Wirral University Teaching Hospital NHS
NHS Foundation Trust

Board of Directors Meeting

28 October 2015

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MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 28 OCTOBER 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	0930	d
6. Strategy and Development			
6.1	**Annual Plan – Mid-Year Review** Chief Executive / Director of Strategy	0945	d
7. Performance and Improvement			
7.1	**Integrated Performance Report**	1000	
	7.1.1 Integrated Dashboard and Exception Reports Director of Infrastructure and Informatics		d
	7.1.2 Month 6 Finance Report Chief Executive / Deputy Director of Finance		d
8. Quality			
8.1	**Francis Report: Hard Truths Commitment: Publishing of Nurse Staffing Data: September 2015** Director of Nursing and Midwifery	1030	d
9. Governance			
9.1	**External Assurance** • **Monitor Quarterly Return – Q2 2015/16** Deputy Director of Finance	1045	d

9.2	**Chair's Report of the Finance, Business Performance and Assurance Committee – 23 October 2015** Chair of the Finance, Business Performance and Assurance Committee	d
9.3	**Research Annual Report** Medical Director	d
9.4	**Board of Directors**	d

9.4.1 Minutes of the Previous Meeting

- **30 September 2015**

9.4.2 Board Action Log
Director of Governance / Corporate Secretary

10. Standing Items

10.1	**Items for BAF/Risk Register** Chairman	v
10.2	**Any Other Business** Chairman	v
10.3	**Date and Time of Next Meeting** Wednesday 25 November 2015 at 9am	v

Board of Directors	
Agenda Item	5
Title of Report	Chief Executive's Report
Date of Meeting	28 October 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

Whilst the emphasis is on progressing new models of care/vanguard, and in particular concluding funding discussions with NHS England, a specific concern regarding community paediatric capacity and related waiting times is under discussion.

Monitor

Following formal notification of the breach of its Provider Licence, the Trust is due to hold its second Performance Review Meeting with Monitor on 19 November 2015 where a full review of progress against the recovery plan will be undertaken together with an update on A&E performance. A verbal update of the outcomes of the meeting will be provided at the meeting on 28 October 2015.

2. Internal Activities

Recovery Plan

Monitor has requested that we produce a strategic recovery plan for the period to 2019/20 incorporating year 2 of the Financial Improvement Plan. The first of four workshops designed to generate the bulk of this plan is scheduled for 5 November with the second following on a week later. We are adopting an inclusive approach to the development of the plan and will benefit from the input of partner agencies, staff and Governors amongst others.

Our Financial Improvement Plan for 2015/16 continues to be reviewed weekly and currently mitigating actions are being implemented to ensure delivery to target.

Infection Prevention & Control

The Trust is currently reporting 27 avoidable cases of C.difficile against an annual target of 29. The emergence of 5 cases in October raises a governance concern which has been formally reported to Monitor. The Trust has put in place an action plan, the key points of which are outlined below, and remains committed to reduce instances of C.difficile wherever possible

1. Routine HPV of side rooms vacated by patients known to have C.difficile or any other cause of diarrhoea will continue
2. Sluice/dirty utility areas will continue to be HPV decontaminated when a patient has had confirmed C.difficile on the ward or when there are Periods of Increased Incidence of diarrhoea on any ward.
3. The full ward cleaning programme (in the absence of full ward HPV) will continue targetting high risk areas of concern to reduce some of the bioburden of C.difficile in the environment
4. Continue to promote and develop the HABITS campaign
5. The Infection Prevention Control Team will continue to review new technology for decontamination, however at this stage there is nothing available on the market as effective as HPV for eradicating C.difficile from the environment.
6. Maintain a commitment to allow the C.difficile unit to function as a C.difficile unit only and promote ‘stepping down’ of patients as a high priority to avoid re-exposure.
7. From the 5th November ward 26 will be availble as a decant facility to allow a reactive HPV programme to commence.
8. Revisit the feasibility of using ward 1 at weekends to perform some HPV

The MRSA bacteraemia investigated during August/September was deemed to be a healthcare associated infection and assigned to the Clinical Commissioning Group. Therefore we continue to report zero MRSA bacteraemia against a zero tolerance objective.

There were no significant issues associated with Pseudomonas during September.

There have been 6 new colonised Carbapenemase Producing Enterobacteriaceae (CPE) cases identified. All cases were linked to other CPE positive patients, indicating transmission.

There was only 1 new colonised case of Vancomycin Resistant Enterococci (VRE) identified within orthopaedics in September demonstrating that the strategy to cohort positive and exposed patients has been effective.

Never Event

It is with regret that the Trust has had to report the 2nd Never Event since April 2015. The Incident occurred on 18 October 2015 and involved two patients who were prescribed oxycodone, one orally one subcutaneously. Both patients were due the drug; the patient due subcutaneous oxycodone was given oral oxycodone subcutaneously by mistake. The patient was assessed by the on call medical staff immediately. The patient was informed of the error. Immediate actions put in place included a review of the systems and processes in place across the Trust and monitoring of staff compliance with policies and procedures in place on the ward. The Route Cause Analysis has been commenced.

A&E Update

Against the A&E standard of a minimum 95% of patients to be admitted, transferred or discharged within four hours, the position for the month of September was 90.25% as measured across a combined Emergency Department (ED) and All Day Health Centre performance at the Arrowe Park site. For ED alone it was 87.09%. The cumulative joint position for Q2 was 93.34% and compares favourably against the Q1 position of 87.59%.

The level of ED attendances increased by 255 compared to the same period last year which is against a declining rate of attendance (overall fall of 953 since the beginning of the year). NHS111 has transferred to NWAS and work is being undertaken to see if this is a driver for higher numbers of ED attendances.

Work continues to improve patient flow and weekend discharging has started to improve considerably.

The Patient Flow work stream has identified that the length of stay (LOS) in medicine for patients over 74 has significantly increased since the introduction of the Care Act in April. Patient assessment numbers have risen and the duration of the assessments has also increased. The impact is equivalent to 39 beds. The Trust is in discussion with relevant stakeholders and ECIST to improve the speed of assessments and reduce the number of assessments that require completion.

Workforce & Organisational Development

Health & Wellbeing / Attendance

Trust sickness absence rates remain below the target of 4%. September 2015 was 3.81% this is the fifth consecutive month the target has been achieved. The importance of health and wellbeing cannot be underestimated in terms of reduction in absenteeism. The Health & Wellbeing Plan 2015-2018 continues to be enacted and the plan continues to be monitored on a monthly basis via the health and wellbeing group. Interventions include a specific plan being implemented in facilities, smoking cessation, stress management, mental and physical wellbeing, manual handling and alcohol management. Key over the next 2 months will be to achieve our 75% target for flu vaccinations. The vaccination

campaign has now started and it is vital staff get their jab as soon as possible. The Wellbeing group will also be looking to promote mental health support for staff with a targeted event in the New Year.

Education and Development Key Performance Indicators

As at 11 September 2015:

- Mandatory Training Block A has dropped to 94.41% against the 95% KPI for the first time in over 12 months;
- Mandatory Training Block B has increased to 84.27%. As this falls below the 95% KPI, divisional action plans are in place to address this;
- Appraisal compliance is 84.95%. This falls below the 88% KPI, divisional action plans are in place to address this;
- Safeguarding/MCA Level 1 has increased to 85.83%. As this falls below the 95% KPI the Leadership and Development Centre are targeting non-compliant areas;
- Safeguarding Level 2: has increased to 84.95%. As this falls below the 90% KPI the Leadership and Development Centre are targeting non-compliant areas;
- Safeguarding Level 3: compliance is 75.55%. This falls below the 90% KPI, divisional action plans are in place to address this;
- MCA Level 2 has increased to 40.78%. This falls below the 90% KPI, divisional action plans are in place to address this;
- MCA Level 3 is at 5.97%. The 62 non-compliant staff will be targeted individually.

Organisational Development

In line with the Workforce and Organisational Development Strategy 2015 -18 the Leadership and Management Development Framework continues to be implemented.

Key Features:

- Refresher training has commenced for previously trained coaches to further develop our capacity for in house coaching;
- External coaching support for bands 8+;
- Coaching skills embedded in all in house leadership, management, supervisory programmes;
- Trained in house mentor champion;
- Trained 360 Degree appraisal facilitators;
- External 360 for executive team completed and in progress for Operational Management Team;
- Coaching for Clinicians;
- Middle Manager Leadership Programme for Band 6 to 7 programme established and currently recruiting to this. Programme will focus on principles of effective leadership, communication skills employee engagement and change management;
- New Consultant Development Programme;
- Clinical Leadership Development Programme;
- Care Certificate for clinical support workers.

Nurse recruitment

Over the last year the Trust has developed a strict monitoring and action regime to develop and oversee measures to ensure substantive recruitment and retention of band 5 nurses

During September : 13 nurses were appointed at the monthly Corporate recruitment event, the divisional recruitment leads have been to Poland and recruited 9 Registered nurses, 1 nurse has commenced employment and the remaining nurses will commence 2nd November. A further 24 nurses have been recruited from Spain and Portugal who will be available from 23rd November onwards.

The majority of the 38 newly qualified graduate nurses have now registered with the NMC and have commenced preceptorship

ESR report demonstrated that at the end of September 2015 there were 12.51 WTE band 5 registered nurses vacancies on in patient areas. Vacancy rate of 1.88%

Ward 25 and ward 26 are also 90% recruited to in preparation for their opening in November

NMC Revalidation

From April 2016 the NMC are introducing a new process of revalidation. The Final Guidance was published beginning of November.

All our n urses and midwives have been asked to start preparing for revalidation now by making sure they have an NMC Online account and familiarising themselves with the provisional revalidation requirements and start to developing their portfolio. The Clinical excellence team HR/OD have benchmark information showing all registrants who will need to revalidate QTR 1, and have commenced a pilot to review our readiness to revalidate. Revalidation roadshows have commenced in October and revalidation clinics are available for staff to book into

Staff Engagement / Listening into Action / Values

The Trust-wide staff satisfaction and engagement action plan continues to progress well. Highlights include:

- A PROUD booklet entitled “We said, We did” has been distributed across the Trust this month highlighting what the Trust and Divisions have achieved and done in response to last year’s national staff survey. The National Staff Survey is now open and closes on 27th November;
- Phase two of the 100 Day Challenge is nearing completion and all departments have now had an opportunity to take part. To date: Over 160 Mini LiA huddles have taken place and from these 853 improvement actions have been identified with many now completed. The Staff Engagement Team have been revisiting the first 100 Departments 100 days post huddle and seeing many improvements;
- Wave 6 LiA Teams are now in progress and include: Winter Planning, Head Injury, End of Life, Paediatrics, Ultrasonography, Preceptorship and 6 Wards. Additional LiA Work streams have been established including Paediatrics Flow, Paediatrics Transition to Adult Services and Complaints;
- 360 feedback for the Executive Team has been completed. The Operational Management Team has been registered to complete 360 feedback through the NHS Leadership Academy which will take place by 31 December 2015. Cultural Barometer CQUIN milestones met for Quarter 1 and submission of milestone requirements for Quarter 2 in October 2015;
- Positive communications continue to be promoted including Chief Executive’s weekly blog, ‘Culture Engagement Round-up’, PROUD messages from LiA Mini-Huddles, ‘Team in the Spotlight’ and leaders in the spotlight to share what they have done to improve staff satisfaction and engagement;

- Individual Recognition cards will be introduced this month which involves the use of individual recognition cards aligned to the PROUD core values;
- Executive Team have continued to visit their partner wards and departments and a feedback review has been very positive. This will now be extended to all other areas and include members of the Senior Team;
- Staff Guardians continue to be accessed and all contacts have been followed up and activity monitored;
- Two Schwarz Rounds have taken place in September and October 2015 with 85 staff attending to date. Overall feedback has been very positive;
- Progress has been monitored through the Staff Friends and Family Test with additional staff engagement questions. The results for Quarter 1 and 2 showed significant improvement in the staff engagement score from 3.48 (Quarter 3 National Staff Survey 2014) to 3.83 (Quarter 2 2015/16), exceeding the trajectory target and national average of 3.75. The Friends and Family questions have also shown improvement in Quarter 2 from 75% to 81% of staff recommending the Trust for Care and from 47% to 62% recommending the Trust for work;
- Positive verbal feedback was received during the recent Care Quality Commission and Investors in People Assessments regarding the staff engagement work within the Trust.

Celebrating Success

- PROUD Team of the Quarter nominations are open for Quarter 3;
- Teams and leaders "In the Spotlight" continues through weekly Trust communications;
- Many nominations have been made this year for the Health Service Journal Excellence in Healthcare Awards and two nominations have been shortlisted ie: Dr Beverley Oates for Clinical Leader of the Year and Early Supported Discharge for Hip Fractures for the category Specialised Services Redesign. The Outcome will be announced on 18 November. Several nominations have been made for the Leadership Academy Regional Awards with the winners to be announced on 3rd December;
- The Team of the Quarter was introduced as part of the 100 Day Challenge and is now open. A very successful annual PROUD awards evening took place at the Floral Pavilion on 21/9/15. Over 500 nominations were made and winners of the Ownership Award was the Staff Engagement Team to reflect the work of the Team through the 100 Day Challenge;
- Our Informatics team were shortlisted for the e-Health Insider (EHI) Awards in "Digital NHS Trust or Health Board of the Year" and "Best Use of IT to support clinical treatment and care" categories. In addition, Gerry O'Sullivan, ENT Consultant, was shortlisted for the CCIO award for Clinical Informatics Leadership.

David Allison
Chief Executive

October 2015

BOARD OF DIRECTORS	
Agenda Item	6.1
Title of Report	Annual Plan – Mid Year Review
Date of Meeting	28 October 2015
Author	Mike Coupe Director of Strategy
Accountable Executive	David Allison Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Strategic objectives: all Key measure: all Principal risk: all
Level of Assurance • **Positive** • **Gap(s)**	Gaps with mitigating actions
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To note
Data Quality Rating	Gold/ Silver/ Bronze: metrics of performance against some targets are externally validated; other measures of performance use quantitative data that is not externally validated or qualitative data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

1. Introduction

1.1 This paper provides a review of performance at the mid year point against the objectives set out in the Annual Plan for 2015/16.

1.2 Progress against each objective is colour coded (Red or Green) to indicate whether the organisation is on track to deliver. Where objectives have been coded Red, commentary is provided setting out actions to ensure delivery or mitigate the expected impact.

2. Objectives and performance to date

2.1 Objectives for 2015/16 are at Appendix 1.

2.2 An assessment of performance at the mid year point is at Appendix 2.

3. Recommendations

3.1 The Board is asked to note the mid year position in delivery of objectives for 2015/16.

What will this mean (Our Strategic Objectives)	What will we do in 2014/5 to move towards this (Our Annual Objectives)
To be the top NHS Hospital Trust in the north west for patient, customer and staff satisfaction	Improve our patient experience to deliver a Friends and Family Test where >95% recommend and <2% do not recommend Create a strong culture of empowered employees delivering an improved overall Staff Engagement Score of 3.59 or better
Leading on integrated shared pathways of care with primary, community and social care	Work with partners in Wirral in the development of care closer to home so reducing • delays in transfers of care to no more than 3.5 per month • readmissions to 7% of total admissions
Delivering consistently high quality secondary care services, enhanced through the provision of regional specialist services	Implement our Quality Improvement Strategy to reduce mortality to 85 (HSMR) Ensure that our Harm Free Care Score is no lower than 95% for each month of the year
Ensuring our people are aligned with our vision	Launch our Workforce & Organisational Development Strategy Improve attendance rates to 96.3% Improve appraisal rates to 91%
Maximising innovation and enabling technologies	Implement the next stage of our Cerner IT systems and deliver full electronic nursing documentation, pilot paper-free outpatients and enhance our ability to share documents with primary care so achieving HIMMS level 7 Ensure recruitment of 80% to research studies Ensure that the first patient is recruited within 30 days of a research study commencing
Building on partnering for value	Increase our share of the local market to 86% of Wirral CCG referrals through engagement with GPs Continue to develop a range of partnerships with NHS and non NHS providers thus securing the clinical sustainability of our regionally significant services
Supported by financial, commercial and operational excellence	Ensure • full compliance with the terms of our registration with the Care Quality Commission • a Monitor Continuity of Service Rating of *1* (meaning we have delivered our £13m cost improvement programme) • a Monitor *Green* Governance Rating (meaning we have met all our performance targets, including A&E, 18 weeks and cancer)

Delivery of 2015/16 Objectives **Appendix Two**

Objective	Rating (Green/ Red)	Performance against agreed metric(s)	Commentary
Improve our patient experience to deliver a Friends and Family Test where >95% recommend and <2% do not recommend	GREEN	September inpatient scores: 97% recommend 1% do not recommend	
Create a strong culture of empowered employees delivering an improved overall Staff Engagement Score of 3.59 or better	GREEN	Current score = 3.83	
Work with partners in Wirral in the development of care closer to home so reducing delays in transfers of care to no more than 3.5 per month	RED	12 month rolling average = 3.7	Although the 12 month rolling average is 3.7 there was a significant spike in July of 9 and in August of 6. The DTOC is the number of patients who are waiting to transfer to another provider or return to their place of normal residence who have completed the assessment process. This does not relate to the number of patients who are "medically optimised" and still in hospital or the time taken to complete the assessment process. There is a lot of work ongoing with the Local Authority and Community Trust supported by ECIST to reduce the time that patients remain in hospital once "medically optimised". The Trust has seen a significant increase (approximately 3 days) in the amount of time taken to carry out assessments since the implementation of the care act in April 2015 and this has been escalated to the System resilience group. Improvements in this area would significantly improve patient flow as well as the DTOC position

Work with partners in Wirral in the development of care closer to home so reducing readmissions to 7% of total admissions	RED	9.3%	Improvement in performance to be delivered by continued joint work with partner agencies via fortnightly Urgent Care Meeting and monthly System Resilience Group.
Implement our Quality Improvement Strategy to reduce mortality to 85 (HSMR)	RED	91.51	Improvement will be achieved by focusing on Acute Kidney Injury and Sepsis: e-alerts in place for both conditions; monitoring via Advancing Quality and CQuIns; trajectory positive
Ensure that our Harm Free Care Score is no lower than 95% for each month of the year	GREEN	N/A	Objective delivered with the exception of August (94%)
Launch our Workforce & Organisational Development Strategy	GREEN	N/A	Strategy launched
Improve attendance rates to 96.3%	GREEN	Latest score = 96.19	
Improve appraisal rates to 91%	RED	Latest score = 84.95	Divisions have produced recovery plans
Implement the next stage of our Cerner IT systems and deliver full electronic nursing documentation, pilot paper-free outpatients and enhance our ability to share documents with primary care so achieving HIMMS level 7	GREEN	N/A	Nursing documentation in place Paper free outpatient being piloted Direct communications with GPs agreed with majority of local practices
Ensure recruitment of 80% to research studies	GREEN	92%	
Ensure that the first patient is recruited within 30 days of a research study commencing	N/A	N/A	NOTE: current studies all exempt from this objective

Increase our share of the local market to 86% of Wirral CCG referrals through engagement with GPs	GREEN	Q1 share of new outpatients was 85.27%	
Continue to develop a range of partnerships with NHS and non NHS providers thus securing the clinical sustainability of our regionally significant services	GREEN	N/A	Current work focuses on gynaecology, maternity, neonatology and paediatric services. WUTH has signed up as a partner to the Cheshire & Merseyside vanguard project (August 2015) to review and remap these services across the city/region. No specific proposals have been made to date. The project will need to take note of the National Maternity Services Review led by Baroness Cumberledge (due to report in December.
Ensure full compliance with the terms of our registration with the Care Quality Commission	RED	May 2015 visit: Requirement Notice relating to staffing levels received	Report on September 2015 visit awaited
Ensure a Monitor Continuity of Service Rating of *1* (meaning we have delivered our £13m cost improvement programme)	GREEN	Current rating: 1 Forecast rating: 1	
Ensure a Monitor *Green* Governance Rating (meaning we have met all our performance targets, including A&E, 18 weeks and cancer)	RED	RED	At Q1 the Trust received a *Red* rating on relation to A&E performance. This level of performance will continue into Q2 with compliance expected in Q3.

Board of Directors	
Agenda Item	7.1.1
Title of Report	Integrated Dashboard and Exception Reports
Date of Meeting	28 October 2015
Author	John Halliday, Assistant Director of Information
Accountable Executive	Mark Blakeman, Director of Infrastructure and Informatics
FOI status	Document may be disclosed in full
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	All Strategic Objectives (1 through 7) All Key Measures (1A through 7D) All Principal Risks
Level of Assurance • **Positive** • **Gap(s)**	Partial with gaps
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

1. Executive Summary

This report provides a summary of the Trust's performance against agreed key quality and performance indicators. The Board of Directors is asked to note the performance to the end of September 2015.

2. Summary of Performance Issues

Whilst the performance against the key performance indicators associated with meeting our vision and a health organisation remain good, the Trust contuse to struggle to achieve against its objectives relating to operational excellence and external validation.

The key issue relating to external validation are;

- Achievement of the A&E target.
- Advancing quality indicators.
- The CQC risk assessment, though this is predominately associated with poor results of last year's staff survey results which are expected to improve this year.

Delivering the operational excellence KPIs remains a significant issue with poor performance in;

- Medicine length of stay, which in turn is having an impact on delivery of the A&E 4 hour target.
- Delivery of the expected activity volumes and income targets, particularly in elective surgey.
- Non core expenditure
- CIP performance.

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

Despite the range of actions being put in place in August, performance against the Emergency Access Standard deteriorated further in September to 90.25% and is currently 89.06% for October.

Key issues being addressed by the division with an aim of resolving the underperformance are;

- **The level of ED attendances** - increased by 255 compared to the same period last year which is contrary to the declining rate of attendance since the beginning of the year.

- **Changing responsibility for the NHS111 service** – which transferred to NWAS in month. Work is being undertaken to see if this is a driver for higher numbers of ED attendances.

- **Patient flow processes** – increased emphasis on effective discharge continues, with discharge numbers increasing from an average 105 discharges per day in August to 110 per day in September.

- **Discharges at week-ends** – ongoing improvements have been partially effective. Average Discharges on Saturdays were consistently increased across September compared with August levels. This appears to be to the detriment of Sunday discharges however.

- **Community Beds** - The local authority has now opened further beds and pressure is being applied via the System Resilience Group to ensure the remaining planned community beds are opened up to reduce the numbers of medically fit patients awaiting discharge.

- **Length of Stay** - The Patient Flow work stream has identified that the length of stay in medicine for patients over 74 has significantly increased since the introduction of the Care Act in April. Patient assessments have risen and the duration of the assessments has also increased. The impact is equivalent to 39 beds. The Trust is in discussion with relevant stakeholders and ECIST to improve the speed of assessments and reduce the number of assessments that require completion.

4. Advancing quality indicators

In line with all other organisations, the Appropriate Care Score (ACS) targets for WUTH have been reset for 2015-16, based on the twin principles of raising the bar on minimum attainment and continuous system-wide improvement and stretch.

