Wirral University Teaching Hospital NHS
NHS Foundation Trust

Board of Directors Meeting

26 November 2014

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MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 26 NOVEMBER 2014 COMMENCING AT 9.00AM IN THE BOARD ROOM EDUCATION CENTRE, ARROWE PARK HOSPITAL

AGENDA

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Director of Nursing and Midwifery

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Director of Nursing and Midwifery

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Medical Director

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- **29 October 2014**

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Chairman

10.2 **Any Other Business** v
Chairman

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Wednesday at 28 January 2015 at 9am

Board of Directors		
Agenda Item	5	
Title of Report	Chief Executive's Report	
Date of Meeting	26 November 2014	
Author	David Allison, Chief Executive	
Accountable Executive	David Allison, Chief Executive	
FOI status	Document may be disclosed in full	
BAF Reference	1,2,4, 5, 6,8,9,11,12	
Data Quality Rating	N/A	
Level of Assurance	Full	Board confirmation

1. External Activities

NHS Five Year Forward View

NHS England, Monitor and the Trust Development Authority (TDA) have published their Five Year Forward View of challenges and choices the NHS must make in order to deliver a sustainable future for the NHS in England. The document makes three key assertions –

i) That the NHS must move from an organisation which treats illness to one which prevents illness through a relentless focus on health and well being – particularly encouraging employers to encourage healthy lifestyles.

ii) The NHS must change the way care is provided, through integrating care models across health and social care provision, physical and mental health provision and primary and secondary care provision. Health communities will be encouraged to develop their own local view of models of care and to incorporate this thinking into their plans for 2015/16.

iii) The NHS must continue to improve its efficiency and productivity, delivering high quality care in the most cost effective way, but that the NHS also will need additional resource to do this.

At a follow up event held in early November attended by the Director of Strategy and Organisational Development, Simon Stevens, David Bennett and David Flory (CEOs of the three national organisations publishing the Five Year Forward View) emphasised the importance of the planning document, but also that in order for the NHS to credibly demand additional resource, then delivery of access and quality targets over the pre-election period was a pre-requisite.

The Trust will take forward discussions related to the key aspects of the Five Year View with partners in the local health and social care community as part of planning for 2015/16 – in particular making the case for greater integration of health and social care organisations. A health community summit is scheduled to be held on 27 November 2014 to commence these discussions.

Countess of Chester

The Trust held a very successful Executive to Executive Meeting on the 12h November 2014 which provided both organisations with an opportunity to share their approaches to the 5 year vision and the response to Simon Stevens address. This indicated a good level of alignment.

Both organisations agreed to establish a Collaboration Steering Board which will meet ideally before Christmas and will in turn provide the governance structure for progressing future joint work.

It was clear from the meeting that the Countess of Chester had undertaken quite a lot of work with the University of Chester and they were keen for us to join in those discussions. A meeting is being arranged to progress these with the two Chief Executives and the Vice Chancellor of the University.

Part of this meeting focussed on the clinical engagement in the different specialities and the next steps in each of these. The job description and advert for the new Clinical Director post for SMART has been agreed, interviews for the post will be held on Wednesday 3rd December in Chester to ensure that the new appointee can work with Paul Moody, Clinical Director of Vascular network prior to his retirement in February.

The concern with regards to the CPE outbreak and the impact on waiting lists has been resolved with Ward 54 back in operation.

Monitor

Feedback on Strategic Plan

We have now received feedback from Monitor on our Five Year Strategic Plan. Board members will recall that this plan was developed after a period of intense deliberation and discussion in early June 2014. The feedback letter, which rates our Strategic Plan as amber, is attached as an Appendix to this report and identifies three areas for improvement. These are:

- The level of CIP included in the plans looks exposed given both absolute historical levels and delivery against plan. Notwithstanding the need to be ambitious for patients, submitted plans should be realistic and we will monitor you against the delivery of these;
- Analysis of income included in your plan compared to commissioner values suggests there may be a level of misalignment with your main commissioner;
- To be able to deliver high quality care sustainably, the strategies and initiatives of your Foundation Trust need to have broad acceptance across the local health economy and reflect the priorities and intentions of commissioners - and where appropriate those of other providers.

This feedback will be considered carefully as the Trust progresses thinking and action associated with the planning process for 2015/16. Particularly important in this regard will be dialogue between the Trust, partner providers and commissioners in respect of contractual discussions for 2015/16. A health community 'summit' for all Chief Executives has been scheduled for 27 November 2014 which is intended to ensure transparency on all assumptions and pressures faced by all health and social care organisations on the Wirral which it is hoped will offer a positive and open view on challenges and solutions going forward.

Q2 Monitoring Call

Our Q2 monitoring call took place with Monitor on the 11th November 2014. We updated Monitor on our current financial position which included an update on progress being made with regards to our savings plans along with a detailed review as to how we would bridge the gap between the current deficit and the planned deficit by the year end. An overview in respect of our key performance standards was provided together with the associated actions plans.

During the call Monitor discussed that the Trust had triggered criteria under the Risk Assessment Framework to 'Consider the Trust for investigation', the triggers being:

- Three consecutive quarter failures of the A&E four hour wait target
- On-going financial planning and delivery concerns following the previous financial investigation, with some actions that are yet to evidence sustainable improvement.

They informed us that they were making a recommendation to the Regional Directors that they would not open an investigation with regards to the A&E trigger and that they would not open an investigation into finances at this stage given the actions being taken by the Trust and the external support being / about to be provided. They noted the Trust had evidenced improvement in its cash balance, as a result of actions taken following the KPMG cash management review, and that the actions/recommendations from KPMG's financial governance review will take additional time to deliver and embed.

The Regional Directors agreed with the recommendation to not open an investigation at this stage. However, it is recommended that the Trust's governance rating is amended from 'Green' to a 'Narrative' rating, which will indicate 'Under Review – requesting further information'. This reflects the on-going discussions Monitor will have with us to discuss progress against the recommendations and it also reflects the planned visit with Paul Chandler, Regional Director to the Trust to understand further the Trust's financial position and actions.

CQC

As advised in my September report, the Trust has received the draft report from CQC following their responsive inspection undertaken on the 18th and 19th September 2014. The Trust has responded to the factual accuracies in the report and is now awaiting the final version. The Trust has developed an action plan which is to be reviewed by the Board at its meeting in November.

External Review

The Board approved the appointment of Terry Watson as the Senior Advisor on Turnaround working with the Trust over the next 12 weeks. Terry will focus on some of the strategic issues facing the Trust as well as holding the Trust to account on the implementation of the savings plans for 2014/15 and progressing plans for 2015/16. Terry will work with a

Turnaround team that as well focussing on delivery will help shape a sustainable future moving forward as agreed with the Board.

Regulatory Changes

The new standards for the fit and proper person requirements (FPPR) and the duty of candour for directors will come into force for all NHS bodies from 27 November 2014, the Government has announced. The scope of the new requirements cover all NHS bodies including NHS trusts and NHS foundation Trusts, and will be extended to all providers required to register with the Care Quality Commission (CQC) from 1 April 2015.

What's new under the requirements?

There should be minimal impact on recruitment processes, as employers already have a general obligation to ensure that they only appoint people who are suitable for the role they are recruiting. The type and level of checks required when considering applicants for NHS positions, including director level positions, are outlined in the NHS Employment Check Standards, which remain accurate and up to date.

The new requirements relate to ongoing employment, rather than what assurances can be obtained as part of the recruitment process. Providers will be required to confirm that directors in their employment remain fit, and they have access to ongoing development to make sure they continue to be fit.

The requirements also focus on assessing the applicant's honesty, integrity, suitability and fitness. For example that they have the right level of qualifications, skills and experience and, with all reasonable adjustments, are able to undertake the roles and responsibilities of the position being offered.

A more unfamiliar element to the new requirements is the test of unfitness, which will include misconduct and mismanagement.

Guidance for employers will be published by the CQC imminently. The Trust will of course ensure this guidance is followed.

Internal Activities

Infection Prevention & Control

The Trust is preparing for Ebola and can assure the Board that it is responding to National Guidance as this is received.

The Trust is pleased to report that the CPE outbreak is in containment and the position is being reviewed daily. The pilot on early detection has proved to be successful and the Trust is now looking at making this a more permanent position.

The options for future isolation facilities have been reviewed by the Executive Team who have endorsed the approach being taken but require further detail in terms of the impact on the capital programme.

A total number of 11 C. Difficile cases have been recorded as at the end of October 2014 (none in October) and a further 3 cases in November that are going through the Root Cause Analysis process.

Winter Planning

A Winter Plan has been agreed which focuses on a range of initiatives both within the hospital and the community to avoid admissions and facilitate earlier discharge. Although additional beds will be in the hospital, the focus of the plan is about working with the economy to keep patients in their normal place of residence or get them back there as quickly as possible; therefore we are also commissioning 12 additional community beds to help discharge to assess.

The main schemes that will have the greatest impact on the Trust are:

- Early Support Discharge
- Discharge to Assess
- IV antibiotics pathway development
- Medical Assessment Model
- Respiratory expansion
- Heart Failure expansion

This plan builds on the work done in recent months to improve patient flow such as Ticket Home, 8am Ward/Board Rounds, Check and Act and improved Care Pathways.

Wirral Millennium Phase 2B

On Saturday 15th November, medicines administration and prescribing as well as nursing and AHP documentation successfully went live across the Trust. This required involvement of large numbers of staff, from many areas of the Trust, many of whom worked throughout the night to ensure that the change over from PCIS to Wirral Millennium went smoothly.

Over the past week, iPads and laptops have been distributed to doctors, AHPs, Pharmacists and nursing staff. Training on the system has been taking place over the past 6 weeks and, following a final push, the vast majority of staff have now been trained in the new functionality.

From Saturday morning, floorwalkers have been working on the wards to support staff. They have been logging any issues as they arise. These issues then get reported to the teams based in the Informatics office to work on. Over the next two weeks there will be over 4500 hours of support given by floor walkers to staff in departments. There is a robust and open communication plan in place with regular meetings, attended by senior management to review all issues and progress of the go live. Although there have been number of issues logged, the go live has been tremendously successful, with no significant issues and all wards and departments are working well and getting used to the new way of working.

Whilst this is a major IT programme, this is really about providing the highest quality of care consistently to each and every patient, at the right time and in line with latest best practice.

We've been on a long journey to reach this juncture and we're now at a tipping point where the vast majority of the clinical care we deliver will be enabled by Cerner Millennium functionality. The information that the system collects will enable us to review the quality of care we provide in real time and take action if it detects, for example, that a patient is deteriorating, or at risk of Sepsis or of a UTI.

Workforce

Although the Trust is undergoing a large number of difficult organisational change schemes, Staff Side engagement remains positive but challenging and support is being offered to Staff Side colleagues to ensure we can maximise the input they have into some difficult workforce changes.

The Trust has made some progress in developing a strong ethos of engagement and empowerment, particularly through its award winning work on 'Listening into Action'. This work has produced some successful results which have impacted directly on the quality and safety of patient care through improvements in direct engagement of colleagues in the better delivery of services.

However despite this work and in some ways related to the difficulties being faced by the wider public sector and change programme described above a number of issues remain.

In order to address these issues, a deeper and more sustained effort must be made to engage and empower all colleagues through a strong values driven culture, which in the first instance helps them to understand the challenges we are facing and secondly offers a route and map through which these challenges can be addressed.

In order for this to be successfully delivered, it needs to be owned and signaled through behaviours of all Board members and will form the basis of a fuller discussion later in the meeting.

The health trade unions involved in a pay dispute with the Government, have now announced that they will stage a further period of strike action with a four-hour stoppage in the morning on Monday 24 November 2014 from 7am to 11am.

It has been agreed with the Trade Union organisations that critical posts will be exempt from taking strike action and as such there is a clear expectation that those staff who work in the critical posts will not be expected to take strike action.

Listening into Action (LiA)

The Trust has been working with Listening into Action as part of the National Pioneer's Programme for the last 2 years. We are now into our 3rd year of Listening into Action working independently of Optimise Consultancy but remaining part of the national network. The Year 3 implementation plan was agreed by the LiA Sponsor group and is now being integrated into a wider Staff Engagement Plan which will be presented to the LiA Sponsor Group and Workforce and Communications Group in December 2014. This plan underpins the Workforce and OD Strategy and includes the following key themes:

Leadership and Management

- Clear vision and goals
- Transformational leadership culture
- Leadership capacity and capability, values and behaviours

Employee Voice

- Staff involvement in change and transformation
- Partnership working
- Listening into Action conversations, projects and schemes
- Other transformational projects
- Staff Surveys, Staff Friends and Family Test, LiA Pulse check, Cultural Barometer, "Back to the Floor" programme

Healthy Organisation

- Organisational culture including openness, transparency, candour
- Fully integrated values and behaviours
- Training and Development / Education & Learning Strategy
- Clear roles and responsibilities, annual appraisals
- Flexible working policies and practices
- Attendance management
- Implementation of Health and Wellbeing plan

Every Role Counts

- Rewards and Recognition Approach
- Workforce planning

Communications Culture

- Implementation of Communications Strategy
- Staff engagement in cascade process
- Staff engagement in review and development

The focus of the LiA CEO led Big Conversations this year is engaging our leaders and managers in the challenges ahead. These are scheduled to take place in December 2014.

The 4th wave of LiA teams are due to feedback to the organisation on what they have achieved on 5th December at the next "Pass it On" Event which for this year has been combined with the annual Best Practice event. The event will be held in the Education Centre, APH from 0900-1700. LiA Teams or topics include:

- IT Enabled Healthcare – Maternity
- Hospital Readmissions
- World Class Dementia Care
- Pressure Ulcers
- Safe Hospital Out of Hours
- Handover
- Health and Wellbeing
- Clinical Service Leads
- Sterile Services
- Learner Engagement
- HROD
- Trainee Doctors

LiA continues to be used as a methodology to engage staff in change with an increasing number of work streams getting involved. All wards will be hosting LiA events in 2015 and there is a schedule supported by the LiA Sponsor Group to enable this to happen.

A detailed staff engagement action plan monitored by the Staff Satisfaction Steering Group and LiA Sponsor Group, which is assured by the Workforce and Communications Group, will enable the integrated plan to be effectively monitored.

David Allison
Chief Executive
November 2014

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31st October 2014

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

Dear Mr Allison

Wirral University Teaching Hospital NHS Foundation Trust

Your foundation trust's five-year strategic plans

Thank you for the huge efforts of your foundation trust during this planning round to address the major challenges faced by the healthcare sector. Below I have summarised key findings from our review of the five year plans and next steps.

Background

Our review of last year's strategic planning concluded that there were significant opportunities for the majority of foundation trusts to improve[1]. This is important as a clear and well thought-out strategy helps foundation trusts achieve the vision and values of the NHS by sustaining safe, effective care for patients in the medium term. Supporting the sector to improve was therefore a key objective of the 2014/15 planning round and why we added the five-year strategic plan to the process. More recently, we launched the Strategy Development Toolkit with guidance for foundation trust boards and their teams on every stage of the strategy development process.

In our letter of 16 May 2014, we stressed the importance of foundation trusts having a realistic view of the scale of the financial challenge over the next few years. Furthermore, we reassured you that we want to engage with you in a supportive manner if risks to sustainability are identified. Our approach to reviewing this year's five-year plans has been governed by these principles.

Overview

Our review of the five-year plans has highlighted a number of improvements:

- the "optimism bias" identified in previous plans has become less pronounced
- there is a higher quality of diagnosis and analysis of the various issues facing foundation trusts
- there is evidence of providers and commissioners working more closely together to identify and confront emerging pressures
- some truly innovative transformational initiatives are being developed and implemented across local health economies.

[1] See Meeting the needs of patients: Improving strategic planning in NHS foundation trusts, available at https://www.gov.uk/government/publications/nhs-foundation-trusts-improving-strategic-planning

However, our analysis shows that there are still some key issues in strategic planning at many foundation trusts:

- overall cost improvement programmes (CIPs) appear insufficient to offset the financial pressures facing the system
- transformational changes are not yet widespread enough across the sector
- there is evidence of poor alignment between provider and commissioner plans
- in aggregate, financial pressures continue to be under-modelled in plans.

As a result, there are concerns about the robustness of foundation trusts' plans to deliver quality care on a sustainable basis.

Our approach to the assessment of your strategic plan

We have not undertaken an in-depth review of foundation trusts' strategies and plans. Instead, we have tested the robustness of the financial projections which describe those plans. We did this by applying a limited number of sensitivities to foundation trusts' own financial projections to adjust for parameters generally known to be poorly modelled[2].

We have used a RAG rating to categorise our assessment of the level of risk in each case:

Green	No undue concerns were raised from review of the strategic plan. We will continue to monitor ongoing delivery as normal.
Amber	The sensitisation of the projections identifies that the foundation trust's sustainability may be marginal. We therefore ask the trust to review its plans in light of our findings, and to consider what improvements in strategic planning may be required.
Red	There appears to be a high risk to sustainability. Where appropriate, we will invite foundation trusts in this category to a meeting with Monitor so we can reach a shared understanding of possible gaps and agree what is required to close these in terms of resources, support and milestones.

We recognise that there may be limitations in some cases to using top-down sensitivities and will not base any response on this alone. We are of course happy to discuss the outcome and approach applied for your foundation trust with you.

Outcome of the assessment of your strategic plan and next steps

Your strategic plan has been rated as Amber.

The sensitisation of the projections identifies that the Foundation Trust's sustainability may be marginal and we have a number of concerns/issues which we wish to raise with you:

- The level of CIP included in the plans looks exposed given both absolute historical levels and delivery against plan. Notwithstanding the need to be ambitious for

[2] The following adjustments to trusts' assumptions were made:

i. expected CIP delivery was adjusted in light of past performance and delivery against plan
ii. anticipated pressures to tariff and costs were uplifted in line with Monitor guidance
iii. contingencies in plans were released (this mitigates against the above adjustments)
iv. capital expenditure forecasts were reduced to reflect the historical underspend in the sector against plan.

patients, submitted plans should be realistic and we will monitor you against the delivery of these;

- Analysis of income included in your plan compared to commissioner values suggests there may be a level of misalignment with your main commissioner. We ask that you consider if this presents a risk to your organisation and continue to work with commissioners now and in future planning rounds to develop a common understanding of the future;

- To be able to deliver high quality care sustainably, the strategies and initiatives of your Foundation Trust need to have broad acceptance across the local health economy and reflect the priorities and intentions of commissioners - and where appropriate those of other providers. We are asking you to continue to engage with your local health economy to develop a wider understanding of what sustainability looks like across your local area.

Should you wish to discuss our findings in more detail, please contact us.

Further information

In early November you will receive a letter from Monitor, NHS England and the NHS Trust Development Authority which sets out the timetable and high level principles for the 2015/16 planning round. Monitor's full guidance will be published in early December.

The summarised version of your strategic plan will be published on our website shortly.

As referred to earlier, we recently published our Strategy Development Toolkit. The toolkit describes a seven-stage framework for boards and their teams, and offers practical guidance at every step of the process together with case studies from other NHS providers. It is a series of frameworks, analyses and ideas intended to provide direction and inspiration, rather than to be prescriptive. Please download the toolkit here[3]; you can also find a link to the landing page, together with further information, here[4]. We hope you find it helpful.

If you have any queries, please feel free to contact me.

Yours sincerely

Tania Openshaw

Senior Regional Manager

Direct line: 02037470352

Cc: Mr Michael Carr, Chairman

[3] Available at https://drive.google.com/uc?export=download&id=0B8FRBEcO1QyULXYxRWlza0xSRjQ

[4] Available at https://www.gov.uk/government/publications/strategy-development-a-toolkit-for-nhs-providers

Board of Directors		
Agenda Item	6.1	
Title of Report	Vision 2018 – An update for partner organisations' Boards	
Date of Meeting	26 November 2014	
Author	Terry Whalley, Project Director Anna Rigby, Programme Manager	
Accountable Executive	David Allison, Chief Executive	
FOI status	Document may be disclosed in full	
BAF Reference	Risk - That engagement of NHS and non NHS providers in active collaboration and cannot be achieved resulting in synergies and collective work not being undertaken	
Data Quality Rating	Bronze – qualitative data	
Level of Assurance	Concerned	Board confirmation To note

1. Executive Summary

The attached report offers an update on progress made on the Vision 2018 programme of health and social care reform across the Wirral. The Board has noted previous updates on the progress of the programme and the changes suggested by the Trust to improve both the programme and process underpinning the programme to catalyse progress. Whilst some good progress has been made to reform and refine objectives, actual progress against the objectives has remained challenging, given capacity and competing priorities. The Trust will continue to work with all partners to push for a collaborative approach to both engagement and reform and a health and social care summit of Chief Executive leaders is to take place on 27 November to plan and discuss both the current position but also plan for the contracting round due to commence for 2015/16.

2. Background

The Wirral health community is facing a very significant challenge in respect of both operational and strategic sustainability. Both the CCG and the Trust now face financial concerns and as part of its strategic plan, the Trust indicated that there were a number of services which will require a fundamentally transformed approach to enable it to deliver sustainable services across the Local Health Economy (LHE) in a clinical, operational and financial way.

Through the Vision 2018 process, all health and social care partners have indicated a strong common desire to improve quality, experience and efficiency through new models of care that better meet needs of citizens.

Workstreams have been established to work on different aspects of the problem under the Vision 2018 banner and process

3. Key Issues

As indicated to the Board previously, whilst the Trust has been very active in influencing the process to date, given the track record of progress over the last 12 months, there remains a risk that despite the renewed process and priorities agreed, that these are not able to deliver the degree of change required to assist the Trust in meeting its sustainability requirements. As part of its strategic plan submission, the Trust agreed that an important part of moving towards health community sustainability was being able to work with health community partners to:

- Collaborate on care pathways, with special attention on urgent care and long term conditions
- Develop new, collaborative and longer-term approaches to contracting
- Explore flexibilities around Payment by Results creating incentives to integrate care and manage patient pathways coherently
- Consider models that allow staff to be deployed more flexibly across the local health economy
- Review the development of integrated care to ensure better coordinated and more effective care.

4. Next Steps

In view of risks related to the current position, the Chief Executive will continue to press partners across the health and social care community for an integrated response to the short and medium term challenges all organization are facing. At the same time, it is important to ensure that regulators and other stakeholders are appraised of the risks and challenges facing the Trust in the absence of a clearly defined commissioner led strategic response to the sustainability issues being faced. The Board will be kept appraised of developments, particularly following the Health and Social Care Summit being held on 27 November 2014.

5. Recommendation

The Board is asked to note the update on the development of Vision 2018 and associated risks.

Vision 2018: an update for partner organisations' Boards

Document History

Authors:
Terry Whalley, Project Director - Vision 2018, North West Leadership Academy
Anna Rigby, Vision 2018 Programme Manager, Wirral Clinical Commissioning Group

Approved:
Vision 2018 Strategic Leadership Group (SLG): 22.10.14

Version:
Final Draft (including amendments noted at SLG): 29.10.14

In partnership with:
Cheshire and Wirral Partnership NHS Foundation Trust
Wirral Community NHS Trust
Wirral University Teaching Hospital NHS Foundation Trust

The purpose of this paper is to provide an update to Board members of partner organisations in respect of the Vision 2018 programme.

Contents

1. Vision 2018 Context

Vision 2018 is the plan to re-shape health services and social care in Wirral, whilst supporting people to take more responsibility for looking after their own health. Over the next 20 years, the number of people who are aged 85 or over will more than double, meaning many more people with multiple, long term health conditions and increased financial pressures. However the challenges also present opportunities. Vision 2018 will transform GP, primary care, community health, hospital and social care services in Wirral.

It will mean:

- Community based health services (e.g. access to GPs, community nurses and social workers) seven days a week
- More hospital services in the community, with consultant led teams
- Health and social care professionals working together for people with on-going needs: one assessment, one care plan, one key coordinator
- Specialist in-patient hospital care for those that need it
- Support for people to look after themselves and stay healthy

We are developing a Vision 2018 Strategy to outline the case for change, to describe the vision for Wirral health and social care economy and how this will be achieved.

We have established a new shape to Vision 2018 which allows us to focus our efforts on 3 key programmes of work; Planned Care, Unplanned Care and Long Term Conditions and Complex needs (Appendix B). We also have a number of enabling programmes, for example Integration Adults, which focuses on the development of integrated teams, services and systems to provide coordinated care for people aged over 18. For the full programme structure see Appendix A.

We have done more work to ensure we have really clear strategic outcomes defined for Vision 2018; these have been informed by local evidence base and national drivers including the Better Care Fund aims and objectives (Section 6 – Strategic Outcomes). Each of the programmes are developing a detailed definition of scope to ensure its aims and objectives are linked back to these strategic outcomes. This will enable a clear description of how those programmes will enable benefits that will ultimately improve health outcomes for the people of Wirral together with their experience of health care. At the same time, balancing quality and value to improve the efficiency of services delivered will be the third major consideration for each programme.

As part of a series of 30 day challenges each of the programmes are identifying the projects that can be done quickly to start to make a real difference in 2015 i.e. 'the Fast 5 projects' along with those bigger, transformational projects that will need further planning 'the Big 5 projects'. It is important that we balance the need to re-imagine health and wellbeing in 2018 and consider how best we achieve this future state vision with the need to make real and practical improvements to the services we have today. It is this balance that the Vision 2018 team is now focused on achieving.

2. Governance

The Vision 2018 Strategic Leadership Group (SLG) is made up of the Chief Executives from NHS Providers and Commissioners along with equivalent Stakeholders from Local Authority. The SLG recognises that there exists already a Health Economy governance framework; the Health and Wellbeing Board and the Joint Strategic Commissioning Group, there are also respective Provider and Commissioner Boards or similar Governance Arrangements. In no way shape or form is any proposed governance arrangement for Vision 2018 intended to replace or interfere with any of these established governance models.

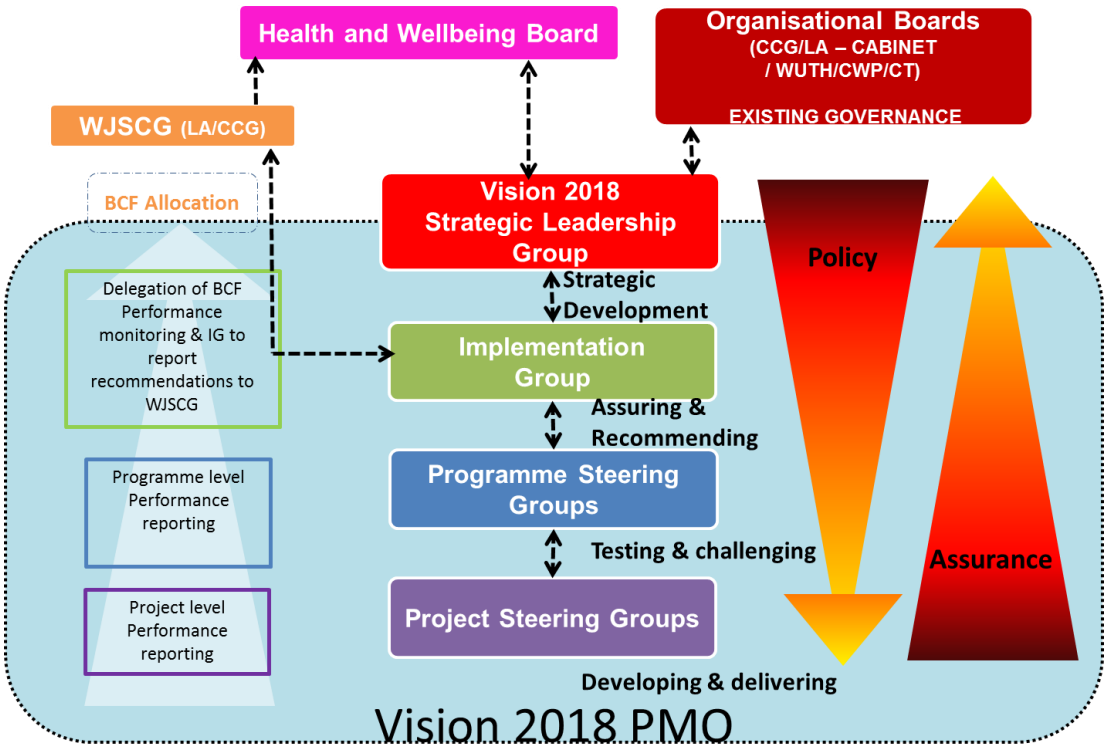
Rather, the Vision 2018 SLG is seeking to establish the best way to integrate decision making within the context of Vision 2018 into this broader established framework, the desired outcome being an appropriate balance of pace and rigour to enable safe but rapid progress to be made meeting the challenges this health economy faces.

It is proposed therefore that respective organisations' Boards delegate through their Chief Executive some level of decision making authority to enable the SLG to take certain decisions in a more timely fashion, but at the same time provide clarity on the expectations each Board has for when their CEOs will refer back to their Boards. It is also proposed that the Implementation Group, on behalf of the SLG, provides recommendations to the Commissioners on matters which affect Commissioning, contracts and use of Better Care Fund (Figure 1).

If this is done, and done effectively, there is increased probability that the organisations can become better performing collaborators in defining solution options for Wirral's Health and Social Care Economy, and that an effective delivery and tracking mechanism can be wrapped around the whole transformation agenda to ensure a joined up approach, informed decision making, robust benefits and costs management plus effective dependency and risk management.

There will need to be different 'checkpoints' during the development and implementation of the projects within Vision 2018 and to ensure that the governance model enables faster projects to be implemented quickly whilst ensuring that that they align to the longer term vision and principles of the individual organisations. There are four scenarios that have been developed to described how the governance model will be applied to 1) Faster projects 2) Bigger Projects 3) Commissioner Led Projects and 4) 'Other' non contractual projects (Appendix D).

Figure 1: Proposed Governance Structure



3. Strategic Leadership Group Terms of Reference

Role/Purpose

- To be accountable for delivering a sustainable Wirral Health and Social Care Economy

Tasks

- To agree the strategy and implications of this
- To agree the processes and resources for delivery
- To steer the implementation group
- To enable delivery/resolution of issues
- To resolve conflict/issues

Interfaces

- Health and Wellbeing Board (the Strategic Leadership Group will report to the Health and Wellbeing Board)
- Wirral Joint Strategic Commissioning Group (this group also reports directly to the Health and Wellbeing Board)
- Strategic planning for each organisation needs to link in with the development of the Vision 2018 strategy
- Organisational Boards to be informed and updated by members of the Strategic Leadership Group
- Implementation Group (this group will report to the Strategic Leadership Group), the Implementation Group Chair will be a member of the SLG to provide a link.

Governance and Accountability

The Strategic Leadership Group (SLG) will be accountable for delivering a sustainable Wirral Health and Social Care Economy. It will hold the Implementation Group to account to lead and manage the successful delivery of the strategy.

The Implementation Group (IG) will hold the programmes identified below to account to organise and manage the delivery of the goals and objectives assigned to the programme of work/enabling groups. The Strategic Leadership Group will report its progress to Health and Wellbeing Board.

The Programme Management Office (PMO), hosted by the CCG, will support the Implementation Group in organising and managing programme development and delivery, providing a central function for the programme in collating and reporting overall status. The programmes will report progress to the Implementation Group on a monthly basis and exceptions and risks to the Strategic Leadership Group.

The members of the group, through the Memorandum of Understanding, will also hold each other to account for delivery of agreed objectives and ensuring each partner contributes appropriately to overall vision and aims.

The SLG, while appropriately empowered by respective organisations to take decisions with delegated limits, will nonetheless ensure that assurance is provided back to respective Boards and to the Health and Wellbeing Board and Joint Strategic Commissioning Group as to those decisions, and will refer recommendations to those Boards when limits of decision making are reached. This mechanism will maximise the opportunity for effective collaboration while eliminating the risk of collusion.

Programmes of Work

A number of programmes of work have been established to deliver specific elements of the overall aims and objectives of Vision 2018, these programmes of work will report into the Implementation Group.

The lead programmes are;

- Planned Care
- Unplanned Care
- Long Term Conditions and Complex Needs

The programmes that deliver care or system enablers are:

- Communications and Workforce
    - Engagement (sub group)
- Integration - Adults
- Integration - Children
- Prevention, Self-Care and Community Development
- Information Technology and Information Governance
- Primary Care Strategy Group
- Finance and Contracting
- Estates

There is also the Outcomes and Quality Assurance group (OQuA), which is charged with providing scrutiny to proposals and providing oversight and responsibility for ensuring that outcomes and modelling support is made available to programmes.

Role of Members

The members of the Strategic Leadership Group will be of senior level within their respective organisations and have the ability to make decisions and escalate issues as appropriate. They will also ensure compliance with governance arrangements. Members will be responsible for disseminating information to and from their organisations, departments or professional groups.

Membership

Name	Title	Organisation	Role
Jon Develing	Interim Accountable Officer	CCG	Commissioner
Clare Fish	Strategic Director of Families and Wellbeing	WMBC	Commissioner
Fiona Johnstone	Director of Public Health	WMBC	Commissioner
Graham Hodkinson	Director of Adult Social Services	WMBC	Commissioner
David Allison	Chief Executive	WUTH	Provider
Simon Gilby	Chief Executive	CT	Provider
Sheena Cumiskey	Chief Executive	CWP	Provider
Dr Peter Naylor	Acting Chair CCG	CCG	Provider

In cases where members cannot attend for a single meeting, apologies should be sent. A deputy would not be permissible for the core members section, but is encouraged for the Business Items for Decision.

Also in attendance at the Business Items for Decision segment of SLG are:

Name	Title	Organisation
Anna Rigby	Vision 2018 Programme Manager	CCG
Terry Whalley	Project Director - Vision 2018	NWLA
Clare Grainger	Vision 2018 Project Manager	CCG
Andrew Crawshaw	Director of Operations and Delivery	NHS England

Additional members will be invited as and when required.

Frequency of Meetings

Monthly (to be reviewed after 6 months)

Communication and Accountability Arrangements

Members will retain accountability to their respective organisational governance arrangements, but with agreed levels of delegated authority from their respective organisations

Resources

In terms of publicity, engagement and other activities related to Vision 2018, member organisations should be prepared to contribute resources on an equitable on-going basis as details arise. In addition, partner organisations will be expected to provide resource to enable members to attend and will not be reimbursed additionally.

Administrative Arrangements

Decisions and Actions will be recorded, but there will be no need for full meeting minutes.

Chair/Vice Chair

Chair: Jon Develing
Vice Chair: Pete Naylor

Quorum

2 Commissioners and 2 Providers

Date of Ratification/Date of Review

First draft: 30.05.14
Second Draft: 10.06.14
Third Draft 10.10.14

Date of approval: 22.10.14
Date for review: 01.03.15

4. Implementation Group Terms of Reference

Role/Purpose

- To lead and manage the successful delivery of the strategy through the core components of Delivery, Grip and Coherence.

Function

- To identify gaps in programme resource and areas of risk to be reported to the SLG
- Utilise the Programme Management Office to:
  - Define the goals and objectives of the workstreams
  - Manage the performance of the workstreams
  - Drive the implementation of the strategy activity
  - Identify if the programme is delivering benefits to the system
  - Link cross cutting themes across programmes
  - To identify gaps in programme resource and areas of risk to be reported to the SLG

Interfaces

- Programmes (chairs to sit on this)
- Strategic Leadership Group

Governance and Accountability (See Governance Structure Figure 1)

The Programme Management Office, hosted by the CCG, will support the Vision Programme in organising and managing programme development and delivery, providing a central function for the programme in collating and reporting overall status. The programmes will be accountable to the Implementation Group and report progress to the group on a monthly basis. A meeting of the programme managers will assist with alignment, cross-cutting themes, delivery and reporting.

The Programme Directors will be held accountable by the Implementation Group for delivery of agreed objectives and for ensuring each member and partner contributes appropriately. Members will retain accountability to their respective organisational governance arrangements, but with maximum levels of delegated authority from their respective organisations. If there are any issues with contribution from work-stream members or sub-groups that tasks are delegated to, the Programme Director will be expected to escalate these to the Implementation group to resolve.

Role of Members

Implementation Group members have the ability to make decisions and escalate issues as appropriate within their organisation. They will also ensure compliance with governance arrangements. Members will be responsible for disseminating information to and from their organisations, departments or professional groups.

Membership

In cases where members cannot attend for a single meeting, apologies and a deputy should be sent. Additional members will be invited as and when required.

Name	Title	Organisation	Representing which Programmes/Functions
Fiona Johnstone	Director of Public Health	WMBC	Outcomes and Quality Assurance
David Allison	Chief Executive	WUTH	Planned Care
Jon Develing	Interim Accountable Officer	CCG	Unplanned Care
Sheena Cumiskey Val McGee	Chief Executive Service Director for Wirral	CWP CWP	Long Term Conditions / Complex Needs
Graham Hodkinson	Director of Adult Social Services	WMBC	Integration – Adults
Clare Fish	Strategic Director of Families and Wellbeing	WMBC	Chair – Implementation Group
Julie Webster	Head of Public Health	WMBC	Prevention, Self-Care and Community Development
Simon Gilby	Chief Executive	CT	Communications and Workforce
Julia Hassall	Director of Children's Services	WMBC	Integration – Children
Mark Blakeman	Director of Informatics	WUTH	IT and Information Governance
Pete Naylor	Acting Chair	CCG	Primary Care Strategy Group
Mark Bakewell	Chief Financial Officer	CCG	Finance and Contracting
Simon Gilby	Chief Executive	CT	Estates
Richard Freeman	Interim Head of QIPP Delivery, Specialised Commissioning	NHS England	N/A provides link to NHS England
Terry Whalley	Project Director - Vision 2018	NWLA	N/A
Anna Rigby	Vision 2018 Programme Manager	CCG	N/A
Clare Grainger	Vision 2018 Project Manager	CCG	N/A

Resources / Capacity and Capability

It is the responsibility of the Implementation group to consider any additional capacity and capability resources identified by workstreams as necessary to deliver the work stream programme.

Frequency of Meetings

Monthly

Leadership

Programme Director /Chair: Clare Fish
Programme Manager / Vice Chair: CCG Accountable Officer

Quorum

Representation from each lead programme of work.

Administrative Arrangements
Decisions and Actions will be recorded, but there will be no need for full meeting minutes.

Reporting
The Implementation Group will review monthly workstream update reports

PMO
Each work stream will need to adhere to PMO principles and methods.

Date of Ratification/Date of Review
First draft: 10.07.14
Final Draft: 16.10.14

Date of approval: 22.10.14
Date for review: 01.03.15

5. The Case for Change

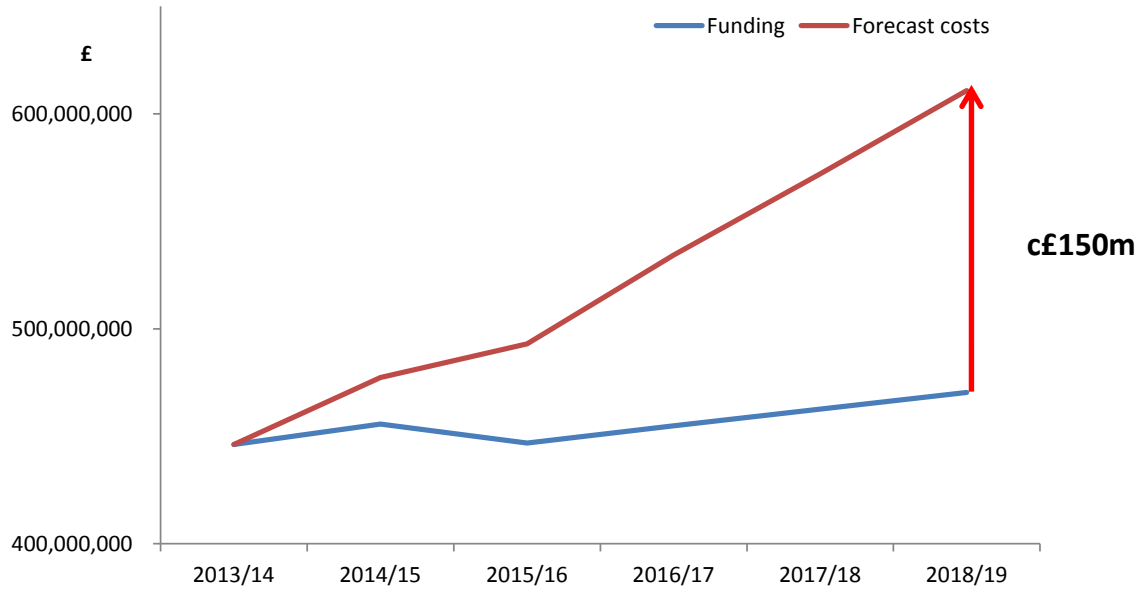
We know from our planning that the demand for health and social care will be increasing against a background of reducing resources across all organisations. In this context, we need to transform the way we provide health and social care, to ensure we are working as efficiently as possible, and we will need services that empower patients to manage their health and wellbeing.

People will need to share in the decision-making process about themselves and their care and support. The interactions between community, residential and hospital services will be improved, with care delivered through integrated services 7 days a week that are joined up around the needs of patients. This integrated care will be provided across the community, bringing specialised care and treatment (when appropriate) into community settings near patients' homes, to enable the right care to be provided at the right time and the right place, with patients supported to self-care as appropriate.

These changes will implemented between now and 2018, and the model of care will be co-developed with the public and staff to ensure it meets the needs of the Wirral population, with the right capacity and balance across the community, residential and hospital services.

