

Board of Directors
Public Board

24 February 2016

**MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 24 FEBRUARY 2016
 COMMENCING AT 9.00AM IN THE
 BOARD ROOM
 EDUCATION CENTRE, ARROWE PARK HOSPITAL**

AGENDA

- | | | |
|------------------------------------|------|---|
| 1. Apologies for Absence | 0900 | v |
| Chairman | | |
| 2. Declarations of Interest | | v |
| Chairman | | |
| 3. Patient's story | | v |
| Director of Nursing and Midwifery | | |
| 4. Chairman's Business | | v |
| Chairman | | |
| 5. Chief Executive's Report | 0930 | d |
| Chief Executive | | |

6. Strategy and Development

- | | | |
|--------------------------------------|--|---|
| 6.1 Vanguard Programme Update | | d |
| Director of Strategy | | |

7. Performance and Improvement

- | | | |
|---|------|---|
| 7.1 Integrated Performance Report | 1015 | |
| 7.1.1 Integrated Dashboard and Exception Reports | | d |
| Director of Infrastructure and Informatics | | |
| 7.1.2 Month 10 Finance Report | | d |
| Chief Executive / Acting Director of Finance | | |

8. Quality

- | | | |
|--|--|---|
| 8.1 Equality and Diversity Annual Report | | d |
| Director of Nursing and Midwifery | | |
| 8.2 Community Paediatrics | | d |
| Interim Director of Operations | | |
| 8.3 Care Quality Inspections | | d |
| Medical Director/Director of Nursing and Midwifery | | |

9. Governance

- 9.1 Report of the Finance Business Performance and Assurance Committee 19 February 2016** *To follow* d
Chair of the Finance Business Performance and Assurance
- 9.5 Board of Directors** d
- 9.5.1 Minutes of the Previous Meeting**
- 27 January 2016
- 9.5.2 Board Action Log**
Director of Corporate Affairs

10. Standing Items

- 10.1 Items for BAF/Risk Register** v
Chairman
- 10.2 Any Other Business** v
Chairman
- 10.3 Date and Time of Next Meeting** v
Wednesday 30 March 2016 at 9am

Board of Directors	
Agenda Item	5.0
Title of Report	Chief Executive's Report
Date of Meeting	24 February 2016
Author	David Allison, Chief Executive
Accountable Executive	David Allison, Chief Executive
BAF References <ul style="list-style-type: none"> • Strategic Objective • Key Measure • Principal Risk 	ALL
Level of Assurance <ul style="list-style-type: none"> • Positive • Gap(s) 	Positive
Purpose of the Paper <ul style="list-style-type: none"> • Discussion • Approval • To Note 	To Note
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken <ul style="list-style-type: none"> • Yes • No 	N/A

CCG

Contract negotiations continue. Efforts have been doubled to ensure that progress is made with the alliance contract around emergency care and our main contract with the CCG with the aspiration of signing off contracts by the 31st March. This deadline will be challenging but we will aspire to deliver this target in line with the planning guidance that has been issued.

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Strategic Estates Partnership

Board members will recall that at the meeting in January 2016 I provided an update on the work being progressed to develop a strategic estates partnership with a view to exploring how the Trust could manage its estate in an alternative way through the use of VAT efficient funding. The Trust has sought legal advice and is currently exploring the benefits of holding a “soft marketing day” with the private sector to help formulate the specification without providing any commitment at this stage.

The Countess of Chester CoCH has also expressed an interest in progressing in this manner and the Trust will therefore look to agree a common process, not necessarily a shared outcome although the costs could be shared. I am pleased that John Sullivan, Non-Executive will be working with myself and Mark Blakeman to progress this work.

Should the Trust wish to progress with a partnership agreement following the “soft Marketing day” and further analysis of the benefits and risks, then the Trust is advised that the OJEU process required to secure a partner would take in the region of 7 months.

The Board will be provided with regular updates as part of its strategic discussions.

Delivering the Five Year Forward View

Attached to this report is the Five Year Forward View authored by the six national NHS bodies, it sets out a clear list of national priorities for 2016/17 and longer-term challenges for local systems, together with financial assumptions and business rules. As previously advised each Trust is required to produce two separate but connected plans as follows:

- a five year Sustainability and Transformation Plan (STP), place-based and driving the Five Year Forward View; and
- a one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP.

The Board will continue its strategic discussions and planning based on this view.

Wirral Vanguard Value Proposition

The Value Proposition submission for 2016/17 was submitted to NHS England on 8th February 2016. The development period was onerous and did not afford the opportunity for full partner engagement. The Trust has met with the Vanguard team subsequently to better understand the submission and have written to the CCG to identify opportunities for improvement and will be fully involved in what will be an iterative process moving forward.

Acute Care Alliance

Discussions with the Countess of Chester continue with the immediate priorities being around the South Mersey approach to the Cheshire and Merseyside Maternity Vanguard and progressing Carter efficiencies focusing on procurement, IT and estates. Emphasis is also being given to developing the necessary governance arrangements and project management resource.

David Allison
Chief Executive

February 2016

The background of the cover features a photograph of a woman holding a baby. A healthcare professional, wearing a white coat and glasses, is leaning over to examine the baby. The image is overlaid with a semi-transparent blue geometric pattern of various shades of blue triangles and squares. The title text is centered over this image.

Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21

December 2015

Delivering the Forward View: NHS planning guidance

2016/17 – 2020/21

Version number: 2

First published: 22 December 2015

Prepared by: NHS England, NHS Improvement (Monitor and the NHS Trust Development Authority), Care Quality Commission (CQC), Health Education England (HEE), National Institute of Health and Care Excellence (NICE), Public Health England (PHE).

This document is for: Commissioners, NHS trusts and NHS foundation trusts.

Publications Gateway Reference: 04437

The NHS Five Year Forward View sets out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care services including:

- NHS England*
- NHS Improvement (Monitor and the NHS Trust Development Authority)
- Health Education England (HEE)
- The National Institute for Health and Care Excellence (NICE)
- Public Health England (PHE)
- Care Quality Commission (CQC)

*The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

Introduction

1. The Spending Review provided the NHS in England with a credible basis on which to accomplish three interdependent and essential tasks: first, to implement the [Five Year Forward View](#); second, to restore and maintain financial balance; and third, to deliver core access and quality standards for patients.
2. It included an £8.4 billion real terms increase by 2020/21, front-loaded. With these resources, we now need to close the health and wellbeing gap, the care and quality gap, and the finance and efficiency gap.
3. In this document, authored by the six national NHS bodies, we set out a clear list of national priorities for 2016/17 and longer-term challenges for local systems, together with financial assumptions and business rules. We reflect the settlement reached with the Government through its new [Mandate to NHS England](#) (annex 2). For the first time, the Mandate is not solely for the commissioning system, but sets objectives for the NHS as a whole.
4. We are requiring the NHS to produce two separate but connected plans:
 - a five year Sustainability and Transformation Plan (STP), place-based and driving the Five Year Forward View; and
 - a one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP.
5. The scale of what we need to do in future depends on how well we end the current year. The 2016/17 financial challenge for each trust will be contingent upon its end-of-year financial outturn, and the winter period calls for a relentless focus on maintaining standards in emergency care. It is also the case that local NHS systems will only become sustainable if they accelerate their work on prevention and care redesign. We don't have the luxury of waiting until perfect plans are completed. So we ask local systems, early in the New Year, to go faster on transformation in a few priority areas, as a way of building momentum.

Local health system Sustainability and Transformation Plans

6. We are asking every health and care system to come together, to create its own ambitious local blueprint for accelerating its implementation of the Forward View. STPs will cover the period between October 2016¹ and March 2021, and will be subject to formal assessment in July 2016 following submission in June 2016. We are asking the NHS to spend the next six months delivering core access, quality and financial standards while planning properly for the next five years.

Place-based planning

7. Planning by individual institutions will increasingly be supplemented with planning by place for local populations. For many years now, the NHS has emphasised an organisational separation and autonomy that doesn't make sense to staff or the patients and communities they serve.
8. System leadership is needed. Producing a STP is not just about writing a document, nor is it a job that can be outsourced or delegated. Instead it involves five things: (i) local leaders coming together as a team; (ii) developing a shared vision with the local community, which also involves local government as appropriate; (iii) programming a coherent set of activities to make it happen; (iv) execution against plan; and (v) learning and adapting. Where collaborative and capable leadership can't be found, NHS England and NHS Improvement² will need to help secure remedies through more joined-up and effective system oversight.
9. Success also depends on having an open, engaging, and iterative process that harnesses the energies of clinicians, patients, carers, citizens, and local community partners including the independent and voluntary sectors, and local government through health and wellbeing boards.
10. As a truly place-based plan, the STPs must cover all areas of CCG and NHS England commissioned activity including: (i) specialised services, where the planning will be led from the 10 collaborative commissioning hubs; and (ii) primary medical care, and do so from a local CCG perspective, irrespective of delegation arrangements. The STP must also cover better integration with local authority services, including, but not limited to, prevention and social care, reflecting local agreed health and wellbeing strategies.

¹ For the period October 2016 – March 2017, the STP should set out what actions are planned but it does not need to revisit the activity and financial assumptions in the 2016/17 Operational Plan.

² NHS Improvement will be the combined provider body, bringing together Monitor and the NHS Trust Development Authority (TDA).

Access to future transformation funding

11. For the first time, the local NHS planning process will have significant central money attached. The STPs will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards. This step is intended to reduce bureaucracy and help with the local join-up of multiple national initiatives.
12. The Spending Review provided additional dedicated funding streams for transformational change, building up over the next five years. This protected funding is for initiatives such as the spread of new care models through and beyond the vanguards, primary care access and infrastructure, technology roll-out, and to drive clinical priorities such as diabetes prevention, learning disability, cancer and mental health. Many of these streams of transformation funding form part of the new wider national Sustainability and Transformation Fund (STF). For 2016/17 only, to enable timely allocation, the limited available additional transformation funding will continue to be run through separate processes.
13. The most compelling and credible STPs will secure the earliest additional funding from April 2017 onwards. The process will be iterative. We will consider:
 - (i) the quality of plans, particularly the scale of ambition and track record of progress already made. The best plans will have a clear and powerful vision. They will create coherence across different elements, for example a prevention plan; self-care and patient empowerment; workforce; digital; new care models; and finance. They will systematically borrow good practice from other geographies, and adopt national frameworks;
 - (ii) the reach and quality of the local process, including community, voluntary sector and local authority engagement;
 - (iii) the strength and unity of local system leadership and partnerships, with clear governance structures to deliver them; and
 - (iv) how confident we are that a clear sequence of implementation actions will follow as intended, through defined governance and demonstrable capabilities.

Content of STPs

14. The strategic planning process is intended to be developmental and supportive as well as hard-edged. We set out in annex 1 of this document a list of ‘national challenges’ to help local systems set out their ambitions for their populations. This list of questions includes the objectives set in the Mandate. Do not over-interpret the list as a narrow template for what constitutes a good local plan: the most important initial task is to create a clear overall vision and plan for your area.
15. Local health systems now need to develop their own system wide local financial sustainability plan as part of their STP. Spanning providers and commissioners, these plans will set out the mixture of demand moderation, allocative efficiency, provider productivity, and income generation required for the NHS locally to balance its books.

Agreeing ‘transformation footprints’

16. The STP will be the umbrella plan, holding underneath it a number of different specific delivery plans, some of which will necessarily be on different geographical footprints. For example, planning for urgent and emergency care will range across multiple levels: a locality focus for enhanced primary care right through to major trauma centres.
17. The first critical task is for local health and care systems to consider their transformation footprint – the geographic scope of their STP. They must make proposals to us by Friday 29 January 2016, for national agreement. Local authorities should be engaged with these proposals. Taken together, all the transformation footprints must form a complete national map. The scale of the planning task may point to larger rather than smaller footprints.
18. Transformation footprints should be locally defined, based on natural communities, existing working relationships, patient flows and take account of the scale needed to deliver the services, transformation and public health programmes required, and how it best fits with other footprints such as local digital roadmaps and learning disability units of planning. In future years we will be open to simplifying some of these arrangements. Where geographies are already involved in the Success Regime, or devolution bids, we would expect these to determine the transformation footprint. Although it is important to get this right, there is no single right answer. The footprints may well adapt over time. We want people to focus their energies on the content of plans rather than have lengthy debates about boundaries.

