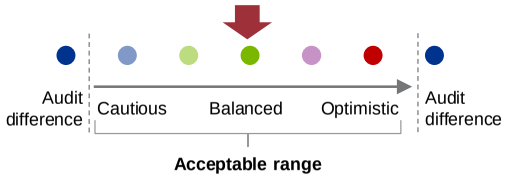
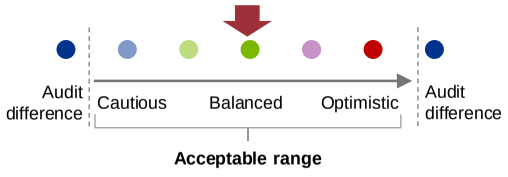
The consideration of the risks below are specifically required by auditing standards.

Areas of significant audit risk	Summary of findings
Management override of controls Audit areas affected ■ All areas	■ Professional standards require us to communicate the fraud risk from management override of controls as significant. Management is typically in a unique position to perpetrate fraud because of its ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively. ■ We have carried out appropriate audit procedures, including over journal entries, accounting estimates and significant transactions that are outside the normal course of business, and that are otherwise unusual. We have not identified any issues through our testing.
Recognition of NHS & non-NHS income & associated fraud risk Audit areas affected ■ NHS income ■ Non NHS income ■ Debtor provisions	■ Professional standards require us to make a rebuttable presumption that the fraud risk from revenue recognition is a significant risk. ■ However, for NHS bodies, we do not consider this to be a significant risk as there is unlikely to be an incentive to fraudulently recognise revenue. ■ In our External Audit Plan 2014/15 we stated that we had chosen to rebut the fraud risk to income recognition as a significant audit risk for 2014/15, instead it would continue to be an area of audit focus. However, due to its materiality in the context of the financial statements as a whole, NHS income was still considered to be one of the areas which had the greatest effect on our overall audit strategy and allocation of resources in planning and completing our audit. Income recognition as a whole was therefore still considered to be a significant audit risk for planning purposes. ■ As we have progressed throughout the audit we have reduced the risk in this area due to the effectiveness of the agreement of balances process and the assurance we have gained from the month 9 exercise. Therefore we no longer consider NHS income to be a significant audit risk and will not be reporting on it in the long form audit report.

Accounts (cont.)

During the audit we have considered a number of significant judgements and estimates affecting the Trust this year and have summarised our findings below, to give the Audit Committee a view as to whether we believe these judgements are reasonable and where within the acceptable range they sit.

Note that, with the exception of valuation of non current assets, none of these judgements are considered to be significant for our external audit.

Areas of audit judgement		Summary of findings
Valuation of non current assets		▪ The Trust has undertaken a 'desktop' revaluation of its land and buildings in year. We have reviewed the calculation of the revaluation gains and impairment losses in line with IAS36 (Impairments) and IAS16 (Property, Plant and Equipment) that arise from this exercise. As outlined in Appendix C, the Trust has elected not to adjust its financial statements in 2014/15 for this matter. We have therefore reported the movements implied by this desktop valuation as a non-material unadjusted audit difference. ▪ We have reviewed the assumptions of the Trust's independent valuer and confirmed that these are in line with RICS standards. Although the revaluation movements have not been accounted for by the Trust, we are satisfied that the figures upon which we have outlined this unadjusted audit difference are subject to balanced judgements. ▪ We have completed work in relation to the valuation of intangible assets, namely the CERNER system and have gained assurance that this is appropriately represented in the accounts. The Trust has undertaken a robust and balanced impairment review of the system during 2014/15. ▪ Overall we consider that the Trust's judgements around the valuation of non-current assets is balanced.
Provisions		▪ The Trust has in place a number of provisions covering claims notified by the NHS Litigation Authority and legal cases outside of the remit of NHSLA notified to the Trust by its solicitors. ▪ Overall we consider the Trust's approach to recognition of provisions as balanced.
Accrued expenditure		▪ The Trust has recognised £11.1m of accruals in the 2014/15 financial statements. This balance is principally comprised of costs incurred that are not yet invoiced such as facilities and estates costs, energy costs and other consumables, where invoicing takes place after the year end but an estimate is able to be calculated based on prior experience. ▪ The processes around calculation of these accruals is in line with our understanding of the Trust. We have substantively tested a sample of year end accruals to ascertain whether these have been correctly classified, as well as reviewing the year on year movements for specific accrual items. We identified no issues as part of this testing.

Next Steps

Following consideration of the issues highlighted in this report, the Audit Committee will be recommending to the Board that they sign the management representations letter at the Board meeting on 27 May 2015.

Once we have received your representations we confirm the final wording of our opinion with our Department of Professional Practice and issue our audit opinion. For 2014/15 this provides confirmation that:

- your financial statements present a true and fair view;
- you have complied with Monitor's disclosure requirements set out in the NHS Foundation Trust ARM in the preparation of your AGS and we are not aware of any inconsistencies with the information that you have recorded within this statement and our other work;
- we have read your Annual Report and in our view it does not contain information which is inconsistent with your financial statements; and
- the numerical part of your Remuneration Report has been presented in a way which complies with the accounting requirements as set out in Monitor's NHS Foundation Trust ARM.

Except for the uncorrected misstatement outlined in Appendix C, we do not have any other matters that we wish to draw to your attention prior to issuing this opinion.

Independence and Objectivity

ISA 260 also requires us to make an annual declaration that we are in a position of sufficient independence and objectivity to act as your auditors. We have provided this declaration at Appendix D.

Audit Fees

Our fee for the audit in 2014/15 was £53,142 plus VAT. This fee was inline with that highlighted within our audit plan issued on 30 January 2015.

Our fee for the external assurance on the quality report in 2014/15 was £10,353 plus VAT. This fee was inline with that highlighted within our terms of reference issued on 29 April 2015.

We have also completed the following pieces of non audit work at the Trust during the year:

Cash Management Review	■ Diagnostic reviews of cash management procedures in place at the Trust ■ £43,840	■ The provision of non-audit services in relation to Project Samlesbury may give rise to threats to: – independence -specifically self-review : We can confirm that the work was an independent review of cash, financial governance and management and planning processes in place at the Trust. The work had no direct impact on the values reported within the financial statements and was not subject to review by the external audit team. All financial plan work was completed by an advisory team, independent of the external audit team. – advocacy and self-interest - in relation to assumption of management responsibility and the significance of the fees associated with these non-audit services: The advisory team worked alongside client staff. The Chief Executive and Director of Finance remained ultimately accountable for the decisions taken as result of the work. Management responsibility for decisions is clearly documented in the engagement letter.
Finance Governance and Reporting Review	■ Review of Finance function and reporting structures ■ £37,550	

Appendix A: Key issues and recommendations

We summarise recommendations identified from our current year audit work:

Priority rating for recommendations		
1 ***Priority one***: issues that are fundamental and material to your system of internal control. We believe that these issues might mean that you do not meet a system objective or reduce (mitigate) a risk.	2 ***Priority two***: issues that have an important effect on internal controls but do not need immediate action. You may still meet a system objective in full or in part or reduce (mitigate) a risk adequately but the weakness remains in the system.	3 ***Priority three***: issues that would, if corrected, improve the internal control in general but are not vital to the overall system. These are generally issues of best practice that we feel would benefit you if you introduced them.

#	Risk	Issue, Impact and Recommendation	Management Response/Responsible Officer/Due Date
1	2	**Formal Impairment Review of Tangible Assets** Through discussion with the Finance Team we have concluded that there is no formal process that takes place within the Trust to identify impairments to tangible assets. There are informal processes in place, which alongside the external valuation completed by DTZ, help the Trust to identify impairments to assets. There is a risk that impairments are not identified through the desk-top valuations completed by DTZ or through the informal arrangements currently completed by the Trust. The Trust should complete a formal impairment review of tangible assets on an annual basis, much the same as the exercise completed for intangible assets. The Trust should consider the Trust strategy and current operations and whether these factors present any indication of impairments to assets. A paper should be presented to the Audit Committee on an annual basis to conclude on this formal impairment review prior to the approval of the financial statements.	As is consistent with prior years the Trust has not produced a formal paper in relation to the impairment review of Tangible Assets. However ■ The building assets of the Trust were reviewed and updated for impairment as part of last year's full scale revaluation as per accounting policies ■ The asset register has been updated for all estate changes in the year (such as the disposal of the C Block) and finance have always been fully involved with potential impacts on the estate (such as site strategy. the sale of Springviewand changes in use of buildings.) ■ The estates department communicate all known estate changes to the finance department on a regular basis via the Space Management Group, Finance Management Group and also through liaising regarding statutory returns such as the ERIC return. ■ The estates department reviews the Trust estate on a regular basis particularly with regards to the backlog maintenance review which is a risk assessed review of both trust sites. ■ All health and safety issues are escalated to the Trust Board if appropriate ■ As per the accounting policies the Trust would only impair an asset if there is objective evidence of impairment which has an impact on the estimated future cash flows of the asset. However, the trust will take advice from external audit to formalise the above processes into a paper for the audit committee for consideration in future years **Responsible Officer and due date:** Financial Accountant March 2016

Appendix A: Key issues and recommendations (continued)

#	Risk	Issue, Impact and Recommendation	Management Response/Responsible Officer/Due Date
2	2	**'Off-payroll' arrangements: compliance with HMRC guidance** Our review of the Trust's disclosures around 'off-payroll' arrangements for 2014/15 has identified that in 5 of the 6 disclosed cases, the relevant contract that is in place between the Trust and the individual performing services for the Trust does not include the standard HMRC wording required to provide 'off-payroll' assurances, per HM Treasury guidance. There is a risk that the required assurances are not delivered as part of the written agreements underpinning the Trust's 'off-payroll' arrangements, which could lead to HMRC challenge around the legitimacy of these arrangements. For clarity, we are satisfied that the Trust has complied with HM Treasury guidance regarding the disclosure in its annual report of these arrangements. We recommend that the Trust work with external agencies and providers to ensure that, going forward, all contracts covered by the 'off-payroll' guidance include standard HMRC assurances.	The trust has recognised the required process changes regarding off payroll arrangements to comply with HMRC requirements. As a result, the Trust has created a Temporary Agency and Self Employed Workers Policy which was ratified by the Workforce & Communication Group on the 2nd April 2015. The Trust also has a generic terms of engagement for locum doctors working through a limited company which does contain some specific HMRC assurances. Of the 5 cases without the standard HMRC wording within the individual contracts, 3 of them related to individuals contracted via the Brookson locum scheme during 2014/15. Going forward, Brookson have confirmed that they can provide evidence of the required assurance of worker compliance with all HMRC Income Tax and National Insurance Contributions. In terms of the remaining 2 cases, these related to staff members contacted directly via the Trusts contracting team. In future, the Trust will ensure that all contracts are covered by the off-payroll guidance including standard HMRC assurances. **Responsible Officers and due date:** Head of Procurement & Supplies / Head of Contracting & Bid Management May 2015

Appendix B: Follow up of prior year recommendations

We summarise below the status of your prior year recommendations:

Number of Prior Year Recommendations	Number of Recommendations implemented	Number outstanding (re-iterated below)
1	1	0

Recommendations Outstanding

#	Risk	Issue and Recommendation	Management Response, Officer Responsible and Due Date	Status as at May 2015
1	3	**Segregation of Duties for posting Journals** We found there to be insufficient segregation of duties in journals posting as users can self-approve journals within their prescribed limits. These limits are operating effectively but the limits of some users are in practical terms unlimited given the size of journal entries being posted to the ledger on a routine basis. This means that these individuals can post journals with no segregation or other approval. There is a risk that users could manipulate balances within the ledger which would not be detected due to a lack of segregation of duties. Compensating controls are in place to mitigate this risk to a certain extent, including effective budgetary control and effective management review of all control account reconciliations on a monthly basis. These controls are, however, largely reactive rather than proactive in detecting any inappropriate journal entries, meaning that this represents an area wherein controls can be strengthened. We would therefore recommend that the Trust reviews its current processes in line with good practice elsewhere in the sector, to provide additional assurance that this risk has been mitigated for all levels of officers and for all journals regardless of size.	The segregation of duties and limits in place are consistent with previous years and those reviewed by Internal Audit. Supplementary controls are in place to support the process (independent review of reconciliations and budgetary review). However, the Trust will undertake the review as recommended during the year. **Responsible Officer:** Finance Systems Manager **Due Date:** 31 March 2015	The Trust has reviewed the practice of journal approval in other finance departments in the NHS and it has found that this varies greatly between bodies, with some having very stringent controls and others having very weak controls. Stringent controls: self approval of journals is switched off at all times meaning that no individual can complete a whole transaction in the ledger system i.e. there is no delegated authority whatsoever. However, this causes operational issues and can cause delays in reporting due to authorisers not being available when journals need inputting. Medium Controls: have a mixture of self approval of journals and other journals requiring approval based on transaction value. This delegated authority model provides control for material values but also provides more flexibility operationally as delays are less likely to happen as a result of journals waiting for authorisation. Low Controls: self approval of journals is switched off at all times meaning that all users can post any journals, irrespective of value. This provides no control at all and is a weak control environment. WUTH would like to position itself in a Medium Control position, as this would have the benefits of providing controls without completely sacrificing the ability of the Finance department to meet its operational targets in respect of journal input deadlines and monthly report production. In order to do this every person in the Finance department has been given a delegated limit which is reasonable i.e. the more senior managers now have an upper limit of self approval of journals up to and including £1,000,000. After this point authorisation would be required. The other mitigating controls of journal error continue to exist i.e. independent review of reconciliations and budgetary review.

Appendix C: ISA 260 Communication of Audit Differences

We are required by ISA (UK and Ireland) 260 Communication of Audit Matters to Those Charged with Governance to communicate all uncorrected misstatements, other than those that we believe are clearly trivial, to those charged with governance. As part of our planning process we agreed a definition of trivial with you which reflected balances below £290,000. We are also required to report all material misstatements that management has corrected but that we believe should be communicated to the Audit Committee to assist it in fulfilling its governance responsibilities.

This appendix sets out the audit differences that we identified following the completion of our audit of the Trust for the year ended 31 March 2015.

Unadjusted audit differences

Detailed below is the audit difference identified during the course of our audit, which does not have an effect on the Trust's reported financial position. We are satisfied that, although the Trust has not adjusted the accounts to reflect these differences, the total unadjusted difference is not material to the overall reported financial position.

Issue	Impact (Dr)	Impact (Cr)
Desktop revaluation of Trust land and buildings – movements identified The Trust commissioned an interim desktop revaluation in 2014/15, following the full valuation exercise that took place as at 31 March 2014. The Trust has analysed the impact of this valuation, and the implied movements in the valuation of its Land and Building assets. The net movement arising from this exercise was an increase in the asset values of £1,513k, which incorporates a decrease in value of £2,011k across 4 specific assets and an increase across all remaining assets of £3,524k. As discussed with external audit prior to the production of the financial statements, the Trust has elected not to amend its financial statements in 2014/15 for the impact of this revaluation exercise, for the following key reasons: ▪ The overall movement in the value of Land and Buildings, at £1,513k (or just over 1% of total fixed assets) is not considered to be sufficiently material to warrant an adjustment to the financial statements in 2014/15, which is in line with the Trust's historic treatment of non-material movements arising from revaluation exercises, and previous treatment as discussed with the external auditors; ▪ The desktop exercise was simply an interim update to the most recent full revaluation exercise (as at 31 March 2014), which is deemed to be sufficiently recent as to not require the accounts to be amended again in 2014/15; and ▪ Processing the revaluation within the Fixed Assets system and General Ledger is time-consuming and places additional pressures on the Finance team at the year end. We recognise that the rationale of the Trust in not adjusting its financial statements is consistent with previous periods and is reasonable, as previously concluded through discussions between external audit and the Trust. However, we are required to report this unadjusted audit difference to those charged with governance as it relates to a significant audit risk that is reported on within the new long form audit report and is clearly above our trivial level. The proposed movements to adjust for this audit difference are outlined in the adjacent columns.	Property, Plant and Equipment (Net Book Value) 1,513 Other Comprehensive Income (Reduction in reserves due to revaluation losses) 2,011	Revaluation Reserve 3,524

Adjusted audit differences

We are pleased to report that there were no material adjusted audit differences.