The two indicators that are currently failing are;

- **Hip and Knee replacements –** whilst there was 100% compliance in May, performance has subsequently dropped to 90% for June and July. A case note audit is being completed on each case that fails to meet the required standards.

- **Sepsis -** the improved position of 49% in June slipped back to 45% in July. The promotion of the paper pathway continues, and it is expected that the electronic alerting will continue to help to raise awareness with staff. The potential for a fully electronic pathway is being developed.. A “Sepsis September” event was held that focussed on the electronic alert and subsequent actions.

5. Elective Performance

Delivery of the Trust's elective activity plans remain a concern and are essential to the delivery of both the core and cost improvement plans, as well as ongoing achievement of the RTT waiting time target.

For September elective activity is down 95 cases (2.2%) against plan, almost exclusively within the surgical specialities which is 162 cases (6%) against the original plan but has met the re-forecasted plan.

Key issues being addressed by the division to resolve the underperformance are;

- **Patient availability and suitability for lists, particularly at a sub-speciality level within orthopaedics -** Whilst there was some in month improvement due to additional outpatients clinics being undertaken and swelling the elective waiting list there remains ongoing problems with consultant availability. Discussions are ongoing with the team.
- **Consultant sickness and leave -** there were 2 Consultants still on sick leave in month, both are being managed appropriately through the Trust's processes.
- **Increased non elective surgical demand** - impacting by 29 cases.
- **Management of beds to reduce the risks of an infection outbreak -** there have been no bed related cancellations in month.

As reported last month, the ongoing issue that 375 hernia patients that would have had their surgery in Wales undertaken by one of our colorectal surgeons, attracting income of £405K is not likely to be commissioned. This activity cannot be replaced by Wirral activity.

Orthopaedics, Oral Surgery, ENT and Ophthalmology remain the specialties causing most risk to activity levels although the risk is increasing in Gynaecology.

Orthopaedics

Key issues being addressed by the speciality to resolve the underperformance are;

- an increased demand for non-elective cases (over performing by 30 which is 20% above plan).
- As has previously been reported, this year there are two major orthopaedic conferences, both in the first half of the year. The second in occurred in September and impacted by 51 cases. There are no further major orthopaedics conferences expected this financial year.

- A shortage of suitable cases which are used to ensure maximum theatre utilisation or fill lists for the Fellow. Consultant availability to do additional clinics has been less than hoped and discussions are ongoing.
- There is still no news on an allocation of RTT funding from Welsh Government so at the moment they are unable to proceed with any outsourcing exercise.

Whilst it is unlikely that Orthopaedics will deliver the original plan, a number of actions are underway to improve the current position and ensure that the specialty delivers as a minimum the revised forecast.

A range of additional actions that have been put in place since the beginning October to improve performance and will be monitored over the next month to assess their impact, including;

- Booking patients straight from fracture clinic
- Trauma cases who are discharged to come back are being booked onto elective lists
- Regular management meetings with TCI staff every Monday to ensure lists are filled,
- Cerner data is now being used to build up lists in blocks of time increasing theatre utilisation

.

With the exception of the Welsh work, it is expected that from October Orthopaedics will deliver monthly activity levels in line with the original plan and this will be monitored on a weekly basis.

Oral surgery

The two main reasons for underperformance are a Trust Grade vacancy (recently resolved) and the long term sickness of one of the two Consultants.

The Division have successfully appointed a locum who took up post in mid October and it is hoped that the absent Consultant will return on a phased return which would allow the division to achieve at the original plan by year end. Discussions were underway with a local Trust which was struggling in this area to see if any activity could transfer; these discussions have concluded and no activity will transfer. it is still anticipated that the division will achieve the revised forecast of 74 (£125k) under original plan

ENT

The two main reasons for this are Consultant sickness and an increase in non-elective activity with an over performance against plan of 49 cases (18.1%).

The Consultant has now returned to work and the Division are working on ensuring that theatre utilisation is maximised. It is therefore expected that ENT will deliver the plan by the year end. Progress is being monitored weekly.

Ophthalmology

A number of actions are being explored in an attempt to recover this underperformance including

- A number of management changes within the area.
- Providing additional administrative support to assist the Consultants in theatre with data collection to increase their available operating time leading to an increase of one case per list. This pilot will commence on 7th November.
- Exploration of moving elective operating to Clatterbridge to increase productivity due to the environment. This is forming part of the wider strategic discussions around use of Clatterbridge.
- Reviewing the number of urgent slots kept on theatre lists which is part of a wider review of the emergency ophthalmology service which will be complete by the end of November.

Whilst the current forecast is for an underperformance of 294 cases (£272K), efforts are continuing to try and reduce this.

To gain assurance regarding the management of the position across the division, the Executive Team continue to support the division on a weekly basis.

The division are on track to deliver the revised forecast presented last month.

Gynaecology

At the September board the division raised a risk against Gynaecology due to an injury sustained by a Consultant.

- The Consultant has confirmed that he is not able to operate until least February 2016.
- In addition another consultant has taken emergency leave for 3 weeks.
- To mitigate, the remaining consultants area picking up lists where possible, registrars are backfilling and an outpatient session has been cancelled to accommodate additional theatre capacity.
- Where appropriate some patients have had their treatment in Liverpool Women's hospital in order to ensure their treatment has been timely, particularly in relation to cancer treatment.

- Additionally the division are trying to recruit a locum consultant.

The net impact of this issue will be a potential deterioration in the reforecast position of approximately 65 cases.

6. 18 Weeks RTT

Although the RTT Incompletes standard has been consistently achieved at Trust level, there are a few specialties that do not achieve in their own right.

As reported in September, of continuing concern are Anaesthetics (pain management) and Community Paediatrics which is commissioned by the CCG on a block payment basis.

- Community Paediatrics remains the largest challenge, as the growth in demand continues to exceed the contracted capacity at the Trust. The quality issues associated with this has been raised with local commissioners and at the Strategic Resilience Group. This area will not achieve the RTT target for the foreseeable future although the division is planning on doing some additional activity to help reduce the waiting time for the longest waiting patients.
- In Anaesthetics (Pain) services, a new consultant has started and we are arranging for long waiting patients to be outsourced. It is anticipated that this service will achieve the RTT target by end of December

7. Non Core Spend

In September 2015 £1.8m has been spent on non core pay categories which is higher than the 14/15 average.

- Agency spend this month remains relatively high and is due to medical vacancies in the Emergency Department, the use of temporary agency staff to cover the consultant gaps in gastroenterology and cardiology (now recruited), histopathology (now recruited) and temporary agency in anaesthetics and junior doctor gaps.
- Nurse agency costs are for largely for the cohort ward managing infection control issues, acuity pressures, and other vacancy cover/sickness cover.
- A significant nurse recruitment plan has been undertaken and it is envisaged to recruit substantively to all qualified nursing vacancies by March 2016.

- Monitor have issued a target 3% ceiling of agency spend on qualified nurses as a % of total qualified nursing spend. Currently the Trust is on average at 2.8%, however some months are higher than the ceiling rate and there will be further additional challenges to manage winter pressures and infection control issues.

8. Summary Financial Position

Despite challenges achieving the required activity volumes, the Trust continues to deliver a financial performance broadly in line with its plan with the in-month position showing a marginal £(0.087)m deterioration.

The cumulative deficit as at the end of September is (£8.173m) which is an (£0.244m) adverse variance to the plan of (£7.928m).

A full year deficit of (£13.494m) continues to be forecast assuming that none of the identified risks are realised. The second half of the year will be challenging for the Trust as we look to deliver two thirds of the CIP over the autumn and winter months, this is in line with current plans and follows historic trends.

The cash position continues to be positive with the cash position at the end of the month being £13.208m which is £6.855m better than plan. The Trust has agreed with its main commissioner advance payment of the contractual payment in December and January therefore moving any requirement for distress funding to March 2016.

The financial performance in month and at month 6 translates into a Continuity of Services (CoS) Rating of 2, which remains in line with plan.

The Executive Directors continue to develop further detailed plans to mitigate any risks that may be realised in the latter half of the year to enable delivery of the financial plan.

Further financial information is contained in the separate Finance briefing paper.

9. Recommendation

The Board of Directors are asked to;

Note the Trust's current performance to the end of September 2015, with particular regard to;

- The risks associated with the delivery of the emergency access target where performance remains challenging despite a range of actions taken.

- Risks against Elective and outpatient activity volumes and contract performance.
- 18 week RTT where ongoing performance is dependent on delivery of at least the activity volumes identified in the annual plan, particularly in light of the increased GP referrals.

Support the range of actions to resolve the current underperforming areas;

- The recovery plans in place to deliver the non-elective access target.
- Ongoing work with the surgical division to improve the performance against the elective and outpatient programmes.
- The additional attention within the organisation being put on the 18 week RTT incomplete target, given the increased national attention and the retirement of the non-admitted and admitted targets.

WUTH Integrated Performance Dashboard - Report on September 2015 for October BoD

Area	Indicator / BAF	July	August	Sept	Trend / Future Concern	*Target (for 'Green')*	Latest Period	Exec Lead
Meeting Our Vision	**Satisfaction Rates**							
	Patient - F&F "Recommend" Rate	96%	97%	97%		*>=95%*	September 2015	JG
	Patient - F&F "Not Recommend" Rate	1%	1%	1%		*<=2%*	September 2015	JG
	Staff Satisfaction (engagement)	3.83	3.83	3.83		*>=3.69*	Q2 2015/16	JS
	First Choice Locally & Regionally							
	Market Share Wirral	86.2%	85.7%	85.2%		*>= 85%*	April to June 2015	MC
	Demand Referral Rates	6.0%	3.7%	2.6%		*>= 3% YoY variance*	Fin Yr-on-Yr to Sept 2015	MC
	Market Share Non-Wirral	9.4%	9.5%	9.4%		*>=8%*	April to June 2015	MC
	Strategic Objectives							
	Harm Free Care	96%	94%	96%		*>= 95%*	September 2015	JG
	HIMMs Level	5	5	5		*5*	September 2015	MB
Operational Excellence	**Key Performance Indicators**							
	A&E 4 Hour Standard	97.22%	92.51%	90.25%		*>=95%*	September 2015	SG
	RTT 18 Weeks Incomplete Position	92.1%	92.3%	92.0%		*>=92%*	September 2015	SG
	Cancer Waiting Time Standards	On track	On track	On track		*All met at Trust level*	Q2 to Sept 2015	SG
	Infection Control	0 MRSA; 16 C diff	0 MRSA; 19 C diff	0 MRSA; 22 C diff		*0 MRSA Bacteraemia in month, and cdiff less than cumulative trajectory*	September 2015	JG
	Productivity							
	Delayed Transfers of Care	4.0	4.1	3.7		*<= 4*	12-mth ave to Sept 2015	SG
	Delayed Complex Care Packages	56	60	62		*<= 45*	September 2015	SG
	Bed Occupancy	89.8%	90.4%	92.4%		*<=85%*	September 2015	SG
	Bed Occupancy Medicine	91.6%	94.1%	92.1%		*<=85%*	September 2015	SG
	Theatre Utilisation	70.5%	70.3%	71.0%		*>=85%*	September 2015	SG
	Outpatient DNA Rate	8.6%	9.3%	8.8%		*<=6.5%*	September 2015	SG
	Outpatient Utilisation	83.2%	83.3%	83.1%		*>90%*	September 2015	SG
	Length of Stay - Non Elective Medicine	7.3	7.5	7.5		*<= 6.5*	September 2015	SG
	Length of Stay - Total	4.8	4.8	5.0		*<=4.2*	September 2015	SG
	Contract Performance (activity)	-3.1%	-3.2%	-3.1%		*0% or greater*	September 2015	SG
	Finance							
	Contract Performance (finance)	-1.5%	-1.7%	-1.5%		*On Plan or Above YTD*	September 2015	AM
	Expenditure Performance	1.3%	1.4%	1.2%		*On Plan or Above YTD*	September 2015	AM
	CIP Performance	-15.0%	-22.0%	-25.0%		*On Plan or Above*	September 2015	AM
	Capital Programme	-10.7%	-2.5%	12.1%		*On Plan*	September 2015	AM
	Non-Core Spend	9.5%	9.6%	9.6%		*<5%*	September 2015	AM
	Cash Position	134%	218%	108%		*On plan or above YTD*	September 2015	AM
	Cash - working days	-10.69	-12.53	-14.33		*> 14 days*	September 2015	AM
A Healthy Organisation	**Clinical Outcomes**							
	Never Events	0	0	1		*0 per month*	September 2015	EM
	Complaints	40.0	40.3	40.9		*<30 per month*	12-mth ave to Sept 2015	JG
	Workforce							
	Attendance	96.0%	96.1%	96.2%		*>= 96%*	September 2015	JS
	Qualified Nurse Vacancies	7.7%	7.8%	7.3%		*<=6.5%*	September 2015	JG
	Mandatory Training	96.2%	95.3%	94.4%		*>= 95%*	September 2015	JS
	Appraisal	85.6%	85.2%	84.95%		*>= 85%*	September 2015	JS
	Turnover	10.5%	9.9%	9.7%		*<10%*	September 2015	JS
External Validation	**National Comparators**							
	Advancing Quality (not achieving)	3	4	2		*All areas above target*	September 2015	EM
	Mortality: HSMR	94.59	90.03	89.25		*Lower CI < 0.90*	April to June 2015	EM
	Mortality: SHMI	0.967	0.967	0.967		*Lower CI < 90*	Oct 2013 to Sept 2014	EM
	Regulatory Bodies							
	Monitor Risk Rating - Finance CoS	2	2	2		*4*	September 2015	AM
	Monitor Risk Rating - Governance		Red	Red		*Green*	September 2015	SG
	CQC	5	5	5		*0*	September 2015	EM
	Local View							
	Commissioning - Contract KPIs	3	4	4		*<=2*	September 2015	SG
	Monitor enhanced monitoring							
	A&E 4 Hour Standard	97.22%	92.51%	90.25%		*>=95%*	September 2015	SG
	Medical Outliers	1.9	6.9	1.54		*<=5*	September 2015	SG
	Bed occupancy	89.8%	90.4%	92.4%		*<=85%*	September 2015	SG
	Staff Friends and Family	62%	62%	62%		*>= 75%*	September 2015	JS
Financial Recovery	**Financial Recovery Plan**							
	Contract / Inventory Management	11.5%	3.2%	4.9%		0% (ie on plan) or greater	September 2015	MT
	Income	-0.5%	-2.5%	-0.8%		0% (ie on plan) or greater	September 2015	MT
	Workforce Value for Money	-0.4%	0.2%	1.8%		0% (ie on plan) or greater	September 2015	MT
	Utilisation - Outpatients	-0.1%	-8.5%	-5.7%		0% (ie on plan) or greater	September 2015	MT
	Utilisation - Theatres	-6.0%	-12.1%	-13.4%		0% (ie on plan) or greater	September 2015	MT
	Productivity - Patient Flow	-6.7%	-9.1%	-13.4%		0% (ie on plan) or greater	September 2015	MT

WUTH Performance Dashboard Exception Report

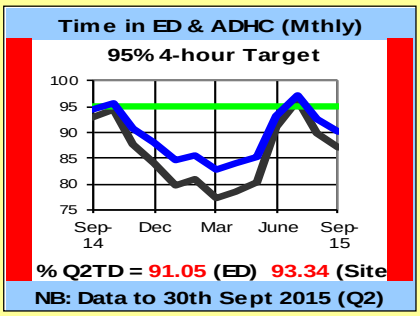
Indicator :
A&E 4-hour Standard

Rating	Target	Actual	Period
Red	>= 95%	90.25%	Sept 2015

Issue:

The standard is a minimum of 95% of A&E attendances being admitted, transferred or discharged within 4 hours. Performance for September was 90.25%, including the All Day Health Centre at Arrowe Park site. For WUTH alone performance was 87.09%.

Historic data:



Proposed Actions:

The level of ED attendances increased by 255 compared to the same period last year which is against a declining rate of attendance (overall fall of 953 since the beginning of the year). NHS111 has transferred to NWAS and work is being undertaken to see if this is a driver for higher numbers of ED attendances .Work continues to improve patient flow and weekend discharging has started to improve considerably.

The Patient Flow work stream has identified that the LOS in medicine for patients over 74 has significantly increased since the introduction of the Care Act in April. Patient assessments have risen and the duration of the assessments has also increased. The impact is equivalent to 39 beds. The Trust is in discussion with relevant stakeholders and ECIST to improve the speed of assessments and reduce the number of assessments that require completion. The cumulative joint position for Q2 was 93.34%.

Assessing Improvement:

Across the first three weeks of October joint performance has been 92.14%, 88.32% and 90.02%. The current combined Q3 performance to the 19th October is 89.06%.

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

Indicator :
Infection Control

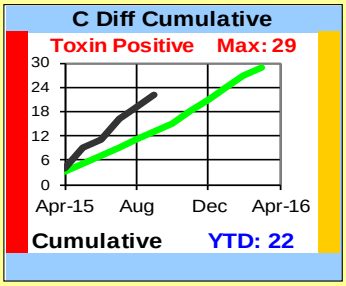
Rating	Target	Actual	Period
Red	Within trajectory	22 c diff cases	To Sept 2015

Issue:

The Trust has a maximum trajectory of 29 C.difficile cases for the year 2015-16 (toxin positive, hospital acquired). During September we reported 3 hospital attributed cases of toxin positive C.difficile. The Post Infection Review performed by the IPCT and CCG identified all 3 toxin cases to be avoidable. This brings the cumulative position to 22 against the trajectory.

The profiled trajectory to the end of December 2015 is a maximum 21 cases. As there are already 22 confirmed cases this will be the third consecutive quarter where the cumulative trajectory profile is breached, and so will automatically trigger a goverenance concern at Monitor.

Historic data:



Proposed Actions:

A robust plan to perform full ward Hydrogen Peroxide Vaporisation (HPV) on the wards at highest risk of C.diff was implemented over a 2 week period during September. A programme of deep cleaning followed. The HPV programme is due to recommence on 5th November for a further 6 weeks.

Assessing Improvement:

The situation is constantly monitored by the IPCT, with weekly meetings including the DIPC and Executive Leads. Updated reports are provided to the Hospital Infection Control and Clinical Governance Groups.

Impact:

Effective infection control is vital to ensuring safe, high quality health services are delivered at our hospitals. Cases of infection not only affect the individual patients directly, but can have a negative impact on the overall capacity of the Trust, and are a high profile measure in the public domain.

Expected date of performance delivery:

Quarter 4 reporting

Director approval:

Jill Galvani, Director of Midwifery & Nursing

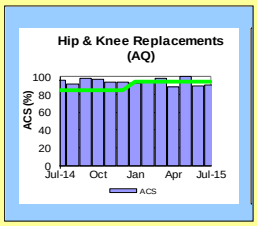
WUTH Performance Dashboard Exception Report

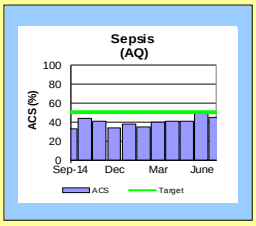
Indicator :	Rating	Target	Actual	Period
Advancing Quality	Red	All achieving	2 areas under target	Sept 2015

Issue:

The measures are composite scores, reflecting individual care to patients. The results are delayed up to 3 months and so lags behind improvement. Areas behind target at the end of July were Hip & Knee Replacements, and Sepsis.

Historic data:





Proposed Actions:

In line with all other organisations, the Appropriate Care Score (ACS) targets for WUTH have been reset for 2015-16, based on the twin principles of raising the bar on minimum attainment and continuous system-wide improvement and stretch.

H&K - there was 100% compliance in May, which has subsequently dropped to 90% for June and July. Due to previous good attainment over the years this AQ measure now only requires a sample review of 30 casenotes. Every indicator had one "missing measure" in both knee and hip surgery. These are all followed up on an individual basis.

Sepsis - the improved position of 49% in June slipped back to 45% in July. The promotion of the paper pathway as well as the electronic assessment continues, with the potential for an electronic solution in the future. A "Sepsis September" event was held that focussed on the electronic alert and subsequent actions.

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.