19. We will issue further brief guidance on the STP process in January. This will set out the timetable and early phasing of national products and engagement events that are intended to make it much easier to answer the challenges we have posed, and include how local areas can best involve their local communities in creating their STPs, building on the [‘six principles’ created to support the delivery of the Five Year Forward View](#). By spring 2016, we intend to develop and make available roadmaps for national transformation initiatives.
20. We would welcome any early reactions, by Friday 29 January 2016, as to what additional material you would find most helpful in developing your STP. Please email england.fiveyearview@nhs.net, with the subject title ‘STP feedback’. We would also like to work with a few local systems to develop exemplar, fast-tracked plans, and would welcome expressions of interest to the above inbox.

National 'must dos' for 2016/17

21. Whilst developing long-term plans for 2020/21, the NHS has a clear set of plans and priorities for 2016/17 that reflect the Mandate to the NHS and the next steps on Forward View implementation.
22. Some of our most important jobs for 2016/17 involve partial roll-out rather than full national coverage. Our ambition is that by March 2017, 25 percent of the population will have access to acute hospital services that comply with four priority clinical standards on every day of the week, and 20 percent of the population will have enhanced access to primary care. There are three distinct challenges under the banner of seven day services:
 - (i) reducing excess deaths by increasing the level of consultant cover and diagnostic services available in hospitals at weekends. During 16/17, a quarter of the country must be offering four of the ten standards, rising to half of the country by 2018 and complete coverage by 2020;
 - (ii) improving access to out of hours care by achieving better integration and redesign of 111, minor injuries units, urgent care centres and GP out of hours services to enhance the patient offer and flows into hospital; and
 - (iii) improving access to primary care at weekends and evenings where patients need it by increasing the capacity and resilience of primary care over the next few years.
23. Where relevant, local systems need to reflect this in their 2016/17 Operational Plans, and all areas will need to set out their ambitions for seven day services as part of their STPs.

The nine 'must dos' for 2016/17 for every local system:

1. Develop a high quality and agreed **STP**, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the **Forward View**.
2. Return the system to **aggregate financial balance**. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality.
3. Develop and implement a local plan to address the **sustainability and quality of general practice**, including workforce and workload issues.

4. Get back on track with **access standards for A&E and ambulance waits**, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.
5. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from **referral to treatment**, including offering patient choice.
6. Deliver the NHS Constitution **62 day cancer waiting standard**, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving **one-year survival rates** by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.
7. Achieve and maintain the **two new mental health access standards**: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a **dementia diagnosis** rate of at least two-thirds of the estimated number of people with dementia.
8. Deliver actions set out in local plans to transform care for people with **learning disabilities**, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.
9. Develop and implement an affordable plan to make **improvements in quality** particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of **avoidable mortality** rates by individual trusts.

24. We expect the development of new care models will feature prominently within STPs. In addition to existing approaches, in 2016/17 we are interested in trialing two new specific approaches with local volunteers:

- secondary mental health providers managing care budgets for tertiary mental health services; and
- the reinvention of the acute medical model in small district general hospitals.

Organisations interested in working with us on either of these approaches should let us know by 29 January 2016 by emailing england.fiveyearview@nhs.net

Operational Plans for 2016/17

25. An early task for local system leaders is to run a shared and open-book operational planning process for 2016/17. This will cover activity, capacity, finance and 2016/17 deliverables from the emerging STP. By April 2016, commissioner and provider plans for 2016/17 will need to be agreed by NHS England and NHS Improvement, based on local contracts that must be signed by March 2016.
26. The detailed requirements for commissioner and provider plans are set out in the technical guidance that will accompany this document. All plans will need to demonstrate:
- how they intend to reconcile finance with activity (and where a deficit exists, set out clear plans to return to balance);
 - their planned contribution to the efficiency savings;
 - their plans to deliver the key must-dos;
 - how quality and safety will be maintained and improved for patients;
 - how risks across the local health economy plans have been jointly identified and mitigated through an agreed contingency plan; and
 - how they link with and support with local emerging STPs.

The 2016/17 Operational Plan should be regarded as year one of the five year STP, and we expect significant progress on transformation through the 2016/17 Operational Plan.

27. Building credible plans for 2016/17 will rely on a clear understanding of demand and capacity, alignment between commissioners and providers, and the skills to plan effectively. A support programme is being developed jointly by national partners to help local health economies in preparing robust activity plans for 2016/17 and beyond.

Allocations

28. NHS England's allocations to commissioners are intended to achieve:

- greater equity of access through pace of change, both for CCG allocations and on a place-based basis;
- closer alignment with population need through improved allocation formulae including a new inequalities adjustment for specialised care, more sensitive adjustments for CCGs and primary care, and a new sparsity adjustment for remote areas; and
- faster progress with our strategic goals through higher funding growth for GP services and mental health, and the introduction of the Sustainability and Transformation Fund.

29. In line with our strategic priorities, overall primary medical care spend will rise by 4-5 percent each year. Specialised services funding will rise by 7 percent in 2016/17, with growth of at least 4.5 percent in each subsequent year. The relatively high level of funding reflects forecast pressures from new NICE legally mandated drugs and treatments.

30. To support long-term planning, NHS England has set firm three year allocations for CCGs, followed by two indicative years. For 2016/17, CCG allocations will rise by an average of 3.4 percent, and we will make good on our commitment that no CCG will be more than 5 percent below its target funding level. To provide CCGs with a total place-based understanding of all commissioned spend, alongside allocations for CCG commissioned activities, we will also publish allocations for primary care and specialized commissioned activity.

NHS England will in principle support any proposals from groups of CCGs, particularly in areas working towards devolution who wish to implement a more accelerated cross-area pace-of-change policy by mutual agreement.

31. Mirroring the conditionality of providers accessing the Sustainability and Transformation Fund, the real terms element of growth in CCG allocations for 2017/18 onwards will be contingent upon the development and sign off of a robust STP during 2016/17.

Returning the NHS provider sector to balance

32. During 2016/17 the NHS trust and foundation trust sector will, in aggregate, be required to return to financial balance. £1.8 billion of income from the 2016/17 Sustainability and Transformation Fund will replace direct Department of Health (DH) funding. The distribution of this funding will be calculated on a trust by trust basis by NHS Improvement and then agreed with NHS England.
33. NHS England and NHS Improvement are working together to ensure greater alignment between commissioner and provider financial levers. Providers who are eligible for sustainability and transformation funding in 2016/17 will not face a double jeopardy scenario whereby they incur penalties as well as losing access to funding; a single penalty will be imposed.
34. Quarterly release of these Sustainability Funds to trusts and foundation trusts will depend on achieving recovery milestones for (i) deficit reduction; (ii) access standards; and (iii) progress on transformation. The three conditions attached to the transitional NHS provider fund have to be hard-edged. Where trusts default on the conditions access to the fund will be denied and sanctions will be applied.
35. Deficit reduction in providers will require a forensic examination of every pound spent on delivering healthcare and embedding a culture of relentless cost containment. Trusts need to focus on cost reduction not income growth; there needs to be far greater consistency between trusts' financial plans and their workforce plans in 2016/17. Workforce productivity will therefore be a particular priority as just a 1 percent improvement represents £400 million of savings. All providers will be expected to evidence the effective use of e-rostering for nurses, midwives, Health Care Assistants (HCAs) and other clinicians to make sure the right staff are in the right place at the right time to ensure patients get the right hours of care and minimum time is wasted on bureaucracy. This approach will enable providers to reduce their reliance on agency staffing whilst compliance with the agency staffing rules will also reduce the rates paid. In addition, providers will need to adopt tightly controlled procurement practices with compliance incentives and sanctions to drive down price and unwarranted variation. For example, all providers will be expected to report and share data on what they are paying for the top 100 most common non-pay items, and be required to only pay the best price available for the NHS.

36. Capital investments proposed by providers should be consistent with their clinical strategy and clearly demonstrate the delivery of safe, productive services with a business case that describes affordability and value for money. Given the constrained level of capital resource available from 2016/17, there will be very limited levels of financing available and the repayment of existing and new borrowing related to capital investment will need to be funded from within the trust's own internally generated capital resource in all but the most exceptionally pre-agreed cases. Trusts will need to procure capital assets more efficiently, consider alternative methods of securing assets such as managed equipment services, maximize disposals and extend asset lives. In January, the DH will be issuing some revisions to how the PDC dividend will be calculated and a number of other changes to the capital financing regime.

Efficiency assumptions and business rules

37. The consultation on the tariff will propose a 2 percent efficiency deflator and 3.1 percent inflation uplift for 2016/17 (the latter reflecting a step change in pension-related costs). This reflects Monitor and NHS England's assessment of cost inflation including the effect of pension changes. To support system stability, we plan to remain on HRG4 for a further year and there will also be no changes to specialist top-ups in 2016/17; the specialised service risk share is also being suspended for 2016/17. We will work with stakeholders to better understand the impact of the move to HRG4+ and other related changes in 2017/18. For planning purposes, an indicative price list is being made available on the Monitor website. The consultation on the tariff will also include the timetable for implementing new payment approaches for mental health.
38. As notified in [Commissioning Intentions 2016/2017 for Prescribed Specialised Services](#), NHS England is developing a single national purchasing and supply chain arrangement for specialised commissioning high cost tariff excluded devices with effect from April 2016. Transition plans will be put in place prior to this date with each provider to transition from local to national procurement arrangements.
39. The 2 percent efficiency requirement is predicated upon the provider system meeting a forecast deficit of £1.8 billion at the end of 2015/16. Any further deterioration of this position will require the relevant providers to deliver higher efficiency levels to achieve the control totals to be set by NHS Improvement.
40. For 2016/17 the business rules for commissioners will remain similar to those for last year. Commissioners (excluding public health and specialised commissioning) will be required to deliver a cumulative reserve (surplus) of 1 percent. At the very least, commissioners who are unable to meet the cumulative reserve (surplus) requirement must deliver an in-year break-even position. Commissioners with a cumulative deficit will be expected to apply their increase in allocation to improving their bottom line position, other than the amount necessary to fund nationally recognised new policy requirements. Drawdown will be available to commissioners in line with the process for the previous financial year. CCGs should plan to drawdown all cumulative surpluses in excess of 1 percent over the next three years, enabling drawdown to become a more fluid mechanism for managing financial pressures across the year-end boundary.

41. Commissioners are required to plan to spend 1 percent of their allocations non-recurrently, consistent with previous years. In order to provide funds to insulate the health economy from financial risks, the 1 percent non-recurrent expenditure should be uncommitted at the start of the year, to enable progressive release in agreement with NHS England as evidence emerges of risks not arising or being effectively mitigated through other means. Commissioners will also be required to hold an additional contingency of 0.5 percent, again consistent with previous years.
42. CCGs and councils will need to agree a joint plan to deliver the requirements of the Better Care Fund (BCF) in 2016/17. The plan should build on the 2015/16 BCF plan, taking account of what has worked well in meeting the objectives of the fund, and what has not. CCGs will be advised of the minimum amount that they are required to pool as part of the notification of their wider allocation. BCF funding should explicitly support reductions in unplanned admissions and hospital delayed transfers of care; further guidance on the BCF will be forthcoming in the New Year.
43. Commissioners must continue to increase investment in mental health services each year at a level which at least matches their overall expenditure increase. Where CCGs collaborate with specialised commissioning to improve service efficiency, they will be eligible for a share of the benefits.
44. NHS England and NHS Improvement continue to be open to new approaches to contracting and business rules, as part of these agreements. For example, we are willing to explore applying a single financial control total across local commissioners and providers with a few local systems.