A piece of work has been undertaken which models the scale of the challenge faced by Wirral Health Economy, the 'Shape Change Analysis'. This piece of work requires further validation in the coming months however shows a potential gap of around £150m given forecast of cost pressures and assumptions around funding growth (Figure 2). This is an unprecedented position, and we need to reimagine how health and wellbeing is delivered and consider making assumptions about the scale of change required.

Figure 2: The challenge facing the system

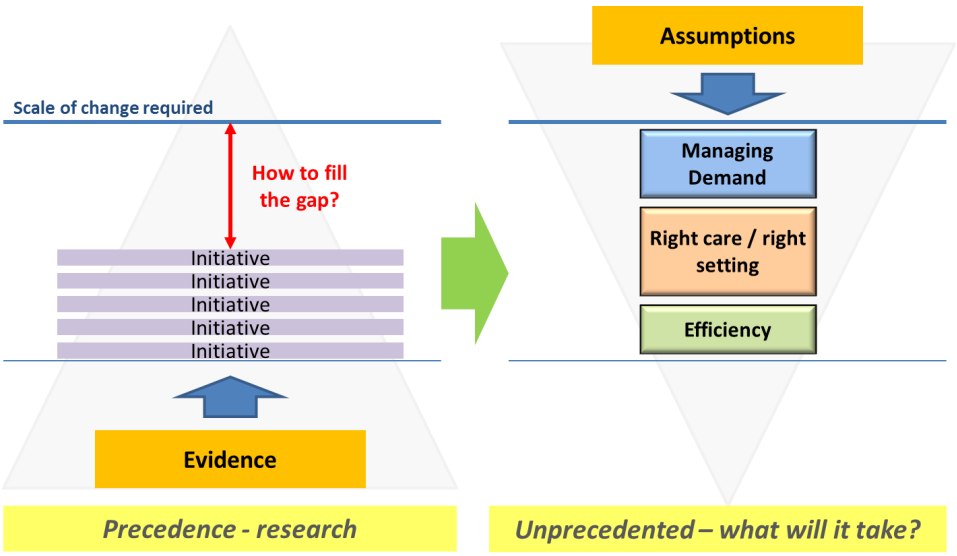


Alongside the financial pressures, the demand for local services is increasing. Wirral's overall population is projected to increase by 1.4% from 319,863 in 2011 to 324,226 in 2021. The older population (aged 65 years and above) are

expected to increase at the fastest rate, with an 18% increase projected by 2021. They are also more likely to have a long term condition; the 2011 Census reported about 36,000 (57%) people living in Wirral aged 65 years and over have a long term condition or disability that limits their daily activities. The health outcomes of Wirral residents vary depending on the area of Wirral in which they live, which has an impact on the health inequalities across the population.

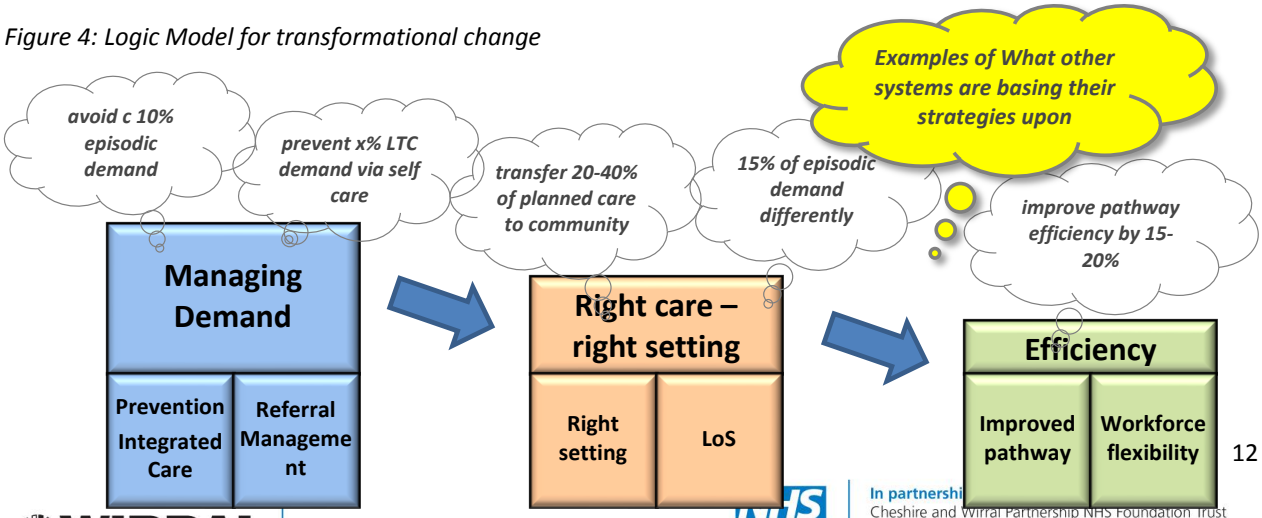
Due to the size of the gap and the needs of the population changing there is a need to reimagine health and social care and make transformational changes that will create a new health and social care system to improve health outcomes, patient and service user experience and value for money (Figure 3).

Figure 3: A significant change in approach



In addition to continuing with traditional incremental change (Cost Improvement Programmes (CIP) based on current operating models), the transformational change that we will need to make begins with **managing the demand** on services e.g. via prevention, referral management, integrated care. Then, making sure that of those people who do require services that they are provided with the **right care in the right setting** and finally a focus on the **efficiency** is needed to ensure the pathways are delivered in the most efficient way (Figure 4). As much of the evidence base is focused on efficiency rather than managing demand and right care right setting it is necessary for us to create some high level assumptions of how we can change the health and social care system in a different way.

Figure 4: Logic Model for transformational change

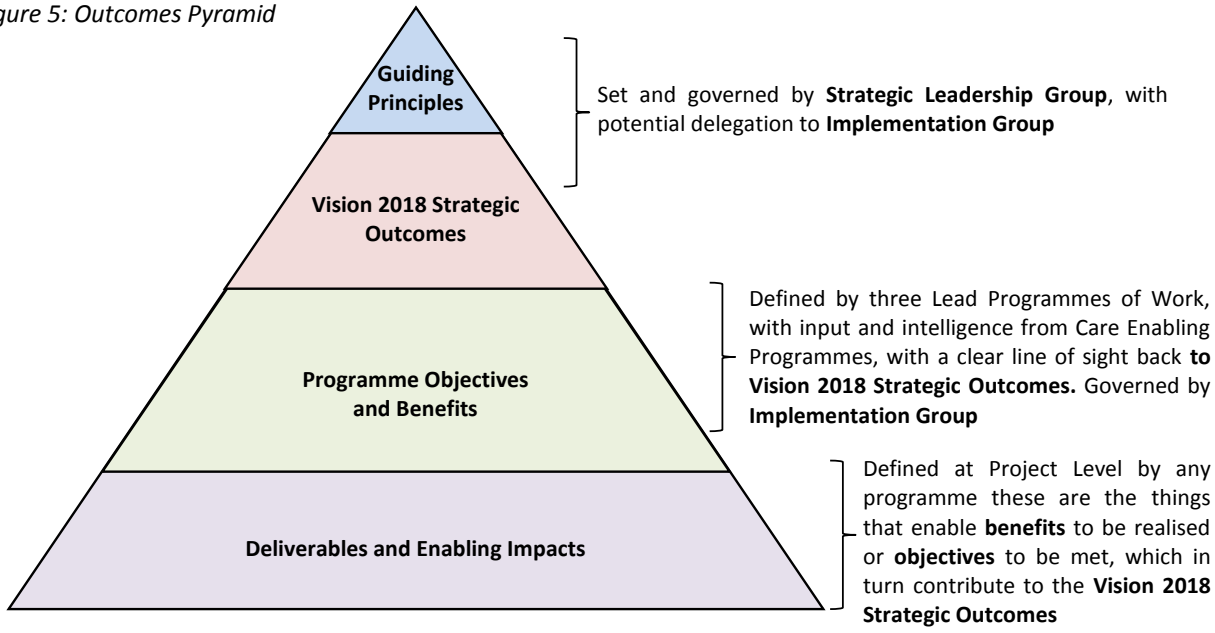


6. Strategic Outcomes

To provide some further guidance to colleagues working on Vision 2018, and to ensure we have the right focus on patient safety and quality in addition to the financials, we have identified three guiding principles that underpin the scope of work within Vision 2018;

1. We will improve Health and Wellbeing outcomes
2. We will improve patients' and service users' experience
3. We will reduce the cost of health and social care

Figure 5: Outcomes Pyramid



These guiding principles, the 'triple aim' have then been further defined in a set of Strategic Outcomes that we are striving to achieve through Vision 2018. Some of these are highly aspirational and ambitious, but they serve as a goal that all programme objectives and benefits should directly link back to. Taking this approach will ensure that the deliverables at project level will be demonstrably and directly linked back to one or more of the triple aims.

The Strategic Outcomes defined are listed below.

Table 1: Vision 2018 Strategic Outcomes

	Vision 2018 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

7. Programme Scopes

Each of the programmes are developing a detailed definition of scope to ensure its aims and objectives are linked back to these strategic outcomes. This will enable a clear description of how those programmes will enable benefits that will ultimately improve health outcomes for the people of Wirral together with their experience of health care. At the same time, balancing quality and value to improve the efficiency of services delivered will be the third major consideration for each programme.

The programmes are identifying the projects that can be done quickly to start to make a real difference in 2015 i.e. 'the Fast 5 projects' along with those bigger, transformational projects that will need further planning 'the Big 5 projects'. The Programme Managers are using a checklist to identify if their project is faster or bigger (Appendix E). The existing projects and evidence base including Better Care Fund schemes and Quality, Innovation, Productivity and Prevention (QIPP) initiatives are being incorporated into this work to enable a coherent view and governance over all change projects across the system.

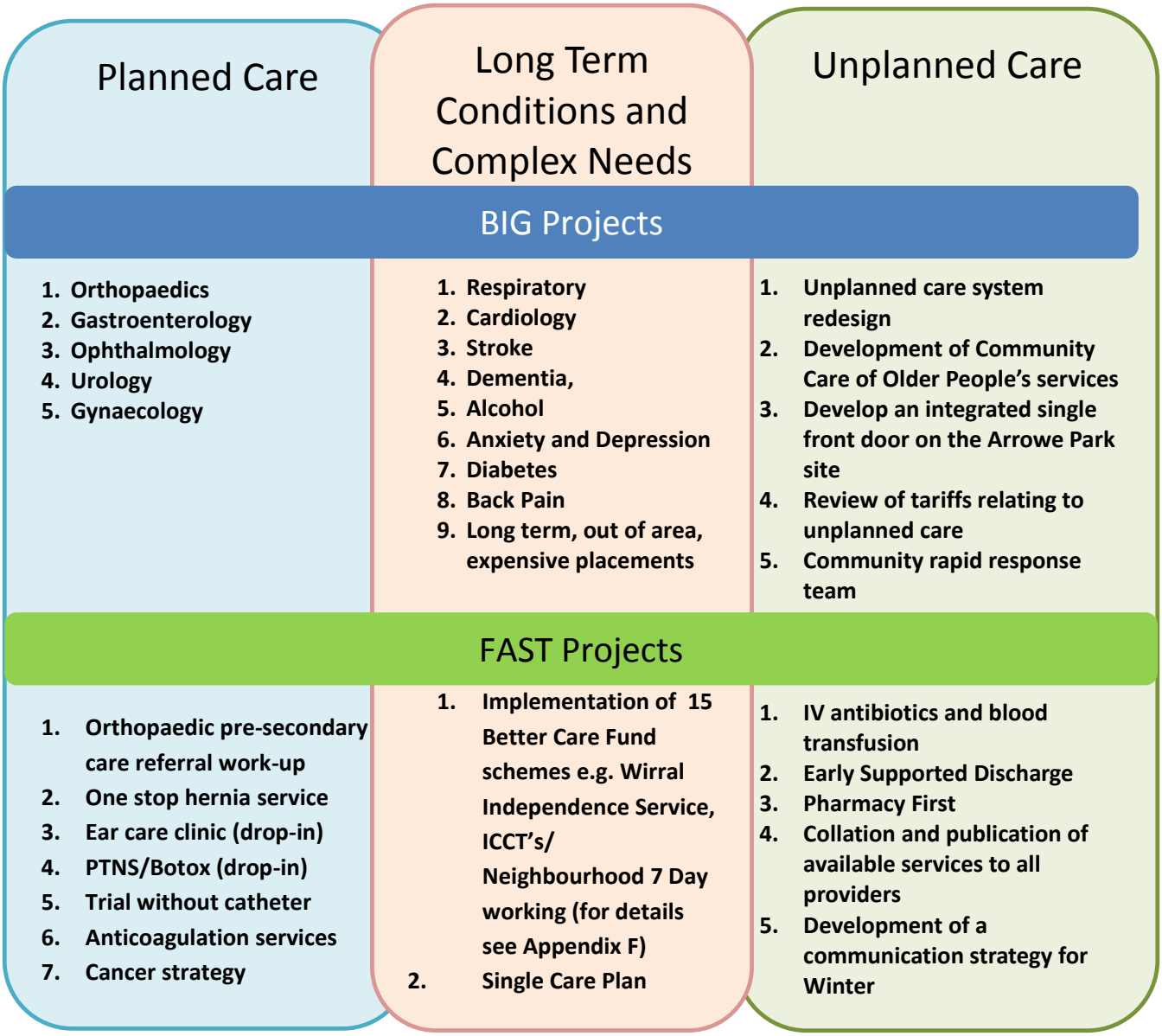
For the Big 5 projects a Hexagon 'Deep Dive' model for data collection is being used to develop a more detailed view of the current model/pathway and opportunities for improvement prior to developing a future state service model with staff, patients and carers (Figure 6). Some initial examples of the Big 5 and Fast 5 projects for the Lead Programmes are in Figure 7.

The next step is to implement the Faster projects identified below and for the Bigger projects to initially focus on a couple that will have the biggest impact such as 'Unplanned care system redesign' and 'Respiratory'. For these Bigger projects a focused approach would be undertaken to identify opportunities to transform models of care in these areas of work and establish the short term and longer term benefits.

Figure 6: Hexagon 'Deep Dive' model

N.B. Including benchmarking data

Figure 7: DRAFT BIG and FAST Projects for Lead Programmes



8. Current Position and Next Steps

As part of the review of Vision 2018 a programme methodology has been developed (Figure 8) that is based upon Public Sector Programme Management Approach. There are five distinct phases each broken into key steps and can be used across all Vision 2018 programmes or individual projects. The current position of the Vision 2018 programme in is at the initiation phase and depending on the pace and complexity of individual programmes and projects within Vision 2018 the speed at which they progress will differ.

Figure 8: Programme Methodology

INITIATE	DEFINE	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	

Progress to date: Review and Initiate Phase

The paper has indicated the progress to date in regards to the review of Vision 2018 governance arrangements and Programme structure and priorities. This has enabled the baseline quantum of change required (£) to enable sustainable health and social care economy between now and 18/19 and a consensus on the Strategic Outcomes. An alignment exercise of all Better Care Fund and QIPP initiatives and along with this strategic direction has informed the development of initial programme plans for each area, identifying co-dependencies and benefits that link back to the endorsed strategic outcomes. It has also led to initial ideas of the 'Faster' and 'Bigger' Projects that aim to deliver the benefits.

Next steps: Define, Design and Implement Phase

The next steps are as follows (see timeline in Appendix G for more information):

- Continue the mapping to commissioning intentions and 15/16 contracting round to ensure that the Vision 2018 planning is linked into the Commissioning Cycle.
- Establish rapid cycle testing frameworks for quick wins to enable benefits to be realised at pace (see Appendix D, Scenario 1).
- Establish plans for delivering bigger initiatives for delivery during 2015/16 to follow a methodology to enable transformational change and clarity on the outputs that will be realised.
- Undertake a focused approach for Respiratory to identify opportunities to transform models of care in these areas of work and establish the short term and longer term benefits.
- Undertake a focused approach for Unplanned Care System Redesign to identify opportunities to transform models of care in these areas of work and establish the short term and longer term benefits.

- Implement tools and templates to enable the Implementation Group to have a 'Grip' on the project planning, so that we can effectively manage delivery, interdependencies, cost and benefit tracking for example see Figure 9.
- Embed the Governance Framework to ensure Programme Directors and Programme Managers have clear checkpoints to report to the Implementation Group and the Strategic Leadership Group so that decision making can be made in a fully informed way by the right people.
- Determine opportunity and right size/capability for a pooled Vision 2018 Change Management Office, and how to align enabling functions 'supply' (e.g. workforce management, communications, engagement, finance, business intelligence) with the 'demand' from primary and system enabling programmes. This will ensure that there is sufficient resource to form the Vision 2018 strategy and deliver it effectively in the timescales necessary.

Figure 9: Example of Project Dashboard

Project Development

Year 1 BCF (2014/15): in year

Project Ref		Impact			Status				
BCF Projects	Project REF	Scale of Opportunity	2015/16 £ benefit	Risk	Start Date	Development of scheme*	Scheme aligned – Vision 2018	Scheme approved by **IG	Delivery date
Flexible social care support at night (6)	BCF6 UPC	Low		Med	In place	1	UPC	To be approved-14.10.14	2014-15
Care arranging team (7)	BCF 7 UPC	Low		Med	In place	1	UPC	To be approved-14.10.14	2014-15
Step up step down (12)	BCF12 UPC	High		High	In progress	1/2	UPC	To be approved-14.10.14	2014-16
Integrated discharge team (13)	BCF 13 UPC	Med		Medium	In progress	1/2	UPC	To be approved-14.10.14	2014-16
Admission prevention (14)	BCF14 UPC	High		High	In progress	1	UPC	To be approved-14.10.14	2014-15
IV antibiotics / blood transfusion (15)	BCF15 UPC	High		High	In progress	1	UPC	To be approved-14.10.14	2014-15
Early supported discharge (16)	BCF16 UPC	Med		Med	In progress	1	UPC	To be approved-14.10.14	2014-15
NWAS demand reduction (17)	BCF17 UPC	High		High	In progress	3	UPC	To be approved-14.10.14	2015-16
NWAS street triage (18)	BCF18 UPC	High		High	In progress	2	UPC	To be approved-14.10.14	2014-16
Joint MH posts (24)	BCF24 LTC	High		Med	In progress	1	LTC/CN	To be approved-14.10.14	2014-15
Dementia nurses (25)	BCF25 LTC	High		Med	In place	1	LTC/CN	To be approved-	2014-15

Key

Vision 2018 Programme
Planned
Unplanned
Long Term Conditions / Complex Needs

Impact Low | Med | High

Low £0-50K

Medium £50-100K

High £100K +

Status Complete | In Progress | Not Started

***Development level of scheme:**

1 – Full impact on non elective modelled, will be implemented prior to April 2015

2 – Non elective impact projected, will be implemented in April 2015

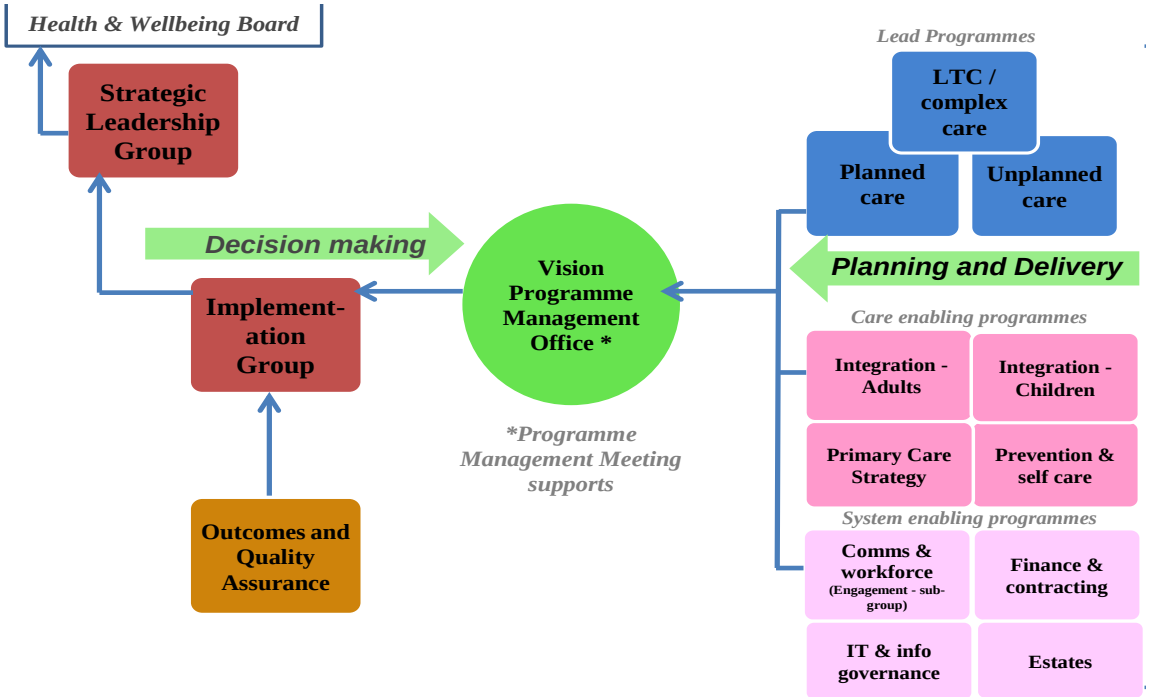
3 – Full impact on non elective not yet known as further work required, will be implemented after April 2015

****IG** = Implementation Group

1

9. APPENDIX

A. Programme Structure



B. Lead Programmes

Integrated health and social care system principles: Right care, right time, right place, rapid response, change in culture and expectations, prioritising elderly care, 7 day integrated care, early intervention and prevention, building on community based assets

Short term care		Ongoing Care
Planned Care begins with a diagnosis in the community, leading to treatment in the community or specialist input for further opinion, diagnosis, treatment or procedure. There is a planned pathway and patient is able to make decisions about their own treatment.	**Unplanned Care** not planned or pre-booked with a GP or hospital. It includes urgent / emergency: •GP appointments •social care •mental health crisis •pharmacists, opticians, dentists •walk-in centres •minor injuries units •North West Ambulance Service •accident and emergency (A&E) • emergency admission to hospital • GP out of hours	**Long term conditions and complex needs** represents the largest proportion of people who access planned and unplanned services and require ongoing support. Eg people with diabetes, suffering from drug abuse, alcohol abuse, mental health condition or homelessness

Self-care, early intervention prevention, building resilience and maintaining wellbeing

C. Programme Directors and Managers

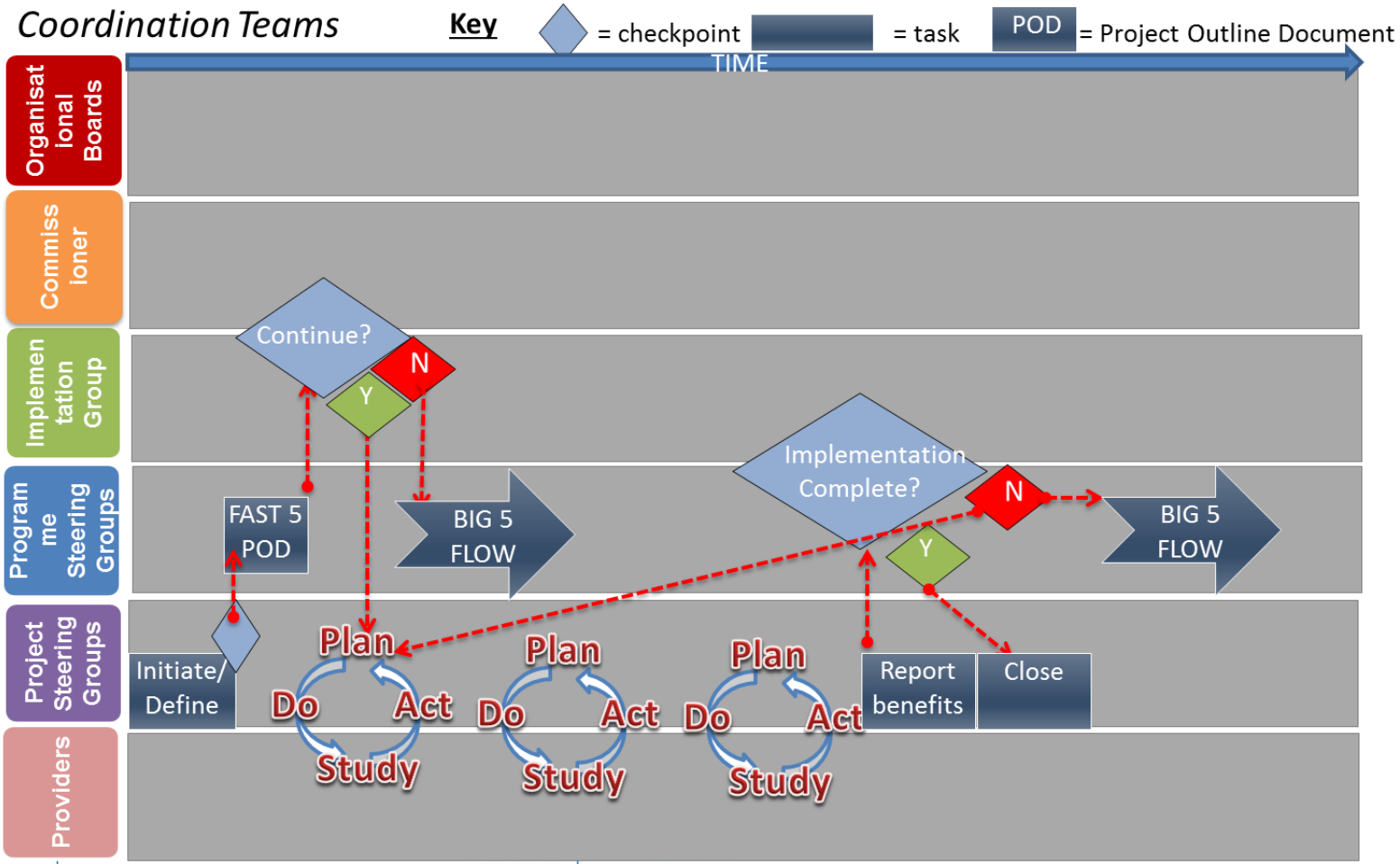
	Group	Chair	Programme Manager
Boards	Strategic Leadership Group	Jon Develing (CCG)	Terry Whalley (NWLA)Project Director - Vision 2018
	Implementation Group	Clare Fish (LA)	Anna Rigby (CCG) PMO Programme Manager

	Programme	Programme Directors	Programme Manager
Lead Programmes	Planned Care	Anthony Hassall (WUTH)	Jo Goodfellow (WUTH)
	Unplanned Care	Jon Develing (CCG)	Andrew Cooper (CCG)
	Long Term Conditions/ Complex Needs	Sheena Cumiskey (CWP)	Val McGee (CWP)
Care Enabling Programmes	Integration -Adults	Graham Hodkinson (LA)	Peter Tomlin (CCG/LA)
	Prevention, Self-Care and Community Development	Clare Fish (LA)	Julie Webster (LA)
	Primary Care Strategy Group	Dr Peter Naylor (CCG)	Christine Campbell (CCG) Barbara Dunton (CCG)
	Integration -Children	Julia Hassall (LA)	Janice Montey(LA)
System Enabling Programmes	Informatics / IT and Information Governance	Mark Blakeman (WUTH)	
	Communications and Workforce	Simon Gilby (CT)	Jane Loughran -Communications (CT), Roger Nielson- Workforce (CWP)
	Engagement (sub group – C and W)	Chairs - Sandra Wall (Older peoples parliament)	Peter Tomlin (CCG) Jane Loughran (CT)
	Finance and Contracting	Mark Bakewell (CCG)	
	Estates	Simon Gilby (CT)	TBC

Key
(CCG) – Clinical Commissioning Group
(LA) – Local Authority
(CWP) – Cheshire and Wirral Partnership NHS Foundation Trust
(CT) – Community Trust
(WUTH) – Wirral University Teaching Hospital NHS Foundation Trust

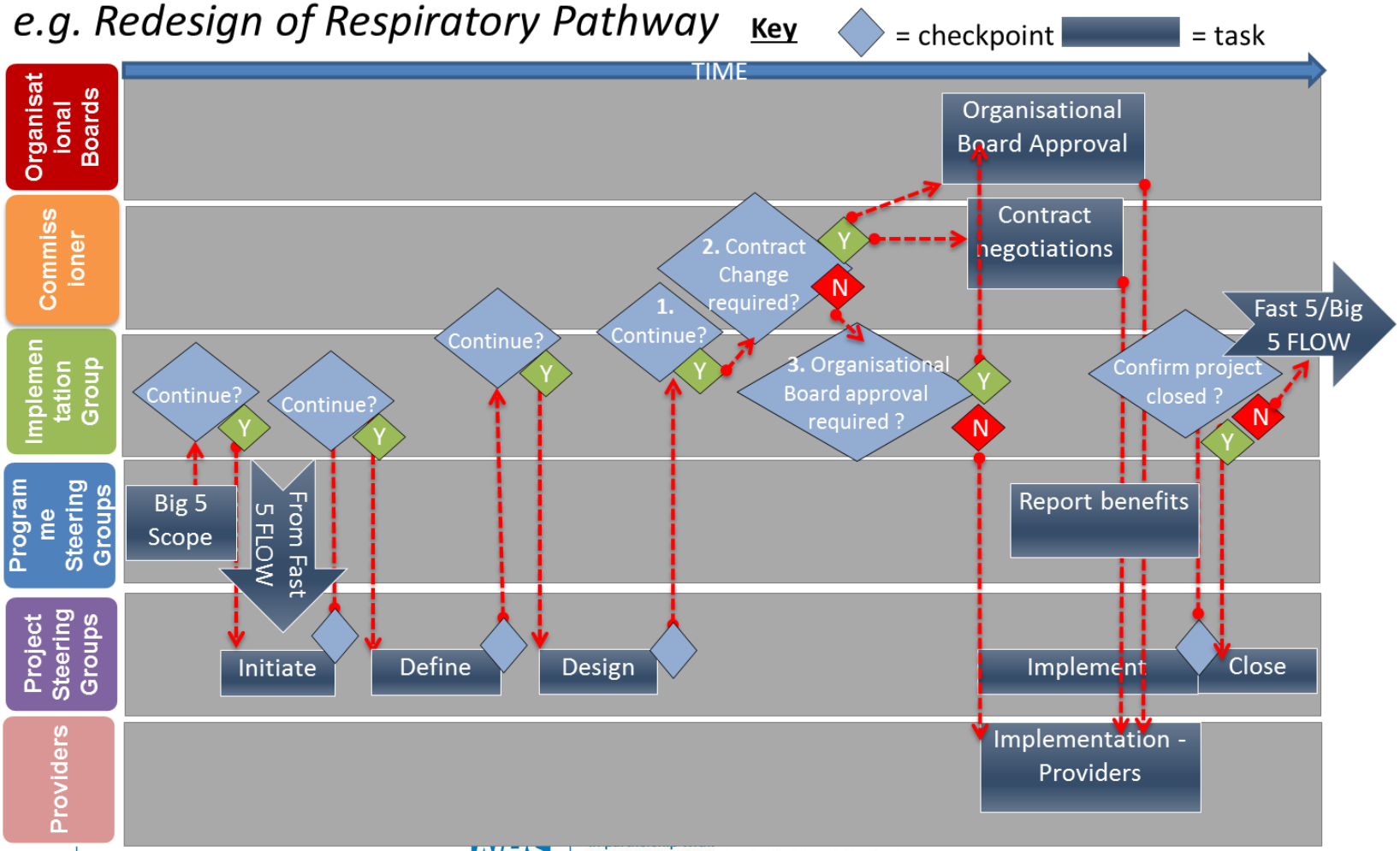
Scenario 1 – FAST 5

e.g. Readmissions Rapid Cycle Testing – Integrated Care Coordination Teams



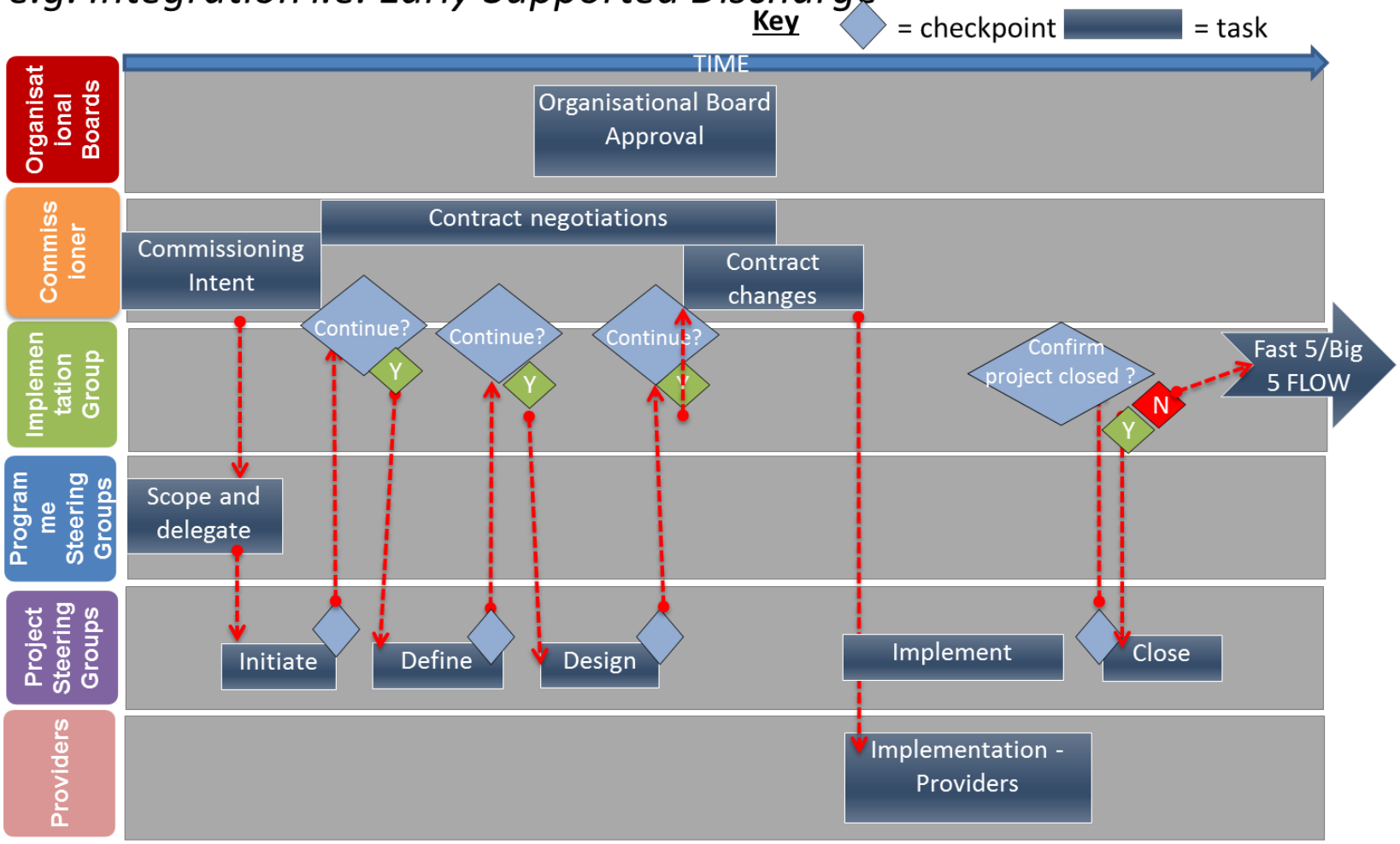
Scenario 2 – BIG 5

e.g. Redesign of Respiratory Pathway



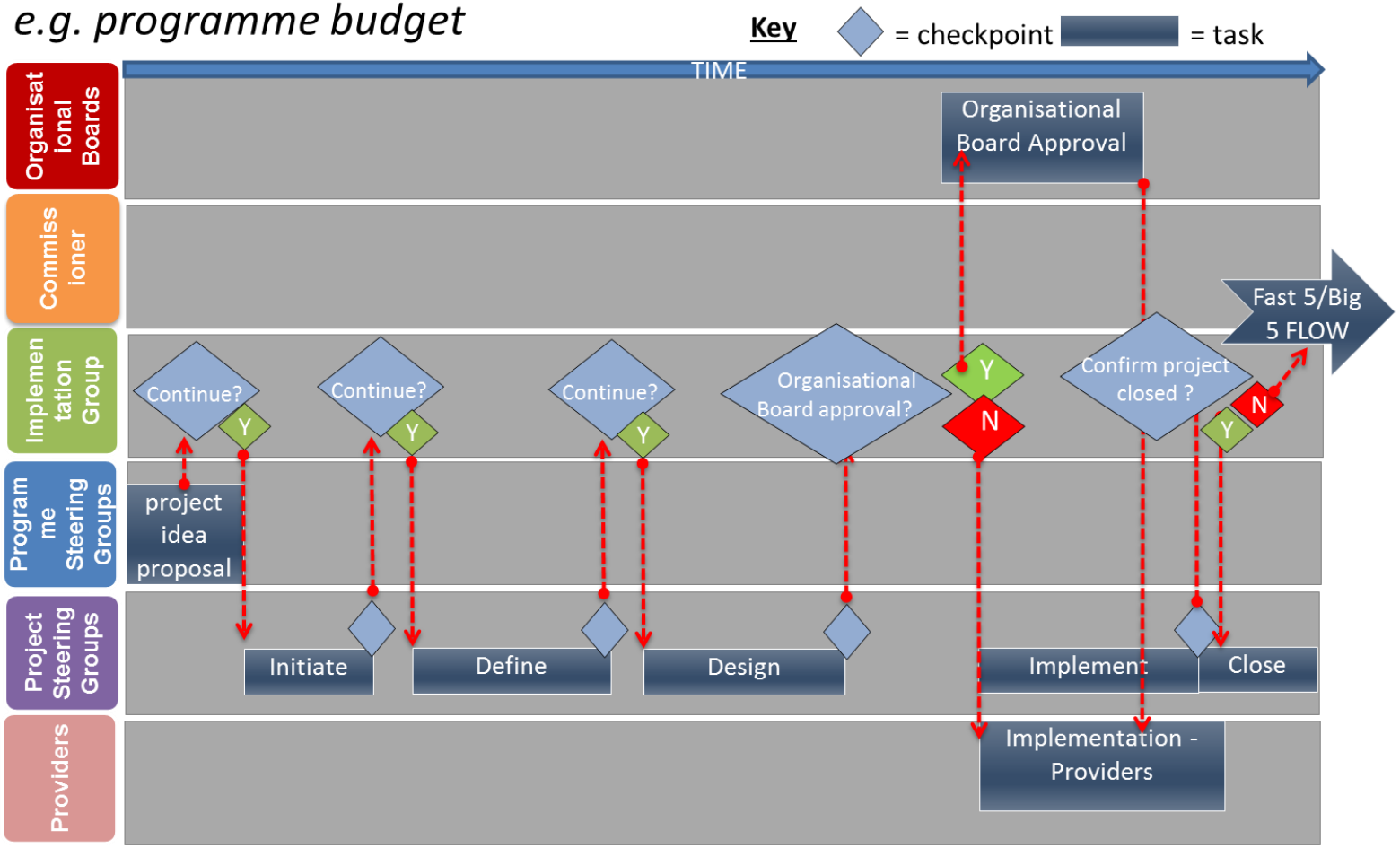
Scenario 3 – Commissioner led

e.g. Integration i.e. Early Supported Discharge



Scenario 4 – Other non contractual

e.g. programme budget



E. Checklist – Big 5, Fast 5

Please answer each of the checklist questions below before proceeding to complete the Project Outline Document. It should help establish if your project can be a Fast or Big 5 project.

