

Board of Directors Meeting

29 July 2015

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**MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 29 JULY 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 | New Model of Care in the Wirral – update and next steps
Director of Strategic and Organisational Development | 0945 | d |
|-----|--|------|---|

7. Performance and Improvement

- | | | | |
|-----|---|------|---|
| 7.1 | Integrated Performance Report | 0955 | |
| | 7.1.1 Integrated Dashboard and Exception Reports
Director of Infrastructure and Informatics | | d |
| | 7.1.2 Month 3 Finance Report
Director of Finance | | d |

8. Quality

- | | | | |
|-----|---|------|---|
| 8.1 | Staff Engagement
Interim Deputy Chief Executive | 1035 | d |
| 8.2 | Update on Nursing & Midwifery Strategy 2013/18:
'Modern, Patient-focused Nursing & Midwifery based on
traditional values'
Director of Nursing and Midwifery | | d |
| 8.3 | Francis Report: Hard Truths Commitment: Publishing of
Staffing Data: 6 Monthly Report
Director of Nursing and Midwifery | | d |

- 8.4 Safeguarding Annual Report 2014-15** d
Director of Nursing and Midwifery

9. Governance

- 9.1 Report of the Quality & Safety Committee 8 July 2015** 1140 d
Chair of the Quality & Safety Committee
- 9.2 Report of the Finance Business Performance & Assurance Committee 24 July 2015** d
Chair of the Finance Business Performance & Assurance Committee
- 9.3 Monitor Quarterly Return – Q1 2015/16** d
Director of Finance
- 9.4 Research Annual Report** d
Medical Director
- 9.5 Procurement Best Practice and the Productivity Challenge** d
Director of Finance
- 9.6 Board of Directors** d
- 9.6.1 Minutes of the Previous Meeting**
• 24 June 2015
- 9.6.2 Board Action Log**
Associate Director of Governance

10. Standing Items

- 10.1 Items for BAF/Risk Register** v
Chairman
- 10.2 Any Other Business** v
Chairman
- 10.3 Date and Time of Next Meeting** v
Wednesday 30 September 2015 at 9am

Board of Directors	
Agenda Item	5
Title of Report	Chief Executive's Report
Date of Meeting	29 July 2015
Author	David Allison, Chief Executive
Accountable Executive	David Allison, Chief Executive
BAF References	
• Strategic Objective	1, 4, 5, 6, 7
• Key Measure	1B, 4A, 5A, 6A, 7C
• Principal Risk	1908, 1909, 2328
Level of Assurance	
• Positive	Positive
• Gap(s)	
Purpose of the Paper	
• Discussion	To Note
• Approval	
• To Note	
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken	
• Yes	N/A
• No	

1. External Activities

CCG / NHSE Contracts

The Trust has signed and concluded the contractual position with NHSE for the specialist services components of its services. The contract with the CCG is largely concluded from a financial and service specification perspective with the actual schedules planned to be signed off by the end of August 2015.

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CQC Update

The Trust are awaiting the final report following the unannounced visit in the evening of 18 May. Member will receive full briefing of this in due course.

2. Internal Activities

CQC Children's Inpatient Services

Children's inpatient services at our Women and Children's Hospital have been rated as some of the best in the country by a national health watchdog. Of the 137 children's units assessed as part of the Care Quality Commission's (CQC) National Survey, our services on Wirral fared 'better than most' in many categories. The survey interviewed thousands of young patients as part of the national audit. Wirral Women and Children's Hospital outperformed other national trusts in areas like the privacy and dignity provided to young patients, communication with parents and the efficiency of our staff. As part of the findings, our children's nursing staff were also commended by parents and patients for their friendly manner and teamwork on the ward, as well as the amount of time they spend caring for each patient.

Infection Prevention & Control

Against the objective of no more than 29 cases for 2015/16, the Trust have reported 11 avoidable cases of Clostridium difficile including 2 cases reported during June. There were no MRSA bacteraemias and there has been no Pseudomonas reported through ongoing surveillance on the neonatal unit.

During June, 10 new CPE cases were identified, this is an increase compared to last month. A sustained focus to promptly transfer positive patients to ward 14 is promoted in order to interrupt the cycle of transmission. The cohorting of positive and highly exposed VRE patients within orthopaedics resulted in no further transmission during June, however a continued reinforcement of the strict admission criteria in haematology is required as 5 new cases were reported.

Recovery Plan

The Board of Directors approved its two year recovery plan at its meeting on 27 May 2015. The comprehensive plan which charts a path to financial improvement through 2015/16 and 2016/17 was shared with Monitor, the Trust's regulator on 29 May 2015. Monitor recognised the plan as challenging but deliverable within the current economic climate and impressed upon the Trust the need to deliver the component elements of the plan as described and in line with the timetable included within the Recovery Plan.

Through the first quarter of the financial year the Trust remains on track with its recovery plan for those schemes identified within the plan, although it should be recognised that delivery of the overall plan is weighted towards the final quarters of the financial year and that the planned schemes are yet to fully address the in year requirement for £13m of savings within 15/16. Plans to close the savings gap, valued at c£2m, are being developed on a rolling basis through the Trusts executive led Transformation Steering Group which considers not only in year delivery of the recovery plan but also additional opportunities to bridge the current shortfall.

A&E Update

The Trust continues to improve patient flow through the organisation. The improvement is demonstrated by achievement of the Emergency Access Standard, which on 21 July was 97.98% for the month and quarter. The first Listening into Action meeting to plan for winter was undertaken. This well-attended multi-disciplinary meeting was the start of learning from last year to develop a robust plan for this winter period. The winter plan will be ready for the Trust Board in October.

Car Parking

Over recent months the Trust has been reviewing its car parking and public transport provision. The Trust has invested in increased parking facilities as well as a redesign of the access and egress to the site for buses servicing Arrowe Park Hospital. As part of the review, the Trust has benchmarked its car parking charges against other local providers and the local authority, and undertaken an equality impact assessment. Following this review the Trust is proposing to increase charges to visitors from £2.50 to £3.20. These changes will not affect the current free provision of 300 spaces on the site nor the free 20 minutes afforded to all visitors using any of the Trust's parking facilities.

Workforce & Organisational Development

Health & Wellbeing / Attendance

Trust sickness absence rates remain below the target of 4%. June 2015 was 3.74% following 3.72% in May. This is the first period the Trust has achieved its target of 4%. HR&OD will continue to work with Line Managers to ensure policy is consistently and correctly applied to support staff that are off sick and maintain rates below target.

The Health & Wellbeing Plan 2015-2018 continues to be enacted. The wellbeing event planned for 30 July 12:00pm – 2:00pm at Elm House, Clatterbridge will include mocktails on the terrace promoting sensible drinking, along with a full range of health related services. The event provides an opportunity for all staff to gain advice and make changes to their lifestyle to positively improve their health and wellbeing. A plan to deal with stress in the workplace has been developed and training for managers will be rolled out over the next 12 months in hot spot areas, with all the key advice required to support individuals to deal with stress more effectively in the workplace.

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

Education and Development Key Performance Indicators

As at 30 June 2015:

- a) Mandatory Training Block A has decreased to 96.66% since 31 May 2015. This still meets the Trust's 95% KPI.
- b) Mandatory Training Block B has increased to 79.47% with a further 1139 staff booked to be trained by September 2015. As this currently falls below the 95% KPI divisional action plans are in place to address this.
- c) Appraisal compliance has decreased to 85.94% since 31 May 2015. This falls below the 88% KPI and divisional action plans are in place to address this.
- d) *Safeguarding Level 1*: Booklet issued on 31 March 2015 - currently 21.23% compliant with notifications received as at 30 June 2015. Further responses are being sought.

Safeguarding Level 2: Trust compliance has increased from 16.29% (31 May 2015) to 22.98% (30 June 2015). An action plan is in place to increase compliance - HROD are working with division.

Safeguarding Level 3: Trust compliance has increased from 45.95% (31 May 2015) to 53.77% (30 June 2015). An action plan is in place to increase compliance - HROD are working with division.

Organisational Development

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

Key Features:

- Development of in-house coaches for staff Bands 3 to 8.
- External coaching support for bands above Band 8.
- Coaching skills embedded in all in house leadership, management and supervisory programmes.
- Trained in-house mentor champion.
- Trained 360 Degree appraisal facilitators.
- Coaching for Clinicians
- New Consultant Development Programme.
- Access to external programmes.
- Clinical Leadership Development Programme.
- Care Certificate for clinical support workers - the Trust is a pilot site for the Care Certificate and implementation of this framework began in May 2015.
- Nurses and Midwife Revalidation Project.

Staff Engagement / Listening into Action / Values.

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

- 100 Day Challenge Part 1 finished on 9 July. 108 department LiA huddles have taken place and from these 562 improvement actions have been identified and are progressing.
- 120 reasons why our staff are PROUD have been communicated and are posted on the intranet.
- Latest LiA "Pass it On" Event took place on Tuesday 14 July.
- Further development has taken place with the Executive Team following the Cultural barometer on 8 June and will also take place with Operational Management team members in July and August.
- The new Staff Charter was distributed to staff with Payslips at the end June 2015.
- Positive communications are promoted including Chief Executive's weekly blog, 'Culture Engagement Round-up', PROUD messages from LiA Mini-Huddles, information on the Staff Friends and Family Test, #HelloMyNames... campaign, 'Team in the Spotlight' .
- Executive Team have been visiting their partner wards and departments.
- Plan for next 100 Days includes: revisiting departments 100 days post huddle, undertaking staff engagement huddles in remaining departments, putting teams and individuals in the spotlight, promoting the staff guardians further, and developing an individual recognition scheme.

- Progress has been monitored through the staff Friends and Family Test with additional staff engagement questions. The results indicate for Quarter 1 that the Trust has significantly improved putting us above our target and almost reaching the national average of 3.75.

Priority Recruitment

There is currently a national shortage of band 5 nurses (950 vacancies for band 5 currently across Cheshire and Merseyside). In comparison to other Trust's WUTH current registered nurse vacancy rate of 6.17% (June 2015) is low, however there is no room for complacency and exceptional corporate driven recruitment exercises have been taking place. Over 50 nurses due to graduate September 2015 have accepted places with the Trust. External support from 'Placement Group' has been sought regarding international recruitment and a project plan in relation to this was agreed on 14 July. Additional incentives to encourage nurses to come to the Trust are planned eg: 50% discount for Frontis accommodation, reward for refer a friend and payment of initial NMC registration fee.

Celebrating Success

The following recent actions have taken place:

- PROUD Team of the Quarter nominations for Quarter 1 are now closed and the winner will be announced at the next CEO Forum.
- Announced as the Winner of the HPMA (Healthcare People Management Association) Appreciate Champion Award 2015 for staff engagement, in recognition of the significant improvements we have made across the organisation by engaging with our staff, primarily through Listening into Action.
- Lewis Baker, ECG Technician, has been announced as the Apprentice of the Year by Wirral Metropolitan College
- Team in the Spotlight continues through weekly Trust communications and Linuji Thomas has been put in the Spotlight in the PROUD magazine in July
- 11 nominations have been submitted from the Trust for the HSJ Excellence in Healthcare Awards 2015
- The Trust has been shortlisted for the HSJ Value in Healthcare Awards for our work with Apprenticeships.
- The Trust has now received 2 NMC reports following their review of pre-registration Adult Nursing and Midwifery programmes. Both reports demonstrate WUTH has good working partnerships and students successfully meet the required programme learning outcomes and competencies at progression points, and meet NMC standards for entry to the NMC register. The commissioner, employers and managers confirm that students successfully exiting the nursing and midwifery programmes are safe, competent and fit for practice.

David Allison
Chief Executive

July 2015

Board of Directors	
Agenda Item	6.1
Title of Report	New Model of Care in the Wirral – update and next steps
Date of Meeting	29 July 2015
Author	Jo Goodfellow, Associate Director of Strategy and Partnerships Anthony Hassall, Executive Director of Strategic and Organisational Development
Accountable Executive	Anthony Hassall, Executive Director of Strategic and Organisational Development
BAF References <ul style="list-style-type: none"> • Strategic Objective • Key Measure • Principal Risk 	6; 6A; There is a risk that the New Models of Care programme does not deliver on the milestones outlined in the application and/or that there is insufficient capacity to meet the milestones within the application
Level of Assurance <ul style="list-style-type: none"> • Positive • Gap(s) 	<i>Positive</i>
Purpose of the Paper <ul style="list-style-type: none"> • Discussion • Approval • To Note 	<i>For discussion and noting</i>
Data Quality Rating	Bronze – qualitative data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken <ul style="list-style-type: none"> • Yes • No 	N/A

Wirral Partners New Model of Care

Update and next steps – July 2015

1. Introduction

In spring 2015, Wirral Partners were selected as one of 9 sites in England to be a Primary and Acute Care Systems (PACS) Vanguard site as part of the New Care Models initiative. In May 2015 the NHS England New Care Models Team visited Wirral Partners to reach collective agreement on what is required to deliver demonstrable improvements in patient care locally over a three year timeline. Wirral Partners presented the aims, objectives and outcomes for their new care model, their progress to date against the objectives and described the support they require from the National New Care Models Team to overcome identified barriers and accelerate delivery. The National New Care Models Team has announced that they plan to publish the support package that they will be offering to Vanguard sites at the end of July 2015.

Vanguard sites were asked to submit a Value Proposition outline to access Transformational Funding to the New Care Models Team (NHS England) by 30th June 2015 for consideration by the NCM Investment committee on 7th July 2015. This has been positively received with the Wirral proposition being classed as category B – needing some clarification on some points, but with strong delegated authority given from the Investment Committee to approve our bid once these points are clarified. We will be making a further submission to NHS England on 24 July in the hope that this can be achieved by 31 July.

This paper provides a position statement on the progress of the Wirral Partners New Care Model and describes the next steps in the Vanguard's work plan.

2. Financial requirements

A small amount of national funding has been made available to each Vanguard site in 2015-16 to assist in the transactional costs being incurred by Vanguards in the development of their new care model. The Wirral Partners application for non-recurring "Initial Support" was approved in June and the resources have been passed to Wirral CCG. These are already being used to support costs being incurred by all parties on developing the New Model of Care plan.

Following receipt of this funding, Wirral Partners were asked to submit a "Value Proposition" to apply for additional Transformational Funding in 2015-16 – out of the £200 million available nationally. The Wirral Partners Value Proposition described how, based on early indicative modelling the Wirral Health and Social Care Economy faces a "do nothing" challenge in the order of £153m by 2018-19. In order to close the gap anticipated between costs and resources available over the next 5 years, Wirral Partners have identified a number of areas which if aligned with the new care models would assist in the delivery of a new health and wellbeing model.

The Wirral New Care Model offer is focused around the acceleration of 6 key objectives in order to transform the health and social care and accelerate service redesign proposals for Wirral Partners models of care over the next 12 months.

These are –

- 1) Engaging local population and health and social care workforce to change culture
- 2) Enhanced integration – integrating health and wellbeing provision around the person
- 3) Workforce redesign
- 4) Informatics
- 5) Commissioning for outcomes

6) Evaluation and monitoring of new models of care and their impact on quality, experience and value for money

The particular areas of change that will help to support these improvements and the impact this will have upon Wirral Partners triple aim to improve outcomes, improve experience and reduce system cost, are detailed in a High Level Programme Plan (Appendix 1).

The additional investment requirement to support the acceleration of delivery of the triple aims is identified in the table below.

Figure 1: Additional Investment requirements (* indicates estimates)

	Appendix	2015-16 £	2016-17 £	2017-18 £
Population Health Management	7	1,875,532	940,032	840,032
Programme Management Arrangements	8	780,399	780,399	780,399
Support from Kings Fund / AQUA	9	58,500	25,000 *	25,000 *
Support from APP		50,000*	50,000*	50,000*
Social Prescribing			200,000	200,000
Consultancy / advice / legals		100,000	200,000	100,000
PumpPrime - Double running		Circa 8,000,000*	Circa 8,000,000*	Circa 4,500,000*
SUB TOTAL		£10.86m	£10.20m	£6.5m
TOTAL (2015-18)			£27.5m	

A number of additional estimates have been included to date for further areas that are currently being developed including additional support for Advocate Physician Partners, additional consultancy / legal advice and in respect of double running costs.

It is anticipated that double running costs will be required to support the delivery of the health and wellbeing model in the areas identified as 1st phase of roll out (respiratory, diabetes, wellness) in support of the development of the population health approach, use of registries and increase in the provision of primary / community based services in these areas.

It is envisaged that beyond 2017-18 the recurrent costs of population health and programme management structure costs required to complete the transformation process will be absorbed with the new system infrastructure and organisational form and become an enabling cost that supports the system in its delivery.

Wirral Partners Value Proposition for additional external support is therefore in the region of £27.5m over the next 3 financial years to complement existing initiatives and most importantly to accelerate the pace of the required transformation.

During the site visit in May 2015, the New Care Models Team indicated that Vanguard sites would be expected to provide an "in-kind" offer to complement National funding. Wirral Partners have identified resources ("in kind") that are committed to the establishment of the Wirral Health and Wellbeing model. The equivalent contribution in terms of WTE equivalent direct support to the project is estimated at £1.343m (full year effect).

Wirral Partner's application for additional Transformational Funding of £10.86m in 2015-16 was submitted to the New Care Models Team (NHS England) on 30th June 2015 for consideration by the NCM Investment Committee on 7th July 2015. Following this Wirral Partners were informed that their Value Proposition had been supported by the New Care Models Team but further details were required on the savings anticipated, and the matched funding. At a telecall on 14th July 2015, Wirral Partners were asked to

- Provide clarification on the total investment to implement its New Care Model, identification of recurrent and non-recurrent double running costs and potential savings the New Model

could incur as a consequence of total investment (accepting that this is the first time the model has been developed in the UK).

The New Care Models team also advised that the Wirral Partners in-kind offer should be expanded to include offers from other organisations, for example, NW Academic Health Sciences Network to support the development of its new Care model.

- Describe in more detail the replicability of its Population Health model and how this can be rolled out at a national (and possible international) level.

Wirral Partners agreed to submit the next draft of its Value Proposition by 24th July 2015 and anticipates it will receive transformation funding of £10.86m by the end of July 2015.

3. Catalysts for Rapid Change

The diagram below shows the catalysts for rapid change which are required to accelerate the delivery of the Wirral Partner's new model of care (Figure 2). Leadership for change will enable and drive these catalysts; including Senior Leadership through the Wirral Partners Board but also dispersed leadership through the organisations and wider partners such as voluntary and community sector, wider public sector and independent sector. The six areas are supported by individual lists of deliverables and timescales in the project plan (Appendix 1). A core theme embedded throughout the deliverables will be a co-design approach, ensuring the developments of the new model of care is reflective of what matters most to the individual, building on the solid engagement work we have delivered to date on the already advanced implementation of integrated care.

Alongside these Catalysts for Rapid Change there are projects that are aligned to the Health and Wellbeing model will be delivered as part of business as usual but will aid the incremental steps required to achieve transformational change. A list of these projects is in appendix 2 along with a description of how these projects will report into the refreshed governance structure

Figure 2: Catalysts for Rapid Change



3.1. Engagement and Cultural change; prevention and self-care

Wirral Partners aspiration is that by having a focus on changing conversations, we give people the motivation and inspiration to alter their thinking, behaviour and actions so that they take more responsibility for their own health. We want to see the local health and social care system move from supporting the medical model of health to promoting and enabling the social model of health i.e. moving the focus from “what is the matter with me” to “what matters to me”.

One of Wirral Partners big ticket projects is the development of a Social Prescribing model to promote health and wellbeing, Social Return on investment (SROI) analysis has demonstrated a £7 return for each £1 invested in social prescribing programmes, economic return on investment modelling shows a ratio of healthcare cost avoidance: wellbeing service spend: 3:1 after 4 years and 8:1 after 10 years of service provision.

A local Social Prescribing care pathway is being planned to include two levels of intervention, depending on complexity of social needs, level of motivation and individual choice:

- Level A Signposting, information and advice to reduce dependency on services.
- Level B Supported community referral/ socially prescribed programmes- referral to a structured intervention, co-ordinated via a local social prescribing programme.

The pathway would look to target 50% of people with low levels of mental wellbeing to be signposted to information, advice and sources of support in the community and 10% of people with low levels of mental wellbeing being supported by socially prescribed psychosocial programmes. Alongside the development of the social prescribing model Wirral Partners will develop and start the implementation of a 3-year engagement strategy; empowering local people to take control of their own health and wellbeing; making sure that health communications across the entire health and social care economy are coordinated and complement the overarching New Model of Care messaging. We will utilise social marketing approaches to change the behaviour – and culture – of patient groups, clinical staff and stakeholders, through the development of a social contract which defines expectations from all aspects of the health and social care economy.

3.2. Enhanced Integration

There are a number of key programmes of work that are being developed to enhance integration as part of Wirral Partner's New Care Model programme. These are:-

Integrated Community Care Hubs – incorporating integrated care co-ordination teams (ICCTs) as illustrated in the Community Integrated Model (Figure 3). The 4 Integrated care co-ordination teams will be in place by September 2015 where a core multi professional staff group will co-ordinate the care of those people with complex needs. These are people who have been identified via risk stratification and who are at risk of hospital admission. The team also supports early discharge.

The predicted contacts will increase to 5% of the population which is approximately 4000 per ICCT, although the caseload will not necessarily be this high at any one time.

Single Front Door including an Integrated Gateway-

A service and delivery model has been developed jointly by the acute and community services, led by primary care to filter people attending the A&E department into the most appropriate care setting. A single gateway to all services is in place where health and social care staff have recently co-located. Work is in progress to understand call referral rates and types with the intention to have a single telephone number by September 2015.

Rapid response service- A rapid response service is being developed by September 2015 jointly with commissioners and a number of current providers to provide an urgent response to GPs where patients are in crisis and may need an acute bed. The team will consider safe alternatives to admission by delivering nursing interventions in people's homes, referring to Intermediate or transitional Beds as appropriate or to a range of social care support and care packages.

Integrated Discharge Team- An integrated discharge team already exist which is based in the acute hospital. Staff from the ICCT's work with this team to support early safe discharge. This team

Figure 3: Community Integrated Model



is vital to ensure flow through the hospital and is being reviewed currently to ensure maximum efficiency.

Intermediate Care response including Beds- Additional Intermediate care beds are being commissioned to be in place by September 2015 and provide an alternative to admission. They provide an additional resource for the Rapid response team to access. This will be supplemented by additional resources in therapies to support follow on discharge as appropriate.

Care Homes-This scheme targets the Care Homes with the greatest number of admission to drive up quality standards

The majority of these schemes are funded through the Better Care Fund and include improved 7 Day working in the Community. They also have an emphasis on reducing unplanned hospital admissions, care home admissions and supporting early discharge from hospital. This dovetails into agreed projections that the Trust will reduce its bed base over the next 5 years. In 2015-16 we will focus on reducing length of stay with the initial aim of reducing bed occupancy to 90% or less, to improve flow and enable the right patient to be placed in the right bed.

Within this work there is a key focus for mental health and physical health to be responded to holistically. Integration of mental health practitioners into the integrated teams will aid this cultural change along with the implementation of the mental health crisis action plan. In response to the Mental Health Crisis Care Concordat Wirral partners have developed a local mental health crisis action plan which aims to wherever possible prevent crises from happening by ensuring early and effective interventions, to ensure that people receive high quality treatment and care, that is safe and effective and to work with individuals and their carers to promote recovery and staying well. This will remove reliance on the acute hospital for individuals requiring urgent mental health care and ensure that care is delivered closer to home. Recent initiatives such as the Mental Health Street Triage service implemented in February 2015 has shown a 50% reduction in individuals being brought to the AED via the police to a health provided place of safety, as more appropriate alternatives and interventions are being provided at the point of assessment. Mental Health practitioners will also form part of the single front door model, forming links with Primary Care Mental Health and third sector and voluntary organisations, allowing for a greater universal response to individuals experiencing a mental health crisis.

3.3. Workforce redesign

Wirral Partners knows that the NHS and the health community face some significant challenges in respect of maintaining existing workforce models. Numbers of traditionally developed nursing and medical roles are unlikely to be able to meet demand for existing care models, let alone new models that emphasise a more proactive approach to prevention and community based care. The health community in the Wirral has already developed robust programmes for Assistant and Advanced Practitioners and the deployment of Apprentices into NHS roles. We want to continue our creative approach to workforce redesign and our clinical leaders need to overcome any professional inertia that may exist.

Workforce pressures and constraints are equally present in primary care and not only is a much more integrated approach to care delivery needed (through the application of the New Care Model approach) but that this also should be accompanied by much greater integration between traditional acute and primary care nursing and medical roles. We know that in order to be sustainable we will need to move outside of traditional roles within the primary, community, secondary health and social care workforce, blending skills from both to develop hybrid roles. We will need support from education and training bodies to enable us to do this at pace, in the best way and which leads to changes in how health and social care professionals are trained and educated. Support from NHSE has been requested regarding blending the medical and social care models, using a framework to analyse the workforce across all sections, introducing new roles e.g. Wirral-wide care navigation role, leadership development for middle manager/care management and looking at the health and wellbeing of staff. It is essential that our workforce is actively engaged in understanding and implementing the changes required to deliver our new model of care as well as encouraging suggestions for improvement in implementing the new care models. Our engagement will be targeted at different groups to ensure that messages are meaningful to individuals whatever their profession or level of function in their organisation e.g. strategic or operational. We also recognise that we need to build trust between the staff working in

our different organisations so that they are confident to hand off and receive the patient into a different setting and do not replicate activity.

As the number of people requiring acute hospital care reduces and length of stay in hospital drops, the anticipated workforce required within this setting will fall. For example, in 2015-16 it is projected that this will release 23 qualified staff and 17 un-qualified staff, who will initially be relocated into vacancies within the Trust, but any surplus staff will be trained and developed to work across the wider health economy in a community based setting. As the new model of care accelerates, the numbers of existing staff to be redeployed from acute to other community based settings will increase and will place greater emphasis on redesign of roles in line with the new care model proposed.

Moving to a new model of care will provide an opportunity for secondary and primary care doctors to work together and within each other's environments. For example, in diabetes care, expert clinicians will provide an MDT approach to assessment, prevention and intervention, delivering services on a hub and spoke model to make full use of community resources such as GP practices or Health centres where appropriate. It is also envisaged that GP's will work within the hospital. Moving towards seven day working in Primary care will enable relationship building and skills sharing between GP practices across Wirral - work that has already commenced in relation to a skills audit and training needs analysis for Practice Nurses which will be incorporated to support these developments.

For the majority of those schemes we have predicated staffing and activity up until 2020/21 in appendix 3. The predicted activity was based on the extrapolation of the number of contacts per year now, and up until 2020 and therefore what extra staff would be required to meet the needs in the community, taking into account the increased population of 18% and associated increase in complexity. The data shows that as the activity in the hospital decreases, the impact on community services increases and therefore the activity and staffing levels are predicted to increase.

3.4. Informatics

The Wirral Partners new care model encompasses three data driven components which will enable us to manage local population health more effectively.

- Risk stratification tool
- Wirral Health Information Exchange (HIE)
- Wellness and Disease registries supported by an integrated record

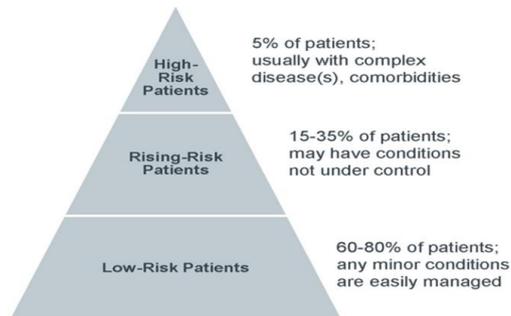
There have already been significant strides towards the roll-out of the risk stratification tool to all GP Practices in August 2015. The new care model will build upon this initiative through the development of wellness and disease registries (i.e. the standard of care we want to deliver to our entire population) that will complement the risk stratification tool. The Health information exchange summary is required while Wirral Partners transition to a full population record while all health and care service providers' data feeds into the single record.

3.4.1. Risk Stratification

The Wirral risk stratification model processes secondary and primary care data against 150 indicators, as supported from research conducted by the King's Fund, to determine a risk score. The findings from the model are then made available to GP's across Wirral to ensure the most appropriate intervention to ensure the right care at the right time for at-risk patients.

Figure 4 shows the risk stratification pyramid which is divided into three groups of patients; high risk, rising risk and low risk. Patients identified as high risk will usually have complex disease and co-morbidities; by proactively identifying these individuals, the GP can capitalise upon the full range of integrated services that are being developed. We are already seeing examples of GPs working with the Integrated Care Coordination Teams, enabling the individuals identified through risk stratification to have a proactive, holistic assessment to optimise their treatment and identify opportunities for intervention to prevent or slow disease progression and ultimately reduce reliance, likelihood and frequency of hospitalisation for those identified.

Figure 4: Patient Risk Stratification Pyramid



Through appropriate intervention we aim to push patients down the triangle. For example, a patient with diabetes will be engaged in programmes to prevent the development of secondary complications which may lead to amputation which would push them into the high risk group. We know that prevention of lower limb amputation linked to diabetic disease would save circa £420,000 per annum (2013-14 data) in acute care costs alone regardless of the on-going cost of rehabilitation to enable the individual to return to their home.

In addition the tool will allow Wirral GPs to focus on cohorts of patients lower down the pyramid to ensure right care, right place, right time for larger patient cohorts within the Wirral population. Low risk patients, for example those with impaired glucose regulation can be directed to participate in lifestyle management education programmes to reduce progression of diabetes thus preventing them moving into the rising risk group.

In order to meet strict information governance requirements the CCG have put in place data sharing agreements with GP practices, conducted privacy impact assessments on relevant data sets and achieved Accredited Safe Haven (ASH) status to allow the data to flow.

It is anticipated that the risk stratification model will be rolled-out to GP practices in August 2015 to enable the benefits of risk stratification to be felt across the whole Wirral health and social care economy, rather than just for a small number of practices. As such, this will significantly increase the impact of this proactive approach to care coordination and further impact the scale of avoided admissions.

3.4.2. Health Information Exchange

The Health information exchange (HIE) has been developed to enable sharing of core clinical information; it is an electronic patient summary that includes the most commonly needed pertinent information about current and past health status of a patient (e.g. demographics, allergies and alerts, conditions or problems, medications, advance directives, immunisations, vital signs, results, encounters, procedures, etc.) in a form that can be shared with other software systems and web browsers.

This patient summary is required while Wirral Partners transition to a full population record while all health and care service providers' data feeds into the single record. By April 2016 we will have enabled the population record with two feeds from the acute and primary care systems.

3.4.3. Development of Registries

The new model of care is developing a population health technical platform (HealthIntent) to bring together population health and care information from the disparate electronic records across Wirral health and social care economy to create a single record. During the process of creating the single

record, for each source, HealthIntent transforms and compiles the pieces of data into a reference record which are cleansed, modelled in a common structure and codified in standard terminology. Reference records support all industry standard vocabularies (for example SNOMEDCT/ICD10) allowing the viewer to see the source of the information as the single population record. The single record will then enable Wirral Partners to define and create wellness and disease registries to assist in standardising pathways of care and ensure compliance both from a provider and people perspective, driving care towards optimal management of the entire population.

In May 2015 core teams of clinical specialists from the areas where our evidence indicated the need for registries to be developed met with informatics specialists to identify the foundations for each registry and establish timelines for development. We have identified areas where we are able to progress at pace the development of registries; these can be seen in Appendix 4.

We recognise our local population and health and care givers demand assurance; understanding the purpose of implementing new ways to derive information and assurance that data is secure and used for appropriate health and care decision making. We have proactively engaged the Caldicott Guardians and Information Governance Leads from across the Wirral health and care economy to provide the programme with specialist advice and guidance as we develop and implement our new technology to support and inform the development of new models of care. They are developing a work programme to inform the new requirements to support the development of new ways to process and use data for improving health and care. A workshop with Cerner colleagues will be held on 30/31st July to understand data flows and their relationship to information governance.

Wirral Partners has identified that it requires National New Care Models Team to support us on our journey to challenge the current views and perceptions both nationally and locally on how data is handled and the opportunities which the use of data provides to improve the health of the population.

3.5 Outcome based commissioning

Wirral Partners want to build their model of integrated care and informatics driven population health into one which explicitly drives improved outcomes for local residents for the medium term, reducing health inequalities and the cost burden of poor health. They will develop a commissioning model where incentives are aligned to actively promote collaborative working between care providers in order to deliver services which meet the specific outcomes identified. The overarching aim of this type of commissioning is to achieve better outcomes through more integrated, person centred services and ultimately provide better value for every pound spent on health and care.

As a Vanguard site, Wirral Partners will develop outcomes and Key Performance Indicators (KPIs) that are person centred and co-designed with staff and the public. Taking a commissioning for outcomes approach will enable Wirral Partners to align payment models to ensure delivery remains focussed on the agreed outcomes (and not just on counting numbers). As a health and social care economy Wirral have some experience in commissioning in this way which we will use to learn from.

Through the new models of care programme Wirral Partners aims to build on this work, together with population health approaches from Cerner and insights from Advocate Physician Partners to implement large scale outcomes based commissioning.

Wirral Partners have moved a long way in testing out new ways of designing and commissioning services that focus on improving outcomes. However, to date, the emphasis has been upon relatively discrete service redesign initiatives, an example of which is detailed above, and we are still learning from the process.

The Vanguard programme provides a unique opportunity to move this approach further and faster in order to transform the local commissioning of services, and the associated payment models and incentives, at pace and at scale. Our vision is to move to a system where incentives are aligned to improve outcomes across pathways of care and where integrated commissioning, contracting and associated payment mechanisms actively support integration across organisational boundaries. This is likely to be achieved by a move to capitated budgets that have incentives built in to the

contract linked to achievement of outcomes. For example, learning from our work with Older People’s services could be used to inform the commissioning of an outcomes-based pathway for the care of Older People that moves away from the current focus on hospital-based care towards integrated provision of care closer to home. Within this example, outcomes based incentives could be linked to wellness and the promotion of self-care, better experience of care, sustained recovery from ill-health etc. Transformation of our unplanned care services is a further example where a strong focus on outcomes aimed at disincentivising unnecessary hospital admission would reap significant benefits in terms of patient experience and service efficiency.

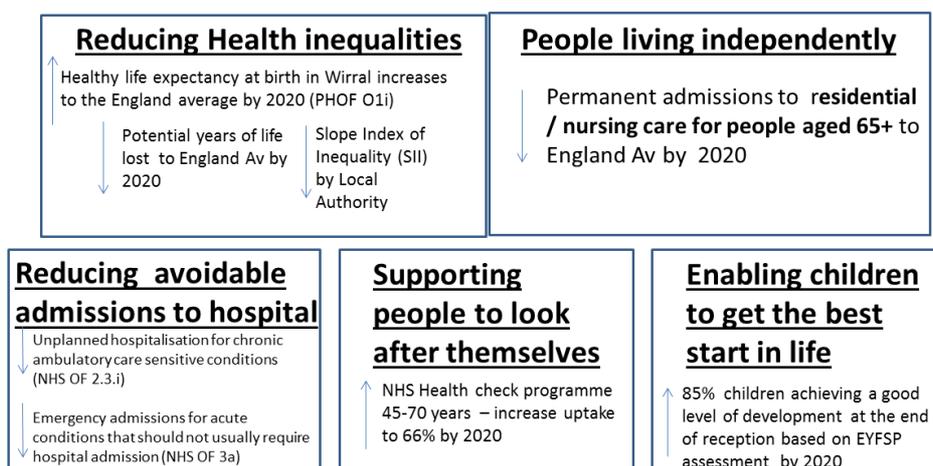
However, in order to take forward this ambitious vision for large-scale outcomes commissioning, additional support will be required. This will involve both the permission and technical expertise to move away from traditional ‘payment by results’ funding mechanisms to outcomes focussed models on a larger scale. In addition, there will be an element of ‘double running’ associated with the transition between the 2 payment methodologies to ensure stability of the system.

3.6 Evaluation and monitoring

When developing “Healthy Wirral” strategic outcomes (Appendix 5) Wirral Partners developed metrics to enable them to measure their progress towards these outcomes. Six themes were identified that will act as a barometer to indicate progress towards Wirral Partners ambitions (Figure 12)

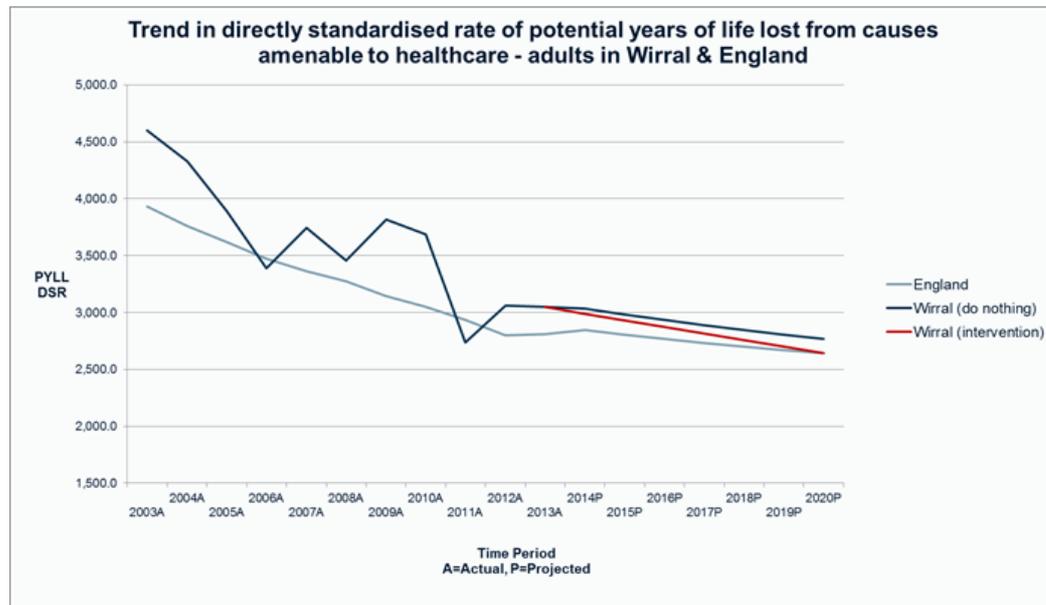
Figure 12

Our Barometer



The graph in figure 13 is an example of how the Wirral Partners Programme will evaluate its metrics. In relation to the potential years of life lost (Reducing Health Inequalities), looking at a do nothing scenario Wirral would be 5% higher than the England rate in 2020. The graph shows how the overall rate has remained higher than the England average over the most recent period. Through the delivery of New Models of Care Wirral Partners have set an objective to match the England average by 2020, improving on the programmes of work already in place by a significant proportion. This measure will be analysed in the context of other measures to accurately assess inequalities locally such as Healthy life expectancy at birth in Wirral (PHOF O1i) and Slope Index of Inequality (SII) by Local Authority.

Figure 13: Outcome measure – potential years of life lost from causes amenable to healthcare – adults.