Presentational Issues

We identified a number of minor presentational issues during our audit and these have all been amended by the Trust.

Other Matters

There are no other matters which we need to bring to your attention at this time.

Appendix D: ISA 260 Declaration of Independence and Objectivity

The purpose of this Appendix is to communicate all significant facts and matters that bear on KPMG LLP's independence and objectivity and to inform you of the requirements of *ISA 260 (UK and Ireland) Communication of Audit Matters to Those Charged with Governance.*

Integrity, objectivity and independence

We are required to communicate to you in writing at least annually all significant facts and matters, including those related to the provision of non-audit services and the safeguards put in place that, in our professional judgement, may reasonably be thought to bear on KPMG LLP's independence and the objectivity of the Engagement Lead and the audit team.

We have considered the fees paid to us by the Trust for professional services provided by us during the reporting period. We are satisfied that our general procedures support our independence and objectivity.

General procedures to safeguard independence and objectivity

KPMG LLP is committed to being and being seen to be independent. As part of our ethics and independence policies, all KPMG LLP Audit Partners and staff annually confirm their compliance with our Ethics and Independence Manual including in particular that they have no prohibited shareholdings.

Our Ethics and Independence Manual is fully consistent with the requirements of the Ethical Standards issued by the UK Auditing Practices Board. As a result we have underlying safeguards in place to maintain independence through: Instilling professional values, Communications, Internal accountability, Risk management and Independent reviews.

We would be happy to discuss any of these aspects of our procedures in more detail. There are no other matters that, in our professional judgement, bear on our independence which need to be disclosed to the Board of Governors.

Audit matters

We are required to comply with *ISA (UK and Ireland) 260 Communication of Audit Matters to Those Charged with Governance* when carrying out the audit of the accounts.

ISA 260 requires that we consider the following audit matters and formally communicate them to those charged with governance:

- Relationships that may bear on the firm's independence and the integrity and objectivity of the audit engagement lead and audit staff.
- The general approach and overall scope of the audit, including any expected limitations thereon, or any additional requirements.
- The selection of, or changes in, significant accounting policies and practices that have, or could have, a material effect on the Trust's financial statements.
- The potential effect on the financial statements of any material risks and exposures, such as pending litigation, that are required to be disclosed in the financial statements.
- Audit adjustments, whether or not recorded by the entity that have, or could have, a material effect on the Trust's financial statements.
- Material uncertainties related to event and conditions that may cast significant doubt on the Trust's ability to continue as a going concern.
- Disagreements with management about matters that, individually or in aggregate, could be significant to the Trust's financial statements or the auditor's report. These communications include consideration of whether the matter has, or has not, been resolved and the significance of the matter.

Appendix D: ISA 260 Declaration of Independence and Objectivity (cont.)

Audit matters (cont.)

- Expected modifications to the auditor's report.
- Other matters warranting attention by those charged with governance, such as material weaknesses in internal control, questions regarding management integrity, and fraud involving management.
- Any other matters agreed upon in the terms of the audit engagement.

We continue to discharge these responsibilities through our attendance at Audit Committees, commentary and annual audit letter and, in the case of uncorrected misstatements, through our request for management representations.

Auditor Declaration

In relation to the audit of the financial statements of the Trust for the financial year ending 31 March 2015, we confirm that there were no relationships between KPMG LLP and the Trust, its directors and senior management and its affiliates that we consider may reasonably be thought to bear on the objectivity and independence of the audit engagement lead and audit staff. We also confirm that we have complied with Ethical Standards in relation to independence and objectivity.

Appendix E: National Audit Office Group Assurance

We are required to report any inconsistencies greater than £250,000 between the signed audited accounts and the consolidation data and details of any unadjusted errors or uncertainties in the data provided for intra-group and intra-government balances and transactions regardless of whether a Trust is a sampled or non-sampled component. We have provided details of the inconsistencies identified below:

Counter party	Type of balance/ transaction	Balance as per WUTH (£'000)	Balance as per counter party (£'000)	Difference (£'000)	Comments on Difference
Wirral Community NHS Trust	Expenditure	995	1,388	393	It appears that the counter-party has not engaged with the Agreement of Balances process in 2014/15, since the Trust has not received a statement of income from Wirral Community NHS Trust. We do not have any concerns with the amount entered by WUTH into its consolidation schedules. The variance is believed to arise from the counter party including charges from the prior year (2013/14) in its 2014/15 income from WUTH, despite these charges arising and being paid in 2013/14. We are satisfied that these have been excluded by WUTH appropriately.
East Cheshire NHS Trust	Expenditure	0	303	303	The variance arises because the Trust accounts for recharged drugs as expenditure outside of government boundaries (ie. expenditure with the ultimate supplier), whereas the counter-party accounts for these transactions as income from WUTH. We are satisfied with the approach taken by the Trust to account for these transactions, which we consider to be appropriate.
NHS Wirral CCG	Income	223,170	223,707	537	The counter-party has adjusted its consolidation schedules with a value of £527k, greater than the income figure entered by WUTH. The Trust is awaiting clarification from NHS Wirral CCG on whether the counter party's consolidation schedules will be amended prior to final submission at the end of May 2015. We are satisfied that the Trust's income figure is based on robust data and can be traced to detailed activity and billing information.

The differences outlined above have been identified through review of Agreement of Balances 'mismatch' reports provided to KPMG by Monitor, and compiled jointly by Monitor and the Department of Health following the second submission of draft FT consolidation schedules on 6 May 2015. The differences above remain unresolved at the time of preparing our ISA260 report and therefore have been reported to the Committee. However, since we are satisfied with the Trust's accounting treatment for each of the above balances, these variances will not be included within our report to the NAO.

(Letterhead of Client)
KPMG LLP
1 St Peter's Square
Manchester
M2 3AE

[Date]

Dear Sirs

QUALITY REPORT 2014/15 - BOARD REPRESENTATION LETTER

This representation letter is provided in connection with your limited assurance engagement regarding the Quality Report of Wirral University Teaching Hospital NHS Foundation Trust ("the Trust") for the year ended 31 March 2015 for the purpose of forming a conclusion, based on limited assurance procedures, on whether anything has come to your attention that causes you to believe that:

• the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2014/15;

• the Quality Report is not consistent in all material respects with the sources specified in the Monitor guidance; and

• the indicator in the Quality Report identified as having been the subject of limited assurance in the Quality Report is not reasonably stated in all material respects in accordance with the 'NHS Foundation Trust Annual Reporting Manual' and the six dimensions of data quality set out in the 'Detailed Guidance for External Assurance on Quality Reports 2014/15' (the Guidance').

The Board confirms that:

(a) The Quality Report has been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15 and supporting guidance;

(b) The content of the Quality Report is not inconsistent with the internal and external sources of information set out in Section 2.1 of the Guidance;

(c) The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;

(d) The performance information reported in the Quality Report is reliable and accurate with the exception of issues identified in relation to the indicator entitled "percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period";

(e) 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;

(f) 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, with the exception of issues

identified in relation to the indicator entitled “percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period”; and

(g) The Quality Report has been prepared in accordance with Monitor’s annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

This letter was tabled and agreed at the meeting of the Board of Directors on [Date].

Yours faithfully

[Name]
Chief Executive

(Letterhead of Client)

KPMG LLP
1 St Peter's Square
Manchester
M2 3AE

[Date]

Dear Sirs

This representation letter is provided in connection with your audit of the financial statements of Wirral University Teaching Hospital NHS Foundation Trust ("the Trust "), for the year ended 31 March 2015, for the purpose of expressing an opinion:

i. as to whether these financial statements give a true and fair view of the financial position of the Trust as at 31 March 2015 and of its income and expenditure for the financial year then ended; and
ii. whether the financial statements have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15.

These financial statements comprise the Statement of Financial Position, the Statement of Comprehensive Income, the Statement of Cash Flows, the Statement of Changes in Taxpayers Equity and notes, comprising a summary of significant accounting policies and other explanatory notes.

The Board confirms that the representations it makes in this letter are in accordance with the definitions set out in the Appendix to this letter.

The Board confirms that, to the best of its knowledge and belief, having made such inquiries as it considered necessary for the purpose of appropriately informing itself:

Financial statements

1. The Board has fulfilled its responsibilities for the preparation of financial statements that:

   i. give a true and fair view of the financial position of the Trust as at 31 March 2015 and of its income and expenditure for that financial year;
   ii. have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15.

   The financial statements have been prepared on a going concern basis.

2. Measurement methods and significant assumptions used by the Board in making accounting estimates, including those measured at fair value, are reasonable.

3. All events subsequent to the date of the financial statements and for which IAS 10 *Events after the reporting period* requires adjustment or disclosure have been adjusted or disclosed.

4. The effects of uncorrected misstatements are immaterial, both individually and in aggregate, to the financial statements as a whole. A list of the uncorrected misstatements is attached to this representation letter.

Information provided

5. The Board has provided you with:

    - access to all information of which it is aware, that is relevant to the preparation of the financial statements, such as records, documentation and other matters;
    - additional information that you have requested from the Board for the purpose of the audit; and
    - unrestricted access to persons within the Trust from whom you determined it necessary to obtain audit evidence.

6. All transactions have been recorded in the accounting records and are reflected in the financial statements.

7. The Board confirms the following:

    i) The Board has disclosed to you the results of its assessment of the risk that the financial statements may be materially misstated as a result of fraud.

    Included in the Appendix to this letter are the definitions of fraud, including misstatements arising from fraudulent financial reporting and from misappropriation of assets.

    ii) The Board has disclosed to you all information in relation to:

    a) Fraud or suspected fraud that it is aware of and that affects the Trust and involves:
        - management;
        - employees who have significant roles in internal control; or
        - others where the fraud could have a material effect on the financial statements; and

    b) allegations of fraud, or suspected fraud, affecting the Trust's financial statements communicated by employees, former employees, analysts, regulators or others.

In respect of the above, the Board acknowledges its responsibility for such internal control as it determines necessary for the preparation of financial statements that are free from material misstatement, whether due to fraud or error. In particular, the Board acknowledges its responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

8. The Board has disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.

9. The Board has disclosed to you and has appropriately accounted for and/or disclosed in the financial statements, in accordance with IAS 37 *Provisions, Contingent*

Liabilities and Contingent Assets, all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

10. The Board has disclosed to you the identity of the Trust's related parties and all the related party relationships and transactions of which it is aware. All related party relationships and transactions have been appropriately accounted for and disclosed in accordance with IAS 24 *Related Party Disclosures*.

11. The Board confirms that all intra-NHS balances included in the Statement of Financial Position (SOFP) at 31 March 2015 in excess of £100,000 have been disclosed to you and that the Trust has complied with the requirements of the Intra NHS Agreement of Balances Exercise. The Board confirms that Intra-NHS balances includes all balances with NHS counterparties, regardless of whether these balances are reported within those SOFP classifications formally deemed to be included within the Agreement of Balances exercise.

12. The Board confirms that:

    a) The financial statements disclose all of the key risk factors, assumptions made and uncertainties surrounding the Trust's ability to continue as a going concern as required to provide a true and fair view.
    b) Any uncertainties disclosed are not considered to be material and therefore do not cast significant doubt on the ability of the Trust to continue as a going concern.

13. The Trust is required to consolidate any NHS charitable funds which are determined to be subsidiaries of the Trust. The decision on whether to consolidate is dependent upon the financial materiality and governance arrangements of the charitable funds. The Board confirms that, having considered these factors, it is satisfied that the charitable funds do not require consolidation as they are not material to the Trust's financial statements.

This letter was tabled and agreed at the meeting of the Board of Directors on *[date]*.

Yours faithfully,

[Chairman]

[Secretary]

Optional cc: Audit Committee

Appendix to the Board Representation Letter of Wirral University Teaching Hospital NHS Foundation Trust: Definitions

Financial Statements

IAS 1.10 states that "a complete set of financial statements comprises:

- a statement of financial position as at the end of the period;
- a statement of comprehensive income for the period;
- a statement of changes in taxpayers equity for the period;
- a statement of cash flows for the period;
- notes, comprising a summary of significant accounting policies and other explanatory information;
- comparative information in respect of the preceding period as specified in paragraphs 38 and 38A; and
- a statement of financial position as at the beginning of the preceding period when an entity applies an accounting policy retrospectively or makes a retrospective restatement of items in its financial statements, or when it reclassifies items in its financial statements in accordance with paragraphs 40A-40D.

Material Matters

Certain representations in this letter are described as being limited to matters that are material.

IAS 1.7 and IAS 8.5 state that:

> "Material omissions or misstatements of items are material if they could, individually or collectively, influence the economic decisions that users make on the basis of the financial statements. Materiality depends on the size and nature of the omission or misstatement judged in the surrounding circumstances. The size or nature of the item, or a combination of both, could be the determining factor."

Fraud

Fraudulent financial reporting involves intentional misstatements including omissions of amounts or disclosures in financial statements to deceive financial statement users.

Misappropriation of assets involves the theft of an entity's assets. It is often accompanied by false or misleading records or documents in order to conceal the fact that the assets are missing or have been pledged without proper authorisation.

Error

An error is an unintentional misstatement in financial statements, including the omission of an amount or a disclosure.

Prior period errors are omissions from, and misstatements in, the entity's financial statements for one or more prior periods arising from a failure to use, or misuse of, reliable information that:

a) was available when financial statements for those periods were authorised for issue; and
b) could reasonably be expected to have been obtained and taken into account in the preparation and presentation of those financial statements.

Such errors include the effects of mathematical mistakes, mistakes in applying accounting policies, oversights or misinterpretations of facts, and fraud.

Management

For the purposes of this letter, references to "management" should be read as "management and, where appropriate, those charged with governance".

Related Party and Related Party Transaction

Related party:

A related party is a person or entity that is related to the entity that is preparing its financial statements (referred to in IAS 24 *Related Party Disclosures* as the "reporting entity").

a) A person or a close member of that person's family is related to a reporting entity if that person:
    i. has control or joint control over the reporting entity;
    ii. has significant influence over the reporting entity; or
    iii. is a member of the key management personnel of the reporting entity or of a parent of the reporting entity.
b) An entity is related to a reporting entity if any of the following conditions applies:
    i. The entity and the reporting entity are members of the same group (which means that each parent, subsidiary and fellow subsidiary is related to the others).
    ii. One entity is an associate or joint venture of the other entity (or an associate or joint venture of a member of a group of which the other entity is a member).
    iii. Both entities are joint ventures of the same third party.
    iv. One entity is a joint venture of a third entity and the other entity is an associate of the third entity.
    v. The entity is a post-employment benefit plan for the benefit of employees of either the reporting entity or an entity related to the reporting entity. If the reporting entity is itself such a plan, the sponsoring employers are also related to the reporting entity.
    vi. The entity is controlled, or jointly controlled by a person identified in (a).
    vii. A person identified in (a)(i) has significant influence over the entity or is a member of the key management personnel of the entity (or of a parent of the entity).

Related party transaction:

A transfer of resources, services or obligations between a reporting entity and a related party, regardless of whether a price is charged.

Mersey Internal Audit Agency

Director of Audit Opinion and Annual Report (2014/15)

Wirral University Teaching Hospital

NHS Foundation Trust

CELEBRATING 25 YEARS OF MIAA

Contents

1. Director of Audit's Opinion

1.1 Introduction

In accordance with Public Sector Internal Audit Standards, the Director of Internal Audit (HoIA) is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee, which should provide a reasonable level of assurance subject to the inherent limitations described below.