Checklist	Sliding scale (0 = faster, 10 = bigger) ‹ Faster Bigger ›	Reference
The problem and the solution are tested and well understood (0 – completely agree, 10 = completely disagree)	0 1 2 3 4 5 6 7 8 9 10	
Cost (0 = no cost, 10 = very high cost)	0 1 2 3 4 5 6 7 8 9 10	
Risk (0 = no risk, 10 = very high risk)	0 1 2 3 4 5 6 7 8 9 10	'Risk and Issues Log'!A1
Time to undertake (0 = days / weeks, 10 = numerous years)	0 1 2 3 4 5 6 7 8 9 10	'Delivery Plan'!A1
Approach – would it benefit from a Plan, Do, Study, Act (PDSA) approach over 4 months or less OR more from breaking the project down into smaller projects / cascade approach (0 = definitely benefit from PDSA, 10 = definitely benefit from breakding down)	0 1 2 3 4 5 6 7 8 9 10	http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
Contentious / controversial (0 = not at all, 10 = very)	0 1 2 3 4 5 6 7 8 9 10	
Contract / Commissioning changes required (0 = none for PDSA, 10 = significant implications e.g. procurement required)	0 1 2 3 4 5 6 7 8 9 10	
Significant impact to patients / staff / carers – *Use stakeholder analysis sheet to establish* (0 = none, 10 = very significant)	0 1 2 3 4 5 6 7 8 9 10	'Stakeholder Communications'!A1
Formal Consultation – *Use stakeholder analysis sheet to establish* (0 = none required for PDSA or anticipated following PDSA, 10 = definitley would require formal consultation prior to PDSA / implementation)	0 1 2 3 4 5 6 7 8 9 10	'Stakeholder Communications'!A1
There will be some value to undertaking a PDSA approach regardless of the outcome of the immediate tests (0 = completley agree, 10 = completely disagree)	0 1 2 3 4 5 6 7 8 9 10	

Projects with a consistent sliding scale toward the lower end can be considered for Fast 5. In addition to the above considerations all projects must be able to contribute to Vision strategic outcomes triple aim or contributes / enables Big 5 projects. All projects should have SMART measures of success (Specific, Measureable Achievable, Time-based)

F. Long Term Conditions and Complex Needs Big/ Fast Projects

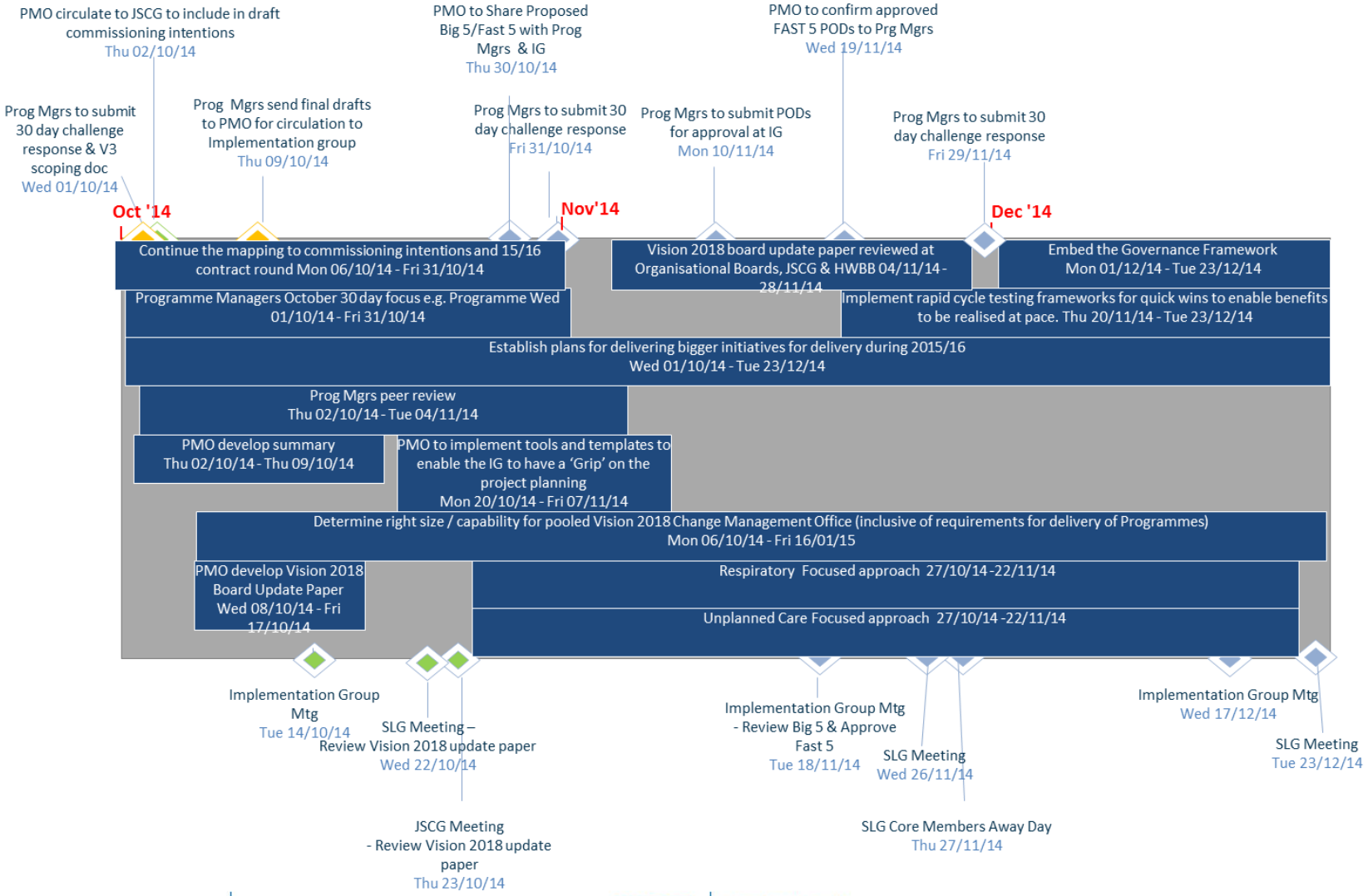
Bigger Projects

Disease group (care pathway)	Pieces of work linked to each disease profile
1. Respiratory	Review of current care pathway Respiratory specialist admission avoidance scheme Psychological input to respiratory patients around prognosis and managing anxiety
2. Cardiology	Review of current care pathway Review opportunities around creating a Community LTC rehabilitation unit – including Cardiac/Pulmonary and Cancer and aligning Live Well programme
3. Stroke	Review of current care pathway
4. Dementia	Review of current care pathway
5. Alcohol	Review of current care pathway ARBD development including ABI
6. Anxiety and Depression	Review of current care pathway Link with the tendering of the PCMH service
7. Diabetes	Review of current care pathway Care planning Community Diabetes Unit
8. Back Pain	Review of current care pathway
9. Long term, out of area, expensive placements	Integrated provider hub – as per West's model

Faster Projects

Topic	Details
BCF – all need to be in place by 31st March 2015	• Wirral Independence – Community Equipment, Telehealth/Telecare and Falls service • Community care of the Elderly services Unplanned care and LTC • CCG/DASS third sector spend LTC – linked to self-care self-management and community assets • ICCT's Investment • Care Home schemes • Flexible social care support at night • Care arranging team Care and support bill implementation • Investment in social services in the community • Dementia • Specialist Alcohol unit • Complex needs service • Direct joint MH posts
Single Care plan	Development of a single care plan (relevant for all programmes)

G. Timeline October – December 2014



Board of Directors		
Agenda Item	7.1.1	
Title of Report	Integrated Dashboard and Exception Reports	
Date of Meeting	26 November 2014	
Author	John Halliday, Assistant Director of Information	
Accountable Executive	Mark Blakeman, Director of Infrastructure and Informatics	
FOI status	Document may be disclosed in full	
BAF Reference	Risks 1 to 9, and 11 to 14	
Data Quality Rating	Silver – quantitative data that has not been externally validated	
Level of Assurance	Full	Board confirmation

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 October 2014.

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

3. Key Issues

Individual metrics highlighted as Red for September are A&E 4-hour Standard, RTT 18 Weeks, Bed Occupancy, Attendance, Expenditure, CIP Performance, Capital Programme, Non-core Spend, Advancing Quality and CQC concerns.

Details on all metrics and their associated performance RAG thresholds are included in the report.

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

4. Next Steps

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

5. Conclusion

Performance across a range of metrics is provided for information

6. Recommendation

The Board of Directors is asked to note the performance to the end of October 2014.

WUTH Integrated Performance Dashboard - October 2014

Meeting Our Vision

Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period
Satisfaction Rates					
Patient Satisfaction - F&F Achievement Score Inpatients			JG	90.7%	October 2014
Patient Satisfaction - F&F Net Promoter Inpatients			JG	69.0	October 2014
Patient Satisfaction - F&F Net Promoter ED			JG	89.1	October 2014
Patient Satisfaction - F&F Net Promoter Maternity			JG	88.3	October 2014
Staff Satisfaction (engagement)			AH	3.64	2013
First Choice Locally & Regionally					
Market Share Wirral			AH	84.0%	April to July 2014
Demand Referral Rates			AH	4.6%	Fin Yr-on-Yr to Oct 14
Market Share Non-Wirral			AH	8.7%	April to July 2014

Organisational Risk Issues

Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period
Key Performance Indicators					
A&E 4 Hour Standard			SG	94.0%	Q3 to 16th Nov 2014
RTT 18 Weeks Standards			SG	2 tgts not met	October 2014
Cancer Waiting Time Standards			SG	All met	Q3 to October 2014
Strategic Objectives					
Delayed Transfers of Care			SG	4	12-mth ave to Oct 2014
Readmissions			EM	9.4%	October 2014
Harm Free Care			EM	95.0%	October 2014
HIMMs Level			MB	5	October 2014
NIHR KPIs			EM	tbc	

A Healthy Organisation

Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period
Clinical Outcomes					
Never Events			EM	0	October 2014
Complaints			JG	35.8	12-mth ave to Oct 2014
Infection Control			JG	0 MRSA; 0 C diff	October 2014
Productivity					
Bed Occupancy			SG	96.9%	October 2014
Theatre Utilisation			SG	65.5%	October 2014
DNA Rate			SG	8.8%	April to October 2014
Workforce					
Attendance			AH	95.1%	12-mth ave to Oct 2014
Qualified Nurse Vacancies			AH	3.5%	October 2014
Mandatory Training			AH	97.7%	October 2014
Appraisal			AH	80.6%	October 2014
Turnover			AH	9.6%	October 2014
Finance					
Contract Performance			AM	1.2%	To M7 October 2014
Expenditure Performance			AM	-1.7%	To M7 October 2014
CIP Performance			AM	-24.1%	To M7 October 2014
Capital Programme			AM	-15.3%	To M7 October 2014
Non-Core Spend			AM	8.4%	To M7 October 2014

External Validation

Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period
National Comparators					
Advancing Quality			EM	3 areas below target	July 2014
Mortality: HSMR			EM	89.2 (low ci 79.6)	April to July 2014
Mortality: SHMI			EM	1.04 (low ci 0.89)	Jan to Dec 2013
Regulatory Bodies					
Monitor Risk Rating - Finance CoS			AM	2	To M7 October 2014
Monitor Risk Rating - Governance			SG	Not Green or Red	To M7 October 2014
CQC			EM	5	October 2014
Local View					
Commissioning - Contract KPIs			SG	3	October 2014
Commissioning - CQUINS			EM	tbc	tbc
Education			AH	Level 2	June 13

integrated Performance Dashboard - Metric Thresholds

Meeting Our Vision

Indicator	Definition	Green	Amber	Red
Satisfaction Rates				
Patient Satisfaction - F&F Achievement Inpatients	Friends & Family Survey - Achievement Score : Inpatients	>=85%	>=71% to < 85%	<71%
Patient Satisfaction - F&F Net Promoter Inpatients	Friends & Family Survey - Net Promoter Score : Inpatients	+86 to +100	+65 to +85	-100 to +64
Patient Satisfaction - F&F Net Promoter ED	Friends & Family Survey - Net Promoter Score : ED	+86 to +100	+65 to +85	-100 to +64
Patient Satisfaction - F&F Net Promoter Maternity	Friends & Family Survey - Net Promoter Score : Maternity	+86 to +100	+65 to +85	-100 to +64
Staff Satisfaction (engagement)	Results from staff satisfaction survey	>=3.69	>=3.59 to <3.69	<3.59
First Choice Locally & Regionally				
Market share : Wirral	WUTH share of Wirral CCG GP Referred New OP Activity	>= 85%	>= 80% to <85%	< 80%
Demand : Referral Rates	Outpatient referrals received from all GP/GDPs - G&A specialties	>= 3% YoY variance	0% to <3% YoY	<0% YoY
Market share : Non-Wirral	WUTH share of West Cheshire GP Referred New OP activity	>=8%	>=6% to <8%	<6%

Organisational Risk Issues

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

A Healthy Organisation

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

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

External Validation

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

WUTH Performance Dashboard Exception Report — September 2014

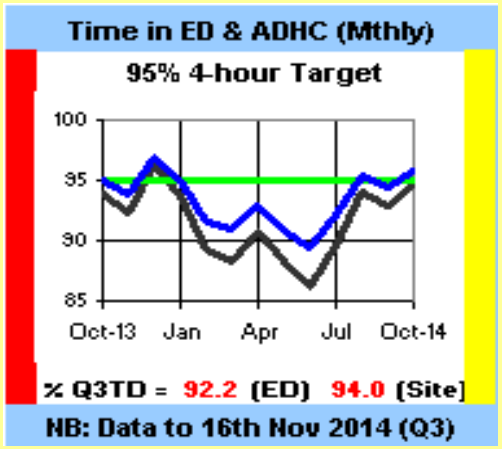
Indicator :
A&E 4-hour Standard

Rating	Target	Actual	Period
Red	>= 95%	94.0%	Q3 2014/15

Issue:

The standard is a minimum of 95% of A&E attendances being admitted, transferred or discharged within 4 hours. Performance for October was above the standard at 95.8%, including the All Day Health Centre at Arrowe Park site. However the first few weeks of November have been extremely challenging, and the cumulative joint Q3 position to the 16th November stands at 94.0%

Historic data:



Proposed Actions:

October saw the Trust achieve the 4-hour standard as a site which was testament to the improvements in Emergency Department processes recommended by the Greater Manchester Central Support Unit as well as the benefits the additional medical staff have delivered. The Trust has seen a significant increase in patient acuity over the last two weeks. Although admissions from the Emergency Department have remained constant, GP direct admissions have increased placing pressure on the assessment units and the bed stock of the Trust, resulting in additional beds being opened for both Medical and Surgical Divisions.

Assessing Improvement:

The difficulties with this standard are continuing. The continued collaboration of all stakeholders working together, both within the Trust and with external partners, is essential to deliver the necessary improvements.

Impact:

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

Expected date of performance delivery:

Quarter 3 in 2014/15

Executive approval:

Sharon Gilligan, Director of Operations

WUTH Performance Dashboard Exception Report — October 2014

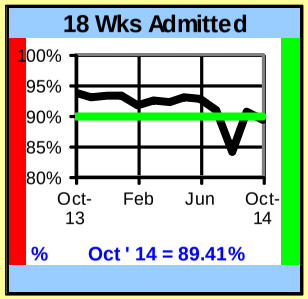
Indicator :
RTT 18 Weeks Standards

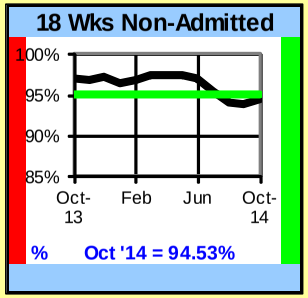
Rating	Target	Actual	Period
Red	All met at Trust level	1 target not met	Sept 2014

Issue:

The Trust did not achieve the RTT standards for admitted and non-admitted patients to be treated within 18 weeks for the month of October. WUTH's performance for admitted was 89.4% against a 90% target, and for non-admitted 94.5% against a 95% target. These failures were anticipated as WUTH, along with many other providers, is currently undertaking additional RTT activity at the request and with funding from NHS England. This is aimed at clearing backlogs of long waiting patients, and so it is acknowledged performance may deteriorate in this period. As a result financial penalties will not be applied for failing specialties for October. Monitor have not suspended the standards for this period, but have indicated their view of Trusts failing these standards will take into account this initiative. This situation may continue through to December.

Historic data:





Proposed Actions:

Continue to treat the additional RTT patients in line with the agreed NHS England plan through December.

Assessing Improvement:

There is weekly reporting to the DH/Monitor on RTT performance, plus weekly progress reports to Wirral CCG on the additional RTT activity. Internal performance management reports are long-established to track progress against all RTT standards at specialty level, and support delivery of the targets.

Impact:

Patients have an expectation, and a right under the NHS Constitution, to be treated within 18 weeks of referral. The standard is a hgh-profile target, underpinned by contractual penalties and Monitor's Risk Assessment Framework. Accessible services for patients are essential to ensure WUTH's ongoing viability.

Expected date of performance delivery:

From Q3 onwards

Executive approval:

Sharon Gilligan, Director of Operations

WUTH Performance Dashboard Exception Report — October 2014

Indicator :
Bed Occupancy

Rating	Target	Actual	Period
Red	<= 85%	96.90%	Oct 2014

Issue:

The bed occupancy analysis is based on daily snapshots of the number of patients occupying a bed at midday, averaged across the month. The threshold for Green is no more than 85% occupancy. This is a historic NHS marker for the optimum level of occupancy, to support flexibility in workload, and a clinically safe environment with minimum risk of infection. Many providers run at higher occupancy levels, and it is a value judgement for each organisation on the appropriate level at a given point in time. The recent very high pressures on urgent care services at WUTH have pushed occupancy significantly above the ideal figure - the average for October being 96.9% occupied, with many contingency beds remaining open.

Historic data:

Proposed Actions:

The increased emergency pressure on services is impacting the number of beds open, and the occupancy rates. Occupancy levels will be managed via appropriate admission pathways and minimising length of stay with timely safe discharge. Actions continue across the health economy to manage the demand on urgent care services, with the contribution from external partners equally important.to deliver improvements.

Assessing Improvement:

Returning to the planned numbers of beds open and occupancy levels is required.

Impact:

Occupancy levels higher than an acceptable maximum cause pressures on clinical staff, infection risk, safe clinical standards and finances.

Expected date of performance delivery:

Quarter 3 in 2014/15

Executive approval:

Sharon Gilligan, Director of Operations

WUTH Performance Dashboard Exception Report — October 2014

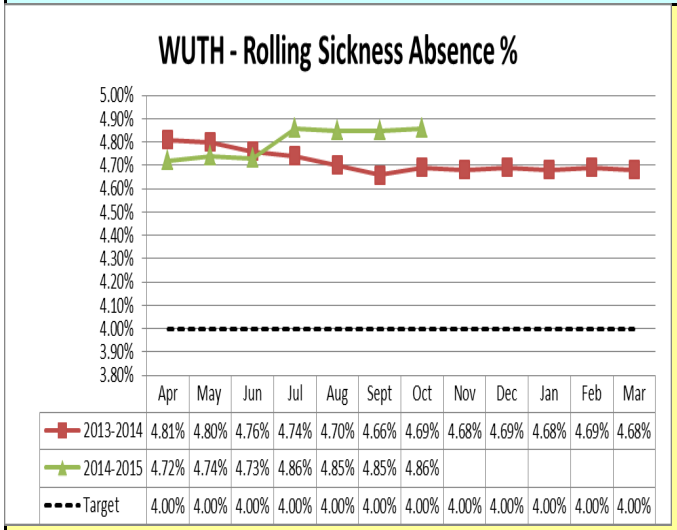
Indicator :
Attendance

Rating	Target	Actual	Period
Red	>= 96%	95.14%	Nov 13 - Oct 14

Issue:

Sickness Absence rolling 12 months was 4.86% at October 14 and therefore above Trust target of 4% and higher than at the same point last year. Urgent actions as detailed below are taking place to address this. The majority of sickness days lost are long term anfd there is a focus on this. The new policy has additional measures aimed at reducing long term absences.

Historic data:



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2013-2014	4.81%	4.80%	4.76%	4.74%	4.70%	4.66%	4.69%	4.68%	4.69%	4.68%	4.69%	4.68%
2014-2015	4.72%	4.74%	4.73%	4.86%	4.85%	4.85%	4.86%					
Target	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%

Proposed Actions:

Rewrite of policy, Validate data, Review staff on long term sick, Audit policy compliance & corrective action, Health and Wellbeing Strategy, Sickness absence training, Detailed monthly reporting and associated drill down, Monthly workforce meetings (HR Managers and line managers), Individual action plans for poor attenders, Self-care scheme, Comprehensive Occupational Health Service, Flu vaccinations

d. Celebration of high levels of attendance.

Assessing Improvement:

Improvements will be monitored via monthly 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

Expected date of performance delivery:

Q1 of 2015/16

Director approval:

Anthony Hassall, Director of Strategy and Partnerships.

WUTH Performance Dashboard Exception Report — October 2014

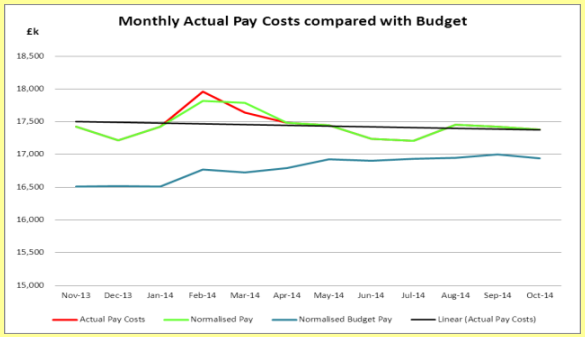
Indicator :
Expenditure

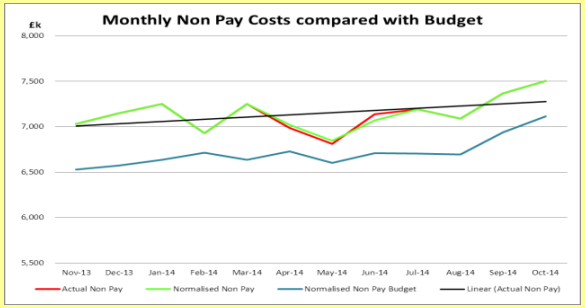
Rating	Target	Actual	Period
Red	On Plan	-1.7%	Oct-14

Issue:

The underlying operational expenditure is £828k overspent in month against plan, £438k on pay and £390k on non pay.
The overspending themes are CIP expenditure scheme slippage of £0.3m, costs associated with delivering planned activity at premium rates of £0.3m, £0.2m of marginal cost impacts of delivering additional NHS clinical activity, £0.1m of costs associated with unplanned opening of capacity and £0.1m on other expenditure categories, offset by other pay vacancies of £0.2m. Work continues to contain pay spend to sustainable levels.
The total pay spend for October was £17.4m, which is broadly consistent with September but at a higher level than June & July (£17.2m in each month).
The total non pay spend is £7.5m in October compared with £7.4m last month. There has been some exceptional items again this month (e.g the costs of the demolition of C block) that have been funded exceptionally from reserves into the budgets.

Historic data:





Proposed Actions:

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

Assessing Improvement:

The divisional reviews will continue to assess performance on a monthly basis and any corrective turnaround plans will be implemented as necessary.
A Turnaround Director has been appointed supplemented by additional resource from FTI to identify and implement the generation/delivery of further ideas to improve /recover the financial position.

Impact:

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

Expected date of performance delivery:

On-going

Executive approval:

Alistair Mulvey - Director of Finance

WUTH Performance Dashboard Exception Report

October 2014

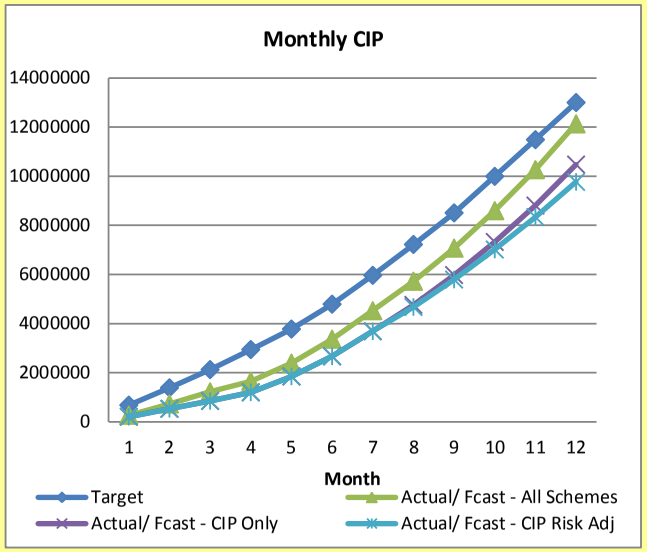
Indicator :
CIP

Rating	Target	Actual	Period
Red	3	1	Oct-14

Issue:

YTD 28% of the in year CIP Target has been delivered with a further 52% forecast to be delivered in the next 5 months, leaving a remaining gap of £2.6m. The step up required to achieve the forecast plans and the requirement to find schemes to fill the gap remains a challenge. Work continues to find new recurrent schemes to close the 2014/15 gap as well as identify non recurrent savings wherever possible. However the lead time needed for savings to be realised means that most schemes currently being worked on will not deliver savings until 2015/16.

Historic data:



Proposed Actions:

The Transformation Steering Group continue to meet on a weekly basis, a Turnaround Director has been appointed with the aim of ensuring delivery of all current schemes and identify new opportunities. The Turnaround Director will be supported by the PMO supplemented by additional resource from FTI in the short term and will continue to drive the increased focus on CIP identification and delivery throughout the organisation. A new PMO communication plan will be launched in November to increase organisational support, including clinical engagement, in the CIP agenda and the financial challenges faced by the Trust.

Assessing Improvement:

The Transformation Steering Group will continue to monitor progress of the 2014/15 delivery and further development of the plans on a regular basis both with the sub theme leads, the Divisions and the Executive team. The Turnaround Director will also be a member of this Group.

Impact:

Failure to achieve the CIP target will put at risk the financial sustainability of the Trust for 2014/15 and beyond.

Expected date of performance delivery:

On-going

Executive approval:

Alistair Mulvey - Director of Finance

WUTH Performance Dashboard Exception Report

October 2014

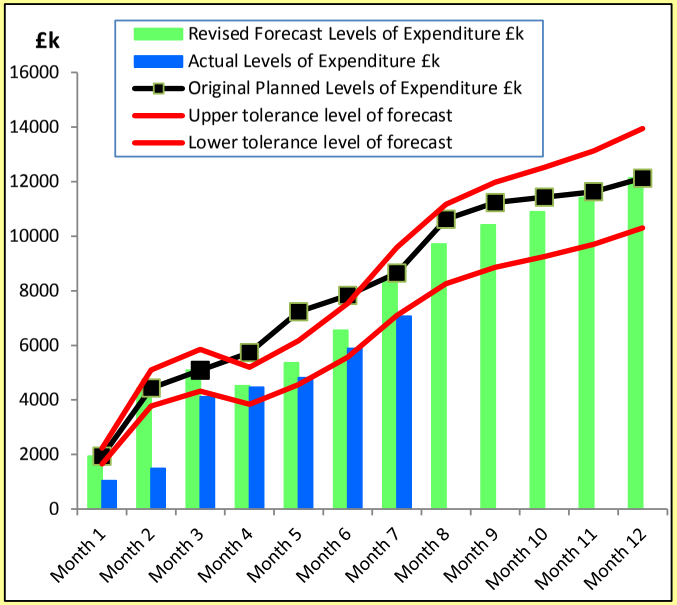
Indicator :
Capital

Rating	Target	Actual	Period
Red	Spend within 15% forecast	84.7%	Oct-14

Issue:

Capital spend to date is 84.7% of the Q1 forecast and therefore outside of Monitor's acceptable range of +/- 15% variance.
Slippage is due to delays and changes to a number of schemes. If this continues at Q3 the Trust will be required to submit a second revised forecast in a year

Historic data:



Proposed Actions:

Finance Group have been asked to confirm that their schemes will progress to forecast for Q3.

Assessing Improvement:

Ongoing improvement in spend profiles against forecast levels and a reduction in the variance

Impact:

If spend levels continue to slip against forecast the Trust will be required to reforecast its capital spend for the second time in a year at Q3

Expected date of performance delivery:

Ongoing

Executive approval:

Alistair Mulvey - Director of Finance

WUTH Performance Dashboard Exception Report

October 2014

Indicator :
Non Core Pay Spend

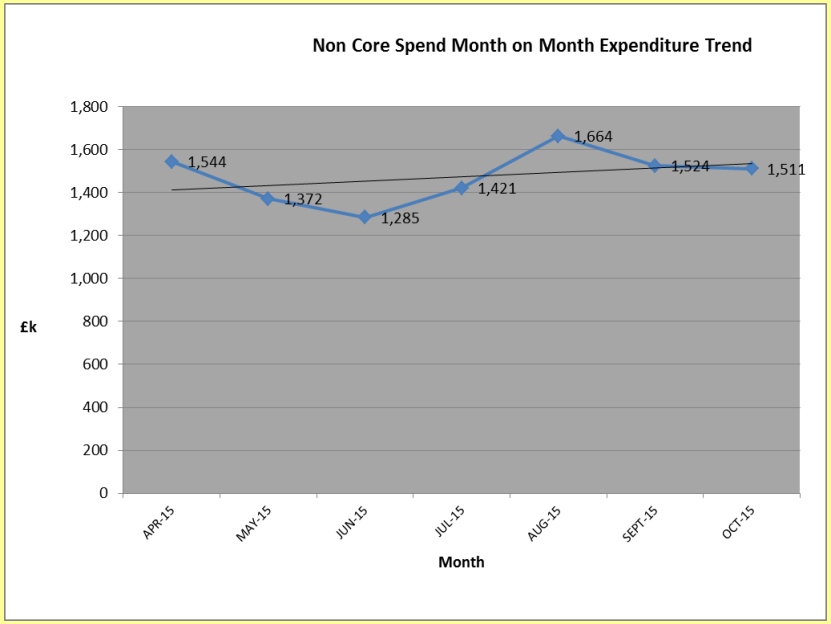
Rating	Target	Actual	Period
Red	<5%	8.4%	Oct-14

Issue:

In October 2014 £1.5m has been spent on non core pay categories. This represents 8.4% of the total pay expenditure in October. From a divisional perspective both the clinical divisions show relatively high spend with the Medicine and Acute division at 12.6%, Surgery/ Women & Childrens at 7.3%, virtually no change from last month and the Clinical Support division combined is at 7.1%. All three Divisions are rated as red against the target of 5%.

The operational issues requiring non core pay categoeies to be utilised are vacancy cover/recruitment issues, sickness cover, patient acuity and staffing the additional beds for the unplanned capacity.

Historic data:



Proposed Actions:

The Workforce Strategy is focused on primarily using core pay spend however from a financial perspective the use of bank has a limited financial impact and allows staffing flexibility.

Continuation of tight control of Non-Core spend will continue in 2014/15 particularly around the impact of premium rates.

Targeted actions are in place to reduce sickness absence and for vacancy control to be managed effectively. WLI rates (change from procedure rates to sessional rates) have been implemented for 2014/15.

Assessing Improvement:

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

Impact:

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

Expected date of performance delivery:

Ongoing

Executive approval:

Alistair Mulvey, Director of Finance

WUTH Performance Dashboard Exception Report

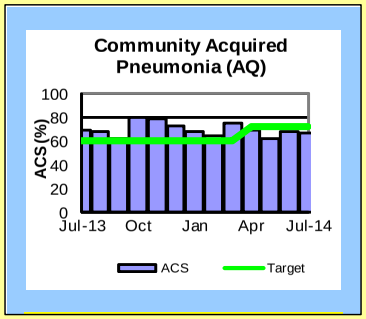
September 2014

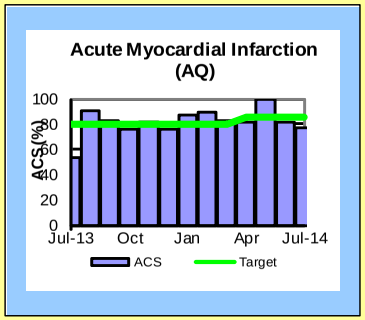
Indicator :
Advancing Quality

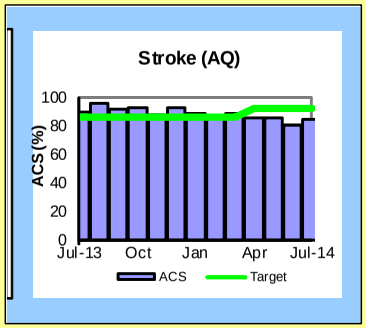
Rating	Target	Actual	Period
Red	All achieving	3 areas under target	July 2014

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

Historic data:







Proposed Actions:
AMI - Continue to have same issues around cardiac rehabilitation; awareness raising did occur until October 2014 when the auditor was transferred back to her ward. There is currently no replacement auditor to support AQ or MINAP - this has been escalated within the division and we will cease reporting this clinical focus group from October discharges. YTD performance 84.9%
CAP - There were a number of smokers not given smoking cessation advice in this month; there was also an issue with the correct antibiotic scripts being prescribed. This ahs been addressed in junior doctors teaching sessions. Alsso during November, the AQ nurses have been on the wards undertaking smoking cessation audits and providing real time feedback to the wards along with promotional materials and training. Any impact will not be seen until the New Year. YTD performance 66.5%.
STROKE - the issue is getting the patients onto the unit within the prescribed timescales, due to the flow of patients and bed availability. YTD performance is 84.1%; a slight improvement on last months report.

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

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

Expected date of performance delivery:
Improvement ongoing through 2014-15

Executive approval:
Evan Moore, Medical Director

WUTH Performance Dashboard Exception Report — October 2014

Indicator :
CQC Concerns

Rating	Target	Actual	Period
Red	Zero	5 concerns	Oct 2014

Issue:

The Trust was inspected by CQC on Thursday 18th & 19th September 2014. The inspectors visited the following wards at the Arrowe Park site: Emergency Department, Wards 21 and 22 - Care of the Elderly wards, Ward 1 - Surgical Day Case Unit, Ward 20 - Urology, Ward 33 - Heart Assessment Centre, Cardiology and Renal ward. This was a responsive inspection which had been triggered by concerns raised directly with CQC by patients or their carers / relatives, and staff. The Trust was given two days' advance notice of the inspection in order to collate the substantial volume of documentation which the Inspectors needed to review, in addition to their work visiting the wards, observing care and interviewing staff and patients. The inspection report was received in draft form on 16th October and the Trust had until 29th October to query any factual inaccuracies in the text. Some errors have been identified in points of detail, but the conclusions of the report have been accepted.

Proposed Actions:

The inspectors provided clear verbal feedback at the end of their visit. In the days following the inspection, the Director of Nursing and Midwifery met with the Associate Director of Nursing for Medical and Acute Specialties, and a number of Matrons with responsibility for the wards that were inspected. They reviewed records and re-visited some of the clinical areas that had been inspected. Immediate action was taken where necessary and possible, and for the remaining issues a list of remedial actions was drawn up with mostly deadlines of one to two weeks from the date of the inspection. A number of the issues identified by the report are wider in scope than just the six wards inspected, necessitating a Trust-wide action plan. In line with our policy on responding to external agency visits, this will be approved by the Clinical Governance Group and recorded on the corporate risk register. It is likely that this will have a high risk score, which will ensure that it is monitored closely at Executive Director level.

Assessing Improvement:

Progress against the obectives in the action plan will be monitored via CGG and the Board Quality and Safety Committee, in a monthly Compliance & Assurance Report.

Impact:

Patients have a right to expect the best possible care from WUTH services, aligned with the Trust's overall strategic aim of placing patients and other customers at the heart of everything we do.

Expected date of performance delivery:

Ongoing

Executive approval:

Evan Moore, Medical Director

Board of Directors		
Agenda Item	7.1.2	
Title of Report	Month 7 Finance Report	
Date of Meeting	26 November 2014	
Author	Julie Clarke, Head of Financial Management	
Accountable Executive	Alistair Mulvey, Director of Finance	
FOI status	Document may be disclosed in full	
BAF Reference	4,5,11,12,19	
Data Quality Rating	Silver – quantitative data that has not been externally validated	
Level of Assurance	Full	Board confirmation

1. Executive Summary

Income and Expenditure Position

The planned income and expenditure position for Month 7 is an in month surplus of £586k. Against this plan, an actual surplus of £494k was delivered, resulting in an adverse variance of £92k in month.

The cumulative position for the first 7 months shows a cumulative deficit of £4,652k against a planned deficit of £3,976k; this represents an adverse variance against plan of £676k. This now means that in order for the Trust to operate within its plan for the year – which is a deficit of £4.2m, it will be necessary for there to be no further deterioration in the position for the remaining months of the year; and furthermore that the adverse variance reported in the first 7 months is recovered. Thus in months 8 to 12 it will be necessary for the Trust to deliver a surplus in order to achieve the plan.

In overall terms NHS Clinical income is above plan for October, which includes non recurrent increases in income from commissioners to support referral to treatment times and urgent care, together with associated costs to support delivery.

A clear message, through the Chief Executive Forum, has been provided within the organisation that given the financial position it is required that:

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

Cash Position & Continuity of Service Ratios (COS)

The cash position is £15.2m, £11.2m better than plan, this is largely due to:

- Increase in net of trade creditors and trade debtors, including specific cash management actions.
- Payments received early (ahead of terms)
- Capital spend below plan
- Draw down of first tranche of the loan
- Positive movements offset by delayed sale of Springview

The overall Continuity of Service rating at month 7 is a 2, which is in line with the planned COS rating. However the Capital Service metric did not increase to a 2 as planned for month 7 due to operational income & expenditure performance. The year-end forecast is forecast to be a 2 as the fall in EBITDA position is offset by the planned sale of Springview (the sale of which was originally scheduled for August). The liquidity position will also benefit from the drawdown of a loan from the ITFF to support the capital programme.

The headline financial position is summarised as follows:

SUMMARY FINANCIAL STATEMENT MONTH 7 2014/15 (OCT)							Comparative 2013/14 Position (Month 7)		
	In Month			Year to Date			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Operating Revenue	25,791	26,237	446	173,774	175,994	2,220	172,685	171,146	(1,539)
Employee Expenses	(16,943)	(17,381)	(438)	(118,431)	(121,625)	(3,194)	(111,387)	(119,132)	(7,745)
All Other Operational Expenses	(7,116)	(7,506)	(390)	(47,500)	(50,098)	(2,598)	(43,154)	(46,719)	(3,565)
Reserves	12	262	250	(3,896)	(1,120)	2,776	(9,014)	(804)	8,210
EBITDA	1,744	1,612	(132)	3,947	3,151	(796)	9,130	4,491	(4,639)
Post EBITDA Items	(1,158)	(1,118)	40	(7,923)	(7,803)	120	(7,336)	(7,352)	(16)
Net Surplus/(Deficit)	586	494	(92)	(3,976)	(4,652)	(676)	1,794	(2,861)	(4,655)
EBITDA %	6.8%	6.1%	(0.6%)	2.3%	1.8%	(0.5%)	5.3%	2.6%	(2.7%)
CIP as % Op Expense	4.9%	4.7%	(0.2%)	3.5%	2.6%	(0.9%)	4.9%	1.5%	(3.4%)

Cost Improvement Programme (CIP)

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

As at month 7 schemes have delivered £3.7m, a shortfall of £2.3m against the year to date target of £6.0m and the latest CIP forecast is £10.5m compared with a £13m target. Please see table below for detail by Division/Executive theme leads.

Month 7 CIP Position

£000	YTD Actual	YTD Budget	YTD Variance	Full Year Forecast Actual	Full Year Forecast Budget	Full Year Forecast Variance	Recurrent Forecast Actual	Recurrent Forecast Budget	Recurrent Forecast Variance
Exec Lead									
Sharon Gilligan	387	895	(508)	1,484	1,950	(466)	3,946	2,600	1,346
Jill Galvani	205	585	(380)	567	1,275	(708)	1,167	1,700	(533)
Alistair Mulvey	499	1,101	(603)	1,549	2,400	(851)	2,576	3,200	(624)
Mark Blakeman	665	1,308	(643)	2,215	2,850	(635)	3,774	3,800	(26)
Anthony Hassall	1,268	1,251	18	2,994	2,725	269	3,389	6,300	(2,911)
Evan Moore	665	826	(161)	1,667	1,800	(133)	2,733	2,400	333
TOTAL	**3,689**	**5,966**	**(2,277)**	**10,476**	**13,000**	**(2,524)**	**17,586**	**20,000**	**(2,414)**
Division									
Medicine & Acute	946	1,652	(706)	2,836	3,600	(764)	5,589	5,500	89
Surgery, W&C	1,421	1,652	(231)	3,112	3,600	(488)	3,135	5,500	(2,365)
Clinical Support - AF	232	964	(731)	915	2,100	(1,185)	2,502	3,200	(698)
Clinical Support - MW	180	688	(508)	786	1,500	(714)	1,791	2,300	(509)
Corporate Support	910	1,010	(100)	2,827	2,200	627	4,570	3,500	1,070
TOTAL	**3,689**	**5,966**	**(2,277)**	**10,476**	**13,000**	**(2,524)**	**17,586**	**20,000**	**(2,414)**
Adjustment for Risk	0	0	0	(706)	0	(706)	(2,386)	0	(2,386)
Risk Adjusted Total	**3,689**	**5,966**	**(2,277)**	**9,769**	**13,000**	**(3,231)**	**15,200**	**20,000**	**(4,800)**

2. Background

The Trust began the year with a deficit plan of £4.2m, which provided a risk rating of 2. The position for the first 7 months of the year translates into;

- a planned deficit of £4.0m, against which an actual deficit of £4.7m has been delivered (£0.7m adverse variance); and
- A COS rating of 2 in line with the planned COS rating of 2, although the Capital Service metric did not increase to a 2 as planned for month 7 due to operational income & expenditure performance.

The cash position is £15.2m, £11.2m better than plan; this is largely due to early settlement of debtors, delays in the payment of creditors, slippage in the capital programme, specific actions taken to improve cash management and the draw down of the first tranche of the loan. The positive variance in cash balances is offset in part by the poor income and expenditure position, and the delay in the sale of Springview.

3. Key Issues

The Trust has a deficit of £4.7m at Month 7 against a plan of £4.0m; this position is not sustainable going forward. The Trust has continued to work closely in order to assist in improving the financial performance and in embedding deeper transformational change.

For the Trust to achieve its plan for the year it will be necessary for there to be no further deterioration in the position for the remaining months of the year; and furthermore that the adverse variance reported in the first 7 months is recovered.

Divisional Analysis
The following table shows the summary Divisional position (cumulative to Month 7). The senior management teams within the Divisions have provided further explanation and context to the respective positions, and this is included in further detail (attached to this document).