Measuring progress

45. We will measure progress through a new CCG Assessment Framework. NHS England will consult on this in January 2016, and it will be aligned with this planning guidance. The framework is referred in the Mandate as a CCG scorecard. It is our new version of the CCG assurance framework, and it will apply from 2016/17. Its relevance reaches beyond CCGs, because it's about how local health and care systems and communities can assess their own progress.

Timetable

Timetable	Date
Publish planning guidance	22 December 2015
Publish 2016/17 indicative prices	By 22 December 2015
Issue commissioner allocations, and technical annexes to planning guidance	Early January 2016
Launch consultation on standard contract, announce CQUIN and Quality Premium	January 2016
Issue further process guidance on STPs	January 2016
Localities to submit proposals for STP footprints and volunteers for mental health and small DGHs trials	By 29 January 2016
First submission of full draft 16/17 Operational Plans	8 February 2016
National Tariff S118 consultation	January/February 2016
Publish National Tariff	March 2016
Boards of providers and commissioners approve budgets and final plans	By 31 March 2016
National deadline for signing of contracts	31 March 2016
Submission of final 16/17 Operational Plans, aligned with contracts	11 April 2016
Submission of full STPs	End June 2016
Assessment and Review of STPs	End July 2016

Please note that we will announce the timetable for consultation and issuing of the standard contract separately. A more detailed timetable and milestones is included in the technical guidance that will accompany this document.

Annex 1: Indicative 'national challenges' for STPs

STPs are about the holistic pursuit of the triple aim – better health, transformed quality of care delivery, and sustainable finances. They also need to set out how local systems will play their part in delivering the Mandate (annex 2).

We will publish further guidance early in 2016 to help areas construct the strongest possible process and plan.

We will also make available aids (e.g. exemplar plans) and some hands-on support for areas as they develop their plans.

The questions below give an early sense of what you will need to address to gain sign-off and attract additional national investment.

We are asking local systems first to focus on creating an overall local vision, and the three overarching questions – rather than attempting to answer all of the specifics right from the start. We will be developing a process to offer feedback on these first, prior to development of the first draft of the detailed plans.

A. How will you close the health and wellbeing gap?

This section should include your plans for a 'radical upgrade' in prevention, patient activation, choice and control, and community engagement.

Questions your plan should answer:

1. How will you assess and address your most important and highest cost preventable causes of ill health, to reduce healthcare demand and tackle health inequalities working closely with local government?
 - How rapidly could you achieve full local implementation of the national Diabetes Prevention Programme? Why should Public Health England (PHE) and NHS England prioritise your geographical area (e.g. with national funding to support the programme)?
 - What action will you take to address obesity, including childhood obesity?
 - How will you achieve a step-change in patient activation and self-care? How will this help you moderate demand and achieve financial balance? How will you embed the six principles of engagement and involvement of local patients, carers, and communities developed to help deliver the Five Year Forward View?

2. How will you make real the aspiration to design person-centred coordinated care, including plans to ensure patients have access to named, responsible consultants?
3. How will a major expansion of integrated personal health budgets and implementation of choice – particularly in maternity, end-of-life and elective care – be an integral part of your programme to hand power to patients?
4. How are NHS and other employers in your area going to improve the health of their own workforce – for example by participating in the national roll out the Healthy NHS programme?

B. How will you drive transformation to close the care and quality gap?

This section should include plans for new care model development, improving against clinical priorities, and rollout of digital healthcare.

Questions your plan should answer:

1. What is your plan for sustainable general practice and wider primary care? How will you improve primary care infrastructure, supported in part through access to national primary care transformation funding?
2. How rapidly can you implement enhanced access to primary care in evenings and weekends and using technology? Why should NHS England prioritise your area for additional funding?
3. What are your plans to adopt new models of out-of-hospital care, e.g Multi-specialty Community Providers (MCPs) or Primary and Acute Care Systems (PACS)? Why should NHS England prioritise your area for transformation funding? And when are you planning to adopt forthcoming best practice from the enhanced health in care homes vanguards?
4. How will you adopt new models of acute care collaboration (accountable clinical networks, specialty franchises, and Foundation Groups)? How will you work with organisations outside your area and learn from best practice from abroad, other sectors and industry?
5. What is your plan for transforming urgent and emergency care in your area? How will you simplify the current confusing array of entry points? What's your agreed recovery plan to achieve and maintain A&E and ambulance access standards?
6. What's your plan to maintain the elective care referral to treatment standard? Are you buying sufficient activity, tackling unwarranted variation in demand, proactively offering patient choice of alternatives, and increasing provider productivity?

7. How will you deliver a transformation in cancer prevention, diagnosis, treatment and aftercare in line with the cancer taskforce report?
8. How will you improve mental health services, in line with the forthcoming mental health taskforce report, to ensure measureable progress towards parity of esteem for mental health?
9. What steps will your local area take to improve dementia services?
10. As part of the Transforming Care programme, how will your area ensure that people with learning disabilities are, wherever possible, supported at home rather than in hospital? How far are you closing out-moded inpatient beds and reinvesting in continuing learning disability support
11. How fast are you aspiring to improve the quality of care and safety in your organisations as judged by the Care Quality Commission (CQC)? What is your trajectory for no NHS trust and no GP practice to have an overall inadequate rating from the Care Quality Commission (CQC)?
12. What are you doing to embed an open, learning and safety culture locally that is ambitious enough? What steps are you taking to improving reporting, investigations and supporting patients, their families and carers, as well as staff who have been involved in an incident?
13. What plans do you have in place to reduce antimicrobial resistance and ensure responsible prescribing of antibiotics in all care settings? How are you supporting prescribers to enable them issue the right drugs responsibly? At the same time, how rapidly will you achieve full implementation of good practice in reducing avoidable mortality from sepsis?
14. How will you achieve by 2020 the full-roll out of seven day services for the four priority clinical standards?
15. How will you implement the forthcoming national maternity review, including progress towards new national ambitions for improving safety and increased personalisation and choice?
16. How will you put your Children and Young People Mental Health Plan into practice?
17. How quickly will you implement your local digital roadmap, taking the steps needed to deliver a fully interoperable health and care system by 2020 that is paper-free at the point of care? How will you make sure that every patient has access to digital health records that they can share with their families, carers and clinical teams? How will you increase your online offer to patients beyond repeat prescriptions and GP appointments?

18. What is your plan to develop, retrain and retain a workforce with the right skills, values and behaviours in sufficient numbers and in the right locations to deliver your vision for transformed care? How will you build the multidisciplinary teams to underpin new models of care? How ambitious are your plans to implement new workforce roles such as associate nurses, physician associates, community paramedics and pharmacists in general practice?
19. What is your plan to improve commissioning? How rapidly will the CCGs in your system move to place-based commissioning? If you are a devolution area, how will implementation delivery real improvements for patients?
20. How will your system be at the forefront of science, research and innovation? How are you implementing combinatorial innovation, learning from the forthcoming test bed programme? How will services changes over the next five years embrace breakthroughs in genomics, precision medicine and diagnostics?

C. How will you close the finance and efficiency gap?

This section should describe how you will achieve financial balance across your local health system and improve the efficiency of NHS services.

Questions your plan should answer:

1. How will you deliver the necessary per annum efficiency across the total NHS funding base in your local area by 2020/21?
2. What is your comprehensive and credible plan to moderate demand growth? What are the respective contributions in your local system of: (i) tackling unwarranted variation in care utilisation, e.g. through RightCare; (ii) patient activation and self-care; (iii) new models of care; and (iv) urgent and emergency care reform implementation?
3. How will you reduce costs (as opposed to growing income) and how will you get the most out of your existing workforce? What savings will you make from financial controls on agency, whilst ensuring appropriate staffing levels? What are your plans for improving workforce productivity, e.g. through e-rostering of nurses and HCAs? How are you planning to reduce cost through better purchasing and medicines management? What efficiency improvements are you planning to make across primary care and specialised care delivery?

4. What capital investments do you plan to unlock additional efficiency? How will they be affordable and how will they be financed?
5. What actions will you take as a system to utilise NHS estate better, disposing of unneeded assets or monetising those that could create longer-term income streams? How does this local system estates plan support the plans you're taking to redesign care models in your area?

Annex 2: The Government's mandate to NHS England 2016/17

The table below shows NHS England's objectives with an overall measurable goal for this Parliament and clear priority deliverables for 2016-17. The majority of these goals will be achieved in partnership with the Department of Health (DH), NHS Improvement and other health bodies such as Public Health England (PHE), Health Education England (HEE) and the Care Quality Commission (CQC). It also sets out requirements for NHS England to comply with in paragraph 6.2.

Read the full [Mandate to NHS England](#)

1. Through better commissioning, improve local and national health outcomes, particularly by addressing poor outcomes and inequalities.	
1.1 CCG performance	<p>Overall 2020 goals:</p> <ul style="list-style-type: none"> • Consistent improvement in performance of CCGs against new CCG assessment framework. <hr/> <p>2016-17 deliverables:</p> <ul style="list-style-type: none"> • By June, publish results of the CCG assessment framework for 2015-16, which provides CCGs with an aggregated Ofsted style assessment of performance and allows them to benchmark against other CCGs and informs whether NHS England intervention is needed. • Ensure new Ofsted-style CCG framework for 2016-17 includes health economy metrics to measure progress on priorities set out in the mandate and the NHS planning guidance including overall Ofsted-style assessment for each of cancer, dementia, maternity, mental health, learning disabilities and diabetes, as well as metrics on efficiency, core performance, technology and prevention. • By the end of Q1 of 2016-17, publish the first overall assessment for each of the six clinical areas above.

2. To help create the safest, highest quality health and care service.

2.1 Avoidable deaths and seven-day services

Overall 2020 goals:

- Roll out of seven-day services in hospital to 100 percent of the population (four priority clinical standards in all relevant specialities, with progress also made on the other six standards), so that patients receive the same standards of care, seven days a week.
- Achieve a significant reduction in avoidable deaths, with all trusts to have seen measurable reduction from their baseline on the basis of annual measurements.
- Support NHS Improvement to significantly increase the number of trusts rated outstanding or good, including significantly reducing the length of time trusts remain in special measures.
- Measurable progress towards reducing the rate of stillbirths, neonatal and maternal deaths and brain injuries that are caused during or soon after birth by 50 percent by 2030 with a measurable reduction by 2020.
- Support the NHS to be the world's largest learning organisation with a new culture of learning from clinical mistakes, including improving the number of staff who feel their organisation acts on concerns raised by clinical staff or patients.
- Measurable improvement in antimicrobial prescribing and resistance rates.

2016-17 deliverables:

- Publish avoidable deaths per trust annually and support NHS Improvement to help trusts to implement programme to improve from March 2016 baseline.
- Rollout of four clinical priority standards in all relevant specialties to 25 percent of population.
- Implement agreed recommendations of the National Maternity Review in relation to safety, and support progress on delivering Sign up to Safety.
- Support the Government's goal to establish global and UK baseline and ambition for antimicrobial prescribing and resistance rates.