Expected date of performance delivery:

Improvement ongoing through 2015-16

Executive approval:

Evan Moore, Medical Director

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 (rolling 3 months)	>= 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%
Strategic Objectives				
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

Organisational Excellence

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	RTT "Incompletes" standard met for the Trust as a whole	>=92%	n/a	<92%
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
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				
Delayed transfers of care	Average No of patients with a delayed transfer of care at month-end	<= 4	> 4 and < 6	>= 7
Delayed complex care packages	Average No of patients on the complex discharge list in the month	<= 45	>= 46 and <= 70	>= 71
Readmissions	% of patients readmitted non-electively within 30 days of discharge	<= 7.5%	>7.5% and <= 10%	> 10%
Bed occupancy	Average % of General & Acute Beds occupied at midday	<=85%	>85% to <95%	>=95%
Bed occupancy - Medicine	Average % of Medial & Acute beds occupied at midday	>=85%	>=65% to <85%	<65%
Theatre utilisation	Average % of scheduled operating minutes utilised	>=85%	>=65% to <85%	<65%
Outpatient DNA Rate	Percentage of booked OP appointments that DNA (Med, Surg and W&C)	<= 6.5%	>6.5% and <= 9%	> 9%
Outpatient Utilisation	Percentage of OP appointments that DNA (Med, Surg and W&C)	>90%	>=80% to <90%	<80%
Length of stay - Non-elective Medical Division	Average length of stay per finished admitted spell (Medical Division)	<= 6.5	> 6.5 to 8.0	> 8.0
Length of stay - Trust total	Average length of stay per finished admitted spell (Trust total)	<= 4.2	> 4.2 to 5.5	> 5.5
Contract performance (Activity)	Cumulative activity % variance against plan for all PODs combined	0% or greater	-2.0% to <0%	< -2.0%
Finance				
Contract Performance (Finance)	Delivering both contracted volumes and values	On Plan or Above YTD	1% below plan YTD	>1% below plan YTD
Expenditure performance	Delivering planned levels of expenditure	On Plan or Above YTD	1% below plan YTD	>1% below plan YTD
CIP Performance	Delivering against the in-year CIP forecast.	On Plan or Above	10% below plan	>10% below plan
Capital Programme	A sound investment programme maintained & resourced appropriately	On Plan	+/- 15% against plan	+/- 25% against plan
Non-Core Spend	Non core as a % of total pay spend	<5%	>=5.0% to 6.5%	>=6.6%

Cash Position	Delivering against cash plan	On plan or above YTD	n/a	Below plan
Cash - working days	Liquidity Days: The number of days the Trust could support it's pre EBITDA expenditure with it's liquid assets i.e.((Current Assets - Inventories - Current liabilites) / Pre EBITDA expenditure)) x number of days elapsed in financial year	> 14 days	>= 7 days to 14 days	< 7 days

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
Workforce				
Attendance	Monthly staff attendance rate	>= 96%	>=95.3% to <96.0%	< 95.3%
Qualified Nurse Vacancies	% vacant posts	<=6.5%	>6.5% to 9.5%	>9.5%
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%

External Validation

Indicator	Definition	Green	Amber	Red
National Comparators				
Advancing Quality (not achieving)	Number of areas not achieving	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
Monitor Enhanced Monitoring				
A&E 4-hour Standard	% of patients attending ED & ADHC treated within 4 hours	>=95%	n/a	<95%
Medical Outliers	Average daily medical outliers in non-medical beds	<=5	>5 to 10	>10
Bed occupancy	Average % of General & Acute Beds occupied at midday	<=85%	>85% to <95%	>=95%
Staff Friends and Family	Recommend Trust to work	>= 75%	>= 50% to <75%	<50%
Financial Recovery Plan				
Contract / Inventory Management	Total non pay expenditure against plan, excluding CNST premium and high cost drugs	>=0%	<0% to -5%	<-5%
Income	Total income against plan	>=0%	<0% to -5%	<-5%
Workforce Value for Money	Total pay expenditure against plan	>=0%	<0% to -5%	<-5%
Utilisation - Outpatients	Percentage of available resource utilised against plan	>=0%	<0% to -5%	<-5%
Utilisation - Theatres	Percentage of available resource utilised against plan	>=0%	<0% to -5%	<-5%
Productivity - Patient Flow	Reduction in non-elective length of stay against plan	>=0%	<0% to -5%	<-5%

Appendix B : Cancer Waiting Time 62-Day Standard

Quarter	2
Period	01/07/2015 - 30/09/2015

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

Quarter 2 - Total

Division	Tumour Group	Breaches			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted
Medicine	Haematology	4	0	4	13	0	13	69.23%	69.23%
	Lung	5	0	5	23	0	23	78.26%	78.26%
	Other	0	0	0	4.5	0	4.5	100.00%	100.00%
Med & Surg	Upper GI	7	0	7	21.5	0	21.5	67.44%	67.44%
Surgery	Breast	1	0	1	39.5	0	39.5	97.47%	97.47%
	Colorectal	2	0	2	22	0	22	90.91%	90.91%
	Head & Neck	5	0	5	15.5	0	15.5	67.74%	67.74%
	Skin	0	0	0	70.5	0	70.5	100.00%	100.00%
	Urology	13	0	13	40.5	0	40.5	67.90%	67.90%
Women's	Gynaecology	1	1	2	10.5	2	12.5	90.48%	84.00%
	Total	**38**	**1**	**39**	**260.5**	**2**	**262.5**	**85.41%**	**85.14%**

Quarter 2 - July

Division	Tumour Group	Breaches			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted
Medicine	Haematology	2	0	2	2	0	2	0.00%	0.00%
	Lung	3	0	3	10.5	0	10.5	71.43%	71.43%
	Other	0	0	0	1	0	1	100.00%	100.00%
Med & Surg	Upper GI	1	0	1	6	0	6	83.33%	83.33%
Surgery	Breast	0	0	0	15.5	0	15.5	100.00%	100.00%
	Colorectal	1	0	1	5.5	0	5.5	81.82%	81.82%
	Head & Neck	2	0	2	6.5	0	6.5	69.23%	69.23%
	Skin	0	0	0	30.5	0	30.5	100.00%	100.00%
	Urology	5	0	5	15	0	15	66.67%	66.67%
Women's	Gynaecology	0	0	0	2	0	2	100.00%	100.00%
	Total	**14**	**0**	**14**	**94.5**	**0**	**94.5**	85.19%	85.19%

Quarter 2 - August

Division	Tumour Group	Breaches			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted
Medicine	Haematology	1	0	1	4	0	4	75.00%	75.00%
	Lung	1	0	1	4	0	4	75.00%	75.00%
	Other	0	0	0	3	0	3	100.00%	100.00%
Med & Surg	Upper GI	1	0	1	6	0	6	83.33%	83.33%
Surgery	Breast	1	0	1	11	0	11	90.91%	90.91%
	Colorectal	0	0	0	7	0	7	100.00%	100.00%
	Head & Neck	1	0	1	4.5	0	4.5	77.78%	77.78%
	Skin	0	0	0	24	0	24	100.00%	100.00%
	Urology	4	0	4	12	0	12	66.67%	66.67%
Women's	Gynaecology	1	0	1	5.5	0	5.5	81.82%	81.82%
	Total	**10**	**0**	**10**	**81**	**0**	**81**	87.65%	87.65%

Quarter 2 - September

Division	Tumour Group	Breaches			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted
Medicine	Haematology	1	0	1	7	0	7	85.71%	85.71%
	Lung	1	0	1	8.5	0	8.5	88.24%	88.24%
	Other	0	0	0	0.5	0	0.5	100.00%	100.00%
Med & Surg	Upper GI	5	0	5	9.5	0	9.5	47.37%	47.37%
Surgery	Breast	0	0	0	13	0	13	100.00%	100.00%
	Colorectal	1	0	1	9.5	0	9.5	89.47%	89.47%
	Head & Neck	2	0	2	4.5	0	4.5	55.56%	55.56%
	Skin	0	0	0	16	0	16	100.00%	100.00%
	Urology	4	0	4	13.5	0	13.5	70.37%	70.37%
Women's	Gynaecology	0	1	1	3	2	5	100.00%	80.00%
	Total	**14**	**1**	**15**	**85**	**2**	**87**	83.53%	82.76%
	Total	**25**	**2**	**27**	**145**	**4**	**149**	82.76%	81.88%

Board of Directors	
Agenda Item	7.1.2
Title of Report	Month 6 Finance Report
Date of Meeting	28 October 2015
Author	Julie Clarke, Assistant Director of Finance – Operational Financial Management. Shahida Mohammed, Assistant Director of Finance – Income & Commissioning
Accountable Executive	David Allison, Chief Executive
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

Overview

The Trust continues to deliver a financial performance broadly in line with its plan with the in-month position showing a marginal £(0.087)m deterioration. The cumulative deficit as at the end of September is (£8.173m) which is an (£0.244m) adverse variance to the plan of (£7.928m).

The Trust continues to forecast achievement of the full year plan with a deficit of (£13.494m) assuming that none of the identified risks are realised. The second half of the year will be challenging for the Trust as we look to deliver two thirds of the CIP over the autumn and winter months, this is in line with current plans and follows historic trends.

The cash position continues to be positive with the cash position at the end of the month being £13.208m which is £6.855m better than plan. The Trust has agreed with its main commissioner advance payment of the contractual payment in December and January therefore moving any requirement for distress funding to March 2016.

The financial performance in month and at month 6 translates into a Continuity of Services (CoS) Rating of 2, which remains in line with plan.

The Executive Team continues to develop further detailed plans to mitigate any risks that may be realized in the latter half of the year to enable delivery of the financial plan.

Income and Expenditure Performance

	MONTH 6			YTD			FULL YEAR FORECAST		
	In Month			Year to Date					
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
NHS Clinical Income	23,557	23,377	(180)	138,427	136,325	(2,102)	279,420	277,418	(2,002)
Other Income	2,277	2,448	170	13,686	14,631	945	27,535	29,117	1,581
Employee Expenses	(17,399)	(17,705)	(306)	(104,170)	(104,772)	(602)	(208,431)	(210,114)	(1,683)
All Other Operational Expenses	(7,501)	(7,835)	(334)	(45,352)	(46,600)	(1,248)	(90,770)	(93,963)	(3,193)
Reserves	(340)	176	515	(3,469)	(925)	2,544	(7,003)	(2,510)	4,493
EBITDA	595	462	(134)	(878)	(1,341)	(462)	751	(52)	(804)
Post EBITDA Items	(1,198)	(1,152)	46	(7,050)	(6,832)	218	(14,220)	(13,441)	778
Net Surplus/(Deficit)	(603)	(690)	(87)	(7,928)	(8,173)	(244)	(13,468)	(13,494)	(25)
EBITDA %	2.3%	1.8%	(0.5%)	(0.6%)	(0.9%)	(0.3%)	0.2%	(0.0%)	(0.3%)

The table above highlights the Trusts overall financial performance in month 6, and cumulatively, to the end of September 2015.

Specifically the table highlights;

- In month the Trust delivered £23.377m of NHS clinical income, £(0.180)m behind plan and is £(2.102)m on a cumulative basis. The in-month position on elective income is in line with the surgical recovery plan. The forecast for clinical income is c£2m off plan. PbR income will be off plan by £(3.7)m which has been mitigated by non-Pbr overperforming.

- In month other income achieved £0.170m more than plan and this has contributed to a continued over achievement against plan on a cumulative basis with a favourable variance of £0.945m year to date.
- Employee costs are £(0.306)m higher than plan in month with a cumulative overspending of £(0.602)m year to date. Overspending in this area is largely associated with the use of temporary staff to fill vacancies for which the Trust is currently well underway on the nurse recruitment plan and continuing to recruit substantively to the medical vacancies. Divisions continually review vacancies and how best to secure substantive staff to fill any temporary gaps to minimize adverse impacts on operational efficiency.
- Other operating expenses are showing an in-month over-spend of £(0.334)m and a cumulative overspend of £(1.248)m. Divisional management and finance teams continue to review non pay spend to ensure that costs are managed back to budget in subsequent months or are offset by income.
- The Trust began the year with a series of reserves to support inflationary costs and pressures, future investments and to provide some mitigation to potential costs or shortfalls in cost improvement plans. In month the application of reserve supported the financial variance by £0.515m with cumulative support being £2.544m.

The aggregation of the above component elements delivers an in month deficit of £(0.690)m against a planned deficit of £(0.603)m giving a marginal adverse in month variance of £(0.087)m.

The table also highlights the forecast outturn position for 15/16, indicating although the planned deficit of £(13.494)m will be achieved the component elements of the deficit will be different to plan. Clinical income is forecast to under recover by £(2.002)m. This is offset by other income, overall expenditure and reserves at £1.198m better than plan and there is a £0.778m underspend in post EBITDA items, this predominately relates to depreciation and PDC payments.

Cash Position & Continuity of Service Ratio (COS)

The cash position is £13.208m, £6.855m better than plan. This is predominantly due to underperformance to date in 2015/16, temporary changes in the profile of some commissioner payments and significant increases in trade creditors and accruals against the largest being those for Cerner and total agency/locum spend.

Capital spend (on accruals basis) to month 6 was £3.9m against a plan of £3.5m. This variance of £0.4m relates to ward improvement scheme variances of £0.3m due to early progression of refurbishment and Isolation Ward works, IT spend is ahead of plan by £0.1m due to early delivery of equipment, and other minor schemes ahead of plan by £0.1m. Partly offset by slippage on Cerner of £0.1m. The capital programme is expected to remain within plan in year.

It is anticipated that the majority of these timing differences will unwind in the coming months and the Trusts cash position will reduce however the Trust continues to actively manage its cash and working capital position.

The overall position returns a Continuity of Service rating of 2, which is in line with plan. The risk rating has been calculated using Monitors revised metrics.

Cost Improvement Programme (CIP)

The 2015/16 plan assumed delivery of £13m of CIP with £11m of identified opportunities at the time of the Plan submission. These plans were extracted according to the profile of the schemes identified, with the unidentified balance of £2m extracted in a flat profile (12ths).
The latest forecast outturn position has reduced to c.£9.8m, £1.2m below initial plans with the in month deterioration to forecast arising primarily within the Patient Flow workstream. Planned reductions in patient length of stay have not transpired due to the increased complexity of patients seen and process changes. In addition the growth in non-elective activity initially anticipated has not materialised to the extent original planned. The PMO are working closely with Divisions and workstreams to quantify any residual risk against plans whilst at the same time seeking opportunities to both fill the original gap and mitigate against the shortfall. Divisions are due to present their plans to fill the gap to the Executive team during October 2015. Although the in year shortfall has increased, recurrently the schemes are expected to deliver just under £12m against a plan of £16.4m. The Trust is mindful of the pressure this places on plans going into 2016/17, and is currently taking to address the shortfall.
Risks inherent in the CIP plans had been identified as part of the planning process, some mitigation is also available within reserves; this is applied on a monthly basis.

The CIP position at Month 6 (including non-recurrent schemes) can be summarised as follows:

	BY SCHEME TYPE		**BY COST**		**TOTAL**
	Income Generation (net of cost of delivery) £m	**CIP £m**	**NHS Clinical Income £m**	**Divisional Budgets £m**	**£m**
Year to date Plan (including unidentified at time of plan)	1.79	2.36	2.13	2.02	**4.15**
Year to date Actual	2.26	1.47	2.37	1.36	**3.73**
Year to date Variance	0.47	(0.89)	0.24	(0.66)	**(0.42)**

2. Key Issues

Through the six months of the financial year the Trust has delivered largely consistent financial performance across expenditure categories including the application of reserves with greater variation being experienced across NHS clinical income.

During the month the total income position was marginally below plan by £(0.010m).

On clinical income the elective position is in line with the surgical recovery plan. From an organisational perspective and at a “Point of Delivery” (POD) level, Appendix 1 includes the breakdown of the Trusts planned and actual income performance covering both price and volume of activity.

Included within the overall position is (c£1.925m) for penalties the main areas include (c£0.951m) for readmissions, (c£0.249m) outpatient follow ups, approximately (£0.133m) applied in relation to 18 wk. breeches (incomplete), (£0.349m) for activity exceeding the NEL marginal rate threshold, and (£0.100m), for ambulance turnaround times.

The financial effect of penalties in relation to the 4 hr, A&E access targets amount to some (£0.4m) cumulatively. This has been mitigated in the financial position, the CCG have recognised via the System Resilience Group, breeches have been impacted due to system wide issues as opposed to Trust processes. On that basis penalties will be re-invested into the Trust, to help improve pathways.

Analysis of Pay Spend

Detail	14/15 Average £k	April £k	May £k	June £k	July £k	August £k	September £k	YTD £k
Budget	**16,916**	**17,140**	**17,337**	**17,430**	**17,386**	**17,480**	**17,399**	**104,172**
Pay Costs								
Substantive	**15,875**	**15,605**	**15,783**	**15,873**	**15,630**	**15,840**	**15,894**	**94,625**
Bank Staff	319	306	291	295	293	289	278	1,752
Agency Staff	518	698	712	605	683	606	747	4,051
Overtime	224	343	278	282	263	276	388	1,830
Locum	362	299	264	332	356	410	300	1,961
WLI (In Year)	155	52	88	126	100	91	98	555
Non Substantive Total	**1,577**	**1,698**	**1,633**	**1,640**	**1,695**	**1,672**	**1,811**	10,149
Total Pay	**17,451**	**17,303**	**17,416**	**17,513**	**17,325**	**17,512**	**17,705**	**104,774**
Variance	**(535)**	**(163)**	**(79)**	**(83)**	**61**	**(32)**	**(306)**	**(602)**

In September 2015 £1.811m has been spent on non core pay categories as detailed in the above table.

Agency spend still remains higher than the 14/15 average spend and reasons are detailed below:-

- Agency spend this month remains high and is due to medical vacancies in the Emergency Department, the continued use of agency staff to cover the consultant gaps in gastroenterology and cardiology (now recruited), histopathology (now recruited) and temporary agency in anesthetics and junior doctor gaps.

- Nurse agency costs are for largely for the cohort ward managing infection control issues, acuity pressures, and other vacancy cover/sickness cover. A significant nurse recruitment plan has been undertaken and it is envisaged to recruit substantively to all qualified nursing vacancies by March 2016. Monitor have issued a target 3% ceiling of agency spend on qualified nurses as a % of total qualified nursing spend. Currently the Trust is on average at 2.8% however some months are higher than the ceiling rate and there will be further additional challenges to manage winter pressures and infection control issues.

Overtime was higher this month largely in medicine with higher levels of nursing costs incurred to staff the wards; this additional overtime is expected to reduce in October. This increase in expenditure was broadly in line with the divisional forecast.

3. 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. The divisions continue to be supported to enable continual delivery of the agreed plan in order to meet the forecast deficit via Transformation Steering Group and Divisional Performance Reviews. Forecast activity is reviewed on a weekly basis and divisions are each developing forecast outturn positions to increasingly consider necessary prospective actions to improve the forward look financial management of the organisation. The forecasts will be reported to the Executive Team through the Chairs Report from the Finance Performance and Business Assurance Committee.

4. Conclusion

The overall I & E position continues to deliver a financial performance broadly in line with its plan. The Trusts cash position continues to be stronger than planned. The Trust has achieved its CoS rating of 2 as planned.

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 and their reinvestment in service delivery continues through the Strategic Resilience Group (SRG).

Within the totality of the position the Trust has achieved its planned level CIP however there remains c£3.2m of CIP further requirement for which plans continue to be explored.

From a risk perspective the key considerations include the requirement to ensure planned activity for the remainder of the year is achieved, in addition to improve patient flow to minimize financial penalties and the development of further CIP schemes to bridge the current CIP shortfall. In addressing these issues divisions are closely monitoring activity levels and seeking opportunities to maximize capacity, investments in patient flow have been supported to ensure the swiftest and most clinically appropriate transition of patients into and out of the organisation and weekly review of CIP development and delivery is undertaken at an executive level. These steps will be supplemented by enhancing the divisional input into the financial forecasts.

At an aggregate level the Trust continues to deliver against its financial plan and is forecasting, recognising the risks specifically associated with achievement of income targets and delivery of CIP schemes, that its planned deficit of £13.5m will be achieved. Close management of cash and working capital balances continues to afford the Trust a stronger position than planned and the requirement for future cash support, as identified within the submitted financial plan, will continue to be reviewed on a monthly basis, with the goal of minimizing the requirement for

support and delaying any requirement to the latest possible point in the financial year.

5. Recommendations

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

Gareth Lawrence
Deputy Director of Finance
October 2015

Appendix 1 – Income

2015-16 NHS Clinical Income -
September 2015 (Month 6) FT PLAN

	ACTIVITY								VALUE inc MFF @ 3.8864%							
	Full Year Plan	Plan	Actual	Penalties	Adjusted Actual	YTD Variance	Previous Month Variance	In Month Movement	Full Year Plan £000s	Plan £000s	Actual £000s	Penalties £000s	Adjusted Actual £000s	YTD Variance £000s	Prior Month Variance £000s	In Month Movement £000s
Elective & Day Case	50,170	24,692	23,830	0	23,830	(862)	(767)	(95)	54,421	26,666	24,180	(107)	24,073	(2,593)	(2,071)	(522)
Elective Excess Bed Days	3,854	1,939	1,610	0	1,610	(329)	(284)	(45)	849	427	347	0	347	(80)	(70)	(10)
Non Elective	44,924	22,100	21,770	(467)	21,303	(797)	(763)	(34)	69,222	33,880	34,497	(1,351)	33,146	(734)	(478)	(256)
Non Elective Non Emergency	5,291	2,571	2,523	0	2,523	(48)	(60)	12	8,333	4,097	4,058	0	4,058	(39)	(88)	49
Non Elective Excess Bed Days	17,434	8,646	10,273	(346)	9,927	1,281	1,037	244	3,722	1,845	2,201	(73)	2,128	283	240	43
A&E Attendances	89,442	46,029	46,004	0	46,004	(25)	(388)	363	10,100	5,198	5,325	(100)	5,225	27	(16)	43
Outpatient First Attendances	93,074	45,531	43,604	0	43,604	(1,927)	(1,341)	(586)	14,060	6,877	6,641	(39)	6,602	(275)	(222)	(53)
Outpatient Follow Up	192,923	94,978	92,457	(2,870)	89,587	(5,391)	(4,575)	(816)	17,223	8,462	8,209	(249)	7,960	(502)	(432)	(70)
Outpatient Procedures	45,597	22,745	21,389	0	21,389	(1,356)	(1,018)	(338)	7,294	3,631	3,524	0	3,524	(107)	(79)	(28)
Outpatient Unbundled Diagnostic Images	27,234	13,512	14,182	0	14,182	670	624	46	2,468	1,227	1,300	(6)	1,294	67	62	5
Maternity	6,498	3,249	3,203	0	3,203	(46)	(18)	(28)	5,272	2,636	2,813	0	2,813	177	157	20
Total PbR	**576,441**	**285,992**	**280,845**	**(3,683)**	**277,162**	**(8,830)**	**(7,553)**	**(1,277)**	**192,964**	**94,946**	**93,095**	**(1,925)**	**91,170**	**(3,776)**	**(2,997)**	**(779)**
Non-PbR									**66,836**	**33,671**	**34,770**	**(1)**	**34,769**	**1,098**	**635**	**463**
PbR Excluded Drugs									**12,942**	**6,471**	**6,110**	**0**	**6,110**	**(361)**	**(457)**	**96**
CQUIN									**6,322**	**3,161**	**3,159**	**0**	**3,159**	**(2)**	**(2)**	**0**
Contracted Income Sub Total									**279,064**	**138,249**	**137,134**	**(1,926)**	**135,208**	**(3,041)**	**(2,821)**	**(220)**
North Wales - Additional Activity									**0**	**0**	**351**	**0**	**351**	**351**	**311**	**40**
Other Income									**356**	**178**	**766**	**0**	**766**	**588**	**588**	**0**
Grand Total									**279,420**	**138,427**	**138,251**	**(1,926)**	**136,325**	**(2,102)**	**(1,922)**	**(180)**

Activity includes 893 U codes which have been valued at the average specialty price based on plan, a prudent estimation has been made for the possible Excess Bed Days that may be associated with U-codes.

Negative Values are an under-performance and are shown in brackets.

BOARD OF DIRECTORS	
Agenda Item	8.1
Title of Report	Francis Report: Hard Truths Commitment: Publishing of Nurse Staffing Data: September 2015
Date of Meeting	28 October 2015
Author	Gaynor Westray, Deputy Chief Nurse Jill Galvani, Director of Nursing and Midwifery
Accountable Executive	Jill Galvani, Director of Nursing and Midwifery
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Strategic objectives: To be the top NHS Hospital in the North West; Delivering consistently high quality secondary care services; Supported by financial, commercial and operational excellence. 1a: Improve our Patient Experience to deliver the Friends & Family score of 95% or better (Risks 2799 & 2798); 1b: Create a strong culture of empowered employees, delivering a staff engagement score of 3.59 or better, through implementation of our nursing, midwifery and customer service strategy (risk number 1908 & 1909); 3a: Implementation of a quality improvement strategy to reduce mortality to 85 HSMR (Risks 2837 & 2611); 3b: Ensure that our harm free care score is no lower than 93% & no lower than 95% for 3 months (Risks 2799, 2837 & 2798); 7a: Full compliance with our registration with CQC (Risks 2798 & new risk scored at 15: The risk of further severe enforcement action should the Trust not respond appropriately to the requirement notice regarding nurse staffing.
Level of Assurance • **Positive** • **Gap(s)**	Gaps: E Roster Version 10: has not been well used to date to record actual staffing levels after mitigation (Bank, overtime, agency and staff flexibility). A team has been established to support the ADNs to optimise the E-roster functionalities and develop a system to assure data quality. Revalidation for Registered Nurses and Midwives is mandated from 1 April 2016; there is a potential risk that nurses may miss this deadline and therefore are unable to work as Registered nurses or midwives. This risk is on the risk register and there are plans in place to mitigate the potential impact. Positive: No additional wards have been open since May 2015 Successful recruitment to ward 25 (isolation ward) and ward 27 (first planned additional ward to support winter plan; both due to open w/c 2 November 2015

	The Trust's recruitment plan is having a positive impact on staffing levels and the Trust's fill rates with overall 98% for September 2015. The total number of RN vacancies across all grades in the Trust at September 2015 has reduced to 48.5 WTE (3.2%), of this there are 12.51 WTE (1.88%) residual vacancies at Band 5 level. Continued improvement in Registered Nurse sickness rate with September 2015 at 4.78% (compared to 5.43% September 2014).
Purpose of the Paper	Discussion
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment	No

Executive Summary

This report provides the Board of Directors with information on the details of the actual hours of Registered nurses/midwives and Clinical Support staff's time on ward day shifts and night shifts versus planned staffing levels for September 2015.