Divisional Analysis of Income & Expenditure Position

Detail	Medicine & Acute £000	Surgery & W&C £000	Clinical Support £000	Op & Lab Medicine £000	Corporate £000	Central £000	Total £000
NHS Clinical Income							
Planned Income	66,341	77,236	5,463	3,967	504	3,653	157,164
Actual Income	68,939	75,662	6,266	4,053	439	3,678	159,037
Variance	2,598	(1,574)	803	86	(65)	25	1,873
Net Expenditure							
Planned Expenditure	45,915	43,136	25,170	16,178	19,288	3,530	153,217
Actual Expenditure	48,493	44,320	26,429	16,778	19,136	730	155,886
Variance	(2,578)	(1,184)	(1,259)	(600)	152	2,800	(2,669)
Variance EBITDA	20	(2,758)	(456)	(514)	87	2,825	(796)
Post EBITDA							
Planned Post EBITDA						7,923	7,923
Actual Post EBITDA						7,803	7,803
Variance	0	0	0	0	0	120	120
Total Variance to Plan	20	(2,758)	(456)	(514)	87	2,945	(676)

Pay Analysis

The most significant area of expenditure for the Trust in October, relates to pay. The total pay spend for October was £17.4m, this is comparable to the costs incurred in August and September, although the preceding period incurred costs of £17.2m. The following figure provides further detail of the monthly and cumulative position in the year to date, and also splits expenditure between permanent (core) spend and other (non-core) spend types.

Analysis of Pay Spend

Detail	April £000	May £000	June £000	July £000	August £000	September £000	October £000	YTD £000
Budget	**16,789**	**16,922**	**16,901**	**16,933**	**16,944**	**16,999**	**16,943**	**118,431**
Pay Costs								
Permanent	15,950	16,081	15,944	15,776	15,785	15,897	15,870	95,433
Bank Staff	299	326	297	355	347	342	330	2,296
Agency Staff	318	357	311	379	537	449	504	2,855
Overtime	318	208	209	162	174	229	195	1,495
Locum	418	336	301	374	435	380	339	2,583
WLI (In Year)	180	138	170	164	171	125	143	1091
Total	**17,484**	**17,444**	**17,234**	**17,210**	**17,449**	**17,422**	**17,381**	**121,624**
Variance	**(695)**	**(522)**	**(333)**	**(277)**	**(505)**	**(423)**	**(438)**	**(3,193)**
Pay Reserves	495	205	70	122	50	60	170	1172
Variance (after reserves)	**(200)**	**(317)**	**(263)**	**(155)**	**(455)**	**(363)**	**(268)**	**(2,021)**

4. Next Steps

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

5. Conclusion

The in month position shows a surplus of £494k, against a plan of £586k, resulting in an adverse variance of £92k. The year to date position shows a deficit of £4,652k, which is £676k worse than planned. In order for the Trust to operate within its plan it will be necessary that the position does not deteriorate any further in the remaining months of the year; and furthermore that the Trust recovers the adverse performance for the first 7 months of the year. A clear message has been provided within the organisation as to the importance of delivering against activity plans, and in controlling and minimising costs.

6. Recommendations

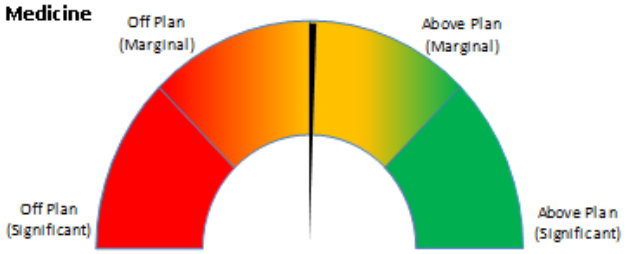
The Trust Board is asked to note the contents of this report.

Alistair Mulvey
Director of Finance
November 2014

Attachment – Divisional Overview & Narratives

Divisional Overview (Month 7)

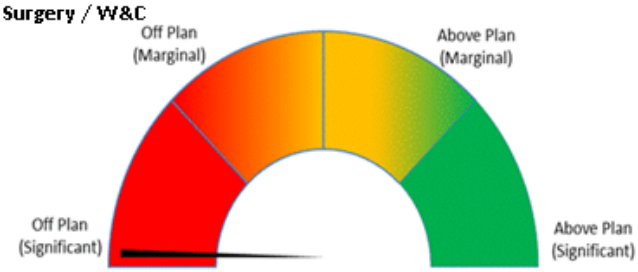
Medicine



Medicine - Key issues

- *Clinical Income over plan by £2.6m.*
- *Net Expenditure exceeds budget by £2.6m .*
- *Overall position is on plan.*

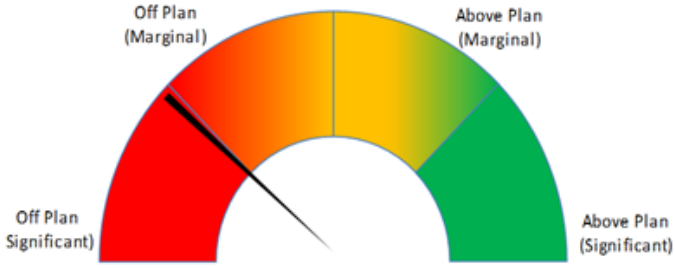
Surgery / W&C



Surgery / W&C - Key issues

- *Clinical Income behind plan by £1.6m.*
- *Net Expenditure exceeds budget by £1.2m.*
- *Overall position £2.8m off plan.*

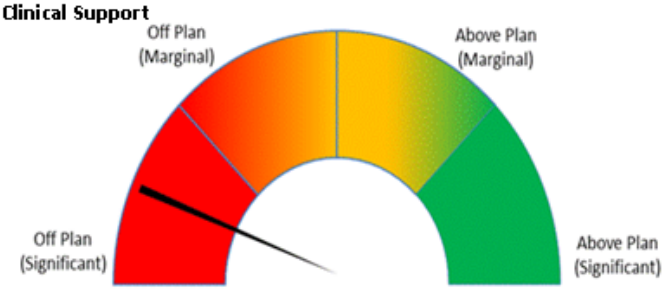
Ops & Lab Medicine



Ops & Lab Medicine - Key issues

- *Clinical Income ahead of plan by £0.1m.*
- *Net Expenditure over plan by £0.6m.*
- *Overall position £0.5m off plan.*

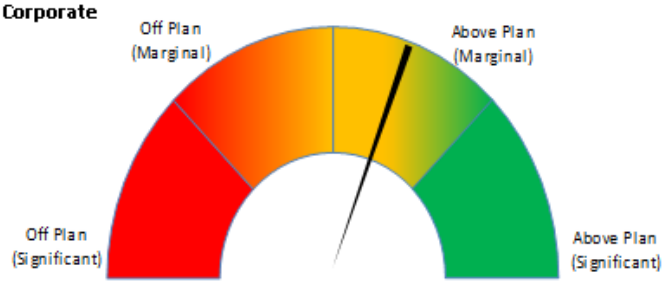
Clinical Support



Clinical Support - Key issues

- *Clinical Income over plan by £0.8m—additional activity.*
- *Net Expenditure exceeds budget by £1.3m, driven by additional activity and CIP shortfall.*
- *Overall position £0.5m off plan.*

Corporate



Corporate - Key issues

- *Divisional income below plan by £0.2m.*
- *Expenditure under spent by £0.4m .*
- *Overall position £0.2m better than plan.*

Medicine & Acute I&E

The division reported a £315k surplus in month 7, the fourth successive month within which a surplus was reported and has resulted in the cumulative position having a surplus against plan of £20k. A concern for the forthcoming months is the shortage of therapy support staff and the pressures this may cause with the additional activity anticipated for the winter months and also the shortcomings of schemes from external providers to aid reductions to length of stay.

Clinical Income within the division is over achieving by c£2.6m, the main drivers of this include additional volumes of activity within planned care work streams both out-patients and in-patient care (£135k and £762k respectively relating to 930 out-patient and 1,374 in-patients) and increased volumes of patients from a non elective care perspective. Non elective activity (net of re-admissions) has over performed against plan by 1,127 patients equating to £1,738k. The Division has generated this additional non elective activity within a reduced bed base of 40 funded beds. However, Emergency Department attendances are up against plan by 626, but due to penalties imposed relating to the 4-hour breaches, the net income position for ED is down against plan by £419k.

The net costs of service delivery have exceeded the planned budget by £2.6m. The most significant element of pressure relates to staff costs, c£2.2m with the balance being slippage against CIP plans and over spending against clinical supplies.
From a pay perspective, the cumulative deficit relates to;

- ED staffing, £0.6m - the current level of overspending has reduced per month as expected rather than the previous £100k per month. The excess costs which will persist relate to the use of temporary/locum staff whilst awaiting substantive staff to be appointed. The department has, in the last month appointed another substantive consultant which reduces the current consultant gap to two wte.
- Gastro currently has overspending of c£534k as locum staff are required to fulfill vacant posts. It should be noted that the current over recovery of income within gastro is £370k and therefore partially off sets these costs. Recruitment processes are underway to fill posts substantively. However, the over-recovery of income is not expected to continue as the speciality planned activity assumptions increase significantly in the latter part of the financial year and there will be additional gaps due to Nurse Endoscopists leaving in December.
- Nursing costs – nursing budgets are currently £920k overspending, keay areas of this are;

    - £200k relates to staffing of additional beds opened through the preceding 6 months as patient demand and infection control and prevention measures have impacted on the core bed stock
    - £285k relates to staff sickness cover. Sickness levels were at 5.6% at their height in 14/15 and through a programme of work have been reduced to under 4% in September
    - £292k relates to the provision of additional staff for Specialing of patients as a function of their acuity needs. A revised process of agreement for the use of additional staff has been implemented and seen favourable financial results in the last two months although is likely to remain a pressure moving forwards.

Pressures through non pay subjective lines include variable costs associated with clinical supplies of c£471k which are in the main driven by over activity and therefore covered by income secured. To ensure controls and best practice processes for ordering goods is in place the divisional teams are working closely with procurement colleagues.

The division continues to work closely with the PMO and FTI to maximize delivery of CIP. Whilst the division is confident that it will achieve its target on a recurrent basis, in year the division is facing a c£706k year to date pressure, which includes slippage on income schemes not being realised. All efforts continue to be focused on bridging the in year gap.

A detailed forecast outturn position based on current performance levels and run rates has been completed, which has the Division delivering a deficit of £1.2m, which has been reduced from a forecast earlier in the year of over £3m and is anticipated to be achieved through additional income, investment in staffing and cost reduction schemes.

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

The divisions overall financial position deteriorated in month 7 by £252k generating a cumulative year to date deficit of £2.76m. Within the overall deficit position expenditure variances are £1.2m year to date deterioration in month of £110k and income under performance is currently £1.57m of which £142k was in month.
The key cumulative drivers of the overall year to date expenditure variance of £1.2m include;

- £249k to support additional bed capacity, of which £108k relates to the provision of the Trust CPE cohort ward;
- £350k relates to Non-PBR excluded devices and high cost drugs, which are pass through costs and attract additional income;
- £435k relates to Park Suite underperformance, against which there is strategic agreement to identify a different PP provision, this will be supplemented with in year price changes where available. Agreement was reached at the beginning of the year that whilst this service sat within the Surgical division any associated pressure would be centrally managed;
- £521k of CIP underperformance and
- Underspend of £300k on Trauma & Orthopaedics costs which is due to Income under performance.

The above costs, which reflect the cumulative position, were also incurred on a proportionate basis in month 7.

From an income perspective the division has a cumulative under performance of £1,574k of which £142k was in month 7.

Whilst there are variations in income across several points of delivery and specialties the key feature within the division both cumulatively and in month relates to orthopaedic activity. Year to date orthopaedics is £1,209k behind its elective plan which includes £109k in Month 7. However, there has been additional work done from Wales in T&O which offset this under performance. The division has also seen year to date under performance against neonatal activity of £278k. Favourable variances, most notably against RTT income and income streams associated with Wales go some way to mitigate these gross income pressures. The Division has seen an improvement in its First Appointment outpatient activity and Non-Elective activity in Month 7 relating to an over performance of £22k and £44k.

The division continues to scrutinise the detail of the orthopaedic position from both a retrospective and prospective perspective increasingly focusing on a daily and weekly basis on the volume of operations booked to ensure slots are filled and resource utilisation maximised and available capacity used for alternative services where appropriate.

The PBR orthopaedic plan was set this year based on available capacity to treat patients. Within the year there has been a significant casemix shift which means that higher volume, lower casemix cases are no longer being received into the Trust thus affecting the ability to deliver the plan.

To help mitigate the impact of this the Division approached Betsi Cadwaladr LHB to undertake cases to help with Welsh waiting time targets for both orthopaedics and ophthalmology to backfill the loss of English activity. These activities are now developing

although there were some initial operational anomalies to over come. Good working between the respective organisational teams have resolved these issues and it is hoped that this will support a longer term strategic alliance for future service delivery and it is forecast that the financial benefits of this service provision will flow into future periods and within September the Division has secured another 116 orthopaedic cases to be undertaken from Betsi. The Division is now starting to see an increase in the number of elective cases coming through for Wales and hopefully this will continue for the rest of the financial year and beyond.

Whilst the overall divisional position remains significantly challenging the focus has been and continues to be on;

- Minimising costs where possible with engagement and support with the PMO and more recently FTI who are specifically supporting changes within theatre use and utilisation;
- Exploring, with success, new markets for the provision of services, specifically within north Wales and potential collaboration with Chester
- Delivering additional RTT volumes where possible to underpin loss of core income and
- Ensuring prospective systems are in place for the booking of patients to allow the divisional management teams can support the maximisation of use of clinics and available in-patient resources.

Ops & Lab Medicine

The Division reported a cumulative overspend of £513k to Month 7 with an adverse movement of £121k in month, however, the month 7 position was slightly better than forecast by £30k. By Directorate the main areas of overspend are within Labs and Hotel Services.

From an income perspective the only area that generates Clinical Income is Pathology which is performing slightly ahead of plan (£86k year to date); this increase being largely driven by direct access income with Blood Sciences and Cellular Pathology being cumulatively ahead of plan whilst Microbiology income is slightly behind. However performance against plan has dipped across Pathology for the last four months and as a result we are now projecting a small adverse variance for the remaining year. There remains an overarching concern around the affordability risk across the economy if these levels of diagnostic demand continue.

The Division is reporting a favourable pay variance £190k year to date with only Patient Flow showing a cumulative overspend owing in the main to sickness cover and pay protection.

Non pay budgets are £670k overspent year to date but this is offset by £382k in associated income. Pathology non pay overspend is £296k offset by £136k income, the bulk of lab costs vary with both GP & Trust activity however Pathology is experiencing a significant cost pressure in the provision of blood products to the broader organisation (£113k year to date net of income recovery – further to last month's comment updated reports were available this month resulting in increased volumes being recharged). Hotel Services non pay overspend is £359k offset by higher associated income of £188k, within this area is the impact of accommodation guarantee (£119k adverse ytd),

The division remains £502k behind its year to date CIP target and this remains the biggest risk to delivering a balanced budget. All service areas are actively seeking to identify further opportunities to bridge any remaining gaps in CIP delivery.

The full year unmitigated position based on current activity levels and run rates is forecast to be £1.3m adrift of budget, a slight deterioration on the P6 forecast mainly as a CIP slippage.

Clinical Support

The Division reported an overspend of £458k year to date to month 7, with an adverse movement of £115k in month. However, the month 7 position was £81k better than forecast. Year to date Radiology remains underspent by £30k, AHP's £75k underspent and outpatients, £66k underspent. Theatres are £665k overspent and moved adversely by £168k in month. This was predominantly due to an increase in clinical supplies expenditure and locum costs.

From an income perspective the Division is performing well and is £801k ahead of plan year to date. This is largely driven by direct access income from Radiology. Radiology has experienced an 18% increase in activity resulting in £567k income over achievement with high demand continuing in areas such as Ultrasound. Whilst these income gains generate a contribution there is an affordability risk across the economy if these levels of diagnostic demand continue.

The Division is reporting an adverse pay variance £328k year to date with Theatres £477k overspent (£207k of which relates to 16RTT work) and Radiology £125k, however, encouragingly Outpatients is in surplus £108k and Therapies is also in surplus by £160k.

Non pay budgets are £331k overspent year to date but this is offset by £147k in associated income. Theatres non pay overspend is £135k offset by £87k income and radiology non pay overspend is £197k but there is a shortfall on income of £12k - the bulk of these costs being variable costs associated with direct access volumes.

The Division remains £748k behind its year to date CIP target. Specifically Theatres and Anaesthetics are £351k behind plan, Radiology £202k behind, Therapies £143k behind and Outpatients £52k behind. This is the biggest risk to delivering a balanced budget. Every service is actively in consultation/implementation to introduce new structures which will reduce cost. The division is working closely with PMO in exploring further opportunities to bridge any remaining gaps in CIP delivery.

The full year unmitigated position for Diagnostics & Clinical Support is forecast to be £1.0m adrift of budget, an improvement of the P6 forecast of £0.2m mainly as a result of the inclusion of benefits associated with the remedial plan to address Direct Access waiting times and the realignment of 16wk RTT from Surgery.

Board of Directors		
Agenda Item	7.2	
Title of Report	Report of the Quality and Safety Committee	
Date of Meeting	26 November 2014	
Author	Dr Evan Moore, Medical Director Dr Jean Quinn, Non-Executive Director/Chair of Quality and Safety Committee	
Accountable Executive	Dr Evan Moore, Medical Director	
FOI status	Document may be disclosed in full	
BAF Reference	1, 2, 4, 5, 6, 11, 13	
Data Quality Rating	Silver – quantitative data that has not been externally validated	
Level of Assurance	Full	Board confirmation

Report of the Quality and Safety Committee

12 November 2014

The meeting was quorate and began on time.

3 Chair's Business

The Medical Director detailed the Trust's plan to "sign up to safety" and the improvement opportunity which that would flow from that. Items 7.5 and 7.6 were received late and the Chair deferred them to the next meeting.

4.1 Patient Story

The meeting began with a patient story which brought a patient care focus to the meeting. The patient related a series of treatments on the Haematology Unit and detailed many areas of caring and safe practice over three in-patient stays.

4.2 Patient Reported Delays

The Director of Nursing and Midwifery gave a description of delays reported by patients through the "Learning with Patients" methodology. The Director of Nursing and Midwifery verbally described a number of measures currently being employed to address these. It appeared that surgical patients seemed to be incurring more delays than other patient groups.

The Quality and Safety Committee asked Clinical Governance Group to follow this issue and track through the CLIPPE log.

Partial Assurance

4.3 Patient and Family Experience Group Annual Report

The Director of Nursing and Midwifery presented the Annual Report and described the work undertaken around Nutrition, Dementia and the Learning Disability Working Team. Members felt this paper would have benefited from additional detail and assurance of improvement.

Partial Assurance

5.1 HR & OD Workforce Information 2014/15 Quarter 2

The Committee received the Quarter 2 report. The Director of Strategy and Organisational Development presented the headlines around the number of vacancies, total spend, reduction in sickness absence, staffing fill rates and mandatory training and appraisal completion rates. The Committee were pleased with the style of the dashboard and found it easy to read. The Committee noted with concern that 25% of bank nursing shifts had been unfilled and cross referenced this with the recent CQC inspection. The Committee noted that the number of employees had not fallen, neither had core spend or non-core spend reduced over the past 12 months. The Committee struggled to triangulate this with information received at the Finance, Business Performance and Assurance Committee.

The Committee requested an update on our strategic staffing solutions as part of a future dashboard.

Partial Assurance

5.2 Improving Communication Skills

The Director of Strategy and Organisational Development presented this paper which described the current ongoing initiative and plans to improve leadership and communication and invited the Committee to note the progress. The Committee welcomed the report and agreed that this is a priority area for the Trust.

Assured

6.1 Clinical Quality Dashboard

The Associate Medical Director presented the Clinical Quality Dashboard, highlighting the continued reduction in SHMI and HSMR, the elevated weekend HSMR was presented and assurance provided that this was reducing. Improvements with AQ were noted, however, the target has been increased in line with continued compliance; the Committee noted the progress towards achieving the new target. Whilst noting the improvement in MEWS scoring, the Committee noted the issues around review at a MEWS of three or more. The Committee was informed that the awaited missed doses report would replace the current medication errors infogram.

The Committee noted the new harm information and triangulated the increased STEIS reports with the change in STEIS criteria.

It was reported that a data error had arisen in the pressure ulcer data which would be addressed in the next meeting. The work to address re-admission rates was noted and the overlap with general admission rates and the dependency on services outside the Trust's control. The Committee noted the increase in falls with harm which had fallen since July, but was higher than last year. The Director of Nursing and Midwifery undertook to bring back a falls report to the next meeting.

The Committee noted the good and sustained Friends and Family Test especially A & E and Maternity.

The Committee received the Serious Harm details and noted the elevated number of incidents in July.

The Committee noted the Quarter 1 and 2 Serious Incidents Trend Report noting the increased number of incidents in Quarter 2 and the improved timeliness of reporting and responding to incidents. It was noted that the Trust's no blame culture came across in the reports.

The Committee noted a risk greater than 20 and the mitigation around it.

The Committee received the report on Never Events, crossed referenced with a discussion at the Board of Directors meeting and noted the steps taken to prevent a recurrence.

The Committee noted the CQC report and the Medical Director described the steps currently being undertaken to return to full CQC compliance. The full plans will be presented at the November Board of Directors meeting.

Assured

6.2 Quality Impact of Cost Improvement Programme Report

The Committee noted the report, previous concerns around pressure ulcers seemed to be resolving, the high number of cancelled out patient appointments and operations was cross referenced with items 7.2, 7.3 and 7.4.

Assured

7.1 Winter Plan and Update on the Medical Division's Bed Base

The Directorate Manager for ED presented the Winter Plan detailing work done and underway to reduce admissions and length of stay and documented the successes achieved and those predicted when additional schemes commence. The plan also outlined winter monies received and how these will be used particularly to fund additional beds over the winter. The Committee expressed concern that the beds identified to be opened as part of the Winter Plan were already in use due to escalation. This did seem to represent some risk to the deliverability of the Winter Plan. Assurance was given that if all the measures to reduce admissions and improve the discharge process were put into place the Winter Plan was deliverable.

Partial Assurance

7.2 Outpatient Improvement Review Group Update

The Associate Director of Operations for Clinical Support Division presented this paper which detailed plans to reduce waiting times, cancellation, DNA's and unnecessary follow up appointments.

Assured

7.3 Outcomes of Patients who DNA'd Procedures During 2013

The Associate Medical Director presented this data which showed that there had been no formal complaints and no evidence of increased admission or A & E attendances for patients who DNA'd.

Assured

7.4 Quality Impact Report: Cancelled Operations

The Director of Operations presented the ongoing downward trend in cancelled operations, although a significant spike in September was noted. The reasons for cancellation were noted and the ongoing work to reduce cancellation.

Assured

7.7 WUTH Dementia Strategy

The Director of Nursing and Midwifery presented the Strategy to diagnose and manage Dementia. The Committee noted that progress with the Strategy could be monitored through the CQUINs and approved the Strategy. The Director of Nursing and Midwifery agreed to bring an update at the end of Quarter 3.

Partial Assurance

7.8 Update on Strategic Actions to address End of Life Care Provision for Adults in Wirral University Teaching Hospitals

The Director of Nursing and Midwifery presented the progress since the last report and the detail of the recent review by Clinical Commissioning Group. The Trust has joined an AQuA Quality Improvement Programme. The need for an economy wide strategy was discussed. The Committee discussed the difference in specialist palliative care and "general" end of life care. A number of good examples of palliative care were noted, the Associate Medical Director provided evidence that the number of deaths out of hospital was increasing.

Partial Assurance

7.9 Quality Improvement Strategy

The Committee was asked to agree to a refresh of the targets already agreed at Clinical Governance Group. The Committee took time to go through the individual metrics and approved the changes.

Assured

7.10 Health and Safety Quarter 2 Report

The Director of Strategy and Organisational Development presented the Quarter 2 report and highlighted a reduction in incidents reported and actions undertaken to ensure an open reporting culture. The Committee asked for responses on specific questions which the Director undertook to supply.

Assured

8.2 Clinical Governance Group Minutes (22 August and 19 September 2014) including CGG Annual Report and CLIPPE Assurance Report

The Committee received the report and accepted the assurances that the group had met its objectives and fulfilled its role in the previous year.

Assured

9.1 Review of BAF

The Committee received an update from the Associate Director of Governance on the ongoing work to update and maintain the BAF.

10.1 Items for the Risk Register

The Director of Nursing and Midwifery to put concerns around end of life care on the Risk Register.

10.2 Recommendations to the Board

The Board is asked to note:

- the approved Dementia Strategy
- the approved changes to the Quality Improvement Strategy metrics

Board of Directors		
Agenda Item	7.3	
Title of Report	Complaints Handling Update Report	
Date of Meeting	26 November 2014	
Author	Michael Chantler, Head of Patient Experience	
Accountable Executive	Jill Galvani, Director of Nursing and Midwifery	
FOI status	Document may be disclosed in full	
BAF Reference	1,2	
Data Quality Rating	Gold – externally validate Silver – quantitative data that has not been externally validated	
Level of Assurance	Full	Board confirmation

1. Executive Summary

This report provides the Board of Directors with an update in relation to complaints management at the Trust.

2. Background

It has been recognised that in recent years the Trust has not managed concerns and complaints to the standard required. There was a significant improvement in the handling of complaints during 2013/14, with 70% of complaints responded to within the agreed timescale compared with just 47% in 2012/13. However, the Trust still did not meet its 80% target for response compliance.

The analysis in this report provides assurance that the improvement in complaints management has been sustained. By the end of October 2014, the Trust had responded to 85% of complaints within the agreed timescale. It is fully expected that the Trust will exceed the 80% target at the end of the business year. It is also expected that the Trust will experience a year-on-year reduction in the number of formal complaints received.

3. Complaints Management Performance

By the end of October 2014 the Trust had received 238 formal complaints for investigation. This is a 20% decrease from the 299 complaints received at the same time in 2013. A key contributing factor to this is that all complaints received have an initial assessment by the Complaints Team and, where possible, a discussion takes place with the person raising the concerns to agree whether they would like us to try resolve their concerns informally or as a formal complaint investigation. The new concerns and

complaints policy also places an increased emphasis on frontline staff resolving concerns with an early intervention before they escalate to a complaint.

Compliance with responding to complaints within the timescale agreed with complainants is monitored on a monthly basis, on both a Trustwide and divisional basis.

There are variances between the divisions with complaints performance, as can be seen by the following chart:

Division	No. of Responses	Response compliance
Medical & Acute Specialties	112	78%
Surgery, W&C	108	92%
Clinical Support	6	83%
Corporate	3	100%

There was an improvement in the response compliance for the Medical and Acute Specialties Division during October, and it is expected that all divisions will exceed the 80% target by the end of 2014/15.

Following the Frances and Clwyd Hart reports, there is an increasing emphasis for Trusts to use complaints to identify trends and themes as they arise and show learning from complaints to improve the care and service provided. For each individual complaint, the complaint response will detail the action that has been and/or will be taken to address any failings if they are identified. On a wider scale, complaints trends and themes are analysed via:

- CLIPPE report – Quarterly
- Executive Director Team – Monthly
- Divisional Management Teams – Monthly
- Annual Concerns and Complaints Report

There has been an increase in the number of complaints investigated by the Parliamentary and Health Service Ombudsman about the Trust. The Ombudsman handled 10 complaints about the Trust in 2013/14, but at the end of October 2014 we already have 11 complaints currently being considered by the Ombudsman. However, it must be stressed that the Ombudsman has changed its methodology as part of its 'More Investigations for More People' strategy which has seen the number of investigations on a national level increase from 300 to 3,000. There have been no concerns raised regarding the increase in Ombudsman complaints regarding this Trust and no trends or themes have been identified in the care provided or complaint handling. Rather, in one investigation report the Ombudsman concluded that "*We consider the Trust has demonstrated it has made and is making significant improvements in complaint handling"*. However, given the increase in investigations, and reputational risk of increased publications of complaints about the Trust, a paper will be presented to the next Clinical Governance Group to review the Trust's governance of Ombudsman investigations.

4. Patient Relations Team

The Complaints and PALS teams will be merged into the Patient Relations Team from the 1st January 2015. This launch will include revised literature for patients and staff in promoting the frontline resolution of concerns and queries as and when they arise before they escalate to a formal complaint. The literature will be in the same corporate style used for the Friends & Family Test and Visiting Hours promotions.

Complaints are now managed centrally by the Complaints Team. The new approach to investigations follows a casework model, whereby each complaint is assigned to a Patient Relations Specialist/Officer who is the case owner and point of contact for the complainant and manages the complaint end-to-end. This process has been implemented for all complaints received from the 1st November 2014 to streamline the complaints process. Whilst there will still be an essential requirement for clinicians and staff to provide timely and appropriate statements during the investigation, the new approach will reduce the traditional over-dependency on divisions, which has led to problems with inconsistencies in the timeliness and quality of complaints investigations and responses.

During Q4, a Complaints Scrutiny Team will also be implemented that will report to the Quality and Safety Committee. The team will review a sample of complaints on a quarterly basis to review whether the complaint was handled reasonably in line with the Trust's policy and whether appropriate learning has taken place as a result of complaints.

5. Conclusion

The improvement in complaints handling during 2013/14 has continued in 2014/15. At the end of October 2014 the Trust has responded to 85% of complaints within the agreed timescale and is expected to exceed the required 80% target at the end of the business year. To date, there has also been a significant reduction in complaints compared to the same stage in 2013/14, indicating that the Trust may again experience a year-on-year reduction in formal complaints.

6. Recommendation

The Board of Directors is asked to note this update report.

Board of Directors		
Agenda Item	7.4	
Title of Report	Francis Report: Hard Truths Commitment: Publishing of Staffing Data: 6 Monthly Report	
Date of Meeting	26 November 2014	
Author	Jill Galvani, Executive Director of Nursing and Midwifery Andrea Hughes, Interim Deputy Chief nurse	
Accountable Executive	Jill Galvani, Executive Director of Nursing and Midwifery	
FOI status	Document may be disclosed in full	
BAF Reference	1, 2, 11	
Data Quality Rating	Gold – externally validate	
Level of Assurance	Concerned	Board confirmation

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. The data 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 performance indicators. June and July data was reported as satisfactory. The months of August and September have proved to be challenging, the reasons for this are discussed in the paper, with the associated actions required for improvement identified.

This paper provides the second 6 monthly update on nurse staffing data to the end of the second quarter. The first 6 monthly report was presented to the Board of Directors on 28 May 2014. Monthly nurse staffing data has been reported to the Quality & Safety Committee since June.

Increasing the bed base in the Trust whether as a result of activity pressures or infection control has a direct impact on the role of the Ward Sister/Charge Nurse and Matron and the ability of the Trust to monitor and improve standards of nursing care for compliance that cannot be sustained without additional improvement schemes. Every effort is being made to ensure improved isolation facilities for infected patients, bed capacity and demand analysis are aligned.

There are a series of schemes that are in place to improve the environment of nursing care and the impact on nurse staffing challenges:

- Ticket Home Initiative
- Nurse-led and criteria-led discharge
- Discharge to assess and Early supported discharge
- Board Rounds and 8am Ward Rounds
- Check & Act
- Embed the Frailty Unit
- New model for the Emergency Department Review Unit
- Improved Care Pathways
- Matrons providing leadership to Wards for patient care and patient flow.

The Infection Prevention and Control agenda was reported to the Quality and Safety Committee in September 2014 and progress has been made in determining how patients will be isolated and rapid testing of samples that minimise the impact of infection on the day to day operations of the Trust that in turn, cause pressures on the nursing workforce.

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

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. The first phase focuses on all inpatient areas including acute and maternity care.

- The first 6-monthly report on nurse staffing was presented to the Board of Directors in May 2014.

- 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 will be 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. The August and September 2014 nurse and midwifery reports follow.

'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 Quality and Safety Committee.

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 and Acute have a daily staffing meeting to determine whether or not planned staffing requirements are met and to take action where there may be a shortfall. The outcomes of these meetings are recorded and contribute to the monthly staffing report. Reports to the Analyst are paper-based as the current Nurse Roster system does not allow upload of data. Version 10 of E-Roster will enable uploading of data as from February 2015. Resources to implement the new system are currently being reviewed. Whilst this is the most appropriate action it does sometimes mean movement of staff to cover unplanned gaps which can lead to staff dissatisfaction. To minimize this staff are advised of rationale for the course of action, and the necessity to put patient safety first.

Evidence Based Decision Making

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

From June to September 2014, the Trust continued 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 Birthrate Plus exercise in Maternity concluded in September 2014, as did the British Emergency Department Staffing Tool Assessment (BEST). Draft NICE guidance for Maternity staffing levels has just been released and the Trust will contribute to the Consultation. NICE guidance for Emergency Department nurse staffing is expected in January 2015.

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. One specific action taken in July 2014 by the Director of Nursing & Midwifery was to inform the Ward Sisters and the Hospital Coordinators that there is a minimum requirement of two Registered Nurses on each ward on every shift.

The Care Quality Commission arranged a responsive inspection in September 2014, 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. In turn, all staff including nurses must receive feed back with regard to their concerns. There has been a prolonged period of pressure during August and September 2014 where nurses have been relocated to staff additional bed capacity in both divisions along with supporting cohort nursing during the recent CPE outbreak. The Flexibank function has not reliably provided Registered Nurses as requested and a detailed analysis of requests to the Flexibank versus fill rates is under way, along with

recent recruitment into the Flexibank to ensure availability of staff. The challenges in safely staffing additional areas during August and September 2014 have resulted in Senior Nurses raising concerns within the divisions. In response to this the Associate Directors of Operations and Associate Directors of Nursing have worked together to establish winter plans to include additional bed capacity and efficient nurse recruitment. The Division of Surgery, Women and Children's is completing a review of the current bed base which has been presented to the Director of Operations for further discussion.

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, during October 2014 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 (The Telford Model). This data is generated from use of the Safer Nursing Tool to determine the nursing requirements of the Ward's patient population. This is a significant move for the Trust where preliminary work has focused on attaining an above nurse to bed ratio of over 1 and in attaining a minimum nurse to patient ratio of 1:8 (days) and 1:10 (nights). This review will include the nationally recognised uplift of 22.4%. The review will consider all the available evidence and research including the National Nursing Research Units' recent overview of staffing research evidence paper; which quotes findings by Kane RL et al (2007) stating that "*Each additional Registered Nurse per patient per day was associated with a 4% decrease in the odds of death"*
The Associate Directors of Nursing will document and present these findings to the Divisional Team as part of the budget setting process for 2015/16.

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

During August and September 2014, 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. Similarly, the Matron role is to oversee nursing care standards, to hold the Ward Sisters and Charge Nurses to account, and to actively support improvements in nursing care. Matrons are currently required to work clinically and to support bed management. 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.

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 in November 2014.

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 Trust workforce plan has been submitted; newly qualified registrants were recruited in advance of qualifying in September 2014 to ensure a supply of Registered Nurses. Preparations are under way to repeat this exercise for nurses due to qualify in March 2015. In addition to this plans are in place to pursue overseas nurse recruitment if this is required. Prior to commencement of overseas recruitment into the Trust, Senior Nurses have agreed the following:

- Rolling programme of Monthly Trust wide recruitment for Registered Nurses;
- To reduce the use of flexi bank
- To deliver E-roster
- Actively recruit newly qualified students
- Develop a recruitment event
- Return to Practice uptake aim of 7 – 8 per year
- Deliver the Preceptorship Programme
- Develop Aspiring Nurse Leaders
- Participate in the Virtual Recruitment opportunity provided by the Nursing Times
- Utilise Cerner Millennium as a recruitment strategy

As part of the Cost Improvement Programme for nursing, it is proposed that Clinical Nurse Specialists will be working 2 ward based clinical shifts per month (from mid December 2014) to augment senior nurse experience at ward level.

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

To date the Clinical Commissioning Group (CCG) has not requested detail of nurse staffing levels. This requirement was raised at the CCG and WUTH Quality and Risk Meeting on 4 September 2014. The finalised CQC report will be discussed with the CCG to secure support for the Trust to move beyond minimum staffing levels and the current uplift of 16% in Ward areas, discussions are ongoing as to how this will be achieved.

3. Staffing Report

3.1 August 2014

The data provided for August 2014 demonstrated that minimum staffing levels were achieved across divisions. Although minimum staffing levels are achieved, in practice higher patient dependency sometimes means that more than minimum levels are required. This was challenging and delivered by close nurse management of nurses who were moved to fill gaps and to staff additional wards. This is not a sustainable model of nurse staffing management as it leads to staff dissatisfaction and dilution of the skill mix and expertise in the original area; this approach is not recommended in NICE guidance.

The staffing data provided for August demonstrated that in the majority of wards across the Trust, the required staffing levels were achieved. The following wards reported a shortfall in staffing levels of registered nurse levels (below the 95% average fill rate for Registered Nurses):

- Day shifts – Wards 12, 17, 21, 22, 54, 53
- Night shifts – Wards 24, OPAU, 30, 33/HAC, neonatal, children's ward, Ward M2 rehabilitation

The RAG scoring system for nurse staffing levels has still not been resolved at a national level. Therefore the Trust uses an internal measure of 95% and 90% fill rate of Registered Nurses required on each ward, this is used to bench mark against national staffing levels.

Whilst additional staff have been recruited to Ward 33 (Cardiology) and the Heart Assessment Unit, Registered Nursing staff from these wards have been relocated to staff contingency beds. This resulted in a ratio of one registered nurse providing care for fifteen acutely unwell cardiology patients, including patients in the heart assessment unit. Although there was no reported harm to patients during this time, the nursing staff have raised concerns through the Trust incident reporting system, expressing concern that they were not able to deliver all aspects of patient care. This was brought to the attention of the CQC in their responsive inspection in September. Actions taken by the division are that, as far as reasonably practicable the 3rd registered nurse on ward 33 is protected from being relocated from ward 33. There was a 15.75% increase in reporting of concerns in Quarter 2 from Quarter 1; as stated previously this is being actively monitored by the Senior Nursing and Midwifery Team (SNMT) to better understand if there are specific areas where staff are recording concerns which may need targeted action and support by the SNMT.

Extra shifts reflected patient acuity and dependency on Wards 32, CRC, 26, Medical Assessment Unit and Ward M2 Rehabilitation. Systems of control are in place to manage 'specials'.

3.2 September 2014

In September there has been deterioration in the average fill rate for Registered Nurses which has resulted in the following wards having less staff than the established required levels:

- Day shifts - Wards 10, 11, 12, 14, 17, 18 and Surgical Assessment Unit, 22, 23, OPAU, 30, 38, Male Assessment Unit

- Night shifts – Wards 10, 17, 21, 24, OPAU, 33/HAC, 38, Male Assessment Unit and the children's ward

Wards 12, 17 and 21 featured in both the August and September report as having less than 95% average fill rate for Registered Nurses.

There has been a significant improvement in the 95% fill rate for CSW confirmed by a reduction in Flexibank spend.

As previously stated there are significant concerns that Registered Nurses have been specifically relocated from Ward 33 / HAC for contingency wards and for September 2014 this action brought the fill rate down to 75% on Ward 33 / HAC. This is being monitored by the Division daily, and it has been agreed that Ward 33 will retain the 3 Registered Nurses at night. The impact is that the wards are working with lower ratios than the national requirement and at times unable to deliver all aspects of nursing care in a timely manner. Professional concerns around safe staffing have been raised within the Medical & Acute Division as per Nursing & Midwifery Council Code; the Director of Nursing & Midwifery has also raised concerns with the Executive Team and with the CEO about the pressure on nursing to fulfill the operational demands of the organisation whilst ensuring patient care needs are safely delivered. It is essential that nurses work to deliver the schemes identified in the Winter Plan to alleviate the pressure on nurse staffing. There are plans to consolidate early detection of infection and provide appropriate isolation facilities to minimize the impact of infection on nurse staffing.

3.3 Opening and Closing of Wards

3.3.1 Infection Control

The outbreak of CPE from 11 July 2014 continues to be a major challenge to nursing. The consequences of the outbreak resulted in the following actions:

- Ward 11 was closed up to 21 August due to outbreak of VRE within Orthopaedics
- The movement of the Urology ward to Ward 20
- Ward 14 was established as the CPE cohort ward, as the number of patients reduced on ward 14, beds were opened on other wards to deliver the service. So although initially the number of beds did not increase, the number of open wards placed extreme pressures on nursing.
- Ward M2 Rehabilitation closed on 11 July 2014 due to infection and part of the ward nursing staff were relocated to ward 14 (CPE cohort ward) . There were significant challenges to maintain safe staffing levels on these wards both ward sisters and matrons worked clinically to cover outstanding shifts.