To further understand the level of impact on cohorts of the population Wirral Partners are also developing a dashboard focused on the improvement we would expect to see in patients affected by the development of the phase 1a and 1b registries; who may have diabetes, asthma, depression and/or factors related to clinical and social wellness (Appendix 5). We would expect to see:

- *Diabetes*: a decrease in lower limb amputations for diabetic patients to the England average by 2020;
- *Respiratory*: a steep reduction in asthma admissions improving on England average by 2019;
- *Diabetes/Respiratory*: a reduction in unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s to the England average by 2020.
- *Depression*: an increase in the IAPT recovery rate- stretching the national target by 10% by 2020;
- *Social Wellness*: improvement in happiness to the North West highest (this is one example of many to be measured for of social wellness - there will be a multitude of factors developed)
- *Clinical Wellness*: an increase in the numbers of diagnosed patients with hypertension and an increase in the proportion of patients with controlled hypertension to increase to 84.3% in 2020 (clinical wellness will include measures currently in the QoF along with additional measures)

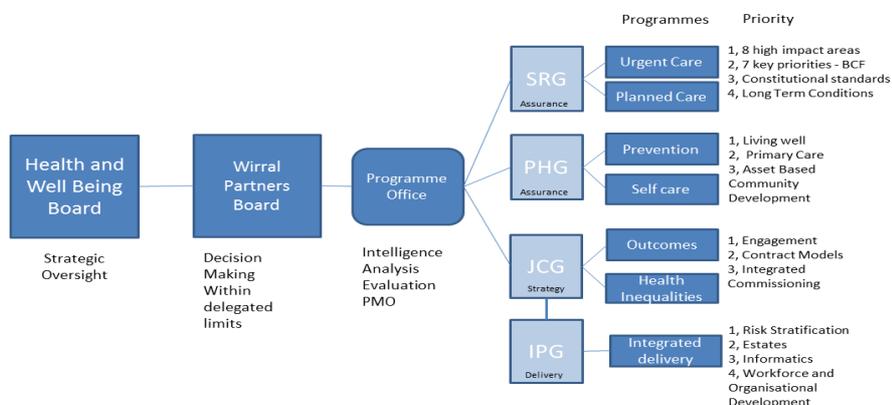
All of these will be proxy indicators that will highlight if our work is starting to show an impact on the health outcomes of the population; these metrics will be one of many ways on which we will measure success

4. Governance Structure

Wirral Partners have reflected on the leadership and governance approach adopted in the development of the programme prior to the Vanguard application. In the light of our status as a New Model of Care site, we have streamlined this structure to ensure that it acknowledges the need to have assurance of short term operational delivery complemented by a strategic population based health (health and wellbeing approach). The revised governance structure is outlined below

Figure 14: Wirral Partners Vanguard governance structure

Vanguard Governance Structure



Through this governance structure Wirral Partners will seek assurances on

a) Operational delivery through the Systems Resilience Group (SRG) which has two key programmes – Urgent Care and Planned Care. The priority for these work streams include

- 8 High Impact Area for Urgent Care
- 7 Key priorities in our Better Care Fund Plan
- Delivery of Constitutional standards during the life of the Vanguard programme
- Approach to risk stratification with Long Term Conditions

b) Health and well-being approach through the Population Health Group (PHG) which will develop new strategies in relation to Prevention and Self Care. The priority for these work streams include

- Living well
- Primary Care
- Asset Based Community development

Wirral Partners will seek the ongoing and continued development of its implementation strategy through the Joint Strategic Commissioning Group (JCG) which will focus on outcomes and outcome based commissioning and commissioning for health inequalities. The priority for these work streams include

- Engagement
- Contracting and payment models
- Integrated commissioning

Working with the JCG, Wirral Partners have developed an Integrated Provider Group (IPG) in order to realise the opportunity of integrated commissioning with integrated delivery. With the intent of jointly developing strategy but also hold to account the JCG, the IPG will seek to further develop the Vanguard approach with the clear understanding that delivery for integration is the responsibility of the IPG. The priority for the IPG will include

- Pathways integration
- Risk stratification
- Estates
- Informatics
- Workforce and organisational development

Oversight of all these programmes will be through an enhanced Programme Office (PMO). The Strategic Leadership Group will act as the “Wirral Partners Board” and will consist of senior leadership from:

- Wirral Clinical Commissioning Group
- Wirral Local Authority (Public Health, DASS, CYPD)
- NHS England as co commissioners
- Wirral University Teaching Hospital NHS Foundation Trust
- Wirral Community NHS Trust
- Cheshire & Wirral Partnership NHS Foundation Trust
- North West Ambulance Service NHS Trust
- Local Representative Council (includes Local Medical, Dentistry, Pharmaceutical and Optometry Councils)

To complete the governance cycle and provide and protect the values of the system across Wirral, the Wirral Partners Board will be held to account by the Health & Well Being Board which is a welcomed development of members - so citing Vanguard as a priority and standard agenda item at the Health & Wellbeing Board.

5. Programme methodology

A programme methodology has been developed to support effective implementation of the new model of care (Figure 15) It is based upon Public Sector Programme Management Approach of which there are five distinct phases each broken into key steps and can be used across all of the new models of care programmes or individual projects.

Depending on the size of the individual project/programme there are checkpoints and appropriate project documentation at distinct phases which link into the governance structure in figure 14 and enable clear approvals processes.

Updated implementation tools and templates will be used to enable the Programme Management Office to have consistent project software to aid project planning, so that Wirral Partners can effectively manage delivery, interdependencies, cost and benefit tracking. This will enable leads of each of the groups and the Wirral Partners Board to have an oversight of deliverables and escalated risks.

Figure 15: Programme Methodology

INITIATE	DEFINE	CO-DESIGN	IMPLEMENT	CLOSE
1. Mandate/ case for change	3. Organise programme	7. Engage stakeholders	11. Plan project	15. Formal close down
2. Programme brief/ vision	4. Define governance	8. Develop future state	12. Change management	16. Learning capture
	5. Investigate/ scope benefits	9. Define metrics	13. Programme monitoring	
	6. Programme blueprint	10. Consult	14. Benefits realisation	

To implement the catalysts for rapid change Wirral Partners will build on the existing Programme Management Structure to create an enhanced core team with assigned roles to each of the four main groups described above. These roles are already partly filled through internal secondments and resources in kind from all partner organisations. Alongside this core team there are also identified staff who are in the existing partner organisations that have committed a proportion of their time in kind to provide the wider programme management support and leadership through the Wirral Partners Board and its sub groups. Interviews for a Programme Director post will be held on 20th July 2015.

6. Risks and mitigation

In establishing our programme arrangements, the Wirral Partners are clear that there are a number of risks and mitigations which they will need to ensure are managed and reviewed. At a strategic level the core risks and mitigations are described appendix 6.

The Strategic Leaders Group which is driving the deployment of the programme reviews these risks on a regular basis, together with the more detailed project risks across the workstreams being deployed to develop the New Model of Care. This is a 'live' approach to ensure that new and latent risks are managed and discarded appropriately and links into the wider governance and risk assessment processes of each of the statutory organisations involved in the Healthy Wirral programme.

7. Conclusion

The Board are asked to note the progress of the Wirral Partners New Care Model Programme to date and the next steps that are due to progress across the Programme.

Appendix 1: High level Programme Plan

Themes	Deliverables				Triple Aim		
	2015/2016	Report to	Lead For	When	Outcomes	Experience	Reduced System Cost
1. Engaging local population and health and social care workforce to change culture	1.1 We will identify effective methods of engagement with our local population to ensure they can articulate "what matters to them" to build clear understanding of our priority areas.	JCG	Engagement Lead/ Core Team	(Ongoing) Review on 1.10.15	✓	✓	
	1.2 We will capture a library of stories from local people that will provide an "acid test" to demonstrate whether we have been able to deliver "what matters to people".	JCG	Engagement Lead/ Core Team	(Ongoing) Review on 1.10.15	✓	✓	
	1.3 Following engagement with local people we will establish and agree their expectation of Wirral Partners and Wirral Partners expectation of local people, developing a "social contract".	JCG	Engagement Lead/PHG	(Ongoing) Review on 1.11.15		✓	
	1.4 We will identify Wirral wide community connectors which will form a key part of our engagement network.	JCG	Engagement Lead/PHG	(Ongoing) Review on 1.01.16	✓	✓	✓
	1.5 We will explore how to stratify population groups to enable targeted and effective engagement of specific groups. (Learning from Children's services and NHSE ask).	JCG	Engagement Lead/PHG	(Ongoing) Review on 1.09.15	✓	✓	✓
	1.6 We will develop and have commenced implementation of a 3 year engagement strategy to empower local people to start to take control of their own health and wellbeing using behaviour change and social marketing approaches.	JCG	Engagement Lead/ PHG	(Ongoing) Review on 1.09.15	✓	✓	
2. Enhanced Integration - Integrating health and wellbeing provision around the person	2.1 Increase the throughput of service users into Integrated Care Co-ordination Teams, including patients requiring end of life care	SRG	IPG	1.09.15	✓	✓	✓
	2.2 Implement a Rapid Community services at home (4hr GP response)	SRG	Integration Lead in PMO	1.0915	✓	✓	✓
	2.3 Commission and implement Bed based Intermediate Care and Transitional care/ Multi-Disciplinary team	SRG	Integration Lead in PMO	1.09.15	✓	✓	✓
	2.4 Develop an Urgent Care Centre (Single front Door) and Integrated Gateway	SRG	Integration Lead in PMO	1.04.16	✓	✓	✓
	2.5 Review and enhance the Integrated Discharge Pathway	SRG	Integration Lead in PMO	1.09.15	✓	✓	✓
	2.6 Improve the quality of care provided in Care Homes	SRG	Integration Lead in PMO	1.04.16	✓	✓	✓
	2.7 Build on existing work within the Children's integration agenda (such as ADHD and Self Harm) to deliver integrated services between Health, Education and Social Care aligned to Adults services.	JCG	Integration Lead in PMO	1.04.16	✓	✓	
	2.8 Integration of health and social care to capture the first phase of the work on developing registries for Diabetes, Asthma, COPD and Clinical Wellness	JCG	Integration Lead in PMO	1.04.16	✓	✓	✓
	2.9 We will enhance the links between health and social care services to the voluntary and community sector by developing an extended model of social prescribing	PHG	Integration Lead in PMO - PHG	1.04.16	✓	✓	✓
3. Workforce redesign	3.1 By March 2016, in conjunction with the development of the New Model of Care and drawing on national support, we will understand the skills required to deliver the new model of care and whether they are available and if not how we develop them	JCG / IPG	Programme Director in PMO	1.03.16	✓	✓	
	3.2 In tandem and by March 2016, we will identify the current skill set of the existing workforce, utilising existing workforce and planning information to draw together a map of workforce strengths and weaknesses, opportunities and threats	JCG / IPG	Workforce Lead in PMO	1.03.16	✓	✓	
	3.3 By the end of March 2016, we will map current skills against those required to:	JCG / IPG	Workforce Lead in PMO	1.04.16	✓	✓	
	3.3a - identify gaps	JCG / IPG	Workforce Lead in PMO	1.04.16	✓	✓	
	3.3b - identify areas where skills need to be transferred within the economy to deliver the right care in the right place	JCG / IPG	Workforce Lead in PMO	1.04.16	✓	✓	
	3.3c - Identify training requirements for the workforce to deliver new care models	JCG / IPG	Workforce Lead in PMO	18.12.15	✓	✓	
	3.4 From April 2016, in collaboration with staff side we will have produced and started to deliver a workforce development strategy to support this transformation	JCG / IPG	Workforce Lead in PMO	1.04.16	✓	✓	
	3.5 Support staff to shift from a medical model to a social model of care so delivery of care is based on what matters to people rather than what is the matter with people	JCG / IPG	Workforce Lead & Engagement Lead in PMO	1.04.16	✓	✓	✓
	3.6 Changing the culture of workforce to improve staff health and wellbeing by: develop a wirral partner wide standard set of measures for our staff to be healthy	JCG / IPG	Workforce Lead and Engagement Lead in PMO	1.04.16	✓	✓	

Themes	Deliverables				Triple Aim		
	2015/2016	Report to	Lead For	When	Outcomes	Experience	Reduced System Cost
4. Informatics	4.1. We will develop a full Informatics Strategy containing data and technology plans to enable the following and prevent duplication	JCG / IPG	Informatics Lead in PMO	31.12.15	✓	✓	✓
	4.2 By September 2015 we will define the patient cohorts and measures for the registries for respiratory and diabetes which will inform the new models of care	JCG / IPG	New Models of Care Lead in PMO	30.09.15	✓	✓	✓
	4.3 By December 2015 we will define the patient/people cohorts and measures for the registries for depression and wellness which will inform the new models of care	JCG / IPG	New Models of Care Lead in PMO	31.12.15	✓	✓	✓
	4.4 Extend HIE to further GP practices (possibly 6 pilots or more) by July 2015	JCG / IPG	Informatics Lead in PMO	31.07.15	✓	✓	✓
	4.5 Set up Wirral Partners Information Governance Workstream May 2015	JCG / IPG	Informatics Lead in PMO	31.05.15		✓	
	4.6 Set out the method for engagement on data sharing and the consent options available for SLG to go to health and social care teams and the public to share health and social care data to enable new models of care	JCG / IPG	Informatics Lead in PMO	31.07.15		✓	
	4.7 Complete consultation on approach to IG and options for population health consent models with GP's and secondary care consultants by end September 2015	JCG / IPG	Informatics & Engagement Leads in PMO	30.09.15		✓	
	4.8 Establish data feeds in the population health management system between primary care and hospital care systems (Cerner and Emis),	JCG / IPG	Informatics Lead in PMO	1.12.15	✓	✓	✓
	4.9 Establish data feeds to mental health, social care and community care systems during (Liquid Logic, System 1 and Care Notes)	JCG / IPG	Informatics Lead in PMO	30.6.16	✓	✓	✓
	4.10 The new platform enable the development of and access to the Wirral wide Integrated Record of Care by April 2016 (EMIS and Cerner data)	JCG / IPG	Informatics Lead in PMO	1.04.16	✓	✓	✓
	4.11 Complete consultation with Wirral service users following approach/ options laid out by Wirral Partners Caldicott and IG leads	JCG / IPG	Informatics & Engagement Leads in PMO	31.10.15		✓	
	4.12 Following approval, we will roll out the risk stratification model to all practices by November 2015 (including Communications with GP practices, processing of data, roll out to GP practices)	JCG / IPG	Business Intelligence lead in PMO	1.11.15	✓	✓	✓
5. Commissioning for Outcomes	5.1 By April 2016, we will have explored and identified suitable payment models that will work in our locality	JCG	Finance and Contracting Lead in PMO	1.04.16	✓	✓	
	5.2 Commissioning arrangements will be conducted in an integrated manner to ensure that all opportunities to improve provision for the people of Wirral are taken	WPB	Chair - Wirral Partner's Board	Ongoing	✓	✓	✓
	5.3 Prepare for implementation of these models for appropriate cohorts from April 2016 onwards by learning from the implementation of an outcomes focussed model for delivery of diabetes care	JCG	Finance and Contracting Lead in PMO	1.04.15	✓	✓	
	5.4 Identify specific pathways of care to commission on an outcomes basis for the 2016/17 contract year	JCG	Finance and Contracting Lead in PMO	31.12.15	✓	✓	✓
	5.5 Identify appropriate payment and contract models to facilitate commissioning of pathways identified in 5.4 above	JCG	Finance and Contracting Lead in PMO	31.12.15	✓	✓	✓
6. Evaluation and monitoring of new models of care and their impact on quality of care, experience and value for money (triple aim)	6.1 With external support, by April 2016 we will design and implement a mechanism to monitor and track the delivery of the new models of care, and where possible, realise immediate benefits (quality outcomes., experience and value for money)	WPB	Programme Director in PMO	1.04.16	✓	✓	✓
	6.2 Produce monthly reports to review feedback and outcomes to ensure continuous improvement	WPB	Programme Director in PMO	Monthly starting 1.09.15	✓	✓	✓
	6.3 Regularly share learning across Wirral Partners and Vanguard sites through NHS E programme	WPB	Programme Director in PMO	Ongoing	✓		
	6.4 Systems intelligence /modelling / forecasting and benchmarking against best practice	WPB	Business Intelligence lead in PMO	Ongoing	✓	✓	✓

Appendix 2: Projects aligning to Programme

The focus of the emerging 'Health and Wellbeing Model' is person-centred and describes the health and social care provision for 'Mrs Smith' and her family. It considers self-care and independence as a foundation to wellbeing with access to public sector services in a timely and rapid manner, only when necessary. The model describes a care navigation approach to support access to layers of provision as appropriate to individual need, which in turn supports people to live. By aligning the projects / programmes in the Vision 2018 programme to the layers described in the model it ensures that the individual projects do not work in isolation but integrate to support the overarching strategic objectives.

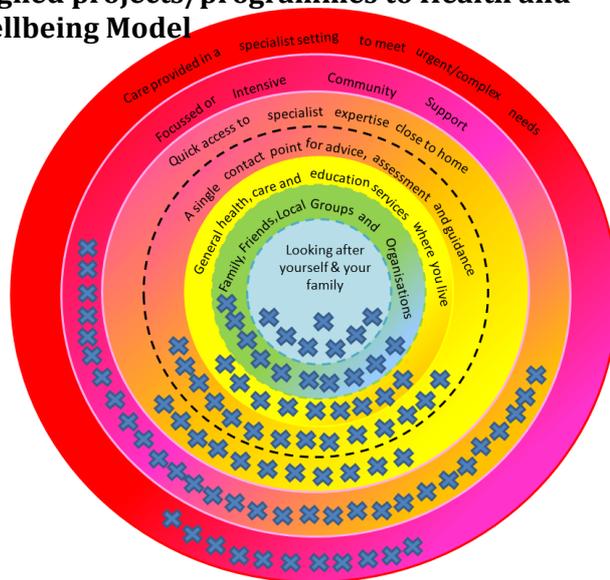
The Vision2018 programme had identified 200+ change projects and programmes across health and social care that were either already in development or due to commence; focussed on delivering integration, efficiency and sustainability. However, following the successful Vanguard site bid there was a need to realign the limited capacity to resource and deliver the existing change projects to quality and deadline. A multi-disciplinary review (clinical, finance, BI, PMO, strategic & planning) was undertaken, with input from health and social care lead commissioners; to prioritise and rationalise the projects to 73 active projects/programmes of work. These projects will aid the development of the new model of care along with the larger transformational projects such as the population health projects inclusive of the planned projects/programmes as part of Vanguard.

Prioritisation Criteria was developed which included a key question to analyse how each project was strategically aligned to the health and wellbeing model and what layer(s) of the model the project supported. The Model below provides a visual demonstration of the projects remaining after the rationalisation and how they align. This overarching view also enables managers to identify if there are any gaps or areas where the programme needs to focus more support and future project development.

The prioritisation criteria and alignment to the health and wellbeing model have now been applied to the project initiation process for future new projects / programmes.

All projects, from the previous change programme – Vision 2018 and those in the Vanguard programme are aligned into programmes in the health and wellbeing model and have clear reporting processes to the Governance structure.

Aligned projects/programmes to Health and Wellbeing Model



Appendix 3: Estimation of community contacts 2015-2021

Services	Baseline 2014/15	April - June 2015/16	2015/16 Activity Prediction	2016/17 Activity Prediction	2017/18 Activity Prediction	2018/19 Activity Prediction	2019/20 Activity Prediction	2020/21 Activity Prediction
Community Nursing Contacts	337,839	78,548	344,366	350,949	357,590	363,671	369,803	376,039
Community Nursing Workforce WTE	310.7	310.7	310.7	316.7	322.7	328.2	333.7	339.9
OT's Contacts	6,072	1,564	6,254	6,442	6,635	6,834	7,039	7,250
OT's Workforce WTE	31.46	33.46	33.64	34.63	35.67	36.74	37.84	38.97
Physio Contacts	8,821	2,272	9,086	9,358	9,639	9,928	10,226	10,533
Physio Workforce WTE	76.8	78.83	78.83	81.3	84	86	89	92
Spec Nursing Contacts	31,249	8,359	33,434	34,655	35,846	36,851	37,801	38,782
Specialist Nursing Workforce WTE	60.3	60.3	63.7	66	68.2	70.1	72	73.8
ICCT's Contacts	994	384	1825	5,126	5,280	5,438	5,601	5,769
ICCT's Workforce WTE	25.5	25.5	28.1	39.34	40.52	41.74	42.99	44.28
Single Front Door Contacts	30630	30,529	122,117	125,780	129,554	133,440	137,444	141,567
Single Front Door Workforce WTE	32.93	32.93	131.72					

Acute Trust	31.3.15.	30.6.15.	31.3.16.		31.3.19
Bedbase	795	741	712		545

*2019/20 Based on a reduction of circa 250 beds within the acute setting

Appendix 4: Phasing for the development of registries to support Wirral Partners New Care Model

Phase	Registries	Anticipated date registry to commence
1a	Asthma - adult	April 2016
1a	Asthma - child	April 2016
1a	COPD	April 2016
1a	Diabetes - adult	April 2016
1a	Diabetes - child	April 2016
1b	Depression	October-December 2016
1b	Clinical Wellness - adult	October-December 2016
1b	Clinical wellness - child	October-December 2016
1b	Social wellness - adult	Dependent upon identified population group
1b	Social wellness - child	Dependent upon identified population group

Appendix 5: Healthy Wirral Strategic Outcomes

Strategic outcomes	
1	We deliver the right care in the right place at the right time. First time and every time.
2	We deliver an improved health and wellbeing experience to all patients, service users and carers, in all health, community and social care settings
3	We reduce the frequency and necessity for emergency admissions and for care in hospital, residential and nursing home settings
4	We enable more people to access appropriate and effective services closer to home
5	We improve health and social care outcomes in early years to improve school readiness
6	We enable more people to live independently at home for longer
7	We improve the health and social care related quality of life for people with more than one long term condition, physiological and/or psychological
8	We increase collaboration and effective joint working between health and social care partners
9	We improve the satisfaction levels for our workforce colleagues across all health, community and social care settings
10	We improve the end of life experience for individuals and their carers.
11	We are better able to prevent ill health and diagnose conditions quickly thereby reducing the burden on treatment facilities
12	We enable people to live longer, healthier lives
13	We reduce the cost of health and social care while maintaining balance of quality and value
14	We ensure equal and fair access to clinically appropriate services for everyone on the Wirral
15	We will reduce health inequalities so that all Wirral's residents can expect and receive the same health and wellbeing opportunities

Appendix 6: Risks and mitigation

Risk	Mitigation
Lack of senior engagement and leadership, impedes delivery and implementation	Established Chief Executive led Strategic Leadership group in place which is meeting fortnightly to drive NMC programme. Programme Management Office being established with Senior Programme Director to be recruited. Each organisation has committed senior resource as PMO is established.
Lack of strong and effective clinical engagement in the New Model of Care	Clinical engagement sessions have already taken place across all organisations and joint GP/Consultant engagement session to be held 2 July 2015. GP and Consultant (together with other clinical champions) to be identified and resourced as part of PMO arrangements. Medical Director of Acute Trust and GP Chair of CCG have already visited Advocate Physician Partners in USA.
Risk that engagement of US partner is seen as threat to existing NHS provision of care	Partnership with APP and with Cerner is presented as 'learning partnership', with strong emphasis on fact that model will be NHS centred and Wirral grounded.
Risk that implementation of model does not deliver expected benefits – both from a clinical and financial sustainability point of view	Metrics for success already agreed and built into model roll out. Outline agreement to work with AQUA (Advancing Quality Alliance) to evaluate progress and to build independent feedback into development of model on roll-out.
Current models of integrated care do not go further and fast enough to impact on large numbers of patients, delivering changes expected	Implementation plan for roll out of Integrated Care Coordination Teams has been developed, with more ambitious targets for patient recruitment to reach numbers likely to have impact on use of mainstream health and social care services.
Information governance concerns about the use of sharing of data to inform population health approach	Wirral wide Information Governance Group is well established and has been working between organisations on the sharing of data for a number of years. Early engagement between IGG and Cerner has already taken place in respect of population health and further discussions are scheduled to ensure early action on potential information governance issues.
Implementation of population health software is impacted by lack of suitable hardware and interoperability	Wirral informatics already well developed across both primary and secondary care. Early engagement from Cerner into both sectors and with EMIS (primary care supplier) to establish operability concerns.
Organisational self-interest prevents rapid progress and implementation of new care models	Strategic Leadership Group meeting on regular basis to drive programme forward and act as forum for open and honest discussion between partners on risks and implementation plan. External and independent facilitation already sourced and planned for dealing with 'difficult' questions of organisational self-interest.

Lack of dedicated programme resource and support to deliver transformation and transition impedes delivery of new care model	All organisations have already committed programme resource to the PMO and strategic development and planning resources in all organisations now aligned to new models of care. Value proposition includes request for funding to supplement this already committed resource to enable both stronger programme management arrangements and 'double running costs'.
Patient and citizen resistance to new care model prevents full roll out and implementation	Engagement already started through existing Vision 2018 'Engagement with People' Group. This group will evolve to become part of revised governance structure with a wider and broader membership and remit around scrutiny of new care model proposals.
Local political resistance to new care model	Early engagement with local Health and Wellbeing Board has already taken place – further and more detailed engagement session is planned for July 2015. Ongoing engagement with local MPs through variety of means.
Financial incentives in the current system do not support delivery of new integrated out of hospital model of care	Issues with current payment systems are acknowledged to be unsustainable and contrary to the ambitions of the new model of care. Proposals ultimately include commitment on all sides to pursue movement to capitated model of payment for services across population cohorts.

Board of Directors	
Agenda Item	7.1.1
Title of Report	Integrated Dashboard and Exception Reports
Date of Meeting	29 July 2015
Author	John Halliday Assistant Director of Information
Accountable Executive	Mark Blakeman Director of Infrastructure and Informatics
BAF References	
<ul style="list-style-type: none"> • Strategic Objective • Key Measure • Principal Risk 	<p>All Strategic Objectives (1 through 7)</p> <p>All Key Measures (1A through 7D)</p> <p>All Principal Risks</p>
Level of Assurance	Full
<ul style="list-style-type: none"> • Positive • Gap(s) 	
Purpose of the Paper	
<ul style="list-style-type: none"> • 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	
<ul style="list-style-type: none"> • 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 June 2015.

2. Background

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

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

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

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

An additional Finance metric has been added from this month relating to the Trust's cash position against plan, however further discussion on future expectations in this area will be undertaken as outlined in the next steps.

3. Key Issues

Metrics highlighted as Red for June are Staff Satisfaction, A&E 4-hours, Attendance, Infection Control, Attendance, Qualified Nurse Vacancies, Contract Performance, CIP Performance, Non-core Spend, Advancing Quality and CQC.

The Board is asked to note that the 62 day Cancer Target position is still being validated, a verbal update will be provided at the meeting.

To avoid duplication, exception reports are only included in the dashboard for those metrics not covered by separate reports, or updates to the Board from the relevant associated Committee. For the annual Staff Satisfaction metric, results from the Q1 Friends and Family Staff Satisfaction are included in the exception report. These will be updated on a quarterly basis. Commentary on the financial performance metrics is contained within the separate finance report to the Board of Directors.

For RTT standards, Monitor and NHS England have recently confirmed Trusts are only to be judged by performance against the Incomplete pathway standard. The Admitted and Non-admitted standards no longer have a weighting under the Risk Assessment Framework, or a financial consequence of failure. The Integrated Performance Dashboard reports will reflect this revised definition in future.

Under Monitor's Risk Assessment Framework for 2015-16 the Governance status for WUTH is currently considered to be neither Green nor Red, with some issues identified and described accordingly.

4. Next Steps

Further work is being undertaken by the Executives to respond to the Board's requirement to clearly show Finance (activity, volume and income plan with actuals and predictions) together with the supporting and related aspects of the business (patient flow, bed occupancy, and theatre utilization as examples). The Board will discuss proposals in further detail as part of its development agenda in July 2015.

5. Conclusion

Performance across a range of metrics is provided for information

6. Recommendation

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

Meeting Our Vision						
Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period	
Satisfaction Rates						
Patient Satisfaction - F&F "Recommend" Rate	●	●	JG	96.0%	June 2015	
Patient Satisfaction - F&F "Not Recommend" Rate	●	●	JG	2.0%	June 2015	
Staff Satisfaction (engagement)	●	●	AH	3.48	2014	
First Choice Locally & Regionally						
Market Share Wirral	●	●	AH	84.5%	April 2014 to March 2015	
Demand Referral Rates	●	●	AH	5.2%	Fin Y1-on-Y1 to June 2015	
Market Share Non-Wirral	●	●	AH	9.1%	April 2014 to March 2015	
Organisational Risk Issues						
Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period	
Key Performance Indicators						
AA&E 4 Hour Standard	●	●	SG	92.96%	June 2015	
RTT 18 Weeks Standards	●	●	SG	All met	June 2015	
Cancer Waiting Time Standards	●	●	SG	On track for qtr	Q1 to June 2015	
Strategic Objectives						
Delayed Transfers of Care	●	●	SG	4	12-mth ave to June 2015	
Readmissions	●	●	EM	9.0%	June 2015	
Harm Free Care	●	●	EM	98.0%	June 2015	
HIMMS Level	●	●	MB	5	June 2015	

A Healthy Organisation						
Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period	
Clinical Outcomes						
Newer Events	●	●	EM	0	June 2015	
Complaints	●	●	JG	39.8	12-mth ave to June 2015	
Infection Control	●	●	JG	0 MRS&A, 11 C diff	June 2015	
Productivity						
Bed Occupancy	●	●	SG	91.7%	June 2015	
Theatre Utilisation	●	●	SG	89.5%	June 2015	
DNA Rate	●	●	SG	8.3%	June 2015	
Workforce						
Attendance	●	●	AH	95.3%	12-mth ave to June 2015	
Qualified Nurse Vacancies	●	●	JG	6.74%	June 2015	
Mandatory Training	●	●	AH	96.7%	June 2015	
Appraisal	●	●	AH	85.9%	June 2015	
Turnover	●	●	AH	10.7%	June 2015	
Finance						
Contract Performance	●	●	AM	-1.8%	To M3 June 2015	
Expenditure Performance	●	●	AM	1.8%	To M3 June 2015	
CIP Performance	●	●	AM	-15.6%	To M3 June 2015	
Capital Programme	●	●	AM	4.2%	To M3 June 2015	
Non-Core Spend	●	●	AM	9.4%	To M3 June 2015	
Cash Position	●	●	AM	60.0%	To M3 June 2016	

External Validation						
Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period	
National Comparators						
Advancing Quality	●	●	EM	4 areas below target	April 2015	
Mortality - HSMR	●	●	EM	92.82 (low of 87.9)	April 2014 to March 2015	
Mortality - SHMI	●	●	EM	0.96 (low of 0.89)	Oct 2013 to Sept 2014	
Regulatory Bodies						
Monitor Risk Rating - Finance CoS	●	●	AM	2	To M3 June 2015	
Monitor Risk Rating - Governance	●	●	SG	Not Green or Red	To M3 June 2015	
CCC	●	●	EM	5	June 2015	
Local View						
Commissioning - Contract KPIs	●	●	SG	2	June 2015	
Education	●	●	EM	Level 2	June 13	

integrated Performance Dashboard - Metric Thresholds

Meeting Our Vision

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

Organisational Risk Issues

Indicator	Definition	Green	Amber	Red
Key Performance Indicators				
A&E 4-hour Standard	% of patients attending ED & ADHC treated within 4 hours	>=95%	n/a	<95%
RTT '18' Week' Standard	All RTT standards met for the Trust as a whole	All met at Trust level	n/a	Not all met at Trust level
Cancer Waiting Time Standards	All Cancer Waiting Standards met for the Trust per quarter	All met at Trust level	n/a	Not all met at Trust level

Strategic Objectives

Delayed transfers of care	Average No of patients with a delayed transfer of care at month-end	<= 4	>4 and <6	>= 7
Readmissions	% of patients readmitted non-electively within 30 days of discharge	<= 7.5%	>7.5% and <= 10%	> 10%
Harm Free Care	Compliance with Safety Thermometer definition of Harm Free Care	>= 95%	>= 93% to <95%	<93%
HIMMS Level	Current HIMMS level under Electronic Medical Record Adoption Model	5	n/a	<5

A Healthy Organisation

Indicator	Definition	Green	Amber	Red
Clinical Outcomes				
Never Events	Number of occurrences of "Never Events"	0 per month	n/a	>= 1 per month
Complaints	Number of occurrences of formal complaints	<30 per month	30 to 50 per month	> 50 per month
Infection Control	MRSA Bacteremia CDIFF	0 MRSA Bacteremia in month, and cdiff less than cumulative trajectory	0 MRSA Bacteremia in month, and cdiff equal to cumulative trajectory	>= 1 MRSA Bacteremia in month or cdiff cases above cumulative trajectory

Productivity				
Bed occupancy	Average % of General & Acute Beds occupied at midday	<=85%	>85% to <95%	>95%
Theatre utilisation	Average % of scheduled operating minutes utilised	>=85%	>65% to <85%	<65%
DNA Rate	Percentage of booked OP appointments that DNA (Med, Surg and W&C)	<=7.5%	>7.5% to <9.0%	>=9.0%
Workforce				
Attendance	Rolling 12-month staff attendance rate	>= 96%	>=95.3% to <96.0%	< 95.3%
Qualified Nurse Vacancies	% vacant posts	<=2.5%	>2.5% to 5%	>5%
Mandatory Training	Rolling 12-month staff mandatory training rate	>= 95%	>= 85% to <95%	< 84.9%
Appraisal	Rolling 12-month staff appraisal rate	>= 85%	>= 80% to <85%	<80%
Turnover	Rolling 12-month staff turnover rate	<10%	>= 10% to <12%	>=12%
Finance				
Contract Performance	Delivering both contracted volumes and values	>=3	2	1
Expenditure performance	Delivering planned levels of expenditure	>=3	2	1
CIP Performance	Delivering a recurrent CIP in-year & deliverable future proposals	>=3	2	1
Capital Programme	A sound investment programme maintained & resourced appropriately	>=3	2	1
Non Core Pay Spend	% of total spend year to date	<5%	>=5.0% to 6.5%	>=6.6%
Cash Position	Delivering against cash plan	On plan or above YTD	n/a	Below plan
External Validation				
Indicator	Definition	Green	Amber	Red
National Comparators				
Advancing Quality	Combined rating	All areas above target	1 area below target	> 1 area below target
Mortality : SHMI	SHMI	Lower CI < 0.90	Lower CI 0.90 to 0.99	Lower CI >= 1.0
Mortality : HSMR	HSMR	Lower CI < 90	Lower CI 90 to 99	Lower CI >= 100
Regulatory Bodies				
Monitor Risk Rating - Finance	Monitor Risk Assessment Framework - Continuity of Service rating	4	3 or 2*	2 or 1
Monitor Risk Rating - Governance	Monitor Risk Assessment Framework - Governance rating	Green	n/a	Red
CQC	Number of concerns raised by CQC following inspection	0	1 to 2	>2
Local View				
Commissioning - Contract KPIs	Number of Quality KPIs in the contract not being achieved	<=2	3 to 4	>=5
Commissioning - CQUINs	Number of CQUINs not being achieved	0	1 to 3	>=4
Education	GMC level	Level 3	Level 2	Level 1

WUTH Performance Dashboard Exception Report

June 2015

Indicator:
Staff Satisfaction (engagement)

Rating	Target	Actual	Period
Red	>= 3.69	3.48	2014

Issue:

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

Proposed Actions:

From Quarter 1 (Staff Friends & Family Test), additional questions have been added which make up the overall staff engagement score (as detailed within the Annual NHS Staff Survey). The Quarter 1 results have exceeded the trajectory targets for improvement which were agreed at the last Trust Board meeting (trajectory set for quarter 1 being 3.52 and delivered 3.74). Whilst the initial signs are positive, these higher staff engagement scores may not directly map out in the NHS Staff Survey 2015. Themes arising from the narrative comments from the Staff FFT are:

1) How likely are you to recommend WUTH to friends and family if they needed care or treatment?

Reasons for Recommending

- staff are polite, friendly, helpful, dedicated, professional, go beyond what is expected
- Good personal experience, conditions of service, specialities working well together
- Proud to work at the Trust, excellent standards

Reasons for Not-Recommending

- Personal experience, waiting times, infection control issues,
- Low staffing levels, rude attitudes of staff, lack of equipment
- Do not live in the area
- Trust too preoccupied with targets/box ticking/paperwork

2) How likely are you to recommend WUTH to friends and family as a place to work?

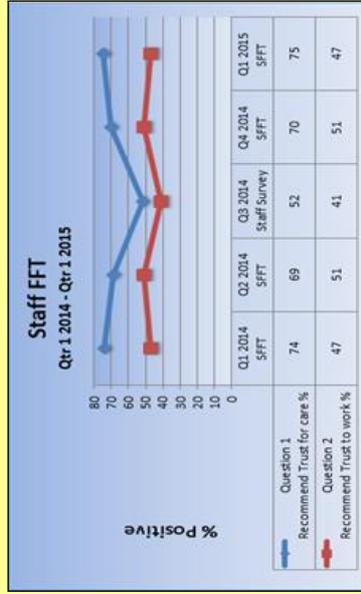
Reasons for Recommending

Staff are friendly, helpful, supportive of each other, achieve the best outcomes, Terms and conditions, opportunities for training & development and career progression, teamwork, improving staff engagement

Reasons for Not-Recommending

- Lack of management support, poor management attitudes, lack of respect by managers and some clinicians
- No management presence or communication, not dealing with issues raised or listening to staff
- Increase in demands/workload with no extra staff, not replacing staff who leave
- No job security, redeployment, down banding
- Lack of career progression
- Equipment is too old
- Stressful/under pressure, low staff morale/feeling undervalued

Historic data:



Impact:

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

Director approval:

Anthony Hassall, Director of Strategy and Partnerships.

Expected date of performance delivery:

2015 Staff Survey

WUTH Performance Dashboard Exception Report

June 2015

Indicator :

A&E 4-hour Standard

Rating

Red

Target

>= 95%

Actual

92.96%

Period

June 2015

Issue:

The standard is a minimum of 95% of A&E attendances being admitted, transferred or discharged within 4 hours. Performance for June was 92.96%, including the All Day Health Centre at Arrowe Park site. For WUTH alone performance was 90.66%. The combined Q1 performance was 87.23%.

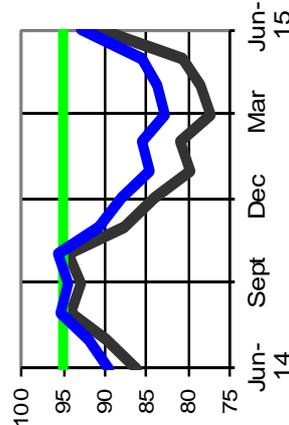
Proposed Actions:

The pressures previously reported continued through Q1 but performance started to improve as the quarter progressed, culminating in the achievement of 92.96% for June. This improvement has continued into Quarter 2 and performance is currently (@20th July 2015) at 97.98% as a site, therefore we are currently achieving the standard.
Work is continuing with partners across the Health and Social economy to deliver the agreed Urgent Care Recovery plan and work has started on the Trust's winter plan.