The purpose of this Director of Internal Audit Opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control. This Opinion will assist the Board in the completion of its Annual Governance Statement.

1.2 Opinion

My overall opinion is:

Significant Assurance, can be given that that there is a generally sound system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design or inconsistent application of controls put the achievement of a particular objective at risk

1.3 Basis of Forming the Opinion

The basis for forming my opinion is as follows:

Assurance Framework

An Assurance Framework has been established which is designed and operating to meet the requirements of the Annual Governance Statement and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation.

Assurance across the organisation's critical business systems:

Financial Systems	•Documentation, evaluation and review of the **Core Financial Systems**, which provided high assurance in a number of the key areas reviewed, including, General Ledger, Non-Pay Expenditure, Income & Debtors, Treasury Management and Asset Management. A specific review around **Budgetary Reporting** provided significant assurance.
IM&T	•A mid-year assessment of the policies, systems and processes established to complete the **Information Governance (IG)** Toolkit provided significant assurance. •Completion of reviews of controls around **Cerner Data Sets** and the management of the **Core Legacy Infrastructure** were assesed as limited assurance with recommendations agreed to enhance controls in these areas.
Performance	•Significant assurance was provided in respect of controls operated in respect of data capture processes for the **4 hour A&E, 2 week & 31 day Cancer targets**. •Limited assurance was provided on the systems and processes established around **Decontamination** with recommendations made to enhance controls which have been subject to further follow up in year.
Clinical Quality	•Significant assurance was provided for reviews of the **Francis II Action Plan**, **Quality Account** systems and processes and the **Quality Governance Framework**. •A review of the **Mortality Framework** and our **Quality Spot Checks** also provided significant assurance. •Limited Assurance was provided for processes for monitoring **Nursing Staffing Levels.**
Workforce	•Significant assurance was provided in respect of the governance arrangements established for the **HR & Wellbeing Service**. •Reviews of controls around **Establishment Management** were assessed as limited assurance with control enhancements recommended.
Governance, Risk & Legality	•Significant assurance was provided for our review of **Incident Reporting**. •We have reviewed the **Assurance Framework** and its supporting processes.

Action has been agreed by Management to address the recommendations made in the internal audit reviews and we will undertake a follow up of the recommendations to provide assurance to the Audit Committee that the issues raised have been addressed.

Contribution to Governance, Risk Management and Internal Control enhancements:

- Detailed insight into the overall Governance and Assurance processes gained from liaison throughout the year with the Senior Management Team, and work to develop the Assurance Framework.
- Involvement with the organisation in respect of advice and guidance relating to Corporate Governance documentation and assurance.
- Involvement and relationship with the organisation e.g. attendance at finance meetings, risk management groups etc).
- Ongoing discussion with lead officers, Executive and Non-Executive Directors throughout the year.
- Follow up, demonstrating significant progress against recommendations to improve systems and controls.
- Involvement through MIAA events, including Non-Executive Director Learning Series, Governor Development and Audit Committee Chairs.

The Opinion does not imply that Internal Audit have reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led Assurance Framework. As such, it is one component that the Board takes into account in making its Annual Governance Statement.

Tim Crowley

Director of Audit, MIAA
March 2015

Appendix A provides a summary of the Audit Reviews undertaken during the year.
Appendix B provides further information to consider when compiling the Annual Governance Statement (AGS).
Appendix C provides assurance regarding the quality of MIAA's service.

Appendix A: Audit Review Outcomes and Delivery

Performance against Plan

The Internal Audit Plan has been delivered in accordance with the schedule agreed with the Audit Committee at the start of the financial year. This position has been reported within the progress reports across the financial year.

Risk Based Reviews

The audit assignment element of the Opinion is limited to the scope and objective of each of the individual reviews. Detailed information on the limitations to the reviews has been provided within the individual audit reports and through the Audit Committee Progress reports throughout the year. The schedule below provides a summary of the reviews and overall objectives contributing to this element of the Opinion.

HIGH ASSURANCE	Our work found some low impact control weaknesses which, if addressed would improve overall control. However, these weaknesses do not affect key controls and are unlikely to impair the achievement of the objectives of the system. Therefore we can conclude that the key controls have been adequately designed and are operating effectively to deliver the objectives of the system, function or process
	• **General Ledger** Objective: To provide an opinion on the key controls to ensure all financial transactions of the organisation are recorded with completeness and integrity. • **Non-Pay Expenditure** Objective: To ensure all goods and services are ordered promptly by authorised officers, are available when required, are of an appropriate quality, and the correct payment is made to the correct payee at the most appropriate time and is properly accounted for in the organisation's records. • **Income & Debtors** Objective: To ensure all income due to the organisation is properly identified, collected and accounted for under management control and management receives timely and adequate information to control this. • **Treasury Management** Objective: To provide an opinion on the key controls to ensure that the financial stability of the organisation is attained and monitored to enable the organisation to meet it's business plan.

HIGH ASSURANCE	Our work found some low impact control weaknesses which, if addressed would improve overall control. However, these weaknesses do not affect key controls and are unlikely to impair the achievement of the objectives of the system. Therefore we can conclude that the key controls have been adequately designed and are operating effectively to deliver the objectives of the system, function or process
	• **Asset Management** Objective: To provide an opinion on the key controls to ensure the assets of the Trust are identified and that transactions are recorded with completeness and integrity.

SIGNIFICANT ASSURANCE	There are some weaknesses in the design and/or operation of controls which could impair the achievement of the objectives of the system, function or process. However, either their impact would be minimal or they would be unlikely to occur
	• **Francis II Action Plan** Objective: To evaluate the Trust's action plan in response to the issues raised and the recommendations arising following the publication of the Francis II report and the Department of Health response. • **HR & Wellbeing Service** Objective: To provide assurance that there are effective and appropriate governance, performance management and contractual reporting arrangements to facilitate the delivery of the HR & Wellbeing Services' (HRWBS) strategic objectives and operation as a profitable service line within the Trust's operating environment. • **Quality Account** Objective: To provide an opinion on the systems and processes in place to support production of the Quality Account. • **Quality Governance Framework** Objective: To undertake an evaluation of Trust processes for assessing and ensuring compliance with Monitor's Quality Governance Framework. • **Quality Spot Checks** Objective: The overall objective of the review was to ensure that key aspects of the quality agenda are operating at local level. This included controlled drugs procedures, evidencing of VTE and dementia checks, resuscitation trolleys, discharge checklists, patient experience and infection control procedures. Four localities were visited, wards 21, 22, 32 and 33.

SIGNIFICANT ASSURANCE

There are some weaknesses in the design and/or operation of controls which could impair the achievement of the objectives of the system, function or process. However, either their impact would be minimal or they would be unlikely to occur

- **Activity Data Capture (4 Hour A&E, 2 week & 31 day Cancer)**
  Objective: To evaluate the systems and processes in place to capture and record data for the identified targets.
- **Mortality Framework**
  Objective: The overall objective of this review is to focus on how mortality information is discussed, reported and, where necessary, actioned.
- **Budgetary Reporting**
  Objective: To ensure financial reports provide accurate and sufficient information for organisational requirements and satisfy external reporting requirements.
- **IM&T: Information Governance (IG) Toolkit – in year assessment**
  Objective: To provide an opinion on the adequacy of the policies, systems and operational activities to complete, approve and submit the IG Toolkit scores.
- **Incident Management**
  Objective: To evaluate the systems and processes in place for escalating, managing and reporting incidents

LIMITED ASSURANCE

There are weaknesses in the design and / or operation of controls which could have a significant impact on the achievement of the key system, function or process objectives but should not have a significant impact on the achievement of organisational objectives.

- **Establishment Management**
  Objective: To provide assurance on the robustness of the systems and processes in place at the Trust to record, authorise, manage and monitor banding changes for existing staff members.
- **Decontamination (TSSU)**
  Objective: The overall objective of the review was to provide an opinion on the adequacy of the processes in place in relation to the Trust's sterile services.

LIMITED ASSURANCE	There are weaknesses in the design and / or operation of controls which could have a significant impact on the achievement of the key system, function or process objectives but should not have a significant impact on the achievement of organisational objectives.
	• **Monitoring Nurse Staffing Levels** Objective: To provide an opinion on the systems and processes for gaining assurance on the management, monitoring and reporting of nurse staffing levels from frontline to Board. • **IM&T: Cerner Data Sets** Objective: The overall objective of the review was to ensure robust processes are in place for quality checking of data extracted and reported from Cerner. • **IM&T: Core Legacy Infrastructure** Objective: To provide a high level opinion on the effectiveness of the control framework activities to be returned to the Trusts control, and highlight areas of improvement, where appropriate.

NO ASSURANCE	There are weaknesses in the design and/or operation of controls which [in aggregate] have a significant impact on the achievement of key system, function or process objectives and may put at risk the achievement of organisational objectives.
	None of the reviews received No Assurance.

CONTRIBUTION TO CONTROL ENVIRONMENT	Areas where MIAA have supported the organisation in strengthening arrangements in respect of governance, risk management and internal control.
	• **Assurance Framework Development** Objective: Workshop facilitated. • **Corporate Governance Manual** Objective: Advice and support provided. • **Review of Taxis** Objective: Advice and support on process. • **Job Planning Information** Objective: Advice and support on process.

CONTRIBUTION TO CONTROL ENVIRONMENT

Areas where MIAA have supported the organisation in strengthening arrangements in respect of governance, risk management and internal control.

- **Follow Up**
  Objective: Ongoing review and update to Audit Committee on progress against prior recommendations.
- **MIAA Events**
  Objective: Our events and conference programmes attract leading speakers from the NHS, government, policy and voluntary sector, giving delegates access to the latest policy thinking, best practice and innovations across the UK, whilst also providing an ideal networking opportunity.

Appendix B: Contribution to Annual Governance Statement

Trust Board and Accountable Officer Roles and Responsibilities

The whole Board is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is an annual statement by the Accountable Officer, on behalf of the Board, including:

- How the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control and governance that supports the achievement of policies, aims and objectives.
- The purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process;
- The conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

The organisation's Assurance Framework should bring together all of the evidence required to support the Annual Governance Statement requirements.

Director of Internal Audit Opinion

The purpose of the Director of Audit Opinion is to contribute to the assurances available to underpin the Board's own assessment of the effectiveness of the organisation's system of internal control (see figure 1 below). This opinion will therefore assist the Accountable Officer and the Board in the completion of its Annual Governance Statement.

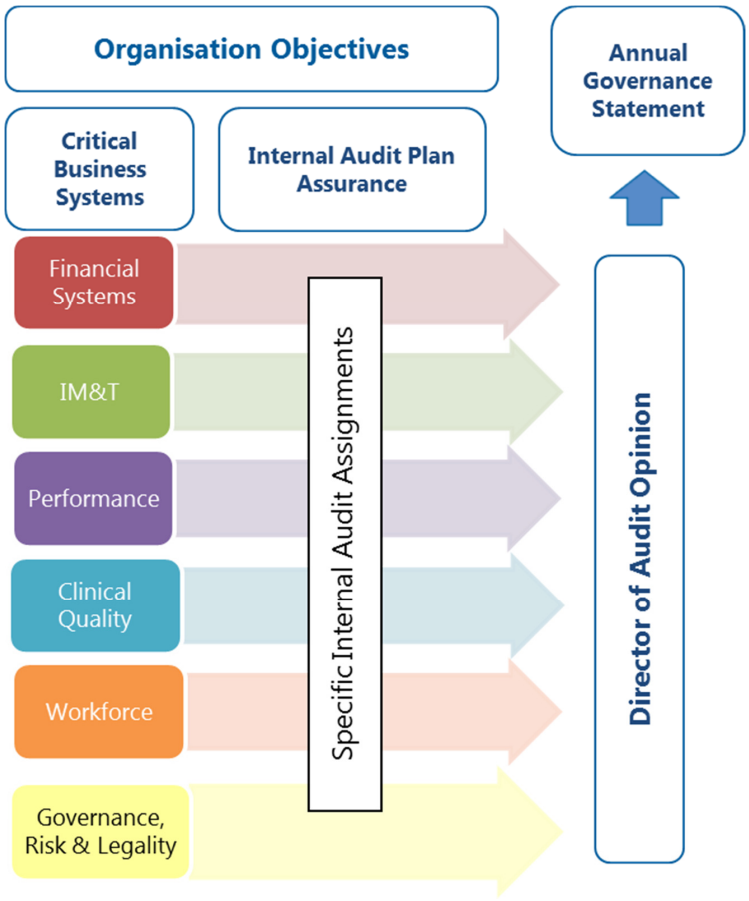


Figure 1 Director of Audit Opinion Contribution to AGS

The Director of Audit Opinion provided includes an opinion on the Assurance Framework and the risk based audit assignments across the critical business systems to inform the Annual Governance Statement.

Key Areas for Consideration in the Completion of the Annual Governance Statement

In addition to the Director of Audit Opinion, we have identified a number of other strategic challenges which were outside the scope of the Internal Audit Plan but which the Board should take into consideration, these include:

- Establishment and ongoing delivery of services within the requirements of the Provider Licence, risk assessment framework and compliance with the UK Corporate Governance Code.
- Regulatory compliance, including MONITOR oversight, CQC ratings and feedback from inspections, as well as other reviews completed by KPMG as external auditor, and other consultants.
- In year changes to the Executive and Senior Management Team.
- Organisation performance, including unprecedented challenges in achieving financial duties, ongoing financial viability, delivery of QIPP, service pressures and key relationships with Commissioners.
- Wider partnership working across the local health economy, including engagement with commissioning planning and transformation programmes.
- Communication and engagement with the membership, key stakeholders and other partners.
- Information governance arrangements, risks and any associated reportable incidents to the Information Commissioner.

Appendix C: MIAA Quality Service Indicators

MIAA Compliance with Internal Audit Standards

MIAA comply fully with professional best practice, internal audit standards and legal requirements. This includes guidelines issued by the Auditing Practice Board, professional bodies, MONITOR's Audit Code and the Institute of Internal Auditors.

The Public Sector Internal Audit Standards (wef. 2013) and our operational Internal Audit Manual are central to our continued external quality accreditation (BS EN ISO 9001:2000).

> *"MIAA's overall arrangements meet the standards and support the provision of an independent and satisfactory service to audited bodies, and we can take assurance from internal audit work contributing to an effective internal control environment at these bodies"*
>
> *Grant Thornton, February 2013*

It is important that client organisations ensure an effective Internal Audit Service and Table 1 below is provided to demonstrate MIAA's complies with Professional Standards. MIAA prides itself in exceeding the basic standards, in particular the quality of our staff, qualifications and provision of an exceptional skill mix recognising the need for this to match the complexity of the organisations with which we work.

Table 1: MIAA's Compliance with the Internal Audit Standards

Internal Audit Standards	MIAA Compliance
1000 - Purpose, Authority & Responsibility	MIAA undertakes audit work to evaluate and improve the effectiveness of risk management, control and governance processes. An annual Director of Audit Opinion is provided to support the Annual Governance Statement.
1100 - Independence & Objectivity	MIAA is managed independently from, and with no executive responsibilities for, the audited body. MIAA have direct access to the Audit Committee Chair and are represented at meetings. All MIAA staff complete an annual declaration of interest, including actions taken to mitigate these.
1200 - Proficiency & Due Professional Care	Professional care is monitored and achieved through compliance with MIAA's quality and review systems. The Director of Audit is a CCAB Qualified accountant and MIAA's staff are either fully or part qualified (including CCAB, IIA, CISA, QICA, and LCFS).
1300 - Quality Assurance & Improvement	MIAA have accreditations for systems, processes and training. We have successfully achieved external accreditation for ISO9001:2000 quality standards, Investors in People, Finance Staff Development (Level 3) and training accreditations with CCABs. All audit reports follow a strict quality assurance process.