<p>2.2 Patient experience</p>	<p>Overall 2020 goals:</p> <ul style="list-style-type: none"> • Maintain and increase the number of people recommending services in the Friends and Family Test (FFT) (currently 88-96 percent), and ensure its effectiveness, alongside other sources of feedback to improve services. • 50-100,000 people to have a personal health budget or integrated personal budget (up from current estimate of 4,000). • Significantly improve patient choice, including in maternity, end-of-life care and for people with long-term conditions, including ensuring an increase in the number of people able to die in the place of their choice, including at home. <p>2016-17 deliverables:</p> <ul style="list-style-type: none"> • Produce a plan with specific milestones for improving patient choice by 2020, particularly in maternity, end-of-life care (including to ensure more people are able to achieve their preferred place of care and death), and personal health budgets. • Building on the FFT, develop proposals about how feedback, particularly in maternity services, could be enhanced to drive improvements to services at clinical and ward levels.
<p>2.3 Cancer</p>	<p>Overall 2020 goals:</p> <ul style="list-style-type: none"> • Deliver recommendations of the Independent Cancer Taskforce, including: <ul style="list-style-type: none"> ○ significantly improving one-year survival to achieve 75 percent by 2020 for all cancers combined (up from 69 percent currently); and ○ patients given definitive cancer diagnosis, or all clear, within 28 days of being referred by a GP. <p>2016-17 deliverables:</p> <ul style="list-style-type: none"> • Achieve 62-day cancer waiting time standard. • Support NHS Improvement to achieve measurable progress towards the national diagnostic standard of patients waiting no more than six weeks from referral to test. • Agree trajectory for increases in diagnostic capacity required to 2020 and achieve it for year one. • Invest £340 million in providing cancer treatments not routinely provided on the NHS through the Cancer Drugs Fund, and ensure effective transition to the agreed operating model to improve its effectiveness within its existing budget.

3. To balance the NHS budget and improve efficiency and productivity

3.1 Balancing the NHS budget

Overall 2020 goals:

- With NHS Improvement, ensure the NHS balances its budget in each financial year.
- With the Department of Health and NHS Improvement, achieve year on year improvements in NHS efficiency and productivity (2-3 percent each year), including from reducing growth in activity and maximising cost recovery.

2016-17 deliverables:

- With NHS Improvement ensure the NHS balances its budget, with commissioners and providers living within their budgets, and support NHS Improvement in:
 - securing £1.3 billion of efficiency savings through implementing Lord Carter's recommendations and collaborating with local authorities on Continuing Healthcare spending;
 - delivering year one of trust deficit reduction plans and ensuring a balanced financial position across the trust sector, supported by effective deployment of the Sustainability and Transformation Fund; and
 - reducing spend on agency staff by at least £0.8 billion on a path to further reductions over the Parliament.
- Roll-out of second cohort of RightCare methodology to a further 60 CCGs.
- Measurable improvement in primary care productivity, including through supporting community pharmacy reform.
- Work with CCGs to support Government's goal to increase NHS cost recovery up to £500 million by 2017-18 from overseas patients.
- Ensure CCGs' local estates strategies support the overall goal of releasing £2 billion and land for 26,000 homes by 2020.

4. To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives.

<p>4.1 Obesity and diabetes</p>	<p>Overall 2020 goals:</p> <ul style="list-style-type: none"> • Measurable reduction in child obesity as part of the Government’s childhood obesity strategy. • 100,000 people supported to reduce their risk of diabetes through the Diabetes Prevention Programme. • Measurable reduction in variation in management and care for people with diabetes. <hr/> <p>2016-17 deliverables:</p> <ul style="list-style-type: none"> • Contribute to the agreed child obesity implementation plan, including wider action to achieve year on year improvement trajectory for the percentage of children who are overweight or obese. • 10,000 people referred to the Diabetes Prevention Programme.
<p>4.2 Dementia</p>	<p>Overall 2020 goals:</p> <ul style="list-style-type: none"> • Measurable improvement on all areas of Prime Minister’s challenge on dementia 2020, including: <ul style="list-style-type: none"> ○ maintain a diagnosis rate of at least two thirds; ○ increase the numbers of people receiving a dementia diagnosis within six weeks of a GP referral; and ○ improve quality of post-diagnosis treatment and support for people with dementia and their carers. <hr/> <p>2016-17 deliverables:</p> <ul style="list-style-type: none"> • Maintain a minimum of two thirds diagnosis rates for people with dementia. • Work with National Institute for Health Research on location of Dementia Institute. • Agree an affordable implementation plan for the Prime Minister’s challenge on dementia 2020, including to improve the quality of post-diagnosis treatment and support.

5. To maintain and improve performance against core standards

5.1 A&E, ambulances and Referral to Treatment (RTT)**Overall 2020 goals:**

- 95 percent of people attending A&E seen within four hours; Urgent and Emergency Care Networks rolled out to 100 percent of the population.
- 75 percent of Category A ambulance calls responded to within 8 minutes.
- At least 92% of patients on incomplete non-emergency pathways to have been waiting no more than 18 weeks from referral; no-one waits more than 52 weeks.

2016-17 deliverables:

- With NHS Improvement, agree improvement trajectory and deliver the plan for year one for A&E.
- Implement Urgent and Emergency Care Networks in 20 percent of the country designated as transformation areas, including clear steps towards a single point of contact.
- With NHS Improvement, agree improvement trajectory and deliver the plan for year one for ambulance responses; complete Red 2 pilots and decide on full roll-out.
- With NHS Improvement, meet the 18-week referral-to-treatment standard, including implementing patient choice in line with the NHS Constitution; and reduce unwarranted variation between CCG referral rates to better manage demand.

6. To improve out-of-hospital care.

6.1 New models of care and general practice**Overall 2020 goals:**

- 100 percent of population has access to weekend/evening routine GP appointments.
- Measurable reduction in age standardised emergency admission rates and emergency inpatient bed-day rates; more significant reductions through the New Care Model programme covering at least 50 percent of population.
- Significant measurable progress in health and social care integration, urgent and emergency care (including ensuring a single point of contact), and electronic health record sharing, in areas covered by the New Care Model programme.
- 5,000 extra doctors in general practice.

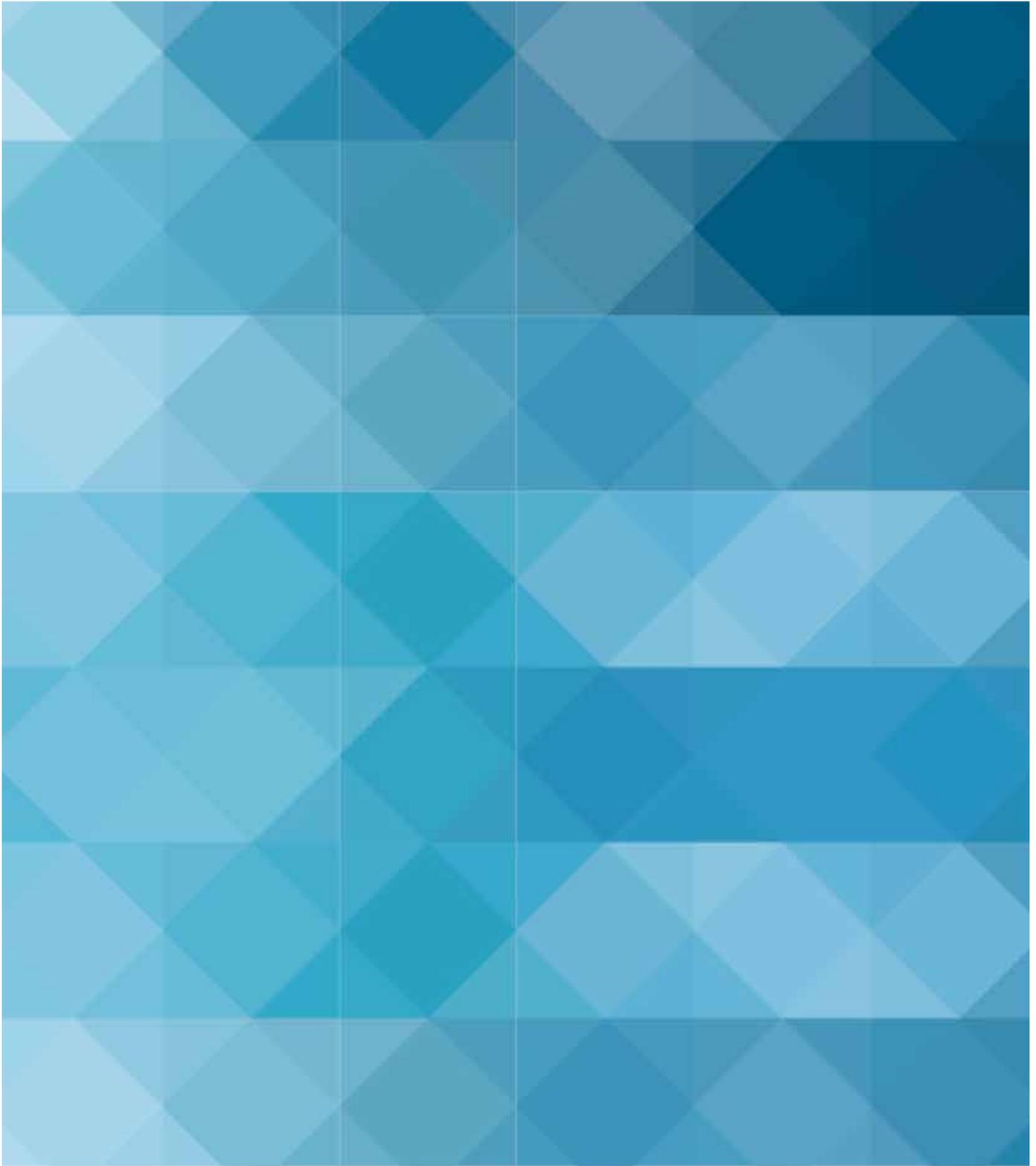
	<p>2016-17 deliverables:</p> <ul style="list-style-type: none"> • New models of care covering the 20 percent of the population designated as being in a transformation area to: <ul style="list-style-type: none"> ○ provide access to enhanced GP services, including evening and weekend access and same-day GP appointments for all over 75s who need them; and ○ make progress on integration of health and social care, integrated urgent and emergency care, and electronic record sharing. • Publish practice-level metrics on quality of and access to GP services and, with the Health and Social Care Information Centre, provide GPs with benchmarking information for named patient lists. • Develop new voluntary contract for GPs (Multidisciplinary Community Provider contract) ready for implementation in 2017-18.
<p>6.2 Health and social care integration</p>	<p>Overall 2020 goals:</p> <ul style="list-style-type: none"> • Achieve better integration of health and social care in every area of the country, with significant improvements in performance against integration metrics within the new CCG assessment framework. Areas will graduate from the Better Care Fund programme management once they can demonstrate they have moved beyond its requirements, meeting the government’s key criteria for devolution. • Ensure the NHS plays its part in significantly reducing delayed transfers of care, including through developing and applying new incentives. <p>2016-17 deliverables:</p> <ul style="list-style-type: none"> • Implement the Better Care Fund (BCF) in line with the BCF Policy Framework for 2016-17. • Every area to have an agreed plan by March 2017 for better integrating health and social care. • Working with partners, achieve accelerated implementation of health and social care integration in the 20 percent of the country designated as transformation areas, by sharing electronic health records and making measurable progress towards integrated assessment and provision. • Work with the Department of Health, other national partners and local areas to agree and support implementation of local devolution deals. • Agree a system-wide plan for reducing delayed transfers of care with overall goal and trajectory for improvement, and with local government and NHS partners implement year one of this plan.

	<p>2016-17 requirements:</p> <ul style="list-style-type: none"> • NHS England is required to: <ul style="list-style-type: none"> ○ ring-fence £3.519 billion within its allocation to CCGs to establish the Better Care Fund, to be used for the purposes of integrated care; ○ consult the Department of Health and the Department for Communities and Local Government before approving spending plans drawn up by each local area; and ○ consult the Department of Health and the Department for Communities and Local Government before exercising its powers in relation to failure to meet specified conditions attached to the Better Care Fund as set out in the BCF Policy Framework.
<p>6.3 Mental health, learning disabilities and autism</p>	<p>Overall 2020 goal:</p> <ul style="list-style-type: none"> • To close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole (defined ambitions to be agreed based on report by Mental Health Taskforce). • Access and waiting time standards for mental health services embedded, including: <ul style="list-style-type: none"> ○ 50 percent of people experiencing first episode of psychosis to access treatment within two weeks; and ○ 75 percent of people with relevant conditions to access talking therapies in six weeks; 95 percent in 18 weeks.
	<p>2016-17 deliverables:</p> <ul style="list-style-type: none"> • 50 percent of people experiencing first episode of psychosis to access treatment within two weeks. • 75 percent of people with relevant conditions to access talking therapies in six weeks; 95 percent in 18 weeks. • Increase in people with learning disabilities/autism being cared for by community not inpatient services, including implementing the 2016-17 actions for Transforming Care. • Agree and implement a plan to improve crisis care for all ages, including investing in places of safety. • Oversee the implementation of locally led transformation plans for children and young people’s mental health, which improve prevention and early intervention activity, and be on track to deliver national coverage of the children and young people’s Improving Access to Psychological Therapies (IAPT) programme by 2018. • Implement agreed actions from the Mental Health Taskforce.