Historic data:

Time in ED & ADHC (Mthly)

95% 4-hour Target



% Q1TD = 82.97 (ED) 87.23 (Sit)

NB: Data to 28th June 2015 (Q1)

Assessing Improvement:

For the week ending the 12th July, the Trust achieved 96.06% on our own, and 97.08% jointly with the ADHC. The following week ending the 19th, performance was 97.94% and 98.49% respectively.

Expected date of performance delivery:

From quarter 3 in 2015/16

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.

Executive approval:

Sharon Gilligan, Director of Operations

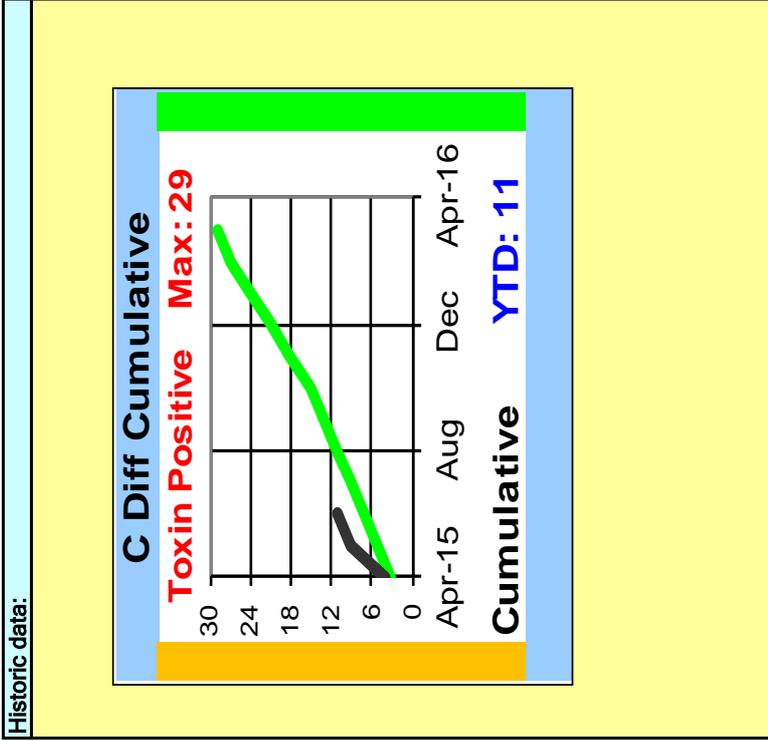
WUTH Performance Dashboard Exception Report

June 2015

Indicator :
Infection Control

Rating	Target	Actual	Period
Red	Within trajectory	11 c diff cases	To June 2015

Issue:
 The Trust has a maximum trajectory of 29 C.difficile cases for the year 2015-16 (toxin positive, hospital acquired). During June we reported 2 hospital attributed case of toxin positive C. difficile bringing the cumulative total to 11 to the end of June. There were also 3 equivocal (non-reportable) cases identified.
 The Post Infection Review performed by the IPCT identified both toxin cases to be avoidable. Both patients had had environmental exposure to C.diff, these being on wards 26 and 33, then receiving the trigger of antibiotics resulting in C.diff associated infection.
 Ribotyping from C.diff cases on ward 26 has demonstrated a pattern seen previously whereby WUTH experienced a significant outbreak of C.diff with the ribotyping suggesting environmental contamination/covert C.diff carriage & excretion as key factors as opposed to patient to patient transmission. The outbreak was interrupted by full ward HPV decontamination.
 Ward 26 received a HPV clean following the patients exposure but before the onset of symptoms with ward 33 also now having had a full ward HPV clean. A programme of bay to bay HPV decontamination is scheduled to commence on 13th July with ward 38 first priority.



Proposed Actions:
 Recommendation:
 • Divisional leads to support and ensure a reduction of 6 beds each Wednesday to allow the bay to bay programme to run as efficiently and effectively as possible.
 • Prompt isolation of patients with symptoms of diarrhoea

Assessing Improvement:
 The situation is constantly monitored by the IPCT, with weekly meetings including the DJPC 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 2 reporting

Director approval:
 Jill Galvani, Director of Midwifery & Nursing

WUTH Performance Dashboard Exception Report

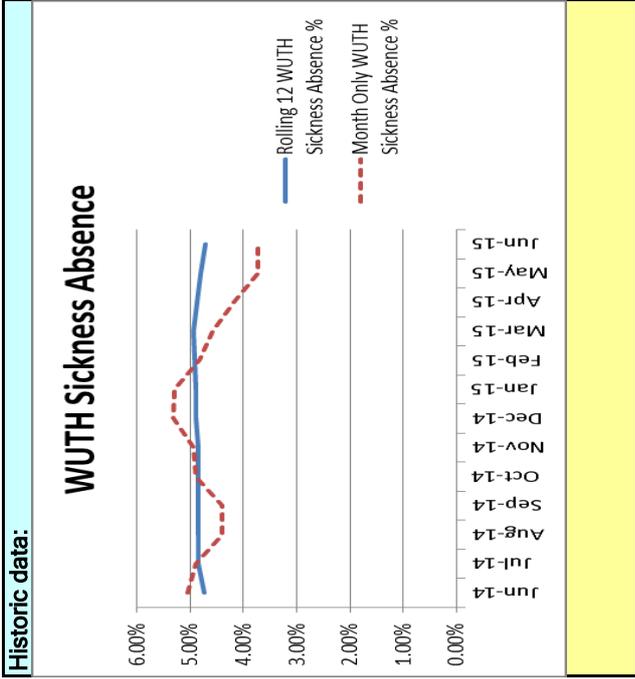
June 2015

Indicator : Attendance (Rolling 12 Months)

Rating	Target	Actual	Period
Red	>= 96%	95.29%	Jul 14 - Jun 15

Issue:
Attendance (Rolling 12 months) was 95.29% at June 2015.
 The new Attendance Capability Policy, training of over 400 managers, Health and Well Being Strategy, action plans for poor attenders, recognition of good attenders and focus on long term sick have produced reduced month only sickness rates since the new policy went live in January. This is now feeding through to a reducing rolling 12 months rate.

Proposed Actions:
 Since the new policy went live sickness rates have reduced every month (June 2015 month only was 3.74% which was the second time the Trust bettered it's target of 4%), Strong focus on staff off long term sick has reduced numbers from 154 in December to 124 in June. Other actions include: Health and Wellbeing Strategy, Monthly reporting and drill down, Monthly workforce meetings, action plans for poor attenders, Occupational Health Service.



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

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

Expected date of performance delivery:
 Quarter 2 reporting

Director approval:
James Mawrey, Director of Workforce

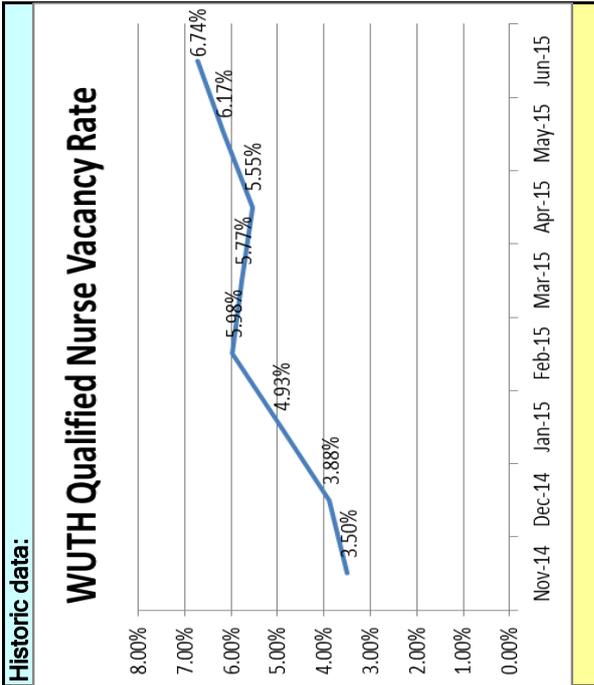
WUTH Performance Dashboard Exception Report

June 2015

Indicator :
Qualified Nurse Vacancies

Rating	Target	Actual	Period
Red	>5%	6.74%	Jun-15

Issue:
Qualified Nurse Vacancies was 6.74% at June 2015 and although this has been reducing over recent months it is still 1.74% above the Trust target of 5%. Actions as detailed below are taking place to address this. A review of Nurse Turnover metrics is taking place including benchmark data from comparator Trusts in order to establish what is a healthy level of Nurse turnover and what level requires escalation.



Proposed Actions:
 Exceptional nurse recruitment is taking place and 75 job offers were made in early 2015 (although many of these will not start for several months due to finishing qualifications or notice periods). Further generic Nurse recruitment is taking place. International Recruitment tender has been offered to the preferred provider. 23 candidates have been shortlisted for the Corporate recruitment in July.

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

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

Expected date of performance delivery:
 Quarter 2 reporting

Director approval:
 James Mawrey, Director of Workforce

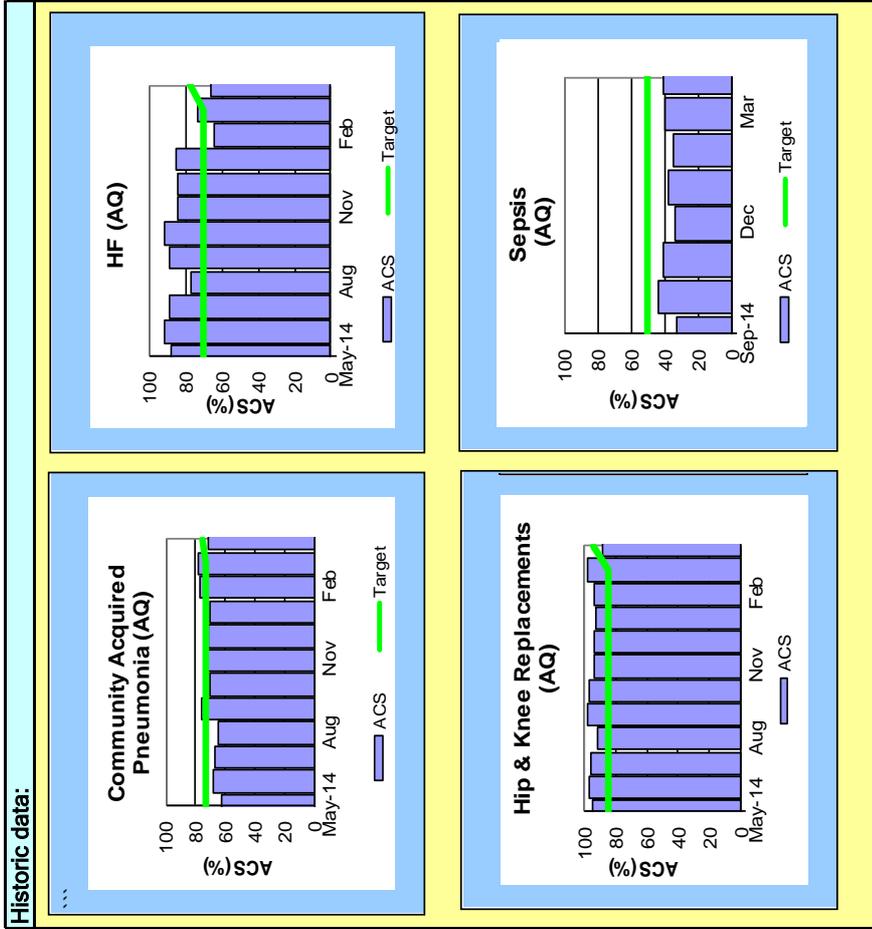
WUTH Performance Dashboard Exception Report

June 2015

Indicator :
Advancing Quality

Rating	Target	Actual	Period
Red	All achieving	4 areas under target	April 2015

Issue:
The measures are composite scores, reflecting individual care to patients; the results are delayed up to 3 months and so lags behind improvement. At the end of April, Community Acquired Pneumonia, Heart Failure, Hip & Knee Replacements and Sepsis were below target.



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. There is just one month's performance (April) available for reporting against the new targets. A greater understanding of any shortcomings will be confirmed in the next couple of months.

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

Board of Directors	
Agenda Item	7.1.2
Title of Report	Month 3 Finance Report
Date of Meeting	29 July 2015
Author	Shahida Mohammed, Assistant Director of Finance – Income & Commissioning
Accountable Executive	Alistair Mulvey, Executive Director of Finance
BAF References <ul style="list-style-type: none"> • Strategic Objective • Key Measure • Principal Risk 	7
Level of Assurance <ul style="list-style-type: none"> • Positive • Gap(s) 	Positive
Purpose of the Paper <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Yes • No 	No

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1. Executive Summary

Overview

In month the Trust delivered a deficit of £1.1m against a planned deficit of £1.5m, an improvement in month against plan of £0.4m. The in month improvement against plan has also improved the cumulative I & E variance to plan to £0.1m favourable at the end of quarter 1, with an actual deficit of £4.8m against a planned deficit of £4.9m.

The Trust also reported a favourable cash position against plan both in month and at the quarter end with the Trust holding £19.6m at the month and quarter end against a plan of £12.2m.

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

The in month and first quarters financial performance reflects a positive position in terms of achievement of the Trusts overall financial plan, albeit against a planned deficit and with variation across different elements of the plan.

The Board of Directors continues to develop further detailed plans to minimize the in year deficit and the requirements for financial support currently contained within the Trusts annual financial plan.

Income and Expenditure Performance

	MONTH 3			YTD			Comparative 2014/15 Month 3 YTD Position		
	In Month			Year to Date			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
NHS Clinical Income	22,973	22,960	(13)	68,604	67,358	(1,246)	66,335	66,660	325
Other Income	2,301	2,610	308	6,895	7,310	416	7,104	7,260	156
Employee Expenses	(17,430)	(17,513)	(83)	(51,907)	(52,231)	(324)	(50,612)	(52,162)	(1,550)
All Other Operational Expenses	(7,549)	(7,742)	(193)	(22,674)	(22,844)	(170)	(20,042)	(20,942)	(900)
Reserves	(633)	(235)	397	(2,367)	(1,018)	1,349	(2,529)	(862)	1,667
EBITDA	(338)	79	417	(1,449)	(1,425)	24	256	(46)	(302)
Post EBITDA Items	(1,152)	(1,126)	26	(3,456)	(3,378)	78	(3,326)	(3,331)	(5)
Net Surplus/(Deficit)	(1,490)	(1,047)	443	(4,905)	(4,802)	102	(3,070)	(3,377)	(307)
EBITDA %	(1.3%)	0.3%	1.6%	(1.9%)	(1.9%)	0.0%	0.3%	(0.1%)	(0.4%)

The table above highlights the Trusts overall financial performance in month 3, and cumulatively, to the end of June 2015. The table also provides the comparative cumulative performance to month 3 2014/15.

Specifically the table highlights;

- In month the Trust achieved against its clinical income target although remains behind plan by £1.24m on a cumulative basis. Plans are in place, specifically within the surgical care division to recover the lost income in the remainder of the financial year although risks associated with overall patient flow may impact upon this plan.
- In month "other income" achieved £308k more than plan and this has contributed to a continued over achievement against plan on a cumulative basis with a favourable variance of £416k year to date.

- Employee costs are overspending against plan in month by £83k and this mirrors the trend seen in the first two months of the year with a cumulative overspending of £324k year to date. Overspending in this area is associated with the use of temporary staff to fill vacancies to which the Trust is currently recruiting or to cover gaps as a result of sickness absence or other forms of absence. Each area reviews its vacancies closely and how best to secure substantive staff to fill any temporary gaps, additionally as sickness levels continue to improve the number of staff required to fill gaps will reduce.
- Other operating expenses had largely been on plan to month two however an in month overspend of £193k has driven a cumulative overspend of £170k. Divisional management and finance teams are reviewing the detail of this to ensure that costs are managed back to budget in subsequent months.
- 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 £0.3m with cumulative support being £1.3m. Whilst elements of this support will be available recurrently the Board of Directors must ensure that the support applied does not mask an underlying pressure that cannot be maintained on a recurrent basis. The detail of this is reviewed through the Trusts Finance, Performance and Business Assurance Committee.

The aggregation of the above component elements delivers an in month deficit of marginally in excess of £1m against a planned deficit of £1.4m giving a favourable in month variance of £0.4m. As previously noted the in month position supports a cumulative favourable variance to plan of £0.1m.

Cash Position & Continuity of Service Ratio (COS)

The cash position is £19.6m, £7.4m better than plan. This is predominantly due to a delay in the settlement of balances with commissioners from 2014/15, underperformance to date in 2015/16 and increases in accruals against plan. The latter is due to a range of issues including delays in the billing and payment of IT, consultancy and Roche costs compared to plan, increased agency spend and accruals for the use of reserves against plan.

In addition, although the capital spend is on plan in cash terms there has been a difference in the mix of spend leading to a delay in cash payment.

It is anticipated that the majority of these timing differences will unwind in the coming months and the Trusts cash position will deteriorate accordingly. In mitigating a deteriorating cash position the Trust continues to actively manage its cash and working capital position.

The overall Continuity of Service rating at month 3 is a 2 which is in line with plan.

Cost Improvement Programme (CIP)

The Trusts plan incorporates a requirement to achieve £13m of in year CIP, to date detailed plans of £11.1m have been identified. The remaining £1.9m still to be identified has been extracted from budgets in a flat profile (12ths). In month 3 the planned schemes have delivered in line with expectations although the gap between requirement and plans remains. Activities continue through the PMO to secure the planned savings and identify areas of over performance to close the gap.

£k	YTD				
	By Scheme Type		By Cost		Total
	Income Generation Net of Cost of Delivery	CIP	NHS Clinical Income	Divisional Budgets	
Plan YTD	111	1,044	349	806	1,155
Actual YTD	124	572	166	530	696
Variance YTD	13	(472)	(183)	(276)	(459)

2. Background

The cumulative plan position as at month 3 was a deficit of £4.9m; the actual position is showing a deficit of £4.8m. The improvement in month is largely driven by an improvement in income with expenditure broadly similar to previous months.

This position provides the Trust with a risk rating of 2; as most components of the budget are as planned then the individual metrics are also as planned.

The cash position is £19.6m, being £7.4m better than plan due predominantly due to timing differences on working capital.

3. Key Issues

Through the first quarter of the financial year the Trust has delivered largely consistent financial performance across expenditure categories with greater variation being experienced across NHS clinical income specifically with months one and two under achieving from an income perspective.

Activity plans for 2015/16 were developed, agreed and signed-off by Divisional leads during the planning process, it is imperative for the delivery of the totality of the financial plan that income levels are achieved and that where initial plans have slipped remedial action plans are enacted.

From an income perspective, overall the Trust has achieved against its planned income target for month 3, although cumulatively planned care under achieved against plan and performance to date also reflects a less complex workload. In contrast unplanned care has over achieved against the plan and benefitted from a richer casemix. As note delivery of the planned volumes of care is a prerequisite to the achievement of the overall financial 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.

Divisionally income performance within total position is detailed below.

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

Within Medicine although unplanned activity is below plan from a volume perspective a richer casemix has mitigated some of the under recovery. Penalties arising due to breeches against the A & E 4 hr. target amount to some £0.3m. However discussions through the localities Strategic Resilience Group (SRG) as to the appropriateness of penalising the Trust for a position which is reliant to a significant degree on economy wide actions have been successful. On that basis within the reported position A&E breach penalties have not been applied and therefore support costs being incurred and mitigate the financial under performance.

Divisional Analysis

The following table shows the summary Divisional position (Month 3). The senior management teams within the Divisions have provided further explanation and context to the respective positions, and this is included in further detail (Appendix 2).

	Medicine & Acute £000	Surgery & W&C £000	Clinical Support £000	Corporate £000	Central £000	Total £000
NHS Clinical Income						
Planned Income	30,375	32,461	4,185	196	1,387	68,604
Actual Income	30,393	30,874	4,265	200	1,627	67,358
Variance	18	(1,588)	80	4	240	(1,246)
Net Expenditure						
Planned Expenditure	(21,245)	(24,058)	(10,267)	(12,179)	(2,305)	(70,053)
Actual Expenditure	(21,447)	(24,057)	(9,962)	(12,372)	(946)	(68,784)
Variance	(202)	1	304	(193)	1,359	1,270
Variance EBITDA	(184)	(1,586)	385	(189)	1,599	24
Post EBITDA						
Planned Post EBITDA					(3,456)	(3,456)
Actual Post EBITDA					(3,378)	(3,378)
Variance	0	0	0	0	78	78
Total Variance to Plan	(184)	(1,586)	385	(189)	1,677	102

Analysis of Pay Spend

Detail	14/15 Average £k	April £k	May £k	June £k	YTD £k
Budget	16,916	17,140	17,337	17,430	51,907
Pay Costs					
Substantive	15,875	15,605	15,783	15,873	47,261
Bank Staff	319	306	291	295	892
Agency Staff	518	698	712	605	2,015
Overtime	224	343	278	282	903
Locum	362	299	264	332	895
WLI (In Year)	155	52	88	126	266
Non Substantive Total	1,577	1,698	1,633	1,640	4,971
Total Pay	17,451	17,303	17,416	17,513	52,232
Variance	(535)	(163)	(79)	(83)	(325)

The table highlights that the quantum of substantive pay costs in month 3 returned to the average levels of cost seen through 2014/15 and is marginally above the costs attracted in month 2 by £100k. As vacancies are filled the goal would be to increase substantive pay costs whilst seeing a larger reduction in the use of flexible labour through non-core expenditure, this expectation is yet to be achieved.

Across non-core areas there is little material variation through each month across either the quantum of cost which is maintained at marginally above £1.6m per month or the different staff groups. Within this position it should be noted that waiting list initiative payments are reflecting the greatest proportional increase and will need to be closely monitored on an on-going basis to ensure they continue to represent best value for money. Relative to the previous financial year the costs associated with flexible labour through the first quarter of the year are, on average, £80k per month greater than the average of 2014/15 and again these costs will need to be closely monitored as we progress through the financial year. The goal being, as noted previously, that there will be a reduction in non-core costs as substantive appointments are made and that costs of replacement of staff, as a function of improved levels of attendance, will also ease the financial burden associated with the use of non-core staff.

4. Next Steps

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

Specifically the divisions are focusing on the delivery of activity plans as being pivotal in the overall achievement of the financial plan, this is specifically relevant as the year progresses and margin contribution schemes which form a component of the CIP programme being to increase in value.

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 Board of Directors through the Chairs Report from the Finance Performance and Business Assurance Committee.

5. Conclusion

The overall I & E position for month 3, at an aggregate level, is marginally better than plan with the Trusts cash position being 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£1.9m of CIP requirement for which plans continue to be explored.

From a risk perspective the key considerations include the requirement to recover the lost income in the early part of the financial year, the requirement 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.

6. Recommendations

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

Alistair Mulvey
Director of Finance
July 2015

Appendix 1 – Income

	ACTIVITY							In Month Movement
	Full Year Plan	Plan	Actual	Penalties	Adjusted Actual	YTD Variance	Previous Month Variance	
Elective & Day Case	50,170	12,191	11,701	0	11,701	(490)	(372)	(118)
Elective Excess Bed Days	3,854	956	875	0	875	(81)	(149)	68
Non Elective	44,924	11,088	10,863	(230)	10,633	(455)	(604)	149
Non Elective Non Emergency	5,291	1,299	1,174	0	1,174	(125)	(80)	(45)
Non Elective Excess Bed Days	17,434	4,324	5,354	(211)	5,143	819	338	481
A&E Attendances	89,442	23,282	22,667	0	22,667	(615)	(760)	145
Outpatient First Attendances	93,074	22,095	21,504	0	21,504	(591)	(869)	278
Outpatient Follow Up	192,923	46,424	45,760	(1,998)	43,762	(2,662)	(2,658)	(4)
Outpatient Procedures	45,597	11,236	10,636	0	10,636	(600)	(100)	(500)
Outpatient Unbundled Diagnostic Images	27,234	6,712	6,647	0	6,647	(65)	(33)	(32)
Maternity	6,498	1,573	1,533	0	1,533	(40)	19	(59)
Total Pbr	576,441	141,180	138,714	(2,439)	136,275	(4,905)	(5,268)	363
Non-Pbr								
Pbr Excluded Drugs								
CQUIN								
Contracted Income Sub Total								
North Wales - Additional Activity								
Other Income								
Grand Total	279,420	68,604	68,512	(1,154)	67,358	(1,246)	(1,234)	(12)

	VALUE inc MFF @ 3.8864%							In Month Movement
	Full Year Plan	Plan	Actual	Penalties	Adjusted Actual	YTD Variance	Prior Month Variance	
	54,421	13,079	11,820	(69)	11,751	(1,328)	(870)	(458)
	849	211	188	0	188	(23)	(36)	13
	69,222	16,634	17,249	(732)	16,517	(117)	(582)	465
	8,333	2,057	1,895	0	1,895	(162)	(107)	(55)
	3,722	923	1,143	(44)	1,099	176	66	110
	10,100	2,629	2,662	(100)	2,562	(67)	(25)	(42)
	14,060	3,348	3,270	(29)	3,241	(107)	(161)	54
	17,223	4,130	4,046	(174)	3,872	(258)	(249)	(9)
	7,294	1,792	1,726	0	1,726	(66)	12	(78)
	2,468	609	622	(6)	616	7	9	(2)
	5,272	1,276	1,373	0	1,373	97	101	(4)
Total Pbr	192,964	46,688	45,994	(1,154)	44,840	(1,848)	(1,842)	(6)
Non-Pbr	66,836	17,011	17,192	0	17,192	181	128	53
Pbr Excluded Drugs	12,942	3,236	2,824	0	2,824	(412)	(303)	(109)
CQUIN	6,322	1,580	1,577	0	1,577	(3)	0	(3)
Contracted Income Sub Total	279,064	68,515	67,587	(1,154)	66,433	(2,082)	(2,017)	(65)
North Wales - Additional Activity	0	0	222	0	222	222	169	53
Other Income	356	89	703	0	703	614	614	0
Grand Total	279,420	68,604	68,512	(1,154)	67,358	(1,246)	(1,234)	(12)

Appendix 2 – Divisional Analysis

Medicine & Acute

Financial Summary – June 2015

	In-Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
	Jun	Jun	Jun	Jun	Jun	Jun
	£000	£000	£000	£000	£000	£000
<u>Income Performance</u>						
NHS Clinical Income	9,865	10,518	653	30,375	30,393	18
Other Income	61	175	114	182	344	160
TOTAL INCOME	9,926	10,693	768	30,557	30,736	179
Total Pay	(5,176)	(5,360)	(184)	(15,535)	(16,192)	(657)
Non Pay	(1,958)	(1,948)	10	(5,892)	(5,598)	295
TOTAL OPERATING COSTS	(7,134)	(7,308)	(175)	(21,427)	(21,790)	(362)
Total Net Position Surplus/(Deficit)	2,792	3,385	593	9,130	8,946	(184)

Executive Summary

- The in month over performance for NHS Clinical Income in the main is attributable to Non Elective which has over performed in terms of activity in month (46 spells) but is still underperforming year to date (553 spells). There has been a significant gain from case mix both in month £459k and year to date £816k which has compensated in terms of income for the variance in activity.
- In terms of Elective activity the main area of concern is Cardiology which is underperforming year to date by 104 spells and £82k due to the gap in a substantive Consultant post that remains. Gastroenterology Elective activity is over performing year to date by 122 spells and £95k which has had to be delivered at premium costs due to the remaining gaps in Consultant posts. Adverts have been made to recruit into these gaps and the Division is also looking at alternative ways in which to deliver the activity that mitigates these premium costs.
- The other income of £114k in month in the main has an offset in expenditure with £85k in month attributable to Research income released.
- The area of pressure in terms of operating costs continues to be pay with the main areas being the unfunded Infection Control Ward which has been staffed at premium rates, Acute Care incurring premium costs due to the gaps in both Consultant and Junior Medical Staff, Gastroenterology incurring premium costs to deliver activity due to the gaps in substantive Consultant and Nurse Endoscopist, Cardiology gaps due to gaps in substantive consultant post.
- Non pay in month has an underspend against High Cost Drugs/Bloods of £90k

(£310k ytd) which has a corresponding underperformance against NHS Clinical Income. Overspend in this area which is offset by Research Income equates to £80k in month and £81k year to date.

Working Capital – June 2015

	Plan	Actual	Variance
	£000	£000	£000
Inventory	125	102	(23)
Debtors (NHS/Non NHS)	27	82	55
Other Debtors & Prepayments	265	350	85
Total Current Assets	417	534	117
Deferred Income	(307)	(318)	(11)
Creditors (NHS/Non NHS)	(707)	(1,367)	(660)
Accruals	(1,656)	(2,013)	(357)
Total Current Liabilities	(2,670)	(3,698)	(1,028)
Net Current Assets / (Liabilities)	(2,253)	(3,164)	(911)

Executive Commentary

- Debtors (NHS/Non NHS) - represents increase in charges
- Other Debtors & Prepayments - increase in maintenance costs and timing of invoices being received
- Creditors (NHS/Non NHS) June ytd represents delays in invoiced being received from CoCH - issue now resolved
- Accruals - June ytd contains increased Agency Nursing costs not anticipated in the plan due to non funded areas being open

Surgery, Women's & Children's

Financial Summary – June 2015

	In-Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000
Income Performance						
NHS Clinical Income	11,119	10,730	(389)	32,463	30,874	(1,590)
Other Income	169	305	136	506	735	229
TOTAL INCOME	11,288	11,035	(253)	32,970	31,609	(1,361)
Total Pay	(6,311)	(6,408)	(97)	(18,970)	(19,194)	(224)
Non Pay	(1,857)	(1,934)	(77)	(5,594)	(5,598)	(4)
TOTAL OPERATING COSTS	(8,168)	(8,342)	(174)	(24,565)	(24,792)	(227)
Total Net Position Surplus/(Deficit)	3,119	2,693	(427)	8,405	6,817	(1,589)

Executive Summary

- The in month under performance for NHS Clinical Income is attributable to Elective and Daycase activity which has underperformed by 69 spells in June. This has led to a shortfall in Income of £243k with a subsequent case mix shortfall of £227k equating to an in-month shortfall of £470k. The majority of this shortfall continues to be within Trauma & Orthopaedics and a recovery plan is being produced to recovery the Elective position by the end of the financial year.
- The Division has over performed on Non-Elective activity in month by £142k in the main attributable to Paediatrics, Upper GI and Urology.
- The other Income over recovery is the income received from the Continuing Care Packages and also the rental of Orthopaedic Theatres in Clatterbridge to COCH.
- Pay overspend of £97k in month is due to premium costs for agency in Anaesthetics and WLI's in Urology and Colorectal for Outpatient clinics. Also there are currently 5 gaps in the Junior Doctor rota in the Division so locum spend is being incurred to cover this rota.
- Non-Pay is broadly on budget year to date with an in month over spend against PBR Excluded Devices which is offset in Non-PBR in NHS Clinical Income.

Working Capital – June 15

	Plan	Actual	Variance
	£000	£000	£000
Inventory	1,943	1,978	35
Debtors (NHS/Non NHS)	197	155	(42)
Other Debtors & Prepayments	723	717	(6)
Total Current Assets	2,863	2,850	(13)
Deferred Income	(262)	(248)	14
Creditors (NHS/Non NHS)	(697)	(831)	(134)
Accruals	(2,126)	(2,404)	(278)
Total Current Liabilities	(3,085)	(3,483)	(398)
Net Current Assets / (Liabilities)	(222)	(633)	(411)

Executive Commentary

- Debtors - decrease in anticipated charges.
- Other debtors and prepayments broadly on plan.
- Deferred Income broadly on plan.
- Creditors - delays in receiving credit notes from Aintree and the Royal for MDT charges so invoices remain outstanding being resolved through July.

Clinical Support

Financial Summary – June 2015

	In Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000
Income Performance						
NHS Clinical Income	1,458	1,480	22	4,185	4,265	80
Other Income	330	317	(12)	989	987	(1)
TOTAL INCOME	1,788	1,798	10	5,174	5,252	79
Total Pay	(2,660)	(2,510)	150	(7,950)	(7,575)	375
Non Pay	(1,119)	(1,141)	(22)	(3,306)	(3,375)	(69)
TOTAL OPERATING COSTS	(3,779)	(3,650)	128	(11,256)	(10,949)	306
Total Net Position Surplus/(Deficit)	(1,991)	(1,853)	138	(6,082)	(5,697)	385

Executive Summary

- Clinical Income continues above plan driven in the main by Direct Access performance particularly within Pathology. Whilst this over performance is expected to continue the benefit will reduce over the coming months as requests are expected to revert back to the simpler mix seen historically.
- Other income is forecast below plan for the year as Private Patient activity continues to track below expectation.
- Pay costs are below plan in month & cumulatively as a consequence of high vacancy levels across the Division which has necessitated agency spend to support activity in some areas. Current recruitment plans will address the vacancies in key areas (Therapies & Histopathology in particular) and as a result the rate of underspend is forecast to reduce as will the reliance on non-core support.
- Non pay budgets are over plan with the main increase on Clinical Supplies as a result of higher activity levels.

Working Capital – June 15

	Plan	Actual	Variance
	£000	£000	£000
Inventory	314	305	(9)
Debtors (NHS/Non NHS)	106	161	55
Other Debtors & Prepayments	295	683	388
Total Current Assets	714	1,149	435
Deferred Income	(58)	(54)	4
Creditors (NHS/Non NHS)	(1,060)	(1,825)	(765)
Accruals	(1,062)	(1,754)	(692)
Total Current Liabilities	(2,180)	(3,633)	(1,453)
Net Current Assets / (Liabilities)	(1,466)	(2,484)	(1,018)

Executive Commentary

- Prepayments: change in timing of receipt of maintenance contracts (will realign by year end); additional spend now added to existing contracts which increases year end position.
- Creditors: at June increase due to delayed SLA invoicing from COCH plus some prior year invoicing still outstanding on Lab tests; year end position now anticipates slow invoicing from other labs
- Accruals: at June significant delay in receipt of invoices relating to key supplier plus higher agency spend than planned; expected to be resolved in coming period.

Corporate Services

Financial Summary – June 2015

	In-Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000
<u>Income Performance</u>						
NHS Clinical Income	69	69	(0)	208	198	(10)
Other Income	994	1,031	37	2,892	2,929	36
TOTAL INCOME	994	1,031	37	2,892	2,929	36
Total Pay	(3,154)	(3,084)	70	(9,415)	(9,195)	219
Non Pay	(2,639)	(2,738)	(99)	(7,953)	(8,317)	(364)
TOTAL OPERATING COSTS	(5,792)	(5,822)	(29)	(17,368)	(17,513)	(145)
Total Net Position Surplus/(Deficit)	(4,729)	(4,722)	7	(14,268)	(14,387)	(119)

Executive Summary

- Improved ICR position in month—remains under-recovered year-to-date and in forecast position
- Energy budget under pressure in month and year-to-date from CHP issues which is forecast to improve later in the year
- IT budget is under pressure due to maintenance contract costs both in-month and year-to-date

Working Capital – June 15

	Plan	Actual	Variance
	£000	£000	£000
Inventory	356	359	3
Debtors (NHS/Non NHS)	78	321	243
Other Debtors & Prepayments	2,261	2,249	(12)
Total Current Assets	2,695	2,929	234
Deferred Income	(1,137)	(1,666)	(529)
Creditors (NHS/Non NHS)	(958)	(781)	177
Accruals	(3,264)	(5,276)	(2,012)
Total Current Liabilities	(5,359)	(7,723)	(2,364)
Net Current Assets / (Liabilities)	(2,664)	(4,794)	(2,130)

Executive Commentary

- Debtors—delay in NHS and non-NHS invoicing for Energy pending clarification of billing information. This is to be resolved in July
- Deferred income—additional income received in year for R&D posts and other projects. Costs will be incurred both in-year and in 2016/17 and income released to offset.
- Creditors—timing issue with CNST premium and delay in receipt of Payroll service invoice
- Accruals—significant delay in receipt of invoices relating to IT, Consultancy and Energy costs
- Variances at June relate to timing differences which will unwind in the coming months

Board of Directors	
Agenda Item	8.1
Title of Report	Staff Engagement
Date of Meeting	29 July 2015
Author	Cathy McKeown, Head of Staff Engagement and OD
Accountable Executive	Jon Scott, Interim Deputy Chief Executive
BAF References <ul style="list-style-type: none"> · Strategic Objective · Key Measure · Principal Risk 	1, 1B, 1908, 1909 4, 4A, 1909
Level of Assurance <ul style="list-style-type: none"> · Positive · Gap(s) 	No Regulatory Issues Identified
Purpose of the Paper <ul style="list-style-type: none"> · Discussion · Approval · To Note 	For noting
Data Quality Rating	Gold - quantitative data that has been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken <ul style="list-style-type: none"> · Yes · No 	Neutral

Executive Summary

This paper provides an update on the high level staff satisfaction action plan that was agreed with the Trust Board in response to the disappointing results from the National Staff Survey 2014. The action plan is being monitored by the Executive Directors Team, Quality & Safety Committee, Workforce and Communications Group with updates to Listening into Action (LiA) Sponsor Group and Partnership Steering Group.

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The Trust Board is asked to:

- a. Note the progress being made on the Staff Engagement Work Programme.
- b. Note the results of the recent Staff Friends & Family Test (Quarter 1). Specifically the improvements made in the overall Staff Engagement Score.
- c. Identify if any further actions or assurance are required

Background

1. Staff satisfaction and engagement is essential in improving quality and productivity and helping us to meet our significant financial and future challenges. This is consistent with the evidence based research conducted by Professor Michael West which indicates links between strong staff engagement and quality improvements. Staff Engagement is not just a work programme for the HR/OD department, it requires real commitment and input from the whole organisation, particularly those in a leadership position at all levels.
2. Trust Board members are reminded that the Staff Satisfaction action plan (Appendix A) was developed on the basis of the bottom ranking scores, the most deteriorated scores and taking into consideration the management recommendations from Quality Health. A key message from Quality Health is that we do not try to focus on everything, but identify a small number of high impact actions that will make the biggest difference to staff.
3. The potential reasons for the drop in satisfaction levels have previously been discussed e.g. at the time of the survey the Trust undertook a major organisational change programme, nevertheless it was noted that the results were a cause for concern given the Trust's desire to be a high calibre employer.
4. As part of the plan, the Trust has increased the pace and focus of Listening into Action (LiA) as there has been clear evidence that where colleagues have been involved in LIA, they report greater levels of Staff Satisfaction.
5. Further to the Trust winning the Health Service Journal Award for Staff Engagement in 2014, the Trust was announced as winners of the Healthcare People Management Association (HPMA) 2015 Award for staff engagement on 19th June, which reinforces the success of this way of working.