Internal Audit Standards	MIAA Compliance
2000 - Managing the Internal Audit Activity	MIAA have a defined approach for risk assessment, planning, performance and reporting. Three year risk based audit plans are developed for our client organisations, with regular progress reported to the Audit Committee.
2100 - Nature of Work	MIAA's internal audit activity evaluates and contributes to the improvement of governance, risk management and internal control. There is regular liaison with the LCFS, External Auditor and other review bodies to facilitate effective coordination of work.
2200 - Engagement Planning	MIAA's work is structured to comply with DH and Monitor requirements and the role as defined in the Audit Committee Handbook. We establish risk based audit plans in conjunction with the organisation and with the approval of the Audit Committee.
2300 - Performing the Engagement	Terms of Reference are established and agreed for each review, including objectives, scope, timing and resource allocations. MIAA staff identify, analyse, evaluate and document sufficient information to achieve the assignment objectives. All assignments are properly supervised.
2400 - Communicating Results	MIAA communicate the results of each assignment. Working with the organisation, we ensure that communications are accurate, objective, clear, concise, constructive, complete and timely.
2500 - Monitoring Progress	MIAA establish follow up processes with client organisations to monitor and ensure that management actions have been effectively implemented or that senior management has accepted the risk. This is operated alongside the organisations own management follow up and provides independent assurance to the Audit Committee.
2600 – Communicating the Existence of Risks	MIAA recognise the professional role of Internal Audit to challenge the level of risk accepted by management, support resolution and ensure transparency in reporting to Audit Committee.

In terms of background, Tim Crowley (Director, MIAA) led the work on the production of NHS Internal Audit Standards, in addition to being a continued member of the Public Sector Internal Audit Standards Board which has led on bringing together sector wide standards. MIAA is also at the forefront of shaping professional standards through our national roles; Chair of CIPFA's Audit Panel (cross sector), and member of HfMA's Governance and Audit Committee. This puts MIAA in a unique position to provide early insight to our clients and ensures that we keep up to date, adopt and promote current practice within the profession (internal and external to the NHS).

MIAA Quality Service

MIAA continue to ensure that quality remains central to our core objective of providing our clients with the best service. To achieve this we have in place a number of internal and external quality processes. These include:

- Investors in People
- BS EN ISO 9001/2000
- Finance Staff Development Level 3
- External Audit Triennial Review
- Comprehensive Internal Quality Assurance
- Continued adoption of the EFQM Business Excellence Model

All of this is supported through our day to day contact with client organisations and the invaluable feedback that this provides to continually improve. In order to demonstrate to our clients the quality of the service delivered by MIAA assurance is provided in accordance with the measures outlined in the balanced scorecard (see Figure 2 below).

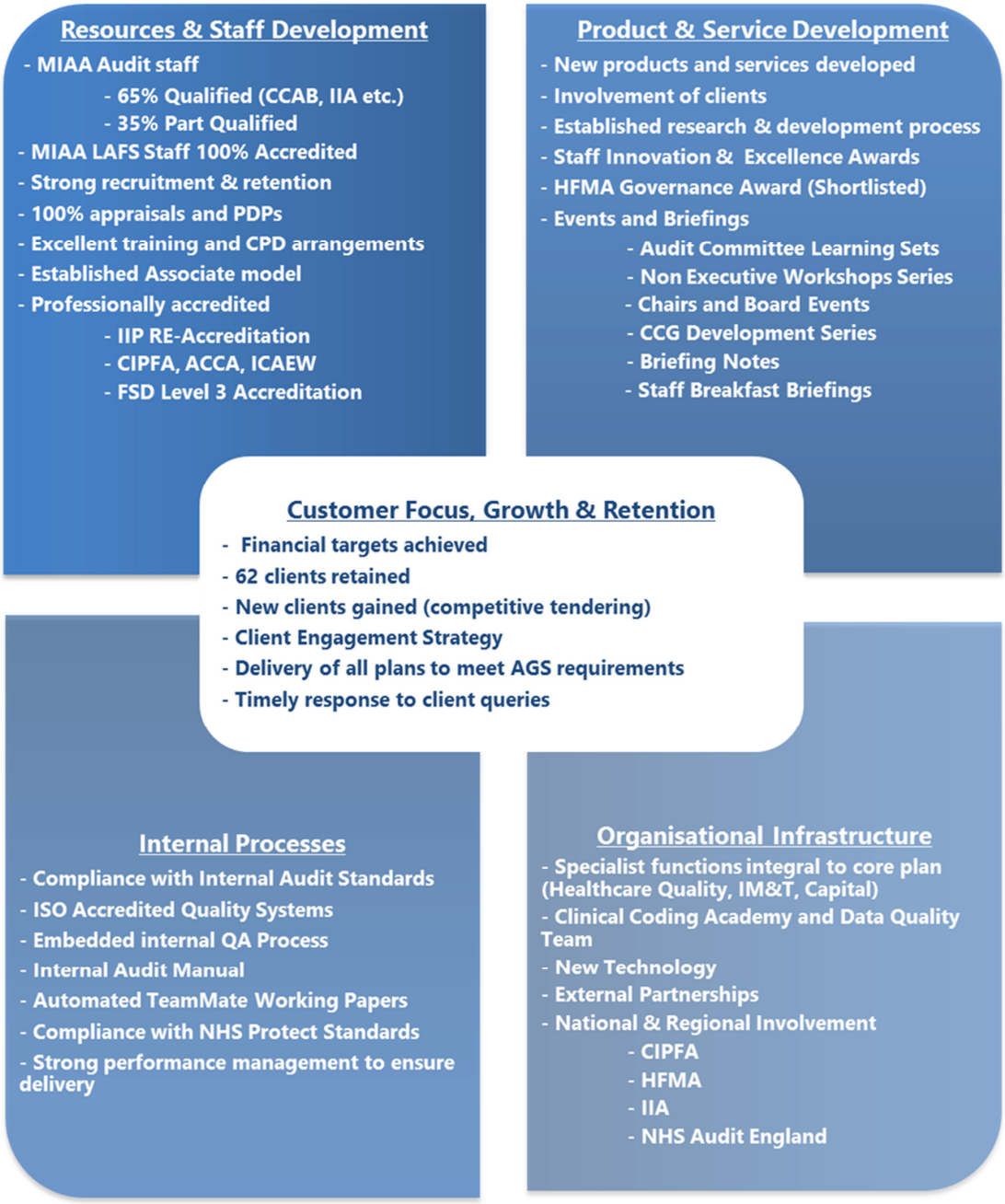


Figure 2 MIAA's Balanced Scorecard Outcomes

Board of Directors	
Agenda Item	8.2
Title of Report	Chair of Audit Committee Report 21 April 2015
Date of Meeting	27 May 2015
Author	Cathy Bond, Chair of the Audit Committee
Accountable Executive	Alistair Mulvey, Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	ALL
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

The Audit Committee meeting to review in detail and make recommendations to the Board on the statutory Annual returns was held on the 21st May, 2015. As is usual at this meeting the Chief Executive was invited to attend to support the presentations to Committee and in particular to present the Annual Governance statement.

Annual Report and Accounts

The Committee reviewed in detail the following:

- The Annual Report and Accounts for 2014/15
- The Quality Report
- The Annual Governance Statement
- The Annual Audit Committee Report
- The External Audit Opinions on both the financial statements and the Quality Report
- Letters of representation by the Board on the Financial Statements and Quality Account.

The Committee recommended some changes to the documents as outlined in the cover report to these documents on the Board agenda and subject to these changes recommend their adoption by the Board.

In making these recommendations to the Board, the Committee wished to bring to the attention of the Board two matters arising from the External Audit opinion:

- Use of resources
  Whilst the Trust achieved a positive Use of Resources outcome; the challenge in achieving this result in future years will be greater and significantly influenced by external affordability factors.
- Limited Assurance Challenge for Quality Account
  The selection of the local indicator should relate to a topic which has a data set capable of being audited. The Auditors will happily advise the Executive, Quality and Safety Committee and the Governors on the selection of a topic. The Committee requested that Internal Audit be commissioned to also do an assurance piece of work on behalf of the Governors on an indicator of their choice to complement the specific terms which must be applied by the external auditors.

As part of the process of improvement each year, the Committee also requested that the policy for interim revaluation of Trust assets be updated to describe the triggers for interim valuations in years 2and 4 and that the process for impairment of tangible assets was updated.

Secondly, the committee requested a report on the outcome of the piece of work on Cash management be undertaken to evidence the improvement to cash management resulting from the changes to working practices rather than from a loan or sale of assets; thus proving the value of the external work undertaken. It was noted that cash management looking forward featured strongly in the Finance Committees work and would be presented more regularly to the wider Board.

Internal Audit

The Committee reviewed 2 internal reviews undertaken in the reporting period as follows:

- HR/ESR Payroll — Significant Assurance
- Clinical Audit Arrangements — Significant Assurance

Counter Fraud

The Committee reviewed the standards for providers self-review tool which is a summary of the anti-fraud, bribery and corruption work conducted over the previous financial year. The review covers the four key areas of activity outlined in the standards these being strategic governance, inform and involve, prevent and deter and hold to account. The majority of the standards were rated as GREEN with two reported as AMBER. Action plans for the AMBER areas were agreed, these being in relation to regular testing of the Code of Conduct and pre-employment checks undertaken by Agencies.

Monitor Licence – Compliance Review

The Committee reviewed compliance with its Provider licence together with the declaration under section G6 to be agreed by the Board. The recommendation from the Committee was to “confirm” the two statements contained in the declaration for reasons outlined in the paper included elsewhere on the Board agenda.

Board Assurance Framework (BAF)

The Committee reviewed the BAF following the work of the Committees and agreed the following:

- Executives to review residual risk ratings in light of action being taken, this was specifically in reference to the risk associated with bed occupancy levels and A & E.
- BAF references in Committee and Board reports to be in narrative form as opposed to numerical to aid with triangulation
- Further consideration to be given to the risks associated with the NHS staff survey; activity levels and the overall Use of Resources in the Trust.

Annual Audit Committee Report

The Committee reviewed the draft Annual Audit Committee Report which highlighted the key elements of its work during 2014/15; the priorities for 2015/16 and the requirements as per the Code of Governance. The final of the Annual Audit Committee Report is attached for the Board's attention with key aspects included in the Annual Report as required.

Annual Governance Statement

The Committee reviewed the draft Annual Governance Statement, noting how this linked in with the Director of Internal Audit Opinion; the key requirements as prescribed by Monitor; the review by the Executive Team and the Chief Executive and the correlation with the financial investigation.

The final Annual Governance Statement is included in the Annual Report and recommended for approval by the Board.

Cathy Bond
Audit Committee Chair

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Annual Report

Audit Committee 2014/15

1. Purpose of the Report

1.1 This annual report 2014/15 has been prepared for the attention of the Board of Directors and reviews the work and performance of the Audit Committee during 2014/15 in satisfying its terms of reference.

1.2 The production of an Audit Committee Annual Report represents good governance practice and ensures compliance with the Department of Health's Audit Committee Handbook, the principles of integrated governance and Monitor's Risk Assessment Framework

2. Overview

2.1 Through the Audit Committee, the Board of Directors ensures that robust and effective internal control arrangements are in place and regularly monitored.

2.2 The Audit Committee receive regular updates of the Board Assurance Framework and is therefore able to focus on risk, control and related assurances that underpin the delivery of the organisational key priorities.

3. Committee Membership

3.1 The Audit Committee membership during 2014/15 comprised:

Cathy Bond	Chair of the Audit Committee
Graham Hollick	Non-Executive Director (Member until end of May 2014)
Jeff Kozer	Non-Executive Director (Member until end of May 2014)
Cathy Maddaford	Non-Executive Director (Member from September 2014)
Andrea Hodgson	Non-Executive Director (Member from September 2014)

4. Compliance with Terms of Reference

4.1 The terms of reference of the Audit Committee are reviewed annually and the last review date was 4th December 2014.

4.2 The Audit Committee met four times during 2014/15 as follows:

22nd May 2014
4th September 2014
4th December 2014
11th February 2015

4.3 All meetings have been quorate.

4.4 The Chair of the Audit Committee submits a report to the next available Board of Director's meeting. The minutes of the meeting are circulated to all members of the Board of Directors.

4.5 Audit Committee members met in private with the Internal and External Auditors prior to the Audit Committee meeting in April.

4.6 The Chair of Audit Committee reports to the Council of Governors after every Audit Committee and as well as making a presentation each year on the duties of the audit Committee. In addition, given the specific duties of the Governors in respect of the Appointment of External Audit the chair of Audit Committee refers to the council of Governors any matter relating to the External Audit.

4.7 The Director of Finance, Head of Corporate Financial Services, Deputy Director of Finance, Associate Director of Governance, Representatives from Internal and External Audit and the Local Counter Fraud Specialist have been in regular attendance

4.8 Executive Directors, Corporate Directors and other colleagues are invited to attend as required.

5. Member Attendance

	Meeting Attendance **Actual / Possible** **1st April 2014 – 31st March 2015**
Cathy Bond, Chair	4/4 100%
Cathy Maddaford	3/3 100%
Andrea Hodgson	3/3 100%
Graham Hollick	1/1 100%
Jeff Kozer	1/1 100%

6. Audit Provision

6.1 Internal Audit has been provided by Mersey Internal Audit Agency

6.2 External Audit has been provided by KPMG. The tenure of KPMG is due to expire in 2015 and to that end the Audit Committee reviewed the timetable and project plan for the tender for future external audit services in February 2015. This was subsequently reviewed and approved by the Council of Governors in March 2015. The tender process for these services is due to be completed by the Autumn of 2015.

7. Assurance

7.1 The Audit agenda is constructed in order to provide assurance to the Board of Directors across a range of activities including corporate, clinical, financial and risk governance and management.

7.2 The Audit Committee's Work Programme for 2014/15 covered the following:

- Review of the Board Assurance Framework
- Review of the Risk Management System
- Review of the work of Quality and Safety Committee and Finance Business Performance and Assurance Committee
- Review and recommendation of the Annual Governance Statement, Annual Report and Account Accounts to the Board
- Review of Whistleblowing Arrangements
- Review of Standing Financial Instructions and Scheme of Delegation
- Review of Compliance against the Trust's Provider Licence
- Review of risks and controls around financial management including losses' special payments and financial assurance
- Review of changes to accounting policies
- External Audit reports
- Internal Audit Report
- Counter Fraud Reports
- Review of Clinical Audit

8. Review of the Work and Performance of the Committee during 2014/15

8.1 Work Programme 2014/15

8.1.1 The Audit Committee has adhered to the Work Programme which was reviewed and updated in September 2014 to include a review of whistleblowing arrangements and clinical audit.

8.2 External Audit

8.2.1 The 2014/15 accounts were audited by KPMG and the findings presented to the Audit Committee in May 2015 and recommended to the Board of Directors later in May 2014. An unqualified opinion on the accounts was given.

8.2.2 Having reviewed the financial statements, operations and compliance The Committee focussed on the following issues as highlighted in the External Audit Plan:

- The Valuation of Property Plant and Equipment – the committee took assurance from the interim "desk top" revaluation of all the Trust's land and buildings undertaken during 2014/15 particularly in view of the competence, capability, objectivity and independence of the Trust's external valuer. In addition the Committee approved the recommendation to redraft the impairment policy to include the rational or interim assessments
- Recognition of NHS and non NHS income and associated fraud risk - The Committee The Committee took assurance from the effectiveness of the agreement of balances process and the month 9 exercise
- Management override of controls – The Committee noted the report from External Audit which identified that through significant testing there was no evidence of management override of controls
-

8.2.3 The Committee also considered other areas of risk in the year as follows:

- Segmental Reporting – the Committee reviewed the options as outlined in the paper reported to the Committee in February 2015 and concluded that as in previous years that this was not appropriate for 2014/15
- Charitable Funds Non-Consolidation – The committee reviewed the option available to the Trust at its meeting in February 2015 and concluded that it was not appropriate to consolidate based on the immaterial value of the charitable funds accounts.
- Going Concern statement – the Finance Business Performance and Assurance Committee reviewed the technical statement at its meeting in April 2015 and recommended this to the Board on 29th April 2015 subject to some additional annotations.
- Cash Management – the improvements to cash management was noted, the Committee requested that the improvement to cash balances resulting from the work that was undertaken to improve cash management processes should be identified separately from the general improvement through the loan and sale of land.