7. To support research, innovation and growth.

7.1 Research and growth	<p>Overall 2020 goals:</p> <ul style="list-style-type: none">• Support the Department of Health and the Health Research Authority in their ambition to improve the UK's international ranking for health research.• Implement research proposals and initiatives in the NHS England research plan.• Measurable improvement in NHS uptake of affordable and cost-effective new innovations.• To assure and monitor NHS Genomic Medicine Centre performance to deliver the 100,000 genomes commitment. <p>2016-17 deliverables:</p> <ul style="list-style-type: none">• Implement the agreed recommendations of the Accelerated Access Review including developing ambition and trajectory on NHS uptake of affordable and cost-effective new innovations.
7.2 Technology	<p>Overall 2020 goals:</p> <ul style="list-style-type: none">• Support delivery of the National Information Board Framework 'Personalised Health and Care 2020' including local digital roadmaps, leading to measurable improvement on the new digital maturity index and achievement of an NHS which is paper-free at the point of care.• 95 percent of GP patients to be offered e-consultation and other digital services; and 95 percent of tests to be digitally transferred between organisations. <p>2016-17 deliverables:</p> <ul style="list-style-type: none">• Minimum of 10 percent of patients actively accessing primary care services online or through apps, and set trajectory and plan for achieving a significant increase by 2020.• Ensure high quality appointment booking app with access to full medical record and agreed data sharing opt-out available from April 2016.• Robust data security standards in place and being enforced for patient confidential data.• Make progress in delivering new consent-based data services to enable effective data sharing for commissioning and other purposes for the benefit of health and care.• Significant increase in patient access to and use of the electronic health record.

7.3 Health and work	<p>Overall 2020 goal:</p> <ul style="list-style-type: none"> • Contribute to reducing the disability employment gap. • Contribute to the Government's goal of increasing the use of Fit for Work.
	<p>2016-17 deliverables:</p> <ul style="list-style-type: none"> • Continue to deliver and evaluate NHS England's plan to improve the health and wellbeing of the NHS workforce. • Work with Government to develop proposals to expand and trial promising interventions to support people with long-term health conditions and disabilities back into employment.



#FutureNHS

BOARD OF DIRECTORS	
Agenda Item	6.1
Title of Report	Vanguard programme update
Date of Meeting	24 February 2016
Author	Mike Coupe Director of Strategy
Accountable Executive	David Allison Chief Executive
BAF References • Strategic Objective • Key Measure • Principal Risk	Strategic objective: To Build on partnering for Value Principal risk: 2891 – new Models of care programme governance risk and risk 2839 – deliver on new models of care key milestones
Level of Assurance • Positive • Gap(s)	Positive
Purpose of the Paper • Discussion • Approval • To Note	To note
Data Quality Rating	Bronze – qualitative data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • Yes • No	No

1. Executive Summary

This report provides the second in a series of routine monthly updates on the Vanguard project.

The Vanguard Programme Management Office have proposed the production on a monthly basis of a suite of three separate papers:

- *The Programme Director's Monthly Report* – a narrative providing an overview of progress in delivery of the overall Vanguard programme
- *An Holistic Status Report* – an exception report on progress in delivery of the Vanguard programme focusing on issues rated 'red' or 'amber'
- *A Highlights Report* – a more detailed report on progress in delivery of Vanguard projects or workstreams in which WUTH is involved.

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The reporting regime remains in development. Currently, only the *Programme Director's Monthly Report* (annex 1) and the *Highlights Report* (annex 2) are available.

2. Items for Noting

The attention of the Board is drawn to the following developments:

Value Proposition 2016/17 Submission

The Vanguard PMO has submitted an update VP for 2016/17 to NHS England. The VP has been reviewed by SMT and feedback on how to progress the Vanguard programme has been provided to the CCG/PMO. Key points raised were as follows:

- The relationship between the Vanguard programme, the wider Healthy Wirral initiative and the Sustainability & Transformation Plan needs to be confirmed
- Vanguard governance arrangements require further refinement and will need reviewing if the Vanguard programme is extended to provide the vehicle for delivery of Healthy Wirral and the STP
- Any extension of the Vanguard programme would require expansion of the PMO
- The 'rules of engagement' relating to how savings are accounted for at organisational and system level need to be agreed
- There is a danger that staff in short supply (eg therapists) recruited to Vanguard schemes are in effect recycled from within the local NHS. A structured approach to avoiding denuding existing services is required
- Any picture of the future provider landscape needs to recognise that there is currently no agreement on – or ability to model – what WUTH's bed base will be in 2020/21. There is a need collectively to understand underlying demand, what interventions will allow deflection of demand to alternative community/domiciliary settings, what interventions will reduce demand and the optimum bed occupancy figure. In the short term, any deflection/reduction in demand will do no more than allow the Trust to reduce occupancy levels to a more manageable 90%. A joint approach to the acquisition of the necessary demand and capacity modelling skills is required.

Finance, Strategy & Planning Group

Subject to approval by FBPAC, the proposed Finance, Strategy & Planning Group will provide oversight of Vanguard projects in which WUTH is involved. In particular, any service developments which have actual or potential financial consequences for the Trust will be subjected to a formal business case process.

3. Recommendation

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

Programme Directors Report February 2016

Item	Update
<p>What Matters to Wirral?</p>  <p><i>What Matters to Wirral?</i></p>	<p>During January, the Healthy Wirral team undertook the “What Matters to Wirral?” initiative. This included 30 public workshops, in partnership with Healthwatch Wirral and our wider community and voluntary sector, speaking in depth and face-to-face with over 200 individual Wirral residents. We also held workshops with groups of staff from across the Wirral Partners.</p> <p>Running concurrently was an online survey, hosted at healthywirral.org.uk – from which 1265 completed entries were received.</p> <p>On initial analysis, the following themes were apparent:</p> <ul style="list-style-type: none"> • Confidence <ul style="list-style-type: none"> - Personal fulfilment and emotional wellbeing - Confidence in personal interactions with health services - Confidence in the future of the NHS as a sustainable entity • Services <ul style="list-style-type: none"> - Accessibility - High quality experience - Integrated, joined up services • Community <ul style="list-style-type: none"> - Use of community assets - Making community assets accessible <p>Additional themes were:</p> <ul style="list-style-type: none"> • Involving and protecting the vulnerable and excluded <ul style="list-style-type: none"> - Involving carers - Good provision for mental health - Reducing social isolation • Establishing a social contract for Wirral <ul style="list-style-type: none"> - Ensuring services are shaped by patients - Ensuring a sense of personal responsibility <p>The next steps are to:</p> <ul style="list-style-type: none"> - Develop the Communications and Engagement strategy for sharing with Partners Board and NHS England - Public feedback on to those that took part. - Embedding the insight into project delivery and the Sustainable Transformation Plan.
<p>Quarterly review with NHS England New Care models team</p>	<p>The Healthy Wirral Team had a successful quarterly review (Q3) with NHSE New Care Models Team on 21st January. Key areas of discussion included progress against milestones (deliverables), emerging learning for wider replication and finance.</p> <p>The meeting was attended by two “clinical assistants” (a GP and Public Health expert). The New Care models Team have recruited clinical assistants on a sessional basis to provide support and act as a critical friend to Vanguard sites. They have been recruited from a number of healthcare professions including GP’s and physiotherapists and are available to sites to support transformation work.</p>

<p>Submission of Value Proposition</p>	<p>The Healthy Wirral Value 2016-17 Value Proposition was submitted on 8th February 2016. An investment of £9.435m was requested and a breakdown of this can be seen in the table below. NHS England has indicated that sites will be informed of the outcome of their bid on 16th March.</p> <table border="1" data-bbox="566 425 1420 1489"> <thead> <tr> <th data-bbox="566 425 938 593"><u>Area of spend:</u></th> <th data-bbox="938 425 1420 593"><u>Value Proposition 2016/17 Costing:</u></th> </tr> </thead> <tbody> <tr> <td data-bbox="566 593 938 698">i) Population Health Management Tools</td> <td data-bbox="938 593 1420 698">160,418</td> </tr> <tr> <td data-bbox="566 698 938 804">ii) Pump Priming of New Care Models</td> <td data-bbox="938 698 1420 804">7,128,281</td> </tr> <tr> <td data-bbox="566 804 938 909">iii) Programme Management Arrangements</td> <td data-bbox="938 804 1420 909">872,193</td> </tr> <tr> <td data-bbox="566 909 938 1014">iv) Additional Support Specialists</td> <td data-bbox="938 909 1420 1014">100,000</td> </tr> <tr> <td data-bbox="566 1014 938 1097">Work stream Development</td> <td data-bbox="938 1014 1420 1097"></td> </tr> <tr> <td data-bbox="566 1097 938 1202">v) People & OD</td> <td data-bbox="938 1097 1420 1202">210,107</td> </tr> <tr> <td data-bbox="566 1202 938 1308">vi) Communication and Engagement</td> <td data-bbox="938 1202 1420 1308">274,073</td> </tr> <tr> <td data-bbox="566 1308 938 1413">vii) Create capacity/capability to utilise Information Technology</td> <td data-bbox="938 1308 1420 1413">690,000</td> </tr> <tr> <td data-bbox="566 1413 938 1489">Total Healthy Wirral Value Proposition 2016-17</td> <td data-bbox="938 1413 1420 1489">9,435,072</td> </tr> </tbody> </table>	<u>Area of spend:</u>	<u>Value Proposition 2016/17 Costing:</u>	i) Population Health Management Tools	160,418	ii) Pump Priming of New Care Models	7,128,281	iii) Programme Management Arrangements	872,193	iv) Additional Support Specialists	100,000	Work stream Development		v) People & OD	210,107	vi) Communication and Engagement	274,073	vii) Create capacity/capability to utilise Information Technology	690,000	Total Healthy Wirral Value Proposition 2016-17	9,435,072
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<p>System wide Financial Plan</p>	<p>Mark Bakewell has established a LHE demand and capacity group with representatives from Wirral Partner organisations. The group is holding its first meeting on Friday 12th February and plans to move forward at pace to establish a combined view of the challenge faced by the LHE.</p> <p>This information will be coupled with work carried out for the Joint Commissioning Group to understand the local resources available. By the end of February a refreshed view of the £150m challenge will be available and presented to Senior leaders on a Vanguard Friday.</p>																				
<p>Healthy Wirral participation in development of regulatory and assurance “valentines notes”</p>	<p>Healthy Wirral is working with PACS sites (Mid Notts, Morecombe Bay and Harrogate) and Kings Fund to explore how the sites can engage constructively with the Arm’s Length Bodies (ALB’s) to co-create new processes and behaviours so that regulatory and assurance processes/behaviours will support the implementation of new care models. The final draft of the Valentine’s note is attached and will be sent by the PACS sites to Simon Stevens on 14th February.</p>																				