As a Trust there has been a systematic approach to staffing wards safely over the past three years; the total investment agreed by the Board of Directors commencing 2012/2013 has been circa £3.45M. This has supported the response to the guidance issued by the National Quality Board and by the National Institute for Health and Care Excellence (NICE 2014), embracing transparency about the planned versus actual staffing levels, and focusing on how to make services as safe as possible within available resources.

Further guidance circulated by Jane Cummings, Chief Nursing Officer, NHS England, in May 2014 clarified that the Board of Directors will be advised of those wards where staffing capacity and capability materially falls short of the plan, the reasons for the gap, the impact and actions being taken to address it. This can be presented as an exception report, providing the Trust website publishes ward by ward data on actual versus planned numbers of staff by registered nurse / midwife / care staff and day duty / night duty. These data are presented in this paper.

All NHS Foundation Trusts have received joint communication from TDA; Monitor; NHS England; Care Quality Commission (CQC) and NICE (13 October 2015); describing how the current staffing guidance has been designed to support decision makers at the ward level and at the Board to get the best possible outcomes for patients within available resources. This guidance supports but does not replace the judgements made by experienced professionals at the frontline. The guidance sets out the responsibility of the Providers to demonstrate that they are able to ensure safe, quality care for patients and that they are making the best use of resources. This should take account of patient acuity and dependency, as well as innovative approaches, e.g. the guidance supports the inclusion of Allied Health Professionals being included in the ward based teams. It is therefore important to look at staffing in a flexible way which is focused on the quality of care, patient safety and efficiency rather than just numbers and ratios of staff. The guidance stresses that the 1:8 ratio is a guide and not a requirement.

This paper presents updated information for September 2015 on the Trust recruitment strategy, vacancies and details of the Registered Nurse, Midwifery and Clinical Support Workers (CSW) staffing, including the fill rate.

Recruitment Strategy

The recruitment and retention strategy within the Trust is continuing to report a positive position. During September 2015, the Trust successfully appointed 13 Registered Nurses (RN) at the monthly corporate recruitment event. In September the divisional recruitment leads have been to Poland and recruited 9 Registered Nurses; 1 RN has already commenced employment and the remaining RNs nurses will commence 2nd November. Further overseas recruitment has resulted in a further 24 RNs being recruited from Spain and Portugal and who will be available from 23rd November onwards.

The divisions have supported this strategy further by releasing a RN currently on restricted duties to join workforce team for 2 days per week. This nurse will further support recruitment, preceptorship, welcome to Wirral for overseas nurses, compliance with ESR data and review of all RN exit interviews. The majority of the 38 newly appointed graduate RNs commencing in September 2015 have now registered with the NMC and have commenced preceptorship. The electronic staff record (ESR) report demonstrated that at the end of September 2015 the total number of RN vacancies across all grades in the Trust 48.5 WTE (3.2%), of this there are 12.51 WTE (1.88%) residual vacancies at Band 5 on inpatient wards.

Ward 25 and ward 27 are also 90% recruited to in preparation for their opening in November 2015. The next corporate recruitment event is 28th October 2015 and will continue each month.

Monthly Safe Staffing Report

Following the publication of the Francis report in February 2013, the Government made a number of commitments in 'Hard Truths: The Journey to Putting Patients First' to make this information more publically available. This report forms part of the Trust's obligation to publish staffing levels on hospital wards. The new style format to present our data was introduced as a means of triangulating the average staff fill rates with key quality indicators and information around sickness at ward level.

The report (appendix 1) shows the actual hours of nursing cover (both Registered Nurse and Care Support Worker) compared to the expected hours for both day and night shifts. It also presents data per ward on the number of falls (moderate and above); the number of patients with a hospital acquired pressure ulcer; the number of patients confirmed as Clostridium Difficile positive, MRSA positive, of which both are reportable to Public Health England. The final part of the report presents data on the sickness levels per ward. 'Red flag' alerts are being recorded at ward level from June 2015 as per Nurse Staffing Escalation Guidance.

There is currently no national standardised compliance target for the staffing fill rate figure. However, the Trust has benchmarked against Salford NHS Foundation Trust, Tameside Hospital NHS Foundation Trust, Sheffield Teaching Hospital NHS Foundation Trust and Countess of Chester NHS Foundation Trust and as result of this benchmarking the following parameters have been adopted for nurse staffing fill rate:

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

These parameters provide information for the Board of Directors on how the Trust is progressing towards safe staffing. The overall fill rate for September 2015 is reported as 98%, a further improvement on the previous two months of 96% fill rate. The table below shows compliance for fill rate for both RN and CSW shifts, both for day and night shifts for the month of September 2015.

Day Shift	Green	Amber	Red
Number of wards compliant with RN fill rate	30	5	0
Number of wards compliant with CSW fill rate	32	2	0
Night Shift			
Number of wards compliant with RN fill rate	30	5	0
Number of wards compliant with CSW fill rate	28	3	0

For the 35 clinical inpatient areas, the optimal number of hours of nursing or midwifery staff time required for day shifts and night shifts has been calculated for the month and the actual fill rate has been recorded. Overall the actual fill rate for in-patient areas has improved with the following to report:

Day shift
RN shifts 10 clinical inpatient areas reported a 100% compliance with RN fill rate
CSW shifts 11 clinical inpatient areas reported a 100% compliance with CSW fill rate

Of the remaining areas:
The lowest fill rate for RN reported was 93.3% for ward 26 (Medicine)
The lowest fill rate for CSW reported was 88.7% for ward 54 (Gynaecology)

Night shift
RN shifts 10 clinical inpatient areas reported a 100% compliance with RN fill rate
CSW shifts 18 clinical inpatient areas reported a 100% compliance with CSW fill rate

Of the remaining areas:
The lowest fill rate for RN reported was 87.1% for ward 53 (Maternity)
The lowest fill rate for CSW reported was 87.1% for ward 53 (Maternity)

The E-roster successfully transferred over to version 10 on 3 June 2015 which will now enable a more effective and efficient rostering of ward nursing staff, as well as the electronic recording of staffing data and the provision to produce good quality reports. The Trust realises that whilst E Roster has become a very valuable tool for planning staffing, it has not been well used to date to record actual staffing levels after mitigation (Bank, overtime, agency and staff flexibility). A team has been established to support the Associate Directors of Nursing to optimise the E Roster functionalities.

Staffing Escalation Guide

The Staffing Escalation Guide was reviewed in July 2015, building on existing practice, which details how to address any shortfalls in staffing, for example because of unexpected absence. Every ward and department across all our sites must have a nurse or midwife identified as 'in charge' at all times. Each group of wards or departments is overseen by a senior nurse or midwife bleep holder to whom the nurse or midwife in charge can escalate

concerns and problems. They are supported by their own nursing/midwifery team in hours and out of hours, by a Duty Matron until 20.00hrs Monday to Friday and until 16.00 hours on Saturdays and Sundays, thereafter, the Hospital Co-ordinator picks up the role. The Duty Matron oversees the whole hospital across both sites and if he/she is unable to solve a problem, it is escalated to the Manager on call and in turn, the Trust Executive on call. Ultimately, if a significant nursing/midwifery problem remains unresolved, the Chief Nurse would be contacted.

Data Quality

In order to submit the information in a timely manner, the data are extracted from the daily staffing review meetings. However, the Trust E-rostering system should have this functionality and this is being explored with Allocate alongside training requirements. The Trust goes live with NHS Professionals system as a provider of temporary staff on 2nd November 2015. Currently there is no interface between these two systems but work has commenced to resolve this issue with a recommendation that a series of audits and checks will be run to confirm that the data submitted is accurate. Wards that are triggering on the safe staffing data over a period of time are monitored and reviewed by the Senior Nursing team, with a report provided for the monthly Divisional Performance reviews.

New Rules on Nursing Agency Expenditure

Each Trust will receive its annual ceilings for October 2015 to March 2016, and for 2016/17 to 2018/19 on 1 September 2015. Once a Trust has received this information it should provide a monthly profile of the planned nursing agency spend that enables it to achieve its ceiling for October 2015 to March 2016. The ceiling trajectory for this Trust is Band A, under 3% of total nurse spend. The information required by Monitor was submitted by the deadline of 14 September 2015. The performance on agency expenditure is already being monitored as part of the Cost Improvement Programme.

NMC Revalidation

All Registered nurses and midwives will be required to revalidate from April 2016. Revalidation has replaced the old PREP system as this failed to ensure all nurses and midwives kept their knowledge up to date, received regular feedback and reflected upon their actions.

All Nurses and Midwives are being encouraged to begin updating their portfolios to comply with the new NMC Revalidation process that will commence from April 2016. Support is being provided from the Trust library service and clinical skills centre. The Trust has benchmarked revalidation dates and is aware the following number of registrants will be required to revalidate each month during Quarter 1 2016/17:

Trust wide	April 2016	May 2016	June 2016
NMC registrants revalidation date	27	42	31

NMC Revalidation has been risk assessed and added to Trust Risk Register (initial score 12 reduced to 8 following mitigation).

Next steps

- Explore further the use of AHP within the ward team staffing levels.
- Review staffing levels at ward level taking into account acuity and dependency, as well as local factors e.g. ward layout.
- Continue with the programme of Monthly Trust wide recruitment for Registered Nurses, including overseas recruitment.
- Continue to update the Board of Directors on a monthly basis.
- Continue to focus on the management of long and short term sickness
- Provide training for the E-Roster leads to ensure that the Trust maximises the functionalities of the system
- Establish a mechanism to assure data quality for nurse staffing
- Undertake the planned audit of revalidation readiness during Quarter 3 for those nurses and midwives due to re-register in Quarter 1 of 2016/17.

5. Conclusion

The impact of the recruitment strategy is being realised in September 2015 and data has been presented to demonstrate this. There is evidence to support improvement in the number of nurse vacancies, nurse and midwifery attendance, in-patient and staff Friends and Family scores and the overall Trust nurse staffing fill rates. All mitigating actions are in place to ensure that safe and appropriate nurse staffing levels are in place.

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

6. Recommendations

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

Wirral University Teaching Hospital NHS
NHS Foundation Trust

#PROUD TO CARE FOR YOU

Monthly Safe Staffing Report - September 2015

			RNs				CSW's				RNs				CSW's				Quality indicators						
			Days								Nights														
Specialty	Ward	Beds	Total monthly planned staff hours	Total monthly actual staff hours	Variance	% RN	Total monthly planned staff hours	Total monthly actual staff hours	Variance	% CSW	Total monthly planned staff hours	Total monthly actual staff hours	Variance	% RN	Total monthly planned staff hours	Total monthly actual staff hours	Variance	% CSW	Falls (moderate and above)	Pressure ulcers (Grade 2 and above)	Cdiff (Reportable to PHE)	MRSA (Reportable to PHE)	Sickness & Absence	RN Vacancies (WTE)	CSW Vacancies (WTE)
Orthopaedics	10	28	1725	1645.75	**79.25**	95.4%	1230	1188.25	**41.75**	96.6%	1080	1068.7	**11.3**	99.0%	690	678	**12**	98.3%	0	0	0	0	6.42	6	4
Orthopaedics	11	25	1725	1712.5	**12.5**	99.3%	1230	1193.5	**36.5**	97.0%	1080	1068	**12**	98.9%	690	690	**0**	100.0%	1	4	0	0	1.96	2	5
Orthopaedics	12	16	1173	1125	**48**	95.9%	1035	997.5	**37.5**	96.4%	690	678.7	**11.3**	98.4%	345	309.7	**35.3**	89.8%	0	0	0	0	3.91	0	0
DME	16 / OPAU	23	2342.5	2295.5	**47**	98.0%	1550	1484.5	**65.5**	95.8%	1069.5	1046.5	**23**	97.8%	713	690	**23**	96.8%	1	0	0	0	1.75	4	0
Colorectal	17	30	1875	1787.5	**87.5**	95.3%	1230	1186.2	**43.8**	96.4%	1080	1013	**67**	93.8%	690	644	**46**	93.3%	0	1	1	0	2.62	4	2
General Surgery	18	29	1725	1662.5	**62.5**	96.4%	1230	1230	**0**	100.0%	1230	1219	**11**	99.1%	690	684.8	**5.2**	99.2%	0	1	0	0	2.66	2	1
Urology	20	30	1725	1663.45	**61.55**	96.4%	1263.25	1245	**18.25**	98.6%	1230	1194.15	**35.85**	97.1%	690	679	**11**	98.4%	0	0	0	0	5.59	4	3
DME	21	31	1572	1553.35	**18.65**	98.8%	1530	1518.5	**11.5**	99.2%	1215	1148.1	**66.9**	94.5%	1035	1035	**0**	100.0%	0	0	0	0	5.1	3	0
DME	22	30	1722.5	1693	**29.5**	98.3%	1356.25	1350	**6.25**	99.5%	1263.25	1252	**11.25**	99.1%	713	713	**0**	100.0%	1	0	0	0	3.89	1	0
Stroke	23	26	2110	2010.75	**99.25**	95.3%	1162.5	1162.5	**0**	100.0%	1069.5	1035	**34.5**	96.8%	713	713	**0**	100.0%	0	0	0	0	1.06	3	0
DME	24 & Isolation	38	2098.52	2003.72	**94.8**	95.5%	1619.73	1586.93	**32.8**	98.0%	1426	1403	**23**	98.4%	1426	1390.5	**35.5**	97.5%	0	0	0	0	2.76	2	0
General Medicine	26	29	2110	1969.35	**140.65**	93.3%	1937.5	1796.85	**140.65**	92.7%	1069.5	1058	**11.5**	98.9%	1069.5	1058	**11.5**	98.9%	0	0	0	0	0	3	0
Haematology	30	22	1722.5	1692.5	**30**	98.3%	1162.5	1109.25	**53.25**	95.4%	906.75	849.75	**57**	93.7%	1069.5	1081.5	**-12**	101.1%	0	2	0	0	0	2	0
Cardiology	32 & CCU	31	3078.75	2896	**182.75**	94.1%	1550	1490.9	**59.1**	96.2%	1426	1414	**12**	99.2%	1069.5	1057.5	**12**	98.9%	0	0	0	0	3.36	3	0
Cardiology	33 & HAC	29	1722.5	1716.25	**6.25**	99.6%	1162.5	1151	**11.5**	99.0%	1069.5	1057.5	**12**	98.9%	1069.5	1057.5	**12**	98.9%	0	1	0	0	1.48	6	0
Gastro	36	32	2253.75	2182.15	**71.6**	96.8%	1550	1526	**24**	98.5%	1069.5	1039.7	**29.8**	97.2%	1069.5	1069.5	**0**	100.0%	0	3	0	0	3.35	3	0
Respiratory	38/37	45	2497.5	2467.25	**30.25**	98.8%	1743.75	1697.75	**46**	97.4%	1426	1414.5	**11.5**	99.2%	1069.5	1069.5	**0**	100.0%	0	5	0	0	0	6	0
Maternity	53	38	1598.5	1575	**23.5**	98.5%	744	719.5	**24.5**	96.7%	1426	1242	**184**	87.1%	356.5	310.5	**46**	87.1%	0	0	0	0	10.06	0	0
Gynaecology	54	16	885.5	832	**53.5**	94.0%	713	632.5	**80.5**	88.7%	713	667	**46**	93.5%	0	0	**0**	-	0	0	0	0	5.98	0	0
General Medicine	AMU	24	1955	1854.25	**100.75**	94.8%	1426	1383.9	**42.1**	97.0%	1069.5	1063.2	**6.3**	99.4%	1069.5	1057.5	**12**	98.9%	0	0	0	0	2.74	2	0
General Medicine	MSSW	21	2311.5	2146.5	**165**	92.9%	1782.5	1746	**36.5**	98.0%	1635.25	1582.7	**52.55**	96.8%	1635.25	1635.25	**0**	100.0%	1	0	0	0	2.74	2	0
Emergency	EDRU	10	885.5	885.5	**0**	100.0%	356.5	356.5	**0**	100.0%	550.25	550.25	**0**	100.0%	356.5	356.5	**0**	100.0%	0	0	0	0	8.68	0	0
	Parksuite	8	840	840	**0**	100.0%	345	332.5	**12.5**	96.4%	690	690	**0**	100.0%	0	0	**0**	-	0	0	0	0	5.4	0	0
Surgical Assessment	ESAU	12	1185	1172.5	**12.5**	98.9%	690	671.25	**18.75**	97.3%	1035	988	**47**	95.5%	690	690	**0**	100.0%	0	0	0	0	3.1	5	0
Critical Care	ITU	11	4822.5	4822.5	**0**	100.0%	212.5	212.5	**0**	100.0%	4278	4278	**0**	100.0%	0	0	**0**	-	0	1	1	0	2.29	3	0
Critical Care	HDU	6	1722.5	1722.5	**0**	100.0%	387.5	387.5	**0**	100.0%	1426	1426	**0**	100.0%	356.5	356.5	**0**	100.0%	0	0	0	0	2.29	3	0
Maternity	Delivery Suite	10	3381	3363	**18**	99.5%	690	690	**0**	100.0%	3208.5	3079.5	**34.5**	96.0%	690	690	**0**	100.0%	0	0	0	0	2.83	0	0
Neo Natal	Neonatal	24	3381	3287	**94**	97.2%	0	0	**0**	-	3208.5	3174	**34.5**	98.9%	0	0	**0**	-	0	0	0	0	4.92	0	0
Children's	Children's	27	2186	2162	**24**	98.9%	356.5	356.5	**0**	100.0%	1782.5	1735	**47.5**	97.3%	356.5	356.5	**0**	100.0%	0	0	0	0	7.51	2	0
Orthopaedics	M1	20	1530	1530	**0**	100.0%	1035	1035	**0**	100.0%	690	690	**0**	100.0%	345	345	**0**	100.0%	0	0	0	0	1.11	1	2
General Surgery	M2	26	345	345	**0**	100.0%	345	345	**0**	100.0%	138	138	**0**	100.0%	138	138	**0**	100.0%	0	0	0	0	0	0	0
DME	CRC	20	1328.75	1328.75	**0**	100.0%	1550	1537.5	**12.5**	99.2%	713	713	**0**	100.0%	906.75	900.75	**6**	99.3%	0	0	0	0	1.99	2	0
Neuro & Rehabilitation	Ward 36 CBH	20	1335	1335	**0**	100.0%	968.75	968.75	**0**	100.0%	713	713	**0**	100.0%	356.5	356.5	**0**	100.0%	0	0	1	0	6.02	2	0
Dermatology	Dermatology	12	602.25	602.25	**0**	100.0%	143.75	143.75	**0**	100.0%	264.5	264.5	**0**	100.0%	264.5	264.5	**0**	100.0%	0	0	0	0	2.22	0	0
Geriatric Medicine	14	30	750	750	**0**	100.0%	750	750	**0**	100.0%	690	690	**0**	100.0%	690	690	**0**	100.0%	0	1	0	0	/	6	0
Totals		829	64223.52	62630.27	1593.25		36038.98	35183.28	855.7		43631.5	42643.75	893.25		23023.5	22768	255.5								

Overall Staffing Hour totals (Rounded to the nearest hour)	Total Planned Hours	166918	Total Actual Hours		163225	Varaiance	3693	Fill Rate		98%

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

BOARD OF DIRECTORS	
Agenda Item	9.1
Title of Report	Monitor Quarterly Return – Q2 2015/16
Date of Meeting	28 October 2015
Author	Shahida Mohammed, Assistant Director of Finance – Income & Commissioning John Halliday, Assistant Director of Information
Accountable Executive	David Allison, Chief Executive Sharon Gilligan, Director of Operations
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	7
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Approval
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

Quarter 2 2015/16 Financial Commentary for Monitor

The following commentary covers the key reasons for the Quarter 2 variations against the 2015/16 plan.

The financial position of the Trust shows a year to date deficit of £8.173m against the planned deficit of £7.928m, therefore an adverse variance of £0.244m.

NHS Clinical Revenue

At Quarter 2 income levels are currently £2.1m behind plan.