8.2.3 The Council of Governors subsequently received the report on the accounts from the Independent Auditor in September 2014.

8.2.4 KPMG carried out an audit on the Quality Account 2013/14 and provided recommendations to the Audit Committee in December 2014.

8.2.5 The Committee reviewed the impact of ISA 700 during 2014/15 and the associated costs. The annual external audit plan, which was risk based, was approved together with the associated costs in February 2015.

8.2.6 KPMG provided regular technical updates to the Audit Committee throughout the year. The Audit Committee requested that KPMG provide them with a view as to the position of the Trust in light of the updates in the future where applicable.

8.2.7 KPMG undertook non-audit services for the Trust in the year 2014/15, these being:

- Financial Governance and Reporting Review - £43,840
- Cash Management Review - £37,550

The committee discussed the requirement to ensure External Audit objectivity and the independence of audit work from the non audit commission. It was noted that KPMG non audit work was conducted by a separate team within KPMG and the value of the additional work was not materially significant such that it would compromise the independence of the External Audit.This conclusion was shared and approved by the Governors in advance of the additional non audit commission.

8.2.8 The Audit Committee reviewed the work of KPMG at the meeting in February 2015 and concluded that the quality of work was to an acceptable standard.

8.3 Internal Audit

8.3.1 The Audit Committee received and approved the Internal Audit Plan for 2014/15 in March 2014.

8.3.2 The Head of Internal Audit Opinion 2014/15 was presented to the Audit Committee in May 2015 and a significant assurance opinion was given on the adequacy of the system of internal control.

8.3.3 The following Internal Audit Reports have been received by the Audit Committee throughout the year.

Report	**Issued**	**Assurance Rating**
CQC Compliance Review	May 2014	Significant
Embedding Clinical Audit	May 2014	Significant
Overtime Processes - Theatres	May 2014	N/A
Establishment Management	May 2014	Limited
Decontamination	September 2014	Limited
Activity Data Capture Processes- A & E and Cancer Targets	September 2014	Significant
Safeguarding follow up	September 2014	N/A
Francis II Action Plan	December 2014	Significant
Quality Account	December 2014	Significant
Quality Governance Framework	December 2014	Significant
IMT: Core Legacy Infrastructure	December 2014	Limited
IMT: Cerner Data Quality	December 2014	Limited
Combined Financial Systems	February 2015	High
Quality Spot Checks	February 2015	Significant
HR & Wellbeing Business Service Review	February 2015	Significant
Corporate Governance Documentation	February 2015	N/A

8.3.4 The Audit Committee sought and received a status report on implementing Internal Audit Recommendations at its meeting in February 2015 and determined that this should be received at every meeting in the future.

8.3.5 The Audit Committee focussed on audit reports which had received a limited assurance rating and where appropriate requested the presence of key individuals to present their actions plans to fulfil the recommendations. The outcomes of the reviews of limited assurances have resulted in changes being made to the Trust's standing financial instructions and schemes of delegation and the implementation of mitigated actions to reduce the risk identified in the future.

8.3.6 The committee noted the quality standards obtained by MIAA in their Audit Approach, noted that the External Auditors placed reliance on the work of Internal Audit in conducting the External Audit of the Trust , questioned the External Auditors on their opinion of the standard of IA and concluded that the service provided by MIAA complied with IA guidance and best practice.

8.4 Counter Fraud

8.4.1 The Counter Fraud Service to the Trust is provided by Cheshire and Merseyside Commissioning Support Unit. The Trust utilised the services of two fully accredited Counter Fraud Specialist .

8.4.2 The Audit Committee received regular progress reports at every meeting.

8.4.3 The Audit Committee approved the Counter Fraud Annual Report 2013/14 in May 2014 which provided a summary of the counter fraud work undertaken based on the annual work plan.

8.4.4 Key referrals during 2014/15 have included:

- Patients from aboard
- Working whilst off sick
- Salary overpayments
- Anaesthetics on-call
- Consultant undertaking private work when being paid for NHS duties

8.4.5 The Audit Committee noted that the resource allocated for Counter Fraud Work was focussed on a mixture of awareness training, supporting national fraud initiatives and investigations work. The work plan follows the National guidance best practice for Counter Fraud work, within the resources made available by the Trust.

8.5 Clinical Audit

8.5.1 The Audit Committee reviewed the Trust's clinical audit process in December 2014. This included reports and presentations on the Clinical Audit Policy, the current Clinical Audit Plan, the process of review through Clinical Governance and the Quality and Safety Committee and the latest Internal Audit report which reviewed the Clinical Audit process in the Trust.

8.5.2 The Audit Committee sought to establish that a sound system of Clinical Audit existed and was supported within the Trust; that this was managed and reviewed within the governance structure of the Trust and that there was evidence of changes to practice as a result of Clinical Audit results. Further, the Audit Committee sought evidence that there was independent review of Clinical Audit and that recommended changes to the process were agreed and action taken to implement the recommendations.

8.5.3 The Audit Committee concluded that an adequate process for Clinical Audit existed within the Trust, there were appropriate systems of review, that change in practice was evidenced through the Advancing Quality programme although it was recognized that the learning was more variable in other areas with further work required to capture this. It was also noted that the Clinical Audit Plan was driven largely by mandatory external requirements and the advancing quality programme leaving little scope for locally determined areas of specific interest.

8.6 Board Assurance Framework (BAF)

8.6.1 The Board Assurance Framework has undergone extensive review and development during 2014/15 with the support of Mersey Internal Audit. The Board of Directors approved the revised framework in July 2014 which now incorporates the Trust's strategic objectives and the key risks associated with the achievement of these objectives.

8.6.2 The Audit Committee has undertaken reviews of the Board Assurance Framework at each meeting throughout the year and recommended improvements as follows:

- Inclusion of risk ratings both current and residual
- A review of all risk descriptors to ensure fit for purpose
- Controls were aligned to the Trust's approved Governance, Assurance and Performance Management Structure
- Assurances are now specific and timebound
- Key actions now include dates for implementation
- The cover report now highlights the top 5 risks and provides an holistic review of all the risks in the framework against the Risk management Policy.

8.6.3 The Board Assurance Framework has now been aligned with the electronic system used for the management of risk.

8.6.4 All Board and Committee Reports now have a stronger alignment to the BAF as recommended by the Audit Committee and require authors to detail the action to be taken to mitigate any gaps in assurance.

8.6.5 The Audit Committee concluded at its meeting in February 2015 that the BAF now provided them with an holistic overview of the risk profile of the Trust which informed the work of the Trust and the Board of Directors.

8.7 <u>Whistleblowing</u>

8.7.1 The Audit Committee reviewed the revisions to the recently ratified policy in December 2014 placing particular focus on the communication of this in light of the recent CQC report. The Committee discussed the options for providing feedback to staff who raise concerns anonymously and requested that this form part of a formal process to ensure that the Trust could demonstrate it acted upon concerns irrespective of whether the whistleblowers' identify was available or not.

8.7.2 The Committee recommended that the outcomes of this process be formally reported to the Board in the future.

9. Priorities for 2015/16

- the roll out of Cerner and the reliance of the IT systems
- The appointment of external Auditors.
- The governance arrangements for the new 'models of care' approach
- Arrangements to secure financial sustainability
- NHS Staff Survey
- Quality and Infection control
- Key aspects from the Internal Audit Programme

10. Developing the role and skills of the Audit Committee

10.1 The Audit Committee undertook a review of the Board Assurance Framework in November 2014 facilitated by Mersey Internal Audit.

10.2 The Chair of Audit Committee attends regular meetings of the Audit Chairs forum and Audit Committee members are encouraged and have attended workshops arranged by Internal and External Auditors.

11. Conclusion

11.1 The Audit Committee has worked within its terms of reference and continued to consider a much wider spectrum of risk during the year. This will continue into 2015/16.

Cathy Bond
Chair
Audit Committee **May 2015**

Board of Directors	
Agenda Item	8.3
Title of Report	Board Declaration – General Condition G6
Date of Meeting	27 May 2015
Author	Carole Ann Self, Associate Director of Governance
Accountable Executive	David Allison, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	7D Compliance with Legislative requirements
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Approval
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

1. Executive Summary

The Board are required to respond "Confirmed" or "Not Confirmed" to the following statements in relation to General Condition 6 – Systems for compliance with license conditions as outlined below as part of its annual declaration procedure:

1. *Following a review for the purposes of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution*

2. *The Board declares that the Licensee continues to meet the criteria for holding a licence*

The Audit Committee met on the 21st May 2015 and reviewed the statements in detail with a view to making a recommendation to the Board.

The Associate Director of Governance has also sought guidance from the Compliance Team at Monitor with regards to any automatic restrictions with making a "Confirmed" statement due to the Trust being in investigation.

2. Recommendation from Audit Committee

The Committee considered the statements separately and agreed that the first statement should be "Confirmed" in view of the work undertaken with external support in relation to the financial position; the additional resource put in place with the interim appointment of a Deputy Chief Executive and the view of the External Auditors as part of the Audit Review which included a clean opinion on the Use of Resources Assessment. The Committee also took into consideration the work undertaken with ECIST to improve A & E performance and the system wide approach taken to improving this.

The second statement afforded greater consideration by the Committee in view of the financial and now A & E investigation and the future look of the statement. The Compliance Team at Monitor have confirmed that being in investigation does not preclude the Board from making a "Confirmed" statement provided it was a reasonable view of the position.

Having revisited the Risk Assessment Framework guidance and the formal notification letter from Monitor regarding the Investigation, the recommendation is to declare "Confirmed" to the second statement for the following reasons:

- The Trust has not as yet been found to be in breach of its licence; the current situation is that the Trust is being investigated for a potential breach, the outcome of which is still unknown. To declare anything other than "Confirmed" at this stage might be seen to pre-judge the outcome.
- The Trust is aware that it has breached the A & E 4 hour standard which has prompted an investigation however this is not the same as breaching our Provider Licence. Again to declare anything other than "Confirmed" at this stage might be seen to pre-judge the outcome.

3. Recommendation

The Board is asked to review the statements, consider the review undertaken by the Audit Committee and declare "Confirmed" against each of these.

Board of Directors	
Agenda Item	9.4
Title of Report:	Health & Safety Annual Report
Date of Meeting:	27 May 2015
Author:	Peter Bohan, Head of Organisational Health & Effectiveness Andre Haynes, Health & Safety Manager James Mawrey, Director of Workforce
Accountable Executive:	Anthony Hassall, Executive Director of Strategy & Organisational Development
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	7D Compliance with H&S Legislation
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	**For Noting**
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

Executive Summary

1. The Health & Safety Annual Report covers the period 1st April 2014 to 31st March 2015, the standard financial year.

2. It was noted in the last Annual report that the Health and Safety Partnership Group (HSPG) will be restructured to maintain a much more strategic focus. Revisions to the governance and assurance process for Health & Safety were subsequently refined with clear reporting lines in to the Trust governance structure and a stronger alignment to an Executive Director's portfolio.

3. There have been positive developments in the management of Health and Safety across the Trust during the last year, with the Health & Safety (H&S) Team continuing to work on all key areas of compliance of systems and processes since the last report to the Board in April 2014 (note progress made in Appendix 1). Of the 52 actions within the previous report to the Board, all have been completed with the exception of three that are still partially compliant (see appendix 1). The remaining 3 actions which are partially compliant relate to asbestos management, management of legionella and the loading bay, all of which have actions to mitigate the risks identified and the Trust is working towards improving compliance.

4. The Health & Wellbeing Plan 2015-2018 continues to be enacted. A successful 'Well Being Event' was held on 24th April, 2015 with many staff attending to receive advice on staying healthy including: advice on mindfulness, cycle to work scheme, weight management, physiotherapy, gym membership, the live well programme, smoking cessation and cholesterol testing for staff.

5. Mandatory Health and Safety training compliance has improved and in the financial year 2014-15 a level of 97.48% was achieved which is encouraging when considering the target for compliance is 95%.

6. There were a total of 1548 incidents reported in 2014-15 compared with a total of 1563 reported in 2013-14, equating to a decrease of 16 incidents.

7. There were 35 RIDDOR reportable incidents reported to the HSE during 2014 / 2015 (a decrease from the 42 reported in the previous year). All of which were subject to a root cause analysis (RCA) investigation.

8. The Trust Board is asked to:
   a. Note the details of the Report.
   b. Highlight any specific additional assurance / information required.

Health & Safety Team Activity

1. Of the 52 actions within the previous report to the Board, all have been completed with the exception of three that are still partially compliant (see appendix 1). The remaining 3 actions which are partially compliant relate to asbestos management, management of legionella and the loading bay, all of which have actions to mitigate the risks identified and the Trust is working towards improving compliance.

2. A total of 22 new Health and Safety Policies have been developed in 2014-15. In addition to this a range of existing Health & Safety Policies have been reviewed to ensure they remain fit for purpose and legally compliant. There are no Health & Safety Policies that are outstanding and require review.

3. The Occupational Health Department delivered the flu campaign successfully and achieved above the target of 75%.The total number of front line staff receiving the vaccination was 76.4%.

4. The Health & Wellbeing Plan 2015-2018 continues to be enacted. A successful 'Well Being Event' was held on 24th April, 2015 with many staff attending to receive advice on staying healthy including: advice on mindfulness, cycle to work scheme, weight management, physiotherapy, gym membership, the live well programme, smoking cessation and cholesterol testing for staff.

5. The current 'month only' attendance rate is 4.17%. This has improved substantially from last month (4.59%, March 2015) and represents a large improvement on the same period last year (4.75%, April 2014). To support with this critical agenda the team actively supported on:-
    a. The introduction of the new Attendance Capability Policy.
    b. Re-training of over 400 managers.
    c. The continued focus on sickness action plans for poor attenders.
    d. Recognition of good attendance.

6. Health surveillance for specific work activities has progressed. For example:-
    a. Assessments have been undertaken for noise, including audiometry of 12 estates staff.
    b. Assessments have been undertaken for night working with 240 night staff undertaking a health review. It was identified that of these staff 4 required additional support.
    c. Skin surveillance has been undertaken throughout 2014-15 to support staff with issues that relate to dermatitis.
    d. Additional surveillance has taken place for staff using COSHH products with exposure limits within endoscopy and consideration of current control measures for the quality of maintenance of extraction systems and Personal Protective Equipment provided.

7. Mandatory Health and Safety training compliance has improved and in the financial year 2014-15 a level of 97.48% was achieved which is encouraging when considering the target for compliance is 95%.

8. There have been a number of initiatives in the management of Health and Safety across the Trust during this financial year 2014-15, with the Health & Safety (H&S) Team undertaking 10 audits, assisting with the completion of 59 Root Cause Analysis and continuing to work on all key areas of compliance of systems and processes.

9. The Health & Safety Executive recently audited the Trust in August 2014. The focus of the inspection was on the management of sharps. The Trust received positive feedback following this inspection.

Strengthening Governance and Assurance

1. As previously agreed, Health and Safety reporting to the Trust Board and the Quality & Safety Committee has taken place on a quarterly basis.

2. The Executive Director of Strategy & Organisational Development has chaired the Health & Safety Group and this group has been reporting directly to the Workforce & Communication Group (ensuring vertical alignment to the Quality & Safety Committee and ultimately Trust Board).