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Healthy Wirral Team	<p>Mark Bakewell has commenced full time in the team as Chief Finance Officer.</p> <p>Diane Harvey has joined the team as interim administrator</p> <p>We have recently undertaken recruitment and successfully appointed Angela King, Alina McColville and Marie Taylor to role within the team (start dates TBC)</p>
NWC AHSN study visit	<p>James Barclay, Project Lead for Technology and Informatics Programme and Jayne Marshall from DASS have been successful in securing a place on a North West Coast AHSN study visit to Slovenia. The visit in March will study how by using an HIE platform and integrating it with citizen facing software and apps we can open access to citizens and patients in the NHS and Social services. The trip provides a look at the possibilities of opening up the various Health and social care systems to professionals and the citizen and developing applications to allow self-management and monitoring of health and wellbeing.</p>
New York State Study Visit	<p>We have recently applied and secured two places to attend a Study Tour in New York, details below. This is an excellent opportunity to gain and embed any key learning and there are mainly synergies to the ambition of the Vanguard programmes of work.</p> <p>New York State is transforming Medicaid, the federally-funded service that provides healthcare for over six million low-income citizens in the state. Through an ambitious nine-year programme that started in 2011, New York is investing \$8 billion in creating new models of provider integration that will dramatically reduce avoidable hospital admissions and help achieve the triple aim of better care, better health and lower costs.</p> <p>At the heart of New York’s transformation is a ground-breaking payment reform programme through which over 80% of Medicaid payments will be linked to value-based payments by 2020. These innovative payment structures – combined new integrated care delivery models, workforce transformation and sophisticated data analytics to support the change – will enable New York to reduce avoidable hospital admissions by 25% and lower costs in the face of ongoing increases in demand.</p> <p>Learning objectives for the study tour</p> <p>With many similarities to the new care models programme, New York’s Medicaid reform programme offers valuable lessons for how provider integration, payment reform and data analytics can be used to support healthcare transformation in the UK. This study tour is designed to enable participants to learn from New York’s experience, including the successes they’ve enjoyed and the challenges they have had to overcome.</p> <p>Through the experience, participants will have the opportunity to learn:</p>

- | | |
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| | <ul style="list-style-type: none">• How New York is using 25 new integrated care provider networks to create innovative healthcare delivery models to meet the state's healthcare diverse needs;• How New York has structured its nine-year transformation programme, with a specific focus on understanding what support it provides directly from the centre and what it provides via local support packages for the provider networks;• The theory behind New York's value-based payment reforms and how value-based payments are being applied in practice by the new provider networks;• How data analytics is being used to underpin the payment reforms and help providers and commissioners identify opportunities for transforming care. |
|--|--|

MONTHLY PROGRAMME DELIVERY: HIGHLIGHT REPORT

Programme	Cross Functional Workstream	Workstream	Communications and engagement	Reference	
SRO	HW PMO	Executive		Overall Status	G
Project Manager	Ben Capper	Reporting Period	15.01.2016 – 10.02.2016	Gate	

Delivery	Risks	Issues	Benefits
G	A	A	G

Delivery Status			
Milestones achieved		Milestones for next reporting period	
Milestone	Date	Milestone	Date
"What matters to Wirral" month completed and insight gathered through multiple sources. Insight analysed and interpreted to inform the development of 3 year comms and engagement strategy, a Social Contract, and a HW strategic positioning statement for 16/17 - currently in progress	31/01/2016	Three year comms and engagement strategy compiled and published	28/02/2016
30 public workshops held. 1265 online survey responses received. 20 paper surveys received from Wirral Livewell team.	31/01/2016	Feedback to public and Economy partners on the outcomes of "What Matters to Wirral" - engagement programme shared	28/02/2016
29k views on "What matters to Wirral" promotional video on Facebook - supported through paid for posts. 523 clicks through from ad.	31/01/2016	More detailed website infrastructure developed, further work, scope and timelines to be agreed, following confirmation of VP funding.	20/03/2016
Visit from NHS England Comms and Engagement Team - excellent feedback on our approach.	31/01/2016	One-year comms plan initiated (assuming approval of 16/17 VP proposal around prevention and self care) further work to continue post VP funding confirmation.	28/02/2016
Article with Nursing Standard exploring impact of Vanguard status on frontline nursing initiated with colleagues from WUTH and WCT comms teams.	31/01/2016	Feedback to Champions on line management support to enable work on Healthy Wirral, and on supporting the development of Market place. Meeting with Public Health to explore the possibilities of HW Champion involvement of the Marketplace.	20/03/2016
Commencement of Hannah Ward (Insight and Engagement Specialist) in the team - already making excellent contribution.	31/01/2016	Meeting with Wirral Partners comms teams to feedback on insights around What Matters to Wirral and next steps.	28/02/2016
Press coverage for What Matters to Wirral in Wirral News and Wirral Globe	31/01/2016		

Risk & Issue Tracker				
Date	Risk	Mitigating Action	O	Status
10/02/2016	There's a risk in relation to capacity of the Communication and engagement resource available. The potential issue will be effectively managing deliver strategy and items within it.	Meeting with comms teams leads prior to the publishing of strategy to understand their capacity to assist over the coming year. Within the VP submission we have included a Band 4 role to assist with the need for content development and delivery.	BC	A
Date	Issue	Mitigating Action	O	Status
10/02/2016	We've received some feedback following 2 of the 30 sessions ran in relation to the format and content, raised from Healthwatch.	We have looked into this, and have a meeting arranged with Karen Prior on Thursday 25th February to discuss and agree solutions and any potential learning to inform future sessions.	BC	A

MONTHLY PROGRAMME DELIVERY: HIGHLIGHT REPORT					
Programme	Healthy Wirral	Project	Informatics & Technology Workstream	Reference	
SRO	Mark Blakeman	Executive		Overall Status	G
Project Manager	James Barclay	Reporting Period	15/01/2016 - 10/02/2016	Gate	3
Delivery	A	Risks	G	Issues	G
Milestones achieved			Milestones for next reporting period		
Milestone	Date	Milestone	Date		
WCR Project Mobilisation - Intensive mobilisation activity well underway working very closely with Cerner to develop project structure, roles & responsibilities, governance flow, controls (risks/issues), plan development, resource requirements and benefits realisation. Working towards formal partner launch event 25 Feb	on-going	Mobilisation - Programme developed in readiness for programme launch event on 25 Feb.	25/02/2016		
Information Governance - HE ISA and accompanying letter to be sent to GP practices WC 15 Feb. Some dependencies for WCR ISA still outstanding. Plan to resolve in order for ISA, FAQ pack and accompanying letter to be sent to GP practices towards end of Feb.	on-going	Information Governance - HE ISA and accompanying letter to be sent to GP practices	19/02/2016		
Benefits realisation - Forward approach agreed with Cerner for our benefits realisation delivery. Joint development session scheduled late Feb to develop individual project scopes. Indicatively looking at 6 areas of redesign per registry theme.	27/01/2015	Information Governance - Outstanding dependencies further developed for IG group to endorse - enabling WCR ISA to be sent	29/02/2016		
Technical delivery - All HW partners have been engaged with Cerner to discuss data on-boarding considerations and identity management and approach agreed. Options papers to be produced by Cerner WC22 Feb	28/01/2015	Benefits realisation - Joint Transformational workshops with HWP and Cerner to develop Project Charters	29/02/2016		
Registries - Paediatric Diabetes crosswalk scheduled on 8 Feb to validate measures included in registry. Other 4 Phase 1a registries with Cerner Clinical design Team for final review. All registries (Adult Asthma, Paediatric Asthma, Adult Diabetes, COPD) to go to Clinical senate for assurance (scheduled for March). Initial engagement around 1b registries took place with Workshop for Wellness (26 Jan)	on-going	Technical delivery - Options papers produced by Cerner identifying on-boarding options	22/02/2016		
Project Vision - Conference call with HWP Partners and supplier ahead of planned workshop WC8 Feb to understand scope, functionality and agreed implementation approach.	12/01/2016	Registries - Paediatric Diabetes crosswalk session	08/02/2016		
Digital Road Map - Partner roadmaps currently being provided. Awaiting guidelines from NHS England	22/01/2016	Project Vision - HWP / supplier workshop	11/02/2016		
Assistive technology - Included in latest VP submission - awaiting outcome of funding decision	05/02/2016				

Risk & Issue Tracker				
Date	Risk	Mitigating Action	Owner	Status
29/09/2015	Contract signature Delay to contract signature between WUTH and Cerner leading to delay with release of central funding	<ul style="list-style-type: none"> Discussions have taken place between Wirral Partner CEOs about mechanisms for proceeding at risk (one or more Trusts act as 'Guarantor') Contract now signed 4 Jan 16 	MB	G
23/10/2015	Contract deliverables Deliverables set out in contract does not include required scope for all Wirral Partners (including EMIS sub-contracted work) leading to failure of delivery	<ul style="list-style-type: none"> Summary of contract deliverables and scope in set out in Roadmap paper which went to Wirral Partners Contract now signed 4 Jan 16 Subsequent joint review with Cerner taken place no issues raised 	MB	G
23/10/2015	Integration - Phase 1 Failure to integrate GP system records with Population Health due to an issue (resource, availability of technical solution) with EMIS leading to failure of delivery of phase 1 solution	<ul style="list-style-type: none"> Contract review has taken place to ensure deliverables are clear with expected timescales Development and monitoring of programme plan in respect of reliance on all third-party providers. Engagement planned with EMIS, to be lead by Cerner. Governance established and escalation mechanism defined 	MB	A
29/09/2015	Integration - Vision practices Inability to integrate with Inpractice Vision GP Practices leading to inconsistent approach across primary care and potential detriment to perception of Healthy Wirral Programme	<ul style="list-style-type: none"> Effective tailored engagement with Inpractice Vision GP practices Activity captured in plan Governance established and escalation mechanism defined 	MB	A
23/10/2015	Benefits Realisation Failure to realise benefits across the whole project as a result of lack of clarity on what is being set out to achieve, failure in delivery or poor adoption once activated.	<ul style="list-style-type: none"> Benefits set out in Roadmap paper which went to Wirral Partners Benefits workstream established to focus of delivery of benefits All activity captured and monitored against plan As part of project communications plan articulation of benefits to be captured for care providers and patient. Training plan to be articulated and form part of project plan 	MB	A
23/10/2015	Information Governance Inability or delay to achieve ISA signatures within required timeline leading to delay in delivery of capability	<ul style="list-style-type: none"> Wirral Partners IG group formed to ensure development of ISA is delivered and compliant. Meaningful engagement with GPs promoting benefits of the programme to practices to take place Direct engagement through LMC and other events. Engagement of GPs in the design of registries and clinical pathways. ISA's to be provided to GP's as part of a package of information when in the best possible position to achieve signature. Tracking and support to be provided by Healthy Wirral Team Communication and engagement of all partners planned at all stages of the programme 	MM	A
23/10/2015	Integration - Phase 2 Failure to integrate records outside of phase 1 delivery as a result of an issue with a partner or 3rd party supplier (resource, availability of technical solution) leading to failure of delivery of phase 2 solution	<ul style="list-style-type: none"> Governance established and escalation mechanism defined MOU and transparency between HWP's to ensure continuation of agreement and funding conditions Phased approach to implementation 	MB	A
29/09/2015	Project Resource Insufficient or inappropriate resource available to deliver the project within the required timeframe	<ul style="list-style-type: none"> Project plan to capture all activity, resource requirement and roles and responsibilities defined as early as possible Governance established and escalation mechanism defined 	MB	A
23/10/2015	3rd party supplier management Lack of control with 3rd party suppliers in respect to buy in, delivery of solution and issue resolution leading to failure to delivery capability	<ul style="list-style-type: none"> Programme plan articulates all activity and used to track performance MOU define role and responsibilities for all partners Governance established and escalation mechanism defined Early, effective and regular planned engagement with 3rd party suppliers Plan in place to track delivery 	MB	A
31/07/2015	Service Continuity Failure of existing partner system delivery due to an impact of project delivery resulting in impact on delivery of services	<ul style="list-style-type: none"> Establishing, checking and reviewing Business Continuity and Disaster Recovery plans with all partner organisations and GP Practices. Activity captured and monitored against plan. Governance established and escalation mechanism defined 	MB	A
23/10/2015	Data quality Inaccurate or misleading information once activated due to data quality issues or system issues leading directly to safety issues	<ul style="list-style-type: none"> Data quality strategy to be developed Rigorous testing period with follow-on validation by clinical and professional stakeholders from each Partner organisation All activity captured and monitored in plan 	MB	A
23/10/2015	Future Integration Sub optimal integration with current patient record systems or potential future systems where there is an opportunity for potential future integration	<ul style="list-style-type: none"> Development of organisational roadmaps to identify future opportunities for integration and linking with senior stakeholder vision Current issues identified and taken forward through defined Governance structure 	MB	A
23/10/2015	Information Governance Compliance Lack of IG compliance once system activated leading to potential significant reputational and financial damage to programme and HWP's	<ul style="list-style-type: none"> Wirral Partners IG group to maintain compliance and appropriate remediation if problems found. Regular checks to ensure DPA compliance of all partners and GPs. Governance established and escalation mechanism defined Data strategy to set out all data processes 	MM	A
23/10/2015	High opt-out rate High proportion of patients opt out of shared record diluting overall benefits set out to achieve	<ul style="list-style-type: none"> Effective and robust communications plan to reassure members of the public and explain the vision and benefits to them 	MB	A
09/02/2016	Reputational Reputational damage to Healthy Wirral programme and individual partner organisations through failure or part failure of delivery.	<ul style="list-style-type: none"> Clear roles and responsibilities define in programme All activity captured and monitored against plan Effective Comms plan developed and executed Governance established and escalation mechanism defined 	MB	A
09/02/2016	Unrealised need identified Unrealised need identified during delivery such as previous unidentified cost or unexpected poor data quality leading to potential increased costs and/or delay in delivery	<ul style="list-style-type: none"> Governance established and escalation mechanism defined Issue management process defined Effective engagement with partners at earliest opportunity to identify risks areas as soon as possible 	MB	A