3.3.2 Bed Capacity

- Due to internal bed pressures both Wards 22 and M2 reopened mid August 2014 whilst Ward 14 was operational to cohort patients with CPE, or highly exposed to CPE. There were significant challenges to maintain safe staffing levels on these wards and both Ward Sisters and Matrons worked clinically to cover these shifts.
- Ward 26 is staffed for 22 beds and is regularly opened to 29 beds to accommodate patient flow. The ward has been identified as a ward of concern and is undergoing performance management of its Patient Focused Audits. The additional beds on this ward have now been funded from urgent care monies. Recruitment for the additional staff is underway and has proven successful for CSW, but there are concerns regarding the availability of suitable registered nurses. Please see Expectation 9 for recruitment strategies.
- Ward 25 was opened on 14 July 2014 to accommodate additional surgical work as a result of Referral to Treatment times (RTT). Decisive action was taken by the division to close the ward on 1 September 2014 as a result of concerns raised by nursing and medical staff regarding the standard of care and patient safety. Recruitment was initiated as soon as the decision was made to open additional beds on ward 25 but there was a poor response to recruitment. The Trust workforce plan has been submitted; newly qualified registrants were recruited in advance of qualifying in September 2014 to ensure a supply of Registered Nurses. Preparations are under way to repeat this exercise for nurses due to qualify in March 2015.
- As a result of the closure of Ward 25, Ward 1 (Surgical Day Case Unit) was required to be opened to accommodate inpatients on 2 – 11 September and 16 – 17 September, which was, at the time, part of the Trust escalation plan. This option has now been removed from the escalation plan. This was an area of focus by the CQC during their responsive inspection in September 2014. Ward 1 was closed to inpatients; however as a result of this Ward 25 was re-opened on 11 September 2014. There have been significant challenges in staffing this unplanned capacity
- Due to internal bed pressures Ward 25 has remained open, accommodating up to 22 patients. This is currently unfunded and has resulted in staff being relocated from their base ward, supplemented with Flexibank staff and Agency nurses to enable minimum staffing levels of nurses with the right skills. This however has not been achieved on every shift and has relied on charge nurse and matrons working a

significant number of clinical shifts. The division is currently reviewing its pathways, bed capacity against demand, and discharge planning.

- The net impact at its height, was that the Trust had an additional 40 beds open during August / September 2014; of these 40 beds, 16 beds have been used throughout the financial year, these being 10 beds on medical day ward and 6 beds on Ward 26. These beds have now been funded as part of urgent care.

3.4 Nursing Performance

The Patient Focused Nursing and Midwifery Care Audits have now been in place for one year since implementation in November 2013. The results provide a level of assurance about performance and care delivered at ward level and enable early identification of areas of concern for escalation and action. During Quarter 1 five wards achieved a level of compliance rated green this was increased to seven wards at the end of Quarter 2. The detailed outcomes of the audits demonstrate variable compliance and are discussed below.

3.4.1 Improvement has been maintained in MEWS being completed on admission, scores of 4 – 6 and twelve hourly. Concern remains with MEWS scores of 1-3 and plans are in place to address this on the specific wards identified.

3.4.2 The Friends and Family test response performance for inpatients showed improvement from August and was rated green for September at 32% the forecast is that areas needed to reach 35% by the end of Quarter 2 .The net promoter score has fallen since the high of 77 in May 2014. The scoring against Friends and Family is a cause for concern; returning to the usual bed base will have a positive impact on this.

3.4.3 Patient Focused Nutrition and Hydration results identified that there has been a significant decline in performance against this measure. The overall Quarter 2 figures were significantly impacted by September's data, when the Trust was under a period of pressure. This coincides with deterioration in the average fill rate for Registered Nurses, and the significant challenges in staffing unplanned additional capacity.

3.4.4 We have sustained a tolerance of zero Grade 4 pressure ulcers. Incidence of Grade 3 ulcers requires further focus as achieving the 80% reduction of no more than 4has been breached as at Quarter 2 there were 5 recorded. Analysis of investigations performed on the patients acquiring Grade 3s identified:

- Inadequate skin inspection on admission and throughout episode
- Inaccurate recordings of the Braden score
- Lack of pressure ulcer prevention care plans

The daily review of all patients with a pressure ulcer of any description has served to highlight lapses in care which may contribute towards further deterioration of skin integrity. This information has been shared with the clinical teams to demonstrate that there is further focus required on pressure ulcer prevention and that there are changes to be implemented to ensure that staff are fully compliant with practices to prevent pressure ulcers forming or deteriorating to the next stage. Cerner implementation will assist with proactive risk management.

3.4.5 Trust wide incidents of Patient falls with serious harm for Quarter 1 and Quarter 2 are shown in the table below. There is a falls group led by a senior nurse investigates all serious incidents involving falls provides a report to both SNMT and Clinical Governance Group.

April	1
May	4
June	1
July	5
August	3
September	4

4. Next Steps

Using the framework in the NICE guidance for Safe Staffing the Divisions are undertaking a review in preparation for budget setting for 2015/16 as described in Expectation 5.

The Associate Directors of Nursing will present the outcome of the establishment/acuity review to the Director of Nursing & Midwifery which will form part of the Division's financial planning for 2015/16.

Further work will be required in the development of the Nursing quality dashboards to triangulate at Trust wide level the relationship between quality of care and nursing fill rates. This work will link with, and support, the continued development of ward performance dashboards, to provide comprehensive information and analysis of the patient experience, quality of care and safety in a timely and proactive way.

Work continues to address the issues identified by the Care Quality Commission. and further develop the Ward Performance Dashboards to

5. Conclusion and Recommendations

The Board of Directors is asked to note that during the months of August and September 2014 there have been serious concerns with regard to the provision of minimum staffing levels and 95% fill rate of registered nurses. Although challenging, minimum staffing levels were achieved in August, and there were occasions during September where the minimum staffing levels were not met, despite intense effort.

Whilst Nursing has responded to the organisational pressures: minimising the impact of an infection outbreak, responding to bed management issues, the requirements to deliver Cost Improvement Plans and minimising expenditure, has negatively impacted 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.

Nursing at all levels in the organisation is aligned to the delivery of the schemes in the Winter Plan that will have a positive impact on capacity and patient throughput to minimise the impact on nursing of opening additional capacity at short notice.

Plans to reduce the impact of infection on nursing in terms of cohorting infected patients and additional isolation are well-developed with particular emphasis on early detection and diagnosis of infection and appropriate isolation facilities.

A review of ward establishments, including the uplift requirement is currently under way and outcomes will be presented to the Executive Director of Nursing & Midwifery by November 2014. This information will inform the Annual Planning cycle and will be presented to the Board of Directors with recommendations.

There is also a review of the current bed capacity versus demand in the Division of Surgery Women and Children's and the results of this will also be presented to the Executive Team for their consideration.

The opening of additional beds is only ever done under the guidance of an experienced nurse, often out of hours this is with the Hospital Clinical Co-ordinator, and during hours with the ADN's. 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 Board of Directors are asked to receive this update and discuss the content in the context of the schemes to improve patient flow, capacity and infection prevention and control.

	Day		Night	
Ward name	Average fill rate - registered nurses/mi	Average fill rate - care staff (%)	Average fill rate - registered nurses/mi	Average fill rate - care staff (%)
10	98.2%	99.1%	97.0%	99.2%
11	100.0%	100.0%	98.5%	
12	93.5%	98.4%	97.8%	100.0%
14	98.8%	100.0%	97.8%	100.0%
17	91.2%	100.0%	95.7%	100.0%
18	95.4%	100.0%	100.0%	100.0%
21	90.6%	99.6%	96.6%	100.0%
22	92.2%	97.8%	98.2%	100.0%
23	95.1%	96.2%	95.9%	100.0%
24	96.3%	100.0%	90.0%	96.8%
OPAU	95.0%	97.0%	89.2%	92.0%
30	96.8%	100.0%	93.5%	100.0%
32	97.9%	110.8%	96.8%	116.1%
33 / HAC	97.1%	100.0%	82.3%	101.5%
36	97.1%	96.0%	95.2%	97.8%
38	97.1%	97.3%	91.1%	98.9%
26	95.7%	99.0%	95.2%	101.6%
MAAU	96.5%	99.6%	95.0%	102.1%
FAAU	97.1%	98.9%	98.6%	99.3%
EDRU	100.0%	100.0%	95.5%	100.0%
Parksuite	100.0%	100.0%	100.0%	
SAU	98.4%	100.0%	100.0%	100.0%
CCU	100.0%	100.0%	100.0%	100.0%
ITU	100.0%	100.0%	100.0%	
HDU	100.0%	100.0%	100.0%	100.0%
54	92.0%	100.0%	100.0%	
M1	100.0%	98.5%	100.0%	96.8%
M2	100.0%	100.0%	100.0%	100.0%
Delivery Suite	96.3%		95.4%	
53	92.8%	99.4%	100.0%	100.0%
Neonatal	72.3%		73.8%	
Childrens	96.6%	100.0%	94.4%	100.0%
CRC	95.4%	104.1%	100.0%	96.1%
Dermatology	100.0%	100.0%	100.0%	100.0%
36 CBH	96.8%	98.1%	94.4%	106.5%
Isolation	100.0%	100.0%	100.0%	100.0%

August

RGN Days

Ward	Fill	Reason
Neonatal	72.3%	Outstanding vacancies

RGN Nights

OPAU	89.2%	Outstanding vacancies
33 / HAC	82.3%	Staff relocated to fill contingency areas
Neonatal	73.8%	Outstanding vacancies

Extra shifts

CSW Days

32	110.8%	These additional shifts were for specials in a consecutive time period
CRC	104.1%	These additional shifts were for specials in a consecutive time period

CSW Nights

32	116.1%	These additional shifts were for specials in a consecutive time period
33 / HAC	101.5%	CSW used for Grade change / backfill
26	101.6%	Shift required Special
MAAU	102.1%	Shift required Special
36 CBH	106.5%	These additional shifts were for specials in a consecutive time period

	Day		Night				
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)			
10	93.6%	97.7%	94.9%	96.0%	**September**		
11	94.4%	93.8%	98.5%		**RGN Days**		
12	94.9%	98.6%	100.0%	96.8%	Ward	Fill	Reason
14	91.8%	88.5%	98.9%	98.3%	17	85.3%	Sickness and outstanding vacancy
17	85.3%	79.4%	94.4%	91.7%			
18	92.7%	89.8%	98.9%	98.4%	**RGN Nights**		
21	98.8%	98.5%	94.7%	100.0%	Ward	Fill	Reason
22	91.3%	92.4%	97.2%	99.2%	24	88.2%	Taken to cover contingency areas and vacancy
23	93.1%	96.8%	97.2%	100.0%	33 / HAC	75.0%	Taken to cover contingency areas
24	97.3%	99.5%	88.2%	100.0%	38	89.9%	Outstanding vacancy
OPAU	94.9%	95.7%	92.9%	95.0%			
30	90.9%	96.7%	100.0%	100.0%	**CSW Days**		
32	95.2%	96.8%	100.0%	100.0%	Ward	Fill	Reason
33 / HAC	100.0%	100.0%	75.0%	100.0%	14	88.5%	Sickness
36	98.3%	97.9%	96.7%	96.6%	17	79.4%	Outstanding vacancy
38	94.4%	98.5%	89.9%	100.0%	18	89.8%	Sickness
26	95.9%	99.5%	100.0%	100.0%			
MAAU	90.9%	95.2%	93.2%	97.8%	**Extra shifts**		
FAAU	95.2%	96.2%	99.3%	99.3%	**CSW Nights**		
EDRU	100.0%	100.0%	100.0%	100.0%	Ward	Fill	Reason
Parksuite	100.0%	100.0%	98.3%		CRC	100.7%	Additional staff for special
SAU	92.8%	97.4%	100.0%	100.0%			
CCU	100.0%	100.0%	100.0%	100.0%			
ITU	100.0%	100.0%	100.0%				
HDU	100.0%	100.0%	100.0%	100.0%			
54	100.0%	89.1%	100.0%				
M1	99.6%	99.7%	100.0%	100.0%			
M2	100.0%	100.0%	100.0%	100.0%			
Delivery Suite	97.6%	92.5%	99.0%	100.0%			
53	99.0%	92.7%	100.0%	100.0%			
Neonatal	98.5%		98.5%				
Childrens	95.5%	98.3%	93.8%	96.7%			
CRC	99.6%	96.4%	100.0%	100.7%			
Dermatology	100.0%	100.0%	100.0%	100.0%			
36 CBH	100.0%	98.7%	100.0%	100.0%			
Isolation	100.0%	100.0%	100.0%	100.0%			

Board of Directors		
Agenda Item	7.5	
Title of Report	Care Quality Commission – Action Plans	
Date of Meeting	26 November 2014	
Author	Joe Roberts, Head of Assurance	
Accountable Executive	Dr Evan Moore, Medical Director	
FOI status	Document may be disclosed in full	
BAF Reference	12	
Data Quality Rating	Bronze – qualitative data	
Level of Assurance	Full	Board confirmation

1. Executive Summary

This agenda item consists of two action plans, which will be included on the Trust risk register. The first action plan is to address the findings of the CQC responsive inspection which took place on 18th and 19th September. The second action plan is to prepare us for the main planned inspection which will take place before the end of December 2015 (the exact date is not yet known).

2. Background

The inspection in September was arranged in response to a number of concerns which had been raised directly with CQC by patients and members of our staff. The inspectors visited Accident and Emergency, and surgical and medical wards, with a particular focus on care of the elderly wards.

We were inspected against five standards: care and welfare of patients; records; respecting and involving service users; assessing and monitoring the quality of services; and staffing. We were judged to be non-compliant with all five. For two (records, care and welfare), CQC's concerns were graded 'moderate' (amber); for the other three, the concerns were 'minor' (yellow).

The inspection to take place in 2015 will be a planned inspection. Over a three year period, every Trust in England is to be inspected. Each inspection will cover eight core services: medicine; surgery; critical care; accident & emergency; maternity; paediatrics; end of life care; and outpatients. The inspection teams can number up to forty people, most of whom are practicing clinicians with experience of working in the types of services they are inspecting and who have been seconded from their NHS posts for short periods. The inspections include focus group meetings with Trust staff, and public meetings for the local population to give their views. This will be a more intensive level of scrutiny than we have ever experienced before.

3. Key Issues

A range of issues were identified by the inspectors in September, but in our response to the findings, several key themes emerged. The first is that there should be closer scrutiny of the standard of nursing care. A programme of Matrons' spot checks is in place, and this has been expanded and formalized, with the results collated and monitored centrally. We also concluded that the profile of nursing leadership at divisional and ward level should be raised, by defining expectations more clearly and rostering Matrons and band 7 nurses to work clinical shifts. Staffing levels were a concern, and the establishment review which is being completed against NICE guidance should help to ensure that all wards are staffed appropriately.

With regards to the forthcoming full-scale inspection, the principal challenges are to make staff aware of what is expected of them; to identify and improve areas where we may be under-performing; and to help staff to raise with management any concerns which they may have about the standard of service we are delivering.

4. Next Steps

Many of the actions in the action plan resulting from the inspection in September have already been completed and are just documented to assure the Board, and for the sake of completeness. On the weekend following the inspection, the Director of Nursing and her senior nursing colleagues worked on some of the wards which had been inspected and took corrective action over the following fortnight to deal with the problems they had seen. Most of the remaining actions are due for implementation no later than the end of December.

The action plan for the forthcoming inspection is a draft document and is subject to change. It is being presented to the Board to give a broad outline of how we intend to prepare and to seek feedback and approval for our approach.

5. Conclusion

The Trust's performance in the inspection was disappointing, not least because CQC's own quarterly Intelligent Monitoring Report assessed us as being in the lowest-risk band of hospitals. The report pointed out that our clinical governance and assurance processes are well-developed, but sometimes issues that are of concern at ward level may not reach the Board's attention, and vice-versa. Both of these action plans attempt to close this gap.

6. Recommendation

The Board is asked to review the attached action plans and comment on our planned approach.

Risk Reference No: *(Risk Mgt Use Only)*

Wirral University Teaching Hospital NHS Foundation Trust

GENERIC RISK ASSESSMENT FORM

This form is to be used for identification and mitigation plans for ad hoc risks which arise and do not replace any existing Health & Safety Risk Assessment tools - supplementary proformas are available from the Health & Safety Team.

RISK INFORMATION

Summary of risk (brief description to populate the Trust Risk Register):
There is a risk that we fail to correct the shortcomings which were identified by the CQC inspection which took place in September 2014. The effect of this would be that patients would receive care and treatment of an unsatisfactory standard, and that we may perform unsatisfactorily at the main CQC inspection which is due at some time during 2015.

Description of risk (background information / detail to give risk context):
The Trust was inspected by the Care Quality Commission on 18th and 19th September 2014. They visited the following clinical areas: Emergency Department; ward 1; 20; 21; 22; and 33. They inspected us against five of the Essential Standards: assessing and monitoring the quality of services; respecting and involving service users; care and welfare of service users; staffing; and records. We were rated as non-compliant with these five standards. For care and welfare, and records, the non-compliance was judged to have a moderate impact on patients. For the other three standards it was judged to have a minor impact.

Does this risk relate to national guidance standards / legislation: YES

If this risk relates to national guidance please outline: Care Quality Commission regulations

Does this risk affect patient safety? Yes

Division:	**Directorate:**	**Ward/dept:**	**Assessment date:**
Trustwide	N/A	N/A	

Which staff groups were involved in the assessment?
Senior nurses and managers from the clinical divisions, from Corporate Nursing and the Quality and Safety Department

Persons / groups at risk: staff and patients	**Frequency of exposure to the risk:** Daily

Existent control measures: (i.e. what is currently in place to reduce the risks)
Standard nursing documentation; risk assessments; corporate policies; ward staffing reports; workforce strategy; clinical audit; root cause analysis investigations; assurance framework

Does the risk meet any of the following criteria: (Please note only one option may be selected)

Audit	**IG**	**Internal alerts**	**CAS**	**Health & Safety**	**Medical devices**	**Confidential enquiry**
Annual plan	**CQC**	**NICE**	**Security**	**External review**	**Infection control**	
	X					

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

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

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

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

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

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

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

Table 1 – Consequence

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

	1	2	3	4	5
Descriptor	**No Harm / insignificant**	**Very low harm / minor**	**Low harm**	**Moderate**	**Severe/Death**
Clinical impact on the safety of patients (physical/ psychological harm)	No harm: Impact prevented- any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care. Minimal injury requiring no/minimal intervention or treatment No time off work	Impact not prevented any patient safety incident that ran to completion but no harm occurred to people receiving NHS funded care. Minor injury or illness, requiring minor intervention, will probably resolve within one month Staff injury requiring time off work or light duties for 6 days or less Hospital acquired **colonisation** affecting one or more patients, member of staff or the public	Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS funded care. Staff injury requiring time off work or light duties for 7 – 35 days Hospital acquired **infection** affecting one or more patients, members of staff/the public or where a bay closure occurs	Any patient safety incident that resulted in moderate increase in treatment and which caused significant but not permanent harm to one or more persons receiving NHS funded care Moderate increase in treatment is defined as return to surgery, an unplanned readmission, prolonged episode of care, extra time in hospital or as and outpatient , cancelling of treatment or transfer to another area such as ITU as a result of the incident Moderate/ major injuries/Dangerous Occurrences reportable under RIDDOR Requiring time off work or light duties for >36 days with eventual recovery Unexpected admission to critical care area with eventual recovery	Severe: any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS funded care. Death: any patient safety incident that directly resulted in the death of one or more persons receiving NHS funded care. Unexpected death or significant permanent disability where outcome is directly attributable to a safety incident All Never Events* (See list below) Part 1 of death certificate stating hospital acquired infection

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

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

Table 2 – Likelihood

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

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

Initial Risk Rating

Consequence Descriptor Used For Final Score: Statutory duty / inspections

Consequence Score **(C)**: 4

Likelihood Score **(L)**: 4

16 Risk Score **(C x L)**

Predicted Risk Rating (risk score after actions complete)

Consequence Descriptor Used For Final Score: Statutory duty / inspections

Consequence Score **(C)**: 0

Likelihood Score **(L)**: 0

0 Risk Score **(C x L)**

ACTION PLAN SUMMARY				
Issue	**Action**	**Responsible Person Name/Designation**	**Due Date**	**Completed Date**
Outcome 1 – Respecting and Involving people who use services				
Patients' Appearance and Hygiene On two wards patients were observed to look 'not well cared for' with little attention spent on their hair, facial hair and fingernails	Relaunch process of Patient Focused (intentional) rounding within Medical and Acute Specialties, and roll out in other clinical areas	Naomi Holder, Julie Tunney, Gaynor Westray	End Nov 2014	
	Recruit Patient Focused Rounding champions	Naomi Holder, Julie Tunney, Gaynor Westray	End Nov 2014	
	Revise Matron Ward Round checklist to include whether patient focused rounding has been done	Jill Galvani	End Sept 2014	September 2014
Dignity at the end of life CQC observed one instance where a patient was at the end of life and their dignity was not maintained by drawing the curtains around their bed.	Conduct an RCA investigation into the incident that was observed by CQC where a patient was not recognised as being at the end of life	Claire Price (Matron)	End Nov 2014	
	Review leadership arrangements of the ward where this was observed	Julie Tunney	End Sept 2014	September 2014
Ward 1 – Same Sex Accommodation The ward is a mixed sex ward but there is only one shower area, which is adjacent to the male patient bays. Our Escalation Policy does not mention the issue of same sex shower facilities.	Cease to use Ward 1 as an escalation area by removing it from the Escalation Policy	Jill Galvani	October 2014	October 2014
Ward 1 – Lack of Lockers Ward 1 did not have appropriate storage facilities, e.g. patient lockers, for patients to store their personal belongings securely.	As ward 1 will no longer be used as an escalation area, this is no longer an issue as lockers are not provided for day case patients.	Jill Galvani	October 2014	October 2014
Outcome 4 – Care and welfare of service users				
Availability of 'bumpers' A patient was found to be in a bed with rails and to have suffered a bruise. No padded rail covers had been used and staff said that the hospital did not have any of these or use them.	Procure bumpers and provide two to each ward	Margi Davies (Dementia Specialist Matron)	End Nov 2014	
Medical Early Warning Scores CQC noticed that in some cases not all observations had been completed, with the risk that doctors might not be alerted promptly to a deterioration in the patient's condition.	Implement red card alert system	Caroline Smith	End Nov 2014	
	Ensure staff on the wards where this was found, are aware of the exemption policy	Caroline Smith	End Sept 2014	22.9.14
	Monitor compliance through revised Matron's Ward Round	Matrons	End Sept 2014	Oct 2014
	Use laminated action cards by patient's bedside as a visual prompt of when MEWS next needs to be completed	All nursing staff	End Sept 2014	Oct 2014

	Investigate how the new Cerner Millennium electronic patient records system can be adapted to alert staff that observations need to be completed	Gaynor Westray	End Nov 2014	
Patients at risk of malnutrition CQC selected a random sample of four patients to review their nutrition plans. All four patients had lost significant amounts of weight in hospital. Food and fluid intake charts had not been completed so it was unclear whether they had received enough food.	Revise food chart and fluid chart to show weekly nutrition rather than daily, and to show dietetics plan on the chart rather than in the casenotes		End Oct 2014	October 2014
	Monitor the above as part of the revised Matrons' Ward Round checklist	Matrons	End Sept 2014	October 2014
Discharge Some relatives told the inspectors that they had been dissatisfied by the level of communication regarding a patient's discharge to a care home. Nine patients on ward 22 were medically fit for discharge but remained in hospital because there were no social care arrangements in place.	Revise Discharge Policy to provide greater consistency across the hospital and reflect the implementation of Millennium	Nicky Martin (Matron)	Dec 2014	
	Hold 'Check and Act' meetings consisting of divisional leadership triumvirates and ward sisters to review the cases of individual patients who present a problem regarding discharge	Julie Tunney, Gaynor Westray	Already occurring	September 2014
	Implement 'Ticket Home' project within clinical divisions	Julie Tunney, Gaynor Westray	Already occurring	September 2014
	Improve patient flow within the hospital by streamlining bed management in surgery with medicine, moving across to bed management team	Julie Tunney, Gaynor Westray	Nov 2014	November 2014
Outcome 13 - Staffing				
Ward 33 – Night-time staffing levels CQC observed from staff rotas that there were occasions when the target staffing level of one nurse to ten patients at night was not being met.	Plan on a daily basis through divisional staffing meeting to retain the third registered nurse on the ward	Julie Tunney	End Sept 2014	September 2014
General issues regarding staffing levels Several wards had not met the 90% fulfilment target for registered nurses on night shifts for reasons including: outstanding vacancies; short notice sickness; additional beds being opened; and staff being transferred to contingency areas. Current staffing levels allow only limited flexibility to respond to these situations. CQC observed that some wards were moved very frequently between wards, meaning that there was a lack of continuity in patients' care.	Target areas with high levels of sickness absence in certain areas of Medical Specialties by requesting additional support from the Absence Management Team and monitoring adherence with the Attendance Capability Policy through regular 1:1s with Matrons and Ward Sisters	Naomi Holder	End Sept 2014	September 2014
	Undertake full establishment review of current ward nurse staffing levels against NICE guidance to inform budget setting for 2015/16 financial year	Jill Galvani	End Sept 2014	October 2014
Outcome 14 – Supporting staff				
Leadership Visibility The topic of nursing leadership was not explicitly covered by the inspection report, but we consider that more visible leadership at ward level may help to identify some of the problems which CQC observed and ensure that they are dealt with promptly.	Meet with ward sisters and matrons to define clear expectations for individuals in those roles, and how they will be held to account	Julie Tunney, Gaynor Westray	End Sept 2014	September 2014
	Arrange for Band 7 sisters to be rostered for two clinical shifts per week, and for Matrons to be rostered for one clinical shift per week	Julie Tunney, Gaynor Westray	End Nov 2014	
	Ensure attendance by sisters and staff nurses from each area at the leadership event to be held on 1st October	Julie Tunney, Gaynor Westray	Oct 2014	October 2014

Supervision and Preceptorship Although this was not referenced in the inspection report, the Inspectors did speak to some new nurses who had not been able to access preceptorship.	Clinical Facilitators to complete spot check on records of twelve preceptees across the Trust	Practice Education Facilitators	End Sept 2014	
	Matrons to provide assurance over preceptorship arrangements in their own areas of responsibility – specifically that there are mentors for all staff who require preceptorship and that they meet regularly with their preceptors	Linda Ormson, Heather Gassab, Jasleen Kaur	End Nov 2014	
Outcome 16 – Assessing and monitoring the quality of services				
Patient Focused Audit The report commented that some of the issues which CQC had observed had not been identified by the Patient Focused Audit which is carried out monthly by Corporate Nursing and that *"this meant the systems in place had not identified some of the risks to inappropriate care and treatment at ward level".*	Review content of, and approach to, Patient Focused Audit, which will also need to be revised in any case to reflect the implementation of Cerner Millennium	Jill Galvani, Ronnie Devlin	End Nov 2014	
	Revise content of Matron ward rounds to focus more specifically on issues of concern	Jill Galvani	End Sept 2014	September 2014
	Develop a programme of mock inspections against the new CQC Fundamental Standards, based on the Lead Nurse Gemba walks which were done in 2012/13	Tracey Lewis, Joe Roberts	End Nov 2014	
	Improve response rate for Friends and Family Test in the wards which were visited by engaging with Consultants, making more use of promotional materials, and publishing achievement charts to compare results from different areas. This provides an extra source of assurance and a 'reality check' against which to compare our own audit results.	Naomi Holder	End Nov 2014	
Root Cause Analysis Reports CQC reviewed a sample of RCA reports. It was not clear from the reports whether root cause analysis tools and techniques were used, and there was no formal section in the report template for care and service delivery problems.	Review NPSA Level 1 and 2 template to include care and service delivery problems and a reference to the tools used	Tracey Bills	End Nov 2014	
Board Assurance Framework The Assurance Framework did not include risk scores and did not correlate with the risk register, making it difficult for the Board to understand the level of risk which the Trust was making and how this had changed over time.	The two Assurance Committees (Quality and Safety and Finance, Business Performance and Assurance) to review the BAF in terms of the generic natures of the risks, controls and assurances and also how they should be risk-scored	Carole Self	Oct 2014	October 2014
	Meet with Internal Audit to agree revised methodology for the Assurance Framework	Carole Self	End Nov 2014	
	Present revised Assurance Framework to Audit Committee for approval	Carole Self	Dec 2014	
Risk Ratings CQC considered that the risk ratings of entries on the risk register were not always appropriate to the severity of the risk presented.	The risk score of all risks on the risk register have been reviewed and agreed by the appropriate group as per the Trust Governance Structure. However it has previously been highlighted that the Trust does not currently use a residual risk score when actions are completed to mitigate the risk, therefore this will be reviewed in line with the full policy and process review of the Risk Management Strategy	Tracey Bills	End March 2014	
Outcome 21 - Records				

Record-keeping by nursing staff The inspectors found shortcomings and gaps in the following areas: - Bed rails assessments - Food and fluid intake charts - Discharge checklists - Information to be used by social workers regarding patients' rehabilitation, mobility and required level of supervision	Revise Matron Ward Round checklist – includes completion of documentation for DNAR, falls assessment, bedrails assessment and MUST	Jill Galvani, Gaynor Westray	End Nov 2014	
	Develop a daily ward routine, including a checklist for the Ward Sister / shift co-ordinator to complete	Gaynor Westray, Heather Gassab	End Sept 2014	September 2014
Discharge Plans CQC found that patients were not always provided with a clear written record of their discharge plan, with only verbal discussions taking place, and not being recorded.	See actions relating to discharge for outcome 4 above			
'This is Me' booklets for dementia patients The inspectors noted that for some dementia patients, these booklets, which document their needs, preferences, interests and likes and dislikes, had not been completed. This put the patients at risk of receiving inappropriate care.	Monitor whether 'This is Me' booklets have been given out and completed as part of the quarterly Dementia Carers and Relatives' Audit and escalate any areas of concern to ward sister or Matrons as appropriate	Margi Davies	End Dec 2014	

If further actions need to be recorded, please continue on a separate sheet and attach to this document

LEAD FOR RISK ASSESSMENT (TO BE ENTERED ONTO THE RISK REGISTER)		
Name	**Designation**	**Date**
Jill Galvani	Director of Nursing and Midwifery	
RISK ASSESSMENT COMPLETED BY:		
Name	**Designation**	**Date**
Joe Roberts	Head of Assurance	6.11.14
REPORTED TO (LINE MANAGER):		
Name	**Designation**	**Date**
Maryellen Dean	Associate Director of Risk Management	10.11.14
STAFF INVOLVED IN THE ASSESSMENT		
Name	**Designation**	**Date**
Julie Tunney	Associate Director of Nursing – Acute and Medical Specialties	5.11.14
Naomi Holder	Deputy ADN – Acute and Medical Specialties	5.11.14
Gaynor Westray	Associate Director of Nursing – Surgery	5.11.14

Linda Ormson	Deputy ADN - Surgery	5.11.14
Andrea Hughes	Interim Deputy Chief Nurse	5.11.14
Carole Self	Associate Director of Governance	4.11.14
Maryellen Dean	Associate Director of Risk Management	5.11.14
Tracey Bills	Risk Manager	10.11.14

Please send a copy of initial assessment and relevant reviews to: the Quality & Safety Department, APH
wih-tr.riskmanagement@nhs.net

Risk Reference No: *(Risk Mgt Use Only)*

Wirral University Teaching Hospital NHS Foundation Trust

GENERIC RISK ASSESSMENT FORM

This form is to be used for identification and mitigation plans for ad hoc risks which arise and do not replace any existing Health & Safety Risk Assessment tools - supplementary proformas are available from the Health & Safety Team.

RISK INFORMATION

Summary of risk (brief description to populate the Trust Risk Register):
There is a risk that the Trust fails to prepare adequately for the forthcoming CQC inspection, with the effect that we perform poorly. This would undermine public confidence and affect the organisation's future viability.

Description of risk (background information / detail to give risk context):
The Trust will undergo a full CQC planned inspection at some time before December 2015. The new inspection process is more thorough than the old. Eight core services (A&E, medicine, surgery, critical care, maternity, childrens' services, outpatients, and end of life care) are always inspected at every inspection. There are large inspection teams which include practising clinicians with experience of working in those types of services.

Does this risk relate to national guidance standards / legislation: YES

If this risk relates to national guidance please outline: Care Quality Commission Fundamental Standards

Does this risk affect patient safety? Yes

Division:	**Directorate:**	**Ward/dept:**	**Assessment date:**
Trustwide	N/A	N/A	11th November 2014

Which staff groups were involved in the assessment? Executive Directors, managers from the Quality and Safety department

Persons / groups at risk: Staff and patients	**Frequency of exposure to the risk:** Daily

Existent control measures: (i.e. what is currently in place to reduce the risks): CQC Evidence Portfolio, Compliance and Assurance Monthly Report, inspection action plan

Does the risk meet any of the following criteria: (Please note only one option may be selected)

Audit	**IG**	**Internal alerts**	**CAS**	**Health & Safety**	**Medical devices**	**Confidential enquiry**
Annual plan	**CQC**	**NICE**	**Security**	**External review**	**Infection control**	
	X					

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

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

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

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

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

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

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

Table 1 – Consequence

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

	1	2	3	4	5
Descriptor	**No Harm / insignificant**	**Very low harm / minor**	**Low harm**	**Moderate**	**Severe/Death**
Clinical impact on the safety of patients (physical/ psychological harm)	No harm: Impact prevented- any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care. Minimal injury requiring no/minimal intervention or treatment No time off work	Impact not prevented any patient safety incident that ran to completion but no harm occurred to people receiving NHS funded care. Minor injury or illness, requiring minor intervention, will probably resolve within one month Staff injury requiring time off work or light duties for 6 days or less Hospital acquired **colonisation** affecting one or more patients, member of staff or the public	Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS funded care. Staff injury requiring time off work or light duties for 7 – 35 days Hospital acquired **infection** affecting one or more patients, members of staff/the public or where a bay closure occurs	Any patient safety incident that resulted in moderate increase in treatment and which caused significant but not permanent harm to one or more persons receiving NHS funded care Moderate increase in treatment is defined as return to surgery, an unplanned readmission, prolonged episode of care, extra time in hospital or as and outpatient , cancelling of treatment or transfer to another area such as ITU as a result of the incident Moderate/ major injuries/Dangerous Occurrences reportable under RIDDOR Requiring time off work or light duties for >36 days with eventual recovery Unexpected admission to critical care area with eventual recovery MRSA Bacteraemia with eventual recovery Hospital acquired **infection** affecting > 1 bay	Severe: any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS funded care. Death: any patient safety incident that directly resulted in the death of one or more persons receiving NHS funded care. Unexpected death or significant permanent disability where outcome is directly attributable to a safety incident All Never Events* (See list below) Part 1 of death certificate stating hospital acquired infection Hospital acquired **infection** affecting > 1 ward
Health & Safety / Non clinical	Minimal injury requiring no/minimal intervention or treatment No time off work	Minor injury or illness, requiring minor intervention, will resolve in 6 days or less Staff injury requiring	Injury or illness, requiring intervention, is expected to resolve within one month Staff injury requiring	Major injuries / dangerous occurrences reportable under RIDDOR Staff injury requiring time off work or light duties for	An accident at work resulting in a fatality Significant permanent disability where outcome is directly

	1	2	3	4	5
Descriptor	**No Harm / insignificant**	**Very low harm / minor**	**Low harm**	**Moderate**	**Severe/Death**
impact on the safety of patients, staff or public (physical/ psychological harm)		time off work or light duties for 6 days or less	time off work or light duties for 7-35 days	>36 days with eventual recovery	attributable to a health and safety incident
Objectives / Projects	Insignificant project slippage Barely noticeable reduction in scope or quality	Minor project slippage Minor reduction in scope or quality	Serious overrun on project Reduction in scope or quality	Project in danger of not being delivered Failure to meet secondary objectives	Unable to deliver project Failure to meet primary objectives
Service / Business Interruption Environmental Impact	Loss / Interruption of service Up to 1 hour Minimal or no impact on the environment including contamination, not directly coming into contact with patients, staff or members of the public	Loss / Interruption of service 1 to 4 hours Minor impact on the environment	Loss / Interruption of service 4 to 8 hours Moderate impact on the environment	Loss / Interruption of service 8 hours to 2 days Major impact on the environment including ward closure	Loss / Interruption of service More than 2 days Catastrophic impact on the environment including multiple ward or hospital closure
Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training on an ongoing basis
Finance including claims	No obvious / small loss < £5k	£6k - £99k	£100k to £250k	£251k to £999k	Over £1m
Statutory duty/ inspections	No or minimal impact or breach of guidance/statutory guidance	Breach of statutory legislation reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices low performance rating. Critical report	Multiple breaches in statutory duty Prosecution Complete system change required Zero performance rating. Severely critical report
Adverse Publicity / Reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Element of public expectation not being met	Local media coverage – long term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the house). Total loss of public confidence

	1	2	3	4	5
Descriptor	**No Harm / insignificant**	**Very low harm / minor**	**Low harm**	**Moderate**	**Severe/Death**
Quality/ Complaints	Unsatisfactory patient experience not directly related to patient care Locally resolved concern	Overall treatment or service suboptimal Justified formal complaint peripheral to patient care	Treatment or service has significantly reduced effectiveness Justified formal complaint involving lack of appropriate clinical care, short term effects	Non-compliance with national standards with significant risk to patients if unresolved Justified multiple formal complaints. Serious mismanagement of care, long term effects	Totally unacceptable level or quality of treatment/service Ombudsman Inquiry Legal Claim
Information Governance	Less than 5 people affected or risk assessed as low e.g. files were encrypted	Serious potential breach & risk assessed high e.g. unencrypted clinical records lost. Up to 20 people affected.	Serious breach of confidentiality e.g. up to 100 people affected.	Serious breach with either particular sensitivity e.g. sexual health details, or up to 1000 people affected.	Serious breach with potential for ID theft or over 1000

Table 2 – Likelihood

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

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

Initial Risk Rating

Consequence Descriptor Used For Final Score: Statutory duty / inspection

Consequence Score **(C)**: 4

Likelihood Score **(L)**: 4

16

Risk Score **(C x L)**

Predicted Risk Rating (risk score after actions complete)

Consequence Descriptor Used For Final Score	Statutory duty / inspection
Consequence Score **(C)**	0
Likelihood Score **(L)**	0

0	Risk Score **(C x L)**

ACTION PLAN SUMMARY				
Issue	**Action**	**Responsible Person Name/Designation**	**Due Date**	**Completed Date**
Evidence Portfolio The current evidence portfolio is based on the sixteen *Essential Standards of Quality and Safety*. These are being replaced in April by the new Fundamental Standards.	Update portfolio of evidence and re-file according to the new Fundamental Standards	Joe Roberts, Karyn Dean	Dec 2014	
	Complete gap analysis based on this desktop document review and record on the Risk Register	Joe Roberts	Dec 2014	
Staff Awareness It is important that staff know that an inspection is to take place, the purpose of the exercise, and what is expected of them.	Organise information stall at audit day in November 2014	Joe Roberts, Mike Singleton, Claire Ashton	Nov 2014	
	Draft, design and circulate newsletters with information about the CQC standards and the inspection	Joe Roberts, Claire Ashton	Dec 2014	
	Draft information for inclusion in the Start the Week newsletter and other Trust-wide communications	Joe Roberts	Dec 2014	
	Organise and deliver presentations for staff groups during lunchtimes in the Education Centre, and also in wards / departments on request	Joe Roberts	Dec 2014	
	Identify Clinical Champions within divisions and specialties	Dr Evan Moore, Jill Galvani	Dec 2014	
Hands-on assurance It was evident from the recent unannounced inspection that we cannot rely solely on casenote-based audits to get our assurance and that we also need to be observing care actually being given on the wards, and speaking to staff and patients	Develop an inspection checklist by adapting the original mock inspection checklist used in 2012/13 to reflect the new Fundamental Standards and changes in Trust policies and processes	Joe Roberts, Tracey Lewis	End Nov 2014	
	Draw up a programme of departments to be visited, ensuring that all patient-facing clinical areas are inspected, whether they serve inpatients or outpatients, and that appropriate persons are involved, e.g. Executive Directors, Associate Directors of Nursing etc., depending on the areas to be visited	Joe Roberts, Tracey Lewis	End Nov 2014	
	Confirm governance and reporting arrangements for the mock inspections, i.e. which groups and committees will receive the reports	Joe Roberts, Tracey Lewis	End Nov 2014	
Performance Management Information We will need to be able to clearly identify which services and which wards / departments are likely to be of concern to the CQC Inspectors. Currently we have a lot of audit evidence but it is not always analysed down to ward level.	Develop and populate 'data packs' for each of the eight mandatory services that the inspection will cover	Joe Roberts, Mike Singleton	Dec 2014	
	Collate results of Q&S Audits, Nursing and Midwifery Patient Focused Audits, and mock inspections to RAG-rate wards and identify 'worry wards'	Joe Roberts, Mike Singleton, Johanna Ashworth-Jones	Dec 2014	
	Report this information on a monthly basis to the appropriate groups and committees	Joe Roberts, Mike Singleton, Johanna Ashworth-Jones	Dec 2014	

	Identify any areas for which there is a lack of performance data, e.g. outpatients, end of life care, and how this can be addressed	Joe Roberts, Mike Singleton, Johanna Ashworth-Jones	Dec 2014	
Staff Concerns In recent months members of staff have raised concerns directly with CQC on various occasions and this triggered the responsive inspection which took place in September 2014. We should do more to ensure that our employees are aware of how to raise concerns through internal channels, and feel confident to do so.	Raise awareness of existing internal channels through which concerns can be raised	Dr Evan Moore, Jill Galvani, James Mawrey	Dec 2014	
	Consider establishing additional means by which concerns can be raised, e.g. safe havens, or Ambassadors for Cultural Change	Dr Evan Moore, Jill Galvani, James Mawrey	Dec 2014	
Public Engagement As part of their inspection, CQC hold listening events for residents of the local area to share their views about our services. The Trust has well developed systems to record the views of patients and carers, but we also need to know the views of the wider public so that we know what to expect from these listening events.	Liaise with Health Watch Wirral to see what information they hold which could be useful, and what they would be prepared to share with us	Mike Chantler, Mark McKenna	Dec 2014	
	Organise public engagement events, e.g. stalls in local town centres with questionnaires, etc. to obtain feedback from the wider population in preparation for the inspection	Joe Roberts, Mike Chantler	Dec 2014	

If further actions need to be recorded, please continue on a separate sheet and attach to this document

LEAD FOR RISK ASSESSMENT (TO BE ENTERED ONTO THE RISK REGISTER)		
Name	**Designation**	**Date**
Dr Evan Moore	Medical Director	12.11.14
RISK ASSESSMENT COMPLETED BY:		
Name	**Designation**	**Date**
Joe Roberts	Head of Assurance	12.11.14
REPORTED TO (LINE MANAGER):		
Name	**Designation**	**Date**
Maryellen Dean	Associate Director of Risk	12.11.14
STAFF INVOLVED IN THE ASSESSMENT		
Name	**Designation**	**Date**
Jill Galvani	Director of Nursing and Midwifery	11.11.14

Please send a copy of initial assessment and relevant reviews to: the Quality & Safety Department, APH
wih-tr.riskmanagement@nhs.net

Board of Directors		
Agenda Item	8.1	
Title of Report	Emergency Planning and Business Continuity Update	
Date of Meeting	26 November 2014	
Author	Andrea Hughes, Interim Deputy Chief Nurse Rob Cooper, Divisional Manager, Acute Care	
Accountable Executive	Jill Galvani, Director of Nursing and Midwifery	
FOI status	Document may be disclosed in full Document includes FOI exempt information Entire document is exempt under FOI	
BAF Reference	14	
Data Quality Rating	Silver – quantitative data that has not been externally validated	
Level of Assurance	Full	Board confirmation

1. Executive Summary

Under the Civil Contingencies Act (2004), NHS organisations and providers of NHS funded care must show that they can effectively respond to emergencies and business continuity incidents while maintaining services to patients. This work is referred to in the health service as 'emergency preparedness, resilience and response' (EPRR). Under the Act, the Trust is identified as a Category 1 responder. Category 1 responders are those organisations at the core of emergency response.

The NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) are the minimum standards which NHS organisations and providers of NHS funded care must meet and are included in the NHS standard contract and, through this, the NHS Commissioning Board Emergency Planning Framework (2013). The director level accountable emergency officer and/or governing body in each organisation are responsible for making sure these standards are met.

The Care Quality Commission Essential Standards of Quality and Safety (2010) look specifically at what providers should do to make sure that people who use the service, workers and others who visit are as safe as they can be and that risks are managed. Emergency planning duties are referenced in Outcome 6.

This report is to assure the board of the process and the self assessed compliance with the revised core standards for EPRR and to approve the actions identified.

2. Background

Each NHS organisation is required to ensure that they have in place robust command and control mechanisms to enable them to plan for and respond to major incidents in coordination with the command and control arrangements of the wider response community.

All NHS organisations are required to deliver their responsibilities as defined by the Civil Contingencies Act (CCA) 2004. In addition, from 1 April 2013 as part of the changes that the Health and Social Care Act (2012) made to the health system in England, the EPRR responsibilities of strategic health authorities (SHAs) and primary care trusts (PCTs) were transferred to the NHS commissioning board (NHS CB) and to clinical commissioning groups (CCGs). Local health resilience partnerships (LHRPs) are now the forum for coordination, joint working and planning for EPRR across all relevant health bodies.

The 2014/15 EPRR Assurance Process is based on the revised Core Standards. To comply with the national requirements the Local Health Resilience Partnership LHRP has requested that each organization:

1) Undertake a self-assessment against the revised core standards identifying the level of compliance for each standard (red, amber, green);

2) Submit an action plan addressing any areas of improvement required;

3) Complete the statement of compliance identifying the organisation's overall level of compliance - full, substantial, partial, non;

4) Present the above outcomes to the Board of Directors or through appropriate governance arrangements where the Board has delegated their responsibility for EPRR

Following assessment, the organisation has to declare to the NHS England via the LHRP as demonstrating compliance from the four options in the table below against the core standards.

This statement of compliance is signed by the organisations' Accountable Emergency Officer, and is reported to the organisation's Board/ governing body.

Compliance Level	Evaluation and Testing Conclusion
Full	The plans and work programme in place appropriately address all the core standards that the organisation is expected to achieve.
Substantial	The plans and work programme in place do not appropriately address one or more the core standard themes, resulting in the organisation being exposed to unnecessary risk.
Partial	The plans and work programme in place do not adequately address multiple core standard themes; resulting in the organisational exposure to a high level of risk.
Non-compliant	The plans and work programme in place do not appropriately address several core standard themes leaving the organisation open to significant error in response and /or an unacceptably high level of risk.

NHS organizations are required to undertake a 'live' major incident test at least every 3 years, in order to ensure both competence and effectiveness of staff and processes are maintained. On the 26th March 2014, a 'live table top' exercise entitled 'Exercise Echo' was undertaken in conjunction with Wirral Community NHS Trust. This was reported to the Operational Management Team in April 2014. The event included representation from NHS England who passed the exercise as compliant with requirements. The exercise was positive, highlighting many areas of excellent practice with all 'fictitious' casualties following pre-set pathways.

3. Outcomes and Key Issues

The Trust has completed the required self-assessment against the 47 core standards applicable to Acute Trusts and has concluded that there are no Red areas of concern, 7 Amber areas requiring further improvement with the remainder being green. The Trust overall therefore is evaluated as being substantially compliant as described above.

Areas identified as requiring improvement to achieve compliance are:

- Recruitment to the role of Emergency Planning Officer, as identified in previous reports to Sub-Board Groups and during the self assessment
- Clarity about the representation at local, regional and national forums
- Co-ordination of emergency and business continuity planning and operation across the organisation
- Establishment of a forward plan which includes revision of policies and associated governance actions
- Establish and undertake the required training, and plan validation activities
- Refresh plans in light of new and emerging requirements

4. Next Steps

1. Recruitment to the role of Emergency planner is being progressed who will coordinate the development of the detailed action plan in response to the 2014/15 Self assessment.
2. The plan will be submitted to the Quality and Safety Committee and monitored on a regular basis.
3. Exceptions will be reported to the Quality and Safety Committee.

5. Conclusion

The Trust has plans in place to respond to a major incident which have been reviewed and tested on the 26 March 2014.

The Trust has self assessed against the NHS England's revised Core Standards for Emergency Preparedness, Resilience and Response and is declaring Substantially Complaint.

6. Recommendations

The Board of Directors is asked to note the content of this report and the proposed governance arrangements for the development and monitoring of the improvement plan.

Board of Directors		
Agenda Item	8.2	
Title of Report	Equality and Diversity Report	
Date of Meeting	26 November 2014	
Author	Michael Chantler – Head of Patient Experience	
Accountable Executive	Jill Galvani – Director of Nursing & Midwifery	
FOI status	Document may be disclosed in full	
BAF Reference	All	
Data Quality Rating	Silver – quantitative data that has not been externally validated	
Level of Assurance	Incomplete	Board confirmation

1. Executive Summary

This report details the progress the Trust is making to meet its obligations to advance Equality and Diversity from both a workforce perspective and in its role as a major provider of healthcare services on the Wirral.

The report provides a brief overview of the Equality Act 2010 and associated public sector duties and provides commentary on the following subjects:

- Assessing the impact of our services on diverse groups
- Engagement activity with diverse groups
- Access to services for diverse groups
- Understanding experience
- Workforce composition
- Training and Development

It also includes an overview of the Equality Delivery System and the process for developing Equality & Diversity objectives.

2. Equality Act 2010

The Equality Act 2010 consolidated previous equality legislation in one legislative framework with associated duties for public sector organisations. It introduced the statutory Public Sector Equality Duty (PSED) as detailed below:

Public Sector Equality Duty (PSED)

The public sector equality duty requires public bodies to consider equality when carrying out their day-to-day work, in shaping policy, in delivering services and in relation to their own employees.

It also requires that public bodies:

- have due regard to the need to eliminate discrimination
- advance equality of opportunity
- foster good relations between different people when carrying out their activities

This is called the **General** duty. In addition to the general duty, there are specific duties which require public bodies to publish relevant, proportionate information showing compliance with the Equality Duty, and to set equality objectives. The information contained within this report meets the requirement of the specific duties as part of PSED.

The Act also defined a number of groups that have protected characteristics as follows:

- Gender
- Age
- Disability
- Race
- Sexual Orientation
- Religion or belief
- Pregnancy and Maternity
- Marriage and Civil Partnership
- Gender reassignment

3. Equality Delivery System

The Trust is required to develop Equality Objectives to demonstrate its ongoing commitment to Equality & Diversity and to address any gaps in service provision that impacts on anyone with a protected characteristic. The principle method by which Equality & Diversity objectives are being developed is via an assessment using the NHS Equality Delivery System (EDS) framework. An initial internal assessment has been completed against the 4 goals and outcomes of EDS; this will be subject to external verification by local representative groups, including Healthwatch in December 2014.

Goal 1 - Better Health Outcomes		**Initial Assessment Rating Undelivered/Delivering/Achieving/Excelling**
1.1	Services are commissioned, procured, designed and delivered to meet the health needs of local communities.	Achieving
1.2	Individual people's health needs are assessed and met in appropriate and effective ways.	Delivering

1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed.	Delivering
1.4	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse.	Achieving
1.5	Screening, vaccination and other health promotion services reach and benefit all local communities.	Achieving
Goal 2 – Improved Patient Access and Experience		
2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds.	Achieving
2.2	People are informed and supported to be as involved as they wish to be in decisions about their care.	Achieving
2.3	People report positive experiences of the NHS.	Achieving
2.4	People's complaints about services are handled respectfully and efficiently.	Achieving
Goal 3 – A representative and supported workforce		
3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels.	Achieving
3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfill their legal obligations.	Achieving
3.3	Training and development opportunities are taken up and positively evaluated by all staff.	Achieving
3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source.	Achieving
3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives.	Achieving

3.6	Staff report positive experiences of their membership of the workforce.	Achieving
Goal 4 – Inclusive Leadership		
4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations.	Delivering
4.2	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed.	Undelivered
4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination.	Delivering

4. Assessing the impact of our services on diverse groups

A specific requirement of the PSED General Duty is for public sector bodies to consider Equality and Diversity when delivering its services, shaping policy and in relation to its workers.

An Equality Analysis tool was implemented in 2012 to meet this requirement and to provide a framework to assess the impact of any new policy, strategy or business change in the organisation. The requirement to complete an Equality Analysis was incorporated into the policy development process and in this regard the process is robust. All policies since 2012 are only ratified if there is a fully completed Equality Analysis present for the approving group to consider alongside the policy.

This requirement also extends to reports, strategies or business development proposals being considered by the Board of Directors or other principle approving groups within the Trust's governance structure. The requirement to complete an Equality Analysis was built into the relevant cover sheets/report templates in 2012; however this has been removed with subsequent revisions to the cover sheets. There is currently no reference in cover sheets of Equality and Diversity or the requirement to consider Equality and Diversity as part of either the main content of any report, strategy or business proposal or by completing an Equality Analysis.
This does present a risk as any external scrutiny of decisions made by the organsiation may require the Trust to evidence how it has considered the impact of any decision on people with protected characteristics under the Equality Act 2010. This is particularly relevant where any decision is subject to judicial review.

5. Access to services

Facilities Management

The Trust has a designated Access Champion within the facilities department whose role is to ensure that the organisation complies with the provisions of the Disability Discrimination

Act 1995 in both its current and future development proposals. Examples of this activity in 2013/14 include the redevelopment of the main entrance at Arrowe Park Hospital and the reconfiguration of the Emergency Department.

Procurement

The Trust has appropriate processes in place to ensure that potential service providers or contractors can evidence their compliance with the Equality Act 2010 during the tendering process.

Interpretation and Translation

In order to meet the needs of service users whose first language is not English, the Trust has a number of providers in place to meet interpretation and translation requirements. These are summarised as follows:

Action on Hearing Loss – provides face to face British Sign Language interpretation for either planned or emergency admissions to hospital.

Beacon Languages – provides face to face interpretation across a range of languages, mainly for planned admissions to hospital.

Language Line – this service is mainly used in emergency situations and is telephone based.

The following table summarises the spend on Interpretation and Translation services between 2011- 2014.

Name of Supplier	April 2011 to end March 2012	April 2012 to end March 2013	April 2013 to end March 2014
Action on Hearing Loss	£24,454.25	£30,678.35	£39,684.21
Novas Languages	£20,800.00	£17,351.28	N/A
Beacon Languages	N/A	£10,084.97	£40,408.13
Language Line	£1,564.68	£906.36	£1,410.24
TOTAL	**£46,818.93**	**£59,020.96**	**£81.502.58**

Improving care for patients with Learning Disabilities

This has been a significant area of focus for the Trust since 2010 and over the last four years the Trust has implemented innovative solutions for patients admitted with a Learning Disability. This has been primarily driven by the use of the Reasonable Adjustment (RA) Care Plan. The RA Care Plan assesses the patient's needs and provides a decision tool to determine the level of support required. For patients with the greatest need, this may require the Trust to pay for their own care provider to attend to assist with the patient's admission and stay in hospital.

In addition to the introduction of the RA Care Plan, Learning Disability training was delivered to all staff in 2011 and this has since been supplemented by localised training by exception. Providing information in Easy Read has also been a particular focus and principle hospital communications are now available in Easy Read format, these include the 'Coming into Hospital' elective brochure, the Ward Bedside Information Folder as well as the Trust Quality Accounts. Information about care and treatment in Easy Read are also available from Aido. The Trust works with Community Action Wirral to provide information in Easy Read and any information is reviewed by a Learning Disability service user panel for acceptance testing.

Providing an electronic flagging system for patients with Learning Disability has been a key aspiration for the Trust prior to the implementation of Cerner Millennium. The flagging system to date has been manual and forms part of the nursing assessment documentation. An electronic flag has been developed and will be live with Cerner 2b and the main requirements of the RA Care Plan are also built into Cerner 2b. The Trust will complete a retrospective flagging exercise by December 2014 to load flags onto patient records, this uses the patient information held by Cheshire and Wirral Partnership Trust.

The Trust's Safeguarding Team has a significant involvement in the planning process for patients with severe learning disabilities, especially when there is asociated challenging behaviour. They work with community and clinical staff to ensure that the RA Care Plan is used to appropriately manage the patient's admission, this may include visits to the patient's home and undertaking desensitisation visits prior to admission. This has been particularly successful in the dental pathway and the Trust has a specific theatre list for patients with learning disabilities. This work was presented at the National Dental Association Annual Conference in April 2014.

Whilst the actions taken to date have been encouraging, the Trust has recognised that there is still work to do to fully embed the RA Care Plan into day to day practice. A working team has been established as a sub team of the Patient & Family Experience Group to review the work undertaken to date and to plan future actions. The Trust will be holding a Learning Disability 'Big Conversation' in December 2014 which will involve staff from both the Trust and Community as well as service users and carers.

Religious and Spiritual needs

The Chaplaincy service within the Trust is multi faith and services are held in the hospital chapel as well as Chaplaincy staff visiting patients on wards. The Chaplaincy service will make necessary referrals to other faith groups in the community were required.

The Trust has a prayer/faith room available for both staff and patients and also has a spiritual needs information resource available for staff on the Trust Intranet.

6. Engagement activity with diverse groups

We have continued to engage with many groups across our community, many of which represent people with protected characteristics. These include the Older Peoples Parliament, Community Action Wirral, Carers Association, WIRED (Wirral Information Resource for Equality and Disability) Wirral Multicultural Organisation and the Alzheimer's Society. The Older Peoples Parliament has a quarterly meeting with the Director of Nursing & Midwifery and this provides an opportunity to discuss any issues arising from their members.

Some of the most prominent activities throughout 2013/14 have been as follows:

- Launch of Carers Week at Arrowe Park Hospital attended by the Mayor and the Trust Chief Executive.
- Supporting the Older Peoples Parliament in its recognition of the United Nations Older Persons Day
- WUTH hosting the Alzheimer's dementia forum at Arrowe Park Hospital.

The Trust has also continued its already strong relationship with Healthwatch and supports its activity by facilitating enter and view visits as well as the Trust participating in Heathwatch

events within the community. Both Healthwatch and the Older Peoples Parliament are standing members of the Patient and Family Experience Group.

7. Understanding experience

The Trust has varied methods of understanding the experience of our service users. Optional demographic data was included in the Learning with Patients Questionnaire from 2010 and this has enabled us to understand if there are any variances in experience according to demographical data. We are one of the few Trust's nationally to have this level of understanding.

		WUTH		Female		Male		BRM		Disability		16-30		31-64		65+	
		n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
I was provided with information that helped me understand my care	2011-12	3464	84	449	84	388	84	36	72	924	83	163	75	1412	88	1410	88
	2012-13	8363	87	4033	87	2825	88	33	76	2040	84	554	81	4008	87	3496	87
	2013-14	This question is no longer asked in this format															
I was involved as much as I wanted to be in decisions about my care and treatment	2011-12	3499	76	462	70	387	70	36	72	936	90	162	76	1423	80	1432	74
	2012-13	8435	76	4050	77	2849	77	37	70	2063	71	560	77	4009	78	3538	76
	2013-14	5368	74	1848	76	1437	73	41	73	1187	67	320	72	764	74	1808	74
I was treated with courtesy & respect	2011-12	3480	95	455	93	390	96	40	95	931	93	161	88	1415	96	1429	96
	2012-13	8438	96	4066	95	2863	97	41	95	2092	95	557	91	4020	95	3549	97
	2013-14	This question is no longer asked in this format															
My privacy & dignity was maintained when being examined	2011-12	3430	98	448	98	385	98	40	93	919	97	163	95	1399	98	1398	91
	2012-13	8307	98	4009	98	2834	99	35	100	2053	98	555	96	3979	98	3494	99
	2013-14	3954	94	1710	94	1338	94	41	81	1144	93	301	91	616	93	1593	96
I got the care that mattered to me	2011-12	3291	98	434	97	365	98	33	91	869	97	161	93	1377	98	1333	98
	2012-13	8021	98	3925	97	2735	99	27	100	1963	97	551	95	3926	98	3335	98
	2013-14	5376	98	1864	97	1482	99	45	100	1185	97	317	97	761	96	1828	98

Overall, patient's experiences are generally positive from a demographic perspective especially with patients stating that they got the care that mattered to them. There are however some specifics that will require further analysis as follows:

- Involvement in decisions about care and treatment for disabled patients has shown a decline to 67% in 2013/14.
- Information to help patients understand their care and treatment is lower for patients from Black and Racial Minorities (BRM) communities, people with a disability and for younger people.
- Privacy and Dignity for patients from BRM communities has shown a decline to 81% although the sample size in very small.

8. Workforce Composition

Understanding our workforce composition by Equality and Diversity demographics is important to ensure that we are a fair and open organisation and to monitor the effectiveness of our policies and procedures.

Workforce data as at 31/10/14

Gender	Total
Female	4531
Male	1210
Grand Total	5741

The workforce numbers by gender reflects the fact that the largest staff group is nursing and that this group is predominately female. This is reflective of most NHS Acute Trusts.

Band	Female	Male	Grand Total
Band 1	438	93	531
Band 2	1035	276	1311
Band 3	412	109	521
Band 4	282	63	345
Band 5	1061	137	1198
Band 6	634	111	745
Band 7	357	68	425
Band 8A	74	31	105
Band 8B	25	13	38
Band 8C	17	8	25
Band 8D	2	1	3
Band 9	1		1
M&D	175	284	459
Other	18	16	34
Grand Total	4531	1210	5741

The gender split by band does not reflect any significant issues; however it is encouraging that women are well represented in senior grades.

Age Band	Total
30 and under	1013
31-40	1295
41-50	1523
51-60	1556
61-65	292
65+	62

Disabled	Total
No	1403
Not Declared	410
Undefined	3878
Yes	50
Grand Total	5741

Understanding how many staff have declared a disability is dependent on disclosure and this is mainly captured at recruitment, therefore there will most likely be staff who have been in the Trust for a number of years who have not declared a disability. There is also evidence that people with disabilities are more reluctant to share this information with their employer, this is not restricted to the NHS but is an issue across employment in general.

The Trust has appropriate policies and processes in place to support disabled employees in the workplace. Any consideration for reasonable adjustments is managed through Occupational Health and were appropriate the governments Access to Work scheme is used to part fund any necessary adjustments in the workplace.

Ethnic Origin	Total
White - British	5196
White - Irish	32
White - Any other White background	39
White Unspecified	2
White English	1
White Greek	2
White Turkish	2
White Italian	1
White Irish Traveller	1
White Polish	2
White Other European	9
Mixed - White & Black Caribbean	1
Mixed - White & Black African	5
Mixed - White & Asian	5
Mixed - Any other mixed background	5
Mixed - Black & Asian	1
Mixed - Chinese & White	2
Mixed - Asian & Chinese	2
Asian or Asian British - Indian	166
Asian or Asian British - Pakistani	18
Asian or Asian British - Bangladeshi	4
Asian or Asian British - Any other Asian background	14
Asian Mixed	4
Asian East African	1
Asian Sri Lankan	4
Asian British	2
Asian Unspecified	5
Black or Black British - Caribbean	3
Black or Black British - African	28
Black or Black British - Any other Black background	2
Black Nigerian	1
Black Unspecified	1
Chinese	13
Any Other Ethnic Group	24
Filipino	1

Malaysian	1
Other Specified	29
Undefined	2
Not Stated	110
Grand Total	5741

Sexual Orientation	Total
Bisexual	14
Gay	15
Heterosexual	2057
I do not wish to disclose my sexual orientation	497
Lesbian	14
Undefined	3144
Grand Total	5741

Disclosure of sexual orientation is a sensitive subject and currently the only way in which this is captured is at recruitment. The recorded numbers for the organisation are very low and what is more evident is that 497 staff have chosen to not to disclose their sexual orientation.

The EDS assessment framework Goal 3 refers to a Representative and Supported Workforce. Whilst the Trust has many policies and processes in place to support staff, our knowledge of staff with protected characteristics such as disability and sexual orientation is limited and as part of the EDS objective setting the Trust may wish to progress an exercise to offer staff the opportunity to refresh their details on the Electronic Staff Record. This would require careful positioning and is closely linked to the wider organisational culture; it would also require visible commitment by the Trust's leadership.

9. Training and Development for staff

Equality & Diversity training is part of the Essential Training Matrix and is completed by staff every 3 years or at Trust Induction. A new Equality and Diversity training booklet was sent to all staff in October 2014.

The following numbers of staff have received Equality & Diversity training at Trust Induction since 2011.

2011-12: 391

2012-13: 628

2013-14: 567

10. Supporting young people into work

Apprenticeships

The Trust's Apprenticeship has achieved national recognition by being awarded the National Apprenticeship Service Large Employer of the Year Award for the North West and shortlisted to the top twelve in England for its work on providing high quality training, development and jobs for 16-23 year olds across Wirral. In the past 3-months alone the Trust has taken on nine apprentices across roles such as Healthcare Assistants, Laboratory and Pharmacy Technicians, New Born Hearing Screeners and Clinical Administration to support patient

care. We have a 100% success rate for our apprentices gaining their Level 2 Intermediate Apprenticeship which is equivalent to 5-GCSEs including English and mathematics and 69% progressing to a Level 3 Advanced Apprenticeship equivalent to 2-A Levels. The transition into a permanent post has been a huge success and the value that young people bring to the organisation in enthusiasm, energy and ideas has been recognised across the Trust.

Traineeships

The Trust led the way in Merseyside in introducing Traineeships. This programme for 16 to 24 year-olds supports young people to develop the skills they need to secure and succeed in employment or apprenticeships. We are providing a 3 month programme linked to participants gaining work skills, GCSE English and mathematics and work experience is a setting of their choosing. Staff across the Trust invest their time and experience in developing these young people and with the majority wanting to understand the role of Healthcare Assistant this investment will be reaped in the future and we already have our first trainee gaining employment in this role. With our partnership with Wirral Metropolitan College we have seen other organisations support this initiate and have seen an overall success rate of 50% where participants have gained employment. At present we have trainees working in our Surgical Wards supporting patient care and some being trained on our new Cerner Millennium system.

Supported Internships

Supported Internships are for young people with severe learning difficulties and/or disabilities aged 16 to 24 with a Statement of Special Educational Needs, a Learning Difficulty Assessment, or an Education, Health and Care Plan who want to move into employment and need extra support to do so. The Trust is running the Merseyside pilot and has provided training, support and work placements across the Trust in clinical areas, facilities and administration roles for nine months to June 2014. The parents have commented on the change in the interns since they started and their colleagues have seen them grow and participate in supporting patient care.

11. Key Issues

The EDS assessment and verification process will identify gaps in meeting the goals and outcomes which in turn will lead to the development of Equality and Diversity objectives. There are two issues arising from the production of this report which require more timely action as follows:

- Equality Analysis requirements for reports, strategies or proposals that may impact on people with protected characteristics - it is recommended that this is reintroduced into the relevant report templates/cover sheets and an audit is completed on the principle decisions that have been made by the Trust within the last two years to assess any relevant risk.
- A more detailed analysis of patient experience data is completed to understand the reduction in some indicators.

12. Next Steps

The Board of Directors is asked to note this report. It is recommended that a further report is submitted in February 2015 detailing the results of the EDS assessment and verification along with draft objectives for approval. The Patient and Family Experience Group will monitor actions against objectives once these are agreed by the Board of Directors.

Board of Directors		
Agenda Item	9.1	
Title of Report	Month 7 Monitor Compliance Report	
Date of Meeting	26 November 2014	
Author	Alistair Mulvey, Director of Finance	
Accountable Executive	Alistair Mulvey, Director of Finance	
FOI status	Document may be disclosed in full	
BAF Reference	13	
Data Quality Rating	Gold – externally validate	
Level of Assurance	Full	Board confirmation

EXECUTIVE SUMMARY

The Trust is on monthly monitoring for finance due to its financial position. It is therefore required to submit a template showing the financial position each month and a (brief) commentary on the year to date and in month I&E position at quarter end. It is not required to submit any financial or governance certifications, these are part of the separate quarterly submission.

The Trust is now required to submit its commentary to Monitor on Working day 10, therefore it has been agreed that the Director of Finance, Chief Executive and Chairman review the paper in advance of submission and that post submission the report is circulated to the members of the Finance Business Performance and Assurance Committee (FBP&AC) for information on submission. This process was followed in month.

The Board of Directors is asked to note the commentary that has been sent to Monitor for Month 7.

Month 7 2014/15 Financial Commentary for Monitor

The following commentary covers the key reasons for the Month 7 year to date variations against the 2014/15 plan and the movements in month 7.

The Trust posted a surplus in month of £494k against a planned in month surplus of £586k, this position reduced the actual year to date deficit from c£5.1m to c£4.7m, although the Trust remains c£0.7m away from its planned cumulative deficit position of £4.0m at this stage of the year.

NHS Clinical Revenue

As at the end of Month 7 there is a gain of £1.9m against planned levels, a gain of £0.4m in month.

Key variances for Month 7 are as follows:

Point of Delivery	Month 7 variance £m	Cumulative variance to plan £m	Commentary
Elective	0. 2	(0.1)	On a cumulative basis the variance is largely driven by an underperformance in Surgical specialties of £1.1m, partly offset by an over performance in Medicine of £0.2m and through additional patients cared for under the national RTT initiative which organisations were not aware of during the planning period and additional North Wales activity, totaling £0.9m, secured in year to support achievement of Welsh access targets, again this was unknown during the initial planning submission timelines. The in month over achievement mirrors the cumulative position with regards to RTT and North Wales note above. Previous underperformance of Trauma and Orthopaedics has slowed in the month to £36k.
Non elective	0.0	1.7	Over performance in the Medicine & Acute Division continues across specialties at £1.7m and also Surgery and Women & Children's Division by £0.2m. There is a £0.9m reduction for activity over and above the non elective block which is offset by the readmission cap and other income risk adjustments. In month the gains in Medicine & Acute (£0.3m) and Surgery/Women & Children's (£0.2m) and the readmission block gain of £0.1m are offset by the non elective block agreement (£0.6m) which has changed significantly in month due to a reduction in uncoded activity.

Day Case	(0.1)	0.5	On a cumulative basis there has been an over-performance in Gastroenterology of £0.3m, Cardiology of £0.1m, Clinical Haematology £0.2m and Vascular of £0.4m. In addition, £0.4m has been generated through RTT work and from activity from North Wales. These are offset by underperformances in Opthalmology (£0.3m), Trauma and Orthopaedics (£0.3m), Upper GI (£0.1m) and Gynecology (£0.2m). In month the small adverse movement was due to total Surgery and Women & Children's underperformance of £0.2m, partly offset by additional work from North Wales / RTT activity of £0.1m.
Outpatients	(0.1)	(0.1)	Outpatient procedures are cumulatively £0.1m over plan. Outpatient Attendances (both first and follow up) are continuing to underperform across most specialties with a total value of £0.5m. The key areas being Gynecology and Paediatrics. Included in this total is a reduction of £0.4m for the outpatient follow up cap penalty. The balance of the variance is due to additional RTT and North Wales activity of £0.4m. The in month adverse variance mirrors that of the year to date narrative.
A&E	0.2	0.6	This area continues to over perform due to increased activity by circa. £0.2m, but is offset by a penalty for activity that has breached the 4 hour wait threshold of £0.3m. It also includes non-recurrent Urgent Care/Winter funding of £0.7m released in year at a national level. In month, as compliance with the national A & E access standard has improved penalties have reduced and additional winter pressures resource has been applied to offset expenditure already incurred.
Other – tariff	(0.0)	(0.2)	The year to date and in month underperformance is due to Unbundled Diagnostic Imaging of £0.2m.
Other non tariff	0.2	(0.5)	Over and under performances in a number of Non PbR areas, in particular over performance in Direct Access Radiology £0.4m, Pathology £0.1m and Device Exclusions £0.3m. Offset by an under recovery on AMD (£0.2m), Renal Block (£0.3m), Critical Care (NNU) (£0.3m), High Cost Drugs (£0.3m), Audiology (£0.2m) and High Cost Bloods (£0.1m). CQUIN is reported at breakeven and is planned at 90%.

			In month the £0.2m favourable variance is generated by a number of small over recoveries, in particular Adult Critical Care, Direct Radiology and Device Exclusions, offset partly by underperformances in the Renal Block and Rehabilitation Unit.
Total	**0.4**	**1.9**	

Included in the above figures is a £1.6m increase in NHS Clinical income due to Income Generation schemes across a range of points of delivery (with a net value of £1.2m). This is remains marginally ahead of planned levels.

Other Income and Operating Expenditure

Net costs are cumulatively above plan at Month 7 by £2.7m, an increase of £0.6m in month. The key elements are:

Reason for variance	Month 7 Variance £m	Cumulative variance to plan £m	Commentary
CIP delivery	(0.1)	(1.7)	At the outset of the year, it was recognized that not all the recurring and cash CIP schemes would be implemented and delivered from the start of the year, as noted in more detail below. The consequence of this is that cash slippage for the year against the CIP and cost avoidance plan for divisional expenditure and income (net of costs of delivery) is £1.7m, across most cost categories. In month there has been an increase in this adverse variance of less than £0.2m.
Reserve release	0.3	2.8	As at Month 7 the Trust has released £2.8m of reserves. In month only £0.25m of reserves were released, which continues to be considerably lower than earlier in the year.
Emergency care	(0.1)	(0.7)	The Trust has invested in emergency care from reserves in year therefore this variance is expected to be lower for the rest of the year. However, there remains a small pressure as vacancies are filled by flexible labour as recruitment continues, therefore this variance has increased marginally in month by £0.1m.
Unplanned beds / capacity	(0.1)	(0.5)	Costs have risen in month due to increases in surgical capacity to accommodate RTT and welsh activities covered by associated income.
Premium costs	(0.3)	(1.4)	Planned and unplanned activity at premium prices. This has increased by £0.3m in month which is above trend due to high agency costs to cover leave and vacancies, largely in Radiology and Theatres within Clinical Support.
Additional activity	(0.1)	(0.9)	There has been over spend of £0.9m which has been directly offset by an increase in NHS clinical income, most notably the income for the RTT scheme, the additional Welsh activity and Urgent Care. This variance has increased by over £0.1m in month.
Non PBR offset	(0.1)	0.0	There is now a cumulative breakeven position on items offset by a reduction in non PbR income (e.g. High Cost Drugs, Bloods and Device exclusions).

			There has been a £0.1m change to this variance in month due to an overspend in device exclusions.
Other	(0.1)	(0.3)	There has been a year to date overspend of £0.3m on "other" expenditure/loss of income such as specialling, sickness and maternity cover, loss of private patient income, other overspends, etc., partly offset by vacancies. Minimal variation in month.
Total	**(0.6)**	**(2.7)**	

EBITDA

The favourable year-to-date NHS clinical variance and the operational adverse variance therefore give an unfavourable Month 7 EBITDA variance of £0.8m, and £0.1m in month.

Post EBITDA Items

There is a minor favourable variance to the post EBITDA budget at month 7 of £0.1m due to the underspend on the capital programme against plan. This variance has increased in Month 7, due to the delay in Cerner spend.

Therefore, although there has been a £0.5m reduction in the overall actual deficit position from £5.1m to £4.6m there is a marginal, £0.1m, further deterioration against plan.

Achievement of the 2014/15 Cost Improvement Programme

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

The Trust continues to work closely with FTI and its recently appointed Turnaround Director to continue to strengthen both in year delivery and sustainable future delivery.

The CIP position at Month 7 (including cost avoidance and non recurrent schemes) can be summarised as follows:

	BY SCHEME TYPE		**BY COST**		**TOTAL**
	Income Generation (net of cost of delivery) £m	**CIP (including cost avoidance)** £m	**NHS Clinical Income** £m	**Divisional Budgets** £m	£m
Year to date Budget (including unidentified at time of plan)	1,096	4,870	1,359	4,607	**5,966**
Year to date Actual	1,150	3,377	1,634	2,893	**4,527**
Year to date Variance	54	(1,493)	275	(1,714)	**(1,439)**

Statement of Position (Balance Sheet)

The actual Total Assets Employed and Total Taxpayers Equity equal £147.7m.

The main variations against plan are as follows:

- Trade receivables across NHS and non NHS are largely on plan. With early receipts from debtors and internal cash actions have been partly offset by invoices raised for additional work and other over performances

- There is a £2.4m debtor for the planned sale of Springview which has not yet taken place. This is now expected in December 2014, at a sale value of c£3.3m

- Trade creditors and accruals are significantly higher than planned due to delays in the receipt and agreement of charges received, creditors for contract underperformance (due to the difference between the planned and contracted income and under performance against the contract) and the internal cash management changes

- Deferred income is higher than planned due to the receipt of the "maternity prepayment" monies

- Capital spend (on accruals basis) for month 7 was £7.1m against a plan of £8.7m. This variance of £1.6m is due to the decision to lease equipment that was due for purchase at £0.6m and slippage on the Cerner and IT projects of £1.4m, (of which £1.0m is offset by delays on PDC drawdown) and other smaller variances

- The Trust submitted a reforecast of its capital spend at quarter 1. The forecast to Month 7 was £8.4m, therefore there is a £1.3m variance. This is due largely to a £0.8m timing difference on Cerner spend, a delay on Endoscopy spend of £0.3m and other smaller variances

- Borrowings – the Trust has drawn down the first tranche of the loan with the ITFF at £2.1m

- There is a variance of £1.0m for the PDC not drawn down against the Cerner spend above. This is part of a £3.5m allocation in 2014/15 which is still due to be spent this year and was built into the Trust's reforecast

- The cash balance at the end of Month 7 was £15.2m, being £11.2m above the planned £4.0m. As noted above, this is due to the significant increase in creditors and accruals, slippage on capital payments, the maternity deferred income, and the draw down of the first tranche of the loan. Within these variances are also those improvements derived from the internal cash management work undertaken which impact the month end cash position. These increases have been partly been offset by the delays in the receipt from the sale of Springview and the bottom line position

- The overall position returns a Continuity of Services rating of 2, in line with plan

Alistair Mulvey
Director of Finance
November 2014

APPENDIX 1 - INCOME STATEMENT

October Reporting - Income Statement

Wirral University Teaching Hospital NHS Foundation Trust

	FY 14/15		
	FT Plan	**Actual**	**Variance**
	October 2014	October 2014	Octobber 2014
	Year to Date	Year to Date	Year to Date
	£m	£m	£m
Operating			
NHS Clinical Revenue			
Elective revenue, long stay:			
Tariff revenue	£14.423	£14.332	£(0.091)
Elective revenue, short stay:			
Tariff revenue	£0.000	£0.000	£0.000
Non-Elective revenue:			
Tariff revenue	£43.733	£45.452	£1.719
Planned same day (day case):			
Tariff revenue	£16.468	£16.919	£0.451
Outpatients:			
Tariff revenue	£21.149	£21.008	£(0.141)
Non-Tariff revenue	£0.000	£0.000	£0.000
A&E:			
Tariff revenue	£5.809	£6.385	£0.576
Other NHS Activity:			
Direct access & Op, all services (Tariff revenue)	£1.692	£1.504	£(0.188)
Maternity Pathway (Tariff revenue)	£3.602	£3.603	£0.001
CQUIN revenue (Non-Tariff revenue)	£3.007	£3.007	£(0.000)
Diagnostic tests & Imaging revenue (Non-Tariff revenue)	£2.608	£3.122	£0.514
Critical care - Adult, Neonate, Paediatric (Non-Tariff revenue)	£6.843	£6.724	£(0.119)
High cost drugs revenue from commissioners (Non-Tariff revenue)	£5.154	£4.880	£(0.274)
Other drugs revenue (all types all bands including Chemotherapy) (Non-Tariff revenue)	£1.425	£1.612	£0.187
Other (Non-Tariff revenue)	£31.252	£30.489	£(0.763)
Total	**£157.164**	**£159.037**	**£1.873**
Non Mandatory / non protected revenue			
Private Patient revenue	£0.918	£0.508	£(0.410)
Other Non Mandatory / non protected clinical revenue	£0.854	£0.564	£(0.290)
Total	**£1.772**	**£1.072**	**£(0.700)**
Other operating income			
Research and Development income	£0.190	£0.331	£0.141
Education and Training income	£5.386	£5.519	£0.133
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	£0.710	£0.779	£0.069
Catering Income	£1.168	£1.182	£0.014
Revenue from non-patient services to other bodies	£4.461	£5.028	£0.567
Misc. Other Operating Income	£3.120	£3.233	£0.113
Total	**£15.035**	**£16.072**	**£1.037**
Total Operating Income	**£173.971**	**£176.181**	**£2.210**
Operating Expenses			
Employee Benefits Expenses	£(120.798)	£(117.445)	£3.353
Employee Benefits Expenses - agency and contract staff	£0.000	£(5.406)	£(5.406)
Drug Costs	£(12.238)	£(11.797)	£0.441
Clinical Supplies and Services	£(17.632)	£(18.533)	£(0.901)
Non Clinical Supplies and Services	£(2.960)	£(3.300)	£(0.340)
Consultancy expense	£0.000	£(0.084)	£(0.084)
Movement of Impairment of receivables	£0.000	£0.210	£0.210
Misc other Operating expenses	£(16.397)	£(16.676)	£(0.279)
Total operating expenses	**£(170.025)**	**£(173.031)**	**£(3.006)**
EBITDA	**£3.946**	**£3.150**	**£(0.796)**
Non operating income and expense			
Interest income	£0.172	£0.121	£(0.051)
Interest expense on Non commercial borrowings	£(0.136)	£(0.142)	£(0.006)
Interest expense on finance leases	£(0.042)	£(0.043)	£(0.001)
Depreciation and amortisation - owned assets	£(4.821)	£(4.697)	£0.124
Depreciation and amortisation - donated assets	£(0.168)	£(0.113)	£0.055
Depreciation and amortisation - finance leases	£(0.168)	£(0.169)	£(0.001)
Other Finance Costs - Unwinding Discount	£(0.030)	£(0.030)	£0.000
PDC dividend expense	£(2.729)	£(2.729)	£0.000
Loss 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)	**£(3.976)**	**£(4.652)**	**£(0.676)**
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	**£(3.976)**	**£(4.652)**	**£(0.676)**