Key variances to Quarter 2 are as follows:

Point of Delivery	Variance in Q2	Cumulative variance to plan £m	Commentary
Elective	(0.6)	(1.4)	Cumulatively the variance is driven by an underperformance in Surgical, Women's and Children specialties of (£1.4m), mainly in Trauma & Orthopedic. This has been off set slightly by additional North Wales activity £0.2m secured during 2014/15 to support achieve Welsh access targets. Referrals had been made during March 2014, and procedures were undertaken during May 2015. During the quarter the variance in elective activity can be attributed entirely to Surgery, Women's & Childrens. Trauma and Orthopedic deteriorated by (£0.3m), Colorectal (£0.2m), and Breast Surgery (£0.1m), other small movements across a number of areas (£0.1m), offset by North Wales activity of £0.1m.
Non elective	(0.4)	(0.5)	The year to date position predominantly relates to the Medicine and Acute Division showing a deficit of (£0.4m), this reflects actual volumes of activity underperforming by approximately 900 spells particularly in Diabetic, Gastro, Cardiology and Respiratory Medicine. This is financial supported by a more complex case mix of patients, which in turn has seen excess bed days over perform significantly. Surgery and Women and Children's Division is showing a break-even position. Within this however it has to be noted there is a significant under performance in Colorectal surgery, which is offset by over performances in Trauma & Orthopedics, Upper GI and Urology from an activity perspective. This is partially mitigated by a reduction in casemix complexity. Approximately (£0.1m), relates to penalties applied for activity exceeding the NEL threshold. The movement in the quarter is driven by the underperformance in Medicine in the areas highlighted above (£0.5m), offset by improvements in Obstetrics £0.1m.
Day Case	(0.5)	(1.0)	On a cumulative basis Medicine and Acute Division are showing an under recovery of (£0.1m) this includes an over performance in Gastroenterology which has been offset by the underperformance on Cardiology. Surgery Women's & Children's are underperforming by (£0.9m), (£0.5m) relates to Trauma & Orthopedics, Ophthalmology (£0.2m), Upper GI (£0.1m), Oral

			Surgery (£0.1m) and ENT (£0.1m). The underperformances are due to volume and casemix. The position was been supported by additional North Wales activity of £0.2m, seen during the early part of the year. This relates to patients referred during 14/15; however the procedures were undertaken in 15/16 as per the agreement with North Wales. During the quarter Surgery, Women's & Children's under performed by (£0.4m), primarily in T&O and Upper GI. Medicine under recovered by (£0.1m), mainly in Cardiology.
Outpatients	(0.4)	(0.8)	Cumulatively outpatient procedures under performed by (£0.1m), mainly relating to ENT. Outpatient first attendances are under performing by (£0.2m) relating to Trauma & Orthopedics, Pain Management and Gynecology. Outpatient follow-up attendances are also below plan across a number of specialties with a total value of (£0.5m). Included within this position is a penalty of (£0.2m) for outpatient follow up caps as imposed by the CCG. During the quarter performance in outpatient procedures remained static, however both outpatient first and follow up attendances under recovered by £0.2m respectively. This relates entirely to Surgery, Women's & Children's in the same areas noted above.
A&E	-	-	The YTD activity is achieving plan, this position has been supported by more complex patients attracting a higher tariff. However this has been offset by the Ambulance breech penalty. Although the income position for the quarter is shown as break even, actual activity under taken has improved significantly.
Other – tariff	0.1	0.3	The year to date over recovery reflects over performances in both Maternity antenatal pathways £0.2m, and Diagnostics £0.1m. The quarterly positive movement reflects the over performance in Diagnostics.
Other non tariff	1.0	1.3	The year to date position reflects over and under performances in a number of Non PbR areas, in particular DA Pathology £0.1m, Rehabilitation (Elderly and Stroke) £0.3m, Renal. £0.1m and Optometry £0.1m over performed. Income recovered from high cost drug "pass through" payments is below plan by (£0.4m). This is mitigated within the cost of drugs in the expenditure position. £0.6m relates to the release of provisions made in 2014/15 for specific items which had been queried by Commissioners and payment was not certain. The position also includes the release of £0.5m from the income performance reserve as planned. The quarterly movement largely reflects small adverse movements across a number of non PbR elements, offset by the release of the performance reserve.
Total	**(0.9)**	**(2.1)**	

The above figures includes a £0.5m gross favorable variance on Income Generation schemes, after delivery costs are deducted the net benefit is £0.2m.

Contractual Status

The Trust agreed and signed its contract with the host Commissioner Wirral CCG (responsible for commissioning approximately 80% of the Trusts clinical income), on 4th September 2015. The contract with NHSE, the second largest commissioner, has been completed. Monthly contract monitoring meetings with the host Commissioner and bi-monthly meeting with NHSE are scheduled.

CQUIN targets for 15/16 have been agreed and the Trust is working towards delivery. The Trust is confident we will achieve Quarter 2, with some re-negotiation on milestones and actual delivery dates due to late contract sign-off.

Other Income and Operating Expenditure

Costs and other income continue to be well controlled and at the end of quarter 2 have a positive £1.6m variance against planned levels with a further £0.4m saving in the quarter.

The key elements are:

Reason for variance	Variance in Q2 £m	Cumulative variance to plan £m	Commentary
CIP delivery	(0.3)	(0.7)	There has been a cumulative shortfall against the CIP plan for divisional expenditure and income of (£0.7m) across most cost categories. This is largely due to the unplanned CIP balance. In the quarter the position has deteriorated by £0.3m. Work continues with the PMO to look for further opportunities to deliver the CIP target.
Emergency care	(0.2)	(0.3)	The Trust has a cumulative overspend in emergency care of (£0.3m), of which (£0.1m) has arisen in month. This is due to operational pressures arising due to medical staff vacancies and ensuring urgent care access levels are maintained in the Emergency Department. The Trust has overspent in emergency care of (£0.2m) in the quarter, reflecting the issues stated above.
Unplanned beds / capacity	(0.3)	(1.0)	The year to date position largely reflects costs associated with dealing with infection control issues and extended LOS impact. In the quarter there has been a further deterioration of (£0.3m). A new infection control isolation unit is to open in November to improve the operational management of infection control and the opening of unplanned capacity.
Premium costs	(0.6)	(1.1)	Cumulatively the variance is due to activity incurred at premium prices by agency staff/providers covering critical medical staff gaps to deliver activity, costs associated with supporting patient flow, and maintaining improved urgent care access levels. Premium costs have increased (£0.6m) in the quarter. This includes costs for work outsourced to an external provider to deliver planned activity.
Additional activity	(0.1)	(0.1)	Cumulatively the variance is due to costs incurred to deliver additional diagnostic activity, largely direct access and is offset by additional income.
Non PBR offset	(0.2)	0.1	There is a (£0.2m) overspend in the quarter, decreasing

			the cumulative underspend to £0.1m on pass through costs which are offset by a corresponding under-recovery in non PbR income. (E.g. High Cost Drugs, Bloods and device exclusions).
Other	0.5	1.2	£0.5m underspend in the quarter The cumulative underspend is largely due to current vacancy levels. Qualified nurse recruitment is well underway to substantively recruit to all gaps. There is also an active recruitment plan to fill therapy staff vacancies.
Reserve release	1.6	3.5	In quarter 2 the Trust released £1.6m of reserves and cumulatively a total of £3.5m of planned reserves and exceptional release of accruals.
Total	**0.4**	**1.6**	

Work of the Turnaround Director and PMO Team

The CIP work streams for 2015/16 were identified earlier in the planning cycle. Detailed comprehensive plans to support each workstream have been developed, outlining all savings opportunities, including current plans and additional opportunities. Dedicated project managers are in post for the larger, more transformational projects. Regular meetings are held by the Turnaround Director and PMO team with all workstreams to monitor KPIs, milestones and progress against plans.

The PMO team has also been strengthened and now has a sole focus on governance and assurance, with the delivery aspects of project management separated out to the workstream leads. The team is now in place with an interim resource temporarily covering the Head of PMO role prior to the start of the new appointee.

Achievement of the 2015/16 Cost Improvement Programme

£13.0m of CIP was extracted from the budget at the start of the year. Identified CIP plans of £11.1m were extracted according to the profile of the schemes identified, with the balance extracted in a flat profile (12 ths). At the time of the plan the balance was £2m so under £0.2m was unidentified each month.

The year to date plan assumed c. £4.1m CIP would be realised, the actual amount delivered is c. £3.7m, an under achievement of some £0.4m.

The CIP position at Quarter 2 (including non recurrent schemes) can be summarised as follows:

	BY SCHEME TYPE		**BY COST**		**TOTAL**
	Income Generation (net of cost of delivery) £m	**CIP (including non-recurrent) £m**	**NHS Clinical Income £m**	**Divisional Budgets £m**	**£m**
Year to date Budget (including unidentified at time of plan)	1.79	2.36	2.13	2.02	**4.15**
Year to date Actual	2.26	1.47	2.37	1.36	**3.73**
Year to date Variance	0.47	(0.89)	0.24	(0.66)	**(0.42)**

The full year and recurrent Income Generation / CIP values, based upon the latest forecast at Quarter 2, are as follows:

	Income Generation (net of cost of delivery) £m	CIP (including non-recurrent) £m	TOTAL
Full Year Value			
At time of annual plan	6.7m	4.3m	**11.1m**
At Q2	5.2m	4.6m	**9.8m**
Recurrent Value			
At time of annual plan	10.4m	6.1m	**16.4m**
At Q2	6.0m	5.8m	**11.8m**

The main areas contributing to the underperformance are Coding, Theatre Productivity and Patient Flow Workstreams. Initial assumptions regarding reduced length of stay, increased complexity and coding related improvements have not materialised to the extent originally anticipated.

Although the in year shortfall has increased, recurrently the schemes are expected to deliver just under £12m against a plan of £16.4m. The Trust is mindful of the pressure this places on plans going into 2016/17, and is currently taking action to address the shortfall.

The PMO are working closely with Divisions and workstreams to quantify any residual risk against plans whilst at the same time seeking opportunities to both fill the original gap and mitigate the shortfall.

The Trust has a full year CIP mitigation reserve of £1.5m to mitigate against in year slippage.

EBITDA

The under performance in NHS Clinical Income (£1.0m), is partly offset by the favourable variance of £0.5m in operational expenditure. The combined EBITDA position is an over spend of (£0.5m).

Post EBITDA Items

There is a minor favourable variance to the post EBITDA budget at Quarter 2 of £0.2 m due to reduced depreciation charges compared to the original plan.

Full Year 2015/16 Outturn and distressed funding

The Trust anticipates generating a full year outturn deficit at planned levels of £13.5m, with a forecast delivery of Continuity of Services rating of 2 based on Monitors revised metrics.

The Trust has been continually reviewing its working capital requirements, and the need for distressed funding of £4.8m as identified during the planning process.

The current short term cash forecast has identified that no distressed funding will be required in December 2015. This is a result of increased cash preservation activities that have taken place within the Trust and advance contractual payments being agreed with the main commissioner. The agreement of early contractual payments will move any distressed funding requirement to March 2016.

Statement of Position (Balance Sheet)
The actual Total Assets Employed and Total Taxpayers Equity equal £141.0m.

The main variations against plan are as follows:

- Trade receivables across NHS and non NHS are £1.5m below plan. This is largely due to underperformance against the income plan; this has been partially offset by early payments of certain key debtors.

- Trade creditors are slightly behind plan, this relates to two issues, the agreement and subsequent settlement of significant outstanding charges, offset by commissioning repayments required for both 2014/15 and 2015/16 underperformance.

- Accruals are significantly above plan by £4.0m due to delays in the receipt of key charges; the largest being those for Cerner and total agency/locum spend.

- Deferred income is above plan by £2.5m, largely due to early payment from a Commissioner, in addition to a range of smaller income balances being received earlier than had been planned.

- Capital spend (on accruals basis) to month 6 was £3.9m against a plan of £3.5m. This variance of £0.4m relates to ward improvement scheme variances of £0.3m due to early progression of refurbishment and Isolation Ward works, IT spend is ahead of plan by £0.1m due to early delivery of equipment, and other minor schemes ahead of plan by £0.1m. Partly offset by slippage on Cerner of £0.1m. The capital programme is expected to remain within plan in year.

- The cash balance at the end of month 6 was £13.2m, some £6.9m above the planned £6.3m. This is predominantly due to the working capital position noted above.

Continuity of Service Rating (COS) & Certification
The Trust has achieved a COS rating of 2 against a planned rating of 2.

Although the Trust has achieved against the planned metrics for, Capital Servicing Capacity (CSC), Underlying performance and Variance from plan. The liquidity ratio has deteriorated slightly, reflecting under recovery of NHS clinical income.

The Trust has submitted an operational plan showing a deficit for 2015/16, the forecast COS rating based on Monitors revised metrics is 2. Therefore the Board cannot confirm the financial governance statement that “The Board anticipates that the Trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months”.

Validation Errors
All “validation errors” identified on the template have been reconciled and explained on the excel template.

Executive Team membership

There has been one change to the Executive Team membership during Qtr. 2, Anthony Hassall – Director of Strategic & Organisational Development left the Trust on 31st July 2015. He has been replaced by Dr Mike Coupe who commenced as Director of Strategy on the 7th September 2015, however this is not an Executive Director position.

3. CONCLUSION

The Trust overall year to date financial position is marginally off plan, reflecting the under performance in NHS clinical income, offset by underspends in both pay and non-pay items. It is recognised that the adverse income variance to date is not sustainable, as a result the Surgery Division have constructed a recovery plan which includes capacity and demand modeling to manage and inform activity projections going forward. The Executive Team is working closely with the Division to ensure remedial action plans are operationalized.

The CIP programme is monitored and scrutinised on a weekly basis, to flush-out risk and ensure pace is maintained. Plans to fill the in-year shortfall are due to be presented to the Executive Team in October 2015.

The Trust is forecasting to deliver the planned deficit and as a result of obtaining advance contractual payments from the main commissioners will move any distressed funding requirement to March 2016.

Gareth Lawrence
Deputy Director of Finance
October 2015

Board of Directors	
Agenda Item	9.2
Title of Report	Report of the Finance Business Performance & Assurance Committee 25 September 2015
Date of Meeting	28 October 2015
Author	Andrea Hodgson, Acting Chair of Finance Business Performance and Assurance Committee
Accountable Executive	David Allison, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	5A, Risk 2718, 6B, 7B, Risk 1927 and 2550, 7C Risk 2328, 7D, Risk 2689
Level of Assurance • **Positive** • **Gap(s)**	Gaps with mitigating actions
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

Matters arising

The Chief Executive updated the Committee on the appointment of an interim experienced Director of Finance, Mr Andrew Morris, on a part time basis to support the Deputy Director of Finance who had now been confirmed as the interim acting Director of Finance until the substantive position was appointed to.

M6 Financial Position

The Committee reviewed in detail the cumulative deficit position at M6 which was reported as £8.2M this being a £0.244m adverse variance to the plan of £7.928m. The Committee noted that the Trust was continuing to forecast achievement of the full year plan although it was recognised that the second half of the year would be challenging with delivery of two thirds of the CIP over the autumn and winter months. The under performance in Payment

by Results PBR clinical income was highlighted as a concern which despite some areas in non-PBR offsetting this was still £2M off plan.

The cash position was reported at £6.9M above plan. The early payment of the CCG contract had enabled the Trust to push back the requirement for distressed funding. The overall CoS rating (on the new basis) was reported as 2 in line with plan,

The Committee was advised that the Capital Programme was £0.4m over plan, albeit still within the 15% Monitor tolerances, the over spend was attributed to acceleration of the infrastructure spends.

The Committee expressed concerns with the overspend in non-pay over a number of months and requested that a “deep dive” into this area in order to understand this much better.

The review of the Surgical Recovery plan concluded that activity in the period was tracking largely in line with the revised plan despite the risks associated with the consultant availability in some areas. Risks associated with the bed base going into winter had mitigating action plans in place.

The Committee requested that a review of the non-recurrent CIP balance for this year be undertaken in order to establish the impact on 2016/17.

The Committee was also advised that the work on length of stay was delivering the actions required however this was against a background of increased length of stay due to a change in the assessment process for discharge which equated to approx. 39 beds being consumed into the normal bed base. The plans agreed at the recent Systems Resilience Group to address this issue were outlined with further detail to be agreed a week on Monday by the Chair of that group.

The Committee reviewed the short term cash flow position before and after the agreement with the CCG to make the contract payment early. The forecast showed that as a result of the income prepayment, the Trust would not need distressed funding prior to December 2015 and the Committee concluded that it needed to have more information on the options available to further defer or mitigate the need for distressed funding before it was in a position to advise Monitor of its position beyond December.

Monitor Quarterly submission

The Committee requested the following areas be amended ahead of presentation to the Board on 28th October 2015:

- The commentary on elective performance was felt to be too optimistic without the context of the mitigating actions which had supported this.
- The position with regards to the Welsh work needs to take into account the work the Trust is no longer doing
- Amend the Board declarations to take into account the changes in the Risk Assessment Framework, the current picture in A & E and the trigger of a governance concern in reportable C difficile rates.
- Extrapolate the cash flow analysis post March 2016 to help inform the distressed funding requirement.

Progress Report on the Recovery Plan 2015-16

The Committee noted concerns with the in- month deterioration from M5 to M6 in terms of variance against plan at £4.6M for recurrent performance. This was attributed in the main to the £2M gap in CIP plans together with around £2M slippage in the workstreams of patient flow, coding and the hernia element of theatres offset in some cases by the identification of some new schemes. The allocations to corporate and clinical teams of £3.2M of further CIP targets would have been sufficient to close the gap at M5 with £400K contingency however this was no longer the case.

Further work to improve the position was highlighted as follows:

- Levers to constrain spending in certain areas being reviewed
- The procurement initiatives
- Coding remained at £2.5M against the original plan. Further work required
- The patient flow workstream was aimed at reducing length of stay by half a day and it had now increased by half a day. There has been a number of interventions by the operational team that have started to address the risk but the impact was not as yet evident
- Central constraints to be considered to mitigate risks

Cerner Contract

The Committee agreed to raise the concerns associated with this contract with the Board for discussion during the private part of its agenda.

Sector Performance Update

The Committee reviewed Monitor's Q1 financial performance data for the NHS Provider sector which was published on 9th October. The data showed that the sector was circa £1bn in deficit for the first quarter with 73 of 83 Acute Trusts reporting a deficit.

Performance Report

Key points from the performance report included:

- Achievement of all cancer targets.
- Achievement of all RTT targets. Main pressures were highlighted in the "other" category and in particular in pain management and community paediatrics. The Committee was advised of the recommendation from clinicians to close the list to new patients for community paediatrics as there was a risk to new patients who were not being seen for 47 weeks. Additional action taken by the Trust in this area included negotiations with the CCG on future funding to support the demand; the recruitment of a locum; the validation of the list and the movement of some acute paediatrics patient to the community. Monitor had been informed of the Trust's planned action to close the list and were supportive of this. The Committee was also advised on the legal implications of this action in terms of the contract with the CCG and the impact on the Trust's Provider licence.

The Committee requested an update at the Board meeting of the actions to ensure that the Trust did not breach RTT together with the impact that pain management and community paediatrics were having on the overall achievement of RTT.

The Committee supports the clinical recommendations in light of quality and patient safety. The Committee noted the discussions held with the CCG and Monitor to mitigate patient service and licence implications, and recommends the action to the Board.

The Committee was advised of the governance concern triggered by the number of avoidable cases of C difficile reported this quarter. The current position was outlined as 27 cases against an annual target of 29. The Committee agreed that a full route cause analysis would be required in order for the Trust to understand what had led to the current position together with a clear action plan that would manage the situation going forward.

The Committee was updated on the current position in A & E which was at 89.6% for the current quarter. The work to reduce the assessment process was highlighted with a further update due in the next couple of weeks. Further discussions at the Board were required in relation to consultant engagement.

Procurement Performance Framework

Following a review of the procurement performance framework the Committee requested the following actions be undertaken:

- The concerns with raising orders after the event to be escalated to the Audit Committee in order that this would be considered as part of the Audit Plan work
- Explanations of what is in and what is out of the procurement process be included in future progress reports in order that the Committee could assess the benefits and risks accordingly.
- The actions required to improve the metrics
- An update on the recruitment process in the team

Board Assurance Framework

The committee noted the plan to include a new risk in relation to the community paediatric contract and reviewed the gaps in assurance/control as part of the agenda programme.

The Committee agreed to escalate to the Board the themes and concerns emerging around consultant engagement together with the potential impact on the Trust's cash position should the CCG not be in a position to continue with the early payment of contracts into 16/17.

Reporting from Finance Management Group

The Committee agreed to review the terms of reference and work of the Finance Management Group in view of concerns raised previously associated with attendance, its remit and the process of escalation.

Andrea Hodgson
Acting Chair of Finance Business Performance and Assurance Committee

BOARD OF DIRECTORS	
Agenda Item	9.3
Title of Report	Research Annual Report 2014-15
Date of Meeting	28 October 2015
Author	Paula Brassey Research Manager
Accountable Executive	Dr Evan Moore Medical Director
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	**Strategic Objective** - To maximise innovation and enabling technologies. **Key Measure** - Participate in research and ensure patients are notified of opportunities to participate in suitable studies. **Principal risk -** There is a risk that participation in research reduces because of limited capacity. This will reduce research income and incur staffing cost pressures.
Level of Assurance **Positive** **Gap(s)**	Positive
Purpose of the Paper **Discussion** **Approval** **To Note**	To note
Data Quality Rating	Bronze
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken **Yes** **No**	N/A

1. **Executive Summary**
   The Research Annual Report provides information of the Trust's research activity and is being presented to provide information.

2. **Background**
   The Trust is a research active organisation and aims to increase and improve research activity by embedding research into everyday practice.

3. Key Issues/Gaps in Assurance

The report addresses national research targets and the Trust's ability to meet these targets; failure to meet targets may impact upon future research funding. During 2014/15 the Trust continued to exceed two national KPI's and improved significantly in another.

The report also highlights the increase in research funding awarded to the Trust.

4. Next Steps

To work towards continual improvement on national KPIs. To review our service, capacity and plan.

5. Conclusion

The report highlights the clinically diverse range of research undertaken within the Trust and the improvements made in overall targets and funding during the past 12 months.

6. Recommendations

To note the report.

Research Annual Report 2014/15

Paula Brassey, Research Manager

July 2015

Contents **Page**

Appendix

1. Introduction

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

The research core team consists of a Research Manager (1.0 WTE), Research Coordinator (0.4 WTE), Data Coordinator (1.0 WTE), 13 Research Nurses (9.0 WTE) and a Research Midwife (0.67 WTE). The majority of these posts are funded by National Institute of Health Research and some are partially funded from commercial research or the Trust.

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

2. Research Governance

The Research Department is responsible for ensuring all research within the Trust complies with the Research Governance Framework for Health and Social Care, 2005 and that all appropriate approvals are place prior to issuing NHS Permission (R&D Approval). It is the responsibility of each individual member of staff to ensure any research they wish to undertake has received NHS Permission from the Research Department.

Prior to granting NHS Permission the Research Department will ensure all external approvals have been gained (if applicable); these include Health Research Authority (HRA) ethical approval and Medicines and Healthcare Products Regulatory Agency (MHRA) approval.

It is a requirement that all staff involved in research must have up-to-date Good Clinical Practice (GCP) Training. GCP is the ethical and practical standard to which all clinical research is conducted.

3. National Institute of Health Research

The National Institute for Health Research (NIHR) is a national organisation funded through the Department of Health. The NIHR Clinical Research Network consists of 15 Clinical Research Networks, the local network is North West Coast Clinical Research Network (NWC CRN); this is hosted by The Royal Liverpool and Broadgreen University Hospitals

NHS Trust. The NWC CRN is responsible for ensuring the effective delivery of research in the Trusts, primary care organisations and other qualified NHS providers throughout the North West Coast area.

The majority of the research undertaken within the Trust has been adopted onto the NIHR portfolio of studies. During 2014/15 the Trust granted NHS permission (R&D approval) for 27 new NIHR adopted studies:

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

See appendix 1 for details of NIHR studies and appendix 2 for details of PIC studies granted NHS permission during 2014/15.

4. Targets

4.1 NIHR Recruitment

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

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

See appendix 3 for recruitment information by speciality. See appendix 4 for information of cancer patients diagnosed at this Trust and referred to specialist cancer centres for routine treatment who were subsequently recruited onto a study by the specialist cancer centre.

4.2 NIHR High Level Objectives

Every month the North West Coast Clinical Research Network (NWC CRN) forwards a Research Summary Report for each Trust within the Network. The Research Summary

Report provides information with regard to NIHR key performance indicators; details below for 2013/14 & 2014/15.