Employee Incidents

1. There were a total of 1548 incidents reported in 2014-15 compared with a total of 1563 reported in 2013-14, equating to a decrease of 16 incidents (-1%). Although the data suggests a small decline in the number of incidents reported it is worth noting that at the time of writing this report, there were 249 PSI (Patient Safety Incidents / Non clinical incidents) in the web holding file which are excluded from the overall number of 1543. These will be reported in the Quarter 1 Health & Safety Report.

2. Of the incidents reported by employees the top five categories reported were:

    a. Disruptive / Aggressive behaviour incidents. In 2014-15 there were a total of 365 disruptive / aggressive behaviour type incidents reported, compared with 428 reported in 2013-14. This represents a decrease of 63 incidents and this equates to a 15% decrease. Of the total of 365 Disruptive / Aggressive incidents reported in 2014-15, none required reporting to the Health & Safety Executive and no days were lost as a result of assaults to our staff.

    b. Injuries as a result of staff using clinical sharps. In 2014-15 there were a total of 84 sharps incidents reported, compared with 107 incidents reported in 2013-14 representing a decrease of 23. Of the 84 reported in 2014-15, there was one clinical sharp incident that was reported to the Health & Safety Executive. Following this report the Trust then received an inspection from the Health & Safety Executive in August, 2014. The feedback following the inspection was that they were satisfied with the Trusts policies and arrangements and asked whether our policies and processes could be shared with other Trusts to promote good practice.

    c. Security incident. In 2014-15 there were a total of 166 security incidents reported, compared with 200 reported in 2013-14. This represents a decrease of 34, which equates to a 17% decrease.

    d. Work Related Ill Health. In 2014-15 there were a total of 104 Work Related Ill Health incidents reported, compared with a total of 173 reported in 2013-14. This represents a substantial decrease of 69 which equates to a decrease of 40%.

    e. Staffing (clinical) issues. In 2014-15 there were a total of 264 Staffing (clinical) type incidents reported. There is no comparable data as previous to October 2014 these types of incidents were reported as clinical incidents due to the detrimental impact lack of suitably trained staff have on patients. The main

trend related to inappropriate nursing numbers of nursing skill mix. This matter is being reviewed and addressed via the weekly Nurse Management meetings with the Director of Nursing & Midwifery.

Incident Reporting RIDDOR (Reporting of Injuries, diseases and dangerous occurrence Regulations.)

1 There were 35 RIDDOR reportable incidents reported to the HSE during 2014 / 2015 (a decrease from the 42 reported in the previous year). All of which were subject to a root cause analysis (RCA) investigation.

Health & Safety Audits

1. A recently developed Health & Safety Framework audit tool has been developed by the Health & Safety team which reflects Health & Safety Executive guidance. The audit tool was introduced in September 2014 and the process involves splitting key areas of risk into the following four categories:-

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

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

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

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

2. The revised Health & Safety Framework tool has been introduced in those areas with poor attendance rates, for example:- Hotel Services, Pharmacy Dispensary – APH, Rehabilitation Ward – CCG, Accident & Emergency, Park Suite, Micro path, maternity, Paediatrics A&E, Medical Records – APH.

3. The overall results of the initial audits have indicated positive results and where systems require improving a specific action plan is developed for the service area. The results of the audits are reported at the Health & Safety Group and any necessary actions are monitored at this meeting.

Health and Safety Training

1. In 2014-15 financial year the training provided by the Health and Safety Team was as follows:

Training description	Number of sessions
Induction Presentation - Health and Safety	19
Induction Presentation – Moving & Handling	19
Induction practical-People Handling	19
Mandatory Training Presentation – Manual Handling	26
Mandatory Training – People Handling , practical	25
Traineeships manual handling	1
Student radiographers manual handling	1
Cadets Health & Safety	1
Mandatory Practical Training for W&C	11
Corporate Manslaughter Training	3

*Please note the above includes training provided by the Health & Safety Team, there are of course further training programs that are supplied by infection control and security management team. If required this can be included in future reports.

Health & Safety Key Issues / Update

1. The main regulatory updates in 2014-15 arose out of several consultations and audits that commenced during the reporting period. These are:

    i) A new risk relating to improving the management of clinical sharps has been entered onto the risk register which includes a detailed action plan.
    ii) The workplace transport risks particularly in the delivery area at Arrowe Park Hospital have now been reviewed. As detailed within the action plan (Appendix 1) all the actions will be completed by 31st May 2015.
    iii) Stress is a concern with a significant number of stress related absences being evidenced in attendance data. The Trust has developed a stress action plan which includes a review of both the pro-active and re-active measures that need to be taken to support our staff. This is being monitored at the Workforce & Communication Group.
    iv) The Health & Wellbeing Plan 2015-2018 continues to be enacted. A successful 'Well Being Event' was held on 24th April with many staff attending to receive advice on staying healthy including: advice on mindfulness, cycle to work scheme,

weight management, physiotherapy, gym membership, the live well programme, smoking cessation and cholesterol testing for staff.

v) The new Security Manager is now in post and issues relating to violence and aggression are being dealt with in a systematic manner.

vi) The asbestos entry on the risk register and relevant actions has been reviewed and completed. The competent contractor has completed the survey of the Clatterbridge site, which will be used to inform the management plan. A recent finding in Child Development Centre boiler room (Clatterbridge) identified asbestos material including Amosite and Crosidilite (Brown & White) in poor condition, despite an air clearance certificate being issued in January 2014. As detailed within Appendix 1 all the remedial work highlighted will be completed by the 30th June, 2015.

vii) The work continues on all aspects of the legionella report provided by Clearwater. All the Estates structural work has been undertaken. It has been highlighted that due to staffing levels the infection control audits have not been undertaken centrally by the Infection Control Team. The Deputy Director of Nursing has confirmed that these audits will now be undertaken at Ward level by the Ward Managers. A risk register will be developed by Estates relating to water safety and will be discussed and monitored at the Health & Safety Partnership Team and the Water Safety Group

4. **Conclusion & Summary**

1. Since the last Annual Report progress has been made on the Health & Safety agenda and this is reflected in the action plan (appendix 1).

2. The improved governance and assurance processes outlined in this document are intended to provide the Trust Board with a greater level of assurance as to the rigour being placed on the Health & Safety agenda.

5. Recommendations

The Board of Directors is asked to:

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

Appendix 1

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance May 15th 2015	Compliance Nov 14th 2014
Corporate Manslaughter & Corporate Homicide Act 2007	There was no policy covering Corporate Manslaughter & Corporate Homicide Act within the Trust	Existing Health & Safety Policy 118 to be updated to reflect Corporate Manslaughter and Corporate Homicide Act	A Haynes	31-01-14	14-02-14	Policy 118 updated to be reviewed 31-01-17.	Compliant	Compliant
Corporate Manslaughter & Corporate Homicide Act 2007	There was no signed statement of intent within the existing Health & Safety Policy 118	Existing Health & Safety Policy 118 to be updated with signed statement of intent	A Haynes	31-01-14	25-02-14	Statement of intent included within revised Policy 118 has been signed on the 25-02-14 to be reviewed 31-01-17.	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance May 15th 2015	Compliance Nov 14th 2014
Corporate Manslaughter & Corporate Homicide Act 2007	The Board had not received training on the requirement of Corporate Manslaughter & Corporate Homicide Act 2007.	Board require training covering Corporate Manslaughter & Corporate Homicide Act 2007	P Bohan	31-01-14	26-03-14.	A training presentation has been completed on 26th March to Board members. Training dates for staff 8B and above have been set for the next 12 months.	Compliant	Compliant
Corporate Manslaughter & Corporate Homicide Act 2007	The Trust had no Health & Safety Strategy in place	Health & Safety Strategy to be developed and implemented	P Bohan	31-03-14	25-02-14	Health & Safety Strategy has been developed and has been signed by the CEO. The Trust Board will be kept informed on a quarterly basis on progress with H&S matters via the Quality & Safety committee. to be reviewed	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance May 15th 2015	Compliance Nov 14th 2014
						31-01-17.		
Control of Substances Hazardous to Health Regulations 2002	The Trust had no policy covering all the requirements of the Control of Substances Hazardous to Health Regulations 2002	A policy detailing the requirements of COSHH will be developed	A Haynes	28-02-14	14-02-14	A COSHH policy has been approved in accordance with Trust procedure and will be reviewed 28-02-17.	Compliant	Compliant
Control of Substances Hazardous to Health Regulations 2002	Not all areas within the Trust are carrying out appropriate COSHH risk assessments	Appropriate COSHH assessments to be audited using H&SMF to ensure COSHH is implemented in service areas including facilities and estates.	A Haynes	31-08-14. .	31-08-14	An Occupational Health & Safety framework has been developed and includes a section on COSHH. A two year rolling programme has been developed to monitor compliance via the audit system. This is monitored at the Health & Safety Group and Workforce &	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance May 15th 2015	Compliance Nov 14th 2014
						Communication Group		
Control of Substances Hazardous to Health Regulations 2002	The Trust was not carrying out appropriate Health Surveillance for Vibration White Finger, Noise, night work, latex & pesticide.	An Occupational Health & Safety Policy will be developed	P Bohan	31-05-14	25-05-14	The process for undertaking Health surveillance for grounds maintenance is complete along with a policy. Continuous monitoring by the Occupational Health team will ensure all aspects of health surveillance identified through the risk assessment process are implemented.	Compliant	Compliant
Control of Substances Hazardous to	The Trusts Control of Legionellosis	The Trusts Control of Legionellosis	Gary Lewis / A Haynes	28-02-14	14-02-14	The Policy is complete and live on the intranet	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance May 15th 2015	Compliance Nov 14th 2014
Health Regulations 2002	Policy does not reflect recent HSE guidance although it was reviewed in June 2013 and is in date	Policy requires updating to reflect recent HSE guidance published Nov 2013				and will be reviewed on 14-02-17.		
Control of Substances Hazardous to Health Regulations 2002	There are currently approx. 130 fire hose reels that are not flushed in accordance with legionella legislation or as they are not fitted with a double check valve	Clearwater to undertake bi-annual inspection as per plan to review monitoring of risks and flushing regime	Gary Lewis	31-03-14	31-03-14	Clearwater have reviewed fire hoses and dead legs and provided a timescale for action (see below for actions / timescales).	Compliant	Compliant
Control of Substances Hazardous to Health Regulations 2002	There is a policy in place the bi-annual report by Clearwater will be undertaken to identify	The planned review of the Legionella management systems including the flushing regime	G. Lewis/Dewi Jones/A Ledgerton	30-06-15		All the Estates structural work has been undertaken. It has been highlighted that	Partial Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance May 15th 2015	Compliance Nov 14th 2014
	systems are in place for flushing and water management.	and audit process will be carried out				due to staffing levels the infection control audits have not been undertaken centrally by the Infection Control Team. The Deputy Director of Nursing has confirmed that these audits will now be undertaken at Ward level by the Ward Managers. All issues relating to water safety are discussed and monitored at the Health & Safety Partnership Team and the Water Safety		

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance May 15th 2015	Compliance Nov 14th 2014
						Group.		
Control of Asbestos Regulations 2006	The Trust had no policy covering the statutory requirements of the Control of Asbestos Regulations 2006.	The Trust to develop a policy covering the requirements of The Control of Asbestos Regulations 2006	Gary Lewis / A Haynes	31-03-14	14-02-14	A Control of Asbestos policy has been developed and has been sent out for approval in accordance with Trust policy. Policy to be reviewed 14-02-17.	Compliant	Compliant
Control of Asbestos Regulations 2006	Asbestos survey undertaken in Nov 2013 raises several concerns over the quality of the survey.	The findings from the original Asbestos survey in 2006 to be provided and reviewed to determine if actions have been completed	Gary Lewis	28-02-14	14-02-14	The survey has been completed	Compliant	Compliant
Control of Asbestos Regulations 2006	Asbestos survey carried out may be not sufficient and	A full non-destructive asbestos management	Gary Lewis	27-09-14.	27-09-14	Survey of Willow House complete and control measures put in	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance May 15th 2015	Compliance Nov 14th 2014
	suitable for Willow House	re-survey is required of Willow House				place to manage risks.		
Control of Asbestos Regulations 2006	High priority risk assessments for areas the survey prompted the development of an action plan which requires placing on the risk register entry	High priority assessment and action plan will be placed on risk register	Gary Lewis	20-12-14.		The survey of CDC plant room at Clatterbridge site identified asbestos debris on the floor and walls. PPE is being provided to staff to enter the premises safely. A management plan has been agreed for the removal of all debris and this will be completed by 30th June, 2015.	Partial Compliant	Compliant
Work at Height Regulations 2005	The Trust had no policy covering the statutory requirements of the Work at Height	The Trust to develop a policy covering the statutory requirements of the Work at Height	A Haynes / Gary Lewis	31-01-14	14-02-14	A Working at Height Policy has been completed. A specific permit system has been developed to be implemented for	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance May 15th 2015	Compliance Nov 14th 2014
	Regulations 2005 although some aspects are covered with the STF Policy 012	Regulations 2005				all staff and contractors. Policy to be reviewed 14-02-17.		
Work at Height Regulations 2005	Not all fragile roofs have a site-specific risk assessment in place.	A process for carrying out site-specific risk assessments for fragile roofs/surfaces to be developed.	Gary Lewis	15-08-14	15-12-14	Funding has been approved for high risk areas and this work has been undertaken.	Compliant	Partial compliance
Work at Height Regulations 2005	There is no permit to work system for high risk working at heights for estates and facilities personnel and contractors requires review	A process similar to a permit to work system in existence for contractors and estates and facilities personnel needs to be further developed.	Gary Lewis	31-03-14	31-03-14	There is controlled access to all roofs. A Memorandum has been sent out to all works personnel instructing them not to work near the roof edges or fragile roofs. Permit to work now in place.	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance May 15th 2015	Compliance Nov 14th 2014
Confined Space Regulations 1997	The Trust has no policy covering the statutory requirements of the Confined Space Regulations 1997	The Trust to develop a policy covering the statutory requirements of the Confined Space Regulations 1997	A Haynes / Gary Lewis	31-01-14	14-02-14	A Working in Confined Spaces policy has been implemented.	Compliant	Compliant
Confined Space Regulations 1997	Confined spaces across APH and CGH to be identified.	All confined spaces across APH and CGH have been identified.	Gary Lewis	31-01-14	14-02-14	All confined spaces at APH and CGH have been identified.	Compliant	Compliant
Confined Space regulations 1997	Ensure a specific task is assessed for confined spaces to determine risks and controls.	Ensure task specific assessment undertaken.	Gary Lewis/D Jones/A Haynes.	30-7-14	01- 07-14	A task specific risk assessment has been put in place which is described within the policy. The Policy to be reviewed 01-07-17	Compliant	Compliant
Confined Space Regulations	Not all relevant staff within Estates and	All key personnel within Estates and	Gary Lewis	31-01-14	07-02-14	All key personnel have received training on	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance May 15th 2015	Compliance Nov 14th 2014
1997	Facilities have received training on working in confined spaces	Facilities will receive training on working in confined spaces				working in confined space.		
Confined Space Regulations 1997	The site specific risk assessments for working in confined spaces are dated 2010	Site specific risk assessments to be reviewed	Gary Lewis	30-06-14	01-07-14	Working in confined spaces assessment completed in 2010. The risk assessment has been reviewed and signage has been put in place in all areas identified as confined spaces. A task specific assessment will be undertaken for all future work in confined spaces.	Compliant	Compliant
Control of Noise at Work Regulations 2005	The Trust had no policy covering the statutory requirements	The Trust to develop a policy covering the statutory requirements of	A Haynes/D. Jones	28-02-14	14-02-14	A Control of Noise at Work policy has been agreed. Policy to be reviewed 14-	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance May 15th 2015	Compliance Nov 14th 2014
	of the Control of Noise at Work Regulations 2005.	the Control of Noise at Work Regulations 2005				02-17.		
Control of Noise at Work Regulations 2005	There are no site specific risk assessments for noise control within Estates and Facilities	A rolling program of site specific risk assessments which will be prioritised according to the degree of risk will be developed	Gary Lewis	30-08-14	30-01-15	A baseline assessment has been undertaken; Noise assessment questionnaires have been distributed to all relevant staff and are being evaluated and staff have been referred for audiometry testing. Further noise assessments are ongoing in specific areas.	Compliant	Partial Compliance