Current position and additional steps being taken

1. The Staff Satisfaction plan is being implemented in full force. The 100 Day Challenge was intended to create drive and impetus to the staff engagement agenda. Moving forward the emphasis is on "the way we do things around here", with LiA huddles becoming the norm, along with recognition schemes so that our staff feel proud as an employee of the Trust. Detailed below is a high level update on key actions from the 100 day challenge (not exhaustive). As follows:-
 - a) LiA Huddles - The LiA Huddles have been very well received and to date 108 huddles have taken place, from which 287 quick wins and 275 high impact actions have been identified for improvement over the 100 days following each huddle. Pulse check surveys have been taken at each huddle and will be repeated at the end of each 100 day period. Where executive team members have attended huddles, this has been seen to be extremely well received along with visits from Executive Partners.
 - b) Leaders and Managers - The 100 Senior Leaders event on 12th May saw 98 attendees and all committing to personal pledges to improve staff satisfaction and engagement by 21st August. The PROUD Way Leaders Guide to staff engagement and the Leadership and Management Development Framework was provided to all attendees and sent out to all leaders and managers in the Trust. The Executive Team have since had an

additional development day and the Operational Management Team will have an additional day in July and August.

- c) Communication of positive messages - Working closely with the Communications and Marketing team, regular positive messages are being communicated about the Trust's achievements, what our staff have said they are proud of and putting teams in the 'Spotlight' to understand what they do and what they have achieved.
 - d) Recognition - The Team of the Quarter was introduced in Q4 2014/15 and the first winner was announced at the CEO Forum which was the Endoscopy Unit. £100 team prize and certificates for four divisional finalists were presented. Quarter 1 2015/16 closed on 30/6/15 and the winner to be announced at the next CEO Forum.
2. At previous Trust Board meetings, it was agreed that the Staff Friends and Family Test (Staff FFT) will be used to monitor whether the required improvements are being made on an incremental basis in advance of the next National Staff Survey. This aims to give us a greater sense of how we are progressing internally and that the actions put in place are effective. The table below provides an overview of the measurable improvements to date:-

Staff Friends and Family Test Questions	Q1 2014/15 Staff FFT	Q2 2014/15 Staff FFT	Q3 2014/15 (from staff survey)	Q4 2014/15 Staff FFT	Q1 2015/16
Question 1 Recommend Trust for care	74%	69%	52%	70%	75%
Question 2 Recommend Trust to work	47%	51%	41%	51%	47%
Staff Engagement Score			3.48		3.74
Number of respondents	567	208	2448	377	340

3. Trust Board members will note that the Quarter 1 results have exceeded the trajectory targets for improvement which were agreed at the last Trust Board meeting (trajectory set for quarter 1 being 3.52 and delivered 3.74). Colleagues are reminded that from Quarter 1 (Staff Friends & Family Test), additional questions have been added which make up the overall staff engagement score (as detailed within the Annual NHS Staff Survey).
4. Trust Board members are advised that whilst the initial signs are positive, these higher staff engagement scores may not directly map out in the NHS Staff Survey 2015.
5. The Executive Directors team have agreed the next phase of the Staff Satisfaction Plan (beyond the 100 days). This plan involves building on the good work to date with the emphasis on going 'further and deeper'. Detailed below is a high level update on key actions for the next phase (not exhaustive). As follows:-
 - a. LiA Huddles:-
 - i. The First 100 Departments (April – July 2015)
 - Continue with 50 day reminders to managers to keep the actions from the huddles on track.
 - Meet with managers and staff after 100 days to repeat the pulse check, check actions have been completed and communicated back to staff within departments, distribute the staff guardian leaflet and Staff Friends and Family Test for Q2. This will also be an opportunity to raise awareness of the LiA Huddle process being adopted as "business as usual" within teams on a min of 6 monthly basis.
 - Trust Board Partners to complete first visit to each partner area by end July 2015.

- ii. Remaining Departments (August-October)
 - HR/OD facilitator to visit the remaining departments to commence the challenge through an LiA Huddle, manager to identify and agree actions with department staff and commit to completion within 100 days post huddle.
 - Trust Board Partners to visit partner areas on regular basis at least monthly.
- b. Leaders and Managers:-
 - Ensure Senior Managers have delivered on their personal pledges made at the senior leaders' events on 12th May. This will include a 'spotlight' on leaders and managers to share what they have done locally.
 - Complete 360 feedback as detailed within the Leadership and Management Development Framework for Executive Team, Directors and Divisional Triumvirate by 31 March 2016.
 - Introduce a 2 day middle manager development programme (Band 6/7) focused on excellent leadership, culture and engagement by October 2015.
- c. Communication of positive messages:-
 - Proud messages to continue via weekly communications, Start the Week, e bulletin
 - Continue the theme of teams and individuals in the 'spotlight'
 - Additional promotions of key achievements in the front entrance of the Hospital.
 - Achievements will also be promoted through the LiA "Pass it On" event on 14th July
- d. Recognition:-
 - The Team of the Quarter recognition scheme has been introduced and this will now continue on a regular basis to supplement the annual PROUD awards.

Monitoring and Assurance Arrangements

1. Progress will continue to be monitored by the Quality & Safety Committee, Workforce and Communications Group, Divisional Management Teams and the Partnership Steering Group (Trade Union organisations).
2. The Trust Board will receive updates on performance against the trajectories set via the normal Dashboard reports.

Conclusion

1. Feedback from the key actions from the Staff Satisfaction Action Plan has so far been extremely positive and colleagues have welcomed all aspects of the 100 Day Challenge. The key to success will be commitment to improvement actions identified by staff at the huddles and sustaining this level of engagement with staff beyond the first 100 Days so that this becomes a way of working.

Recommendations

1. The Trust Board is asked to:
 - a. Note the progress being made on the Staff Engagement Work Programme.
 - b. Note the results of the recent Staff Friends & Family Test (Quarter 1). Specifically the improvements made in the overall Staff Engagement Score. Trust Board members are advised that whilst the initial signs are positive these higher staff engagement scores may not directly map out in the NHS Staff Survey 2015.
 - c. Identify if any further actions or assurance are required

Action Plan - Staff Satisfaction and Engagement 2015

Target Outcomes	Key Actions	Ownership	Timeframe	Progress @ 10/7/15
NHS Constitution Staff Pledge 3: To provide support and opportunities for staff to maintain their health, wellbeing and safety NHS Constitution Staff Pledge 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services				
1 Refresh the PROUD Programme to improve organisational culture and engagement <i>(Link to WoD Strategy: Healthy Organisational Culture P3-2, P3-4)</i>	Implement the 100 Day Challenge 1.1.1 - 100 Departments in 100 Days have mini LiA huddle (30 mins) to identify what staff are most PROUD of in last 100 days, what they could do to improve staff satisfaction in next 10 days (Quick Wins), 100 days (High Impact Actions)	CMcK, SL, SC, AMcL	March – July 2015 GREEN	Commenced 31/3/15 to 8 th July 2015. 1.1.1 Huddles & 1.1.2 100 Positive messages <ul style="list-style-type: none"> EDT and LiA Sponsor group members attending huddles on drop in basis. 100 Day challenge finished on 8th July 2015. 108 huddles took place and from these 287 quick wins and 275 high impact actions have been identified for improvement over next 100 days following each huddle. Bottom 5 areas in Trust staff survey league tables and all medical wards included in early LiA huddles and all other wards will be included by end October 2015 along with remainder of Trust departments. This work is progressing well but will be reliant on managers completing realistic actions agreed in huddles with their teams. Beyond the 100 Day Challenge The plan for the next 100 days has begun and includes: <ul style="list-style-type: none"> Undertaking huddles in the remaining departments by 1st October Revisiting the first 100 departments at the 100 day mark to complete pulse check, provide awareness of staff guardian role, reinforce the message that this becomes a normal way of working, checking that actions have been completed Continuation of Trust Board Partners and executive visibility Leaders in the spotlight to share what they have done to improve staff satisfaction and engagement based on commitment pledges <ul style="list-style-type: none"> Proud messages communicated twice weekly based on feedback from staff at each huddle and also posted on the intranet. Teams put in the Spotlight in Trust communications to promote what they do and what they have achieved.
	1.1.2 - Communicate 100 positive messages	BC/ET/CMcK	April – July 2015+ GREEN and regular, on going	
	1.1.3 - Host 100 Senior managers and leaders	Janet Donnelly	12 th May	1.1.2 100 Senior Leaders and Managers Event 12th May 2015.

Target Outcomes	Key Actions	Ownership	Timeframe	Progress @ 10/7/15
<p>Refresh the PROUD Programme to improve organisational culture and engagement</p> <p><i>(Link to WoD Strategy: Healthy Organisational Culture P3-2, P3-4)</i></p>	<p>event re cultural survey and staff survey and understand what it would take to be in the top 20% of acute Trusts for staff satisfaction and engagement and what their personal commitment / pledge will be in the next 10 days. 100 days</p>	(Sharepoint) CMcK/JM/DA	2015 GREEN	<ul style="list-style-type: none"> 98 attended and commitment pledges made to improve staff satisfaction and engagement. Attendees included Executive team, Operational Management Team (OMT), matrons, divisional managers, Clinical Service Leads and other senior managers. Event content included detailed feedback on internal culture by Janet Donnelly approved consultant from StartPoint. Additional content included staff survey highlights, key actions, leadership framework, staff charter and guidance for leaders. Cultural barometer feedback has been presented to : <ul style="list-style-type: none"> Chief Executive 31st March 2015 EDT 16 April 2015 and 2nd event 8th June 2015 OMT specific sessions 17th July and 3rd August The PROUD Way leaders Guide introduced and sent out to all leaders and managers. Further to the above, it has been agreed to set up and development programme for middle managers (band 6/7) in 2015.
	<p>1.1.4 - £100 Prize for Team of the Quarter</p>	BC/CMcK	30/4/15 GREEN	<p>1.1.4 Team of the Quarter</p> <ul style="list-style-type: none"> First winner announced at CEO Forum (Endoscopy Unit) prize and certificates presented. Q1 2015/16 closed 30/6/15 and winner to be announced at CEO Forum July 2015.
	<p>1.2 All in patient wards to host LiA led by consultant and nurse to improve patient and staff satisfaction</p>	LiA SG	Jan-Oct 2015 AMBER	<ul style="list-style-type: none"> 8 wards completed ward LiA's and will feedback at Pass it On event on 14th July. Remaining wards put on hold to create capacity for huddles.
	<p>1.3 Raising Concerns LiA events Feb / March to understand what the barriers are to raising concerns internally, how we can improve internal mechanisms and raise awareness of the process. This will include developing an internal anonymised submission field on the intranet homepage.</p>	CMcK, BCa SL, CS	Feb/March 2015 events GREEN	<ul style="list-style-type: none"> Raising concerns LiA events and pulse check survey completed and reported back to EDT, LiA Sponsor Group and WCG March/April 2015 with detailed action plan. Team sponsor group taking action plan forward and update paper to WCG and EDT June 2015. All actions on target. Website live from 24/4/15 http://www.wuth.nhs.uk/staff/services-for-staff/raising-concerns/ Staff Guardians identified and promoted at CEO Forum 22/4/15 and Health and Wellbeing Event 24th April 2015, including Non-Executive Director. Communications plan in progress.
Refresh the				

Target Outcomes	Key Actions	Ownership	Timeframe	Progress @ 10/7/15
<p>NHS Constitution Staff Pledge 3: To provide support and opportunities for staff to maintain their health, wellbeing and safety</p> <p>NHS Constitution Staff Pledge 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services</p>				
<p>PROUD Programme to improve organisational culture and engagement</p> <p>(Link to WoD Strategy: Healthy Organisational Culture P3-2, P3-4)</p>	<p>1.4 Establish Cultural Ambassador and Culture Guardian as recommended by Francis Review (Feb 2015)</p> <p>1.5 Focus on values and behaviours of the whole workforce 1.5.1 - Relaunch agreed values and behaviours so that colleagues are clear about expectations of them and what they can expect of others including "hello my name is..."</p>	<p>CMcK, BCa SL, CS</p> <p>CMcK/SL</p> <p>SL/BCa</p>	<p>July 2015 action plan and promotions AMBER</p> <p>March 2015 GREEN</p> <p>March 2015 GREEN</p>	<ul style="list-style-type: none"> • Role of staff guardian included in induction and mandatory training from end April 2015 to reach new staff. • Communications to existing staff via payslip leaflet end July and Pass it On event 14 July 2015. • Posters and banners available for all guardians July 2015 for promotion around the Trust. • Head of Staff Engagement agreed as Cultural Ambassador to lead on culture and engagement plan. • Non-Executive Director, OD facilitator and Staff Side rep agreed as Staff Guardians. • Role overview developed and agreed. • Feedback via monthly meeting re concerns raised with Director of Workforce have commenced. • Quarterly report on activity/themes to WCG and Q&S via workforce report • Agreed annual to be submitted Trust Board via Non-Executive Director as Staff Guardian. • Behaviours now aligned to recruitment, induction, training, appraisal. • Report to WCG April and June 2015. • PROUD Wall Boards in place. • Behaviours integrated into Staff Charter sent out to all staff with June 2015 payslips. • Guide for leaders on staff engagement "The PROUD Way" launched 12th May senior leaders event and for further distribution June 2015. • "Hello my name is..." campaign launched 12th May at Nurses day and further part 2 event on 28th May with guest speaker Kate Granger (NHS Doctor and founder of the campaign). • Communications team supporting this with ongoing

Target Outcomes	Key Actions	Ownership	Timeframe	Progress @ 10/7/15
<p>NHS Constitution Staff Pledge 3: To provide support and opportunities for staff to maintain their health, wellbeing and safety</p> <p>NHS Constitution Staff Pledge 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services</p>				
	<p>1.5.2 - Identify behaviours/core competencies expected of all leaders and managers and build this into HR processes (recruitment, induction, training, appraisal - as 3.2 above)</p>	CMcK/LB	May 2015 GREEN	<p>communications plan to promote.</p> <ul style="list-style-type: none"> Developed in line with best practice standards, staff feedback through LiA and integrated into staff charter. PROUD Way Guide for leaders and Staff Charter now available and distributed Staff Engagement and Communications included in revised appraisal documentation for Band 7+ from July 2015
	<p>1.5.3 - Develop and agree Staff Charter of expectations</p>	CMcK/SL	June 2015 GREEN	<ul style="list-style-type: none"> Developed from LiA events and linked with recently agreed behaviours to underpin core values. Website developed. Included in leaders guide to employee engagement available from 12/5/15. Staff Charter developed and sent out to all staff with payslips June 2015
	<p>1.5.4 – Review Health & Safety, Infection Control and Equality and Diversity training requirements for staff</p>	PS	June 2015 GREEN	<ul style="list-style-type: none"> H&S reviewed by HROD with implications. Note risk assessment in 2014 reduced the frequency to 3 yearly and following update paper, EDT agreed to remain at this frequency. Infection Control moved to every 18 months in Sept 2014 and will remain at this frequency. E&D Training was provided to all staff via a leaflet with payslips in October 2014 but may not have been recognised as training although the leaflet indicated this. 100% staff therefore received this training in 2014. Reminder to be communicated September 2015
Target Outcomes	Key Actions	Ownership	Timeframe	Progress
2 Improve the internal communications clear link to the WOD Strategy	<p>2.1 Engage with staff via LiA to review communication processes and messages to understand:</p> <ul style="list-style-type: none"> What works, doesn't work, barriers What we need to do to enable staff to feel informed How we can ensure messages are 	BC, CMcK	LiA by May 2015 GREEN	<ul style="list-style-type: none"> Report to LiA Sponsor Group March 2015 and WCG 2 April 2015. Team Brief process commenced at CEO Forum 22/4/15. Audit commenced after May Team Brief to check this is effective and how this can be supported. Report to WCG August based on audit following May, June, July Team Brief Audit

Target Outcomes	Key Actions	Ownership	Timeframe	Progress @ 10/7/15
and cultural priorities (Link to WoD Strategy: Healthy Organisation al Culture P1-1, P1-2, P3-2)	positive, effective, timely, owned etc. <ul style="list-style-type: none"> Value of open meetings Refresh Team Briefing process with audit 		LiA Actions by end July 2015 AMBER	LiA event held 11 th May and actions include: 1. Target areas of poor communications identified in Team Brief audit and LiA Pulse Checks and support being offered to these areas by Communications and Marketing Team 2. Link communications skills into training programme being planned for Autumn 2015 for middle managers band 6-7 3. Re. raising awareness of what departments do – update website with departments list and sentence on what they do/function and include teams in the Spotlight 4. Set up drop in sessions in restaurants to support staff in setting up twitter accounts
	2.2 Identify key priorities from W&OD Strategy and ensure closer working with Communications Team to promote positive messages	JM, CMcK, BC	April 2015 GREEN	<ul style="list-style-type: none"> Staffing support identified to enable closer working between Head Staff Engagement and Communications Team. Links with 1.1.3 0.5 WTE Communications and Marketing Assistant resource for 12 months to Staff Engagement Team with close working across Communications and engagement teams. HROD team also ensuring swifter and focused management of organisational change. LiA brainstorming event held between teams 29/6/15 to align communication and staff engagement priorities.
Target Outcomes	Key Actions	Ownership	Timeframe	Progress
NHS Constitution Staff Pledge 2: To provide all staff with personal development, access to appropriate education and training for their jobs and line management support to enable them to fulfill their potential	NHS Constitution Staff Pledge 2: To provide all staff with personal development, access to appropriate education and training for their jobs and line management support to enable them to fulfill their potential			
3 Capable leaders and managers that support and engage staff (Link to WoD Strategy: Effective	3.1 Develop a leadership and management development framework that sets out the development required at each level to enable transformational, supportive and engaging styles of leadership and management, enhanced by coaching and 360 feedback	LB/CMcK	May 2015 GREEN	<ul style="list-style-type: none"> Framework agreed EDT 24th March 2015 and WCG 2 April 2015 and available on intranet under leadership and development and within the leaders Guide "The PROUD Way". Priorities for 360 feedback process linked to Cultural Barometer CQUIN for 2015/16 (for EDT and Divisional Triumvirate commencing July 2015). Developed capacity to deliver coaching priorities within the framework. Trust Board Partners and EDT visibility programme initiated by 100 Day Challenge agreed April 2015 and in progress.

Target Outcomes	Key Actions	Ownership	Timeframe	Progress @ 10/7/15
NHS Constitution Staff Pledge 3: To provide support and opportunities for staff to maintain their health, wellbeing and safety NHS Constitution Staff Pledge 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services				
<i>Leadership and Managers P3-2, P4-1)</i>	3.2 Identify behaviours/core competencies expected of all leaders and managers and build this into HR processes (recruitment, induction, training, appraisal - as 1.5.2)	LB/CMcK	May 2015 GREEN	As 1.5.2
	3.3 Communicate Top 3 expectations of leaders and managers from CEO following LiA event with leaders and managers Dec 2014/Jan 2015	DA	March 2015 GREEN	<ul style="list-style-type: none"> CEO letter sent to leaders and managers following LiA events including next steps and expectations. Next staff survey will identify improvement in Key Finding related to support from managers and the staff friends and family test in Q1 and Q2 will give the organisation a sense check that improvement is being made. Messages reinforced at 100 senior leaders event 12th May and via CEO forum.
4	4.1 Complete back to basics review of the appraisal process benchmarked against top 20% organisations for the quality of appraisals and personal development plans	PS	31 st May 2015 AMBER	<ul style="list-style-type: none"> Benchmark completed Add KPI re annual quality review to policy and KPI increased to 88% from 85% for compliance Consider pilot of self-appraisal Introduce separate appraisal process for band 7 and above LiA held 30th April 2015 and actions in progress for feedback at Pass it On event 14th July
	4.2 Implement an improved process and communicate widely	PS	1 June 2015 AMBER	<p>Actions agreed after LiA event:</p> <ul style="list-style-type: none"> Appraisal Training for managers and staff – dates planned from end June 2015 in relation to revised documentation, process and style Documentation – bands 1-6 and band 7+ (Team Sponsor Group reviewed documentation 8th June 2015) Communications - Mandatory training / appraisal monthly reports to be cascaded by Divisions, use of Start the Week and News Bulletin to highlight Mandatory Training / appraisal and other communication messages
	4.3 Provide simplified training and guidance on a page	PS	1 June 2015 AMBER	<ul style="list-style-type: none"> Dates planned from end June with revised guidance WCG requested Quality Pulse check in July meeting
NHS Constitution Staff Pledge 3: To provide support and opportunities for staff to maintain their health, wellbeing and safety				
5	5.1 Complete back to basics review of the incident reporting procedures benchmarked against top 20% organisations for fairness	Q&S Team	30 June 2015	<ul style="list-style-type: none"> Meeting held with Q&S lead with feedback from raising concerns LiA that included comments re incident reporting process and national staff survey findings.

Target Outcomes	Key Actions	Ownership	Timeframe	Progress @ 10/7/15
NHS Constitution Staff Pledge 3: To provide support and opportunities for staff to maintain their health, wellbeing and safety NHS Constitution Staff Pledge 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services				
reporting procedures (Link to WoD Strategy: Healthy organisational culture)	and effectiveness of incident reporting procedures. Understand employee expectations regarding incident reporting procedures and how these could/should be met		GREEN	<ul style="list-style-type: none"> Top 5 NHS organisations provided to Q&S for benchmarking. Actions developed by Q&S team include: Awareness raising/myth busting communications completed. Mandatory feedback field added to web based incident form. Continue with feedback question in appraisal document for next 12 months in interim until electronic feedback process on web based reporting is embedded for all.
Reduction in Stress in work (Link to WoD Strategy: Healthy organisational culture P3-2)	6.1 Monitor stress hot spot areas across the organisation and agree interventions needed	PB	Quarterly GREEN	<ul style="list-style-type: none"> Undertaken by Organisational Health and Effectiveness team and support provided for targeted areas Gynaecology Theatres & Micro Pathology, Human Resources. Work completed in the areas identified and Departments to implement actions. Stress Management Plan and actions on report to WCG July 9 2015.
	6.2 Ensure robust stress risk assessment process is in place	PB Managers	30 June 2015 AMBER	<ul style="list-style-type: none"> Work in progress. Policy has been reviewed, robust action plan to be developed for next 12 months to audit areas identified through staff survey and sickness absence data. Stress Management Plan report to WCG 9 July 2015.
	6.3 Support the implementation of Schwartz Rounds	PB/TP/JS	30 June 2015 GREEN	<ul style="list-style-type: none"> Pilot undertaken and business case submitted and approved Linked to CQUIN for 2015/16 Juline Smit/Teresa Pugh leading. 2nd Schwartz Round 15th July 2015 based on Never Events Schwartz Steering Group established with Head of Staff Engagement as member.
	6.4 Implement the Health and Wellbeing Plan 2015-18 and agree key priorities for 2015 monitored and assured via H&WB Group and WCG	PB	30 June 2015 AMBER	<ul style="list-style-type: none"> H&WB Plan launched 24th April 2015 at H&WB event with information stands and presentations/workshops, health advice, health checks, mindfulness, culture and engagement, relaxation and launch of SingMe WUTH choir. Further wellbeing event planned for 30th July at Clatterbridge and actions monitored via H&WB group. Need further communications to staff on progress.

- **Please note:** Timescales are tight as the 2015 staff survey will be launched end of September 2015. Divisions have produced local staff satisfaction plans and these plans will be monitored by the Staff Satisfaction Steering Group with senior leadership to represent divisions at this group to ensure robust and consistent monitoring and accountability. HROD Team is supporting the Divisions in enabling their plans to be delivered.

Board of Directors	
Agenda Item	8.2
Title of Report	Update on Nursing & Midwifery Strategy 2013/18: 'Modern, Patient-focused Nursing & Midwifery based on traditional values'
Date of Meeting	29 July 2015
Author	Jill Galvani, Executive Director of Nursing and Midwifery Gaynor Westray, Deputy Chief Nurse
Accountable Executive	Jill Galvani, Director of Nursing and Midwifery
BAF References <ul style="list-style-type: none"> • Strategic Objective • Key Measure • Principal Risk 	<p>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.</p> <p>1A. Key Measure – Improve our Patient Experience to deliver the Friends and Family recommend rate of 95%; 1B. Key Measure – 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; 7A. Key Measure – Full Compliance with our registration with CQC; Principal risk – delivering the recruitment plan; reduced staffing levels due to additional beds open (isolation unit)</p>
Level of Assurance <ul style="list-style-type: none"> • Positive • Gap(s) 	<p>Positive: Continued delivery of the Patient focused objectives throughout 2014/15 with increase in pace following the appointment of the Deputy Chief Nurse. Gaps: Continued improvement in Fundamental Standards of Nursing Care has been challenged when additional capacity has been required to care for patients; The Trust has a comprehensive plan to recruit and retain registered nurses to ensure Safer Staffing levels.</p>
Purpose of the Paper	To update the Board of Directors on progress with the Nursing & Midwifery Strategy 2013/2018. For discussion and approval.
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment	N/A

1. Executive Summary

The Nursing and Midwifery Strategy was developed during the first 6 months of 2013/14 in response to the Francis Report published in February 2013. The Board of Directors approved the Strategy in October 2013 and there was a celebratory but formal launch event in December 2013. All nurses and midwives in the Trust have received a copy of the Strategy and these are being signed with a record of this held by the Assistant Directors of Nursing & Midwifery. The Strategy has 67 patient focused actions. Of these 62 are completed or for completion in 2015/16 with an associated audit or monitoring process. Only 5 actions are not completed and in preparation for this paper 2 of these are no longer relevant or are superceded by other developments. Developing aspiring nursing and midwifery leaders is a key requirement for implementation in 2016/17.

The fundamental standards of nursing care are audited through the Nursing and Midwifery audit processes. The Care Quality Commission (CQC) Fundamental Standards were launched earlier in 2015. The Nursing & Midwifery Strategy was reviewed as part of the portfolio of the Deputy Chief Nurse in February 2015. It was agreed by the Senior Nurse & Midwifery Group (SNMG) that all nursing & midwifery elements of the CQC compliance requirements are covered in the Strategy and that there is a framework for evidencing this. The review by the Deputy Chief Nurse resulted in one change EOL care.

The outcomes for nursing and midwifery are captured in the Director of Nursing & Midwifery's quarterly reports to the Quality & Safety Committee; monthly reports on nurse staffing are presented to the Quality & Safety Committee and a six monthly report has been presented to the Board of Directors.

The Nursing and Midwifery agenda is not static and new areas for attention continue to emerge since the Strategy was developed. For example the National Institute of Clinical Excellence (NICE) Guidance on nurse staffing for nursing in adult in-patient wards was published on 16 July 2014. There has been a recent decision to review how NHS England determine safe staffing levels through NHS Improvement with a plan to review learning disability, mental health, community and emergency department nursing requirements as well as the requirements for maternity care. Future work will focus on Care Contact time (time spent with patients in direct and indirect care) and how technology impacts on care delivery and the Trust is well placed to be in the lead for this approach following Wirral Millennium Implementation. There will be national work on developing a training package on effective establishment setting and how to report safe staffing levels effectively. The Trust has a workstream and action plan dedicated to nurse and midwifery recruitment and retention and to modernising how we utilise the nursing workforce that compliments the Lord Carter review of efficiency in the NHS. Since the last report to the Board, the Trust has committed to 'Sign up to Safety' and nursing & midwifery has a key role in this.

There are several national initiatives that are main focuses for the Trust. These are preparation for revalidation with the Nursing and Midwifery Council in early 2016; this is a substantial change with a project team dedicated to it in partnership with Human Resources and Operational Development teams. A further review of the future education and training of registered nurses and care assistants has been undertaken by NHS England and chaired by Lord Willis : 'Raising the Bar: Shape of Caring' and has just been published. The Trust will contribute to further discussion of this important review as NHS England respond to it. Finally, there will be a review of Midwifery Supervision following the Kirkup review into Morecombe Bay that the NMC are considering that will impact on the Trust in the next few years. The Board of Directors will be briefed on each of these developments as more information becomes available.

The Board of Directors is asked to discuss and note the substantial progress being made on delivering the Strategy by the nursing and midwifery workforce. Progress will continue to be reported to the Quality and Safety Committee.

2. Background

The Trust's Nursing & Midwifery Strategy: 'Modern Patient-Focused Nursing & Midwifery based on Traditional Values, 2013/18' was developed in response to the publication of the Francis Report in 2013. Subsequent key documents informed the Strategy:

Keogh review into the quality of care and treatment provided in 14 Hospital Trusts in England (2013);

Berwick Report on improving the safety of Patients in England (2013);

Cavendish Review, an independent enquiry into healthcare assistants and support workers in the NHS & Social Care setting (2013);

How to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing midwifery and care staffing capacity & capability (National Quality Board 2013);

Hard Truths: The Journey to putting patients first (Department of Health 2013).

Having a Strategy such as this provides a framework for the Director of Nursing & Midwifery to set out what is expected of nurses and midwives but also identifies the ingredients of excellent nursing care: leadership, sufficient numbers of correctly trained staff working in a culture of support and constructive challenge that is focused on putting patients first.

3. Key Issues

The Strategy document was well received both internally and externally, although a small number of nurses were reluctant to 'sign up' to it initially. This issue has been resolved and the revised Strategy has begun to be disseminated through the Trust as an opportunity for the Director of Nursing & Midwifery and the Deputy Chief Nurse to meet and engage with nurses, midwives and care support workers.

Safe nurse staffing continues to be a key focus of work and in particular as the Trust both responds to recent unannounced inspections (September 2014 and May 2015) where staffing was a concern.

The Fundamentals of Care are also a key focus and have been reviewed alongside the revised CQC Fundamental Standards and also in the context of the implementation of Wirral Millennium Care Compass in November 2014. There has been a major focus on nurse staffing levels since the appointment of the Director of Nursing & Midwifery. Having sufficient numbers of nurses is fundamental to enabling excellent nursing care to be delivered.

The link between ward leadership capacity and capability, staffing levels and nursing outcomes in a challenging operational climate continues to be a theme in the Director of Nursing & Midwifery's quarterly performance reports to the Quality and Safety Committee. The Nursing and Midwifery audit system has been reviewed since the implementation of Care Compass and are linked with Ward Sister/Charge Nurse Developing Leadership at Ward level performance framework, linked with the Complaints, Concerns, Litigation and Patient Experience processes alongside 'soft' intelligence' enable Senior nurses to quickly identify areas of concern.

In addition to the Patient Focused actions, corporate nursing and lead nurses continue to lead on Service Development Improvement Programmes (SDIPS) and on nursing, maternity and patient experience CQUINs. Corporate Nursing has developed the cost improvement programme workstream to reflect the nursing workforce requirements and efficient management during 2015/16. Both of these areas serve to focus attention on quality and the best use of resources.

4. Next Steps

There is an action plan in place for delivering the actions in the Nursing & Midwifery Strategy that is linked with the International Nurses' Day presentation in May and with performance objectives for Senior Nurses and Midwives that are cascaded down to the Ward Sister/Charge Nurses. The Deputy Chief Nurse will lead delivery on the Strategy following on from the Interim arrangements that were in place during the last 6 months of 2014.

5. Conclusion

Substantial progress continues to be made on delivering the Strategy by the nursing and midwifery workforce in the 18 months since its launch. Quarterly performance reports are presented to the Quality and Safety Committee that demonstrate the impact of the Strategy on the nursing and midwifery workforce and on outcomes for patients and their experience.

6. Recommendations

The Board of Directors are asked to discuss the report, and note the progress that has been made.

Modern, Patient Focused Nursing and Midwifery based on traditional values Nursing and Midwifery Strategy 2013 – 2018 Review and future actions – July 2015				
Issue	Action	Lead	Status	Evidence / Sustainability
Patient focused values and behaviours	<ul style="list-style-type: none"> Launch Nursing and Midwifery values and behaviours 	Senior nurse & midwifery group (SNIMG)	Green	Launched 2103; reviewed and updated June 2015. Plan by end of August to share with all staff SNMG to deliver
	<ul style="list-style-type: none"> Director of Nursing to see all Nurses, Midwives and Nursing and Midwifery Assistants 		Green	DoN&M shared strategy with ADN; DADN; HoM; Matrons; Sisters. All other staff received copy from ward/dept Sister / Charge Nurse
	<ul style="list-style-type: none"> Review of all job descriptions to reflect 6 Cs values and patient focused outcomes 		Amber	JD review underway with plan to have completed by Jan 2016
	<ul style="list-style-type: none"> Monitor the appearance of nurses and midwives to inspire trust and confidence 		Green	Clear expectations of dress code (uniform policy) shared with all staff
	<ul style="list-style-type: none"> Introduce a distinctive new uniform for Staff Nurses and Nursing and Midwifery Assistants 		Amber	New uniform for ward / dept Sisters / charge nurse; theatre co-ordinators; deputy Sr / CN. Plan in place for CSW (nursing assistant; then staff nurse)
	<ul style="list-style-type: none"> Provide name badges to avoid confusion and promote transparency 		Green	Introduced #hellonymameis,,,,, campaign
	<ul style="list-style-type: none"> Introduce value-based 'compassionate' recruitment 		Green	Recruitment now includes testing of 6Cs and Trust core values
	<ul style="list-style-type: none"> Potential recruits to meet the Director of Nursing and Midwifery 		Green	Monthly recruitment events supported by DoN&M, DCN, ADNs
	<ul style="list-style-type: none"> Develop a system of monitoring disciplinary issues and referrals to NMC 		Green	All referral to NMC discussed at SNMG; record keeping by DCN
	<ul style="list-style-type: none"> Create a culture of challenge 		Amber	Evidence of challenge by nurses re attitude and observation of care, staff guardians; visibility of matrons, ward sisters / charge nurse
Patient focused population health and well being	<ul style="list-style-type: none"> Excellence in patient experience and Friends and Family Test. 		Green	Improvement achieved now to ensure sustainability
	<ul style="list-style-type: none"> Work with partners to support people to remain independent and healthy 		Amber	New models of care project
	<ul style="list-style-type: none"> Maximise the contribution of School Nurses 		Green	School nurses now TUPEd to Community Trust, still excellent working relationship maintained
	<ul style="list-style-type: none"> Promote immunisation and vaccination for patients and staff 		Green	Flu Vaccine for 2014/15 = 76%
	<ul style="list-style-type: none"> Deliver excellence in Infection Prevention and Control in the hospital setting 		Amber	Continued focus on IP&C agenda; isolation unit due to open 1 Nov 2015; IP&C reviewed and re-established, to provided visible leadership and guidance

Review and action plan for Nursing & Midwifery Strategy 14/07/15

	<ul style="list-style-type: none"> • Display 'who to contact' details in case of concerns • Celebrate success through an annual celebration of Nurses' Day • Promote nursing and midwifery through presentations, publications and awards • Arrange regular lectures from national and international speakers • Develop and support 'Link' Nurses in specific specialist areas • Support the re-validation of Nurses and Midwives. 			Amber	Poster type information being developed for entry to each ward including key information re visiting contact numbers etc for patients an visitors.
				Green	Annual celebration of nursing and midwifery continues to be a popular hospital event
				Green	Good evidence of promoting the work achieved within WUTH by nursing colleagues,
				Amber	Senior nurses invited to attend Kings Fund lectures
				Amber	Link nurse project part of PDRP plan
				Green	Revalidation workstream established within clinical excellence team; further communication and expectations to staff planned

Board of Directors	
Agenda Item	8.3
Title of Report	Francis Report: Hard Truths Commitment: Publishing of Staffing Data: 6 Monthly Report
Date of Meeting	29 July 2015
Author	Jill Galvani, Executive Director of Nursing and Midwifery Gaynor Westray, Deputy Chief Nurse
Accountable Executive	Jill Galvani, Director of Nursing and Midwifery
BAF References <ul style="list-style-type: none"> • Strategic Objective • Key Measure • Principal Risk 	<p>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.</p> <p>1A. Key Measure – Improve our Patient Experience to deliver the Friends and Family Recommend rate of 95%</p> <p>1B. Key Measure – 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</p> <p>7A. Key Measure – Full Compliance with our registration with CQC</p> <p>Principal risk – delivery of recruitment & retention plan; reduced staffing levels due to additional beds open;</p>
Level of Assurance <ul style="list-style-type: none"> • Positive • Gap(s) 	<p>Positive: Comprehensive recruitment & retention action plan in place to meet current & future staffing requirements; Completion of the actions required by Mersey Internal Audit Agency June 2015; Improvement in nursing staff attendance; reduction in clinical incidents related to safe staffing in June 2015; Review of Trust Escalation Policy in relation to Safe Staffing;</p> <p>Gaps: Impact on safe staffing levels due to the opening of additional beds without the provision of suitably qualified and experienced nursing team impacting on delivering improvements in nursing care standards and compliance with CQC regulations.</p>
Purpose of the Paper	For discussion and approval.
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment	N/A

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1. Executive Summary

The Trust has been presenting nurse staffing data since June 2014 with the aim of achieving a minimum Registered Nurse Staffing ratio of 1:8 patients for day shifts, and 1:10 for night shifts. No target fill rate for nursing shifts has been set nationally therefore the Trust has applied a target of 95% of shifts both days and nights meet the planned requirement, given that 100% is optimum. The compliance is monitored on a monthly basis. Wards where the fill rate of actual Registered Nurse hours to planned Registered Nurse hours is less than 95% are reviewed against achievement of key performance indicators.

This paper provides 6 monthly update on nurse staffing data for the period January to June 2015 (Q4 2014/15 & Q1 2015/16). Monthly nurse staffing data continues to be reported to the Board of Directors.

Increasing the bed base in the Trust, whether as a result of activity pressures or infection prevention and control has a direct impact on availability of nursing staff for provide the required level of care to patients. There continued to be concerns with regard to the provision of minimum staffing levels of registered nurses during this reporting period. It is to be noted that the additional wards have now been closed; ward 27 was successfully closed on 25 April 2015 and ward 25 closed on 22 May 2015. Ward 14 is still in use as the interim solution for management of Multi Drug Resistant Organisms until the isolation ward opens 1st November 2015. Every effort is being made to ensure improved isolation facilities; patient flow; bed capacity and demand analysis are aligned.

Matrons and Ward Sisters have resumed their usual roles where staffing levels permit. Registered nurse vacancies continue to be reviewed weekly by the Director of Nursing & Midwifery and the Senior Nurse Team. A robust workforce plan has been developed, including a recruitment campaign and the planned transfer to NHS Professionals to manage the temporary workforce, with a 'Go-Live' date of 2 November 2015 after a thirteen week implementation schedule supported by the Trust and NHS Professionals.

The E-roster staffing system 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.

Following a review from Mersey Internal Audit Agency in January 2015 a robust action plan had been developed with all actions completed. In February 2015 we introduced a nurse staffing escalation guide, this provides guidance and supports decision making to ward sisters / charge nurses and their teams regarding the required actions to be taken if concerns are raised with regard to staffing. This guide outlines an absolute minimum of 2 registered nurses per ward at all times. June 2015 we introduced the monitoring and reporting of 'red flag' incidents. Nationally the red flag alerts are described as, 'unplanned omission' in providing patients medications; delay of more than 30 minutes in providing pain relief; patient vital signs (MEWS) not assessed or recorded as outlined in the care plan, and less than 2 registered Nurses on a ward during any shift. The Trust has added patient focused rounding not evident; Patient repositioning not carried out as outlined in the care plan and staff unable to take breaks as local indicators.

The Board of Directors is asked to receive the update and discuss the content of this report.