Target Information	Target	Trust Achieved 2013/14	Trust Achieved 2014/15
Recruitment Target: **2013/14** **2014/15**	 400 440	860	640
Proportion of active **commercial** studies recruiting to time and target (achieving or surpassing recruitment target during their planned recruitment period).	80%	88% N° of studies = 8 7 achieved target	67% N° of studies = 3 2 achieved target
Proportion of closed **commercial** studies recruiting to time and target (achieving or surpassing recruitment target during their planned recruitment period).	80%	67% N° of studies = 3 2 achieved target	60% N° of studies = 5 3 achieved target
Proportion of active **non-commercial** studies recruiting to time and target (achieving or surpassing recruitment target during their planned recruitment period).	80%	53% N° of studies = 34 18 achieved target	53% N° of studies = 34 18 achieved target
Proportion of closed **non-commercial** studies recruiting to time and target (achieving or surpassing recruitment target during their planned recruitment period).	80%	0% N° of studies = 6 0 achieved target	46% N° of studies = 13 6 achieved target
Proportion of local processes completed and NHS permission (R&D approval) issued.	80%	100% N° of studies = 21 21 achieved target.	96% N° of studies = 23 22 achieved target

2013/14 target = 30 days 2014/15 target = 15 days			
Proportion of all studies achieving NHS permission (R&D approval) to first patient recruited within 30 calendar days.	80%	43% N° of studies = 7 3 achieved target	47% N° of studies = 15 7 achieved target
Proportion of studies achieving SSIF to first patient visit within 70 days	80%	57% N° of studies = 7 4 achieved target	53% N° of studies = 15 8 achieved target

4.2.1 NIHR Target Summary

Whilst the Trust, along with many other Trusts in the NWC CRN, is not yet achieving all the NIHR High Level Objectives the Trust does continue to exceed its overall recruitment target and to grant NHS permission within the target of 15 days. A notable area of improvement for the Trust during 2014/15 was the number of non-commercial studies closing that achieved their recruitment target. The other targets have remained fairly static since 2013/14.

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

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

The NIHR CCF PID reports relate to clinical trials given NHS permission from 1 April 2014 onwards and to clinical trials only (therefore observational / data only / questionnaire studies are excluded). The report is for both NIHR adopted and non-NIHR adopted studies. The Trust has complied with the requirement for this information to be available on the Trust public web-site. During 2014/15 the Trust granted NHS permission for 17 new clinical trials.

The reports provide information on:

- The length taken to grant NHS permission.
- The length taken to recruit the first patient.

- The Trust's ability to deliver to time and target (i.e., did the Trust recruit the agreed number of patients in the agreed timescales).

4.3.1 The length taken to grant NHS permission

The benchmark is for 80% of studies to grant NHS permission within 15 days of a valid research application. The Trust achieved 94% (n=16).

4.3.2 The length taken to recruit the first patient

The benchmark is for 80% of studies to recruit the first patient within 70 days from receipt of valid research application. The Trust achieved 18% (n=3). The reason for not achieving this benchmark is included within the reports; brief information below:

5 x delays due to study sponsor issues
3 x no patients identified
3 x patients identified but declined to participate
1 x study opened in case there is a flu pandemic
1 x study opened as an extension to an earlier study. Only one patient eligible and patient must have completed earlier study before becoming eligible for this study.
1 x staff availability issues

4.3.3 Deliver to time and target

This benchmark relates to commercial studies only. The benchmark is for 80% of studies to recruit to time and target. Of the four commercial clinical trials approved during 2014/15 all are still open and recruiting therefore we are unable yet state if this target has been met.

4.3.4 NIHR CCF PID Target Summary

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

A more thorough feasibility assessment of new studies has been introduced and it is anticipated that the percentage of studies achieving targets will be increased A new Research SOP "Escalation process for studies not recruiting to time and target" was approved in April 2015; this will be monitored during 2015/16 to establish if targets have improved.

5. Non NIHR Research

In addition to NIHR portfolio research the Trust undertakes non-portfolio research; this is generally single site studies led by Trust consultants or Trust staff undertaking research

modules within masters or PhD qualifications. During 2014/15 the Trust granted NHS permission for 14 non-NIHR adopted studies.

See appendix 5 for full list of non NIHR studies.

6. Collaborative Working

6.1 Clatterbridge Cancer Centre

The Trust continues to work in conjunction with Clatterbridge Cancer Centre (CCC). Some of the studies opened at CCC require this Trust to undertake some research specific activities, e.g. Ophthalmology tests that CCC is not able to perform. During 2014/15 this Trust signed 6 new sub-contracts relating to this work.

6.2 Innovation

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

6.3 Research Passports

Under the NIHR Research Passport Scheme during 2014/15 the Trust issued 10 Letters of Access to allow researchers from other Trusts or universities to undertake research related activities within the Trust.

Research Passports are recommended by the Department of Health and were introduced to provide a process for handling HR arrangements for external researchers. The process, agreed with Trust HR, provides a streamlined approach for confirming details of the pre-engagement checks of each researcher (this includes Occupational Health Check, confirmation of Disclosure Barring Service [previously CRB] clearance, Trust Code of Confidentiality and basic mandatory training, if applicable).

6.4 Key-Service Support

One of the aims of the NIHR was to ensure that a broad-based infrastructure was in place to enable researcher's access to facilities and support services in order to be able to participate in studies. The Trust receives funding to support the Pharmacy, Pathology and Radiology

Departments to cover costs for any research related activity for NIHR adopted studies. (Also see Finance 7.1 below).

6.4.1 Pharmacy

The Trust pharmacy department continues to support clinical trials involving Investigational Medicinal Products (IMPs) and provides a dispensing and aseptic preparation service for IMPs. During 2014/2015 eight trials involving IMP were opened and five closed down. At the end of March 2015 there were 27 active trials involving IMPs. Pharmacy has continued to manage IMP stock at ward level for two trials. This involved supervising the correct storage and temperature monitoring of the IMP.

WUTH were approached by Cheshire & Wirral Partnership in December 2014 to provide pharmacy services for a trial due to the Royal Liverpool Hospital being unable to do so. A Service Level Agreement has been developed and the trial is about to start.

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

Training of new pharmacy staff in clinical trials has continued. Additional training has also been provided to pharmacy aseptic staff.

6.4.2 Pathology

The Pathology Department supports research within the Trust by providing a wide-range of clinical services, including histopathology, cytology, blood sciences and microbiology. During 2014/15 six of the studies granted Trust NHS permission (R&D approval) also required pathology approval. In addition to undertaking research related activity for the Trust, the Pathology Department also provides a service to Clatterbridge Cancer Centre for some of their research related activity.

6.4.3 Radiology

The Radiology Department supports research within the Trust by offering a full range of imaging including MRI, CT and plain films. For some studies the department provides investigations for outside review; other studies rely on diagnosis and interpretation by sub-speciality radiologists. During 2014/15 five of the studies granted Trust NHS permission also required radiology approval. The Radiology Department occasionally provides a service to Clatterbridge Cancer Centre for some of their research related activity.

7. Funding

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

7.1 NIHR funding

The Trust receives income from North West Coast Clinical Research Network to cover the costs of working on NIHR adopted studies. The initial funding allocation for 2014/15 was £404,810. Following successful bids for additional funding made by the Research Department the total income from NWC CRN for 2014/15 was £542,549; breakdown below of 2013/14 and 2014/15 funding:

	2013/14 Funding from Merseyside and Cheshire Comprehensive Local Research Network	**2014/15 Funding from North West Coast Clinical Research Network**
Research Nurses	£313,136	£331,329
Pharmacy key-service support	£39,956	£60,791
Pathology key-service support	£20,000	£40,000
Radiology key-service support	£20,000	£20,000
Research Management & Governance	£29,700	£20,974
Data Support	£13,239	£19,455
PA Allocation	0	£50,000
TOTAL	**£436,031**	**£542,549**

7.1.2 Consultant PA Allocation

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

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

7.2 Research Capability Funding

During the past few years the Department of Health have allocated £20,000 Research Capability Funding (RCF) to research active Trusts if they recruited more than 500 participants to non-commercial NIHR studies in the previous financial year. During 2013/14 and 2014/15 the Trust qualified for this payment.

In March 2015 the NIHR announced that it was rewarding all Trusts additional RCF funding for commercial studies that had recruited to time and target between April 2013 and March 2014. Trusts have received £25,000 for the first study recruiting to time and target and £2,000 for each subsequent study. This Trust was awarded £31,000.

7.3 Commercial Income

The Trust receives income from commercial sponsored research; the majority of which goes directly to the speciality undertaking the research though the Research Department does keep a proportion to cover costs and also for capacity building. Breakdown below of 2013/14 and 2014/15 commercial:

	2013/14	**2014/15**
Divisions	£85,025	£93,229
Research Department	£40,971	£39,769

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

7.4 Commercial Income 2015/16

The NIHR has produced new guidelines regarding the allocation of income from commercial studies; these came into effect on 1 April 2015 and the Research and Finance Departments are currently working together to ensure the Trust complies with these new requirements.

7.5 Contracts

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

8. Library

Since June 2012 the Trust library has been recording all publications that have been publicised via the Library Blog. The criteria for inclusion are that the articles have been listed on PubMed, Medline or EMBASE and have been written by members of WUTH staff. This is not a comprehensive list of WUTH publications as the library is not always informed of articles published elsewhere. The Research Department have display space within the library including a list of these articles. See appendix 6 for list of articles added to the blog between 1 April 2014 to 31 March 2015.

9. Health Research Authority Approval

During 2015/16 the Health Research Authority (HRA) is rolling out a new system of approving studies within the NHS in England. HRA Approval will remove the need for NHS Permission (R&D Approval) to be granted by each participating Trust. Trusts will instead be required to confirm local capacity and capability with the study sponsor prior to starting recruiting. The Research Department is working with representatives from the HRA and the NWC CRN to ensure the transition runs as effectively as possible.

10. Additional Information

10.1 Advice and support

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

10.2 Future Research Annual Reports

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

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

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

APPENDIX 1

List of NIHR adopted studies granted NHS permission (R&D Approval) 01/04/14 – 31/03/15

Study Title	Type of Study	Principal Investigator / Speciality
RESTART: REstart or STop Antithrombotics Randomised Trial	Clinical trial of an investigational medicinal product	Dr Ruth Davies, Stroke
DAPPA: Spot protein creatinine ratio (SPCr) and spot albumin creatinine ratio (SACr) in the assessment of pre-eclampsia: A diagnostic accuracy study with decision analytic model based economic evaluation and acceptability analysis	Basic science study involving procedures with human participants	Mrs Stella Mwenechanya, Reproductive Health
SNAP: A national Survey of patient reported outcome after anaesthesia	Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology	Dr Suresh Singaravelu,
EMPIRE: AntiEpileptic drug Monitoring in PREgnancy: An evaluation of effectiveness, costeffectiveness and acceptability of dose monitoring strategies.	Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice	Miss Salwa El-Taher, Reproductive Health
OPAL: Pfizer A3921091 Phase 3 Tofacitinib (CP690,550) for Active PsA	Clinical trial of an investigational medicinal product	Dr Emmanuel George, Rheumatology
HUMOX: A pilot study to assess whether humidified oxygen is more effective than standard oxygen therapy in treating children with severe asthma	Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice	Dr David Lacy, Paediatrics
FADES: Feeding and Autoimmunity in Down's Syndrome Evaluation study	Basic science study involving procedures with human participants	No Local Investigator
ASAP: Early low dose steroids for adults admitted to hospital with influenza-like illness during a pandemic: a randomised placebo controlled trial	Clinical trial of an investigational medicinal product	Dr Andrew Wight, Respiratory

Study Title	Type of Study	Principal Investigator / Speciality
PROVENT: Practice of ventilation in critically ill patients without ARDS. An international observational study.	Study limited to working with data (specific project only)	Dr P Prashast, Critical Care
MINESS: The Midlands and North of England Stillbirth Study	Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology	Mrs Stella Mwenechanya, Reproductive Health
PIVOTAL: UK Multicentre Openlabel Randomised Controlled Trial Of IV Iron Therapy In Incident Haemodialysis Patients	Clinical trial of an investigational medicinal product	Dr Thomas Ledson, Nephrology
FAST: The clinical and cost-effectiveness of temporarily quadrupling the dose of inhaled steroid to prevent asthma exacerbations; a pragmatic, randomised, normal care-controlled, clinical trial	Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice	Dr Nikki Stevenson, Respiratory
AML 19 Pilot: A phase ll randomised study to evaluate the feasibility of sequential administration of the inhibitor ponatinib given sequentially with standard chemotherapy in younger patients aged 18 to 60 years with acute myeloid leukaemia.	Clinical trial of an investigational medicinal product	Dr Ranjit Dasgupta, Haematology
HEALTH: A multicentre randomised controlled trial comparing laparoscopic supracervical hysterectomy with second generation endometrial ablation for the treatment of heavy menstrual bleeding	Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice	Tom Aust, Reproductive Health
RESPITE: Remifentanil intravenous patient controlled analgesia (PCA) versus intramuscular pethidine for pain relief in labour: a randomised controlled trial	Clinical trial of an investigational medicinal product	Dr Sadashivaiah Jagadish, Reproductive Health
SIMS: Adjustable Anchored SingleIncision MiniSlings Versus Standard TensionFree MidUrethral Slings in the Surgical Management Of Female Stress Urinary Incontinence; A Pragmatic Multicentre Non–Inferiority Randomised Controlled Trial:	Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice	Dr Mark P Doyle, Reproductive Health

Study Title	Type of Study	Principal Investigator / Speciality
Zoster Vaccine: A3921237: Immune response to zoster vaccine in rheumatoid arthritis	Clinical trial of an investigational medicinal product	Dr Emmanuel George, Rheumatology
Genetic and biochemical investigations of children with symptoms suspicious for an inherited metabolic disease	Basic science study involving procedures with human participants	Dr Adrian Hughes, Paediatrics
GLORIA: Global Registry in Patients with Atrial Fibrillation	Study administering questionnaires / interviews for quantitative analysis, or using mixed quantitative/qualitative methodology	Dr Ruth Davies, Stroke
ARREST: Adjunctive Rifampicin to Reduce Early mortality from Staphylococcus aureus bacteraemia: a randomised controlled trial.	Clinical trial of an investigational medicinal product	Dr David Harvey, Microbiology
ARCHIE: The early use of Antibiotics for at Risk CHildren with InfluEnza in primary care: a double-blind randomised placebo-controlled trial	Clinical trial of an investigational medicinal product	Dr Elizabeth Breen, Paediatrics
RHAPSODY - A Double Blind,Randomized, ParallelGroup, ActiveControl Study to Compare the Efficacy and Safety of CHS0214 Versus Enbrel® in Subjects With Rheumatoid Arthritis and Inadequate Response to Treatment With Methotrexate	Clinical trial of an investigational medicinal product	Dr Emmanuel George, Rheumatology
Pfizer A3921092 Phase 3 Tofacitinib (Active PsA) Extension Study	Clinical trial of an investigational medicinal product	Dr Emmanuel George, Rheumatology

APPENDIX 2

List of NIHR adopted studies granted NHS permission (R&D Approval) for the Trust to become Participant Identification Centres (PICs)
01/04/14 – 31/03/15

Study Title	Type of Study	Trust Lead / Local Collaborator
REMEMBRIN: Rehabilitation of Memory following Traumatic Brain Injury – a Phase III Randomised Controlled Trial.	Clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice	Colin Pinder
PROVE: Physiotherapy Rehabilitation for Osteoporotic Vertebral fracture	Clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice	Dr Simon Lea
OPEN: Open urethroplasty versus endoscopic urethrotomy	Clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice	Mr P Kuturski
The provision of antenatal information for the NHS Newborn Bloodspot Screening Programme	Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology	Dr Fiona Ulph

APPENDIX 3

Total NIHR Recruitment Data 2014/14 & 2014/15

Speciality	No of participants recruited 2013/14	No of participants recruited 2014/15
Anaesthetics	0	126
Cancer	36	35
Cardiovascular	19	10
Critical Care	546	164
Dementia	21	22
Dermatology	15	10
Diabetes	0	7
Microbiology	17	47
No Local Investigators	10	0
Ophthalmology	21	3
Paediatrics	95	88
Renal	0	2
Reproductive Health	48	93
Respiratory	4	10
Rheumatology	22	10
Stroke	3	13
Surgery	3	0
TOTAL	**860**	**640**

APPENDIX 4

EDGE Referring Cancer Data

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

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

APPENDIX 5

List of non-NIHR adopted studies granted NHS permission (R&D Approval) 01/04/14 – 31/03/15

Study Title	**Type of Study**	**Principal Investigator / Speciality / Name of University if applicable**
Investigating the impact of the NIHR CRNs on the approval process of clinical research studies by NHS R&D departments	Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology	Dr Nicola White. Student Pooja Sharma, Cranfield University
Establishing a Research Database: Autism Spectrum Database UK (ASD-UK)	Research Database	Dr Jeremy Parr, Northumberland Tyne and Wear NHS FT
Exploring attitudes of nursing staff towards witnessed resuscitation in The Emergency Department: A qualitative study	Study involving qualitative methods only	Laurie McLellan, University of Chester
An exploration of health professionals' knowledge, attitudes and beliefs surrounding the occurrence of childbirth trauma, using a convergent parallel mixed methods design.	Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology	Emma Mathews, University of Chester
A qualitative study examining the perceptions of doctors in training towards the development of the role of Advance Nurse Practitioner in a Trauma and Orthopaedic Department	Study involving qualitative methods only	Femi Joy Thondickal, University of Chester
The recognition of the role of Advanced Nurse Practitioners working within a surgical team – A mixed method study of attitudes / beliefs of doctors-in-training towards the role of Advanced Nurse Practitioners on a Surgical Team	Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology	Lisa Gibb, University of Chester
Pulse on the Finger: Is an iphone app accurate enough to measure heart rates in adult patients presenting to the emergency department compared to radial pulse palpation	Clinical Investigation or other study of a medical device	Dr Nadia Roberts, Emergency Departmennt

Study Title	Type of Study	Principal Investigator / Speciality / Name of University if applicable
ACALM	Research Database	Dr Rahul Potluri, Aston University
SimvAstatin in Neurofibromatosis Type 1-Autism (SANTA) PIC	Clinical trial of an investigational medicinal product	Christine Steiger, Local Collaborator, University of Manchester
Patient need for information about medicines on discharge from hospital	Study administering questionnaires/interviews for quantitative analysis, or using mixed	Gareth Nickless, Local Collaborator, University of Kent and Greenwich
IO Swean: Practice Pattern Variation in Discontinuing Mechanical Ventilation in Critically Ill Adults: An International Prospective Observational Study	Study limited to working with data (specific project only)	Mr J Gannon, Critical Care
A pilot study examining whether a dementia awareness film, delivered through a dementia workshop, can improve Clinical Support Worker confidence in communicating with dementia patients within a general hospital setting	Study involving qualitative methods only	David Tasak, University of Liverpool
Knowledge of ward nurses about sepsis – A quantitative study	Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology	Sony Aiynattu, University of Chester
GCA Consortium	Study limited to working with human tissue samples and data	Dr Emmanuel George, Rheumatology

APPENDIX 6

Trust Publications (see inclusion criteria in Library section 7)

Title of article	Citation	Author
A case report highlighting the diagnostic difficulty of granular cell tumour of the breast	Journal of Pathology. 2013, 229, S10	Vargiamidou A.; Maurice Y.; Clark A.; Killeen D.; Holland M.; Poonawala S.
A dedicated peripherally inserted central catheter (PICC) line service: 2 year review	International Journal of Surgery. 2013, 11(8), 649	Appleton N.D.; Corris A.; Edwards C.; Kenyon A.; Walsh C.J.
A prospective and nationwide study investigating endophthalmitis following pars plana vitrectomy: clinical presentation, microbiology, management and outcome	The British journal of ophthalmology. 2014, 98(8), 1080-6	Park JC, Ramasamy B, Shaw S, Ling RH, Prasad S
A prospective and nationwide study investigating endophthalmitis following pars plana vitrectomy: Incidence and risk factors	British Journal of Ophthalmology. 2014, 98(4), 529-533	Park J.C.; Ramasamy B.; Shaw S.; Prasad S.; Ling R.H.L.
A prospective study of a ceramic-on-metal bearing in total hip arthroplasty: Clinical results, metal ion levels and chromosome analysis at two years	Bone and Joint Journal. 2013, 95B(8), 1040-1044	Kazi H.A.; Perera J.R.; Gillott E.; Carroll F.A.; Briggs T.W.R.
A quality control study of practice of urinary catheterization and knowledge among junior medical staff	American Journal of Infection Control. 2013, 41(6 SUPPL. 1), S67	Cheema M.R.
A review of endophthalmitis following vitrectomy	Expert Review of Ophthalmology. 2012, 7(3), 227-240	Park J.C.; Ramasamy B.; Ling R.H.; Prasad S.
A successful pregnancy outcome after Stevens-Johnson Syndrome	Journal of Obstetrics and Gynaecology. 2014, 34(5), 445-446	El Daief S.G.; Das S.; Ekekwe G.; Nwosu E.C.
American college of cardiology foundation recommendations assume incorrectly that cardiac troponins T and i are equally cardiac specific	Journal of the American College of Cardiology. 2013, 61(13), 1466-1467	Rittoo D.
Amnioinfusion in preterm premature rupture of membranes (AMIPROM): a randomised controlled trial of amnioinfusion v expectant management in very early preterm premature rupture of membranes - a pilot study	Health Technology Assessment. 2014, 18(21), 1-136	Roberts D, Vause S, Martin W, Green P, Walkinshaw S, Bricker L, Beardsmore C, Nj Shaw B, McKay A, Skotny G, Williamson P, Alfirevic Z