MB = Mark Blakeman (WUTH); MM = Melanie Maxwell (WUTH)

MONTHLY PROGRAMME DELIVERY: HIGHLIGHT REPORT					
Programme	New Models of Care	Project	Finance, Measurement & Evaluation	Reference	
SRO	Mark Bakewell	Executive	Mark Bakewell	Overall Status	A
Project Manager	Mark Bakewell & Andy Moran	Reporting Period	Jan-16	Gate	
Delivery	Risks	Issues	Finance		
A	A	A	A		
Delivery Status					
Milestones achieved		Milestones for next reporting period			
Milestone	Date	Milestone	Date		
Value Proposition 'Ask' Submitted including Pump Priming	8th February 2016	Await NHS E NMC response to ask	Early March 2016		
Recruitment to Finance & BI Posts (2/3 completed)	January 2016	Recruit to vacant 'Modelling' support post	March 2016		
1st Draft Outcomes measures (as part of VP) with Gap Analysis	8th February 2016	Adoption of agreed Outcome Measures by respective project / clinical leads / organisations	End of March 2016		
Business Intelligence Strategy	January 2016	Confirm reporting methodology, information flows, responsibilities and outputs for Programme Arrangements	End of March 2016		
Initial discussions with respective finance and information leads with regards to Healthy Wirral Programme and potential future requirements	January & February 2016	Confirm future work stream arrangements for sub groups to support Finance and Business Intelligence / Information requirements to deliver Healthy Wirral Programme	March 2016		
Provided support to wider 'system' Modelling in order to develop the 'as is' and potential future state comparisons working with Western Cheshire Vanguard and external support	January & February 2016	Confirm system wide requirements (meeting 12th Feb), and updates to current commissioner and provider models through JCG & IPG workstreams	March 2016		
Support to 'Task & Finish' groups and system wide enabling workstreams to develop measures / benefits realisation as appropriate (e.g population health / registry design)	January 2016	Ongoing as part of workstream deadlines	March 2016		
Provision of information to registry workshops (Depression & Wellness) to enable further design discussions	January 2016	Awaiting confirmation of next steps from programme lead / project manager for smaller sub group to take forward (interdependency with project support)	March 2016		
Risk & Issue Tracker					
Date	Risk	Mitigating Action	Owner	Status	
Jan-16	Clarity In /Out of Scope for Healthy Wirral / Vanguard programme and availability / capacity of resources to deliver as appropriate	Governance Arrangements, Review with Senior Leadership Group		R	
Jan-16	2016-17 Value Proposition Funding	Review potential scenarios and prioritisation of funding requirements within Value Proposition		R	
Jan-16	Provision of information from Finance, Information and Intelligence teams from organisations in a timely & robust manner to enable development of measurement / analytical reporting of programme	Healthy Wirral team to clarify information requirements, schedule of availability		A	
Jan-16	In-Kind offer from respective organisations, regarding priority of information release and availability of staff time to develop future approach	Healthy Wirral Exec leads to clarify 'in-kind' offer and approach between organisations when information requested		A	
Jan-16	Modelling Capacity within Health Wirral team to support Value Proposition (and also wider Modelling support to system wide requirements)	Advertise Vacant post within Healthy Wirral team, also confirm wider modelling 'task' and internal / external support support requirements		R	
Date	Issue	Mitigating Action	Owner	Status	
Jan-16	Information Governance / Data Sharing between organisations in order to develop appropriate analytical / modelling support to Healthy Wirral and wider Programme Requirements	Short Term - Define Scope / Interim Arrangements for sharing of appropriate / relevant information in order to perform measurement and evaluation tasks Long Term - Clarify arrangements for anonymised reporting solution in conjunction with HealthIntent Platform and Population Health Solution		A	
Jan-16	Lack of agreed outcome measures (short -long term) for programme / project measures including Benefits Realisation Approach & Return on Investment Assumptions	Project leads to provide better information to inform system wide impact assumptions based upon evidence / local clinical agreement of pathway redesign as appropriate		A	
Jan-16	External Evaluation of Programme as per New Models of Care team requirements	Marketplace Event on 3rd March, Contact with local Evaluation options (universities etc) to form a potential approach for Healthy Wirral Vanguard programme		A	

MONTHLY PROGRAMME DELIVERY: HIGHLIGHT REPORT

Programme	New Models of Care	Project	Diabetes Transformation	Reference		
SRO	Val McGee	Executive	Val McGee	Status		G
Project Manager	Anna Rigby	Reporting Period	15/12/2015 to 15/01/2016	Gate		2

Delivery	Risks	Issues	Finance
G	A	G	A

Delivery Status

Milestones achieved		Milestones for next reporting period	
Milestone	Date	Milestone	Date
Recruitment process for GPwSI started	28.01.16	Second spoke to be identified and implemented	23.02.16
Value Proposition submission complete and submitted	8.02.16	Operational documentation established (referral pathways, protocols etc.)	23.02.16
Podiatry clinic scoped and set up for start date 23.02.16	8.02.16	Podiatry Clinic to be initiated	23.02.16
Evaluation Framework drafted	8.12.15	Evaluation Framework for spokes initiated	23.02.16
Person Centred Outcome Measures workshops undertaken (Insights collected from 55 diabetes patients & carers)	27.01.16	Analysis of Insights from workshop collated and reviewed	3.02.16
Patient Education Programme Review Initiated	27.01.16	End to End pathway redesign plan developed	11.03.16
		Outline High Level Programme plan, timeline and risk register to be reviewed and further developed.	End February

Risk & Issue Tracker

Date	Risk	Mitigating Action	Owner	Status
18.12.15	Lack of certainty on funding for posts beyond the current Y1 and the potential risk of redundancy	Value Proposition Submitted 8.02.16 - contains a bid to pump prime the new models of care for diabetes and respiratory. Risk has been raised with the WBP. MOU and Risk Sharing Agreement which describes mitigation signed off 22.01.16 Clearing house in development via People and OD workstream.	JG	A
Date	Issue	Mitigating Action	Owner	Status
12.01.16	Spending against allocation is less than forecast for December.	Raise with MB as Finance Lead. MB plans to meet project leads to understand next steps for 15/16	MB/VM C	A
8.02.16	Delay in registry metrics updated and ready assurance from Clinical Senate.	Programme plan and timeline under review, to be launched 25th Feb.	AR	G
8.02.16	Delay in second spoke and associated documentation due to start date of appointed staff	Start date postponed to 23.02.16, referrals continue to be triaged and seen by first spoke.	AR	G

MONTHLY PROGRAMME DELIVERY: HIGHLIGHT REPORT

Programme	New Models of Care	Project	Respiratory	Reference	
SRO	Val McGee	Executive	Val McGee	Overall Status	A
Project Manager	Anna Rigby	Reporting Period	15/01/2016-15-02/2016	Gate	

Delivery	Risks	Issues	Finance
A	A	A	A

Delivery Status			
Milestones achieved		Milestones for next reporting period	
Milestone	Date	Milestone	Date
Value Proposition submission complete and submitted	8.02.16	Integrated Respiratory Service Consultant in post	4.03.16
Respiratory patient involvement draft plan developed	9.02.16	GPwSI training initiated	22.03.16
Estates confirmed for 4 Community services	29.01.16	Outline High Level Programme plan, timeline and risk register to be reviewed and further developed.	End February
Psychology support explored	29.01.16	Staffing model developed	11.03.16
Referral criteria drafted	29.01.16	End to End pathway redesign plan developed	11.03.16
Evaluation Framework drafted	8.02.16	Pharmacy opportunities explored	11.03.16

Risk & Issue Tracker				
Date	Risk	Mitigating Action	Owner	Status
18.12.15	Lack of cohesive understanding of the impact of new model of care on future activity e.g. to outpatients. Healthy Wirral modelling post is currently vacant.	Raise the risk with the WBP, MB and AM. MB identifying next steps. part of wider set of actions re identifying modelling resource & capacity to support both vanguard and system wide requirements. MB is exploring external and internal support to fill this gap.	MB	A
18.12.15	Lack of certainty on funding for posts beyond the current Y1 and the potential risk of redundancy	Value Proposition Submitted 8.02.16 - contains a bid to pump prime the new models of care for diabetes and respiratory. Risk has been raised with the WBP. MOU and Risk Sharing Agreement which describes mitigation signed off 22.01.16. Clearing house in development via People and OD workstream.	JG	A
Date	Issue	Mitigating Action	Owner	Status
12.01.16	Delay in recruitment of Locum Consultant to back fill the Respiratory Service Consultant- milestone impacted.	Recruitment agencies have been contacted and CV's are being reviewed. 8.2.16 - this is still an issue, therefore exploring additional sessions to be undertaken by existing Consultant.	GP	A
12.01.16	Spending against allocation is less than forecast for December.	Raise with MB as Finance Lead. MB plans to meet project leads to understand next steps for 15/16	MB/VM C	A
29.01.16	Difficultly establishing baseline data for cohort of patients	Explore the use of the secondary data within Healtheintent to be able to track patients	AM	G
29.01.16	Sustainable approach needs to be developed alongside pilot with modelling and commissioning support	End to End Service Redesign approach will be implemented alongside input from Finance, Benefits & Evaluation Workstream, Commissioning and Contracting Workstream	AR	G
8.02.16	Delay in registry metrics updated and ready assurance from Clinical Senate.	Programme plan and timeline under review, to be launched 25th Feb.	AR	G

Board of Directors	
Agenda Item	7.1.1
Title of Report	Integrated Dashboard and Exception Reports
Date of Meeting	24th February 2016
Author	John Halliday Assistant Director of Information
Accountable Executive	Mark Blakeman Director of Infrastructure and Informatics
FOI status	Document may be disclosed in full
BAF References	<ul style="list-style-type: none"> • Strategic Objective All Strategic Objectives (1 through 7) • Key Measure All Key Measures (1A through 7D) • Principal Risk All Principal Risks
Level of Assurance	<ul style="list-style-type: none"> • Positive Partial with gaps • Gap(s)
Purpose of the Paper	<ul style="list-style-type: none"> • Discussion Discussion • Approval • To Note
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken	<ul style="list-style-type: none"> • Yes No • No

1. Executive Summary

This report provides a summary of the Trust's performance against agreed key quality and performance indicators. The Board of Directors is asked to note the performance to the end of January 2016.