2. Background

Safe nurse staffing levels were a feature of the Francis, Keogh and Berwick Reports published in 2013. The National Quality Board issued guidance in November 2013, 'How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability'. This document informs this paper and is augmented with the June publication of the National Institute for Care and Healthcare Excellence (NICE) guidance.

Following the publication of the Francis report in February 2013, there has been focused work in the nursing and midwifery community to promote openness and honesty about nurse staffing levels and nurse sensitive outcomes. Patients and the public have a right to know how the hospitals they are paying for are being run and therefore the Government has made a number of commitments in 'Hard Truths: The Journey to Putting Patients First' (2014) to make this information more publically available.

The Director of Nursing and Midwifery has taken steps to ensure that the Trust has responded to meet the milestones set out in the guidance published on 31 March 2014.

- A six monthly report on nurse staffing is presented to the Board of Directors.
- Information about the numbers of nurses, midwives and care staff are displayed for each shift compared to what was planned. A board is available at the entrance to each inpatient area.
- A report containing details of planned and actual staffing on a shift-by-shift basis at ward level for the previous month is to be presented to the Board every month. The reports on nurse staffing have been delegated to the Quality & Safety Committee. The report is published on the Trust's website and will be linked to the relevant hospital webpage on NHS Choices.

The expectations of the Board of Directors have been presented previously and are re-presented with an update to demonstrate focus and progression of the nursing and midwifery staffing agenda.

'Hard Truths: The Journey to Putting Patients First' Expectations, Accountability and Responsibility

Expectation 1: The Board of Directors has responsibility for the quality of care provided to patients and as a key determinant of quality takes full and collective responsibility for nursing, midwifery and care staffing capacity and capability

The Director of Nursing is provided with information on staffing capacity and capability on a monthly basis by the Associate Directors of Nursing. This information is collated and presented to the Board of Directors on a monthly basis

Expectation 2: Processes are in place to enable staffing establishments to be met on a shift-to-shift basis

The Divisions of Surgery and Medicine & Acute have an established daily staffing meeting to determine whether or not planned staffing requirements are met and to take action where there may be a shortfall. To support the additional beds this has meant the movement of staff from their base wards to cover unplanned gaps which can lead to staff dissatisfaction and impact on staff FFT results. To minimise this, staff are advised of rationale for the course of action, and the necessity to put patient safety first. There has been reduced movement of staff since the closure of two of the three additional wards in April and May 2015. The outcomes of these meetings are recorded and contribute to the monthly staffing report. Reports to the Analyst are still paper-based; however Version 10

of E-Roster system will in future enable the uploading of this data. This project is currently part of the nursing workstream which is to ensure 'good housekeeping' of the system is established and maintained.

Evidence Based Decision Making

Expectation 3: Evidence based tools are used to inform nursing, midwifery and care staffing and capability.

The Trust continues to work on a minimum requirement of 1 Registered Nurse (RN) to 8 patients during the day and 1 RN to 10 patients at night as per funded establishments. The Trust continues to work in line and recommendations from 'Birthrate Plus' in Maternity; British Emergency Department Staffing Tool Assessment (BEST); NICE guidance for Maternity staffing levels published February 2015; draft NICE guidance for Emergency Department nurse staffing published in January 2015. There has been a recent development nationally in that the Chief Nursing Officer for England has announced that the National Institute for Clinical Excellence (NICE) no longer has the mandate for developing the guidance on Safer Nurse Staffing. Instead, this work programme will be absorbed by the CNO office in NHS England. Concerns have been expressed by Directors of Nursing, the Unions and Academics as well as the Safer Staffing Alliance that was established in the wake of the Francis Report (2013).

In addition, work is progressing through NHS Workforce to develop a different level of nursing support to the Registered Nurse. It is not clear whether or not this work has been endorsed by the CNO at this stage. There are advantages and disadvantages in terms of regulation of nursing care and how care can be delegated through the Registered Nurse workforce.

The Director of Nursing & Midwifery will provide updates to the Board of Directors as this work develops.

Supporting and Fostering a Professional Environment

Expectation 4: Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns.

At the monthly Strategic Nursing and Midwifery Team meeting, the Director of Nursing and Midwifery and the Associate Directors of Nursing review the staffing incidents report for the previous month and feedback actions taken within the divisions. The nurse staffing escalation guide has been circulated to all ward sisters / charge nurses and hospital clinical co-ordinators this provides guidance and supports decision making if concerns are raised with regard to staffing.

The Care Quality Commission arranged a responsive inspection in September 2014, and an unannounced inspection May 2015 partly in response to concerns raised by staff relating to staffing levels. It is evident that we need to continue working with staff to encourage them to raise concerns initially to their line managers. The senior nursing team are actively visiting wards and departments reinforcing the agreed workforce plan including recruitment and retention and ensuring staff at ward level understand what the staffing levels are within their own areas and the compliance against these.

To encourage staff to raise concerns the Trust has introduced a team of staff guardians, whose role is to support our staff if ever they need to raise a concern, or simply require some impartial advice on a work-related issue.

Expectation 5: A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments

Following the publication of the NICE guidance for safe staffing, each ward sister and charge nurse supported by matron have reviewed their current staffing establishment taking into consideration patient acuity, ward layout, environmental issues and professional judgment. There has been significant work within the Trust in attaining a minimum nurse to patient ratio of 1:8 (days) and 1:10 (nights), this work also included the recommendation of the nationally recognised uplift of 25%. A further investment of £1,064M was approved by the Board of Directors in January 2015.

Expectation 6: Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties

Due to the requirement to safely staff the additional wards, ward sisters and charge nurses have been required to work some shifts clinically to ensure minimum staffing levels are achieved. Given the scope of the ward sister / charge nurse role it is essential that they are supernumerary / supervisory to enable them to monitor and improve nursing care standards. This position has improved since the end of May 2015 when two of the three additional wards were closed. Similarly, the Matron role is to oversee nursing care standards, to hold the Ward Sisters and Charge Nurses to account, and to actively support improvements in nursing care. Matrons were also required to work clinically and to support bed management. In terms of the improvement schemes, Matrons are required to focus on care standards and delivery of discharge schemes to reduce the length of stay as key strategies to avoid opening additional beds. This has also improved since the closing of the additional wards.

Openness and Transparency

Expectation 7: Boards receive monthly updates on Board workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review

Systems are in place to ensure this expectation is being met, and this report forms part of meeting this expectation by presentation to the Board of Directors.

Expectation 8: NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift

This expectation is being met.

Planning for Future Workforce Requirements

Expectation 9: Providers of NHS services take an active role in securing staff in line with their workforce requirements

The nursing workforce plan has been developed to support the recruitment and retention of nursing staff to support the provision of safe care to patients admitted to all areas within the Trust. This plan includes the requirements identified in 'turnover' of staff as well as recruiting into existing vacancies and the additional vacancies identified to support the isolation unit due to open 1st November 2015 and the additional wards identified within the 'winter plan' (wards 14 and 27). The following have been actioned:

- Established programme of Monthly Trust wide recruitment for Registered Nurses;
- Transferred over to V10 e-roster system to enable a more effective and efficient rostering of ward nursing staff
- Local and international recruitment strategies

- Agreed transfer to NHS professional to manage temporary nursing workforce.
- Reviewed nursing workforce and non-ward based nurses to support adult in patient wards over winter period (Oct –Mar)

The Role of Commissioning

Expectation 10: Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract

A copy of this six monthly staffing report is presented to the Wirral Clinical Commissioning Quality and risk meeting for information and progress.

3. Staffing Report

Nursing staffing is presented on a monthly basis to the Board of Directors, as well as part of the Quarterly performance report presented to the Quality and Safety Committee. The method of reporting this information has been discussed within the senior nursing team and now presented in a table format which clearly identifies trends of improvement or deterioration. 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.

Data for June 2015 is attached as Appendix 1 to this paper, as there is no target fill rate set nationally the Trust has applied a target of 95%. This measure is that 95% of shifts both days and nights meet the planned requirement, given that 100% is optimum. Appendix 1 shows this report with the average fill rates for June 2015 on all wards for both day and night shift. The report 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.

There continued to be concerns with regard to the provision of minimum staffing levels of registered nurses during the first five months of this reporting period. This has been impacted by the additional wards remaining in place to manage patient demand (wards 25 & 27), as well the need for an interim isolation facility (Ward 14) with cohort nursing to manage the outbreak of Carbapenamase Producing Enterobacteriaceae (CPE). Ward 27 was successfully closed on 25 April 2015 and Ward 25 closed on 22 May 2015. This is reflected in the number of wards across the Trust that are now achieving a fill rate for RN and CSW shifts, and in particular the night shifts. From the end of May 2015 matrons and ward sisters / charge nurses have resumed their usual roles where staffing levels permit.

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. This project is currently part of the nursing workstream which is to ensure 'good housekeeping' of the system is established and maintained.

In June 2015 the Trust introduced the monitoring and reporting of 'red flag' incidents. Nationally the red flag alerts are described as: 'unplanned omission' in providing patients medications; delay of more than 30 minutes in providing pain relief; patient vital signs

(MEWS) not assessed or recorded as outlined in the care plan; and less than 2 registered Nurses on a ward during any shift. The Trust has added patient focused rounding not evident; Patient repositioning not carried out as outlined in the care plan; and staff unable to take breaks as local indicators. The table below provides a summary of reported 'red flag' incidents for June 2015. This is the first month for reporting such incidents and there is evidence that all were escalated to matron on duty for the appropriate actions to be taken

Red Flag Incidents for June 2015				
Ward	Pain Management	MEWS	Patient Focused Rounding	Staff Breaks
10	1			
ESAU	2	2	2	
20				1
32		3		6
CCU		1		
36			1	1
Children's				11
Total	3	6	3	19

Reported clinical incidents regarding staffing, reflects an open and honest reporting culture and is also a mechanism for concerns related to staffing to be recorded by staff. Each incident is reviewed at the time of raising it by the local manager and an overview is undertaken by the Strategic Nursing & Midwifery Team. The table below shows the number of incidents reported related to staffing levels. This demonstrates a reduction in the number of staffing incidents being reported by the staff at WUTH

Month	Number of incidents reported
January 2015	102
February 2015	46
March 2015	75
April 2015	36
May 2015	52
June 2015	37

4. Nursing workforce requirement

Registered nurse vacancies continue to be reviewed weekly by the Director of Nursing & Midwifery and the Senior Nurse Team, alongside a robust recruitment and retention plan

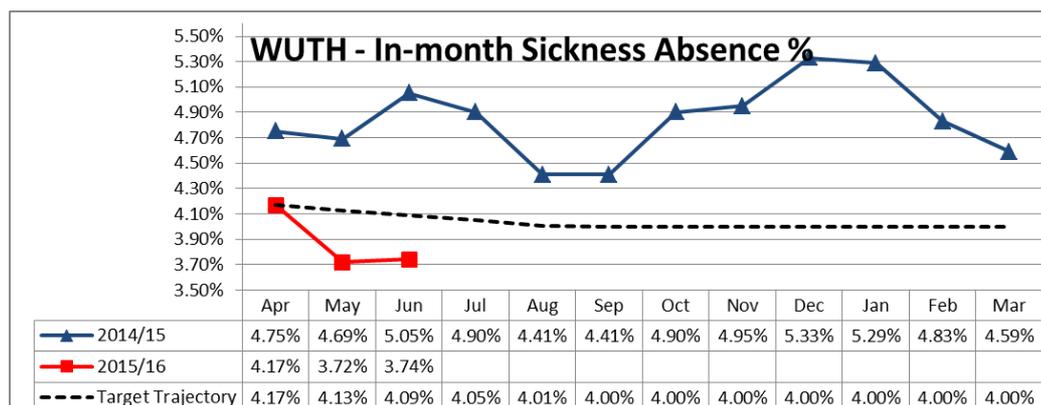
The workforce requirement within nursing for 2015 / 2016 is as follows:

Workstream	WTE
Routine replacement of Band 5 Nurses through turnover calculated at 8%	88
Outstanding additional Registered Nurses & Midwives to deliver the Headroom of 25% approved by the Board of Directors in January 2015	11
Maintenance of an interim isolation unit through to staffing the Isolation Unit planned to occupy Ward 25 in October 2015	12
The need to ensure that there are sufficient staff to allow the 'Additional Wards' to be planned for Winter 2015/16 from October 2015 to April 2016	54
Total anticipated requirement	165

A comprehensive recruitment strategy is in place including local and international recruitment. Clear expectations are set to exhaust all local options and opportunities to ensure we promote WUTH as the hospital of choice to work in. A planned transfer to NHS Professionals to support the management of temporary workforce will also support recruitment campaign. Exit interviews were formalised during June to contribute to the analysis of staff turnover.

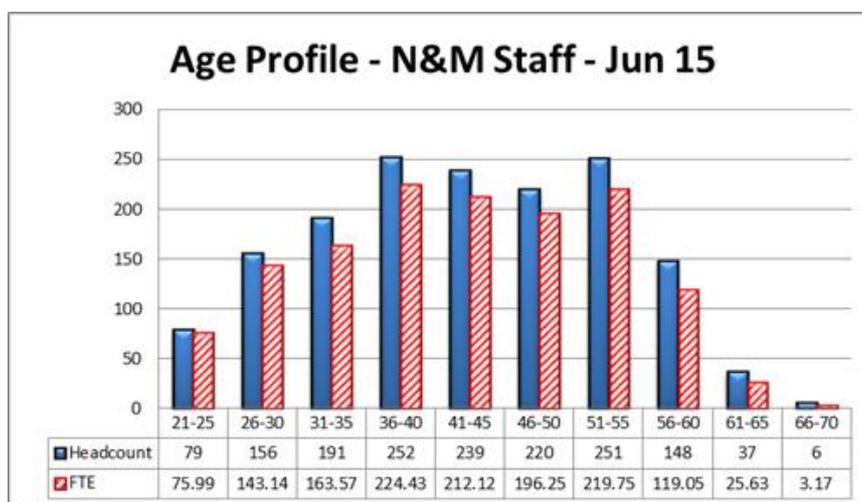
5. Trust sickness absence rate

The Trust sickness absence rates remain below the target of 4%. June 2015 was 3.74%, this has slightly increased from last month (3.72%, May 2015) but represents a vast improvement on the same period last year (5.05%, June 2014). This is the first period the Trust has achieved its target of 4%. HR&OD continues to work with Line managers to ensure policy is consistently and correctly applied to support staff that are off sick and maintain rates below target. All clinical areas have a reported 100% compliance with regard to adherence to the attendance policy. Registered Nurse sickness continues to fall, after being over 6% in March it is now under 5%.



6. Nursing staff age profile

An age profile of nursing and midwifery staff employed within the Trust has been obtained in order to have a better understanding of the predictions in gaps for the future and help to support and influence the workforce plan. It is noted that registered nurses have the option to retire at the age of 55, this being the one of the largest age group with a head count of 251. Further analysis is required to understand the potential risks associated with nurses retirement age.



7. Conclusion and Recommendations

The Board of Directors is asked to note that during the first five months of 2015 there have been serious concerns with regard to the provision of minimum staffing levels and attainment of the 95% fill rate of registered nurses despite intense effort. It is recognised that this position has marginally improved in June 2015 due to the closure of two of the three additional wards. An aspect of the draft response to the Unannounced CQC Inspection in May 2015 is to undertake further benchmarking of other acute Trust's attainment of the fill rate and at what % and how this reflected in their CQC inspection.

There are national developments in Nurse Staffing and Education that are emerging following the announcement by the Chief Nursing Officer in a letter on 11 June 2015. These are referenced in the Nursing Strategy update paper submitted to this Board of Directors. As further information becomes available this will be included in the monthly updates to the Board.

Whilst Nursing has responded to the organisational pressures of minimising the impact of an infection outbreak; responding to internal bed capacity versus demand issues; the requirements to deliver cost improvement plans and minimising expenditure, did have a negative impact on the nurse leadership team's ability to fulfil core roles of supervision and monitoring of standards as exemplified in the draft CQC responsive review undertaken in September 2014. This position has also now improved and work is underway following the CQC unannounced inspection in May 2015 and in preparation for the planned CQC inspection in 14 September 2015.

Plans to reduce the impact of infection on nursing in terms of cohort nursing patients with positive colonisation of multi drug resistant organisms are well-developed with particular emphasis on early detection and diagnosis of infection and appropriate isolation facilities.

The Trust escalation policy has been reviewed and now includes the opening of additional beds is to only be actioned under the guidance of an experienced senior nurse with clear emphasis on the provision of suitably qualified and experienced nursing staff. Providing a timely response to organisational pressure is a challenge to the nursing management team. The organisation will continue to work to adequately plan in preparation for 2015/2016 as this poses a risk to Care Quality Commission (CQC) compliance. The recruitment plan for 2015/16 includes staffing for the wards planned to be used this winter for additional capacity.

The Board of Directors are asked to receive this update and discuss the content.

Specialty	Ward	Days			Nights			Quality Indicators												
		Expected RN Hours	Actual RN Hours	% CSW	Expected CSW Hours	Actual CSW Hours	% RN	Falls (moderate and above)	Pressure ulcers (Grade 2 and above)	Colif (Reportable to PHE)	MRSA (Reportable to PHE)	Sickness & Absence	RN Vacancies (WTE)	CSW Vacancies (WTE)						
Orthopaedics	10	1434.3	1321.8	92.2%	906.75	809.75	89.3%	713	690	713	667	96.8%	93.5%	0	0	0	0	10.42	6.00	4.40
Orthopaedics	11	2156.8	2014	93.4%	1468.3	1468.3	91.1%	1426	1391.5	713	678.7	97.6%	95.2%	0	1	0	0	5.51	2.00	5.00
Orthopaedics	12	1222.5	1132.8	92.7%	763	763	84.1%	713	690	356.5	322.2	96.8%	90.4%	0	0	0	0	2.75	0.00	0.33
DME	16 / OPAU	2342.5	2087	89.1%	1550	1408.8	90.9%	1069.5	991.5	713	665	92.7%	93.3%	1	1	0	0	4.82	3.89	2.39
Colorectal	17	1947.5	1910	98.1%	1302	1220.8	93.8%	1069.5	1069.5	713	667.2	100.0%	93.6%	0	1	0	0	0	3.80	1.50
General Surgery	18	1829.5	1708.9	93.4%	1263.3	1250.8	99.0%	1069.5	1058	713	713	98.9%	100.0%	0	0	0	0	2.71	1.60	0.80
Urology	20	1800.3	1507.2	83.7%	1196.7	1196.7	94.7%	1069.5	954.9	713	693	89.3%	97.2%	0	4	0	0	12.36	4.00	1.60
DME	21	1916.3	1800.8	94.0%	1550	1509.3	97.4%	1263.3	1188.6	1069.5	1069.5	94.1%	100.0%	1	0	0	0	5.68	3.01	0.00
DME	22	1722.5	1722.5	100.0%	1356.3	1317.3	97.1%	1263.3	1263.3	713	713	100.0%	100.0%	0	0	0	0	5.12	0.00	0.00
Stroke	23	2110	1907.7	90.4%	1162.5	1134.6	97.6%	1069.5	1069.5	713	677	100.0%	95.0%	0	0	0	0	0	2.37	0.50
DME	24 &	2098.5	1981	94.4%	1619.7	1596.7	98.6%	1426	1307	1426	1414	91.7%	99.2%	1	0	1	0	3.89	3.04	0.00
General Medicine	26	2110	1874	88.8%	1937.5	1870.7	96.6%	1069.5	1069.5	1069.5	1033.5	100.0%	96.6%	0	0	0	0	6.5	1.45	3.00
Haematology	30	1722.5	1518	88.1%	1162.5	1069.5	92.0%	1069.5	906.75	1069.5	1057.5	80.6%	98.9%	0	1	0	0	3.64	2.44	3.00
Cardiology	32 & CCU	3078.8	2856.4	92.8%	1550	1464.8	94.5%	1426	1204	1069.5	889.8	84.4%	83.2%	0	1	0	0	5.64	3.15	2.43
Cardiology	33 & HAC	1722.5	1633.8	94.8%	1162.5	1126.8	96.9%	1069.5	1045.5	1069.5	1069.5	97.8%	100.0%	1	0	1	0	1.97	4.85	0.70
Gastro	36	2253.8	1913.8	84.9%	1550	1499	96.7%	1069.5	1033.5	1069.5	1069.5	96.6%	100.0%	0	3	0	0	9.19	3.46	2.00
Respiratory	38	2497.5	2043.2	81.8%	1743.8	1289.5	73.9%	1426	1236	1069.5	1033.5	86.7%	96.6%	0	2	0	0	4.21	4.5	1.31
Maternity	53	1598.5	1534.5	96.0%	744	744	100.0%	1426	1322.5	356.5	333.5	92.7%	93.5%	0	0	0	0	7.27	0	0
Gynaecology	54	885.5	701.5	79.2%	713	701.5	98.4%	713	701.5	0	0	98.4%	0	0	0	0	0	0.41	0	0
General Medicine	AMU	1955	1852.5	94.8%	1426	1257.9	88.2%	1069.5	1028	1069.5	1009.5	96.1%	94.4%	0	0	0	0	5.45	3.17	1.41
General Medicine	MSSW	2311.5	2066.2	89.4%	1782.5	1614.4	90.6%	1635.3	1562.9	1635.3	1564.3	95.6%	95.7%	0	0	0	0	5.45	3.17	1.41
Emergency	EDRU	885.5	885.5	100.0%	356.5	356.5	100.0%	550.25	550.25	356.5	356.5	100.0%	100.0%	0	0	0	0	0	0.62	0.69
	Park suite	857	850.75	99.3%	345	326.25	94.6%	690	690	0	0	100.0%	0	0	1	0	0	10.39	0.43	0.11
Surgical Assessment	ESAU	1240.5	1234.3	99.5%	533	451.75	84.8%	533	521.5	356.5	338.75	97.8%	95.0%	0	0	0	0	5.25	6.40	1.40
Critical Care	ITU	4822.5	4822.5	100.0%	212.5	212.5	100.0%	4278	4278	0	0	100.0%	0	0	2	0	0	1.81	0	0
Critical Care	HDU	1722.5	1722.5	100.0%	387.5	387.5	100.0%	1426	1426	356.5	356.5	100.0%	100.0%	0	0	0	0	1.81	0	0
Maternity	Delivery	3381	3315	98.0%	690	666	96.5%	3208.5	3160.5	690	654	98.5%	94.8%	0	0	0	0	7.27	0	0
Neo Natal	Neonatal	3381	3333	98.6%	0	0	0	3208.5	3070.7	0	0	95.7%	0	0	0	0	0	0.91	0	0
Children's	Children's	2186	2120	97.0%	356.5	356.5	100.0%	1782.5	1770.5	356.5	356.5	99.3%	100.0%	0	0	0	0	3.3	2.00	0.23
Orthopaedics	M1	1443.8	1298.8	90.0%	906.75	823.25	90.8%	713	701.5	356.5	345	98.4%	96.8%	0	0	0	0	0.91	0.67	2.18
General Surgery	M2	304	304	100.0%	172.5	172.5	100.0%	161	161	161	161	100.0%	100.0%	0	0	0	0	0	0.00	0.00
DME	CRC	1328.8	1278.9	96.2%	1530.5	1530.5	98.7%	713	713	906.75	906.75	100.0%	100.0%	0	0	0	0	4.74	2.16	0.69
Neuro & Rehabilitation	Ward 36	1335	1323.5	99.1%	968.75	962.5	99.4%	713	713	356.5	356.5	100.0%	100.0%	0	0	0	0	6.03	1.84	3.39
Dermatology	Dermatology	602.25	602.25	100.0%	143.75	143.75	100.0%	264.5	264.5	264.5	264.5	100.0%	100.0%	0	0	0	0	0.3	0	0

NB: RAG rating has been applied as 'green' 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 divisions at the time of this report

Board of Directors	
Agenda Item	8.4
Title of Report	Safeguarding Annual Report 2014 – 2015
Date of Meeting	29 July 2015
Author	Sue Fogarty – Head of Safeguarding/Named Nurse for Safeguarding Children Gaynor Westray – Deputy Chief Nurse
Accountable Executive	Jill Galvani – Director of Nursing & Midwifery
BAF References <ul style="list-style-type: none"> • Strategic Objective • Key Measure • Principal Risk 	To be the Top NHS Hospital Trust in the North West for Patient, Customer and Staff Satisfaction 1A; Improve our patient experience Supported by financial, commercial and operational expertise 7A; Full compliance with our registration with CQC 7D; Compliance with legislative requirements
Level of Assurance <ul style="list-style-type: none"> • Positive • Gap(s) 	Positive; Restructure of Safeguarding Team; Launch of Safeguarding Strategy; Compliance with Clinical Commissioning Group Accountability and Assurance Framework self-assessment framework except for training; Gap; Await training compliance against updated Training Needs Analysis.
Purpose of the Paper <ul style="list-style-type: none"> • Discussion • Approval • To Note 	For discussion and approval
Data Quality Rating	Gold – Validated by CCG Commissioning Accountability and Assurance Framework
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken <ul style="list-style-type: none"> • Yes • No 	No

Safeguarding Annual Report 2014–2015

Purpose

The purpose of this report is to provide the Trust Board with an annual review of the work undertaken in 2014-2015 and assurance in relation to safeguarding children and young people (including Looked After Children – also referred to as Children in Care) and adults.

The report will focus on how the responsibilities of the Trust have been met, an overview of the work undertaken and identifying the key objectives for 2015-2016. In particular it provides assurance on how the organisation has fulfilled its duty to ensure its functions are fulfilled with regard to the need to safeguard and promote the well-being of children and young people in line with *Section 11 of the Children Act 2004* and *Working Together to Safeguard Children (HM Government, 2015)*. In relation to Children in Care, the report focuses on how the Trust has met its duties and responsibilities as outlined in the *Statutory Guidance on Promoting the Health of Looked after Children (DCSF, 2009)*. For Safeguarding Adults, the report will focus on how it meets the standards set by Care Quality Commission for Safeguarding and following a recommendation by the Select Committee on the *Mental Capacity Act (MCA)* to now include MCA and Deprivation of Liberty (DoLs).

1. Introduction

The Director of Nursing & Midwifery at Wirral University Teaching Hospital commissioned a review of safeguarding governance and staffing arrangements within the Trust following the identification of issues that needed attention to ensure the provision of continued safe and effective care for vulnerable people. The overall aim of the review was to focus on the Trust's strategy, leadership and governance arrangements in fulfilling their statutory and contractual responsibilities and to safeguard and promote the welfare of children, young people and adults.

The new structure provides clear lines of accountability and governance within the Trust. In addition the Safeguarding Strategic Team, which reports into the Clinical Governance Group and Quality and Safety Committee, provides external scrutiny from the Designated Professionals to whom the Trust provides evidence of compliance within the statutory and contractual framework. This provides assurance for Safeguarding Children and Adults at Risk. The self-assessment document is submitted to the Designated Professionals and an action plan is monitored by the Trust Strategic Safeguarding Team.

The newly appointed Head of Safeguarding/Named Nurse for Safeguarding Children will ensure the key functions are undertaken for the Trust and provide effective leadership, monitoring and maintenance of safeguarding training programmes, collaborative inter-agency working and accountable for the delivery of a high quality patient centred service across the Safeguarding Agenda.

Safeguarding children and adults at risk is core to the business of Wirral University Teaching Hospital and is embedded in the Trust Nursing and Midwifery Strategy 2013-2018.

The requirements upon health are enshrined in statute within the children's services. The *Children Act 2004* provides the legislative framework for safeguarding children. *Section 11 and 13 of the Children Act 2004* states that the Trust has a duty to safeguard and promote the welfare of children and to be members of the Local Safeguarding Children Board. This is supported by *Working Together to Safeguard Children (2015)* which provides the guidance for the roles and responsibilities of all agencies, including Health, in ensuring their functions are fulfilled with regard to the need to safeguard and promote the welfare of children and young people.

The legislative framework for Safeguarding Adults is enshrined in the Care Act 2014. The Care Act puts adult safeguarding on a legal platform and came into force on the 1st April 2015. The Care Act recognises that Local Authorities cannot safeguard individuals on their own but working together with partner agencies such as Police, NHS and other key organisations.

The Care Act also sets out that the Care Quality Commission (CQC) registration requirements introduce a Duty of Candour which places a duty on NHS providers to be open and honest with patients and their families.

The Accountability and Assurance Framework focuses on the statutory requirements to safeguard children, and makes clear reference to best practice in relation to safeguarding adult arrangements. The Trust delivers to the most vulnerable and/or high risk across the age spectrum. Wirral University Teaching Hospital (WUTH) is affiliated with Wirral Safeguarding Children Board and Safeguarding Adult Partnership Board and their respective subgroups.

Over the past few years, the safeguarding agenda has proliferated. Health organisations are now involved actively in the child sexual exploitation agenda, the radicalisation agenda including PREVENT, Female Genital Mutilation, Forced Marriage and 'Honour' Based Violence. This is due to increased awareness and understanding of health professionals and their involvement and the safeguards they can provide.

The professional awareness in relation to Domestic Abuse and changes in legislation has resulted in an increase in high risk cases discussed at the Multi Agency Risk Assessment Committee (MARAC). The Mental Capacity Act (MCA) and the Deprivation of Liberty (DOLS) agenda have also come under the spotlight in line with the Care Act. Health organisations will have to demonstrate their compliance in ensuring staff are trained in MCA.

The political landscape for safeguarding is also changing. Following Winterbourne, Baby P, Daniel Pelka, and The Francis Report, organisations have come under the spotlight in how well their staff are trained and respond to safeguarding concerns as well as leadership.

The effect has been that the Clinical Commissioning Groups (CCG's), Safeguarding Boards and regulators are scrutinising and challenging organisations in their safeguarding responsibilities.

The safeguarding agenda is no longer clearly divided into Children and Adults, therefore this requires the Safeguarding teams to work in a more integrated way. Safeguarding continues to be addressed under one combined agenda following a 'Think Family' approach, underpinned by the principles of the 6 C's. Within WUTH we have adopted this approach of "Think Family" specifically in regard to training.

During this past year, the Trust has seen many challenges and change across other partner agencies. Safeguarding activity continues to highlight a year on year increase. For example, in the complexity of referrals to social care for both adults and children; a greater number of children are subject to a Child Protection Plan or Care Proceedings than before.

Maintaining the consistency and quality of all aspects of safeguarding practice across the Trust has been essential during this challenging period. Over the past year the safeguarding arrangements within all areas of the Trust have continued to be strengthened, with a particular focus on ensuring our staff receive an appropriate level of safeguarding training and are competent to undertake their safeguarding roles.

The report will cover how the Trust has responded to safeguarding agenda at a Trust Wide level and then focus on how the Trust has implemented its statutory functions.

2.0 Trust Wide Response

2.1 Safeguarding Leadership and Accountability

Section 11 of the Children Act 2004 outlines the requirement for a clear line of accountability within NHS organisations in respect of safeguarding and promoting the welfare of children and young people. The NHS Safeguarding and Accountability Assurance Framework support this requirement and extend it to include adults at Risk.

The Board has an identified Executive Director who leads on Safeguarding for the Trust. This is the Director of Nursing and Midwifery who champions safeguarding throughout the organisation and represents the organisation on both the Local Safeguarding Children Board and Local Safeguarding Adult Partnership Board. This role is supported by the Deputy Chief Nurse.

The Trust has a safeguarding team consisting of:

- Head of Safeguarding/Named Nurse for Safeguarding Children and Young People
- Named Midwife
- Lead Nurse for Adults at Risk
- Lead Nurse for Domestic Abuse, Female Genital Mutilation (FGM), Forced Marriage (FM), Honour Based Violence (HBV)
- Lead Nurse for Safeguarding Children and Young People
- Safeguarding practitioner for Adults at Risk

The team is managed by the Head of Safeguarding/Named Nurse for Safeguarding Children and is supported by an administrator. The Trust also has a Named Doctor for Safeguarding Children and Designated Doctor for Safeguarding Children and Designated Doctor for Looked after Children.

2.2 Safeguarding Governance Arrangements and Assurance

The Safeguarding Strategic Team (SST) is chaired by the Director of Nursing and Midwifery. Terms of reference include:

- To ensure that safeguarding is at the forefront of service planning
- To provide assurance in respect of safeguarding all vulnerable people
- To ensure that the agreed systems, standards, protocols are in place to effectively work together within a clear framework of managerial supervision and multi-agency procedures
- To ensure that concerns related to safeguarding are escalated appropriately and in a timely manner
- Contracts and service specifications, including safeguarding standards which has a red, amber, green rated audit tool is completed and subsequent action plan formulated

- To monitor and review action plans, and audit tools
- To monitor compliance in safeguarding and MCA training

The SST reports into the Trust Quality and Safety Committee and Clinical Governance Group and is responsible for overseeing the Trust's responsibilities to the adult and children safeguarding agenda (including Looked after Children and Domestic Abuse).

Prior to November 2014, the Safeguarding Operational Team for Children (SOTC) and Safeguarding Operational Group for Adults (SOTA) were chaired by the Named Nurse for Safeguarding Children and Young People and Lead Nurse for Adults at Risk. The Safeguarding Operational Groups reported into the Safeguarding Strategic Team. This structure has been reviewed and plans are underway to embed safeguarding into each division, supported by representation from the safeguarding team.

The Safeguarding Team complete the Safeguarding Assurance Framework for the Clinical Commissioning Group (CCG) on a monthly basis and co-ordinate the completion of the Self-Assessment Standards for Safeguarding Children and Adults at Risk for the CCG that commission the services of the Trust. In addition, the Designated Nurses are receiving monthly Safeguarding Dashboard figures and quarterly reports provided to the Wirral Clinical Commissioning Group Quality and Risk Group.

2.3 Safeguarding Team Activity

During April 2014- March 2015, the Safeguarding Team have seen an overall general increase in activity and complexity. Table 1 below details the activities and compares this with the activity of 2013-2014.

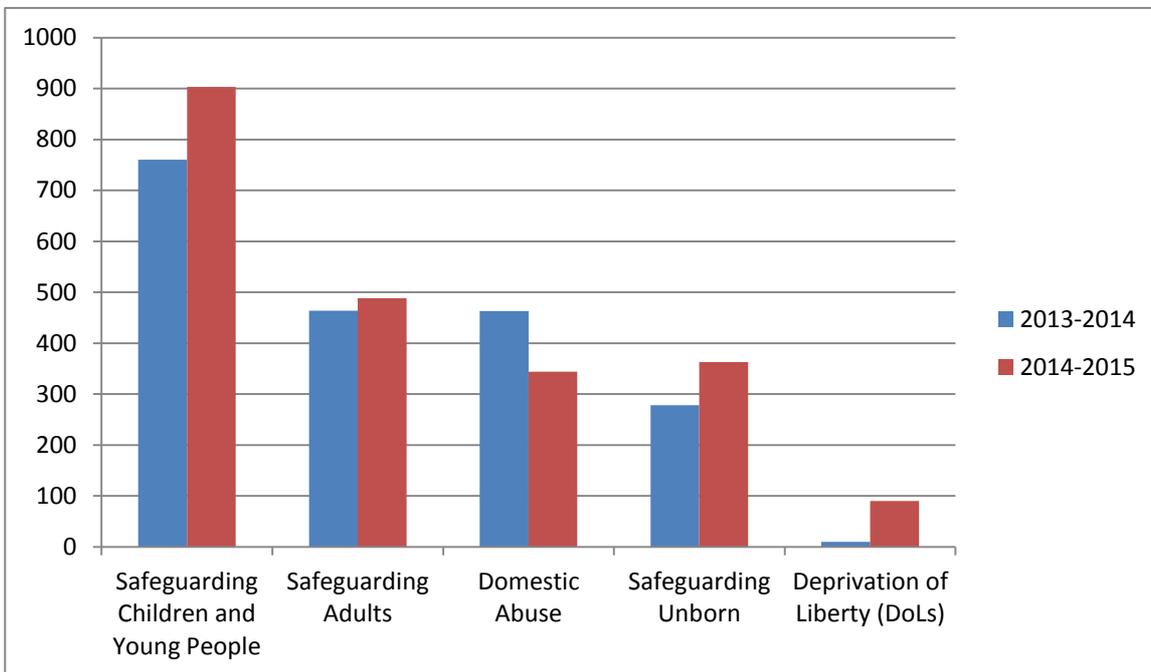


Table 1 illustrates that there has been a steady rise (19%) in Safeguarding Children referrals, mainly due to the training regarding the 16-18 year age group following the Serious

Case Review of a seventeen year old Wirral young person and subsequent actions that were implemented throughout the Trust.

Safeguarding Adults at Risk referrals have a 5% increase; however a significant rise in DoLS referrals, 10 referrals in 2013-14, has increased to 90 referrals in 2014-15.

Out of the 90 Deprivation of Liberty Urgent and Standard applications that were made to the Supervisory Body (Local Authority) by the Managing authority (WUTH), 65 of these applications resulted in a full Deprivation of Liberty whilst in hospital.

There has been a significant rise in unborn referrals (36%) - this may be attributed to the rise in obstetric referrals in Wirral and also could be explained by frontline practitioners making appropriate detailed referrals utilising the Common Assessment Framework/Team around the Family Process (CAF/TAF). From 1st April 2015 the Trust is required to submit data for this referral group.

There is anticipation with regards to the future of DoLS applications in the coming year with the implementation of the Care Act 2014 commencing 1st April 2015.

2.4 Safeguarding Training

The Safeguarding training strategy is under review to ensure compliance with the Intercollegiate Document 2014 guidance. The training needs analysis which arises from this will provide the framework within which the development of a more robust and pragmatic strategy for Safeguarding Training will be developed. The intention is that the strategy will be deliverable with resources currently available and will provide assurance that both legislation and local/national guidance is embedded within all aspects of clinical practice where applicable.

A decision has been made to ensure all safeguarding training within the Trust is Mandatory not Essential. Currently only Level 1 is Mandatory.

Ongoing discussions with Learning and Development are continuing with regard to the Training Needs Analysis, scoping for e-learning packages and the transfer of safeguarding training to the Learning and Development Team within the Trust. The funding for an administration post has been agreed. The post holder will be in place by beginning of April 2015 and will be responsible for the administration, maintaining the compliance data. This action has been completed.

The e-learning packages for Level 2 training (child and adults) were available on the staff intranet from mid June 2015 and the safeguarding team and Learning and Development presented an action plan to the Clinical Governance Group in May 2015 to provide assurance of the Trust's compliance with all safeguarding training.

Table 2 illustrates the compliance rate to all levels of Safeguarding Training at end of March 2015.

Specialty & Level	Compliance (%)
Safeguarding Level 1 (<i>All areas inc MCA</i>)	98.77
Child Protection Level 2	Not validated *
Child Protection Level 3	Not validated *
Child Protection Level 4	100%
Adult Protection Level 2	Not validated *
Mental Capacity Act Level 2 and 3	Not recorded

- * There has been a change in systems of data collection. A new data cleanse is underway and upon completion the training compliance figures will be validated.