Title of article	Citation	Author
An audit of the use of iloprost (prostacyclin analogue) for raynaud's phenomenon (RP) in the rheumatology department, Arrowe park hospital, Wirral	Annals of the Rheumatic Disease. 2013, 71	Chandratre P.N.; Chiu Y.H.; George E.
An unusual presentation of a retroperitoneal cyst	BMJ Case Reports 2014 Nov 3;2014	Sarkar D, Gulur D, Patel S, Nambirajan T
An unusual variant of metaplastic mammary carcinoma, pseudo-angiosarcomatous / acantholytic variant	Journal of Pathology. 2013, 229, S10	Maurice Y.M.M.; Azhar U.; Kamla Sidky K.S.
Anaesthetic management of a patient with escobar syndrome (multiple pterygium syndrome) for LSCS	Regional Anesthesia and Pain Medicine. 2013, 38(5 SUPPL.1), E202-E203	Singaravelu S.; Ahmed D.; Frias C.; Tierney J.
Are prescribed doses of medicine for children measurable?	Archives of Disease in Childhood. 2012, 97(5), e18	Morecroft C.W.; Gill A.; Caldwell N.A.; Wood R.; Crolla J.; Antwi-Boasiako L.
Are we failing our trainees in providing opportunities to attain procedural confidence?	British Journal of Hospital Medicine (Lond). 2015 Feb 2;76(2):105-108	Lagan J, Cutts L, Zaidi S, Benton I, Rylance J
Audit of two week rule referrals for suspected head and neck cancer - A comparison over ten years	International Journal of Surgery. 2013, 11(8), 633	Williams C.; Byrne R.; Holden D.; Sherman I.; Srinivasan V.
Audit on the anaesthetic antenatal clinic, how obesity is impacting our service, with comparison across Merseyside	Anaesthesia. 2013, 68, 9	Davies J.E.; Frias-Jimenez C.
Calculating the prevalence of 1st MTP joint arthritis in the subclinical population using X-ray analysis	International Journal of Surgery. 2013, 11(8), 670	Cowan C.; Howard N.; Platt S.
Comment on 'Herpes zoster ophthalmicus reduction: implementation of shingles vaccination in the UK'	Eye (London, England). 2014 Sep 5. [Epub ahead of print]	Clearkin L
Contralateral acute lower limb ischaemia following total hip replacement in a patient with an endovascular AAA repair.	J Surg Case Rep. 2015;2015(3)	Brookes-Fazakerley SD, Thorpe P, Chan C, Jackson GE
Core temperature changes following lower limb tourniquet deflation in patients receiving sub-arachnoid anaesthesia for knee arthroplasty	Anaesthesia. 2012, 67, 77	Cliff D.; Tierney J.; McGrath C.
Corneal protection during general anaesthesia for non-ocular surgery	Ocular Surface. 2013, 11(2), 109-118	Grixti A.; Sadri M.; Watts M.T.
Could failure of the spring ligament complex be the driving force behind the development of the adult flatfoot deformity?	The Journal of Foot & Ankle Surgery. 2014, 53(2), 152-5	Williams G, Widnall J, Evans P, Platt S

Title of article	Citation	Author
Current performance of ERCP in the clearance of bile duct stones in UK centres-working towards robust key performance indicators	Gastrointestinal Endoscopy. 2014, 79(5, SUPPL. 1), AB230	Wadsworth C.A.; Dwyer L.K.; Paranandi B.; Mahmood S.; Johnson G.J.; Chapman M.; Pereira S.P.; Stern N.; Singhal A.; Webster G.; Sturgess R.
Diagnostic difficulty: Myeloid sarcoma masquerading as pyoderma gangrenosum	British Journal of Dermatology. 2014, 170(3), e11-e12	Cutts L.; Brown P.
Early morning salivary cortisol and cortisone, and adrenal responses to a simplified low-dose short Synacthen test in children with asthma	Clinical Endocrinology. 2014, 80(3), 376-383	Blair J.; Lancaster G.; Titman A.; Peak M.; Newlands P.; Collingwood C.; Chesters C.; Moorcroft T.; Wallin N.; Hawcutt D.; Gardner C.; Didi M.; Lacy D.; Couriel J.
Ebola virus disease in Africa: epidemiology and nosocomial transmission.	Journal of Hospital Infection. 2015 Jan 20	Shears P, O'Dempsey TJ
Elevation of cardiac Troponin T but not cardiac Troponin I in patients with neuromuscular diseases: Implications for the diagnosis of myocardial infarction	Journal of the American College of Cardiology. 2014, 63(22), 2411-2420	Rittoo D, Jones A, Lecky B, Neithercut D
Emergency transfer of patients into a neurosurgical intensive care unit	Anaesthesia. 2012, 67, 40	Cliff D.; Loh N.H.W.
Epidermoid cyst of testis: 3 cases of testicular mass with normal tumour markers	Journal of Pathology. 2013, 231, S43	Azhar U.A.; Seneviratne R.H.
Epithelioid haemangioma: a rare cause of painful erections and sleep deprivation	International Urology and Nephrology. 2014 Mar 30.	Lucky MA, McGuinness LA, Floyd MS, Azhar U, Shanks JH, Li C, Shenjere P, Nonaka D, Robinson LQ, Parr NJ
Expand your options with an MBA	Clinical Pharmacist. 2010, 2(6), 221-224	Malson G.
Falling mortality rates in type 2 diabetes mellitus in the Wirral Peninsula: A longitudinal and retrospective cohort population-based study	Postgraduate Medical Journal. 2012, 88(1046), 679-683	Nwaneri C.; Bowen-Jones D.; Cooper H.; Chikkaveerappa K.; Afolabi B.A.
Feasibility study of a randomised controlled trial to compare (deferred) androgen deprivation therapy and cryotherapy in men with localised radiation-recurrent prostate cancer	British Journal of Cancer. 2014, 111(3), 424-9	Salji M, Jones R, Paul J, Birrell F, Dixon-Hughes J, Hutchison C, Johansen TE, Greene D, Parr N, Leung HY, CROP study team

Title of article	Citation	Author
First metatarsophalangeal arthrodesis for hallux valgus	Foot and Ankle Clinics. 2014, 19(2), 245-58	Wood EV, Walker CR, Hennessy MS
Guideline for the diagnosis and management of myelofibrosis	British Journal of Haematology. 2012, 158(4), 453-471	Reilly J.T.; Mcmullin M.F.; Beer P.A.; Butt N.;Conneally E.; Duncombe A.; Green A.R.; Michaeel N.G.;Gilleece M.H.; Hall G.W.; Knapper S.; Mead A.; Mesa R.A.; Sekhar M.; Wilkins B.; Harrison C.N.
Idiopathic brachial plexus neuritis after laparoscopic treatment of endometriosis: a complication that may mimic position-related brachial plexus injury	Journal of minimally invasive gynecology. 2013, 20(6), 891-3.	Minas V, Aust T
Idiopathic brachial plexus neuritis vs brachial plexus injury following laparoscopy. Can you spot the difference?	Gynecological Surgery. 2013, 10, S13-S14	Minas V.; Thomas A.
Idiopathic massive fetal ascites and mildly elevated middle cerebral artery dopplers: A diagnostic dilemma	BJOG: An Intl. Journal of Obstetrics & gynaecology 2013, 120, 137	Chong D.M.; Mwenechanya S.; Bricker L.; Agarwal U.
Importance of communication skills and adopting a woman centred care approach when setting up a research project: A medical student's perspective	BJOG: An Intl Journal of Obstetrics & Gynaecology. 2013, 120, 68	Higgs C.; Edwards S.; Mwenechanya S.
Induction of abortion following radio-frequency ablation of the endometrium: A case report and search for evidence-based practice	European Journal of Contraception and Reproductive Health Care. 2014, 19(1), 66-70	Khafizova L.; Minas V.; Alam M.A.
Ipsilateral cortical activation in fibromyalgia patients during brushing correlates with symptom severity	Clinical Neurophysiology. 2013, 124(1), 154-163	Fallon N.; Chiu Y.H.; Li X.; Nurmikko T.J.; Stancak A.
Is possum a valid risk assessment model for predicting outcomes of major urological surgery?	International Journal of Surgery. 2013, 11(8), 724-725	Farrell A.; Stephenson R.
Juxta CURES: An innovative method of providing compression for leg ulcer management	Wounds UK. 2014, 10(1), 64-70	Lawrence G.
Lack of effect of 8 weeks atorvastatin on microvascular endothelial function in patients with systemic sclerosis	Rheumatology (Oxford, England). 2010, 49(5), 990-996	Sadik H.Y.; Moore T.L.; Vail A.; Murray A.; Anderson M.; Blann A.; Herrick A.L.
Laparoscopic hemi hysterectomy with preservation of ovaries, a novel treatment option for Herlyn-Werner-Wunderlinch syndrome	BJOG: An International Journal of Obstetrics and Gynaecology. 2012, 119, 205	Myagerimath R.; Gul N.; Rowlands D.J.

Title of article	Citation	Author
Laparoscopic subtotal hysterectomy for a 30-week sized uterus. Specimen extraction by open knife morcellation	BJOG: An International Journal of Obstetrics and Gynaecology. 2013, 120, 601-602	Minas V.; Chong D.; Aust T.
Lipoleiomyoma of the ovary-a rare tumour	BJOG: An International Journal of Obstetrics and Gynaecology. 2013, 120, 268	Mohammed R.O.; Kubwalo B.; Maurice Y.; Doyle M.
Localised amyloidosis of the glans penis presenting as a painless lump with progression after 10 years	International urology and nephrology. 2014 Jun 7.	Floyd MS, Glendinning J, Hiew K, Avram AM, Seneviratne R, Parr NJ
Loss of donor responsiveness in T cells exposed to the fish oil derivative eicosapentaenoic acid	Transplant International. 2013, 26, 47	Archer L.; Regan S.; Khan U.; Najam O.; Yonan N.; Saravanan P.; Fildes J.; Critchley W.
Lower limb amputation in England: prevalence, regional variation and relationship with revascularisation, deprivation and risk factors. A retrospective review of hospital data.	J R Soc Med. 2014 Dec;107(12):483-9	Ahmad N, Thomas GN, Gill P, Chan C, Torella F
Malignant melanoma, a cause for postmenopausal bleeding	BJOG: An International Journal of Obstetrics and Gynaecology. 2012, 119, 180	Myagerimath R.; Kubwalo B.; Gul N.
Management of migrated intravesical staples post laparoscopic colposuspension	Urology Journal. 2014, 11(4), 1853	Floyd Jr MS, Hughes D, Kutarski PW
Management of patients with high output stomas and enterocutaneous fistulae: Do proton pump inhibitors really help?	e-SPEN Journal. 2014, 9(3), e136-e140	Appleton N.D.; Neithercut W.D.; Edwards C.; Duncan M.; Walsh C.J.
Metrics for obstetrics: Evidence based targets for clinicians and organisations in preconception and early antenatal care	BJOG: An International Journal of Obstetrics and Gynaecology. 2013, 120, 419-420	Adams T.; Cooper J.; Rowlands D.; Bricker L.
Mortality in type 2 diabetes mellitus: Magnitude of the evidence from a systematic review and meta-analysis	British Journal of Diabetes and Vascular Disease. 2013, 13(4), 192-207	Nwaneri C.; Cooper H.; Bowen-Jones D.
Nicorandil associated complications of the gastro-intestinal tract: Side-effects requiring surgical intervention	International Journal of Surgery. 2013, 11(8), 616	Shapey I, Agbamu D, Newall N, Titu L
Non-Hodgkin lymphoma (NHL) in the puerperium - A rare case	BJOG: An International Journal of Obstetrics and Gynaecology. 2012, 119, 82	Myagerimath R.; Azhar L.; Mwenechanya S.; Gul N.

Title of article	Citation	Author
Outpatient fluid and electrolyte management for patients with high output stomas and enterocutaneous fistulae	International Journal of Surgery. 2013, 11(8), 621	Appleton N.D.; Corris A.; Edwards C.; Kenyon A.; Walsh C.J.
Patient acceptability of a locally designed insulin passport card and insulin safety information booklet: A patient survey	Diabetic Medicine. 2013, 30, 119-120	Hodgkinson R.S.; McFarlane F.M.; Leong K.S.
PC.111 Survey of Sildenafil Use for Treatment of Persistent Pulmonary Hypertension in Tertiary Neonatal Intensive Care Units in England & Wales.	Archives of disease in childhood. Fetal and neonatal edition. 2014, 99(Suppl 1), A74-6	Murphy A, Turnbull C, Nesbitt V, Guratski V, Kamalanathan A
PC.121 The Different Presentations and Management of Congenital Cytomegalovirus Infection - A Case Series.	Archives of Disease in Childhood. Fetal and neonatal edition. 2014, 99(Suppl 1), A78	Murphy A, Nesbitt V, Babarao S, Kamalnathan A
PC.71 Formal chatter makes them "Fatter"! How Introducing a Weekly Nutrition Ward Round (WR) Improves Calorie Intake and Weight Gain in Very Low Birth Weight (VLBW) Infants.	Archives of disease in childhood. Fetal and neonatal edition. 2014, 99(Suppl 1), A60	Guratsky V, Kalamanathan A, Nielsen M, Eyton-Chong C, Holt S
Personal birth preferences and actual mode of delivery outcomes of obstetricians and gynaecologists in South West England; with comparison to regional and national birth statistics	European journal of obstetrics, gynecology and reporoductive biology. 2014 Jul 30	Lightly K, Shaw E, Dailami N, Bisson D
Phacoemulsification surgery in eyes with neovascular age-related macular degeneration	ISRN ophthalmology. 2014 Jan 22.	Grixti A, Papavasileiou E, Cortis D, Kumar BV, Prasad S
PMM.50 A case of small bowel obstruction and ischaemia in second pregnancy after a laparoscopic Roux-en-Y gastric bypass surgery.	Archives of Disease in Childhood. Fetal and neonatal edition. 2014, 99(Suppl 1), A139.	Palmer C, Shaw E, Adishesh M
Post-operative management of diabetic patients requiring major amputation is more challenging than those having open abdominal aortic aneurysm surgery (AAA)	International Journal of Surgery. 2013, 11(8), 734-735	Barkat M.; Appleton N.; Chatha R.; Chan C.
Predictive value of PSA, PSAD and %free PSA for PCa diagnosis, Gleason score (GS) and cancer volume (CaV) in men undergoing transperineal template guided saturation biopsy (TTSB)	BJU International. 2012, 109, 17	Ekwueme K.C.; Simpson H.; Zakhour H.D.; Parr N.J.
Preoperative mapping of fistula-in-ano: a new three-dimensional MRI-based modelling technique	2013, 15(11), e699-701	Day NJ, Earnshaw D, Salazar-Ferrer P, Walsh CJ

Title of article	Citation	Author
Prescribing liquid medication: Can the dose be accurately given?	Archives of Disease in Childhood. 2013, 98(10), 831-832	Morecroft C.W.; Caldwell N.A.; Gill A.
Primary peritoneal carcinoma found at caesarean section, value of routine abdominal examination at caesarean section	BJOG: An International Journal of Obstetrics and Gynaecology. 2012, 119, 82-83	Myagerimath R.; Azhar L.; Mwenechanya S.; Gul N.
Prophylactic balloon occlusion of the common iliac arteries for the management of suspected placenta accreta/percreta: conclusions from a short case series	Archives of gynecology and obstetrics. 2014 Sep 2	Minas V, Gul N, Shaw E, Mwenenchanya S
PTH-006 Current Performance Of Ercp In The Clearance Of Bile Duct Stones In Uk Centres - Working Towards Robust Key Performance Indicators.	Gut. 2014, 63(Suppl 1), A210	Wadsworth C, Dwyer L, Paranandi B, Philips N, Mahmood S, Krishnan B, Taylor T, Seward E, Wilson P, Singhal A, Williams E, Westaby D, Webster G, Sturgess R,
PTH-058 A Centres Experience Of Setting Up A New Bowel Cancer Screening Centre And Preparing For Bowel Scope.	Gut. 2014, 63(Suppl 1), A234	Taggart N, Batterton J, Mcguinness D, Fitzgerald G, Morton B, Otoole P, Subrumanian S, Haslam N, Oates B, Sarkar S
PTU-012 Development Of Standards For Delivery Of Training In Gastroenterology: Defining Quality And Providing Accurate Assessment Of Units.	Gut. 2014, 63(Suppl 1), A42	Britton E, Sarkar S, Flanagan P
Radiological Prevalence of Degenerative Arthritis of the First Metatarsophalangeal Joint	Foot & Ankle International. 2014 Nov 6 [epub ahead of print]	Howard N, Cowen C, Caplan M, Platt S
Rectal mucocoele following subtotal colectomy for colitis	Annals of the Royal College of Surgeons of England. 2014, 96(6), 13-4	Appleton N, Day N, Walsh C
Refractory hyperemesis gravidarum-a rare presentation of maternal hydrocephalus	BJOG: An Intl Journal of Obstetrics & Gynaecology. 2013, 120, 138	Chong D.M.; Mohammed O.; Mwenechanya S.
Response to Dawson S, 'Blood culture contaminants', J Hosp Infect 2014, vol. 87, pp. 1-10	The Journal of Hospital Infection. 2014, vol 87, 1-10 Jul 30 [epub ahead of print]	Shakeshaft M, Cunniffe J, Harvey D
Rituximab monotherapy (without cyclophosphamide) in anca associated vasculitis in patients with serumcreatinine above and below 500 mumol/l	Nephrology Dialysis Transplantation. 2013, 28	Naz N.; Hiremath M.; Banerjee A.; Shah Y.

Title of article	Citation	Author
Screening for type 2 diabetes and population mortality over 10 years	The Lancet. 2013, 381(9870), 901-902	Nwaneri C.; Bowen-Jones D.; Cooper H.
Secondary prevention of fragility fractures at Wirral University Teaching Hospital	European Geriatric Medicine. 2012, 3, S131	Cheema M.; Haque R.; Azad M.
Sialendoscopy audit	International Journal of Surgery. 2013, 11(8), 634	Mamais C, Williams C, Davies K, Munir N, Shehata N
Simple measures to improve inpatient referrals for patients with diabetes foot ulcers to the podiatry diabetes service	Diabetic Medicine. 2013, 30, 192	Lyons C.; Raza F.; Harris G.; Leong K.S.
Standardized definition of contamination and evidence-based target necessary for high-quality blood culture contamination rate audit	Journal of Hospital Infection. 2013, 83(3), 265-266	Harvey D.J.; Albert S.
Structural alterations in brainstem of fibromyalgia syndrome patients correlate with sensitivity to mechanical pressure	NeuroImage: Clinical. 2013, 3, 163-170	Fallon N.; Alghamdi J.; Chiu Y.; Sluming V.; Nurmikko T.; Stancak A.
Successful pregnancy in a patient with untreated pituitary driven Cushing's disease	BJOG: An International Journal of Obstetrics and Gynaecology. 2013, 120, 125	Mohammed R.O.; Mwenechanya S.; Khoo C.
Surgical management of scalp squamous cell carcinoma: Predictive value of tumour thickness and deep marginal clearance for regional recurrence	International Journal of Oral and Maxillofacial Surgery. 2013, 42(10), 1354	Pinto A.; Raphy P.; Jones C.; Parikh S.A.; Mahdmina A.; Elwazani B.; Ho M.W.
Survival as medical registrar on call: remember the doughnut	Clinical Medicine. 2014, 14(5), 506-9	Blayney S, Crowe A, Bray D
Takotsubo cardiomyopathy case series: typical, atypical and recurrence.	BMJ Case Rep. 2015;2015	Lagan J, Connor V, Saravanan P
The adequacy of anticoagulation with IV unfractionated heparin	International Journal of Surgery. 2013, 11(8), 739	Syla Z, Harrison G, Williams L
The epidemiology of community paediatric outpatient referrals 2006	Child: Care, Health & Development. 2013, 39(1), 50-4	Thompson E; Ni Bhrolchain C
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The silent cancer - male breast cancer	Supportive Care in Cancer. 2013, 21, S69	Pritchard M.J.
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Title of article	Citation	Author
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Time course variations in the mechanisms by which cerebral oxygen delivery is maintained on exposure to hypoxia / altitude	High Altitude Medicine and Biology. 2014, 15(1), 21-27	Imray C.; Chan C.; Stubbings A.; Rhodes H.; Patey S.; Wilson M.H.; Bailey D.M.; Wright A.D.
Two-week referrals for suspected head and neck cancer: two cycles of audit, 10 years apart, in a district general hospital	The Journal of Laryngology and Otology. 2014 Jul 22:1-5. [epub ahead of print]	Williams C, Byrne R, Holden D, Sherman I, Srinivasan VR
UK AMD EMR USERS GROUP REPORT V: benefits of initiating ranibizumab therapy for neovascular AMD in eyes with vision better than 6/12.	Br J Ophthalmol. 2015 Feb 13;	Lee AY, Lee CS, Butt T, Xing W, Johnston RL, Chakravarthy U, Egan C, Akerele T, McKibbin M, Downey L, Natha S, Bailey C, Khan R, Antcliff R, Varma A, Kumar V, Tsaloumas M, Mandal K, Liew G, Keane PA, Sim D, Bunce C, Tufail A, on behalf of UK AMD EMR Users Group
Unplanned conversion of regional anaesthesia (RA) to general anaesthesia (GA) in patients undergoing caesarean section (CS)	Regional Anesthesia and Pain Medicine. 2013, 38(5 SUPPL. 1), E155	Airey N.; Singaravelu S.; Wankhade K.
Unusual presentation of a scrotal tumour.	BMJ Case Reports, 2014, May 30.	Sarkar D, Parr NJ
Use of a monofilament fibre debridement pad to treat chronic oedema-related hyperkeratosis	Wounds UK. 2013, 9(3), 85-88	Pidcock L.; Jones H.
Use of colchicine for skin conditions	Pharmaceutical Journal. 2012, 289(7719-7720), 203	Malson G.
Use of prophylactic antibiotics in gynaecological endoscopy in the UK. Do we need a guideline?	Gynecological Surgery. 2013, 10, S13	Minas V.; Nahid G.; David R.
Using the hospital anxiety and depression scale in surgical patients	Nursing standard (Royal College of Nursing (Great Britain): 1987). 2011, 25(34), 35-41	Pritchard M.J.
Zinc induced damage to kidney proximal tubular cells: studies on chemical speciation leading to a mechanism of damage	Journal of Trace Elements in medicine and biology. 2013 Jul;27(3):242-8	Sargazi M, Shenkin A, Roberts NB

Wirral University Teaching Hospital

NHS Foundation Trust

Arrowe Park Hospital, Wirral, CH49 5PE

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BOARD OF DIRECTORS

UNAPPROVED MINUTES OF MEETING

30 SEPTEMBER 2015

BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL

Present

Michael Carr	Chairman
David Allison	Chief Executive
Cathy Bond	Non-Executive Director
Jill Galvani	Director of Nursing and Midwifery
Sharon Gilligan	Director of Operations
Andrea Hodgson	Non-Executive Director
Graham Hollick	Non-Executive Director
Cathy Maddaford	Non-Executive Director
Evan Moore	Medical Director
Jean Quinn	Non-Executive Director
John Sullivan	Non-Executive Director

Apologies

None

In attendance

Carole Self	Associate Director of Governance
Jon Scott	Senior Advisor to the Chief Executive
Mark Blakeman	Director of Informatics and Infrastructure
Mark Taylor	Recovery Adviser
Gareth Lawrence	Deputy Director of Finance
Mike Coupe	Director of Strategy

Public

David Steele	Public Governor

Reference	Minute	Action
BM 15-16/126	**Apologies for Absence** Noted as above	
BM 15-16/127	**Declarations of Interest** The Director of Operations declared a potential declaration of interest in view of her successful appointment to the Chief Operating Officer at Warrington and Halton Hospitals.	
BM 15-16/128	**Patient Story** The Director of Nursing and Midwifery relayed a patients story regarding care on Ward 16, following a fall, the tone of the story was positive.	
BM 15-16/129	**Chairman's Business** The Chairman welcomed Mr Lawrence, Deputy Director of Finance and Mr Coupe, Director of Strategy to their first Board Meeting. The Board was updated on the work of the Remuneration and	