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance May 15th 2015	Compliance Nov 14th 2014
Pressure Systems Safety Regulations 2000	The Trust had no policy covering the statutory requirements of the Pressure Systems Safety Regulations 2000	The Trust to develop a policy covering the statutory requirements of the Pressure Systems Safety Regulations 2000	Gary Lewis /A.Haynes	31-03-14	31-03-14	Currently Alliance Insurance undertakes pressure systems tests for insurance purposes. A written scheme of work is in place by the external assessor. Policy developed in accordance with internal process. Policy to be reviewed 31-03-17.	Compliant	Compliant
Health and Safety At Work Act 1974	The Health and safety Policy requires further guidance on risk assessment processes and references to new policies	The Health and safety Policy will be amended to include further guidance on risk assessments and reference to newly developed policies	A Haynes	31-03-14	14-02-14	The Health and safety Policy has been amended to include further guidance on risk assessments and reference to newly developed policies is available on the	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance May 15th 2015	Compliance Nov 14th 2014
						intranet.		
Health and Safety (Consultation with Employees) Regulations 1996	Although the Health and safety Policy includes some of the requirements of the Health & Safety (Consultation with Employees) further detail is required within Trust policy	The Health and safety Policy requires further detail on the consultation with employees processes OR a new policy will be developed	A Haynes	31-03-14	31-03-14	Policy Complete to be reviewed 31-03-17.	Compliant	Compliant
Electricity at Work Regulations 1989	The Trust had no policy covering the statutory requirements of the Electricity at Work Regulations 1989 although staff are	A policy covering the requirements of the Electricity at Work Regulations 1989 will be developed	D Hatch/Gary Lewis	31-03-14	31-03-14	The Policy complete and will be reviewed 31-03-17.	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance May 15th 2015	Compliance Nov 14th 2014
	competent and work in accordance with the revenant HTM's							
Provision and Use of Work Equipment Regulations 1998	The Trust has no policy covering the statutory requirements of the Provision and Use of Work Equipment Regulations 1998.	A policy covering the statutory requirements of the Provision and Use of Work Equipment Regulations 1998 will be developed.	D Hatch	30-04-14	01-05-14	Policy complete and is live on the intranet. To be reviewed 01-05-17.	Compliant	Compliant
Lifting Operations and Lifting Equipment	The Trust has no policy covering the statutory	A policy covering the statutory requirements of	D Hatch / Gary Lewis	27-07-14	25-7-14	Policy is complete and live on the intranet. Policy to be reviewed 25-	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance May 15th 2015	Compliance Nov 14th 2014
Regulations 1998	requirements of the Lifting Operations and Lifting Equipment Regulations 1998	the Lifting Operations and Lifting Equipment Regulations 1998 will be developed				07-17.		
Management of Health and Safety at Work Regs 1999. To cover RA's on activities including Young Workers.	The Trust has no policy covering the statutory requirements to protect Young Workers	The Trust will develop a policy covering the statutory requirements to protect Young Workers	A Haynes	31.04.14	31.04.14	Policy is complete and live on the intranet. To be reviewed 01-04-17	Compliant	Compliant
Occupational Health	The Trust has no policy describing the Occ Health Services which will include arrangements for appropriate Health Surveillance	Specific policy is required to describe all OH Services- This is to be developed and describe requirements for Health Surveillance of staff and appropriate	P Bohan	30-04-14	31-03-14	Policy is complete and live on the intranet. To be reviewed 30-03-17	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance May 15th 2015	Compliance Nov 14th 2014
		documented system						
Security	The Management of Violence and Aggression (including lone workers) 068 Policy in place requires reviewing to ensure risks associated with violence and aggression appropriately managed.	Policy in place will be reviewed to ensure risks associated with violence and aggression appropriately managed	J. Mclaughlin	30-06-14	05-06-14	The Local Security Management Specialist (LSMS) has reviewed the policy as part of security review. The policy has been updated and is live on the intranet. To be reviewed 30-06-17.	Compliant	Compliant
Workplace (Health, Safety and Welfare) Regulations 1992	The Trust has no policy covering the statutory requirements of all the requirements within the Workplace	Internal guidance covering these regulations is required in the policy – will include ventilation, thermal comfort,	A Haynes	27-08-14 .	01-10-14	The policy is live and available on the Intranet. To be reviewed 01-10-17.	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance May 15th 2015	Compliance Nov 14th 2014
	(Health, Safety and Welfare) Regulations 1992	and other general requirements.						
Workplace (Health, Safety and Welfare) Regulations 1992	The Trust has no guidance covering the statutory requirements for Transport Safety	A policy covering the statutory requirements for workplace transport is to be developed	A Haynes / Gary Lewis	15-08-14	01-10-14	The policy is live and available on the Intranet. To be reviewed 01-10-17	Compliant	Compliant
Workplace (Health, Safety and Welfare) Regulations 1992	The Trusts loading bay at APH requires assessment due to the high risk activities 'carried out within this workplace.	Issues identified as part of the assessment process will be entered onto the risk register.	Gary Lewis	15-08-14 * Note issue placed on register and funding approved 19th March 2015.	19-03-15	Risk register entry (2506) with specified actions has been reviewed following initial costings and a revised scheme has been approved work will be completed by 31st May 2015.	Partial Compliant	Partial Compliant
Health and Safety (First Aid) Regulations	The Trust has no policy covering the statutory	A policy will be developed covering the statutory	A Haynes	30-07-14	28-07-14	The policy is live and available on the Intranet. To be reviewed 30-	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance May 15th 2015	Compliance Nov 14th 2014
1981	requirements for The Health and Safety (First Aid) Regulations 1981	requirements of the Health and Safety (First Aid) Regulations 1981				07-17.		
Personal Protective Equipment at Work Regulations 1992	The Trust has no policy covering the statutory requirements for Personal Protective Equipment at Work Regulations 1992	The Trust will develop a policy covering the statutory requirements for Personal Protective Equipment at Work Regulations 1992	A Haynes	30-07-14	28-07-14	The policy is live and available on the Intranet. To be reviewed 30-07-17.	Compliant	Compliant
Ionising Radiation Regulations 1999	Although the Health & Safety policy covers some of the requirements of the Ionising Radiation Regulations	The Trust will develop a policy detailing the statutory requirements of the Ionising Radiation Regulations 1999	J O'Connor	30-07-14	28-07-14	Policy is complete. To be reviewed 30-07-17.	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance May 15th 2015	Compliance Nov 14th 2014
	1999 a more detailed and separate policy is required.							
Gas Safety (Installations and Use) Regulations 1998	The Trust has no policy covering the statutory requirements of the Gas Safety (Installations and Use) Regulations 1998.	The Trust will develop a policy detailing the statutory requirements of the Gas Safety (Installations and Use) Regulations 1998	A Haynes / D Hounslea	31-03-14	30-04-14	Policy is complete To be reviewed 30-04-17.	Compliant	Compliant
Fire Regulatory Reform Order 2005	Existing fire risk assessments will require review on a rolling basis	A rolling program of site/department specific fire risk assessment updates to be developed which will be prioritised according to the degree of risk.	B Jones	31/01/2014	31-01-14	Fire Safety advisor Brian Jones has developed a working plan to cover a review of all fire risk assessments over the next 12 months which was completed 31-01-15.	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance May 15th 2015	Compliance Nov 14th 2014
The Health & Safety at Work etc. Act 1974	The Trust has no specific policy on non-notifiable projects	The Trust will develop a policy covering the statutory requirements to ensure robust management and control of contractors working on non-notifiable projects.	A Haynes / Gary Lewis	30-07-14	28-07-14	The existing Control of Contractors Policy has been updated to reflect arrangements for managing non notifiable projects. To be reviewed 30-11-17.	Compliant	Compliant
Manual Handling Operations Regulations 1992 (as amended)	The Trusts manual handling policy to be reviewed to ensure it reflects statutory requirements	The Trust's manual handling policy has been reviewed and reflects current legislation	D Hatch	30-05-14	31-01-14	Policy review is complete and the policy is live on the intranet. To be reviewed 31-01-17.	Compliant	Compliant
Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013	The reporting arrangements for Riddor reportable Occupational health diseases require review	The reporting arrangements for Riddor reportable Occupational health diseases will be reviewed as part of the	P Bohan	30-04-14	31-01-14	All recognised diseases that are directly related to work activities and confirmed as work related by an Occupational Health Physician	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance May 15th 2015	Compliance Nov 14th 2014
	to ensure robust reporting to the HSE	Occ Health review.				are reported to the HSE. To be reviewed 30-04-17.		
Health and Safety (Display Screen Equipment) Regulations 1992	The Trusts policy covering the requirements of the DSE regulations require review	The Trusts Policy for DSE will be reviewed	D Hatch	31-03-14	31-01-14	Policy review is complete and the policy is live on the intranet. To be reviewed 31-03-17.	Compliant	Compliant
Construction (Design and Management) Regulations 2007.	The Trusts policy covering the requirements of the Construction (Design and Management) Regulations 2007.	The Trusts Policy for Construction (Design and Management) Regulations 2007 will be reviewed.	Gary Lewis/A. Haynes	31-09-14	31-01-14	Policy review is complete and the policy is live on the intranet. To be reviewed 30-09-17.	Compliant	Compliant
Hazardous Waste (England and Wales)	The Trusts policy covering the requirements	The Trusts policy covering the requirements of	Gary Lewis	31-09-14	31-01-14	Policy review is complete and the policy is live on the intranet. To	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance May 15th 2015	Compliance Nov 14th 2014
Regulations 2005	of the Hazardous Waste (England and Wales) Regulations 2005 requires review	the Hazardous Waste (England and Wales) Regulations 2005 will be reviewed				be reviewed 31-01-17.		
HTM 07-01 - Safe Management of Healthcare Waste 2006	The Trusts policy covering the requirements of the Hazardous Waste (England & Wales) Regulations 2005 requires review to ensure it reflects statutory requirements	The Trusts policy covering the requirements of the Hazardous Waste (England and Wales) Regulations 2005 will be reviewed to ensure it reflects statutory requirements	Gary Lewis/A. Haynes	31-09-14	31-01-14	Policy review is complete and the policy is live on the intranet. To be reviewed 30-07-17.	Compliant	Compliant
Health & Safety at	The Trusts procedure and	Stress Policy and procedure	P. Bohan/J.	30-09-14	30-09-14	A stress working group has now	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance May 15th 2015	Compliance Nov 14th 2014
Work etc Act 1974.	process for managing stress in the workplace requires reviewing as sickness absence figures indicate stress as the highest area of sickness absence.	to be reviewed.	Mawrey			merged with the wellbeing group and continues to monitor trends. The group also support specific targeted programme to deal with hotspots and raise the profile of the wellbeing agenda. This reports to the Workforce & Communication Group.		
H&S (Sharp Instruments in Healthcare) Regulations 2013.	The Trusts procedure and process for managing sharps will be reviewed by the HSE in relation to a RIDDOR incident when a staff member received a needle stick	Review RCA and ensure procedures are robust and if necessary learn lessons from incident.	P. Bohan/A Haynes/ D. Hatch	08-08-14	01-08-14	A revised pathway and information now included in the policy to be agreed at the Needle Stick Injuries and Trends of Sharps (NITS) Group. Amended policy out for consultation and	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance May 15th 2015	Compliance Nov 14th 2014
	injury from a Hep C patient.					will be reviewed 30-05-15.		

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF MEETING

29th APRIL 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
James Mawrey	Director of Workforce
Mark Taylor	Turnaround Director
Terry Whalley	Project Director

Governors
None

Members of the Public
None

Reference	Minute	Action
BM 15-16/006	**Apologies for Absence** None	
BM 15-16/007	**Declarations of Interest** None	
BM 15-16/008	**Patient's Story** The Director of Nursing and Midwifery presented a patient's story taken from NHS Choices Website. The concern was in relation to the mixed waiting room for gynaecology and maternity patients which left the patient,	

Reference	Minute	Action
	who was looking for an IVF procedure, feeling unwanted and that the care was unsympathetic as she was waiting with patients who were in quite different circumstances. The Director of Nursing and Midwifery advised that it was incumbent on the Trust to resolve this issue which she was now progressing. The Board agreed as part of this process to consider highlighting staff stories at its meetings in the future.	
BM 15-16/009	**Chairman's Business** The Chairman reported on the meeting of the Remuneration and Appointments Committee which was held on 21st April 2015 which included: • Directors and Chief Executive's appraisals for 2014/15 and their objectives for 2015/16. • The Committee also reviewed the future Executive structure in light of the resignation of Mr Hassall and the turnaround programme required. The Committee agreed to progress with the appointment of a Director of Strategy to continue with the work on the new Models of Care, although the agreement was that this would not be a voting member of the Board. The Committee also approved Mr Jon Scott to the interim Deputy Chief Executive position following the meeting of the formal panel of the Committee in the preceding week. • The Committee agreed to further consider the substantive post of Deputy Chief Executive within the next 3 months. The Committee also reviewed the preliminary proposal for the recruitment of the Director of Nursing and Midwifery as a result of the forthcoming retirement of Mrs Galvani. • A review of the fit and proper persons Test, as required by the Care Quality Commission, was undertaken on all Executive Directors of the Board as outlined in the paper to the Board in January 2015. The Chairman updated the Board on a recent consultant appointment, this being Mr Richard Glendinning in Urology. The Board was updated on the planned forthcoming meetings, these included: • PWC check and challenge event on 11th May • Final check and challenge on 13th May ahead of the formal Board sign off of the Annual Plan • Further check and challenge session to be held on the 22nd May 2015 ahead of full sign off of the turnaround plan on at the public Board meeting on the 27th May 2015 • Council of Governors Meeting – 10th June 2015	
BM 15-16/010	**Chief Executive's Report**	

Reference	Minute	Action
	The Chief Executive presented the report and highlighted the following areas: **New Models of Care** – The Board was updated on the Chief Executive's attendance at the national launch of the Vanguard Sites held on the 22nd April in London. He outlined the key messages from the event which included the need for Trusts to be much more ambitious with the pace. The Board was reminded of the two day visit with NHS England on 5th and 6th May 2015. In preparation for this event the Director of Strategic and Organisational Development attended a similar session in Hampshire to gain insight into the process. The Chief Executive advised the Board that on the 23rd April 2015 the Senior Leaders of the health economy met to outline the preparations for the 5th and 6th May which included the requirements in relation to programme management; the work required on population health and the indicative "running costs" at this stage. The Board raised concerns as to the extent that the Chief Executive and this Trust were expected to drive this programme recognising that this was in the interests of the whole health economy, set against the work required internally in the hospital, again recognising the additional resources being put in place to assist with this. The Chairman acknowledged the concerns however he reiterated the arrangements put in place to enable the Chief Executive to "drive" this programme which was of fundamental importance to the future of the hospital within a reshaped health economy. Risks of not progressing this as planned were greater than the mitigated internal risk. The Board sought to understand how Non-Executives could be used to support this and other external relationships in the future, and the Chairman explained the steps planned to progress this. **Infection Contro**l - the Director of Nursing and Midwifery clarified the position at the year-end in relation to the C difficile.	
BM 15-16/011	**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. **Friends and Family** – The Director of Nursing and Midwifery advised that 13 out of 27 wards had a score of 95% or above with good response rates. The Board sought and received clarification on the correlation between the staff friends and family test results and the staff engagement scores. The Board asked whether out of the wards that hadn't achieved 95% whether there were any that were failing considerably. The Director of Nursing and Midwifery confirmed that Ward 25, the contingency ward, scored 50 with low response rates, however she confirmed that this ward had now closed. The Board was advised that less than 5 wards overall were performing below Trust expectations, all of which were the focus for improvement.	