2.5 Safeguarding Supervision and Support

The Trust is required to provide safeguarding supervision to all health practitioners who case load safeguarding cases. The Safeguarding Supervision Policy which was ratified during 2014-2015, states that safeguarding supervision is offered to all professionals who hold a caseload with safeguarding children concerns, and staff/departments that have direct involvement with safeguarding children and young people cases. Following recommendations from the Care Act 2014, the policy has been amended to include practitioners who support adults. Safeguarding Supervision is provided by members of the safeguarding team who have undertaken the accredited NSPCC Safeguarding Supervisors course.

The Named Nurse for Safeguarding Children has provided group supervision for all A&E staff, and plans to expand this service to staff on the paediatric ward. The Named Midwife, Named Nurse, Safeguarding Practitioner and Lead for Domestic Abuse provide supervision to appropriate midwives.

The Named Nurse, Named Midwife, Lead for Adults at Risk, Lead for Domestic Abuse and Named Doctors also access safeguarding supervision from Designated Professional. An audit of the quality and effectiveness of the supervision provided is currently underway and the result will be provided at the SST.

2.6 Serious Case Reviews/Domestic Homicide Reviews/Learning Reviews for Children and Adults

There has been no Serious Case Review (SCR) or Domestic Homicide Review commissioned for WUTH during this reported period. However, the SCR for Child G was published in March 2013, the action plan was completed during this period.

There have been no Serious Case Reviews for adults in this period.

There is an ongoing Critical Case Review of Child 2. WUTH had no actions from this review to implement.

WUTH has attended a Learning Review of a young person and the outcome of the review highlighted the excellent commitment and challenge to partner agencies in respect of this young person by the Named Nurse for Safeguarding Children.

At the time of writing there are three critical case reviews pending which WUTH will contribute to as required.

2.7 Inspections/Reviews

There have been no Care Quality Commission themed safeguarding children inspections in the last year, however, preparation is underway for the anticipated CQC single agency inspection which will look at the quality and effectiveness of arrangements that the Trust have made to ensure children are safeguarded and how health providers promote the health and wellbeing of Looked After Children. This process is being overseen by the Designated Nurse for Safeguarding Children. The Trust has identified cases and all preparations are in place awaiting the inspection.

There have been no OFSTED inspections during the last year.

2.8 Partnership Working

In supporting partnership working the Trust participates in various multi-agency forums and delegates from the Trust attend.

Forum	Responsibility
LSCB (Local Safeguarding Children's Board)	Director of Nursing & Midwifery
LSAPB (Local safeguarding Adult Partnership Board)	Director of Nursing & Midwifery
Serious Case Review	Lead Nurse – Adults at Risk
Staying Safe	Head of Safeguarding/Named Nurse for Safeguarding Children & Young People
Learning & Development	Lead Nurse Safeguarding Children and unborn
Performance	Named Midwife
Child Sexual Exploitation	Head of Safeguarding/Named Nurse
Communications	Safeguarding Practitioner for Adults
Domestic Abuse	Lead for Domestic Abuse

2.9 WUTH Safeguarding Activity

	April 2014 to March 2015
Number of Unborn's subject to Child in Need	52
Number of Unborn's subject to a Child Protection Plan	31
Number of Unborn's subject to ICO/Sec 20	10
Number of Children subject to Sec136 (MHA)*	10
Number of Case Conferences attended (Child)	112 *
Number of Case Conferences attended (Unborn)	40
Number of MARAC's attended**	27
Urgent DoLS Applications made***	90
Standard Authorisations granted	63
Number of allegations against staff (met ALADO/LADO criteria)****	11
Looked After Children:	
Number of Initial Health Assessments(IHA) received	162
Number of IHA's completed within 21 days	107
% completed within 21 days of receipt	63.5%

* 0-19 service contract ended in February, therefore the figures for case conferences attended by school nurses reflect this change

2.10 Paediatric Liaison Role in relation to Child Death Overview Panel (CEDOP)

In accordance with *Safeguarding Vulnerable People in the Reformed NHS – Accountability Assurance Framework (NHS Commissioning Board 2013)*, states that all child deaths (excluding neonatal deaths) that occur for Wirral children are reported to the specialist nurse

for Child Death. Within WUTH, this has been embedded into the role of Paediatric Liaison for Children. This role is accountable for gathering, coordinating and sharing this sensitive information surrounding the death of the child. The role is responsible for liaising with Wirral Safeguarding Children Board Death Coordinator and managing the health response in accordance with the *Children Act (2004)* and *Working Together (2015)*. This is in place to improve the understanding of how and why local children die. These findings aim to identify subsequent actions to prevent future death and improve the health and safety of children.

There have been eleven child deaths in Wirral during 2014-2015. All of the deaths were reviewed at the Merseyside Child Death Overview Panel.

2.11 Looked after Children

A separate report for Looked after Children will be produced in accordance with statutory guidance by the Designated Nurse for Looked after Children, employed by the CCG.

2.12 Safe Recruitment and Vetting Procedures

The Trust adheres to the standards in accordance produced by HM Government Disclosure and Barring Service. The Trust undertakes DBS for all staff, new recruits and volunteers and has robust policies and procedures. Following the *Lampard Report 2015 – Lessons Learned from Saville* – the Trust has an action plan in place and is currently completing a VIP/Celebrity Policy.

3 Key objectives for 2015-2016

The Safeguarding Team developed the Safeguarding Strategy 2015-2017 which is embedded in all divisions across the Trust that “Safeguarding is everyone’s responsibility” and the “One Chance Rule”. The key priorities and objectives are:

- Mainstreaming Safeguarding to support excellence
- Effective safeguarding, leadership, structure and processes
- Learning and improvement through experience and partnership
- Continuing the development of a caring, safe and effective workforce
- Engaging with service users and external agencies

A copy of the strategy is uploaded onto the Safeguarding web page for all Trust staff.

3.1 Next steps

- To launch the safeguarding team and governance structure – 10th July 2015
- To further develop the Cerner Millennium function to ensure all safeguarding information is kept in one location and accessible by all Trust staff. This is currently on the Trust Risk Register and is monitored by the Clinical Governance Group
- To ensure safeguarding training becomes mandatory at all levels appropriate to post and monitor compliance
- To ensure the safeguarding team is recognised as an expert advisory, supportive role, and to ensure clinical staff have the required skills and knowledge to undertake their statutory obligations within the safeguarding arena
- To support the transfer of responsibility to clinical staff for the completing of referrals to the Local Authority when concern or abuse is identified for adults at risk

- To support the transfer of responsibility to key clinical staff in the completion of the Domestic Abuse Risk Assessments
- To support the transfer of responsibility to midwives in relation to safeguarding children cases
- To review and further develop safeguarding information for both patient and public on the Trust's website, including how to raise concerns.

4 Conclusion

The Trust has worked in partnership with the LSCB and LSAPB and other partners to improve the safeguarding element of the service it provides, and to ensure compliance with the statutory and contractual responsibilities of the Trust.

This report has detailed how the Trust has fulfilled its duty to ensure its functions are completed with regard to the need to safeguard and promote the wellbeing of children, young people and adults in line with *Section 11 of the Children Act 2004*, *Working Together to Safeguard Children 2015* and the *Care Act 2014*.

5 Recommendations

The Board are asked to receive and approve the Annual Report on Safeguarding Adults and Children 2014-2015

Wirral University Teaching Hospital

NHS Foundation Trust

Arrowe Park Hospital, Wirral, CH49 5PE

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Board of Directors	
Agenda Item	9.1
Title of Report	Report of the Quality & Safety Committee 8 July 2015
Date of Meeting	29 July 2015
Author	Dr Jean Quinn, Chair of the Quality and Safety Committee
Accountable Executive	Evan Moore, Medical Director
BAF References	
<ul style="list-style-type: none"> • Strategic Objective • Key Measure • Principal Risk 	1,3,4,5,6,7 1a,1b,3a,3b,4a,5b,6b,7a,7c,7d 1445,1908,1909,2328,2485,2611,2678
Level of Assurance	Gaps with mitigating action
<ul style="list-style-type: none"> • Positive • Gap(s) 	
Purpose of the Paper	Discussion
<ul style="list-style-type: none"> • Discussion • Approval • To Note 	
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken	N/A
<ul style="list-style-type: none"> • Yes • No 	

This report provides a summary of the work of the Quality and Safety Committee which met on the 8 July 2015.

Chairs Business

An overview of the responsive CQC inspection in May 15 was provided which is described in more detail in the CQC Board Report.

The results from the first National CQC Paediatric Inpatient Survey was reported upon, which is included in the Chief Executive Report. The results were particularly pleasing.

An overview of the Adult Inpatient Survey was provided, the results of which were similar to the previous survey with one area of significant statistical variance which related to the time a patient had to wait for a bed on a ward which has since improved.

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End of Life Care Audit and Strategy

Results of an audit of 30 predicted deaths were mapped to the 5 priorities of care for people in the last days of their life as follows:

Recognise – a reduction in the numbers of patients dying was recognised

Communicate – increased communication from 8% in 2013 to 18% to the patient and in 95% of cases where relatives were involved

Involve – discussions regarding plans of care with patients occurred 14% of the time and 73% of the time with relatives. Examples were found of patients and families leading the way in decision making, but views were not always acted upon.

Support – poor evidence of support for families highlighted, only explored in 9% of cases.

Plan and Do – noticeable improvement in anticipatory prescribing and use of syringe drivers. Assessment of comfort documented remains poor. However when symptoms were documented they were treated in 95% of cases. 57% of cases reported help with eating and drinking.

Additional key findings included the increasing medicalization of dying ie: routine observations. Up to 40% of patients die alone. Documentation of after death care was universally poor. There was a noticeably high standard of care on stroke unit which was a good area of best practice.

Actions to improve End of Life Care included:

- The requirement for a standardised record to prompt and document significant discussions, plan of care and record comfort assessments/measures.
- Continued work to raise awareness of symptom control algorithms was necessary. This will be targeted in the Division of Medicine.
- The need to quality assure care for dying patients in real time.
- Psychosocial and spiritual support for families must be improved.
- Neuberger Review must be followed up.

The Committee was advised that the areas highlighted were being included on the Cerner electronic system. The Committee agreed that training was essential although were advised that this would only be successful if done appropriately which is difficult to release staff for.

The Committee approved the End of Life Care Strategy but sought assurance that the time orientated action plan and key performance metrics were developed as soon as possible and presented to the Committee in September 2015. The Committee agreed to escalate to the Board concerns with resources and capacity to deliver end of life care.

Workforce Dashboard

Areas of Good or improving performance highlighted were recruitment; attendance rates and the staff engagement work

Areas for Improvement highlighted were compliance with safeguard training and the flexi bank provision. A verbal update on safeguarding training would be provided at the July Board meeting by the Director of Nursing and Midwifery and the options for flexi bank were being progressed. The Committee agreed to escalate to the Board the urgency required to ascertain compliance with safeguarding training.

Quality Impact of CIP Report

Agreed that the dashboard should include how many patients were on the list for discharge in the future as well as delays transfers of care to track this more effectively. Bed occupancy rates were reducing and were moving back towards 90% which correlated with the success in performance in A & E. The position with Fractured Neck of Femur and C difficile rates were a concern although

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the first of these being verbally reported as resolved and the second being not dissimilar to last year with improvements seen in June and July.

Clinical Audit Annual Report

Good level of assurance provided through this report supported by the MIAA report which recorded "significant assurance". Of particular note were the changes made as a result of undertaking local clinical audits.

Clinical Quality Dashboard

Areas of Good or Improving performance highlighted were HSMR which continues to be below the national average at 93.9; Sepsis which is improving and Friends and Family Test results which were on target.

Areas for improvement highlighted were harm from falls; the number of ward moves which had increased; medicines allergies and 1 grade 4 pressure ulcer which following the investigation was deemed to be unavoidable. The falls group are progressing the work on falls; the number of ward moves was being investigated and reviewed with a greater emphasis on prioritisation of who moves in the future linking the findings from falls. Task and finish group established to review past medication allergy incidents and the actions being undertaken to address this.

Patient Acuity Audit

Good levels of assurance provided through this report on the funded establishment figures although the gap in available staff was a concern. However improvements in staff attendance rates; the recruitment campaign and the closure of the escalation wards would impact positively on this.

Surgery, Women and Children's Divisional Presentation

Key themes included an update on the clinical leadership; the work being undertaken to align the Division's work with the strategic objectives; the performance in each speciality and plans for the future; patient experience; clinical effectiveness; integration with other providers and partnerships.

Of note was the improvement in the number of key performance indicators which had improved since June although work still required on CQC preparation; finance; complaints; assistance with eating and drinking and referral to treatment targets.

Dr Jean Quinn
Chair of Quality and Safety Committee

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Board of Directors	
Agenda Item	9.2
Title of Report	Report of the Finance Business Performance & Assurance Committee 24 July 2015
Date of Meeting	29 July 2015
Author	Graham Hollick, Chair of FBP & AC
Accountable Executive	Alistair Mulvey, Director of Finance
BAF References <ul style="list-style-type: none"> • Strategic Objective • Key Measure • Principal Risk 	5A, Risk 2718, 6B, 7B, Risk 1927 and 2550, 7C Risk 2328, 7D, Risk 2689
Level of Assurance <ul style="list-style-type: none"> • Positive • Gap(s) 	Gaps with mitigating actions
Purpose of the Paper <ul style="list-style-type: none"> • Discussion • Approval • To Note 	Discussion
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken <ul style="list-style-type: none"> • Yes • No 	N/A

M3 Financial Position

The Committee reviewed in detail the cumulative position at M3 which shows the Trust meeting its Income and expenditure plan for the quarter and maintaining a stronger than planned cash position. As at the end of the quarter the Trust reported an Income & Expenditure deficit of £4.8m against a planned deficit of £4.9m and cash of £19.6m against a plan of £12.4m. These positions provide a Continuity of Services rating of 2, in line with plan, and provide assurance that through the first quarter the Trust is achieving against its financial objectives. The position in month 3 reflecting an improving income position which is key to the Trust achieving its full year financial plan, the improvement on income providing further assurance on operational and financial achievement.

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It was recognised that some pressure was being experienced across pay lines as flexible labour is used to fill vacancies and that flexible labour, especially across the medical workforce, attracts an additional premium cost. Whilst the in month adverse variance is relatively immaterial (less than 0.5% of total paybill) this is causing a cumulative pressure and will need to be addressed as the year progresses. In gaining assurance on the management of pay costs the Committee Scrutinised the rigour applied to the vacancy control process together with the impact of the cost improvement plans associated with the workforce which were anticipated in Q2. For pay costs to be maintained within the planned costs it is essential that cost improvement programmes, associated with pay costs, achieve as planned through quarter 2 and the remainder of the financial year. The Turnaround Advisor noted that these schemes were on track at this stage. The Committee sought to balance the delivery of the financial plan with the need to ensure that the hospital was appropriately and safely staffed and noted that the excess costs were not driven by the availability of resources rather the inability to recruit and the use of flexible labour at a premium cost.

The Committee reviewed the volume and activity at M3 by points of delivery to understand variances from plan; the levels of penalties applied in each area and the overall impact therefore on delivery of the financial plan. The Committee also reviewed the proposed future reporting that would include the forecast for the forthcoming month in terms of both volume and value.

As requested by the Committee, further narrative on working capital was provided this month for each of the Divisions as well as at an aggregate level. Improved ownership and visibility of working capital and cash balances at an operational divisional level will support the Trust's structured programme in improving medium term forecasting and identification of potential future distressed funding requirements at the earliest possible stage.

The capital programme was reported to be on track for this year with work being undertaken as part of the planning process for next year.

2015/16 Forecast

The Committee reviewed the current forecast for 2015/16 which shows, based upon the performance through the first quarter combined with forecasts for income and expenditure, a balanced position relative to the plan with a forecast deficit of £13.5m against a planned deficit of £13.5m. The Committee noted the favourable and adverse variances in the forecast position and also the requirement to ensure that all elements were addressed not only on an in year but also recurrent underlying basis. The Committee noted that based upon the strength of the cash position through quarter 1 that the requirement for distressed financial support and the timing of that support would continue to be reviewed with the aim of minimising and delaying any requirements, this will be contingent upon achievement of the I&E plan. The key risks were highlighted as pay costs and performance in income. A review of the forecast ranges from a base position and the assumptions driving the forecast position together with the upside and downside positions were undertaken. The review enabled the Committee to understand the key risks and opportunities through the first quarter for the achievement of the totality of the financial plan over the full year.

Monitor Quarterly Return

The Committee recommended the declarations included in the Q1 2015/16 return together with the narrative. The Board will review and approve this as part of its meeting on 29 July 2015.

Progress Report on the Recovery Plan 2015-16

The Turnaround Advisor provided an update on progress against the Recovery Plan which included:

- The plan was delivered in Q1 although there was recognition that many of the schemes were due to deliver later in the year.
- The recruitment to the Programme Management Officer post on an interim basis with the recruitment of the permanent manager position being undertaken on 4 August 2015 which would provide the Trust with a more sustainable position for the future.
- Work was underway on coding in terms of staffing; validation and re-coding for the months of May and June, all of which was expected to enable the Trust to assess the delivery of the opportunity identified of £3.75M by the end of July 15.
- £500K of the £2M CIP gap had been identified, with plans being developed to achieve this although there was degree of risk with these at this stage.
- Planning for 16/17 was due to commence along with the annual planning programme
- Agreed to include the Key Performance Indicators in the Recovery Plan in future reports to enable the Committee to monitor this appropriately.

Surgical Care Activity Improvement Report

The Associate Director of Surgery, Women and Children's Division provided an update on the work of the Division to achieve activity levels as per their signed off and agreed operational business plan. The Committee was advised of the reasons for non-achievement of the plan for the first 2 months of the year which were attributable to consultant leave; infection control and increases in trauma. The Committee was assured that the re-phased plan addressed the reasons for early failure and drew upon the success in gynaecology which had been evidenced. Further assurance was provided through the improvements already seen in July and the patient bookings, in particular for orthopaedics, in August 15. The Committee agreed that assurance would be strengthened as the detailed work being undertaken within the division translated into the delivery of activity volumes on a consistent basis and that improvement would need to be demonstrated through July, August and September as evidence of achievement of the plan.

Performance Report

Key highlights included performance in A&E which was currently 98.16% for Q2; Referral to Treatment Times which were all achieved at an aggregate level; the achievement of all the Cancer Targets although this was proving more and more difficult and the reported rates of C difficile which were above the trajectory of 7 at 11 although the HPV programme was continuing with every opportunity being made to undertake this work whilst the hospital is experience less operational pressure as the flow of patients improves

Cash Reporting

An update on the development work being undertaken to support cash reporting was provided, this activity which has been in train for some months supplements the work undertaken by PwC.

Procurement Best Practice and Performance Management Framework

The Committee received an update on the work the Trust is undertaking to improve procurement delivery in line with the recommendations of Lord Carter's report, further

detail of which will be discussed at the Board in July 2015. The Committee were assured, given the contribution of procurement across the level of influenceable spend, that activities were already being sought across the main areas of the Carter report. The Committee noted the developments in the procurement supply chain for orthopaedic implants, in partnership with NHS Supply Chain, that the Trust was engaged in to minimise the cost to serve with anticipated savings of c10-15% on these supplies.

The Committee noted the criticality of operational and clinical engagement in the procurement process and noted some of the successes the procurement function had in this area including national recognition for the procurement savings associated with wound care therapy.

A review of the Trust's position against each of the key indicators for Q1 was undertaken. Of note was the high number of qualified staff in the procurement team; the availability of equipment and low number of incidents due to failure; the achievement of the procurement team in terms of cost improvement savings. The Committee noted the criticality of recruitment and retention of high quality procurement staff and that the Trust was currently in the recruitment process to replace buyers which had secured promotional opportunities with other NHS organisations.

IT Infrastructure Update

The Committee received an update on the Trust's IT infrastructure which included a review of all its existing IT assets; costs; maximum life spans and the cost of annual replacement. The Committee requested that some sensitivity analysis be undertaken in this area to aid with capital planning.

The Committee noted that a further paper was required specifically on Cerner components of the IT strategic delivery.

Board Assurance Framework

The Committee concurred with the Quality and Safety Committee to include 3 new risks on the BAF in relation to achievement of the CIP programme; the issues with regards to the Hospital infrastructure and the risk that activity levels do not meet planned targets. The Committee also agreed to remove two risks related to the submission of the Annual Plan for 15/16 and the remote hosting of Cerner as both of these areas of work had been successfully completed.

The Committee agreed to track the risk of delivery of the identified CIP plans as well as the gap of circa £2M and would further consider the outcomes of the Monitor Investigation in terms of its inclusion in the BAF

Graham Hollick
Chair of Finance Business Performance and Assurance Committee

Board of Directors	
Agenda Item	9.3
Title of Report	Monitor Quarterly Return – Q1 2015/16
Date of Meeting	29 July 2015
Author	Emma Pridgeon Assistant Director of Finance – Financial Services Shahida Mohammed Assistant Director of Finance – Income & Commissioning John Halliday Assistant Director of Information
Accountable Executive	Alistair Mulvey, Director of Finance 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

1. EXECUTIVE SUMMARY

The Board is asked to approve the statements that accompany the year end monitoring returns that are detailed in Appendix 5 as recommended by the Finance Business Performance and Assurance Committee.

The Board is also asked to review and approve of the quarterly financial commentary which will be submitted to Monitor.

Foundation Trusts are required to submit a report to Monitor on a quarterly basis using templates provided, covering targets and indicators, governance and finance. The basis of the report for Quarter 1 2015/16 is described below. The key financial statements are included in the Appendices 1-4.

2. BACKGROUND

Governance Targets & Indicators

Under Monitor's Risk Assessment Framework, each indicator has an equal weighting of 1 point for each standard not achieved. The overall Governance ratings are Green for no concerns (i.e. all targets met). Beyond this, the failure against targets raises Governance concerns at Monitor, with no RAG rating being assigned until such time as formal regulatory action is taken and a Red rating applied.

WUTH will not be considered Green for Quarter 1 and issues of note with the Risk Assessment Framework standards are detailed below.

Against the A&E standard of a minimum 95% of patients to be admitted, transferred or discharged within four hours, the final Quarter 1 position was 87.23% as measured across a combined ED and All Day Health Centre performance at the Arrowe Park site.

The pressures previously reported continued through Quarter 1 but performance started to improve as the quarter progressed, culminating in the achievement of 92.96% for June. This improvement has continued into quarter 2 and performance is currently (@16th July 2015) at 97.84% as a site, therefore we are currently achieving the standard.

Work is continuing with partners across the Health and Social economy to deliver the agreed Urgent Care Recovery plan and work has started on the Trust's winter plan. For c Difficile, the Trust has a maximum trajectory of 29 toxin positive for the year 2015-16. The profile for Q1 is an expected maximum 7 cases. To the end of June there have been 11 cases, and so we are above our maximum trajectory. A full HPV programme is in place.

Performance against the cancer waiting time standards can take some time after quarter-end to finalise due to the nature of the shared pathways crossing organisations, and the need for diagnostic confirmation that treatment already commenced was for cancer. Currently all cancer waiting time standards were achieved in Q1 with the exception of the maximum 62 day wait for treatment following urgent referral. WUTH's 62-day performance for Q1 currently stands at 84.35% against an expected minimum 85% threshold. Validation of all pathways under this standard is continuing, and a verbal update will be provided at the meeting in advance of the final deadline of 4th August.

The 62-day standard is the one cancer target that is frequently the most difficult to achieve, and this is reflected in performance levels at a national level. Monitor and NHS England are stepping up the level of scrutiny, and support, to ensure this standard is given the priority and attention it warrants by health economies. This is

supported by adopting the reporting recommendations from Sir Bruce Keogh, and includes reporting to the centre on a weekly basis.

Other national changes in performance reporting relate to Referral to Treatment (RTT) within 18 weeks. Monitor has confirmed that performance against the admitted and non-admitted standards for RTT are no longer required under the Risk Assessment Framework in 2015-16. The RTT standard for Incomplete pathways remains in force, and is likely to have a higher financial consequence of failure from Q3 onwards. For Q1, WUTH achieved all three of the standards at Trust level. From this point on only performance against the Incompletes standard will be highlighted. Although the Incomplete RTT standard is regularly achieved by the Trust, the size of the RTT waiting list has been steadily growing over the last 12 months. This is primarily due to a large increase in GP referrals through 2014-15. The Clinical Divisions have been tasked with formulating plans to reduce their backlog before the greater consequences are applied from October onwards.

CQC Standards

The Trust received an unannounced inspection overnight on 18th and 19th May 2015, covering the medical and surgical assessment units, escalation areas, and wards 37 and 38. A draft report has been issued by CQC although is not yet finalised.

Compliance Rating

WUTH will not be Green for Quarter 1 under Monitor's Risk Assessment Framework. Governance concerns may again be raised by Monitor over the repeated failure to achieve the A&E 4-hour standard. The Trust has ensured there has been engagement with Monitor on a regular basis in terms of the plans for improvement in A & E performance.

Governance Information

Information relating to relevant election results will be updated to Monitor separately.

Finance Declaration

The Trust has submitted an operational plan showing a deficit for 2015/16 and a resulting year end COS rating of 1. Therefore the Board is unable to confirm the finance 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".

Quarter 1 2015/16 Financial Commentary for Monitor

The following commentary covers the key reasons for the Quarter 1 variations against the 2015/16 plan.

The financial position of the Trust shows a year to date deficit of £4.8m against the planned deficit of £4.9m, therefore a favourable variance of £0.1m.

NHS Clinical Revenue

To Quarter 1 there is a shortfall of just over £1.2m against planned levels.

Key variances to Quarter 1 are as follows:

Point of Delivery	Cumulative variance to plan £m	Commentary
Elective	(0.7)	Cumulatively the variance is driven by an underperformance in Surgical specialties of (£0.8m), mainly in Trauma & Orthopedics. This has been offset slightly by the additional North Wales activity £0.1m secured during 2014/15 to help achieve Welsh access targets. Referrals had been made during March 2014, and procedures were undertaken during May/June 2015.
Non elective	(0.1)	Although Medicine & Acute Division are showing an over recovery of £0.3m, actual activity is underperforming by approximately 600 spells particularly in Diabetic, Gastro. and Respiratory Medicine. The position has been supported due to a complex case mix of patients, which in turn has seen excess bed days over perform significantly. Surgery and Women & Children's Division is under performing by (£0.2m). Under performances in Colorectal, Obstetrics and Pediatrics have been offset by an over performance in Trauma & Orthopedics and Urology. The overall position includes a penalty of (£0.5m) in relation to readmissions.
Day Case	(0.4)	On a cumulative basis Medicine & Acute Division are achieving plan, under performance is apparent in Trauma & Orthopedics, (£0.2m), Ophthalmology (£0.2m), and Gynecology (£0.1m), reflecting both a reduced volume and less complexity of casemix. In addition the position has been supported by Welsh activity £0.1m relating to referrals received in March 2015 for patients receiving treatment in May/June 2015.
Outpatients	(0.4)	Overall Outpatient first attendances are under performing by (£0.1m); with over performance in Medicine and Surgery, Women's & Children's underperforming. Outpatient follow-up attendances are below plan across all specialties with a total value of (£0.3m). The key areas being Trauma and Orthopedics and Gynecology. Included within this position is a penalty of £0.2m for outpatient follow up caps.
A&E	(0.1)	Although activity in this area is under performing, due to a complex case mix, the position is break even. The financial effect of penalties in relation to the 4 hr. A&E access targets amount to some (£0.3m) cumulatively. This has not been reflected in the financial position; the CCG have recognised the breeches result due to system wide issues as opposed to Trust processes. On that basis the CCG via the System Resilience Group have agreed penalties will be re-invested into the Trust, to help improve pathways.
Other – tariff	0.1	The year to date over recovery relates entirely to the Maternity

		pathways.
Other non tariff	0.4	The year to date position reflects small over and under performances in a number of Non PbR areas, in particular DA Pathology £0.1m, Rehabilitation (Elderly and Stroke) £0.1m over performed. In addition £0.2m was released from provisions made in 2014/15 in relation to specific items which had been queried by Commissioners and payment was not certain.
Total	(1.2)	

The above figures include a year to date adverse variance of £0.2m on Income Generation schemes, with a breakeven position when costs of delivery were deducted.

Contractual Status

The Trust has agreed a contract with its host Commissioner Wirral CCG (responsible for commissioning approximately 80% of the Trusts clinical income), actual contractual sign-off is schedule to be completed by 31st July 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 1, with some re-negotiation on milestones and actual delivery dates due to late contract sign-off.

Other Income and Operating Expenditure

These net costs are below plan at Quarter 1 by c£1.3m.

The key elements are:

Reason for variance	Cumulative variance to plan £m	Commentary
CIP delivery	(0.3)	There has been a year to date shortfall against the CIP plan for divisional expenditure and income (net of costs of delivery) of £0.3m across most cost categories. The shortfall relates to the Trusts overall in year shortfall of £2m with plans of £11.1m identified against a target of £13m.. The rate of slippage has remained fairly constant across the quarter.
Reserve release	1.8	As at Quarter 1 the Trust has released £1.8m of reserves and accruals following an ongoing review. The rate of reserves applied in month three was at a lower level than in months one and two.
Emergency care	(0.1)	The Trust has a cumulative pressure of costs of emergency care of £0.1m due to vacancies in nursing, medical staff and locum spend, which has continued at low levels in month.
Unplanned beds / capacity	(0.6)	This spend is associated with dealing with the impact of norovirus and CPE issues, the extended LOS impact. The cost of additional wards has fallen considerably during the final month of the quarter as additional wards were closed as admissions fell against plan. However costs of meeting CPE pressures continue.

Premium costs	(0.4)	Planned and unplanned activity at premium prices due to vacancies in histopathology, theatres and gastroenterology, some of which are expected to continue for several months.
Additional activity	(0.1)	Additional expenditure directly related to increases in activity has been minimal to date.
Non PBR offset	0.3	There is a cumulative £0.3m underspend on items offset by a reduction in non PbR income (e.g. High Cost Drugs, Bloods and Device exclusions).
Other	0.7	There has been a year to date underspend of £0.7m on "other" expenditure/loss of income such as specialising, sickness and maternity cover, loss of private patient income, other overspends, etc., however these are more than offset by vacancies in a wide range of areas, gains of other income and other smaller variances.
Total	(1.3)	

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 is also undergoing a restructure to give it sole focus on governance and assurance and separate out the delivery aspects of project management to the workstream leads. The additional support required to do this should be in place by the end of the month.

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 £11m 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 CIP position at Quarter 1 (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)	0.111	1.044	0.349	0.806	1.16
Year to date Actual	0.124	0.572	0.165	0.531	0.70
Year to date Variance	0.013	(0.472)	(0.184)	(0.275)	(0.46)

The full year and recurrent Income Generation / CIP values, based upon the latest forecast at Quarter 1, 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 Q1	6.6m	4.4m	11.0m
Recurrent Value			
At time of annual plan	10.4m	6.1m	16.4m
At Q1	10.4m	6.1m	16.4m

The above shows that the schemes identified during the planning stage are still largely expected to deliver as planned, both in year and recurrently.

A process of review of all workstreams is currently underway through the Transformation Steering Group (TSG) with the objective of identifying further opportunities to fill the in year gap, to date c£0.4m has been provisionally identified and plans are being developed to realise these savings.

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

EBITDA

The unfavourable NHS Clinical Income variance and the operational favourable variance give a net breakeven EBITDA position at Quarter 1.

Post EBITDA Items

There is a minor favourable variance to the post EBITDA budget at Quarter 1 of £0.1 m due to the change in the mix of spend in the capital programme. This is generating an overall favourable bottom line variance of £0.1m at Quarter 1.

Full Year 2015/16 Outturn and distressed funding

The Trust anticipates generating a full year outturn deficit at planned levels of £13.5m, with the delivery of a Continuity of Services rating of 1 as planned.

The Trust forecasts that the planned distressed funding of £4.8m will still be required in December 2015. However it is continually reviewing its working capital requirements to assess if the amount required can be deferred or potentially reduced.

Statement of Position (Balance Sheet)

The actual Total Assets Employed and Total Taxpayers Equity equal £143.9m.

The main variations against plan are as follows:

- Trade receivables across NHS and non NHS are marginally below plan.
- Trade creditors are significantly higher than plan. This is predominantly due to the non settlement of prior year balances with commissioners of £1.7m (the majority of which is expected to be settled in the next month) and the commissioning underperformance to date in 2015/16
- Accruals are significantly higher than planned due to delays in the receipt and agreement of charges received; in particular due to the higher use of agency staff (especially for infection control), timing of IT maintenance / RHO costs, consultancy support payments, clinical support contracts and reserves
- Prepayments are higher than planned for radiology and other maintenance contracts.

- Deferred income is higher than planned due to the early receipt of central funding for Sign up to Safety, clinical trials monies received and funds received for invoices raised in advance.
- Capital spend (on accruals basis) to Quarter 1 was £1.5m against a plan of £1.4m. Within this small variance IT schemes have overspent due to timing issues, this is partly offset by a further delay in the car park conversion scheme until later in the year.
- The cash balance at the end of Quarter 1 was £19.6m, being £7.3m above the planned £12.3m. As noted above, this is due to the significant increase in creditors and accruals, slippage on capital cash spend, and increased deferred income, partly offset by increased prepayments.

Continuity of Service Rating (COS) & Certification

The Trust has achieved a COS rating of 2 against a planned rating of 2.

Both the Capital Servicing Capacity (CSC) and Liquidity ratios and metrics are as planned due to the overall financial performance being largely as budgeted.

The Trust has submitted an operational plan showing a deficit for 2015/16 and a resulting COS rating of 1. 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 no change to the Executive Team membership in the quarter.

3. CONCLUSION

The Trust has faced a difficult first two months to the financial year and has shown improvement in its performance into month three so that the quarterly position remains on plan. . Within the overall position it is recognised that the adverse income variance to date is not sustainable and is taking action to address the initial trends seen so that they do not continue for the remainder of the financial year.. Its CIP programme is largely performing to planned levels, for identified schemes although activities continue to bridge the CIP gap identified at the start of the year, CIP planning and delivery will continue to be subject to weekly scrutiny to maintain the planned pace of change.