Reference	Minute	Action
	Appointments Committee which met on 29 July 2015 to review the following: • Compliance against the Fit and Proper Persons for Executive Directors • The development of a revised Executive Structure • Off Payroll arrangements in light of the guidance received from the Department of Health The Chairman updated the Board on the recent Governor Elections as follows: **Public Constituency** • Leasowe, Moreton & Saughall Massie – Suzanne Mitchell, newly elected • Oxton and Prenton – George Wadham, newly elected • Greasby, Frankby, Irby & Upton – Eileen Hume, newly elected • Bebington and Clatterbridge – no candidate • Heswall, Pensby and Thingwall – poll abandoned, new election to finish 29.10.15 **Staff Constituency** • Medical and dental – Rosemary Morgan – re-elected • Nurses and Midwives – Paula Clare – re-relected • Allied Health Professionals – no candidate The Chairman confirmed that the new Governors would take up their posts after the Annual Members Meeting on the 1st October 2015 for a three year period. The Chairman was pleased to report positive feedback from the recent PROUD awards as well as offering his thanks to everyone who had worked so hard before and during the recent CQC visit whether it be by meeting with inspectors or providing information. He gave particular thanks to the Medical Director and the Director of Nursing and Midwifery for their leadership. The Board showed their appreciation and thanks to 4 retiring Governors these being Donald Shaw, David Steele, Brian Cummings and Brian Beechey. The Board was updated on 4 recent Consultant Appointments as follows: Dr Ajmal Khan Mohaned Yunus – Consultant in Diabetes & Endocrinology Dr Sennimalai Sankar & Dr Antonios Benopoulos – Consultants in Cardiology Dates of Forthcoming Meetings were outlined as follows: • Annual Members Meeting – 1 October – commencing at 4:00pm	

Reference	Minute	Action
	• Board of Directors Meeting – 28 October 2015 – commencing at 9:00am • Joint Board/Governor Workshop – 3 November commencing at 2:00pm with particular emphasis on the learning from the recent CQC inspection and how the Board walkabouts could be improving to take into account some of the experience gained from the mock inspections.	
BM 15-16/130	**Chief Executive's Report** The Chief Executive presented the report and highlighted the following: • The signing of the contract with Commissioners which recognised good partnership working and the importance of this for Vanguard. • The level of activity referred and subsequently upheld by the Parliamentary Health Service Ombudsman, the Chief Executive confirmed that this reflected well upon the organisation in terms of its approach to complaints handling. • The good progress being made on the Recovery plan in terms of closing the £1.9M CIP gap. The Board was advised that the focus of attention was on understanding the strength of delivery of the £11.1M plans in particular in relation to coding, lengths of stay, theatres and outpatients. • The Board formally approved the Chairman/Chief Executive action to De-register the Dialysis Unit at Chester from its CQC registration, following advice from the inspection team. It was confirmed that there would be no impact on service delivery by the Trust as a result of this change. • The Chief Executive provided an update on the development work in relation to car parking access and egress which had seen significant improvements over the last few weeks. • The circulation of the NHS Staff survey was highlighted to the Board with confirmation that this would be open for responses until the 25th November 2015. • An overview of the recent Progress Review Meeting with Monitor was outlined. The Chief Executive reported that on the whole the meeting was positive with Monitor thanking the Trust for the quality of the preparation and for being broadly on track with plans. The Board was advised that the next meeting would take place in November 2015. The Board sought to understand whether all or some of the enforcement undertakings would have to be fulfilled before the Trust could be considered for a review of compliance against its licence. • The Deputy Director of Finance provided an overview of the	

Reference	Minute	Action
	changes to the Risk Assessment Framework with a particular emphasis on the value for money measures. The Board was advised that if the Trust was to achieve its plans, the CoS rating of 2 would be secured for the remainder of the year, noting that under the previous methodology this would have led to a CoS rating of 1. The Board thanked the Chief Executive for the report.	
BM 15-16/131	**Wirral Partners New Models of Care – Healthy Wirral – Position Statement September 2015** The Chief Executive presented the progress report and in particular highlighted the positive feedback received from NHS England on the bid although the financial resources had still not been forthcoming despite several attempts to provide clarification. The financial constraints from NHS England were beginning to emerge with a limit of £5M funding being placed on this financial year. The Chief Executive outlined the difference in the Wirral Vanguard bid from other Vanguard bids due to the requirement for upfront investment in technology. He confirmed that the establishment of the PMO was progressing well with key posts being filled; the milestones for delivery needed to be agreed by the end of October together with the governance arrangements to allow for critical resources to be deployed and the Cerner contract to be agreed. The Board was advised of plans for a Healthy Wirral Expo on the 25th and 26th November 2015 which would be the start of the staff and public engagement. The Chief Executive confirmed that key messages needed to be agreed with respective Boards ahead of this, with further details to be presented at the October Board meeting. The Board sought to understand at what stage it would be able to quantify the benefits anticipated from the project. The Director of Strategy reminded members of the £150M funding gap that Partners were trying to address over the next 5 years and the hope that Vanguard would not only improve efficiency in the way Partners respond and deliver demand but also how this is commissioned and contracted in the future. The Board reviewed the anticipated expenditure once the Partners were in receipt the first £5M of funding. Members requested that a high level programme summary be circulated together with the anticipated benefits of the programme. The Chief Executive updated the Board on the level of support for the Wirral Care Record following the outcomes of the recent survey. Although the level of support was increasing, members were keen to understand how full support would be achieved from all GP practices. The Board sought to understand how the learning from the Trust's current performance was being included in the new Cerner contract to ensure that appropriate recognition was received if the programme was rolled out to other NHS organisations. The Director of Informatics and Infrastructure advised that this was a contract variation and not a change in the	**DA** **DA**

Reference	Minute	Action
	fundamental contract itself. The Board expressed the need to develop the Memorandum of Understanding as soon as possible in order that any concerns from Partners could be addressed. The Medical Director reported good progress from the Clinical Governance Senate which had now approved the healthy registry for diabetes and paediatric diabetes.	
BM 15-16/132	**Integrated Performance Report** The Director of Informatics and Infrastructure presented the newly developed Integrated performance dashboard and highlighted the following areas for discussion: **A & E 4 hour standard** – Mr Scott provided the Board with an explanation of the work being undertaken on patient flow and the focus on weekend discharge processes, which up until last weekend had not had the desired impact. The change in senior leadership at the weekend had begun to have a positive impact in terms of delivering improvement in discharges and in patient flow. Mr Scott also advised the Board that the acuity levels in patients presenting in the Emergency Department in September were the same as those seen in December of last year and January of this year. He confirmed that the Trust had introduced 5 new pathways of care as part of the winter plan however the success of this was reliant on the additional 40 beds being available in the community. He confirmed that the Systems Resilience Group (SRG) were addressing this as a matter of urgency. The Board was also advised that ECIST had identified that discharge processes needed addressed from a Trust perspective and that of its partners. The number of medically fit patients in the hospital was increasing following changes in the Health and Social Care Act. Mr Scott confirmed that ECIST was attending the SRG in an enhanced position to hold the health economy to account. The Board asked the Executive to consider those actions which were within its gift such as applying rigour to consultant leave; frontloading the emergency department with therapy staff and improving triage. The Board sought to understand whether the handover process for Junior Doctors was fundamentally different this year as this had been highlighted as one of the reasons for the deterioration in achievement of the target. Mr Scott advised that more work was required to fully understand the impact of Cerner but in the first instance additional floorwalker had been put in place to assist with the handover. The Director of Informatics and Infrastructure was keen for the Board to note that Cerner should have made the process easier for Junior Doctors as there was only one process to follow where previously there had been two. Mr Scott reiterated the fact that the Trust was still forecasting that it would achieve the Q3 target having seen a 6% increase in performance following implementation of previous actions. The work being undertaken on the	

Reference	Minute	Action
	front end; discharges including weekends and the work with ECIST on medically fit patients would hopefully ensure that the Trust was not as reliant on the health economy as in previous years although there was recognition that the additional 40 beds planned in the community was essential to the success of the overall winter plan. The Board requested that the actions being taken to address areas of underperformance were ranked in terms of desired impact, where possible, to aid with review. The Director of Informatics and Infrastructure agreed to undertake this action where possible. **Opthalmology** - The Chief Executive advised the Board that the Trust was exploring moving ophthalmology to the Clatterbridge site. He advised that the Executive team were still understanding the merits of this move and were committed to ensuring that any decision formed part of the overall work of the strategic recovery plan. **Community Paediatrics** – the Chief Executive confirmed that the 47 week wait in this area had been raised with commissioners which had arisen as a result of demand outstripping the resource for a block contract. He confirmed that the commissioners had rejected the Trust's request for additional support and therefore the Trust was considering its position which posed risks not only from a 18 week RTT perspective but also from a quality perspective. The Board debated the risks of taking action to close the list to new referrals in view of the concerns from clinicians, the discussions being undertaken with the Accountable Officer of the CCG and the views of Monitor. The Board was pleased that contract negotiations in this area had been raised for the coming year but felt that agreement to the current contract had weakened the Trust's position. The Board requested that the Chief Executive reach a clear position with the CCG as soon as possible. The Board agreed with the recommendation from Finance Business Performance and Assurance Committee to raise this as a risk on the Board Assurance Framework. **Surgical Activity Levels** – the Board agreed to discuss these following the presentation from the Division as part of its private agenda. **Pain Services** – The Chief Executive confirmed that Monitor had agreed to provide some support to the Trust and escalate strategic conversations. The Board concurred that it would probably be good to have a wider discussion on pain services as this was traditionally a difficult area. The Medical Director advised the Board of a recent Never Event in ophthalmology which was currently being investigated. He confirmed that no harm had come to the patient involved and that a series of actions had been implemented to ensure that it did not happen again. The Board agreed that the report was much improved and agreed with the recommendations in the paper.	**MB** **DA**

Reference	Minute	Action
BM 15-16/133	**Month 5 Finance Report** The Deputy Director of Finance presented the Month 5 Finance Report and highlighted the following: **Income and Expenditure** – In month, the Trust delivered a £0.155M deficit compared to plan giving the Trust an overall year to date deficit of £7.482M against a plan of £7.327M. **Cash** – The Trust recorded a favourable cash position against plan at month 5 with the Trust holding £21.3M at the month end against a plan of £6.7M. **Cos Rating** – The financial performance in month and at month 5 translated into a CoS rating of 2, which remains in line with plan and had been calculated in line with Monitor's new guidance. **CIP** – The latest forecast outturn position had now been reduced to £10M, £1M below initial plans with deterioration primarily in coding improvements. The Deputy Director of Finance summarised the report by confirming that the Trust continued to deliver its plans and the message therefore was largely positive. The Board sought clarity as to whether the ceiling on nurse agency costs of 3% would impact on the new arrangement with NHS professionals. The Board was advised that NHSP staff were classified as bank staff and would therefore not be included in this ceiling. The Board raised concerns with current activity levels and the lack of confidence in these improving for the remainder of the year and the slippage on CIP. The Recovery Advisor confirmed that the scale of the risk had increased overall hence the need for a "deep dive" into activity levels together with a thorough review of CIP plans which would be undertaken during the private part of the agenda.	
BM 15-16/134	**Francis Report: Hard Truths Commitment: Publishing of Nurse Staffing Data: July and August 2015** The Director of Nursing and Midwifery presented the latest report covering July and August 2015 and highlighted the following: The closure of the escalation wards in April and May of this year which had had a positive impact on staff morale and patient care and as a result had not been opened since. The opening of the new infection control ward together with 2 escalation wards planned for winter, both of which were challenging but positive for the organisation.	

Reference	Minute	Action
	Ward sisters and matrons were now back in their substantive roles although they would be included in the number of RGN's available when required in line with expectations from other Trusts. The recruitment strategy was reported positively although there was more work to do in this area. The number of vacancies was reported as 12.05 WTE according to the ESR data although the Trust was still recruiting to take account of turnover and the plans for the opening of winter wards. The Director of Nursing and Midwifery confirmed that 5 nurses had been recruited within the week as a result of a local Trust event with a further 30 shortlisted. She advised the Board that a team of Ward Sisters were out in Poland and so far they had recruited 20 nurses with a further 15 being interviewed. She confirmed that the challenge was to ensure that this recruitment translated into positive feedback from the nurses on the wards. The Board was advised of parallel increases in midwifery staff which put the Trust in the top quartile across the UK. The Director of Nursing and Midwifery provided the Board with an overview of the methodology previously used to report nurse staffing fill rates and the benchmarking work undertaken with Salford, Tameside, Sheffield and the Countess of Chester NHS Foundation Trusts which had resulted in the new RAG rating system being presented. Full details of any areas of non-compliance were provided for openness and transparency together with actions taken to address this. The results were much more positive overall as the recruitment programme had begun to produce dividends. The Director of Nursing and Midwifery highlighted some concerns which had arisen over the previous couple of weeks associated with E Roster due to the lack of recalibration in the system when staff moves take place thus meaning the Corporate Nursing Team were constantly have to review this to ensure correct. The Board was advised that MIAA had been asked to undertake a further piece of work on nurse staffing in order to provide further assurance. The Board sought to understand whether the Trust was at risk following the recent introduction of a cap on agency rates. The Director of Nursing and Midwifery advised the Board that this was being managed in conjunction with the Finance team to ensure the Trust remained within the limit recognising that this was one of the lowest bandings nationally. Any impact on quality would be escalated. The Director of Nursing and Midwifery advised the Board of the potential risks and impact should nurses not comply with the new NMC Revalidation process due to commence in April 2016. She confirmed that the Trust had a process in place to ensure preparedness which would be closely monitored. The Board sought and received assurance that the concerted efforts this year to address the nursing requirements would continue to ensure sustainability for the future. The Board also discussed those areas that were much more difficult to recruit to and the plans to address this. The	

Reference	Minute	Action
	national picture around nurse staffing was debated and the potential risk in relation to the removal of ring fencing of Health Education England funding. The Board welcomed the new way of reporting however requested that the RAG rating took into account particular needs of wards to ensure that the Trust did not record non-compliance inappropriately.	
BM 15-16/135	**External Assurance - Quarterly Monitor Report** The Associate Director of Governance presented the Quarterly Monitor Report for noting by the Board of Directors. The Chief Executive updated the Board on the Trust's response to the Department of Health request, in line with all Trusts, to deliver greater savings than those planned. As the Trust had been subject to rigorous scrutiny of its recovery plan during a two day site visit from Monitor together with external validation, the Trust responded by confirming that the savings challenge was significant enough and could therefore not stretch this further to meet the national shortfall. The Trust's response was in line with many Trusts locally and nationally and the impact of this is therefore awaited.	
BM 15-16/136	**Report of the Quality and Safety Committee 09 September 2015** Dr Quinn presented the report from the Quality and Safety Committee meeting undertaken on 09 September 2015. Dr Quinn highlighted the change implemented in the construction of the committee agenda in order to address the gaps in the Board Assurance Framework. Dr Quinn highlighted the risk recommended for inclusion on the BAF in relation to End of Life Care together with the amendment to the descriptor of the Emergency department risk. The Board accepted the recommendations. The Board was updated on the positive nature of the CLIPPE report; the recent concerns with the eye clinic and the web holding file due to difficulties with levels of access. Dr Quinn highlighted the areas of improvement in the workforce dashboard with particular emphasis on the improvement in safeguarding training. The Board was updated on the continued good progress with mortality data; MEWs data and the Friends and Family results which were reported as excellent. Areas for improvement highlighted were community acquired pneumonia although this was expected to be on target by the end of the year; the reporting of a new Grade 4 pressure ulcer after a long period of none which is now being investigated and the continuing decrease in Grade 2 pressure ulcers. Improvements were reported in MEWs scores; eating and drinking and assessing patients with dementia which was at 100%. Concerns were discussed around end of life care and actions to improve this which would be monitored at the Committee going forward.	

Reference	Minute	Action
	Dr Quinn updated the Board on the presentation by the Medical Acute and Specialties Division which showcased lots of areas of good improvement although the Committee did focus on triage in A & E in view of the various complaints and concerns arising from this. The positive impact of Wirral Millennium was reported in particular around nursing assessments.	
BM 15-16/137	**Report of the Finance Business Performance and Assurance Committee 25 September 2015** Mr Hollick presented the report from the last Finance Business Performance and Assurance Committee on 25 September 2015 and highlighted the following areas: Concerns were raised with activity levels and the impact on income and the gaps in the Cost Improvement Programme both of which presented challenges going forward. There was some comfort in the fact that the Trust was managing the plan in terms of expenditure but activity performance would have undoubtedly put the Trust in a much better position. The Committee was pleased that the cash position still remained higher than plan. The new metrics in the Risk Assessment Framework were reviewed with acknowledgement that this would impact favourably on the CoS rating for the remainder of the year. Mr Hollick advised that the Committee had discussed extensively the Cerner strategic partnership which would require further debate ahead of any contract variation. A full review of the Board Assurance Framework was undertaken with the recommendation for a new risk to be added in relation to Community Paediatrics. The Board was also advised that the Committee had noted the work undertaken on service level agreements which had been well received.	
BM 15-16/138	**Report of the Audit Committee 10 September 2015** Mrs Bond presented the report from the Audit Committee held on 10 September 2015 and highlighted the following areas: The Local counter fraud service was at risk due to the current provider, the Commissioning Support Unit,no longer being on the procurement framework. The Committee agreed to recommend to the Board that the contract with MIAA be extended to deliver this going forward. The Board approved the recommendation. The limited assurance outcome of the MIAA report on IM & T Threat and	

Reference	Minute	Action
	Vulnerability Management was highlighted to members with confirmation that the recommendations contained therein would be completed by the end of October 2015. The Director of Informatics and Infrastructure reminded members of the anticipation of a number of limited assurance reports in relation to IT as a result of the Trust taking over the service from the Commissioning Support Unit. Mrs Bond updated the Board on the decision by the Committee to receive updates on all high level recommendations outside of the meeting cycle in order that early escalation of any delays could be addressed. Mrs Bond advised of the 3 new risks that the Committee was recommending to the Board for inclusion in the Board Assurance Framework, these being in relation to compliance with the enforcement undertakings; response to the formal notice from CQC in relation to safe staffing and the risks associated with partnership governance and sustainability arising from the Vanguard project. These risks were in addition to the risks recommended from the Quality and Safety Committee and Finance Business and Performance Committee. The Board approved all the new risks to the Board Assurance Framework. The Board was advised of the review of risks in the web holding file undertaken by the Committee as a result of a previous audit concern. Mrs Bond confirmed that the review included how risks were being managed and scored, the levels of access within the web holding file and the consistency of approach. She confirmed that a further report had been requested to include an aged analysis of the web holding file to ensure that progress was being made to reduce the risks outstanding and provide assurance that there were no risks therein of a high level. Mrs Bond concluded her report by confirming that the Committee had reviewed the recommendations and process for the tender of External Audit Services and as a result of this had agreed to undertake a re-evaluation of the tenders with the final recommendation to be made to the Council of Governors as agreed with Governors at their last meeting.	
BM 15-16/139	**Board of Directors** The Minutes of the Board of Directors Meetings held on 29 July 2015 were confirmed as an accurate record.	
BM 15-16/140	**Board Action Log** The Board action log was updated as recorded	
BM 15-16/141	**Items for BAF/Risk Register** The Board approved the recommendation from the Finance, Business Performance and Assurance Committee to include the risk in Community paediatrics on the Board Assurance Framework.	**CS**
BM 15-	**Any Other Business**	

Reference	Minute	Action
16/142	The Chairman closed the public part of the meeting by asking members to acknowledge the huge amount of work that had been undertaken to improve quality, safety and the finances of the organisation which had been recognised recently by the CQC and Monitor. He confirmed that it was appropriate for members to still be concerned but that this should be balanced with a degree of optimism if our staff were to remain positive. He asked that credit for all the huge work undertaken be given to the Executive and their teams. Thanks were extended to Mr David Steele, retiring governor for all his hard work and dedication over the years.	
BM 15-16/143	**Date and Time of Next Meeting** Wednesday 28 October 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 – October 2015

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 30.09.15						
Sept 15	BM 15-16/131	Key messages from the new models of care programme to be discussed at the October Board meeting.	DA		October 2015	
Sept 15	BM 15-16/131	Members requested that a high level programme summary be circulated together with the anticipated benefits of the New Models of Care programme.	DA		October 2015	
Sept 15	BM 15-16/132	The Board requested that the actions being taken to address areas of underperformance in the performance report ranked in terms of desired impact, where possible, to aid with review.	MB		October 2015	
Sept 15	BM 15-16/132	The Board requested that the Chief Executive reach a clear position with the CCG as soon as possible with regards to Community Paediatrics.	DA		October 2015	
Sept 15	BM 15-16/141	Include the risk in Community paediatrics on the Board Assurance Framework.	CS	**Completed**	October 2015	
Date of Meeting 29.07.15						

July 15	BM 15-16/098	Amend the wording in the performance report relation to CPE to differentiate between cases reported and clinical infections	JG	**Completed**		
July 15	BM 15-16/099	Further consideration to be given to the Board's approval and decision making powers as part of the new models of care programme	DA	**Completed**		
July 15	BM 15-16/107	Build on the "bridging the gap" paper for the Board to assist with forecasting	GL	**Completed**	September 2015	
Date of Meeting 24.06.15						
June 15	BM 15-16/072	Further work is required on the performance report in order that focus is placed on key areas such as bed occupancy, patient flow; activity and income levels as previously discussed. Ms Bond agreed to be part of this work.	MB/MT	**Completed**	July 2015	
June 15	BM 15-16/073	As the recovery plan was based on growth in income and activity, a readjustment of the plan might prove necessary if the underperformance is not addressed as outlined	AM/MT	**Completed as part of new performance report**	July 2015	
Date of Meeting 27.05.15						
May 15	BM 15-16/044	Circulate the updated health economy urgent care recovery plan to the Board	SG	**Completed**	June 15	
May 15	BM 15-16/044	Debate the merits of resetting some of the performance targets in light of the recovery plan	MB/MT	**Completed**	July 15	

May 15	BM 15-16/045	Produce a monthly report linking operations, finance, quality, infection control and the recovery plan to show the whole position and action being taken to address areas of under-performance.	JS	**Completed as part of the review of the performance report**	July 15	
Date of Meeting 29.04.15						
Apr 15	BM 15-16/015	Provide the Board with a monthly update on CQC improvement against compliance	EM/CS	**Ongoing – included on agenda for July 15**	May 15	
Apr 15	BM 15-16/016	Consider adjusting the nurse staffing ratio targets when contingency wards used	JG	**Consider as part of the winter planning process**	June 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	**Well-led Governance Review Tender being developed**	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	**Included as part of 6 monthly nurse staffing paper**	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/MC	**Included on agenda for October 15**	Jan 15	
Oct - 14	BM14-15/121	Consideration to an Annual Research and Innovation Forum	EM	**The research team are considering this recommendation**		