APPENDIX 2
BALANCE SHEET

October Reporting - Balance Sheet

Wirral University Teaching Hospital NHS Foundation Trust

	FY 14/15		
	FT Plan October 2014 £m	**Actual** October 2014 £m	**Variance** October 2014 £m
Non current assets			
Intangible Assets - Donated or granted	£0.000	£0.000	£0.000
Intangible Assets - Purchased or created	£11.893	£12.259	£0.366
Property, Plant and Equipmen - Donated or granted	£2.276	£2.268	£(0.008)
Property, Plant and Equipment - Purchased or constructe	£158.681	£157.114	£(1.567)
NHS Trade Receivables, Non-Current	£0.000	£0.000	£0.000
Other non current receivables	£2.134	£2.105	£(0.029)
Impairment of Receivables for Bad & doubtful debts	£(0.405)	£(0.276)	£0.129
Total non current assets	**£174.579**	**£173.470**	**£(1.109)**
Current Assets			
Inventories	£4.446	£4.305	£(0.141)
NHS Trade Receivables	£7.362	£6.484	£(0.878)
Non-NHS Trade Receivables	£0.905	£1.435	£0.530
Other Receivables	£1.529	£1.951	£0.422
Assets Held for Sale	£0.000	£2.435	£2.435
PDC Receivables	£0.000	£0.000	£0.000
Impairment of Receivables for Bad & doubtful debts	£(0.067)	£(0.278)	£(0.211)
Accrued Income	£1.400	£1.312	£(0.088)
Prepayments	£3.482	£3.068	£(0.414)
Cash and cash equivalents	£4.012	£15.204	£11.192
Total Current Assets	**£23.069**	**£35.916**	**£12.847**
Current liabilities			
Current loans	£(0.265)	£(0.574)	£(0.309)
Deferred income	£(2.289)	£(3.945)	£(1.656)
Provisions, current	£(0.707)	£(0.723)	£(0.016)
Trade Creditors	£(7.646)	£(15.288)	£(7.642)
Taxation payable	£(3.917)	£(3.751)	£0.166
Other Creditors	£(2.828)	£(2.430)	£0.398
Capital Creditors	£(1.270)	£(1.720)	£(0.450)
Accruals	£(7.880)	£(9.332)	£(1.452)
Payments on account	£(0.900)	£(0.900)	£0.000
Finance leases, current	£(0.347)	£(0.347)	£0.000
Interest payable on non commercial loans	£(0.019)	£(0.032)	£(0.013)
PDC creditor	£(0.390)	£(0.389)	£0.001
Total Current Liabilities	**£(28.458)**	**£(39.431)**	**£(10.973)**
Net Current Assets / (Liabilities)	**£(5.389)**	**£(3.515)**	**£1.874**
Liabilities, non current			
Loans, non current, non commercial	£(5.041)	£(7.820)	£(2.779)
Deferred income, non current	£(11.758)	£(11.758)	£0.000
Provisions for Liabilities and Charges	£(2.590)	£(2.485)	£0.105
Finance leases, non current	£(0.239)	£(0.239)	£0.000
	£(19.628)	**£(22.302)**	**£(2.674)**
Total Assets Employed	**£149.562**	**£147.653**	**£(1.909)**
Taxpayers equity			
Public Dividend Capital	£72.385	£71.366	£(1.019)
Retained earnings	£30.351	£29.233	£(1.118)
Revaluation reserve	£46.826	£47.054	£0.228
Total Taxpayers Equity	**£149.562**	**£147.653**	**£(1.909)**

APPENDIX 3
CASH FLOW

October Reporting - Cashflow

Wirral University Teaching Hospital NHS Foundation Trust

	FY 14/15 FT Plan Year to Date October 2014 £m	Actual Year to Date October 2014 £m	Variance Year to Date October 2014 £m
Surplus/(deficit) after tax	**£(3.976)**	**£(4.652)**	**£(0.676)**
Finance income/charges	£0.006	£0.094	£0.088
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	£5.157	£4.979	£(0.178)
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	£2.729	£2.729	£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	**£7.892**	**£7.802**	**£(0.090)**
Movement in Working Capital			
Inventories	£0.000	£(0.168)	£(0.168)
NHS Trade receivables	£1.282	£3.050	£1.768
Non NHS Trade receivables	£0.077	£(0.393)	£(0.470)
Other receivables	£(0.217)	£(0.083)	£0.134
Assets held for sale	£0.000	£(2.435)	£(2.435)
Accrued income	£(0.217)	£(0.049)	£0.168
Prepayments	£(1.902)	£(1.216)	£0.686
Deferred income	£(0.360)	£1.124	£1.484
Provisions for Liabilities and Charges	£(0.008)	£(0.124)	£(0.116)
Tax payable	£(0.001)	£(0.124)	£(0.123)
Trade Payables	£(1.907)	£3.098	£5.005
Other Payables	£(0.314)	£(0.330)	£(0.016)
Payment on Account	£0.000	£0.000	£0.000
Accruals	£(0.760)	£1.182	£1.942
	£(4.327)	**£3.532**	**£7.859**
Net cash inflow / (outflow) from operating activities	**£(0.411)**	**£6.682**	**£7.093**
Investing activities			
Property - new land, buildings or dwellings	£(1.953)	£(0.830)	£1.123
Property - maintenance expenditure	£(0.350)	£(1.084)	£(0.734)
Plant and equipment - Information Technology	£(2.066)	£(0.278)	£1.788
Plant and equipment - Other	£(0.889)	£(1.042)	£(0.153)
Expenditure on capitalised development	£0.000	£0.000	£0.000
Purchase of intangible assets	£(3.393)	£(3.828)	£(0.435)
Increase/(decrease) in Capital Creditors	£(0.330)	£0.358	£0.688
	£(8.981)	**£(6.704)**	**£2.277**
Net cash inflow / (outflow) before financing	**£(9.392)**	**£(0.022)**	**£9.370**
Financing activities			
Public Dividend Capital received	£3.500	£2.481	£(1.019)
Public Dividend Capital paid	£(2.339)	£(2.455)	£(0.116)
Interest (Paid) on non commercial loans	£(0.117)	£(0.117)	£0.000
Interest element of finance lease rental payments	£(0.042)	£(0.043)	£(0.001)
Capital element of finance lease rental payments	£(0.189)	£(0.190)	£(0.001)
Interest (Paid) / Received on cash and cash equivalents	£0.172	£0.119	£(0.053)
Drawdown of non commercial loans	£0.000	£3.087	£3.087
Repayment of non commercial loans	£(0.133)	£(0.133)	£0.000
Non current receivables	£2.400	£2.443	£0.043
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	**£(6.140)**	**£5.170**	**£11.310**
Opening cash and cash equivalents	£10.152	£10.034	£(0.118)
Net cash (outflow) / inflow	£(6.140)	£5.170	£11.310
Closing cash and cash equivalents	**£4.012**	**£15.204**	**£11.192**

APPENDIX 4
RISK RATING

Key Ratios / Risk Rating 2014/15

Based on October 2014 Reported Performance

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

Wirral Hospital Position

Financial Criteria	**Weight %age**	**Metric to be scored**	**2014/15 ratings - Actual**		**2014/15 ratings - Plan**	
Liquidity Ratio (Days)	50%	Liquidity Ratio (Days)	-12.45	**2**	-12.15	**2**
Capital Servicing Capacity (Times)	50%	Capital Servicing Capacity (Times)	1.00	**1**	1.27	**2**
		Weighted average risk rating		**1.50**		**2.00**
		Overall Risk Rating		**2**		**2**

Board of Directors		
Agenda Item	9.2	
Title of Report	CQC Statement of Purpose – Annual Update	
Date of Meeting	26 November 2014	
Author	Joe Roberts, Head of Assurance	
Accountable Executive	Dr Evan Moore, Medical Director	
FOI status	Document may be disclosed in full	
BAF Reference	11	
Data Quality Rating	N/A	
Level of Assurance	Full	Board confirmation

1. Executive Summary

The attached document is a draft of version 4 of the Statement of Purpose which the Trust is required to produce by the Care Quality Commission, and is being presented to the Board for approval.

2. Background

The Care Quality Commission require all organisations which are registered with them to produce a Statement of Purpose. This document should describe the aims and objectives of the Trust, the services it provides, and the locations from which those services are managed and delivered. It must also define the legal status of the organisation (in our case an NHS Foundation Trust) and provide the address and other contact details. We are not specifically required to describe the organisational management structure but we consider it helpful to the reader's understanding to list the services under the divisions by which they are managed.

We first produced this document when we registered with the Care Quality Commission in 2010 and it has been updated annually each year since then. In the past the Quality and Safety Committee has approved the document on behalf of the Board. This year the Statement of Purpose is being presented to the Board of Directors as a whole for approval.

This draft was produced by the Head of Assurance and submitted to each of the divisional Associate Directors of Operations for comment, as they would be in a position to identify any inaccuracies regarding the services in their areas of responsibility.

3. Key Issues

The most significant change compared to the previous edition is to reflect the new divisional structure which took effect in September 2014 following the Corporate Restructuring. The remaining changes are more minor, e.g. changes to the names or venues of services.

The document describes the organization as it is at the time of writing and – with the exception of the delayed move of Pharmacy from Corporate Services to Clinical Support – does not take account of any future changes which may be proposed. If there are any further significant changes, the Statement of Purpose will need to be revised again.

4. Next Steps

Following approval of the attached document, a copy of the Statement of Purpose will be sent to the Care Quality Commission for their records.

5. Conclusion

This draft of the Statement of Purpose is considered up to date and ready for approval.

6. Recommendation

The Board is asked to approve the attached document.

WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST STATEMENT OF PURPOSE

Introduction to the Trust

Wirral University Teaching Hospital NHS Foundation Trust is one of the biggest and busiest acute NHS trusts in the North West region and employs more than 5,600 staff.

The Trust was established as an NHS Foundation Trust on July 1st, 2007 and has around 9,000 Public Members, represented by a Council of Governors consisting of 13 elected Public Governors, 5 elected Staff Governors, and 4 nominated Stakeholder Governors.

The Trust provides a full range of acute healthcare services to around 400,000 people across the Wirral peninsula, the Ellesmere Port and Neston areas of Cheshire, and beyond, operating from two separate sites:

- **Arrowe Park Hospital,** Upton, which offers a full range of emergency and acute services for adults and children, and maternity neo natal intensive care (level 3) and gynaecology services at Wirral Women and Children's Hospital

- **Clatterbridge Hospital,** Bebington, which is home to most of the planned surgical services and some specialist rehabilitation services. Another separate Trust, Clatterbridge Cancer Centre, is also based on the Clatterbridge site, and Cheshire and Wirral Partnership Trust have premises there too

The Trust provides some services from other venues, including premises belonging to other Trusts. Some dialysis services are provided at the Countess of Chester Hospital. X-ray services and some outpatient clinics, are delivered at Victoria Health Centre in Wallasey, and St Catherine's Hospital in Tranmere. In addition some services are provided in the community, at GP practices, and in patient's own homes, although they are managed from one of the Trust's two sites listed above.

The Trust is led by a Board of Directors consisting of the Chairman, the Chief Executive, six Executive Directors and six Non-Executive Directors. Following a restructure which took effect in September 2014, there are three Clinical Divisions, each headed by a triumvirate consisting of a Clinical Head of Division (a Consultant), an Associate Director of Operations, and (with the exception of Clinical Support), an Associate Director of Nursing. The Clinical Support Division also includes some non-clinical services, such as Hotel Services. Administrative services such as finance, estates and human resources are the responsibility of the Corporate Services Function. Pharmacy services are also managed within Corporate Services, reporting to the Medical Director, for a six month interim period following which they will move to Clinical Support.

Aims and Objectives

The Trust aims to be locally focussed and regionally significant, and to be the first choice health care partner for the communities which it serves, supporting patients' needs from the home through to the provision of regional specialist services. Its values are encapsulated by the slogan '**PROUD**':

- **P**atients at the heart of everything we do
- **R**espect each other every day
- **O**ur hospitals are your hospitals
- **U**nited to provide the best possible patient care
- **D**edicated to excellence

The Trust's corporate objectives for the five year period from 2013 to 2018 are listed below:

- **To be**: The Top NHS Hospital Trust in the North West for Patient, Customer and staff satisfaction
- **To Lead On**: Integrated, Shared Pathways of Care with Primary, Social and Community Care
- **To deliver**: Consistently High Quality Secondary Care services enhanced through the provision of regional specialist services
- **To ensure**: Our people are aligned with our vision
- **To maximise**: Innovation and Enabling Technologies
- **To build on**: Partnering for value
- **Supported by**: Financial, Commercial and Operational Excellence

The Trust's three clinical divisions (Medicine and Acute Services; Surgery, Women and Children; and Clinical Support), and its Corporate Services Function all share the Trust-wide goals but also have their own local targets to ensure that these overall goals are achieved by individual services.

The Trust receives most of its income from the local Clinical Commissioning Group (CCG) and from the Local Area Team of NHS England. The CCG sets out its commissioning intentions through service development plans, and through a commissioning intentions document. National and local CQUIN (Commissioning for Quality and Innovation) targets are also agreed to improve quality.

CQC Registration Information

Activities and Service Types

The Trust registered with the Care Quality Commission in April 2010. It is registered to undertake the following activities:

- Treatment of disease, disorder or injury
- Surgical procedures
- Diagnostic and screening procedures
- Transport services, triage and medical advice provided remotely
- Maternity and midwifery services
- Termination of pregnancy
- Nursing care
- Family planning services
- Assessment or medical treatment for persons detained under the Mental Health Act

CQC also define a range of 'service types'. The following are relevant to this Trust:

- Acute Services
- Long-term conditions services
- Hospital services for people with mental health needs, and / or learning disabilities, and / or problems with substance misuse
- Rehabilitation services
- Community healthcare services
- Dental services
- Diagnostic and screening services
- Urgent care services

Management Contacts

The Chief Executive – e-mail david.allison1@nhs.net

The Medical Director, Dr Evan Moore, leads on CQC-related issues within the Executive Team – e-mail evan.moore@nhs.net

Both can be contacted by telephone via the switchboard on 0151 678 5111.

Registered Locations

The Trust has three registered locations, the addresses of which are as follows:

Arrowe Park Hospital
Arrowe Park Road
Upton
Wirral
CH49 5PE

Clatterbridge Hospital
Clatterbridge Road
Bebington
Wirral
CH63 4JY
Tel: 0151 334 4000

Countess of Chester Health Park *(renal dialysis services only)*
Liverpool Road
Chester
CH2 1UL
Tel: 01244 365 000

Overview of Services Provided and Locations

Service	Location			Additional Information / comments (where applicable)
	Arrowe Park (APH)	Clatterbridge (CBH)	Other	
Medicine and Acute				
Acute Care				
Acute Assessment Unit	✓			Integrated GP and Acute Physician Unit
Acute Admission Unit	✓			Short stay acute unit
Acute Oncology	✓			
Critical Care (ITU / HDU)	✓			
Accident and Emergency	✓			
Childrens' Emergency Department and assessment ward	✓			Jointly managed with the Womens and Childrens Division
General Medical Services				
Cardiology	✓			The department provides inpatient facilities, day case and rapid access and general cardiology outpatient services. The catheter lab provides angiography, cardio-versions, pericardial aspirations, pacemaker implants and implantable loop recorders plus a full cardiac testing service. The service also provides CT Angiography in conjunction with the radiography department.
Cardio-respiratory Department	✓	✓		The department is the diagnostic arm of cardiology and respiratory services. The department offers a wide range of diagnostic tests including ECG, Autonomic Function Testing, Pacemaker Follow-up clinics, Peri-operative management of ICDs, Transthoracic Echo, Exercise Tolerance Testing, Tilt Testing, 24 hour ECG, 24 hour BP, Cardiomemo and 7 Day Event recording. There is also support within the ultrasound service for the highly specialist Stress and Transoesophageal Echo procedures.

				Respiratory testing includes full lung studies, Bronchial Provocation Tests, Spirometry+/- reversibility, Spirometry supine & erect, Oxygen Saturation monitoring, Sleep Apnoea service, CPAP Issue and review service.
Chronic Obstructive Pulmonary Disease	✓	✓	✓	The COPD, Home Oxygen and Pulmonary Rehabilitation service provides assessment and treatment to patients with respiratory conditions in the community and supports patients on discharge from the Trust.
Diabetes and Endocrinology	✓	✓		Outpatient services are provided at APH and CGH sites for patients with a wide range of diabetic and endocrine conditions. Inpatient beds are provided at APH. The diabetic team are supported with both inpatient and outpatient acute podiatry resources.
Gastroenterology	✓	✓	✓	The bed base for Gastroenterology is on the APH site. Outpatient clinics are held at APH, CBH and VCH. At APH Hospital services include facilities for patients bleeding acutely, as well as an endoscopy unit.
Haematology	✓			Dedicated inpatient, outpatient and day case services are provided. There is a day ward facility for the administration of chemotherapy and other treatment therapies.
Palliative Care	✓	✓		A Consultant in Palliative Care provides inpatient support to palliative patients and their care teams. The Consultant liaises closely with Consultant and Nursing colleagues in the community and at Wirral Hospice St John's to ensure ongoing support is available.
Renal Services	✓	✓	✓	Renal services are a specialised service with a hub and spoke model of services delivery. The Trust operates as the 'hub', with Countess of Chester Hospital and Clatterbridge as the 'spokes'. This includes general nephrology/pre dialysis service. Renal dialysis is provided at APH, CBH and Countess of Chester. Peritoneal Dialysis and Home Dialysis is provided. Outpatient services are offered on the APH, CBH and Countess of Chester sites.

Respiratory	✓			The Team provide in and outpatient services for a wide range of respiratory conditions and specialist services including Lung Cancer, Mesothelioma, Asthma, TB, Interstitial Lung Disease and sleep disorders. Day case provision for diagnostic tests and treatments take place on the medical day ward and respiratory lab.
Rheumatology	✓	✓	✓	Outpatient clinics are provided from APH, CGH and VCH sites for patients with a range of rheumatoid conditions. There are inpatient and dedicated day case treatment facilities on the APH site.
Sexual Health and HIV Services	✓		✓	In partnership with Wirral Community Trust and Brook, an integrated sexual health service is provided across seven venues in Wirral over seven days. This is for all levels of sexual and reproductive health. An onsite laboratory has been developed to offer same-day testing for certain conditions.
Medicine for the Elderly				
Acute Elderly Wards	✓			Patients are admitted to these wards are above the age of 74 with multi-organ failure. The speciality has Care of the Elderly Consultants with interests in 1) Movement Disorder, 2) Heart Failure, 3) Orthogeriatrics, 4) Gastroenterology as well as general elderly services. An Older Person's Rapid Assessment clinic is also provided on the APH site. Two Community Geriatricians work as part of the Medicine for the Elderly Consultant team ensuring cross boundary working between Community/Hospital services.
Elderly Rehabilitation Services	✓			Both inpatient and outpatient facilities are provided.
Acute Stroke Services	✓			Acute stroke services are provided on the APH site. The service is an approved hyper acute stroke unit with the added benefit of 24/7 stroke nurse coordinators. The service also has 7 day consultant stroke physician working. The dedicated stroke rehabilitation unit is based on the CBH site, with an established early supported discharge team.
Stroke Rehabilitation Services		✓		

Wirral Neuro Rehabilitation Unit		✓		
Elderly Care Outpatient Services	✓	✓	✓	
Movement Disorder Service	✓		✓	Provided at Victoria Central Hospital
Corporate Services				
Pharmacy	✓	✓		*Joining Clinical Support Division in April 2015*
Clinical Support				
Radiology				Services also provided on behalf of other healthcare providers such as Peninsula Health, Clatterbridge Centre for Oncology, and Spire, as well as for the Trust's own patients
Plain film imaging service	✓	✓	✓	Outpatient services also provided at St Catherine's and Victoria Central Hospital
MRI Services	✓	✓		
CT Services	✓	✓		
Fluoroscopy Services	✓	✓		
Interventional Services	✓			
Breast Screening and Symptomatic Mammography		✓		
Ultrasound	✓	✓	✓	Inpatients and outpatients at APH and CBH; outpatients at VCH and St Catherine's
Laboratory Services				Laboratory Services are a regional centre for HERCEPT testing and LBC processing. It acts as a referral laboratory for urology work, autoimmune serology testing, plasma viscosity testing and bile acids. All services are managed from APH except for medical microbiology (managed from MicroPath, 11Bassendale Road).
Clinical Biochemistry	✓	✓		
Haematology and Blood Transfusion	✓	✓		
Histopathology	✓	✓		

Medical Microbiology			✓	Primary site: MicroPath, 11Bassendale Road CH62 3QL. Satellite laboratories are located at Arrowe Park Hospital and Countess of Chester Hospital (Out of hours work and GU-medicine).
Point of Care Testing	✓	✓		
Phlebotomy	✓	✓	✓	Services are provided to inpatients and outpatients at both sites as well as in a range of community clinics and patients' own homes.
Mortuary Services	✓	✓		
Allied Health Professionals				
Physiotherapy	✓	✓		
Occupational Therapy	✓	✓		Occupational Therapy provides services to all areas of the acute and rehabilitation services for all specialities, age groups and directorates within the Trust. It also provides children's services in partnership with Social Services and Education.
Dietetic Service	✓	✓		
Surgery and Women's and Children's				
General Surgery and Urology				
Breast Services	✓	✓		This is an outpatient breast Unit at CBH. The service provides a one stop diagnostic clinic service and is supported by Radiology, Pathology and Clatterbridge Centre for Oncology. The inpatient service is mainly elective, based at Clatterbridge.
Colorectal Services	✓	✓		The service provides support for parenteral nutrition patients on a sub-regional basis.
Vascular Services	✓	✓	✓	We have established links with the Countess of Chester Hospital to provide Endovascular Aneurysm Repair. Specialist Commissioning Team have commissioned services for the establishment of a centre at Chester, with our Vascular consultants visiting and operating there. Community clinics are also provided at St Catherine's Hospital.

Upper Gastro-Intestinal (UGI)	✓	✓		Our consultants also operate on a weekly basis at Aintree Hospitals, on patients who require major operative procedure for UGI cancers.
Urology	✓	✓		The Urology service is a cancer centre for urological cancers in the North West. The service can provide for radical urological diversion, specialist penile cancer work, laparoscopic renal and prostate procedures. The Trust has good links with the Countess of Chester and Warrington Hospitals, and provides surgical capacity for major cancers for patients from these hospitals with prostate and kidney cancer.
Special Surgery				
Ophthalmology	✓		✓	The outpatient department supports all aspects of ophthalmology including patients suffering from Age related Macular Degeneration, Glaucoma, Diabetic Retinopathy etc. It provides an acute service for patients on a walk-in basis and via a triage system for the community Optometrists and GPs. A clinic is also delivered at St Georges' Medical Centre.
Ear, Nose and Throat	✓	✓	✓	The service operates on APH, CBH, St Catherines, VCH and Ellesmere Port sites on an out patient basis, and has inpatient and day case beds in APH. The service is also supported by the Audiology department.
Maxillofacial Surgery and Orthodontics	✓			Our Maxillofacial consultants are joint appointments with Aintree Hospitals and provide sessions there to support major trauma cases.
Trauma and Orthopaedics	✓	✓	✓	The service operates at APH and CBH for both inpatients and outpatients. It also operates at St Catherine's, VCH and Ellesmere Port on an outpatient only basis.
Dermatology	✓	✓		The service has a dedicated purpose built unit housing in patient and day case beds and treatment facilities. Referrals are received from across the Cheshire and Merseyside Cancer Network.

Wirral Limb Centre		✓		Wirral Limb Centre is a district centre providing services for Wirral and Cheshire residents. It provides a consultant led prosthetic service.
Obstetric and Maternity Services	✓	✓	✓	Maternity care is provided in several locations. In addition to care provided in the patient's own home, clinics are provided in the Community in both GP Surgeries and in Children Centres. Care is also provided in satellite clinics at CBH, St Catherine's Hospital and VCH. This includes Antenatal and Postnatal care, breastfeeding support and ultrasound services. Patients arrive for their first appointment at one of four hospital locations (APH, VCH, St Catherine's Hospital, CBH). Following this initial assessment of needs and risks, care is planned individually with the patient using agreed Pathway Guidelines. Patients without significant risk factors receive all of their Antenatal care in the community setting. Those patients who do have significant risk factors have the majority of their care provided at APH where the Maternity Assessment Unit and Obstetric Consultants are at hand. We provide a comprehensive home birth service covering all of the Wirral. Postnatal care is provided initially at APH or in the patient's home depending on place of birth. Ongoing postnatal care can be delivered at venues including GP Practices, Children Centres, the patient's home or the four hospital venues identified above.
Teenage Pregnancy Service			✓	A designated Young Women's Antenatal Clinic is held weekly. Targeted outreach and education to young parents-to-be is provided at venues including local colleges and Wirral Childrens Centres.
Medical Disorders Clinic	✓			This service provides care to women with pregnancies complicated by diabetes, impaired glucose tolerance and thyroid disorders.
Substance Misuse Clinic			✓	A satellite clinic is held at St Catherine's Health Centre, but most care is provided in the patients' homes.

Perinatal Mental Health	✓			This clinic co-ordinates support for patients with mild to moderate health disorders. A specific Care Pathway is followed for patients with diagnosed severe mental illness.
Parentcraft			✓	This aims to equip parents-to-be with the knowledge, and skills to ensure the physical, emotional and social development of the child and family. Sessions are usually conducted within the community setting.
Midwives Shop			✓	This venue, in the Pyramids Shopping Centre in Birkenhead, provides a drop-in facility from Tuesday to Saturday from 10am to 3pm. Registered Midwives provide antenatal and postnatal care and breastfeeding support and education to women and their families here. Collaborative work is undertaken here with the North West Milk Bank, local Children's Centres and other public health providers such as Support, smoking cessation services. The shop lends itself to support various public health campaigns and as a place where families can be signposted to recognised support services.
Integrated Safeguarding Team	✓			This team includes Adult Protection, Safeguarding Children, Domestic Violence and Perinatal Mental Heath, to ensure that appropriate information sharing and collaboration takes place to protect vulnerable adults and children.
Paediatrics				
Children's Outpatient Department	✓			This area provides new and follow-up consultations with medical staff from paediatric, general surgery, dermatology and audiology. There are nurse-led clinics and condition-specific multidisciplinary clinics. In addition there are joint clinics with visiting consultants from tertiary centres such as Alder Hey.
Children's Ward	✓			This provides inpatient accommodation for 0-16 year olds. The ward houses the children's day case area and a bedded High Dependency Unit facility.
Children's Emergency Department	✓			A purpose built children's area jointly managed by paediatrics and Accident and Emergency.
Hospital at Home Service			✓	An acute based nursing service which facilitates admission avoidance or shortened length of stay

Newborn Hearing Screening Service	✓			This services is offered for all new-born babies.
Paediatric Audiology		✓	✓	Clinics are provided in the Child Development Centre at CBH, at VCH and in the community. Purpose-built facilities will be available at St Catherine's Health Centre from September 2012.
School Nursing		✓	✓	The majority of nurses work from schools or locality clinics. There are separate teams for normal and special schools. In addition there are two Attention Deficit Hyperactivity Disorder Nurse Specialists. A team of screeners undertake vision, hearing and weight assessments in schools as part of the national programmes.
Continuing Care Service		✓	✓	A team of staff who provide care for children and young people with complex health needs within their own home / community settings
Community Paediatrics		✓	✓	This service provides: • General community paediatric assessment and diagnosis • Assessment, diagnosis and follow up of children with mental health difficulties and emotional and behavioural difficulties associated with developmental disorders • Timely medical assessments for children who may have been abused, initial health assessments of children taken into care, and the health component of statutory assessments of educational special needs, including co-ordination of special needs services • Detailed assessment reports to other agencies, including family and criminal justice processes. • Through the system of designated and named doctor, advice on health concerns at multi-agency panels for safeguarding, adoption and fostering, and special educational needs • Coordination of immunisation advice and support to the Healthy Child Programme. • High quality training for paediatric trainees

				The Service is community focussed and is delivered within settings including the service user's home. Clinics are held at local clinics throughout Wirral.
Gynaecology	✓		✓	Gynaecology care is provided at APH, VCH, and St Catherine's Hospital.
General Gynaecology Outpatient Clinics	✓		✓	Consultant-led clinics are held at APH, SCH, VCH and a venue in Nestonfor patients experiencing gynaecological complaints.
Pregnancy Counselling Clinics	✓			This clinic provides advice and care to patients requesting termination of pregnancy.
Gynaecology Assessment Unit	✓			The service enables assessment of patients referred to the hospital via General Practitioner, with symptoms of a gynaecological nature such as abdominal pain or menorrhagia.
Early Pregnancy Service	✓			This Unit is an "urgent" clinic for pregnancy related problems, occurring from the point of positive pregnancy test to 19 weeks 6 days gestation. Patients present with a variety of problems including PV Bleeding and pain, abdominal pain, hyperemesis, previous Ectopic Pregnancy, previous Molar Pregnancy and reassurance for recurring miscarriage and investigations.
Fertility Service	✓			The following services are provided: full fertility investigations (female and male); lifestyle and pre-pregnancy advice; ovulation induction monitoring; and counselling support. It acts as a satellite service for IVF in collaboration with Liverpool Womens' Hospital.
Colposcopy	✓			The Colposcopy Service forms part of the National Screening Programme for Cervical Cancer. It is a dedicated outpatient-based diagnostic and treatment service.
Gynaecology Oncology	✓		✓	This service provides psychological and clinical support for cancer patients. A joint oncology clinic is provided at Clatterbridge Centre for Oncology.
Urogynaecology	✓		✓	This service provides specialist advice, treatment and care to women with urinary problems. The outpatient clinic offers specialist investigations and procedures such as

				urodynamics, bladder installations, training for self catheterisation, bladder scans, pessary clinics and botox injections to the bladder. Services are also provided at Port Causeway.
Outpatient Hysteroscopy	✓		✓	This undertakes investigations and treatment for abnormal uterine bleeding. Also delivered at St Catherine's Health Centre.
Paediatric Outpatient Clinic	✓			This clinic offers services to children up to the age of 18 with gynaecological problems.
Neonatal Unit	✓			The Neonatal Unit at Arrowe Park is designated level 3 and as such provides intensive care to babies born at 23 weeks or above.

Board of Directors		
Agenda Item	9.3	
Title of Report	Health and Safety Quarterly Update	
Date of Meeting	26 November 2014	
Author	Peter Bohan, Head of Organisational Health & Effectiveness James Mawrey, Director of Workforce	
Accountable Executive	Anthony Hassall, Director of Strategy and Organisational Development	
FOI status	Document may be disclosed in full	
BAF Reference	1, 14	
Data Quality Rating	Silver – quantitative data that has not been externally validated Bronze – qualitative data	
Level of Assurance	Incomplete	Board confirmation

Executive Summary

1. There have been a number of initiatives in the management of Health and Safety across the Trust during this quarter, with the Health & Safety (H&S) Team undertaking 3 audits, completing 13 RCAs and continuing to work on all key areas of compliance of systems and processes since the last report to the Board in July 2014. Of the 52 actions within the previous report, there were 13 that were partially compliant. This paper describes the remaining 3 actions which are partially compliant, these relate to asbestos management, working at height and the loading bay. These all have actions to mitigate the risks identified.

2. The Health & Safety Executive visited the Trust on the 8th August to review sharps safety arrangements and concluded that the Trust has one of the most efficient streamlined systems they have seen which has reduced the risks to employees from sharps injuries and in the inspectors opinion the trust would appear to be a leader in managing and reducing the risks of exposure to sharps injuries. The findings of the HSE visit have been communicated to the board to provide assurance of compliance.

3. There has been a decrease in employee incidents (as described below) during the reporting period and RIDDOR incidents reported have increased slightly to 13 in Quarter 2 2014-15 from 12 reported in Quarter 2 2013-14. The Health and Safety Partnership Team (HSPG) is now Chaired by the Director of Strategy & Organisational Development which has provided a more strategic focus on Health & Safety. A review is currently underway looking at overall governance and communication associated with Health & Safety.

4. Mandatory Health and Safety training compliance has increased from 93.76% in Quarter 1 to 98% achieved in Quarter 2, which is encouraging when considering the target for compliance is 95%.

5. The MIAA H&S report produced in 2013-2014 has been reviewed with evidence provided of the H&S Strategy, H&S Partnership Team meeting Terms of reference and minutes meeting provided. The initial evaluation by MIAA has indicated that all significant work is now complete. The formal summary of results will be provided to the Audit Committee in December.

Employee Incidents

1. There were a total of 329 incidents reported in Q2 2014-15 compared with a total of 416 reported in Q2 2013-14, equating to a decrease of 21%. Of note the data for Q1 2014-15 showed a 39% fall in reporting figures in comparison to Q1 2013-14 so this is likely an emerging trend towards lack of reporting. In order to improve incident reporting by colleagues, a section within a recent communications newsletter highlighted the importance of incident reporting and requested that staff complete hard copies of incident forms if web reporting is not accessible. The importance of incident reporting is also reinforced within WUTH mandatory and induction training seminars as well as through the risk management training. The top three non-clinical incidents reported were disruptive/aggressive behaviours, security incidents and injuries as a result of clinical sharps.

2. In Q2 2014-15 there were a total of 91 disruptive / aggressive behaviour type incidents reported, compared with 87 reported in Q2 2013-14 which equates to a 5% increase and suggests a slight improvement in the reporting of violent incidents within the WUTH. The main trends in Q2 2014-15 within this category were physical assaults on staff by patients (29) patient's being reported as being disruptive or noisy (17) and patients verbally assaulting staff (23). Although these events should not be occurring, the majority of these incidents resulted in either no injury or a minor injury. All staff working in high risk areas of violence are required to attend the mandatory and essential training so as to ensure they are appropriately trained. The majority of these incidents occur in DME and the Emergency Department.

3. The main trends within the clinical sharps category involved sharps injuries to the user of the clinical sharp (11), improper disposal of clinical sharps but no injury (8) and clinical sharps injuries to non-clinical staff due to improper disposal (5). Although the WUTH policies, risk assessments and training were seen by the HSE as robust, unfortunately some staff fail to comply with these arrangements putting other staff at unnecessary risk. Each needlestick injury is subject to an RCA and a recent paper on sharps safety which included eight recommendations to address sharps safety was presented to the Clinical Governance Group and will be escalated to other appropriate forums including the Executive Team.

Incident Reporting RIDDOR

1. The Trust is required to report specific incidents to the HSE in accordance with the Reporting of Injuries, Diseases & Dangerous Occurrences Regulations (RIDDOR) 2013. In Q2 2014-15 there were a total of 13 incidents reported to the Health & Safety Executive in accordance with RIDDOR, compared with 12 reported in Q2 2013-14, a slight increase of 1.

2. Of the total of the 13 incidents reported to the Health & Safety Executive, 7 were as a result of slips trips and falls, 3 occurred as a result of manual handling, 1 was a dangerous occurrence (gas leak), 1 was as a result of a member of staff being struck by a falling object. The remaining 1 was a scald during the serving of hot soup to patients.

Health & Safety Audits

1. A recently developed Health & Safety Framework audit tool has been developed by the H&S team which reflects HSE guidance. Health & Safety audits began in September 2014 with key services areas with highest sickness rates being targeted. The results described below are positive. The full extent of compliance across the Trust will be established at local level over the next 12 months as the audit program is introduced.

2. The safety management system we now have in place based on HSG65 (HSE Guidance) the process involves splitting key areas of risk into the following four categories:

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

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

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

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

Location	Health & Safety management	Premises Management	People In The Workplace	Activity	Overall Rate
Hotel Services- Domestics APH	90.48%	83.33%	88.46%	44.4%	82.26%
Pharmacy - Dispensary APH	90.91%	100.00%	100.00%	100.%	97.10%
Rehabilitation Ward CGH	95.65%	100.00%	89.66%	100.%	95.00%
Total Average	92.35%	94.44%	92.71%	81.4%	92.35%

3. The overall results of the initial audits have indicated positive results and where systems require improving a specific action plan is developed for the service area. The most significant area of non-compliance (44.4%) related to lack of job activity risk assessments and actions to address this issue have been made following the audit. Audit reports on the findings are provided to the Health & Safety Partnership Team for information. The level of compliance is measured using the following RAG rating.

Red	1% to 50% compliance
Amber	51% to 74% compliance
Green	75% to 100% compliance

Health and Safety Training

1. Quarter two 2014-15 training provided by the Health and Safety Team was as follows:

*Please note the above training includes

Training description	Number of sessions
Induction Presentation - Health and Safety	5
Induction Presentation - Inanimate Loads	5
Induction - People Handling	5
Mandatory Training Presentation – Manual Handling	8
Mandatory Training – People Handling	14
Mandatory Practical Training for W&C	3
Corporate Manslaughter Training	3

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

Health & Safety Key Issues / Update

1. The main regulatory updates during this quarter arose out of several consultations and audits that commenced during the reporting period. These are:

i) The HSE visited the Trust on the 8th August to investigate a needle stick injury to a member of staff in A&E from a patient with Hepatitis C. The inspection was extremely thorough and they interviewed Head of Phlebotomy, procurement, Union representative, the H&S Team and Occupational Health Team and the responsible board level Director for H&S (Director of Strategy & Organisational Development). The Trust had already identified actions from the RCA which included a streamlining of the post exposure prophylaxis with guidance for staff and reporting to Occupational Health and donor bloods tested immediately in high risk cases, all actions are being completed along with a review of the Inoculation Injuries Policy. The H&S Team and Occupational Health had prepared extremely well for the visit and as a result the HSE described the management of sharps from risk assessment, procurement to supply of clinical areas as an efficient streamlined management system. The HSE has asked if we can provide guidance to other Trusts regarding best practice in this area.

ii) The workplace transport risks particularly in the delivery area at Arrowe Park Hospital have now reviewed and mitigated and a capital bid for improvements has been developed which has reduced some of the costings. The capital bid will now be submitted for approval for inclusion within the 2015/16 capital round.

iii) Stress is a major concern with a significant number of stress related absences being evidenced in attendance data. The Trust has developed a stress action plan which includes a review of the policy, better information provided on the intranet for self-help. Audits of areas highlighted as hotspots for stress reviewed and supported and promotion of resilience training.

iv) The asbestos entry on the risk register and relevant actions has been reviewed with an assessment of competence of surveyors undertaken by the H&S Team. A tender document describing the requirement for a management plan has been provided to the surveying companies and the results have been received and will be evaluated by the end of November 2014. Meetings are being arranged to interview prospective companies to undertake the work. It is anticipated the successful tender will be appointed once the capital bid has been agreed which has been included in capital bids for 2015/16, but may be funded through slippage in 2014/15.

v) The legionella actions described within the Clearwater report is being undertaken by the Estates team which includes removal of fire hoses, flexible pipe work and dead legs in the system. All high risk actions for CGH were completed on 30/09/14. All high risk actions identified at APH will be completed by 31/03/15. It has been recognized that the flushing regime is not being undertaken within a number of wards and Departments and is required to ensure the safety system is effective. This issue will be discussed at the Water Safety Group and escalated to the Hospital Infection Control Committee, a communications bulletin has been sent to all staff describing the risks associated with not flushing outlets. A rolling programme of audits of high risk areas are undertaken by the infection control team as part of the annual audit programme.

vi) A recent incident was reported to the HSE regarding a dangerous occurrence when a sub-contractor cut through a live gas pipe with an angle grinder. This has resulted in a review of the permit to work system within the Trust, information provided to contractors and review of the control of contractor's policy. A full RCA has been produced with specific actions to manage these risks in the future.

The responsible site manager who gave the instruction to remove the live gas pipe was dismissed by the principle contractors the day after the incident occurred.

Further details regarding time lines for action are detailed within appendix one.

Health and Safety Team Activity

1. Training on Corporate Manslaughter & Homicide Act 2007 - The Trust's roll out programme has begun and details that all Band 8B and above must attend these training sessions. A communication has been provided via the Communications Team to ensure improved take up. It is anticipated all relevant staff will have received this level of training by July 2015.

2. A range of Health and Safety Policies have been developed with the involvement of key stakeholders and have been consulted on in recent months. Policies that have recently been completed include COSHH which is now live on the intranet. The control of asbestos, control of noise, Workplace Health & Safety and First Aid and Young Workers have recently completed consultation and it is anticipated will be approved at the Workforce and Communications Program Board meeting in December. Work continues to progress on the remaining policies the Health & Safety team are developing and the Team are making good progress with these. All polices that required to be developed have been completed by the Health & Safety team and will follow the consultation and approval process. It is anticipated all outstanding policies will be approved and live on the intranet by January 2015.

3. Health surveillance for specific work activities has progressed with 240 night staff undertaking a health review. Further work is being undertaken on dermatitis and noise induced hearing loss.

4. Additional surveillance has taken place for staff using COSHH products with exposure limits within endoscopy and consideration of current control measures for the quality of maintenance of extraction systems and Personal Protective Equipment provided.

5. The Head of Organisational Health and Effectiveness is currently working to ensure we reach the Trust's Flu Vaccination Target of 75% for Winter 2014/2015 with 54.6% of front line staff vaccinated to date. This figure will increase as we visit all wards and department over the next 2 months. It is encouraging to note that in December 2013 the percentage of staff who had received their flu vaccination was 46% which puts the Trust in a better position that last year.

Conclusion and Summary

1. The documented system continues to improve with a program of planned audits now in place to monitor performance, work is continuing on implementation and escalation and communication of safety information. Risks such as legionella are placed on the risk register by the Estates Department and monitored via the Water Safety Group and Health & Safety Partnership Team. The action plan (Appendix 1) will ensure targets are met to ensure compliance with the recommendations within this report.