Reference	Minute	Action
	Qualified Nurse Vacancies – The Director of Nursing and Midwifery provided an update on the recruitment into nursing in each Division. She also outlined the work being undertaken to determine the current nursing levels for the winter period assuming the need for contingency wards again. **Staff engagement** – The Director of Strategic and Organisational Development provided an update on attendance levels reporting that the in- month performance was lower than the same time last year and lower than the previous month which recognised the pressures from Norovirus and demand on the hospital. He confirmed that focus on long term absence continued with improvements being reported. An update on the health and wellbeing day held on the 24th April 2015 was provided including the expected outcomes. The Board was updated on the quarterly team awards which had received 41 nominations, with the overall winner being the endoscopy team who received their award at the last CEO forum. The positive work being undertaken to award 100% attendance certificates was outlined with Michelle Scanlon announced as the winner yesterday. **A & E 4 Hour Standard** – the Director of Operations provided the Board with an update on the "Breaking the Cycle" programme which commenced on the 23rd April 2015; the update was largely positive with the exception of performance on 27th April 2015 due to the number of attendances and admissions on that day. She confirmed that the Trust was unlikely to achieve the target in Q1 as current performance was at 83.2%. The Board was updated on the increase in performance during the programme which was circa 89%. Board Members were invited to the briefing session to be held on 2nd May 2015 along with an overview of the initiatives established as part of the process. The positive feedback from staff across the hospital was reported. The Board sought assurance on the sustainability of the learning achieved in the week and was advised of the methodology used during the week which would be maintained long term. The Board sought to establish what the trajectory for improvement was and how agreement from the health economy was being progressed. The Director of Operations confirmed that this would be part of the analysis being undertaken following the "breaking the cycle" programme on the 2nd May 2015. **Finance** – The Board agreed that the narrative would be discussed as part of the finance report. **Advancing quality** – The Medical Director advised that stroke services was under great pressure as a function of all the other bed pressures. The Board sought to understand the trajectory or journey of improvement as the narrative summaries in the main only provided a descriptor and therefore requested the Director of Infrastructure and Informatics to review this accordingly.	**SG** **MB**

Reference	Minute	Action
	The Board sought to understand why mandatory training was reported green in view of this being negatively reported in the staff survey. The Director of Strategic and Organisational Development outlined the work being undertaken on the alignment of mandatory training with the staff survey and the proposal which was due to be discussed at the Executive team in the w/c 4th May 2015. Further details would be highlighted in next month's report. The Director of Nursing and Midwifery provided the Board with an update on the position with regards to MRSA as 4 cases had been reported for the year, the latest case being investigated and which would be considered further by the Quality and Safety Committee.	**AH**
BM 15-16/012	**Month 12 Finance Report** The Director of Finance presented the Month 12 position and highlighted the following: • The cumulative out-turn deficit of £4.7M against a plan of £4.2M although this was still subject to audit. • The cash position of £22.9M against a plan of £5.6M • A CoS rating of 3 against plan of 2 • CIP achievement of £9.6M against a plan for £13M with a full year effect £13M The Director of Finance provided an overview of the discussion at the recent Finance Committee which was that the Trust had largely achieved as planned although the underlying position was that this was primarily the result of one-off initiatives and the year-end deal. He confirmed that these were being addressed going forward although the demand continued to challenge this. The Board was advised that there had been some pressure on pay costs in month 12 specifically in relation to delivering RTT targets and the additional costs associated with flexible labour due to the operational pressures. The Board reflected on pay costs in comparison to previous years to evidence that these were moving in a downward trajectory and as a result of the cost improvement programme. The Board debated the level of contract penalties associated with readmissions in light of the recent contract negotiations with the CCG and questioned whether the trajectory for improvement was ambitious enough. The Medical Director confirmed that this was, as it had reduced from 18% to 12% although he would look to continue to improve upon this. A revised summary table was tabled which reflected the positive in-month income and expenditure performance.	
BM 15-16/013	**Report of the Finance, Business Performance and Assurance Committee – 24 April 2015**	

Reference	Minute	Action
	The Chair of Finance, Business Performance and Assurance Committee concurred with the report made by the Director of Finance in relation to the Month 12 position. Mr Hollick confirmed that the Committee had asked for some further annotations be made to the technical wording in relation to the "going Concern" statement. He also confirmed that the Committee had suggested some amendments to the narrative which supported the Monitor Q4 statements which would be discussed later in the meeting. Mr Hollick confirmed that the Committee had approved the disbandment of Risk Management Group in line with the decision made by the Quality and Safety Committee.	
BM 15-16/014	**Chair of the Audit Committee Report – 9 April 2015** Mrs Hodgson presented the Audit Committee Report and outlined the following areas: **Nurse staffing levels** – this had received a limited assurance internal audit report however the Committee was pleased to note that a number of recommendations had already been progressed. Four further internal audit reports were received all of which had achieved a significant assurance rating. **Audit plan** – the Committee noted the correlation with the BAF and the recognition that the BAF had driven the formulation of the plan. **External audit** – received an introduction and overview of ISA 700 and the focus as part of this which was on valuation and income recognition aspects. **Counter fraud and strategy** - draft presented with a further update to be provided to the next meeting as the team had changed dramatically. **Draft annual governance statement –** accepted first draft with slight amendments **Annual audit committee Report** – first draft received, with agreement to slight amendments.	
BM 15-16/015	**CQC Project Plan Compliance Update** The Medical Director presented the CQC Project Plan Compliance Update which included an overview of the activities planned and the increase in pace in terms of preparation for the inspection. He confirmed that the themes being reported from the mock inspections continue to be nurse staffing levels; the estate and the need to fix things quickly; and Cerner. The Director of Infrastructure and Informatics confirmed that the issues log was now almost at the point that this could be shared with the organisation together with an indication of implementation timescales. The Board sought to understand how it would be confident that the issues	

Reference	Minute	Action
	being reported were improving and also how it would know that staff morale was improving. The Medical Director outlined plans to report items that were marked as inadequate to the Quality and Safety Committee and the feedback that was being provided to clinical teams. The Board agreed to receive a monthly update which showed the trajectory of improvement and areas for focus and improvement. The Medical Director highlighted the learning from elsewhere in terms of preparation for the inspection.	**EM/CS**
BM 15-16/016	**Francis Report: Hard Truths Commitment: Publishing of Nurse Staffing Data: March 2015** The Director of Nursing and Midwifery presented the new style report which was based on the methodology used at Salford Hospital. The Board found the new style report to be generally helpful, but sought to understand the correlation between quality issues and staffing levels. The Director of Nursing and Midwifery confirmed that her next report would include red flag issues which would aid with the interpretation. The Board discussed whether it would be appropriate to adjust the targets to take into account the movement of staff to contingency wards in order not to penalise ourselves further. The Director of Nursing and Midwifery agreed to review this although her preference would be not to open contingency wards. The Board also sought to understand the timescales for the decision with regards to international nurse recruitment. The Chief Executive reported that before this option was progressed, the Trust was reviewing internal alternatives through its HR function.	**JG**
BM 15-16/017	**Staff Satisfaction Action Plan** The Director of Strategic and Organisational Development provided the understanding as to how the action plan was part of the overall Organisational Development Strategy. He confirmed that this had been developed and tested with staff to ensure that it addressed the key concerns. He raised a note of caution for the Trust not to try to do everything all at once, but to prioritise and phase the implementation. The Director of Workforce reiterated the comments made by the Director of Strategic and Organisational Development and he also emphasised that the objective was sustainable improvement and engagement. The Board was advised that the plan focussed on the top actions that would enact a change in the staff survey ie the top scoring areas that require improvement. He confirmed that action plans for specific work areas had been developed and underpinned the overall action plan.	

Reference	Minute	Action
	The work with the Listening into Action Programme and the 100 huddles was reported as working well and the Board was updated on the plans for 12th May and the invitation to the top 100 managers to talk about the culture of the organisation. The Board recognised that there was further work required on communications, although it was updated on the new team brief which was launched last week which was receiving good feedback. An update on key initiatives such as the quarterly staff awards and the health and wellbeing events was provided. The Board was advised that the quarterly staff friends and family test would be the key metric to track improvement. The Board sought and received assurance on the correlation of the work on this plan with the CQC preparation, and the areas of prioritisation with regards to the feedback from the staff survey including learning from areas that scored well. The Director of Workforce confirmed that the variation in responses from clinical and non-clinical staff to the question as to whether they would recommend the Trust as a place to work was significant. He confirmed that the greatest variance was in the areas that had undergone huge organisational change at the time of the survey. The Director of Strategic and Organisational Development outlined the key headlines from the Cultural Barometer work which included behaviours; styles of leadership and how the Executive team were signal generators into the organisation. The Board sought to understand how the feedback from the huddles and partnerships would be fed back and should the Trust consider which quality measures should be improved as a result of this work. The Director of Workforce to consider the latter further. Dr Quinn volunteered and was approved as the Non-Executive sponsor for this work.	**JM/AH**
BM 15-16/018	**CPE Strategy** The Director of Nursing and Midwifery introduced Mr Whalley and gave thanks for the work he had undertaken on this agenda. She confirmed that the paper was designed to provide a full overview of the work being undertaken on CPE; it highlighted some of the consequences of taking the proposed actions, not least financial, as well as those of simply reacting to the status quo. Mr Whalley highlighted that the paper was being presented following advice from Public Health England and in line with it's guidance. He emphasised the prevalence of CPE in the Trust which was much greater than elsewhere. The Chairman agreed to defer the approval of the investment outlined in	

Reference	Minute	Action
	the paper until the Board undertook the discussion on the Annual Plan in the private part of the meeting. The Board confirmed that the paper was very informative and helped with its understanding of the direction of travel. It also agreed to continue to seek support from elsewhere and continue to work with public health England. The Board gave thanks to Mr Whalley for his work during his time with the Trust and wished him well for the future. Mr Whalley thanked the Board for allowing him to be part of Board meetings as this was particularly helpful to his development.	
BM 15-16/019	**External Assessment** **Monitor Quarterly Return** The Director of Finance presented the Monitor Quarterly Return highlighting the discussion held at Finance, Business Performance and Assurance Committee on 24th April 2015. The Board's attention was drawn to the statements within the return and in particular to the narrative statements which had been reviewed and revised by the Finance Business Performance and Assurance Committee. The Board approved the statements and the supporting narratives subject to the inclusion of the recognition of the application for distressed funding.	**AM/CS**
	Register of Interests The Board noted the Register of Interests for members. A slight amendment was noted to the Chairman's Register as follows: • Alliance House Foundation – Trustee not Director • Institute of Alcohol Studies – Chairman and Director	
BM 15-16/020	**Board of Directors** **Minutes of the meeting dated 25th March 2015** The minutes of the meeting held on 25th March 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 15-16/021	**Items for BAF/Risk Register** The Board agreed to review the CPE risk on the Board Assurance Framework in light of the strategy now planned.	

Reference	Minute	Action
BM 15-16/022	**Any Other Business** None	
BM 15-16/023	**Date and Time of Next Meeting** Wednesday 27 May 2015 at 9.00 a.m. in the Boardroom, Education Centre, Arrowe Park Hospital.	

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Chairman

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Date

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF MEETING

13 MAY 2015

BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL

Present

David Allison	Chief Executive
Michael Carr	Chairman
Sharon Gilligan	Director of Operations
Anthony Hassall	Director of Strategic & Organisational Development
Andrea Hodgson	Non-Executive Director
Cathy Maddaford	Non-Executive Director
Evan Moore	Medical Director
Alistair Mulvey	Director of Finance
Jean Quinn	Non-Executive Director

Apologies

Mark Blakeman	Director of Informatics and Infrastructure
Cathy Bond	Non-Executive Director
Jill Galvani	Director of Nursing and Midwifery
Graham Hollick	Non-Executive Director
Jeff Kozer	Non-Executive Director
Carole Self	Associate Director of Governance

In attendance

Nicky Brown	Executive Assistant to the Chairman and the CEO (minutes)
Mark Taylor	Turnaround Director
Phil Tydeman	Recovery Director

Reference	Minute	Action
BM 15-16/024	**Apologies for Absence** Noted	
BM 15-16/025	**Declarations of Interest** None	
BM 15-16/026	**Annual Operational Plan – Monitor Submission** **T**he Chairman reminded the Board about the private discussion and consultation process which lay behind this finalized plan, and highlighted the key points considered as part of the approval process. This included the feedback from Monitor on the draft annual plan. Discussion centred around the need to ensure that the plan was robust, met the needs of the community, and was realistic in its assumptions. The need for in-year funding support was also discussed. Subject to the points raised being confirmed the Chairman sought and received approval that the Annual Plan could be signed off based on the amendments as discussed. The Board approved the Declarations as presented.	

Reference	Minute	Action
	The Board agreed that the Council of Governors would receive a full update at the next meeting 10 June 2015.	
BM 15-16/027	**Any Other Business** None	
BM 15-16/028	**Date and Time of Next Meeting** Wednesday 27 May 2015 at 9.00 a.m. in the Boardroom, Education Centre, Arrowe Park Hospital.	

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Chairman

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Date

ACTION LOG
Board of Directors

Updated – May 2015

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 29.04.15						
Apr 15	BM 15-16/011	Provide a trajectory of improvement for A & E following the analysis from the Breaking the Cycle initiative	SG	**Included in the Annual Plan - completed**	May 15	
Apr 15	BM 15-16/011	Ensure the narrative summaries in the performance report include the action being taken to improve performance rather than a description of the issue	MB		May 15	
Apr 15	BM 15-16/011	Update the Board on the work to align the Trust's arrangements for mandatory training with the expectations in the NHS Staff Survey	AH		May 15	
Apr 15	BM 15-16/015	Provide the Board with a monthly update on CQC improvement against compliance	EM/CS	**ongoing**	May 15	
Apr 15	BM 15-16/016	Consider adjusting the nurse staffing ratio targets when contingency wards used	JG		June 15	
Apr 15	BM 15-16/017	Consider which quality measures would be impacted upon as part of the staff engagement work	JM/AH		May 15	
Apr 15	BM 15-16/019	Amend the narrative statement on the Monitor quarterly return to recognise the application of distressed funding	AM/CS	**Completed**		
Date of Meeting 25.03.15						

March 15	BM 14-15/224	Revise the staff attendance graph in the performance report	MB		May 15	
March 15	BM 14-15/224	Consider how topical items not included in the performance report are reported to the Board	DA/CS	**Agreed to include these in the first instance in the CEO report**	April 15	
March 15	BM 14-15/226	Provide the trajectory of A & E Performance	SG	**A further update will be providedfollowing the "Breaking the Cycle" work and the A & E Escalation Meeting**	April 15	
March 15	BM14-15/227	Provide a link to the CQC fundamental standards on the intranet	EM		April 15	
March 15	BM14-15/227	Prepare a briefing on how the Trust is addressing the issues highlighted in the mock inspections to assist with Board walkabouts	EM/AH		April 15	
March 15	BM14-15/230	Consider the inclusion of never events and infection control in the quality account	EM	**Completed**	May 15	
March 15	BM14-15/230	Consider the following areas in the final quality account • Readmissions and the long term plans • Further detail in the CEO opening statement setting out the outline of the report • Communicate wider the good achievements outlined in the report • Clinical coding and the work being undertaken	EM	**Completed**	May 15	
March 15	BM14-15/230	Confirm the national audit requirements associated with the Quality Account	EM		April 15	
Date of Meeting 25.02.15						

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	
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	**The research team are considering this recommendation**		
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**