The Trust anticipates generating a full year outturn deficit at budgeted levels, and forecasts that distressed funding will be required at planned levels during 2015/16

Alistair Mulvey
 Director of Finance
 July 2015

APPENDIX 1 INCOME STATEMENT

June Reporting - Income Statement

	FY 15/16		
	FT Plan June 2015 Year to Date £m	Actual June 2015 Year to Date £m	Variance June 2015 Year to Date £m
Operating			
<i>NHS Clinical Revenue</i>			
Elective revenue, long stay:			
Tariff revenue	£6.147	£5.437	£(0.710)
Elective revenue, short stay:			
Tariff revenue	£0.000	£0.000	£0.000
Non-Elective revenue:			
Tariff revenue	£19.614	£19.511	£(0.103)
Planned same day (day case):			
Tariff revenue	£7.142	£6.700	£(0.442)
Outpatients:			
Tariff revenue	£9.270	£8.862	£(0.408)
Non-Tariff revenue	£0.000	£0.000	£0.000
A&E:			
Tariff revenue	£2.629	£2.562	£(0.067)
Other NHS Activity:			
Direct access & Op, all services (Tariff revenue)	£0.609	£0.617	£0.008
Maternity Pathway (Tariff revenue)	£1.275	£1.373	£0.098
CQUIN revenue (Non-Tariff revenue)	£1.581	£1.577	£(0.004)
Diagnostic tests & Imaging revenue (Non-Tariff revenue)	£1.223	£1.207	£(0.016)
Critical care - Adult, Neonate, Paediatric (Non-Tariff revenue)	£2.946	£2.807	£(0.139)
NHS Clinical Income in respect of pass-through drugs costs	£3.237	£2.824	£(0.413)
NHS Clinical Income in respect of pass-through non-drugs costs	£0.720	£0.729	£0.009
Other (Non-Tariff revenue)	£12.211	£13.152	£0.941
Total	£68.604	£67.358	£(1.246)
<i>Non Mandatory / non protected revenue</i>			
Private Patient revenue	£0.238	£0.171	£(0.067)
Other Non Mandatory / non protected clinical revenue	£0.291	£0.260	£(0.031)
Total	£0.529	£0.431	£(0.098)
<i>Other operating income</i>			
Research and Development income	£0.081	£0.138	£0.057
Education and Training income	£2.231	£2.326	£0.095
Donations & Grants received of PPE & intangible assets	£0.000	£0.000	£0.000
Donations & Grants received of cash to buy PPE & intangible assets	£0.000	£0.000	£0.000
Parking Income	£0.329	£0.316	£(0.013)
Catering Income	£0.362	£0.423	£0.061
Revenue from non-patient services to other bodies	£1.125	£1.537	£0.412
Non Clinical income in respect of pass-through costs where accounted on gross basis	£1.000	£1.041	£0.041
Misc. Other Operating Income	£1.098	£1.041	£(0.057)
Total	£6.226	£6.822	£0.596
Total Operating Income	£75.359	£74.611	£(0.748)
Operating Expenses			
Employee Benefits Expenses	£(52.955)	£(49.900)	£3.055
Employee Benefits Expenses - agency and contract staff	£(0.320)	£(2.910)	£(2.590)
Education and training expense	£(0.151)	£(0.196)	£(0.045)
Clinical Negligence	£(2.828)	£(2.828)	£0.000
Premises	£(3.057)	£(3.136)	£(0.079)
Expenditure on pass-through costs where accounted on gross basis	£(3.863)	£(3.553)	£0.310
Purchase of healthcare services from other NHS bodies	£(0.153)	£(0.143)	£0.010
Purchase of healthcare services from non-NHS bodies	£(0.028)	£(0.075)	£(0.047)
Drug Costs	£(2.300)	£(2.048)	£0.252
Clinical Supplies and Services	£(8.072)	£(8.242)	£(0.170)
Non Clinical Supplies and Services	£(1.231)	£(1.349)	£(0.118)
Consultancy expense	£(0.759)	£(0.760)	£(0.001)
Movement of Impairment of receivables	£0.000	£0.242	£0.242
Misc other Operating expenses	£(1.092)	£(1.138)	£(0.046)
Total operating expenses	£(76.809)	£(76.036)	£0.773
EBITDA	£(1.450)	£(1.425)	£0.025
Non operating income and expense			
Interest income	£0.032	£0.038	£0.006
Interest expense on Non commercial borrowings	£(0.091)	£(0.089)	£0.002
Interest expense on finance leases	£(0.009)	£(0.009)	£0.000
Depreciation and amortisation - owned assets	£(2.206)	£(2.134)	£0.072
Depreciation and amortisation - donated assets	£(0.043)	£(0.049)	£(0.006)
Depreciation and amortisation - finance leases	£(0.072)	£(0.072)	£0.000
Other Finance Costs - Unwinding Discount	£(0.013)	£(0.009)	£0.004
PDC dividend expense	£(1.053)	£(1.053)	£0.000
Net Profit on asset disposal	£0.000	£0.000	£0.000
Impairment (Losses) / Reversals net - purchased / constructed assets	£0.000	£0.000	£0.000
Impairment (Losses) / Reversals net - donated / granted assets	£0.000	£0.000	£0.000
Net Surplus / (Deficit)	£(4.905)	£(4.802)	£0.103
Comprehensive income and expense			
Revaluation gains / (losses) of donated / granted assets straight to reval reserve	£0.000	£0.000	£0.000
Revaluation gains / (losses) of purchased / constructed assets straight to reval reserve	£0.000	£0.000	£0.000
(Impairments) / reversals of purchased / constructed assets straight to reval reserve	£0.000	£0.000	£0.000
(Impairments) / reversals of donated / granted assets straight to reval reserve	£0.000	£0.000	£0.000
Fair Value gains / (losses) straight to reserves	£0.000	£0.000	£0.000
Other recognised gains and losses	£0.000	£0.000	£0.000
Total comprehensive income and expense	£(4.905)	£(4.802)	£0.103

**APPENDIX 2
BALANCE SHEET**

June Reporting - Balance Sheet

	FY 15/16		
	FT Plan June 2015 £m	Actual June 2015 £m	Variance June 2015 £m
<i>Non current assets</i>			
Intangible Assets - Donated or granted	£0.000	£0.000	£0.000
Intangible Assets - Purchased or created	£12.701	£12.703	£0.002
Property, Plant and Equipmen - Donated or granted	£2.365	£2.334	£(0.031)
Property, Plant and Equipment - Purchased or constructed	£156.252	£156.433	£0.181
NHS Trade Receivables, Non-Current	£0.000	£0.000	£0.000
Other non current receivables	£2.094	£2.126	£0.032
Impairment of Receivables for Bad & doubtful debts	£(0.379)	£(0.425)	£(0.046)
Total non current assets	£173.033	£173.171	£0.138
<i>Current Assets</i>			
Inventories	£4.088	£4.194	£0.106
NHS Trade Receivables	£7.282	£6.310	£(0.972)
Non-NHS Trade Receivables	£1.980	£2.656	£0.676
Other Receivables	£1.638	£1.964	£0.326
Assets Held for Sale	£0.000	£0.000	£0.000
PDC Receivables	£0.000	£0.000	£0.000
Impairment of Receivables for Bad & doubtful debts	£(0.450)	£(0.335)	£0.115
Accrued Income	£1.483	£1.381	£(0.102)
Prepayments	£2.796	£3.330	£0.534
Cash and cash equivalents	£12.285	£19.649	£7.364
Total Current Assets	£31.102	£39.149	£8.047
<i>Current liabilities</i>			
Current loans	£(1.015)	£(1.016)	£(0.001)
Deferred income	£(3.294)	£(4.048)	£(0.754)
Provisions, current	£(0.641)	£(0.641)	£0.000
Trade Creditors	£(12.342)	£(15.195)	£(2.853)
Taxation payable	£(3.800)	£(3.792)	£0.008
Other Creditors	£(2.773)	£(2.456)	£0.317
Capital Creditors	£(0.509)	£(1.121)	£(0.612)
Accruals	£(8.555)	£(12.680)	£(4.125)
Payments on account	£(0.900)	£(0.900)	£0.000
Finance leases, current	£(0.280)	£(0.280)	£0.000
Interest payable on non commercial loans	£(0.091)	£(0.097)	£(0.006)
PDC creditor	£(1.053)	£(1.045)	£0.008
Total Current Liabilities	£(35.253)	£(43.271)	£(8.018)
Net Current Assets / (Liabilities)	£(4.151)	£(4.122)	£0.029
<i>Liabilities, non current</i>			
Loans, non current, non commercial	£(11.284)	£(11.283)	£0.001
Deferred income, non current	£(11.430)	£(11.430)	£0.000
Provisions for Liabilities and Charges	£(2.318)	£(2.383)	£(0.065)
Finance leases, non current	£(0.080)	£(0.080)	£0.000
	£(25.112)	£(25.176)	£(0.064)
Total Assets Employed	£143.770	£143.873	£0.103
<i>Taxpayers equity</i>			
Public Dividend Capital	£72.417	£72.417	£0.000
Retained earnings	£25.016	£25.119	£0.103
Revaluation reserve	£46.337	£46.337	£0.000
Total Taxpayers Equity	£143.770	£143.873	£0.103

APPENDIX 3 CASH FLOW

June Reporting - Cashflow

	FY 15/16		
	FT Plan Year to Date June 2015 £m	Actual Year to Date June 2015 £m	Variance Year to Date June 2015 £m
Surplus/(deficit) after tax	£(4.905)	£(4.802)	£0.103
Finance income/charges	£0.069	£0.069	£0.000
Donations & Grants received of PPE & intangible assets (not cash)	£0.000	£0.000	£0.000
Other operating non-cash movements	£0.000	£0.000	£0.000
Depreciation and amortisation, total	£2.321	£2.255	£(0.066)
Impairment losses/(reversals)	£0.000	£0.000	£0.000
Gain/(loss) on disposal of property plant and equipment	£0.000	£0.000	£0.000
PDC dividend expense	£1.053	£1.053	£0.000
Other increases/(decreases) to reconcile to profit/(loss) from operations	£0.000	£0.000	£0.000
Non-cash flows in operating surplus/(deficit), Total	£3.443	£3.377	£(0.066)
<i>Movement in Working Capital</i>			
Inventories	£(0.015)	£(0.121)	£(0.106)
NHS Trade receivables	£(0.426)	£0.546	£0.972
Non NHS Trade receivables	£0.436	£(0.524)	£(0.960)
Other receivables	£(0.238)	£(0.564)	£(0.326)
Assets held for sale	£0.000	£0.000	£0.000
Accrued income	£(0.342)	£(0.074)	£0.268
Prepayments	£(0.924)	£(1.458)	£(0.534)
Deferred income	£(0.436)	£0.319	£0.755
Provisions for Liabilities and Charges	£(0.039)	£0.016	£0.055
Tax payable	£0.068	£0.061	£(0.007)
Trade Payables	£(2.552)	£0.308	£2.860
Other Payables	£(0.250)	£(0.567)	£(0.317)
Payment on Account	£0.000	£0.000	£0.000
Accruals	£(2.507)	£1.618	£4.125
	£(7.225)	£(0.440)	£6.785
Net cash inflow / (outflow) from operating activities	£(8.687)	£(1.865)	£6.822
<i>Investing activities</i>			
Property - new land, buildings or dwellings	£0.000	£(0.060)	£(0.060)
Property - maintenance expenditure	£(0.305)	£(0.331)	£(0.026)
Plant and equipment - Information Technology	£(0.507)	£(0.785)	£(0.278)
Plant and equipment - Other	£(0.533)	£(0.294)	£0.239
Expenditure on capitalised development	£0.000	£0.000	£0.000
Purchase of intangible assets	£(0.038)	£0.000	£0.038
Increase/(decrease) in Capital Creditors	£(0.515)	£0.097	£0.612
	£(1.898)	£(1.373)	£0.525
Net cash inflow / (outflow) before financing	£(10.585)	£(3.238)	£7.347
<i>Financing activities</i>			
Public Dividend Capital received	£0.000	£0.000	£0.000
Public Dividend Capital paid	£0.000	£0.000	£0.000
Interest (Paid) on non commercial loans	£0.000	£0.000	£0.000
Interest element of finance lease rental payments	£(0.009)	£(0.009)	£0.000
Capital element of finance lease rental payments	£(0.090)	£(0.091)	£(0.001)
Interest (Paid) / Received on cash and cash equivalents	£0.032	£0.034	£0.002
Drawdown of non commercial loans	£0.000	£0.000	£0.000
Repayment of non commercial loans	£0.000	£0.000	£0.000
Non current receivables	£0.000	£0.015	£0.015
Other Non current receivables	£0.000	£0.000	£0.000
Other cash flows from financing activities	£0.000	£0.000	£0.000
Net increase / (decrease) in cash and cash equivalents	£(10.652)	£(3.289)	£7.363
Opening cash and cash equivalents	£22.938	£22.938	£(0.000)
Net cash (outflow) / inflow	£(10.652)	£(3.289)	£7.363
Closing cash and cash equivalents	£12.286	£19.649	£7.363

Continuity of Services (CoS) Risk Rating 2015/16

CoS Metrics per Monitor:

Financial Criteria	Weight % age	Metric to be scored	Risk Rating			
			1	2	3	4
Liquidity Ratio (Days)	50%	Liquidity Ratio (Days)	<-14	-14	-7	0
Capital Servicing Capacity (Times)	50%	Capital Servicing Capacity (Times) x	<1.25	1.25	1.75	2.50

Trust Performance - Based on June 2015 Financial Position:

Financial Criteria	Weight % age	Metric to be scored	2015/16 ratings - actual		2015/16 ratings - Plan	
Liquidity Ratio (Days)	50%	Liquidity Ratio (Days)	-9.84	2	-9.65	2
Capital Servicing Capacity (Times)	50%	Capital Servicing Capacity (Times)	-1.11	1	-1.13	1
Weighted average risk rating				<u>1.50</u>		<u>1.50</u>
Overall CoS Risk Rating				<u>2</u>		<u>2</u>

1. Introduction

Under the Terms of Authorisation, the Trust is required to prepare and submit a quarterly return to Monitor detailing its financial and governance risk ratings.

The quarterly submission must be made to Monitor by 4 p.m. on 31st July 2015.

The Board is asked to review the assurances received in this report, as provided by the Director of Operations and Director of Finance respectively, and to self certify three statements as set out below.

2. Recommendation

It is recommended that the Board:

- i) does not confirm for finance, that the Board anticipates the Trust will continue to maintain a Continuity of Service Rating of 3 over the next 12 months;
- ii) does not confirm for governance that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework, and a commitment to comply with all known targets going forwards.
- iii) otherwise confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per Compliance Framework page 16 Diagram 8 and page 58 and the Risk Assessment Framework page 21, Diagram 6) which have not already been reported.

APPENDIX 5b
GOVERNANCE STATEMENTS FOR Q1 – 2015/16

[Click to go to index](#)

In Year Governance Statement from the Board of Wirral University Teaching Hospital NHS Foundation Trust

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (see notes below)

Board Response

For finance, 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.

Not Confirmed

For governance, that:

The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards.

Not Confirmed

Otherwise:

The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework, Diagram 6) which have not already been reported.

Confirmed

Consolidated subsidiaries:

Number of subsidiaries included in the finances of this return. This template should not include the results of your NHS charitable funds.

0

Signed on behalf of the board of directors

Signature 
 Name
 Capacity
 Date

Signature 
 Name
 Capacity
 Date

Responses still to complete: 0

Notes:

Monitor will accept either 1) electronic signatures pasted into this worksheet or 2) hand written signatures on a paper printout of this declaration posted to Monitor to arrive by the submission deadline.

In the event that an NHS foundation trust is unable to confirm these statements it should NOT select 'Confirmed' in the relevant box. It must provide a response (using the section below) explaining the reasons for the absence of a full certification and the action it proposes to take to address it.

This may include include any significant prospective risks and concerns the foundation trust has in respect of delivering quality services and effective quality governance.

Monitor may adjust the relevant risk rating if there are significant issues arising and this may increase the frequency and intensity of monitoring for the NHS foundation trust.

The board is unable to make one of more of the confirmations in the section above on this page and accordingly responds:

A: The Trust has submitted an operational plan showing a deficit for 2015/16 and a resulting COS rating at the end of this period of 1. Therefore the Board cannot confirm that the Trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months.

B: The Trust identified the 4 hour A & E standard as a key risk in its Annual Planning process. The increased pressures on emergency services experienced in Q4 of 2014-15 continued into the first 2 months of Q1 this year, however the Urgent Care Recovery Plan agreed with partners across Health and Social economy is being delivered. This and the increased internal focus was reflected in an improvement through the quarter, with performance for June being 92.96%. The improvements are continuing and in the early weeks of July the 95% standard is being achieved.

C:

Board of Directors	
Agenda Item	9.4
Title of Report	Research Annual Report 2014-15
Date of Meeting	29 July 2015
Author	Paula Brassey, Research Manager
Accountable Executive	Dr Evan Moore, Medical Director
BAF References	<p>Strategic Objective - To Maximise innovation and enabling technologies.</p> <p>Key Measure - Participate in research and ensure patients are notified of opportunities to participate in suitable studies.</p> <p>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. It may impact on patient choice. In the long term, the ability to recruit high calibre staff is likely to reduce and quality indicators may deteriorate.</p>
Level of Assurance	Positive
Purpose of the Paper	To note
Data Quality Rating	Bronze – qualitative data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken	N/A

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1. Executive Summary

The Research Annual Report provides information of the Trust's research activity and is being presented to provide information and also for approval.

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

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 in significantly in another.

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

3. Next Steps

To work towards continual improvement on national KPI's.

4. 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.

5. Recommendation

The recommendation is for the Research Annual Report to be approved.

Research Annual Report 2014/15

Paula Brassey, Research Manager
July 2015

Contents	Page
1. Introduction	4
2. Research Governance	4
3. National Institute for Health Research (NIHR)	4
4. Targets	5
4.1 NIHR Recruitment	5
4.2 NIHR High Level Objectives	5
4.2.1 NIHR Target Summary	7
4.3 NIHR CCF (Central Commissioning Facility) PID (Performance in Initiating and Delivering Clinical Research)	7
4.3.1 Length taken to grant NHS Permission	8
4.3.2 Length taken to recruit the first patient	8
4.3.3 Deliver to time and target	8
4.3.4 NIHR CCF PID Target summary	8
5. Non-NIHR Research	8
6. Collaborative Working	9
6.1 Clatterbridge Cancer Centre	9
6.2 Innovation.....	9
6.3 Research Passports	9
6.4 Key-service support	9
6.4.1. Pharmacy	10
6.4.2 Pathology	10
6.4.3 Radiology	10
7. Funding	11
7.1. NIHR Funding	11
7.1.2 Consultant PA allocation	11
7.2 Research Capability Funding	12
7.3 Commercial Income	12
7.4 Commercial Income 2015/16.....	12
7.5 Contracts	12
8. Library	13
9. Health Research Authority	13
10. Additional Information	13
10.1 Advice and support	13
10.2 Future Research Annual Reports	13

Appendix

1	NIHR adopted studies granted NHS permission 01/04/14-31/03/15	14
2	NIHR adopted PIC studies granted NHS permission 01/04/14-31/03/15	17
3	Recruitment by specialty	18
4	Referring Cancer Data	19
5	Non-NIHR adopted studies granted NHS permission 01/04/14-31/03/15	20
6	Trust Publications	22

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 II 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 II 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: Remifentanyl 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, Parallel Group, Active Control 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 Department

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 Aynattu, 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	Ritto 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.; Michael 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.
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The epidemiology of general paediatric outpatients referrals: 1988 and 2006	Child: Care, Health & Development. 2013, 39(1), 44-9	Thompson E; Todd P; Ni Bhrolchain C
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Board of Directors	
Agenda Item	9.5
Title of Report	Procurement Best Practice and the Productivity Challenge
Date of Meeting	29 July 2015
Author	Jane Christopher- Head of Procurement
Accountable Executive	Alistair Mulvey – Executive Director of Finance
BAF References <ul style="list-style-type: none"> • Strategic Objective • Key Measure • Principal Risk 	7
Level of Assurance <ul style="list-style-type: none"> • Positive • Gap(s) 	Positive
Purpose of the Paper <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Yes • No 	No

1. Executive Summary

This paper sets out at a high level the framework for improving procurement capability. It takes account of the recommendations from the recently published papers and reports and the findings of Lord Carter's interim report (June 2015) of the "Review of Operational Productivity in NHS Providers".

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The Trust has been an early adopter of the NHS Standards of Procurement, and recognises that good leadership and accountability at Board level for procurement will significantly improve the ability of the Trust to deliver a sustainable step change in performance. Procurement is represented at Board level by Graham Hollick - Non Executive Director and by the Director of Finance as the Executive lead. Quarterly review meetings held by the Board representative with the Head of Procurement with regular updates to the Finance, Performance and Business Assurance Committee, a subcommittee of the Board of Directors with discussions reported through to the Board of Directors via the Committee Chairs report. This update includes the nationally prescribed Procurement dashboard which is in its infancy of development.

This report provides a clear view of where the Trust is positioned relative to the findings and emerging thinking on best practice in procurement.

The Board is asked to note the contents of the report and the steps taken to date to align the procurement performance of the Trust with that best practice, and our preparedness for the new initiatives that will undoubtedly emerge when the opportunities to deliver the £5bn. p.a savings target set out in Lord Carter's Interim Review have been validated.

2. Background

A. THE NHS EFFICIENCY CHALLENGE

The NHS Efficiency Challenge report highlighted that the NHS long-run efficiency performance has been 0.8% annually. In recent years this has risen to 1.50- 2% largely due to pay restraint, but the NHS must repeatedly achieve 2% net savings for the rest of the decade (and indeed this may rise to 3% by the end of the period). The subsequent gap identified was in the region of £22bn. The financial challenge is therefore unprecedented and if they are to be achieved a culture of "relentless cost containment, with a forensic examination of every pound spent" must prevail, and everyone must play their part – from the executive board to managers, clinicians and nurses. Lord Carter states very clearly that no stone should be left unturned and nothing sacred or exempt from examination.

B. REVIEW OF OPERATIONAL PRODUCTIVITY IN NHS PROVIDERS – INTERIM REPORT JUNE 2015 – LORD CARTER

The interim review suggests that the NHS could make savings of £5bn. per annum by 2019/20 by taking simple steps to improve performance in four key areas –

- workforce,
- hospital pharmacy and medicines,
- estates and
- procurement.

Of the £5bn savings target Lord Carter maintains that better procurement practice at both national and local levels could save as much as £1bn p.a across the NHS.

Whilst the focus of this paper is the procurement strand of the review, in its broader sense, good procurement has a supporting role in the delivery of the other efficiencies too – for instance, improving workflow and containment of workforce costs relies on a joint strategy for better workforce planning, whilst improving the controls and costs associated with agency staffing.

The Trust has anticipated the DH requirements to manage the cost of temporary labour more effectively and a multi-disciplinary group has been working on several initiatives to introduce greater discipline and rigour into the decision making and engagement processes. A more robust Temporary Worker policy was introduced in May 2015 including a mandate that agencies could only be used where they were a supplier on a national framework, and where rates had been pre-agreed as part of that contract. This has been refined further to reduce costs through the introduction of a supplier tiering system for medical locums, to improve response rates and the quality of candidates presented whilst capping the hourly rates the Trust is willing to pay.

In July 2015 work has started to provide a more integrated approach to the management of the requirement for temporary nursing staff, whereby fill rates through the staff bank will increase and the more costly option of engaging staff via an agency will be minimised. The end to end solution and technology platform will be provided by National Health Service Professionals (NHSP) and will go live in November 2015. This vendor neutral approach supports the requirement to use agencies on framework agreements, and the local supplier tiering system to reduce costs.

Similarly procurement can support the delivery of the suggested £1bn saving against estates expenditure particularly in the areas of energy, cleaning, laundry and waste.

In the foreword to the interim report Jeremy Hunt, Secretary of State for Health states that he believes from the data presented that it is possible for the NHS to deliver savings of £1bn p.a from procurement by adopting best practices and modern systems, and from a combination of nationally mandated initiatives and tighter controls on non-pay expenditure at a local level.

The findings of the interim review are based on a pilot study conducted with a selection of 22 NHS hospitals, known as “Carter’s 22” – the initial findings from which will be explored and the opportunities confirmed in the Autumn.

The initial findings for procurement focus on three key areas of spend:

- **Everyday consumables**- dressings, syringes and other clinical supplies
- **High value medical devices** – hip and knee joints, cardio devices etc
- **Common goods and services** –transport, stationery, cleaning materials and so on.

As well as looking at opportunities for achieving price reductions, the review also concludes that the greater value of the savings are to be made by managing the demand for products more effectively through better inventory management.

Across the £9bn spend on these three key areas the review sets a savings target of £500m - £1bn (against a £9bn spend) which equates to 5.5% - 11%.

Everyday Consumables

Product Standardisation and Core Lists

In the main the review focusses on the savings that could be achieved through the standardisation of products and greater compliance, and pays particular attention to spend with NHS Supply Chain which is by far the largest of the NHS supply and distribution channels.

Currently the DH contract with NHS Supply Chain is based on a retail model – so instead of promoting “core lists” of products which would leverage the spend of the NHS more effectively, the catalogue offers unlimited choice to requisitioners.

The Trust has already taken steps towards a global best practice model, and has restricted the choice of consumables available to end users by masking products in the NHS Supply Chain catalogue- and effectively creating local core lists where possible to ensure we are leveraging our spend most effectively and taking advantage of price breaks and commitment discounts.

WUTH was one of a cohort of NW Trusts who with the support of North West Procurement Development (NRPD) drove the initiative for a core list of stationery items through NHS Supply Chain – a scheme that has since been rolled out nationally.

As part of Lord Carter’s review, senior nursing staff from the NHS and Royal College of Nursing (RCN) have been deployed to look at the feasibility of extending core lists to cover a wider range of consumables; and a national initiative “**Small Changes Big Difference**” designed to get nursing staff engaged in the efficiency agenda has recently been launched by the RCN. The study suggests that savings in the region of £30m p.a (equivalent to 1000 nursing jobs) could be achieved by streamlining the buying of basic clinical supplies

It is anticipated that as a result of the review and the RCN workstream there will be nationally mandated Core Lists for products in the following categories:

- Dressings
- Gloves
- Wipes
- Incontinence products

The Trust has already standardised the products in these categories significantly over several years, and achieved savings of £56k in 2014/15 with planned schemes for 2015/16 anticipated to achieve a further £30k.

However, the Trust recognises that a national collaboration offers the potential to increase savings locally and welcomes the planned approach.

The Procurement Team has been supporting the Small Changes Big Difference initiative regionally and recently presented to Directors of Nursing who attended a session facilitated by NWPD, promoting the benefits of sharing cost saving product switches with other Trusts. Regionally there has been a saving of £107k through the use of the "Share and Save" initiative – an online portal where materials managers from across the region post details of cost saving product switches for others to consider. The potential is estimated by NWPD at £1.2m

Locally the benefit of sharing has not been significant so far as WUTH has been the most prolific contributor of switching ideas, but product switching and standardisation of everyday consumables identified internally accounts for a full year saving of £116k on the 2015/16 workplan.

Locally, Procurement is planning a communications initiative to engage nursing staff in highlighting efficiencies and product waste – with ideas being submitted via an email box.

Demand and Inventory management is cited in Lord Carter's review as presenting the biggest opportunity to deliver savings, rather than the more traditional procurement approach of reducing the unit cost of everyday products. It goes hand in hand with the "Small Changes Big Differences" campaign. Effective inventory management reduces expenditure- buying just in time not just in case, reduces product waste and obsolescence and improves efficiency and productivity in clinical areas.

The Trust has an effective Materials Management service which is part of the main Procurement Team. The service is provided to all wards, and high spends areas. Although difficult to provide an exact value of the savings the Trust has gained from materials management in these areas (due to change in use of wards, infection control and change in bed numbers) it is estimated that rollout programme has achieved cost avoidance in the region of £80k p.a

The Procurement workstream plan for 2015/16 includes a scheme to review the inventory management and purchasing practices in Theatre stores, as there is scope in this area for significant efficiencies.

The Trust currently raises awareness of the cost of clinical supplies by placing price stickers on drawers and shelves in the stock areas. Whilst it proved effective when introduced, as with most campaigns unless refreshed regularly it loses its impact and value quite quickly. So we have been considering how best we can keep nursing staff engaged and for progress to be sustainable by ensuring they see the value of the task and fully understand the why, what and how.

The Traffic Light Support System is an initiative recently introduced by NHS Supply Chain to help nursing teams drive efficiencies by providing a visually striking reminder to nursing staff of the cost of clinical supplies and of the broader value of similar(less costly) items in the stock rooms that could be used instead.



The idea being that nursing staff could double check with ease, to see if a less expensive item that would still ensure patient safety, do the same job and help deliver savings and efficiencies. The stickers can also be used as a reminder to take care with more expensive items selected.

The Materials Manager is currently working with NHS Supply Chain on an implementation plan, and it is anticipated that rollout will take place in September 2015.

Inventory Management Developments

Currently the Materials Management Team provide an ordering top-up service for items from NHS Supply Chain, and whilst that accounts for a high percentage of everyday consumables ordered, Buyers are constantly reviewing supply routes to ensure we get the most cost effective products and increasingly that means we are buying direct from the manufacturer rather than NHS Supply Chain. Where that is the case the wards are ordering this stock themselves and volume is not managed as stringently as there are no pre-determined stock levels.

Procurement is currently working with both NHS Supply Chain (as the inventory management solution provider) and NEP (the finance system provider) to introduce functionality that will enable the Materials Management Team to manage and order supplies regardless of the delivery route. We are assured that this will be available for rollout in the Autumn.

Inventory Management of High Value Medical Devices -EDC Gold

Late 2014/15 the Trust implemented an inventory management system for high value medical devices, piloting this for orthopaedic implants. EDC Gold is a solution offered by NHS Supply Chain to customers that have a significant spend on implants and associated consumables.

The benefits of the inventory management system are:

- Reduction in purchasing price of consignment stock
- Upto 9% cost avoidance via enhanced expiry date management
- Upto 40 % reduction in requisitioning activity (stock is ordered on a top-up basis only)
- 90% faster response rate in the event of product recall

Additionally it provides the Trust with enhanced product management information and improved and better informed decision making.

Having now completed the implementation programme the Trust is now receiving monthly MI reports which greatly enhance the visibility of our stockholding and which are helping to form our procurement strategy for consignment stock and highlighting at an early stage where actions need to be taken to reduce consignment levels or return soon to expire stock. The implementation has required a shift in the purchasing culture – where previously a just in case rather than just in time requisitioning system was the norm. Whilst ultimately successful, changing embedded practices has proved challenging throughout the programme, but the sustainability of the benefits is entirely dependent on a commitment to work differently in the future.

The Procurement Team is now considering the rollout of EDC Gold to cover Cardio devices and consumables, and is working closely with NHS Supply Chain to develop the functionality of this solution.

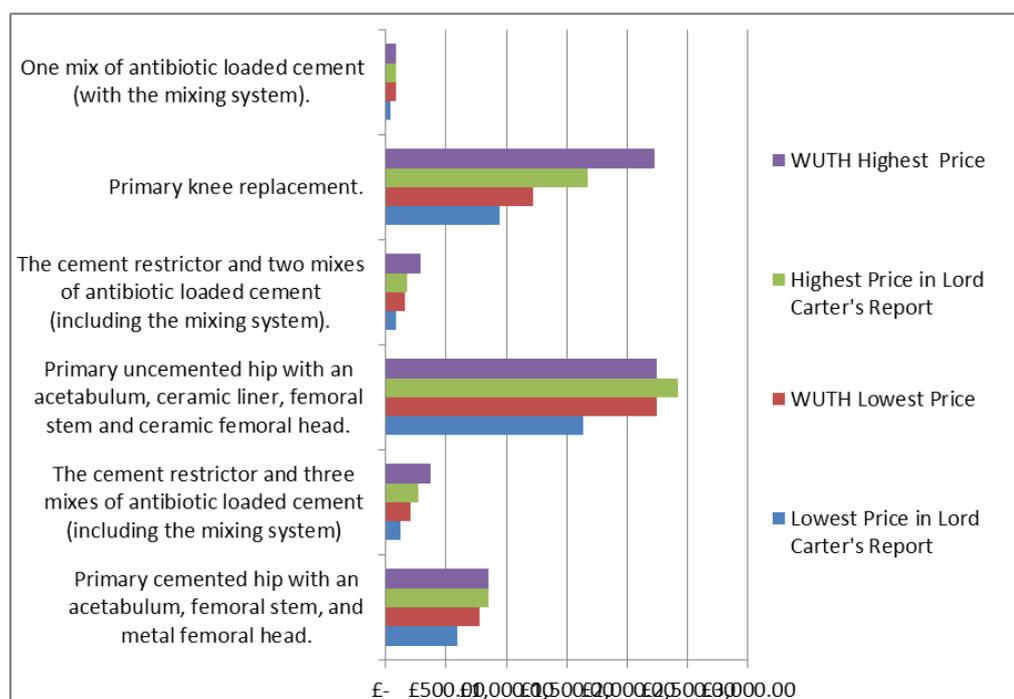
High Value Medical Devices

Lord Carter's Interim Report suggests that the NHS spends around £3bn p.a on products and consumables where clinicians make choices for their patients. Whilst there is no question that clinicians must retain the authority for making such decisions, the report suggests that such choices could be better informed. Professor Tim Briggs-Orthopaedic Surgeon at the Royal National Orthopaedic Hospital Stanmore, and collaborator on the Operational Productivity Review has identified huge variations in practice and outcome that lead to increased cost and inefficiency .

It is not the intention of this paper to look at how changes in practice could reduce costs or generate efficiency savings, which is the thrust of Professor Briggs report, but it is worth noting that the report also included a review of types and prices paid for the most commonly used implants. The Trust does not undertake some of the procedures set out in the review and therefore this is not a full comparison.

The table and chart below illustrate the variation between the Trust's prices and those of Professor Briggs review:

Item No. in line with Carter's Report	Prosthesis type	Lowest Price in Lord Carter's Report	WUTH Lowest Price	Highest Price in Lord Carter's Report	WUTH Highest Price
1	Primary cemented hip with an acetabulum, femoral stem, and metal femoral head.	£ 595.00	£ 780.00	£ 854.00	£ 847.14
2	The cement restrictor and three mixes of antibiotic loaded cement (including the mixing system)	£ 123.00	£ 204.64	£ 270.00	£ 371.99
5	Primary uncemented hip with an acetabulum, ceramic liner, femoral stem and ceramic femoral head.	£ 1,636.00	£2,245.36	£2,420.00	£2,245.36
8	The cement restrictor and two mixes of antibiotic loaded cement (including the mixing system).	£ 82.00	£ 155.45	£ 180.00	£ 286.79
9	Primary knee replacement.	£ 943.00	£1,218.33	£1,674.00	£2,225.36
10	One mix of antibiotic loaded cement (with the mixing system).	£ 41.00	£84.30	£ 90.00	£84.30



The reader will note that the Trust is paying higher prices for many of the implants than those of the 22 Trusts in Lord Carter's review. In the last three years the Trust has reduced the cost of implants by almost £500k, but clearly given the figures in the above table there is still more we can do to reduce costs.

There are a number of potential reasons for this cost differential:

- Patient requirement
- Brand preference
- Volume
- Cost to serve (particularly the cost of consigning stock)

The main element of a supplier's cost to serve is the cost of consignment stock – suppliers provide a considerable volume of free stock which sits on our shelves and which the Trust pays for at point of use. This is a cost burden to the supplier and has an impact on the suppliers pricing strategy for the Trust.

The Trust holds £1.6m of orthopaedic implants under consignment stock agreements with its key suppliers. The recent implementation of a comprehensive inventory management system EDC Gold (details of which appear under the Inventory Management section of this paper) has provided much greater visibility of the stock profile and has highlighted that over 70% of all stock has a zero turnover ie it is sitting on our stock room shelves unused. Clearly this is built into the price of the stock that the Trust replenishes more frequently. More robust management of the consignment levels and replenishment will be critical to reducing the cost to serve and ultimately the cost of these high cost medical devices, and will be the focus of CIP efforts for theatres procurement for the remainder of the calendar year. The identification of this issue was one of the key drivers in the introduction of EDC Gold.

The National Joint Registry Pilot (consisting of 35 NHS Providers and Local Health Boards) concluded that prices for implants do not always have a correlation with the volume used. The Trust joined the North West Procurement Development (NWPD) collaborative workstream for orthopaedic implants in the Autumn of 2013 with the anticipation that the aggregation of volume (and some standardisation) from across the 18 participating trusts would generate further savings locally.

However, the suppliers' pricing strategies and willingness to prefer local deals meant that the regional initiative did not have the necessary traction and whilst not abandoned, the initiative has been put on hold.

Lord Carter is of the view that in order to make any significant savings on the price of implants NHS providers will need to change the business model and relationships with suppliers, and states that proliferation of sales representatives (ex- clinical support) in this area is a cost that neither the NHS or suppliers want or need.

The formation of decision –making groups (above the level of individual hospitals) is given as a possible way forward, together with the creation of national specifications and standards for key product groups. The purchasing of devices would be managed (possibly mandated) through electronic catalogues.

The Trust will continue to review the use and pricing of orthopaedic implants until the national strategy has been more fully developed, and will continue to develop the inventory management programme and stock consignment arrangements to ensure that costs are minimised.

NHSSC has approached the Trust with a proposition to become one of a small cohort of trusts who will be first wave adopters of a new financing agreement between NHSSC and DH. Utilising the DH Capital fund, NHSSC will buy orthopaedic implants from suppliers, and they (rather than the supplier) will have a consignment stock agreement with the Trust. This will reduce the suppliers cost to serve by approximately 20%, 15% will be passed onto the Trust. This will be done in tandem with the letting of an NHSSC "Super Contract" for orthopaedics which is expected to generate further savings when it is awarded in the autumn. These actions should reduce the more pricing variations highlighted in this report, and bring the Trust in line with the better performing members of Carter's 22

Common Goods and Services

There are very few references in Lord Carter's review to how savings from the procurement of common goods and services- such as IT, transport, stationery and other non-clinical supplies can be delivered, and certainly no mention of a nationally mandated approach.

This may be due in part to the fact that the wider public sector has faced the financial challenge earlier than the NHS, the result of which was the emergence of a wide range of accessible framework agreements for common goods and services. These frameworks provide a quick and

compliant route to market and if used correctly – by introducing further competition between suppliers – can generate significant savings. The Trust uses these frameworks widely. The use of such frameworks has been mandated for temporary staffing in a letter to all NHS Providers issued by David Williams of DH in May 2015. Although temporary and agency staffing forms part of the Workforce element of Lord Carter’s review it is worth mentioning that the Trust adopted this approach much earlier, as part of the review of the procurement arrangements for agency staffing. The cap on agency rates was addressed in part at the same time, with the Trust adopting a “Supplier Tiering” system for the engagement of medical locums. The Procurement workstream plan for 2015 seeks to broaden the scope of this approach to other categories of agency worker through the implementation of a vendor neutral provider scheme. This will be progressed when Crown Commercial Service (the framework provider) awards the overarching contracts in August 2015.

The Trust has let contracts for several major non-clinical services in the last 15 months. The contracts for the laundry service and waste collection were let following OJEU tendering exercises. The Trust has benefitted from higher quality services and will achieve savings of £350k over the life of the contracts. Further In –contract efficiencies continue to be explored.

Procurement will use this approach for all contract renewals for common goods and services where appropriate.

Measuring Procurement Performance

The validation of savings and efficiencies achieved from the initiatives set out in Lord Carter’s review is entirely dependent on the visibility of both the improved procurement capacity and the savings across the NHS Provider economy. The DH has previously recognised the need for a more consistent approach to performance reporting in the “Better Procurement Better Value, Better Care” paper the requirements of which have been translated into performance measures and indicators in the “Procurement Dashboard” and “NHS Standards of Procurement”.

The performance management framework for Procurement was approved by the Finance & Performance Committee in October 2014. The Committee is provided with quarterly performance reports

The reports use the metrics from the DH “Procurement Dashboard” which incorporates the Trust’s progress made against the “NHS Standards of Procurement”. The report for Quarter 1 2015/16 has been included in this report at Appendix 1.

C. NHS STANDARDS OF PROCUREMENT

The NHS Standards of Procurement were initially launched in May 2012 with a revised set published in June 2013. The Standards provide a clear vision of good procurement and identify high quality procurement performance. They provide a tool for assessing the procurement performance of the Trust, and aid recognition of areas for improvement to ensure value for money is delivered through procurement activity in its entirety, and from the Trust’s procurement partners.

The Standards provide a framework for consistent approaches to procurement in the NHS, delivering benefits in procurement performance at both locally and across the economy.

There are standards for each of the four key building blocks for improving procurement performance:

- **Leadership**
- **Process**
- **Partnerships**
- **People**

Accreditation & Peer Review

The Standards provide a maturity matrix identifying the attributes of:

Level 1 – Building

Level 2 Achieving

Level 3- Excelling

Since the Standards were launched the Trust has undertaken a self-assessment, the resulting accreditation level being accorded- Level 2- Achieving. However, it is the opinion of the Head of Procurement that this review was subjective, based on views and internal opinion rather than evidence. Subsequently the DH has introduced an “Evidence Tool” which aids consistency and provides more robust challenge.

Regionally, NRPD in conjunction with Procurement Skills Development Network (PSD) has introduced a peer review process to provide challenge and additional assurance. The Procurement Team is currently preparing an evidence file in preparation for a Peer Review which it is anticipated will be undertaken in September 2015. The accreditation levels are cumulative, meaning that to achieve Level three, the attributes of Level 1 and Level 2 will have previously been met. The results of this review will be reported back to the Board.

It is anticipated that the Trust will also be in a position to seek accreditation to Level 2 before the end of the current financial year.

D. THE PROCUREMENT DASHBOARD

The Department of Health’s Procurement Dashboard was introduced in November 2013 And following the publication of the “Better Procurement Better Value, Better Care” paper. It is a tool that has been developed to improve the transparency and understanding of procurement performance of NHS Provider organisations. The Dashboard provides a balanced scorecard of core metrics – focused on three key areas of procurement performance, namely, enabling business continuity, procurement efficiency and the mitigation of risk.

It was designed to support internal governance and continual improvement performance, external reporting, transparency and the identification of good and best practice.

The Dashboard consists of seven core metrics which address the fundamental aspects of procurement practice and performance.

The report on the Trust’s performance against the Dashboard metrics for Quarter 1 -2015/16, appears at Appendix 1 to this report.

Whilst the Procurement Dashboard and NHS Standards of Procurement measure an organisation’s procurement maturity in terms of leadership, alignment with core business objectives and overall contribution to the efficiency agenda they don’t measure the Trust’s performance in terms of demonstrating that the goods and services purchased offer the very best value for money. Nor do they test our price performance relative to that of other trusts.

It is clear that in order to validate the potential savings opportunity, and to measure progress towards it there needs to be a higher degree of visibility and transparency of price and volume data across the provider landscape. The DH document “Procurement Transparency” published in March 2014 (and revised March 2015) sets out the requirement for NHS Providers to submit procurement transaction data to an (as yet undeveloped) national service for the purpose of spend analysis and price benchmarking, which it is hoped will lead to increased competition amongst the supplier base and the prioritisation at a national level of specific expenditure categories for procurement action and presumably it will form the basis of the core lists and national catalogues referred to in the interim review.

E. THE PROCUREMENT ATLAS OF VARIATION

Ahead of the establishment of the national data service, providers have been asked to respond to requests for price information for a rolling basket of goods. Responses are benchmarked and summary reports provided for action/information. The first of these requests was published as “The Atlas of Variation” in August 2014 and was drawn from nationally available data (NHS Supply Chain purchases).

Overall the Trust performed well in this exercise with the prices for the majority of the products falling into one of the two mid quartiles. There were 18 products where the Trust's price fell into the highest quartile and each of these was reviewed. In all but 2 instances the variation was attributable to the product being an outlier – the volume of the product purchased by the Trust being extremely low. Had the Trust been able to purchase the items at the lowest possible price the saving would have been less than £100 per product.