Recommendations

1. The Trust Board is asked to:

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

Appendix 1

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

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance Nov	Compliance July
Corporate Manslaughter & Corporate Homicide Act 2007	The Board had not received training on the requirement of Corporate Manslaughter & Corporate Homicide Act 2007.	Board require training covering Corporate Manslaughter & Corporate Homicide Act 2007	P Bohan	31-01-14	26-03-14.	A training presentation has been completed 26th March to Board members. Training dates for staff 8B and above have been set for the next 6 months.	Compliant	Compliant
Corporate Manslaughter & Corporate Homicide Act 2007	The Trust had no Health & Safety Strategy in place	Health & Safety Strategy to be developed and implemented	P Bohan	31-03-14	25-02-14	Health & Safety Strategy has been developed and has been signed by the CEO. The Trust Board will be kept informed on a quarterly basis on progress with H&S matters via the Quality & Safety committee.	Compliant	Compliant
Control of Substances Hazardous to	The Trust had no policy covering all the	A policy detailing the requirements of COSHH will be	A Haynes	28-02-14	14-02-14	A COSHH policy has been approved in accordance with Trust	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance Nov	Compliance July
Health Regulations 2002	requirements of the Control of Substances Hazardous to Health Regulations 2002	developed				procedure.		
Control of Substances Hazardous to Health Regulations 2002	Not all areas within the Trust are carrying out appropriate COSHH risk assessments	Appropriate COSHH assessments to be audited using H&SMF to ensure COSHH is implemented in service areas including facilities and estates.	A Haynes / D Hounslea	31-08-14. Note the April Board paper detailed a due date of 31.05.14. All staff were seen by 31.05.14 however, further specialist advice regarding sensitization.	31-08-14	An Occupational Health & Safety framework has been developed and includes a section on COSHH. A number of site visits have taken place to evaluate current control measures. Staff members have been referred to Occupational Health surveillance where necessary they will be referred to the Occupational Health Physician. Contact has been made with manufacturers to determine if alternative products are available.	Compliant	Partial Compliance
Control of Substances	The Trust was not carrying out	An Occupational Health & Safety	P Bohan	31-05-14	25-05-14	The process for undertaking Health	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance Nov	Compliance July
Hazardous to Health Regulations 2002	appropriate Health Surveillance for VWF, Noise, night work, latex & pesticide.	Policy will be developed				surveillance for grounds maintenance is complete along with a policy. Continuous monitoring by the Occupational Health team will ensure all aspects of health surveillance identified through the risk assessment process are implemented.		
Control of Substances Hazardous to Health Regulations 2002	The Trusts Control of Legionellosis Policy does not reflect recent HSE guidance although it was reviewed in June 2013 and is in date	The Trusts Control of Legionellosis Policy requires updating to reflect recent HSE guidance published Nov 2013	D Hounslea / A Haynes	28-02-14	14-02-14	The Policy is complete and live on the intranet.	Compliant	Compliant
Control of Substances Hazardous to Health Regulations 2002	There are currently approx. 130 fire hose reels that are not flushed in accordance with	Clearwater to undertake bi-annual inspection as per plan to review monitoring of risks and	D Hounslea	31-03-14	31-03-14	Clearwater have reviewed fire hoses and dead legs and provided a timescale for action. Flushing regime in place from Jan 2014	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance Nov	Compliance July
	legionella legislation or as they are not fitted with a double check valve	flushing regime				and specific risk assessment were put in place to reduce the risk of legionella.		
Control of Substances Hazardous to Health Regulations 2002	There is a policy in place the bi-annual report by Clearwater will be undertaken to identify systems are in place for flushing and water management.	The planned review of the Legionella management systems including the flushing regime and audit process will be carried out	G. Lewis	30-03-14	Review has been undertaken by Clearwater of the Clatterbridge and APH site.	The risk has now been downgraded with an action plan in place. A recent Infection Control Audit identified several wards were non-compliant with the flushing regime. Information was distributed within the weekly communications bulletin on 15th Oct requesting that the flushing of outlets is undertaken in all areas to manage risks in particular the risks to high risk patients.	Compliant	Partial Compliance
Control of Asbestos Regulations	The Trust had no policy covering the statutory requirements of	The Trust to develop a policy covering the requirements of	D Hounslea / A Haynes	31-03-14	14-02-14	A Control of Asbestos policy has been developed and has been sent out for	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance Nov	Compliance July
2006	the Control of Asbestos Regulations 2006.	The Control of Asbestos Regulations 2006				approval in accordance with Trust policy		
Control of Asbestos Regulations 2006	Asbestos survey undertaken in Nov 2013 raises several concerns over the quality of the survey.	The findings from the original Asbestos survey in 2006 to be provided and reviewed to determine if actions have been completed	D Hounslea	28-02-14	14-02-14	Initial survey has been reviewed and established that the whole organizational survey is not complete.	Compliant	Compliant
Control of Asbestos Regulations 2006	Asbestos survey carried out may be not sufficient and suitable for Willow House	A full non-destructive asbestos management re-survey is required of Willow House	G Lewis	27-09-14. * Note Board Paper in April noted due date of 31.05.14. The initial survey was completed for Willow House within timescales. The survey then	27-09-14	The re-survey has identified that the asbestos sample taken in the duct is different to the one described in the 2006. It was decided the duct is not entered and if required licensed contractors to be used to undertake work.	Compliant	Partial compliance

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance Nov	Compliance July
				indicated that it would be helpful to have additional survey for wider organization.				
Control of Asbestos Regulations 2006	High priority risk assessments for areas the survey prompted the development of an action plan which requires placing on the risk register entry	High priority assessment and action plan will be placed on risk register	G Lewis	20-12-14. Note: Date extended as will require capital bid for work to be undertaken above 150k		Tenders have been received. Tenders evaluated by 29th November. To commence work once funding agreed through capital bid whole estate or a phased, risk-based approach to spread the cost of the asbestos surveys. Potential cost 150k plus VAT which has been included within Estates capital bids plan.	Partial Compliant	Partial Compliance
Work at Height Regulations 2005	The Trust had no policy covering the statutory requirements of	The Trust to develop a policy covering the statutory	A Haynes / D Hounslea	31-01-14	14-02-14	A Working at Height Policy has been completed. A specific permit system has been	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance Nov	Compliance July
	the Work at Height Regulations 2005 although some aspects are covered with the STF Policy 012	requirements of the Work at Height Regulations 2005				developed to be implemented for all staff and contractors.		
Work at Height Regulations 2005	Not all fragile roofs have a site-specific risk assessment in place.	A process for carrying out site-specific risk assessments for fragile roofs/surfaces to be developed.	G Lewis	15-08-14 * Note Board Paper in April noted due date of 30.04.14. The capital scheme was completed by that day however, further work was required hence date change. Date to be undertaken over next 6 months.		Funding has been approved to address prioritized program for the highest priority roofs to be addressed, tenders were returned week commencing 10-11-14 and it is anticipated work will be completed week commencing the 15-12-14	Partial Compliance	Partial compliance
Work at Height Regulations 2005	There is no permit to work system for high risk working at	A process similar to a permit to work system in existence for	D Hounslea	31-03-14	31-03-14	There is controlled access to all roofs. Memo has been sent out to all works	Compliant	Compliance

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance Nov	Compliance July
	heights for estates and facilities personnel and contractors requires review	contractors and estates and facilities personnel needs to be further developed.				personnel instructing them not to work near the roof edges or fragile roofs. Permit to work now in place.		
Confined Space Regulations 1997	The Trust has no policy covering the statutory requirements of the Confined Space Regulations 1997	The Trust to develop a policy covering the statutory requirements of the Confined Space Regulations 1997	A Haynes / D Hounslea	31-01-14	14-02-14	A Working in Confined Spaces policy has been developed. The Policy will be sent to the policy lead by the 21/11/14 and will then be sent out for consultation.	Compliant	Compliant
Confined Space Regulations 1997	Confined spaces across APH and CGH to be identified	All confined spaces across APH and CGH have been identified.	D Hounslea	31-01-14	14-02-14	All confined spaces at APH and CGH have been identified.	Compliant	Compliant
Confined Space regulations	Ensure a specific task is assessed for confined	Ensure task specific assessment	D Hounslea/D Jones/A	30-7-14	01- 07-14	A task specific risk assessment has been put in place which is	Compliant	Partial Compliance

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance Nov	Compliance July
1997	spaces to determine risks and controls.	undertaken.	Haynes.			described within the policy.		
Confined Space Regulations 1997	Not all relevant staff within Estates and Facilities have received training on working in confined spaces	All key personnel within Estates and Facilities will receive training on working in confined spaces	D Hounslea	31-01-14	07-02-14	All key personnel received training on working in confined spaces week commencing the 07-02-14	Compliant	Compliant
Confined Space Regulations 1997	The site specific risk assessments for working in confined spaces are dated 2010	Site specific risk assessments to be reviewed	D Hounslea	30-06-14	01-07-14	Working in confined spaces assessment completed in 2010. The risk assessment has been reviewed and signage has been put in place in all areas identified as confined spaces. A task specific assessment will be undertaken for all future work in confined spaces.	Compliant	Compliant
Control of Noise at Work	The Trust had no policy covering	The Trust to develop a policy	A Haynes /	28-02-14	14-02-14	A Control of Noise at Work policy has been	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance Nov	Compliance July
Regulations 2005	the statutory requirements of the Control of Noise at Work Regulations 2005.	covering the statutory requirements of the Control of Noise at Work Regulations 2005	D Hounslea			developed and will be presented at the next Workforce and Communications meeting in December 2014		
Control of Noise at Work Regulations 2005	There are no site specific risk assessments for noise control within Estates and Facilities	A rolling program of site specific risk assessments which will be prioritised according to the degree of risk will be developed	G Lewis	30-08-14 * Note Board Paper in April noted due date of 31.05.14. The initial noise assessment survey was completed within these timescales however, further work on individual assessment is needed, hence revised date		A baseline assessment has been undertaken; Noise assessment questionnaires have been distributed to all relevant staff and are being evaluated and staff have been referred for audiometry testing. Further noise assessments are ongoing in specific areas.	Compliant	Partial Compliance
Pressure Systems Safety	The Trust had no policy covering	The Trust to develop a policy	D Hounslea	31-03-14	31-03-14	Currently Alliance Insurance undertakes	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance Nov	Compliance July
Regulations 2000	the statutory requirements of the Pressure Systems Safety Regulations 2000	covering the statutory requirements of the Pressure Systems Safety Regulations 2000	/ A Haynes			pressure systems tests for insurance purposes. A written scheme of work is in place by the external assessor. Policy developed in accordance with internal process.		
Health and Safety At Work Act 1974	The is no signed statement of intent by the CEO within the Health & Safety Policy 118	The Health and safety Policy requires a signed statement of intent from the CEO	A Haynes	31-01-14	14-04-14	The Health and Safety Policy 118 has been amended and includes a statement of intent which has been signed by the CEO.	Compliant	Compliant
Health and Safety At Work Act 1974	The Health and safety Policy requires further guidance on risk assessment processes and references to new policies	The Health and safety Policy will be amended to include further guidance on risk assessments and reference to newly developed policies	A Haynes	31-03-14	14-02-14	The Health and safety Policy has been amended to include further guidance on risk assessments and reference to newly developed policies and will be available on the intranet once new policies have been approved.	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance Nov	Compliance July
Health and Safety (Consultation with Employees) Regulations 1996	Although the Health and safety Policy includes some of the requirements of the Health & Safety (Consultation with Employees) further detail is required within Trust policy	The Health and safety Policy requires further detail on the consultation with employees processes OR a new policy will be developed	A Haynes / L Ferrie	31-03-14	31-03-14	Policy Complete	Compliant	Compliant
Electricity at Work Regulations 1989	The Trust had no policy covering the statutory requirements of the Electricity at Work Regulations 1989 although staff are competent and work in accordance with the revenant HTM's	A policy covering the requirements of the Electricity at Work Regulations 1989 will be developed	D Hatch / D Hounslea	31-03-14	31-03-14	Competent staff are trained on 17th Edition wiring regulations and are deemed competent to undertake this work. There are two permit to work systems in place for working with electricity used within the Trust which are included within existing	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance Nov	Compliance July
						Hospital Technical Memorandums (HTM's) The Policy once developed will reflect SOPs and Hospital Technical Memorandums (HTM) processes.		
Provision and Use of Work Equipment Regulations 1998	The Trust has no policy covering the statutory requirements of the Provision and Use of Work Equipment Regulations 1998.	A policy covering the statutory requirements of the Provision and Use of Work Equipment Regulations 1998 will be developed	D Hatch / D Hounslea	30-04-14	01-05-14	Policy complete and is live on the intranet.	Compliant	Compliant
Lifting Operations and Lifting Equipment Regulations 1998	The Trust has no policy covering the statutory requirements of the Lifting Operations and Lifting Equipment	A policy covering the statutory requirements of the Lifting Operations and Lifting Equipment Regulations 1998	D Hatch / D Hounslea	27-07-14	25-7-14	Policy is complete and live on the intranet.	Compliant	Partial compliance

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance Nov	Compliance July
	Regulations 1998	will be developed						
Management of Health and Safety at Work Regs 1999. To cover RA's on activities including Young Workers.	The Trust has no policy covering the statutory requirements to protect Young Workers	The Trust will develop a policy covering the statutory requirements to protect Young Workers	A Haynes	31.04.14	31.04.14	Policy is complete and live on the intranet	Compliant	Partial compliance
Occupational Health	The Trust has no policy describing the Occ Health Services which will include arrangements for appropriate Health Surveillance	Specific policy is required to describe all OH Services- This is to be developed and describe requirements for Health Surveillance of staff and appropriate documented system	P Bohan	30-04-14	31-03-14	Policy is complete and live on the intranet.	Compliant	Compliant
Security	The Management of Violence and Aggression (including lone workers) 068	Policy in place will be reviewed to ensure risks associated with violence and	E Garner	30-06-14	05-06-14	The Local Security Management Specialist (LSMS) has reviewed the policy as part of	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance Nov	Compliance July
	Policy in place requires reviewing to ensure risks associated with violence and aggression appropriately managed.	aggression appropriately managed				security review. The policy has been updated and is live on the intranet		
Workplace (Health, Safety and Welfare) Regulations 1992	The Trust has no policy covering the statutory requirements of all the requirements within the Workplace (Health, Safety and Welfare) Regulations 1992	Internal guidance covering these regulations is required in the policy – will include ventilation, thermal comfort, and other general requirements.	A Haynes	27-08-14 * Note Board Paper in April noted due date of 30.04.14. Draft has been completed and within consultation process.	01-10-14	The policy is live and available on the Intranet.	Compliant	Partial compliance
Workplace (Health, Safety and Welfare) Regulations	The Trust has no guidance covering the statutory requirements for	A policy covering the statutory requirements for workplace transport is to be	A Haynes / D Hounslea	15-08-14 * Note Board Paper in April	01-10-14	The policy is live and available on the Intranet.	Compliant	Partial compliance

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance Nov	Compliance July
1992	Transport Safety	developed		noted due date of 30.04.14. Draft has been completed and within consultation process.				
Workplace (Health, Safety and Welfare) Regulations 1992	The Trusts loading bay at APH requires assessment due to the high risk activities 'carried out within this workplace.	Issues identified as part of the assessment process will be entered onto the risk register	G Lewis	15-08-14 * Note Board Paper in April noted due date of 30.04.14. Capital Bid is being developed and bid completed by above timescales.		Risk register entry (2506) with specified actions has been reviewed following initial costings and a revised scheme has been developed which will be submitted as a capital bid for discussion / approval by 01/12/14.	Partial Compliant	Partial Compliant
Health and Safety (First Aid) Regulations 1981	The Trust has no policy covering the statutory requirements for The Health and Safety (First Aid) Regulations 1981	A policy will be developed covering the statutory requirements of the Health and Safety (First Aid) Regulations 1981	A Haynes	30-07-14	28-07-14	The policy is live and available on the Intranet.	Compliant	Partial compliance

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance Nov	Compliance July
Personal Protective Equipment at Work Regulations 1992	The Trust has no policy covering the statutory requirements for Personal Protective Equipment at Work Regulations 1992	The Trust will develop a policy covering the statutory requirements for Personal Protective Equipment at Work Regulations 1992	A Haynes	30-07-14	28-07-14	The policy is live and available on the Intranet.	Compliant	Partial compliance
Ionising Radiation Regulations 1999	Although the Health & Safety policy covers some of the requirements of the Ionising Radiation Regulations 1999 a more detailed and separate policy is required.	The Trust will develop a policy detailing the statutory requirements of the Ionising Radiation Regulations 1999	J O'Connor	30-07-14	28-07-14	Policy is complete and due to be approved at December's Workforce and Communications Program Board	Compliant	Partial compliance
Gas Safety (Installations	The Trust has no policy covering	The Trust will develop a policy	A Haynes /	31-03-14	30-04-14	Policy is complete and due to be approved at	Compliant	Partial

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance Nov	Compliance July
and Use) Regulations 1998	the statutory requirements of the Gas Safety (Installations and Use) Regulations 1998.	detailing the statutory requirements of the Gas Safety (Installations and Use) Regulations 1998	D Hounslea			December's Workforce and Communications Program Board		Compliance
Fire Regulatory Reform Order 2005	Existing fire risk assessments will require review on a rolling basis	A rolling program of site/department specific fire risk assessment updates to be developed which will be prioritised according to the degree of risk.	B Jones	31/01/2014	31-01-14	Fire Safety advisor Brian Jones has developed a working plan to cover a review of all fire risk assessments over the next 12 months which is due for completion by the 31-01-15	Compliant	Compliant
The Health & Safety at Work etc. Act 1974	The Trust has no specific policy on non-notifiable projects	The Trust will develop a policy covering the statutory requirements to ensure robust management and control of contractors working on non-notifiable projects.	A Haynes / D Hounslea	30-07-14	28-07-14	The existing Control of Contractors Policy has been updated to reflect arrangements for managing non notifiable projects and will be available on the intranet by the 30-11-14.	Compliant	Partial compliance

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance Nov	Compliance July
Manual Handling Operations Regulations 1992 (as amended)	The Trusts manual handling policy to be reviewed to ensure it reflects statutory requirements	The Trust's manual handling policy has been reviewed and reflects current legislation	D Hatch	30-05-14	31-01-14	Policy review is complete and the policy is live on the intranet.	Compliant	Compliant
Employers Liability (Compulsory Insurance) Act 1969	The Trust's policy requires reviewing to ensure the Statutory requirements are reflected	The Trust will review its policy to ensure the Statutory requirements are reflected within	A Haynes	30-06-14	31-01-14	Insurance procedure in place Claims Handling Policy and Procedure 108 in place.	Compliant	Compliant
Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013	The reporting arrangements for Riddor reportable Occupational health diseases require review to ensure robust reporting to the HSE	The reporting arrangements for Riddor reportable Occupational health diseases will be reviewed as part of the Occ Health review	P Bohan	30-04-14	31-01-14	All recognised diseases that are directly related to work activities and confirmed as work related by an Occupational Health Physician are reported to the HSE.	Compliant	Compliant
Health and Safety (Display	The Trusts policy covering the	The Trusts Policy for DSE will be	D Hatch	31-03-14	31-01-14	Policy review is complete and the policy	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance Nov	Compliance July
Screen Equipment) Regulations 1992	requirements of the DSE regulations require review	reviewed				is live on the intranet.		
Construction (Design and Management) Regulations 2007	The Trusts policy covering the requirements of the Construction (Design and Management) Regulations 2007.	The Trusts Policy for Construction (Design and Management) Regulations 2007 will be reviewed	D Hounslea	31-09-14	31-01-14	Policy review is complete and the policy is live on the intranet.	Compliant	Compliant
Hazardous Waste (England and Wales) Regulations 2005	The Trusts policy covering the requirements of the Hazardous Waste (England and Wales) Regulations 2005 requires review	The Trusts policy covering the requirements of the Hazardous Waste (England and Wales) Regulations 2005 will be reviewed	D Hounslea	31-09-14	31-01-14	Policy review is complete and the policy is live on the intranet.	Compliant	Compliant
HTM 07-01 - Safe	The Trusts policy covering the	The Trusts policy covering the	D Hounslea	31-09-14	31-01-14	Policy review is complete and the policy	Compliant	Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance Nov	Compliance July
Management of Healthcare Waste 2006	requirements of the Hazardous Waste (England & Wales) Regulations 2005 requires review to ensure it reflects statutory requirements	requirements of the Hazardous Waste (England and Wales) Regulations 2005 will be reviewed to ensure it reflects statutory requirements				is live on the intranet.		
Health & Safety at Work etc Act 1974.	The Trusts procedure and process for managing stress in the workplace requires reviewing as sickness absence figures indicate stress as the highest area of sickness absence.	Stress Policy and procedure to be reviewed.	P. Bohan/J. Mawrey	30-09-14	30-09-14	A stress working group has been established. A LiA event on the 23rd June focused on the requirements to implement specific targeted programme to deal with hotspots and raise the profile of the wellbeing agenda, thus improving sickness absence. Stress absence data is regularly monitored by Humans Resources and the Stress Working Group.	Compliant	Partial Compliant
H&S (Sharp Instruments in	The Trusts procedure and	Review RCA and ensure procedures	P. Bohan/A Haynes/ D.	08-08-14	01-08-14	A RCA recently identified the	Compliant	Partial Compliant

Legislation	Issue Identified	Action Required	Action Lead	Due Date	Completed	Progress Update	Compliance Nov	Compliance July
Healthcare) Regulations 2013.	process for managing sharps will be reviewed by the HSE in relation to a RIDDOR incident when a staff member received a needle stick injury from a Hep C patient.	are robust and if necessary learn lessons from incident.	Hatch			requirement to review the Post exposure prophylaxis (PEP) pathway & information provided to staff by the Emergency Department following a needlestick injury. Revised pathway and information to be agreed at the appropriate forum. .		

Board of Directors		
Agenda Item	9.4	
Title of Report	Risks Scoring 15+	
Date of Meeting	26 November 2014	
Author	Sarah Walsh, Information Analyst	
Accountable Executive	Evan Moore, Medical Director	
FOI status	Document may be disclosed in full	
BAF Reference	1	
Data Quality Rating	Silver – quantitative data that has not been externally validated	
Level of Assurance	Full	Board confirmation

1. Executive Summary

This report relates to all new risks that have been submitted on to the Risk Register with a score of 15 or above during the last 2 months (September / October 2014).

2. Background

The information in this report is analysed on a bi monthly basis.

3. Key Issues

There was just 1 risk added to the risk register since the last report during September / October 2014 with a risk rating of 15 or greater.

This risk is scored 20 and has been escalated to the Operational Management Team. Details of this risk as follows:

- Risk Ref 2637 – Medical staff cannot gain access to a ward during a medical emergency in any of the departments based in the Women's & Children's Unit.

4. Next Steps

All risks have associated action plans which will be monitored until completion in line with the Trust's Risk Management Strategy.

5. Conclusion

All risks are escalated and managed by the appropriate committees in line with the Trust's risk Management Strategy.

6. Recommendations

The Quality and Safety committee have asked to note the report which has been submitted and approved by the Executive Team.

New Risks Scoring 15+ Identified Last Month

R/R Ref No	Division / Directorate / Corporate Department	Source	Description of Risk	Issue	Action Plan Summary	Action Progress	Date Received	Last Review Date	Target Date / Next Review Date	Lead	Risk Level (Initial)	Risk Level (Current/ Residual)
2637	Surgery, Women's & Children Children's Services	Security - Risk	There is a risk that: Medical staff cannot gain access to a ward during a medical emergency in any of the departments that are based in the Womens and Childrens Unit and there is the potential for baby's to be removed from the Maternity Ward as the baby tagging system will not alarm If this occurs this may result in: delays to urgent patient care and the risk to babies being taken from the ward	1) ELPAS failure in the Womens and Childrens Building and A&E Department 2) The department no longer has a door access control system - Investigation Phase 3) The department no longer has a door access control system - Planning Phase 4) The department no longer has a door access control system - Implementation Phase 5) No assurance that staff medical/nursing are able to gain immediate access to Neonatal unit in an emergency situation 6) No assurance can be given - that out of hours access to the building would be immediate in an emergency situation 6)	1) To advise Trust Quality & Safety Team to enable an Internal Alert be issued 1a) Cascade ELPAS failure to all staff 2) Investigate currently used access control systems trust wide to develop a standardised approach to resolving the situation 3) Get quotations for a new door access control system for the unit to allow staff free access during day to day and emergency scenarios. 4) Once quote is agreed, install and configure the new door access control system. 5) As above - replace system In interim - Key pad access to be put on NNU rear door to allow timely access to unit 6) As above - replace system 6a) In interim all staff to use key pad to "buzz" labour ward to gain access 6b) To investigate the feasibility of installing a	1) Complete 02/10/2014 1a) Complete 02/10/2014 2) Complete 24/10/2014 3) Complete 15/10/2014 4) Due 30/11/2014 24/10/2014 Meeting held with Works, Paxton to be fitted and Elpas updated 5) Due 30/11/2014 24/10/2014 Meeting held with Works, Paxton to be fitted and Elpas updated 6) Complete 15/10/2014 6a) Due 30/11/2014 24/10/2014 Meeting held with Works, Paxton to be fitted and Elpas updated 6b) Complete 15/10/201	28/10/14	29/10/14	01/12/14	Pamela Yanez	**20** Severity: 4 Likelihood: 5	**20** Severity: 4 Likelihood: 5

New Risks Scoring 15+ Identified Last Month

R/R Ref No	Division / Directorate / Corporate Department	Source	Description of Risk	Issue	Action Plan Summary	Action Progress	Date Received	Last Review Date	Target Date / Next Review Date	Lead	Risk Level (Initial)	Risk Level (Current/ Residual)
					keypad access to be put on the side entrance Cascade information to staff							

Total Number of Risks: 1

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF MEETING

29th OCTOBER 2014

BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL

Present:	
David Allison	Chief Executive
Cathy Bond	Non-Executive Director
Michael Carr	Chairman
Jill Galvani	Director of Nursing and Midwifery
Sharon Gilligan	Director of Operations
Anthony Hassall	Director of Strategic & Organisational Development
Andrea Hodgson	Non-Executive Director
Graham Hollick	Non-Executive Director
Jeff Kozer	Non-Executive Director
Cathy Maddaford	Non-Executive Director
Evan Moore	Medical Director
Alistair Mulvey	Director of Finance
Jean Quinn	Non-Executive Director
Apologies:	
None	
In attendance:	
Carole Self	Associate Director of Governance (minutes)
Mark Blakeman	Director of Infrastructure & Informatics
Terry Whalley	Project Director
Governors:	None
Members of the Public:	None
Members of Staff :	Barbara Crampton

Reference	Minute	Action
BM 14-15/109	**Apologies for Absence** None	
BM 14-15/110	**Declarations of Interest** None	
BM 14-15/111	**Patient's Story** The Director of Nursing and Midwifery provided the Board with a positive story which had been published on NHS Choices in which the staff on Ward 54 had been praised.	

Reference	Minute	Action
	The Board was pleased with the feedback, however it expressed a preference for stories which reflect some of the current difficulties facing the Trust.	
BM 14-15/112	**Chairman's Business** The Chairman recorded his thanks for the excellent contributions from Trust staff who took part in the Live Broadcasts from the hospital on the previous Sunday for Radio 2 and BBC Sunday Morning Live. He commended the Communications team for their hard work in making this a success. Board Members were reminded of the joint session with Governors on the 4th November 2014, the topic of discussion being "Holding to Account" to be led by Mrs Self.	
BM 14-15/113	**Chief Executive's Report** The Chief Executive provided an overview of the key highlights in the Chief Executive's Report. The Board was informed of the priority areas as agreed by the Vision 2018 partners as well as the Strategic Leaders' Group meeting arranged for 27 November 2014 which was intended to ensure that greater strategic progress was enabled. The Chief Executive updated the Board on the positive telephone call with the Regulator Monitor which included an update on the Trust's cash position; the draft report following the CQC responsive inspection and the change in the relationship team at Monitor. The Board was informed of the handover arrangements from Atkins/FTI on the CIP Programme and the work undertaken on the delivery of 2014/15 plans and the development of plans for 2015/16. The Chief Executive reported good progress following a full review of the workstreams undertaken on the previous day. The Chief Executive was pleased to report on the JAG assessment that had recently been undertaken on the endoscopy suite which was now a state of the art facility. Good levels of leadership and management were noted during the assessment with a verbal recommendation from the assessment team for the Trust to be fully accredited. The Trust is now awaiting the formal outcome which will follow a quality assurance process. The Board was provided with an update on the current levels of C difficile being reported in the Trust which included the discussions with the CCG on cases that were regarded as being unavoidable. The Chief Executive advised that he was hopeful therefore of being back on trajectory very shortly. The Chief Executive updated the Board on the latest position with regards to the CPE outbreak and the positive impact that the ability to undertake rapid detection had made. Concerns were raised over the CPE outbreak at the Countess of Chester and the impact on the Vascular	

Reference	Minute	Action
	Elective Work which was essential to reducing waiting times and improving clinical care. It was agreed that this would be discussed further with the Countess of Chester. The Board was advised of the preparations for the "Go Live" of Millennium on the 15 November 2014 which included the huge amount of training being undertaken. The Chief Executive reported positively on the work being undertaken to reduce the levels of sickness absence. He also commended to the Board the Listening into Action "Pass it on" event which was being held on the 5th December 2014. Finally good progress was reported on the A & E performance for Q2 this being the achievement of 94% against the planned trajectory of 94%. The Chief Executive also reported that compliance had been achieved against the 95% standard for the last 6 weeks.	**DA**
BM 14-15/114	**Half Year Review of Annual Plan 2014-15 Objectives and Outline of Process for Annual Plan 2015-16** The Director of Strategic and Organisational Development presented the half year review of the Annual Plan which included an outline of the methodology used to assess progress using a Red or Green rating. The Board was asked to review the progress made to date and the actions agreed by the Executive Team to deliver the Trust Objectives by the end of the year. The Board was advised that progress was monitored with the Divisions on a monthly and quarterly basis and an overview of the planning timetable for 2015/16 had been undertaken at the Finance, Business Performance and Assurance Committee although the guidance from Monitor was still awaited. The Board sought and received clarity on the latest position with regards to the staff impacted by the Healthy Child Programme following the outcome of the tender exercise. The Board also sought assurance on whether the actions detailed in the half year review would deliver the overall results by the end of the year along with confirmation that the areas reported as green did not mask any areas of concern. The Director of Strategic and Organisational Development assured the Board that the detail behind the plans was discussed at sub-committee level however he agreed to report against a trajectory of improvement in the future.	**AH**
BM 14-15/115	**Integrated Performance Report** **Integrated Dashboard and Exception Reports** The Director of Infrastructure and Informatics presented the integrated performance report and outlined the current position against key	

Reference	Minute	Action
	performance standards. The Board noted that the metrics still needed a refresh to take into account the learning from the recent AQUA event. The Board noted that the Monitor governance rating would not be green for Q2 as the Trust had experienced more than 1 governance concern. The position regarding RTT was discussed following the planned non-achievement of one target in September as a result of the national initiative to reduce long waiting times. The Associate Director of Governance provided clarity to the Board on the impact of non-achievement of the trajectory for C difficile as per the Risk Assessment Framework although she confirmed that the Trust was hopeful that this would not be the case. The Medical Director provided an update on the two Never Events and the root cause analysis now being undertaken, as well as confirming that the World Health Organisation (WHO) checklist had been followed at the beginning of the surgery. The Board sought to establish the impact on patients overall as a result of the RTT initiative. The Director of Operations confirmed that the waiting list had been reduced by over 400 patients at a time when demand continued. She also confirmed that some of the lists had now reduced from 18 weeks to 16 weeks.	
BM 14-15/116	**Finance Report** The Director of Finance presented the Finance Report which provided an overview of the Trust's high level financial performance to the end of Month 6. The planned income and expenditure position for Month 6 showed an in-month deficit of £368k against a plan of £356k resulting in an adverse variance of £12k in- month. The cumulative position for the 6 months showed a cumulative deficit of £5,148k against a planned deficit of £4,563k representing an adverse variance of £585k. The Board was advised that a clear message had been provided to the organisation that given the financial position, it was necessary to cease all non-essential expenditure; where possible delay any necessary expenditure; avoid increases in pay costs wherever possible and to continue to generate and deliver against further savings ideas to close the financial gap. The Director of Finance reported the cash position as £17.4m which was £13.5 m better than plan. He outlined the key reasons for the improvement these being: the cash management actions; payments received early (ahead of terms)'; capital spend below plan in the main due to Cerner and the drawdown of the first tranche of the loan. The Board was advised that a sustainable income and expenditure position was required over the next 12 months in order to avoid being in the same position in the future.	

Reference	Minute	Action
	The Board was advised that as at month 6 the CIP schemes had delivered £2.7m, a shortfall of £2.1m against the year to date target of £4.8m. The Director of Finance confirmed that the latest CIP forecast was £10.6m against a £13m target. The Board was provided with an overview of the new style finance report which now incorporated a focus on Divisional performance, prepared by the Associate Directors of Operations. The Director of Finance reported an improvement in the Medical and Acute Division and a significant deficit in the Womens', Childrens' and Surgical Division for which a recovery plan was being developed. The Board was asked to provide feedback on the content and format of the new style report. The Director of Finance concluded his presentation of the report by confirming that the Trust needed to have a surplus of £586k at Month 7 in order for a return to plan to be achieved. Mr Hollick commended the Trust on its current cash position and the redesigned finance report. Mrs Bond asked whether there were any risks associated with the Trust not completing its Capital Programme. The Director of Finance confirmed that the ITFF loan was predicated on the delivery of the capital programme, he was anxious therefore if there were to be any slippage. He outlined the strategy for capital going forward and confirmed that next year Cerner would consume the bulk of this with the remainder being committed to the maintenance of the estate. He confirmed that the only significant investment so far would be the £0.5m expected for the pharmacy robot. He confirmed that the Financial Management Group and the Finance Business Performance and Assurance Committee would be reviewing the programme as part of its November reporting cycle. The Board discussed the concerns debated at the Finance Business Performance and Assurance Committee associated with the pressures of winter and the closing of beds whilst trying to reduce pay and non-pay expenditure. The Board recognised the requirement for transformational change if the reduction in beds was going to be achieved.	
BM 14-15/117	**Report of the Finance, Business Performance and Assurance Committee – 24 October 2014** Mr Hollick provided an overview of the tabled Chairs report from the Finance Business Performance and Assurance Committee held on the 24th October 2014. The key highlights included the assurance received on the national procurement initiative; the discussion on the recommendation for the Q2 Monitor statement to be agreed later in the Board Meeting; the detailed work being undertaken on the budget planning and service line reporting programme with the agreement that the latter be implemented by January	

Reference	Minute	Action
	2015 and the review of benefits and risks associated with the key stages of the Cerner Programme. The Chairman asked members to review the Finance Business Performance and Assurance papers against the Chair's Report and consider whether assurance was being provided to those members not in attendance.	**ALL**
BM 14-15/118	**15 Steps Board Walkabout Update Report** The Director of Nursing and Midwifery presented the update report on the Board Walkabouts confirming that the recommendation from the Council of Governors was to retain the number of teams at 8; to continue with the announced walkabouts but reflect the 24 hour/7 day nature of the service and align the walkabouts with the CQC inspection methodology to provide additional levels of assurance to the organisation. The Board was advised that the system of feedback was currently being developed and that the walkabouts in the future would cover elements of safety as recommended from the AQUA event. The programme of walkabouts would begin again from December 2014. The Board reviewed and approved the proposals.	
BM 14-15/119	**Annual Medical Appraisal for the Year 2013/14** The Medical Director presented the Annual Medical Appraisal Report for 2013/14 as mandated. He confirmed that the process for revalidation had started well nationally and that no issues had been identified in the Trust. He commended Dr Debra King on her involvement and advised the Board that the work being undertaken was being used as a model to inform other Boards. The Board was advised of the numbers of doctors who had undergone investigation or remediation in the last year, none of which had led to a deferral. The Board was asked to note the report and agree to receive the next report on the 2014/15 position in November 2015.	
BM 14-15/120	**Infection Prevention and Control Annual Report** The Director of Nursing and Midwifery presented the Infection Prevention and Control Annual Report 2013/14 and highlighted the work undertaken to reduce the numbers of MRSA and C difficile infections; the challenges of CPE and the work undertaken to address this and the implementation of the Pseudomonas aeruginosa guidance for Augmented Care Units. The Board was advised of the need to review the isolation facilities in the coming year and sought assurance that the HPV programme would not be suspended.	

Reference	Minute	Action
	The Director of Nursing and Midwifery provided further clarity around the compliance process for staff following hand hygiene audits and the next steps for infection control and the link to the IT strategy. The Board thanked the Director of Nursing and Midwifery for the report.	
BM 14-15/121	**Research and Development Strategy 2014-2019** The Medical Director presented the Research and Development Strategy 2014-19 and confirmed that as per the half year review the Trust was on track with its strategic objective in relation to research. The Board was advised of the four key priorities for research and development and provided with an overview of the current action plan. The Board asked for the Medical Director to consider holding an Annual Research and Innovation Forum in order to showcase some of this work. The Medical Director confirmed that many clinicians did undertake research as part of their academic studies so it was worthy of consideration. The Board noted the contents of the strategy.	**EM**
BM 14-15/122	**Cerner Future Phases** The Director of Infrastructure and Informatics presented the Cerner Future Phases report and asked the Board to note the previous discussions undertaken at the Finance Business Performance and Assurance Committee as reported earlier in the meeting. The Board was advised that the implementation plans for Phase 2B were on track and that over 50% of staff had now been trained at the mid- way point. The Director of Infrastructure and Informatics advised that none of the test issues identified were mission critical from a functionality perspective. He further advised that twice daily meetings were taking place ahead of "Go Live" on the 15th November to ensure minimal negative impact. The Board clarified the situation with regards to the switch off from PCIS and the mitigation of any risks associated with this. The Board was advised that there would be a team of 50 pharmacists and junior doctors available on the weekend of the 15th November in order that the migration onto the new system could take place ward by ward. The Director of Infrastructure and Informatics further assured the Board that a team of "floorwalkers" would be available 24 hours per day for the first week to assist with any " teething" problems. The Board reviewed the revised costs of the programme taking into account the implications of the Trust's successful NHS England "Tech Fund" bid and noted the range of cash releasing benefits which had now been developed into Project Outline Documents which were incorporated into the financial forecasting.	

Reference	Minute	Action
	The Board sought clarity around the communications of the "Go Live" of Phase 2B and were assured that this would be undertaken once the Trust was clear about its success. The Board agreed to continue with Phase 2b and 2c as planned, progress to Phase 3 being subject to a further review by the Board in due course.	
BM 14-15/123	**External Assessment** **Month 6 Monitor Compliance Report** The Director of Finance asked the Board to review the statements on Page 122 and consider each one in turn. The Board agreed with the responses for finance and governance as provided in the report along with the narrative subject to a slight amendment to the sentence regarding c difficile to emphasise that this was also identified as a risk in the annual planning stages. The Board also agreed to the inclusion of an additional statement on Page 114 to support the forecast position following discussion in the private session of the Board.	**CS** **AM**
BM 14-15/124	**Board of Directors** **Minutes of the meeting dated 24 September 2014** The minutes of the meeting held on the 24 September 2014 were agreed as a correct record of the meeting**.** **Board Action Log** The Board reviewed the action log and concluded that this provided an up to date view of progress.	
BM 14-15/125	**Any Other Business** Mr Hollick asked for an overview of the current provision of end of life care. The Director of Nursing and Midwifery provided this and advised that a paper outlining the current position was due to be presented to the Quality and Safety Committee in November.	
BM 14-15/126	**Items for BAF/Risk Register** None	
BM 14-15/127	**Date and Time of Next Meeting** Wednesday 26th November 2014 at 9.00 a.m. in the Boardroom, Education Centre, Arrowe Park Hospital.	

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Chairman

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Date

ACTION LOG

Board of Directors

Updated – 18 November 2014

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 29.10.14						
Oct - 14	BM14-15/113	CEO to discuss with CoCH concerns in relation to CPE and impact on vascular elective work	DA	**Update to be provided in the CEO Report**	Nov 14	
Oct - 14	BM14-15/114	Report against a trajectory of improvement in the future in relation to the Annual Plan	AH		Jan 15	
Oct - 14	BM14-15/117	Review of Finance, Business Performance and Assurance papers against the Chair's Report to ensure assurance is provided to members not in attendance	All		Jan 15	**To be included as part of Governance Review by Associate Director of Governance**
Oct - 14	BM14-15/121	Consideration to an Annual Research and Innovation Forum	EM			
Oct - 14	BM14-15/123	Amend the Board Q2 statement as per the Board minute	CS	**Completed**		
Oct - 14	BM14-15/123	Include additional statement legacy financial forecast in the Q2 Governance Statement	AM	**Completed**		

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 24.09.14						
Sept - 14	BM 14–15/084	CEO to write to commissioners raising concerns around levels of demand that currently exceed significantly the block contract and ask that the risk be shared	DA		Nov 14	
Sept - 14	BM 14-15/087	Board Walkabouts to include a review of Cerner post implementation	JG	**To be included as part of programme from Dec 2014**	Oct 14	
Sept - 14	BM 14-15/089	Narrative to be included in future finance reports when flexible labour is used	AM	**Completed**	Oct 14	
Sept - 14	BM 14-15/089	Further strategic review of future bed requirements to be undertaken at Board	AM	**To be undertaken in Dec 2014 as part of Board Development**	Nov 14	
Date of Meeting 30.07.14						
July - 14	BM 14-15/061	Update on complaints handling	JG	**On Agenda Nov 2014**	Nov 14	
July - 14	BM 14-15/063	Algorithm to be produced that took into account changes in contractual income and mapped through to the impact on activity and productivity	AM/SG		Nov 14	
July - 14	BM 14-15/073	Provide a progress update on compliance with Health and Safety Legislation	AH	**On Agenda Nov 2014**	Nov 14	
July - 14	BM 14-15/073	Explore the possibility of the internal auditors undertaking a governance review on health and safety	AH		Nov 14	

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting: 28.05.14						
May 14-	BM 14-15/039	Undertake a review of headroom percentages for nurse staffing once NICE guidelines were published.	JG	**To be included in Board Nursing Staffing update in November 2014**	Oct 14	