The first version of the Atlas was roundly criticised by providers, because it did not present an accurate benchmark as volume data was not taken into account in the analysis. Providers have not been asked to submit any further pricing information for different product groups subsequently.

In order to continually test the Trust's price competitiveness, and ahead of the national data service being established, the Procurement Team has more recently participated in several regional and trust specific spend analysis and benchmarking initiatives. It is encouraging that no significant variances were identified from any of the three exercises undertaken. The Project Scorpio analysis identified the potential to deliver a further £9k of savings by switching the supply route from NHS Supply Chain to the supplier directly- but this was across a number of products, and the required change in logistics and additional work generated for GDC staff meant that any potential saving would be negated. However, the Health Informatics study has highlighted a number of reasonably significant opportunities where our price is high compared to other trusts taking lower volumes of the same product. These potential opportunities are currently being scoped with a view to adding them to the Procurement workstream plan.

3. Key Issues

Quality of Procurement Data

It is significant that the figures in Lord Carter's review for the three key areas of spend are estimated - the volume and price data collected from NHS Providers to inform the report being described as "patchy". It is clear that high quality procurement data underpins the NHS's ability to identify and achieve sustainable cost savings across the economy. In the recent national price benchmarking review of NHS Providers conducted by DH the poor quality of accounts payable and purchase order data meant that only 18% of the spend could be matched. This lack of reliable procurement data has led DH to develop a national e-procurement strategy which includes the requirement for all NHS providers to implement GS1 coding (unique barcoding system for products). Lord Carter suggests that this action alone could deliver a £3m saving along the entire patient pathway for every Trust, improve patient safety and deliver greater regulatory compliance.

The Trust has appointed the Director of Infrastructure and Informatics as the GS1 Lead, and an outline implementation plan will be drawn up in the next month. The adoption of GS1 coding standards by suppliers has been slow in the UK, and until very recently there has not been an imperative for suppliers to implement it. It is difficult at a local level to force suppliers to adopt- it is time consuming and can be costly. so the Trust welcomes the DH intervention on this matter.

From a Procurement perspective work has already begun to ensure the Trust is in a position to be able to share and benchmark purchasing and volume information with DH, albeit that it won't be to GS1 standards in the short term. We are doing this by increasing the number of commonly used goods that can be ordered through electronic catalogues, through which we are able to control the quality of the data more effectively, and include the vital manufacturer or supplier reference numbers that supports meaningful analysis and price performance comparison with our peers.

In the last year we have exceeded the KPI of 25% increase in volume of orders satisfied via an e-catalogue, and the Trust is currently performing at 63%-65% throughput.

An additional benefit of satisfying purchasing needs through e-catalogues is that it streamlines the purchase to pay (P2P) process, reducing the need for procurement interventions, creating price certainty and accuracy and enabling payment to suppliers first time.

Procurement is currently working with key suppliers to transition from Trust managed e-catalogues to a supplier managed solution. This development will enable the Trust to implement e-invoicing which will streamline the P2P process still further, and it is hoped in time will encourage the adoption of GS1 coding standards

4. Next Steps

The Head of Procurement will ensure that the Trust's progress towards implementing global best practice procurement techniques maintains pace with the recommendations and directives from DH, and that we work towards a state of preparedness for the initiatives that will be brought forward following the conclusion of Lord Carter's review in the Autumn.

Any significant changes to the ongoing local plan or the early emergence of recommendations will be notified to the Board if they arise; otherwise a report will be brought forward when the scope of opportunities identified in the Interim Review has been validated later this year.

5. Conclusion

The Trust is making steady progress in the implementation of the recommendations from the Better Procurement Better Value, Better Care paper. Improvements in the maturity of the procurement function will be evidenced through the regular reporting of procurement performance against the NHS Procurement Dashboard metrics, and the anticipated accreditation to the NHS Standards of Procurement – Level1 later this year.

There is still much work to be done and the challenge will be to maintain the momentum, especially when the national opportunities validation work is completed and an implementation programme is required.

Much of the work to improve the procurement capacity of the Trust has so far been contained within the Procurement Team itself (with the materials management and inventory management pieces). It is recognised that to achieve sustainable benefits there needs to be a programme of consistent and pro-active engagement of the wider staff group, so that the generation of new efficiency opportunities and commitment to existing ones, is owned by all staff across the trust.

6. Recommendation

The Board is asked to note the contents of this report and the progress made by the Trust in working towards best practice as outlined in the DH Better Procurement Better Value Better Care paper, and the more recent emerging thinking as set out in Lord Carter's Review of Operational Productivity in NHS Providers (Interim Report- June 2015).

Appendix 1 – Procurement Performance Report – Quarter 1 2015/16



2015 Q1 nhs
procurement dashboe

References used throughout this report:

1. NHS Procurement Dashboard

<https://www.gov.uk/government/publications/nhs-procurement-improving-transparency-and-understanding-performance>

2. DH Better Procurement Better Value Better Care

<https://www.gov.uk/government/publications/improving-procurement-in-the-nhs>

3. NHS Standards of Procurement

<https://www.gov.uk/government/publications/nhs-procurement-standards>

4.

Review of Operational Productivity in NHS Providers (Interim Report – June 2015)

<https://www.gov.uk/government/uploads/.../carter-interim-report.pdf>

R



Department
of Health



NHS Procurement Dashboard Reporting Template

Version 1

October 2013

Name of organisation

Wirral University Teaching Hospital NHS Foundation Trust

Period

2015

This template has been created to support the collation of data and reporting on the NHS procurement dashboard core metrics.
It is designed for use by a single organisation.

The name of the organisation using this template should be inserted above, in the yellow highlighted box, as indicated.

Data collated by the organisation, in line with the core metric specification, should be entered into yellow highlighted cells on the 'Data Entry' worksheets.

This will generate the performance charts shown on the "Summary" and "Dashboard" worksheets.

On the "Summary" worksheet, space is provided against each chart for free text narrative to be entered, to support reporting. This might include a description of trends, rationale for outlying data points, assumptions or estimations applied to data, or data quality issues. Additional charts are provided on the "Summary" worksheet that might be helpful for internal reporting.

The "Dashboard" worksheet provides a pre formatted presentation of charts for all 7 core metrics, that can be printed out on one sheet.

Note that no cells have been locked in this spread sheet. This allows users greater flexibility over data collation and reporting intervals, however, it does mean that formula or formatting may inadvertently be changed. In view of this, it is recommended that back up copies of the spread sheet are made on a regular basis to avoid losing work or information becoming corrupted.

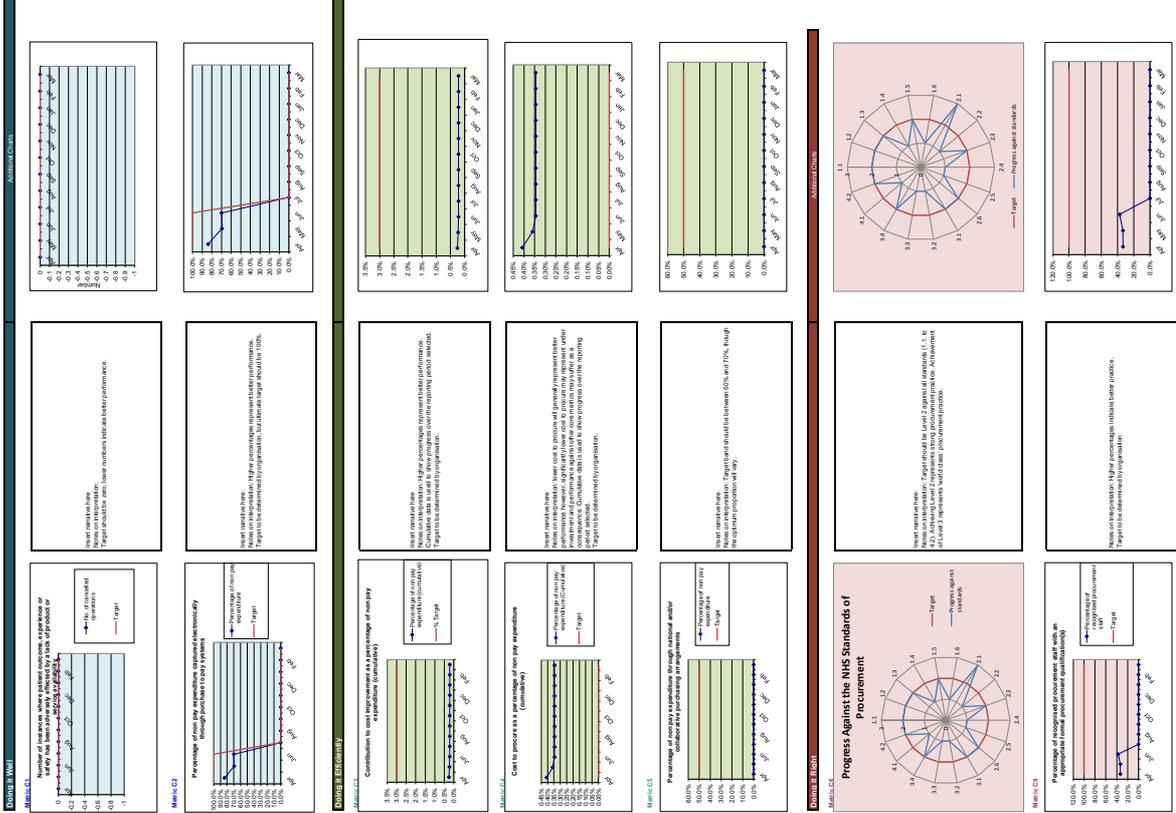
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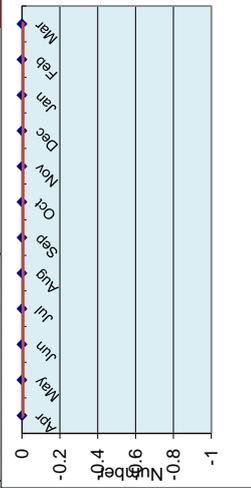
Doing it Well

C1 - Impact on Patient Care

Number of instances where patient outcome, experience or safety has been adversely affected by a lack of product or service availability

RAG

R



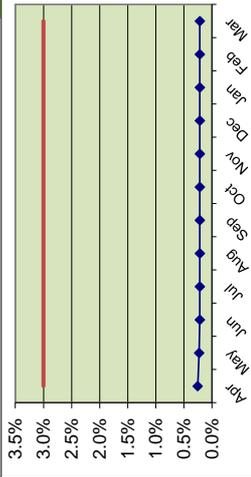
Doing it Efficiently

C3 - Cost Improvement

Value of contribution to cost improvement as a percentage of non pay expenditure

RAG

G



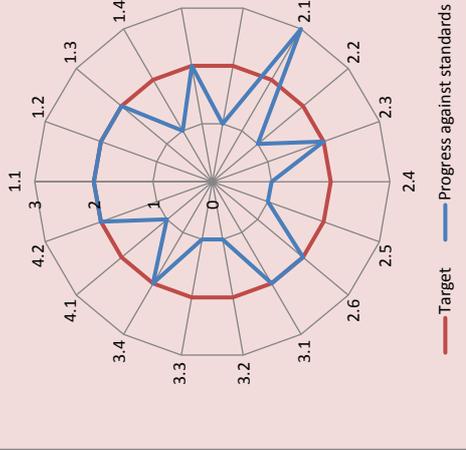
Doing it Right

C6 - Standards of Procurement

Progress against the NHS Standards of Procurement

RAG

A



Enter notes on NHS Standards of Procurement

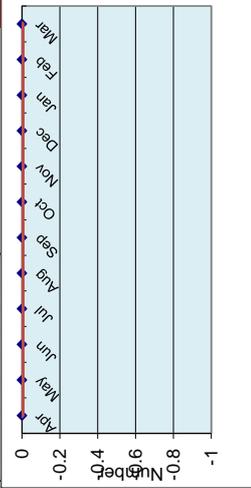
Doing it Well

C2 - Spend Control

Percentage of non pay expenditure captured electronically through purchase to pay systems

RAG

R



Commentary

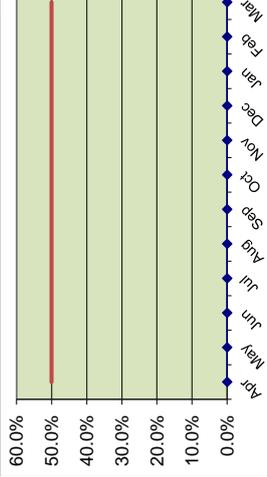
Enter notes to assist interpretation of dashboard

C5 - Collaboration

Percentage of non pay expenditure through national and/or collaborative purchasing arrangements

RAG

G

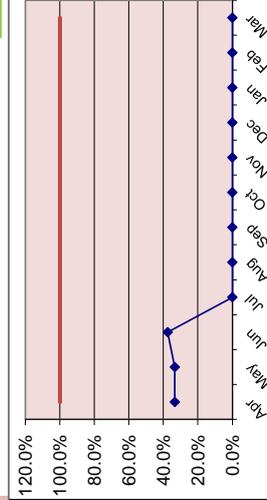


C7 - Staff Qualification

Percentage of recognised procurement staff with an appropriate formal procurement qualification(s)

RAG

G



Notes on Use:
RAG boxes, colour and letter, need to be adjusted manually based on actual performance and local definitions of 'RAG' performance

Charts are automatically generated from the Data Entry worksheets

Trust name and data / reporting period information in the top row, are populated from information entered on the "Intro" worksheet

NHS Procurement Dashboard Reporting Template

Wirral University Teaching Hospital NHS Foundation Trust

Reporting Period: 2015.16 Q1

Notes:

Data collated by the organisation, in line with the core metric specification, should be entered into yellow highlighted cells

Target values should be entered into highlighted cells, in line with locally agreed targets.

Quarterly reporting - if you are only collating and reporting data on a quarterly basis (as opposed to monthly), you can adjust this worksheet to accommodate this by deleting columns H to O (on this worksheet only). Then replace the remaining 'Month' labels with the required quarterly notation (e.g. Q1, Qtr1, Jun, Apr-Jun, etc.), for each of the metrics. Charts shown on the 'Summary' and 'Dashboard' worksheets will automatically adjust to these changes.

This spread sheet is not set up to support data collation and reporting in a mixture of monthly and quarterly formats across the metrics. To achieve this metric input tables and corresponding chart(s) would need reformatting individually.

Generic Data Input	Unit	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Notes
Non pay expenditure	GBP (£) 000's	9581216	11894911	12657519	0	0	0	0	0	0	0	0	0	34133646	
Non pay expenditure (Cumulative)	GBP (£) 000's	9581216	21476127	34133646	34133646	34133646	34133646	34133646	34133646	34133646	34133646	34133646	34133646		

Note: Non pay expenditure applies to metrics: C2, C3, C4 and C5

Doing it Well

Metric	C1	Number of instances where patient outcome, experience or safety has been adversely effected by a lack of product or service availability													Total	Notes
Data Input	Unit	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Notes	
Target	Number	0	0	0	0	0	0	0	0	0	0	0	0	0		
No. of cancelled operations	Number	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Number of recorded incidents Apr =5 May=5 Jun=2. 2 incidents were as a result of equipment failure, 10 result of lack of availability (internal not supply chain failure). No procedures were cancelled and patient harm levels recorded as 1-5% No Harm

Metric	C2	Percentage of non pay expenditure captured electronically through purchase to pay systems													Total	Notes
Data Input	Unit	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Notes	
Target	%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			
Value of non pay expenditure captured electronically through purchase to pay systems	GBP (£) 000's	8042953	8259710	8860264	0	0	0	0	0	0	0	0	0	25162927	Figures used are for purchase orders raised via NHS Supply Chain and the Trust's e-purchasing system in advance of an invoice being received into the Trust.Orders for pharmaceuticals and medicines are captured electronically via the JACS system and are included as satisfying the requirements of this metric. Retrospective orders have been excluded from the data even though the expenditure is captured electronically, it is not at the point of identification of need but later- this type of purchasing reduces visibility of the proper management of non pay expenditure.. There are some types of non-pay spend that do not lend themselves to purchase orders therefore the 100% target is unrealistic. The Trust's KPI for this metric for 2015/16 is to increase compliance by 10% (from a baseline figure of 61%)	
Percentage of non pay expenditure	%	83.9%	69.4%	70.0%	#DIV/0!	73.7%										

Doing it Efficiently

Metric	C3	Value of contribution to cost improvement as a percentage of non pay expenditure													Total	Notes
Data Input	Unit	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Notes	
Value of contribution to cost improvement	GBP (£) 000's	24491	24644	24644	0	0	0	0	0	0	0	0	0	73779	This figure is the agreed value of savings and revenue generated as a result of distinct procurement interventions. Agreed savings are those calculated and approved in line with the Trust's rules and guidelines for calculating procurement cash releasing savings and cost avoidance. The figure presented is the IN YEAR value of the savings achieved.	
As a percentage of non pay expenditure	%	0.3%	0.2%	0.2%	#DIV/0!	0.2%										
Value Target	GBP (£) 000's	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0			
Value of contribution (Cumulative)	GBP (£) 000's	24491	49135	73779	73779	73779	73779	73779	73779	73779	73779	73779	73779			
% Target	%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%			
Percentage of non pay expenditure (Cumulative)	%	0.3%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%			

Metric	C4	Cost to procure as a percentage of non pay expenditure													Total	Notes
Data Input	Unit	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Notes	
Cost to procure	GBP (£) 000's	39062	38201	40298	0	0	0	0	0	0	0	0	0	117561		
As a percentage of non pay expenditure	%	0.41%	0.32%	0.32%	#DIV/0!	0.34%										
Target	%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%			
Cost to procure (Cumulative)	GBP (£) 000's	39062	77263	117561	117561	117561	117561	117561	117561	117561	117561	117561	117561			
Percentage of non pay expenditure (Cumulative)	%	0.41%	0.36%	0.34%	0.34%	0.34%	0.34%	0.34%	0.34%	0.34%	0.34%	0.34%	0.34%			

Metric	C5	Percentage of non pay expenditure through national and/or collaborative purchasing arrangements													Total	Notes
Data Input	Unit	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Notes	
Target	%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%			
Value of non pay expenditure through national and/or collaborative purchasing arrangements	GBP (£) 000's	0	0	0	0	0	0	0	0	0	0	0	0	0	The data for this metric is currently being collected and analysed.	
Percentage of non pay expenditure	%	0.0%	0.0%	0.0%	#DIV/0!	0.0%										

Doing it Right

Metric C6 See separate Data Entry worksheet - click tab below

Metric	C7	Percentage of recognised procurement staff with an appropriate formal procurement qualification(s)													Average	Notes
Data Input	Unit	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Average	Notes	
Target	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
Number of recognised procurement staff	Number	15	15	16	0	0	0	0	0	0	0	0	0	3.8	85.7% of the Staff managing procurement exercises and contracts are CIPS qualified to the level required for their job role.	
Number of recognised procurement staff with appropriate formal qualification(s)	Number	5	5	6	0	0	0	0	0	0	0	0	0	1.3	0% of the Transactional procurement staff (order processing) have a procurement qualification appropriate to their job role	
Percentage of recognised procurement staff	%	33.3%	33.3%	37.5%	#DIV/0!	34.8%	0% of the Materials Management staff have a procurement qualification appropriate to their job role.									

NHS Procurement Dashboard Reporting Template

Metric C6 - Progress Against the NHS Standards of Procurement

Notes:

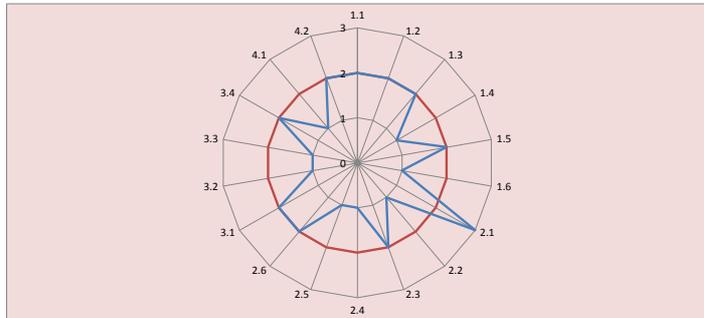
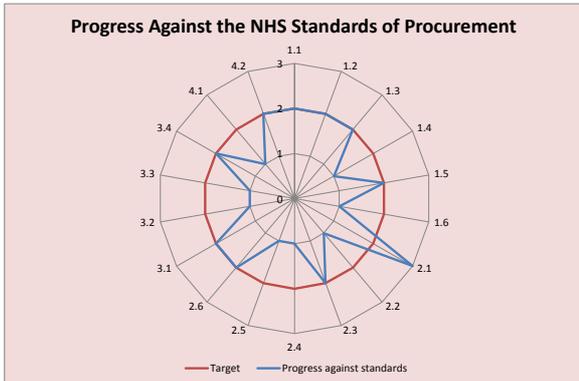
The level that the organisation is assessed to have fully achieved, for each of the 18 standards, should be entered into yellow highlighted cells under the corresponding month in which assessment took place.

To generate the radar charts, paste values from the month that you want to report on, into the "Report" column.

Target values should be entered into highlighted cells, in line with locally agreed targets. All organisations are encouraged to achieve Level 2 as a minimum.

Domain	Standard Ref	Target	Report	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Descriptor
Leadership	1.1	2	2										2			Board accountability for procurement performance
	1.2	2	2										2			Degree to which procurement activity supports Trust Objectives
	1.3	2	2										2			All Trust staff are engaged in making non-pay spend efficiencies
	1.4	2	1										1			Plans are in place to identify and mitigate supply chain risks
	1.5	2	2										1			Transparency of non-pay expenditure and procurement opportunities
	1.6	2	1										1			Innovative technologies are adopted and benefits measured
Policy	2.1	2	3										2			All non-pay expenditure is captured to allow visibility of detailed procurement information
	2.2	2	1										1			Inventory and assets are known and managed
	2.3	2	2										1			e-procurement inc P2P processes are effective and efficient
	2.4	2	1										1			Procurement processes are embedded and strategic and operational requirements are effectively and efficiently delivered
	2.5	2	1										1			Sustainable development is considered and monitored in procurement decision making
	2.6	2	2										2			All non-pay spend is governed by and subject to proficient procurement
Partnerships	3.1	2	2										1			Engagement with other NHS orgs is actively pursued to maximise efficiencies
	3.2	2	1										1			Optimising the benefit of working with procurement partners
	3.3	2	1										1			Contracts are managed and relationships with suppliers suitably managed
	3.4	2	2										2			Opportunities to supply exist for encouraged enterprises
People	4.1	2	1										1			Procurement resourcing requirements are understood and plans in place to meet current and future need
	4.2	2	2										2			Clinical and non-clinical staff are engaged with the procurement function and understand its contribution to delivering their business outcomes

To generate the radar charts, paste values from the month that you want to report on, into the "Report" column.



BOARD OF DIRECTORS

UNAPPROVED MINUTES OF MEETING

24 JUNE 2015

**BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL**

Present	
Michael Carr	Chairman
Cathy Bond	Non-Executive Director
Jill Galvani	Director of Nursing and Midwifery
Anthony Hassall	Director of Strategic & Organisational Development
Andrea Hodgson	Non-Executive Director
Graham Hollick	Non-Executive Director
Jeff Kozer	Non-Executive Director
Evan Moore	Medical Director
Alistair Mulvey	Director of Finance
Jean Quinn	Non-Executive Director
Apologies	
David Allison	Chief Executive
Cathy Maddaford	Non-Executive Director
Sharon Gilligan	Director of Operations
In attendance	
Carole Self	Associate Director of Governance
Jon Scott	Interim Deputy Chief Executive
Mark Blakeman	Director of Infrastructure and Informatics
Mark Taylor	Turnaround Advisor

Reference	Minute	Action
BM 15-16/067	Apologies for Absence Noted as above	
BM 15-16/068	Declarations of Interest None	
BM 15-16/069	Patient Story The Director of Nursing and Midwifery presented a patient story which highlighted a positive example of how the Trust, using its informal systems, could resolve issues quickly for patients.	
BM 15-16/070	Chairman's Business The Chairman advised the Board that the investigation meeting held with representatives of the Trust Board and Monitor on the 18 th June 2015 was a frank and fair exchange; he confirmed that Monitor had sought a range of information prior to and during the meeting. The Board was advised that the Trust would be notified of the outcome of the investigation, informally at the beginning of July and formally towards the end of July. The Board was advised that the Trust had now received the information request from the Care Quality Commission ahead of the formal inspection planned for September 2015. The Chairman updated the Board on the appointment of a new Chief	

Reference	Minute	Action
	<p>Executive at Wirral Community NHS Trust confirming that this was Karen Howell.</p> <p>The Chairman reported that the Trust had recently been successful at the HPMA Excellence in HRM Awards 2015 as the winner of the Appreciate Champion; this award is given to organisations who have significantly improved patient care through improved staff engagement. The Board requested that their thanks be communicated to all involved.</p>	
<p>BM 15-16/071</p>	<p>Chief Executive's Report</p> <p>The Interim Deputy Chief Executive presented the report and highlighted the following areas:</p> <p>New Models of Care – the feedback letter from the new Models of Care Team, included in the papers, was highlighted. Although broadly positive the letter did contain some challenges for the Trust for example in relation to the ability to access capital funds, which the Trust had raised with the national team. The Director of Strategic and Organisational Development confirmed that NHS England did recognise the challenge for organisations and confirmed that the Wirral Partners were required to submit a value proposition by the end of the week, the first of 3 national sites to do so. The Board sought to understand how it would be informed of developments. The Board agreed to receive a fuller update at the next meeting which would include the work undertaken in the reporting period together with the planned work. The Non-Executives requested that they be included in all opportunities to become further involved as the programme allowed.</p> <p>Major Incident Plan – The Board was advised that it was a formal requirement to approve the Major Incident Plan having been reviewed and recommended by the Quality and Safety Committee. The Board approved the Plan.</p> <p>A & E performance – the Board agreed to receive a full update as part of the performance report however it was pleased that the Trust had managed to secure a weekly performance that put the Trust at 31 out of all District General Hospitals in the country, a significant improvement on previous performance.</p> <p>Wirral Millennium – the Board was advised that the Trust had been shortlisted for the E Health Insiders award and was hopeful it would have another good news story to report in the future.</p> <p>Sickness Absence – the in-month performance for sickness absence was reported as a tremendous achievement at 3.72%. The Director of Strategic and Organisational Development confirmed also that the early signs for June were equally as positive. The Board requested that it's thanks be passed on to teams for all their hard work.</p> <p>Staff Engagement – the Board was advised that the raw results for Q1</p>	<p>AH</p>

Reference	Minute	Action
	<p>staff friends and family test were just slightly off national averages at 3.74, which was a significant improvement from 3.48 reported in the NHS national survey.</p>	
<p>BM 15-16/072</p>	<p>Integrated Performance Report</p> <p>The Director of Infrastructure and Informatics presented the Integrated performance dashboard and Executive Directors expanded on areas of focus as follows:</p> <p>The Board was advised that 3 areas had moved from RED to GREEN these were in relation to areas of patient satisfaction and demand referrals.</p> <p>Infection Control – the Director of Nursing and Midwifery confirmed that the Trust had had no incidences of MRSA in the reporting period. She confirmed that there had been a total of 9 C difficile cases reported in April and May with 1 case in June. The Board was advised that all strategies for reducing this were in place.</p> <p>Qualified Nurse vacancies – the Director of Nursing and Midwifery confirmed that the Trust had undertaken some benchmarking work which had highlighted that the Trust’s nurse vacancies levels were lower than many other Trusts. She confirmed that the Trust currently had 65 vacancies however it had recruited to 50 of these which were due to start in September. The Board sought assurance that the Trust could manage the influx of 50 new nurses. The Director of Nursing and Midwifery outlined the plans for preceptorship and mentorship within the first 12 months, as well as the work currently being undertaken with Schools for Health to ensure all recruits were prepared. The Board sought and received assurance that the reductions in sickness absence levels were beginning to impact positively on the need for agency nurse staffing.</p> <p>Staff Engagement Plan – the Director of Strategic and Organisational Development advised the Board that the Trust was nearing the end of 100 huddles in 100 days, with the impact communicated through the Start of the Week; Divisional teams and the Staff Engagement Group. He confirmed that the Trust, as agreed, was using the staff friends and family test as a barometer of success. Although the 100 days was coming to an end he confirmed that the work would not stop as it was important that this work was seen as “business as usual” and not an initiative. The Board sought and received assurance that issues arising from huddles were being addressed.</p> <p>A & E – the interim Deputy Chief Executive provided an update on the work being undertaken to address the underperformance in this standard. He described the themes being deployed to address performance which were to ensure that the hospital was safe and calm; that the solution was in the Trust’s hands and that staff were engaged. He confirmed that improvements had been made and it might be possible to hit the standard for June although this was still ambitious. The Board was advised that the plan was still to achieve the standard from October with the health economy although the aim was to meet this much earlier. The Board</p>	

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Reference	Minute	Action
	<p>sought and received assurance on the sustainability of the achievements An overview of the methodology used to respond to peaks in the future was outlined.</p> <p>Advancing Quality – the Medical Director advised that as at the end of March 15 stroke and sepsis were below target. The key area for improvement in stroke was highlighted as access to a stroke unit bed. The work being undertaken in A & E and on patient flow would impact positively on this. Progress on Sepsis was continuing with further work being undertaken on Cerner from this month which would promote the sepsis pathway and education and training for staff.</p> <p>The Board agreed that further work was required on the performance report in order that focus was also placed on areas key to the recovery plan such as bed occupancy, patient flow; and activity and income levels as previously discussed. Ms Bond agreed to be part of this work.</p>	MB/MT
BM 15-16/073	<p>Month 2 Finance Report</p> <p>The Director of Finance presented the Month 2 Finance Report and highlighted the following:</p> <ul style="list-style-type: none"> • Income and Expenditure – reported a deficit £1.9M against a planned deficit of £1.7m, giving a cumulative deficit position of £3.7M. This had only been achieved by a greater than planned application of reserves • The cash position was reported as £22.3M, £4.3M better than plan. • The underperformance against income in both in surgery and medicine was reported with Surgery underperforming in volume and values and Medicine underperforming in volume but not values. • The penalties for A & E and the reinvestment of these which were the subject of discussions held with the Systems Resilience Group was outlined. • The Cost Improvement Plan was reported as broadly on track in respect of the £11.1M, although work was still ongoing to address the £2M gap. The Director of Finance confirmed that the net impact of the gap was zero at present however the mitigation set aside would run out before the end of the year. • The Pay bill for April and May was reported as relative to the average for 14/15. The Board was advised that the Trust hoped to see a reduction in non-pay costs due to the underperformance in activity. <p>Mr Taylor advised the Board that the quarterly activity figures were emerging which would include June’s performance. He recommended that the Trust ensure delivery and robustness of the Divisional Recovery Plans in terms of forecasting; validity and cash consequence. This was supported by the Board.</p> <p>The Director of Finance outlined the balance sheet flexibilities applied to date together with the remaining levels of reserves.</p> <p>The Board discussed in detail concerns with reductions in activity volumes</p>	

Reference	Minute	Action
	<p>in Surgery and in Medicine and Acute. Plans to achieve normal activity during August were outlined through the utilisation of junior doctors during this period. The Board debated the cost to the Trust of the admission avoidance schemes and how to resolve this.</p> <p>The Board sought to understand whether the Trust was now expecting to access distressed funding earlier or later in the year. The Director of Finance reiterated the work undertaken to date which concluded that the request would be required in December 2015. He confirmed that the working capital assumptions were relatively prudent and would therefore allow the Trust to manage it's cash until the end of the year unless of course the Income and Expenditure position significantly deteriorated.</p> <p>The Board recognised that as the recovery plan was based on growth in income and activity, a readjustment of the plan might prove necessary if this underperformance is not addressed as outlined. The importance of bridging the £2M CIP gap as soon as possible was also emphasised. Further work will be undertaken by the Recovery Advisor and Director of Finance.</p>	<p>AM/MT</p>
<p>BM 15-16/074</p>	<p>CQC Update and Mock Inspection Summary</p> <p>The Medical Director presented the report which highlighted key elements of progress over the reporting period.</p> <p>The Board was updated on the number of standards that had improved in a relatively short space of time with further improvement planned. He confirmed that the Trust was hopeful that many of these areas would move to GOOD ahead of the inspection period.</p> <p>The number of areas reported as good from the Mock Inspections was outlined with one area reported as outstanding. The Trust was on track to inspect all areas by the end of July 2015.</p> <p>Evidence that the key themes highlighted during the inspections were improving was provided with good improvement being reported through the Clinical Service Leads Meeting.</p> <p>The Board was updated on the information request from CQC and plans in place to provide this and the recruitment undertaken to the project team to address some of the gaps within the project plan.</p> <p>The Associate Director of Governance recorded her thanks to all the Executive Directors who had undertaken a full review of each of the fundamental standards to highlight areas of best practice as well as improvement.</p> <p>The Board discussed the need to continue to work hard to improve leadership and engagement at all levels throughout the Trust and to ensure that this was embedded and not just seen as preparing for the inspection. The pace of improvement was encouraging with more work to do.</p>	

Reference	Minute	Action
	<p>The Board expressed its thanks to all involved for the progress made to date.</p>	
<p>BM 15-16/075</p>	<p>Francis Report: Hard Truths Commitment: Publishing of Nurse Staffing Data: April and May 2015</p> <p>The Director of Nursing and Midwifery presented the safer nurse staffing report for April and May 2015 and noted that the gaps related to the contingency ward and interim isolation ward. The Board was updated on the closure of wards 25 and 27.</p> <p>The Board was updated on the progress with the recruitment strategy which included overseas recruitment as well as local and national initiatives. The Director of Nursing and Midwifery provided the Board with an update on the national position and NICE guidance which remained unchanged for adult nursing and maternity.</p> <p>The Director of Nursing and Midwifery outlined the potential for a second level of nurse, which was moving with pace through Health Education England which would help with the recruitment difficulties the country was facing.</p> <p>The Board sought to understand whether the turnover rate of 8% was high and was advised that this included nurses moving within the organisation to other roles. Assurance was provided on the action taken to address any staffing gaps on a daily basis through the staffing meeting and newly approved escalation policy.</p>	
<p>BM 15-16/076</p>	<p>Report of the Finance Business Performance and Assurance Committee – 19 June 2015</p> <p>Mr Hollick expressed disappointment with the Month 2 Finance report acknowledging that the Board had discussed in detail the issues with regards to activity. His main concern related to the Trust's ability to bring the plan back on track with August being traditionally a difficult time.</p> <p>The diminishing reserves and the lack of assurance that the £2M CIP shortfall was being addressed were raised. Mr Hollick also raised issues with coding, and the lack of evidence and assurance that the sums described in the recovery plan would be forthcoming.</p> <p>The Board approved the recommendation to delegate authority to sign off the reference costs submission to the Director of Finance and Chairman.</p>	
<p>BM 15-16/077</p>	<p>External Assessment</p> <ul style="list-style-type: none"> • Monitor Governance Annual Board Statements <p>The Associate Director of Governance presented draft statements for approval by the Board. The Board was reminded of the review undertaken</p>	

Reference	Minute	Action
	<p>in April and the rationale for the recommendations.</p> <p>The Board reviewed in detail the areas highlighted as requiring further consideration, this included statements 4a, 4c, 4d and 5f.</p> <p>The Board supported the statement for 4a as this accorded with the view of the Audit Committee and the External Auditors; 4c as this was in line with the Annual Plan submission and the Annual Governance Statement; 4d as again this was in line with External Audit Reporting although the Board sought to understand the relationship between the Annual Plan declarations on sustainability and the going concern statement. The statement at 5f was confirmed as this recognised the huge amount of work undertaken on escalating concerns and staff engagement.</p> <p>The Board agreed to submit the statements as outlined in the report.</p> <ul style="list-style-type: none"> • Monitor Q4 Feedback <p>The Board noted the Q4 feedback letter from Monitor.</p>	
<p>BM15-16/078</p>	<p>Board of Directors</p> <p>The Minutes of the Board of Directors Meetings held on 27 May 2015 were confirmed as an accurate record, subject to minor amendments to minute no's. 049 and 050.</p>	
<p>BM 15-16/079</p>	<p>Board Action Log</p> <p>The Board action log was updated as recorded</p>	
<p>BM 15-16/080</p>	<p>Items for BAF/Risk Register</p> <p>The Board agreed with the recommendation from the Finance Business Performance and Assurance Committee to ensure that a risk in relation to volumes and activity was included on the register.</p>	<p>CS</p>
<p>BM 15-16/081</p>	<p>Any Other Business</p> <p>The Board was advised that the slight problems with a server this week were not a sign of a wider problem.</p> <p>The Board thanked Mr Jeff Kozar for his many contributions during his 6 year tenure as a Non-Executive Director and wished him well for the future.</p>	
<p>BM 15-16/082</p>	<p>Date and Time of Next Meeting</p> <p>Wednesday 29 July 2015 at 9.00 a.m. in the Boardroom, Education Centre, Arrowe Park Hospital.</p>	

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Chairman

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Date

ACTION LOG Board of Directors

Updated – July 2015

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 24.06.15						
June 15	BM 15-16/071	Provide a regular update on the New Models of Care and consider how Non-Executives can be involved in the programme	AH	Included on the Agenda for July	July 2015	
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	Work In Progress	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		July 2015	
June 15	BM 15-16/080	Ensure a risk in relation to volumes and activity is included on the register.	CS	Completed		
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		June 15	

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May 15	BM 15-16/044	Debate the merits of resetting some of the performance targets in light of the recovery plan	MB/MT		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	Work in Progress	July 15	
May 15	BM 15-16/055	Clarify whether the risk in relation to income and activity levels and commissioner alignment is included in the BAF	CS	Completed	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		June 15	
Apr 15	BM 15-16/017	Consider which quality measures would be impacted upon as part of the staff engagement work	JM/AH	Remove and Include as part of the review of the Integrated dashboard at BM 15-16/072	May 15	
Date of Meeting 25.03.15						
March 15	BM 14-15/226	Provide the trajectory of A & E Performance	SG	Completed	April 15	
Date of Meeting 25.02.15						
Feb 15	BM 14-15/188	Ensure the integrated performance dashboard provides detailed actions for all high risks and consider how the Board might more easily interpret small incremental change to determine the level of risk	MB	Action to be removed as superseded by action log no. BM 15-16/072	March 15	
Date of Meeting 28.01.15						
Jan 15	BM 14-15/165	Review the changes to Corporate Governance agreed at the Board in January 15 in 6 months time	CS	Well-led Governance Review Tender being developed	June 15	

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Date of Meeting 26.11.14						
Nov 14	BM/14-15/138	Include how outpatient nurses were being utilised during period of high demand in the next nurse staffing paper	JG		Jan 15	
Date of Meeting 29.10.14						
Oct - 14	BM14-15/114	Report against a trajectory of improvement in the future in relation to the Annual Plan	AH	Ongoing	Jan 15	
Oct - 14	BM14-15/121	Consideration to an Annual Research and Innovation Forum	EM	The research team are considering this recommendation		
Date of Meeting 24.09.14						
Sept - 14	BM 14-15/087	Board Walkabouts to include a review of Cerner post implementation	JG	Completed	Oct 14	To be included as part of programme from Dec 2014

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