2. Summary of Performance Issues

The Trust continues to make good progress in delivering its strategic performance targets (Meeting our Vision and A Healthy Organisation domains).

Whilst there has been some significant improvement in a number of areas, operationally the Trust continues to struggle to achieve against its operational objectives (Operational Excellence and External Validation domains).

Based on the above January was a challenging month for the Trust, reflecting the increasing demand on non-elective services, compounded with the effects of the junior doctor's industrial action. Within the context of this environment the Trust delivered a deficit of £1.3m during the month. Although this is some £0.5m worse than the original planned deficit of £0.7m for the month, it is an improved position when compared to the summer months.

The cumulative position is showing an actual deficit of £12.7m, against a plan of £11.3m. Despite the in-month deterioration the Trust is still on track to deliver the revised forecast outturn of £15.0m.

Actual cash held continues to be strong, reflecting cash preservation initiatives continuing throughout the year. As at the end of January the cash balance held was £5.4m, this is some £2.1m better than the initial plan.

Issues balancing demand and capacity in Orthopaedics, ENT and Gynaecology have impacted on the financial position (with income down across the three specialties by £0.15m in month). If unresolved this will impact on delivery of the 18 week RTT target and also on market share in future months.

Whilst it is expected that ENT and Gynaecology will improve their position through the rest of the year, the more underlying issues in Orthopaedics are unlikely to be resolved quickly.

The key issues relating to external validation is achievement of the A&E, RTT and c Difficile targets, with detailed comments against each area below.

The Integrated Performance Dashboard is designed to evolve as key metrics are adopted, amended or no longer required. The proposed new high-level metric on adherence to the rules on caps of Agency staff requires more refining to ensure consistency with the very detailed weekly reports, however this will be incorporated from next month's dashboard.

3. Detailed Explanation of Performance and Actions

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

Despite the range of actions being put in place, performance against the Emergency Access Standard remains below the minimum 95%, with January deteriorating to 82.31%.

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

- **The level of ED attendances** - in January there were 1,240 more attendances at ED despite the single front door scheme diverting up to 15% of triaged patients (11 patients a day) compared with January 2015, an increase of 18.1%. This continues the year-on-year increase seen across the last six months, and the cumulative year-to-date position is now 2.6% (1,998 attendances) above 2014/15 levels.
- **Changing responsibility for the NHS111 service** –the situation with high conveyance of ambulance arrivals reported last month has not reduced (1017 more attendances over the last 3.5 months compared with last year). The position was again raised at January's System Resilience Group with a specific action for a task and finish group to meet, explore data to ensure one agreed data set, agree the cause for the increase in conveyance and put in remedial plans to assist with ambulance deflection from the Emergency Department. NWAS have now confirmed WUTH as receiving the highest number of ambulance presentations within Cheshire & Mersey. NWAS along with WUTH have written to the SRG for a full economy summit to be arranged to review the trend and alternatives to ED presentation as seen in other areas of the country. Whilst it is unlikely that this will improve the situation in the short term, this will need to provide a key element of our planning for next winter.
- **Implementation of SAFER** – The Trust continues to roll out the implementation of SAFER with six wards Live.
- **Patient flow processes** – The Trust continues to see low speciality outliers which have enabled the Surgical Division not to cancel any elective activity due to bed pressures. The Trust also continues to maintain within the planned winter inpatient bed capacity. The Trust in early February has a small number of beds closed due to Norovirus, which have now all reopened.
- **Discharges at week-ends** –weekend social care capacity remains a limiting factor. Social Service leads have confirmed that amendments will

be made to care home provision to enable weekend assessment and admission to homes. Feedback from NHS England remains positive with the Trust achieving weekend discharge rates of between 70% & 80% compared to the region at rates of between 50% and 60%.

- **Community Beds** – All planned community beds have been opened. In addition an economy initiative to provide 28 additional community beds at Charlotte House has been successful. A phased approach to full occupancy has built confidence between community and Trust staff. We have been working with the community Trust and the home to deal with any quality concerns raised.
- **Discharge Lounge** - Consistent high usage of discharge lounge continues across both divisions.
- **External Review** – The Trust maintains fully committed to the national Emergency Care Improvement Programme as well as commencing on the national frailty network. The Trust is already seeing improvements within our Older Persons Assessment Unit based on this network and its recommendations and joint working.
- **COPD Early Supported Discharge** has been implemented from November 2015 and continues to be successful in reducing length of stay for respiratory patients.
- **Single front door project** – commenced in November 2015 and is seeing daily deflections of 10%-15% of self presenting patients. In addition the concept has reduced triage waiting times. The economy is now reviewing the second phase of the project.
- **AMU redesign** – as part of next year's capital programme it has been agreed to redesign AMU giving larger chair and trolley / cubical areas. This increased capacity will stop the practice of redirecting to ED due to limited capacity.

b. Advancing quality indicators

In line with all other organisations, the Appropriate Care Score (ACS) targets for WUTH have been reset for 2015-16, based on the twin principles of raising the bar on minimum attainment and continuous system-wide improvement and stretch. We are experiencing increasing difficulty in obtaining case notes for AQ audits and this is impacting on the populations and results. This has been raised as a concern and some actions are in progress.

Detail on the five areas:

- **AMI:** The sample size was complete. The ACS year to date remains above target (92.5% v 91.5%), with all indicators except "referral to cardiac rehabilitation" at 100%. Staff is continually reminded to refer these patients at or before discharge.
- **Heart Failure:** The ACS year to date remains below target (71.78% v 77.3%). There has been a general decline in all the indicators during November. Six sets of case notes were missing out of a population of 35. New more stringent measures were introduced in October and this usually leads to a reduction in compliance. There are also some changes to the clinical leadership of this group and it is anticipated that we will see improvements from February onwards.
- **Hip & Knee:** The ACS year to date remains below expected (94.1% v 95%) The monthly observed ACS have been above target since they reintroduced full population audit rather than sampling. However out of a sample size of 81, 16 case notes were unavailable at the time of audit. In general knee surgery performs better than hip surgery. Delay in post-operative antibiotics and timeliness of VTE prophylaxis as the main concern although both of these indicators are above 92% ascertainment.
- **Community Acquired Pneumonia:** The ACS year to date remains below expected (69.97% v 75.1%) . New more stringent measures were introduced in October – the reduction in time to antibiotics from 6 to 4 hours after arrival in ED led to a significant lowering of performance. We have seen a small increase in compliance during November . Four sets of notes were unavailable out of a population of 152. Work is on-going to promote early antibiotics and CURB scoring; the main areas of concern and both have improved from October to November.
- **AKI:** The ACS year to date remains below expected (5.4% v 50%). This performance is poor; with no patient having a written self-management plan prior to discharge and low levels of specialist review within 12 hours for patients with the most severe disease during November 2015; this was recognised to be a resource issue. There are two specialist nurses now in post who are reviewing patients daily, providing support and training to the wards and it is envisaged we will see significant improvement from the New Year. They are also working to ensure we deliver the CQuIN and this focuses on handover of care at discharge.

c. Elective Performance

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

Elective admitted spells in January was down 274 cases (8.59%) against the original plan, with the Trust elective value £555k down.

Specialties of particular concern:

Orthopaedics

Performance in Orthopaedics remains poor, but is showing signs of improvement. In the medium term, through the job planning process, the division is working to rebalance inpatient and outpatient capacity.

In the short term, the consultants have agreed to undertake additional outpatient activity of approximately 360 attendances through February and March at Trust waiting list rates, which will help to rebalance demand quickly and improve the year end position of the speciality.

ENT

Consultant sickness and increase in non-elective activity earlier in the year has led to a year-to-date underperformance of 227 cases (14.8%)

The Consultant has now returned to work, but unfortunately another consultant has had to take sick leave for an elective procedure. The Division are working on ensuring that theatre utilisation is maximised. In particular, the service had an imbalance in the waiting list for outpatient and elective surgery and therefore a range of theatre sessions have been converted to clinics to address this. The anticipated year-end position is to be 259 cases behind plan.

Gynaecology

Gynaecology is showing a deficit against plan. As previously reported, this is due to consultant sickness. Both consultants have now returned and the team have been working Saturdays to bring the speciality back to plan.

It is expected that Gynaecology will be above plan in February and March but unable to fully recover previous months' underperformance.

Ophthalmology

The underperformance against plan is due to an unexpected resignation of a Clinical Fellow in December. A replacement has been appointed, but will not be in place until April. Additionally, there is one consultant

who has seen a significantly reduction in referrals. The Division are working through the alternatives and a plan will be provided at the March board.

d. 18 Weeks RTT

Ongoing achievement of the RTT standard is directly linked to the delivery of the required activity levels which have been under pressure since the beginning of the year. As previously highlighted to the Board the achievement of the RTT position will be very challenging during quarter four, with the Trust likely to fall short of the 92% minimum standard during January, February and March.

The underperformance in part is due to the planned strikes in January and February plus the issues which impacted on December's position still impacting on some specialities. However, increased waiting times for outpatient appointments in the challenged specialities below, is the main driver.

Most specialities within the Trust are achieving the target at a nationally defined specialty level. The four specialities which will not achieve this target are General Surgery (which includes breast, colorectal, general surgery, and upper gastrointestinal), Orthopaedics, Urology and "Other" which includes numerous specialities but notably Community Paediatrics.

Detailed work with each of these specialities has produced compliance trajectories, which once combined into a Trust position will see the Trust compliant with the April submission and thereafter. A report is expected at Senior Management Team within February to outline a revised method of pathway management to ensure sustainable compliance and a move away from historic validation.

e. Infection Control

At the end of January we reported 3 toxin positive *C.diffis*, with Post Infection Reviews identifying 2 of these to have been avoidable. This makes a cumulative total of 35 avoidable toxin positives reported, against a maximum expected trajectory of 29 for the full year 2015-16.

The hypothesis for these January cases occurring, despite all preventative actions now being in place, is due to the patients being exposed to positive patients at a time prior to when all of the current preventative measures were in place. Post Inspection Review looks retrospectively to previous three months of patient's admission.

In February 2016 to date we have a further 2 toxin positive reported *C.diff*, however initial review is identifying them as unavoidable.

The Director of Infection Prevention & Control and the IPC Team continue to monitor all actions identified within the plan submitted to Monitor.

f. Non Core Spend

In January 2016 c£1.8m has been spent on non-core pay categories.

The Trust continues to submit agency information to Monitor on a weekly basis which is reviewed at the Senior Management Team on a weekly basis. There is continued focus on the non-core spends across the divisions and they are a part of the performance dashboards at the divisional performance reviews.

The Trust still remains under the nursing agency cap of 3%, with the Nursing agency costs in January equating to 2.3% of the substantive nursing wage bill.

g. Summary Financial Position

The financial performance through January was challenging as a result of increased operational demands, industrial action and an increased emphasis on discharges.

Despite these operational challenges the Trust delivered an in month position of (£1.3m) which is £(0.5m) adverse to the original profile used within the Monitor plan. The cumulative deficit as at the end of January 2016 is (£12.7m) which is a variance of some (£1.4m) to the plan of (£11.3m).

The cash position continues to be positive with the cash position at the end of the month being £5.4m which is some £2.1m better than plan. The Trust continues to forecast a year-end cash balance of c£2.3m. However it has to be noted the Trust will require resilience funding in the first quarter of the financial year as a result of NHS England not allowing the CCG to pay quarterly in advance payments.

The financial performance in month and at month 10 translates into a Financial Sustainability Risk Rating (FSRR) score of 2, which remains in line with plan.

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

4. Recommendation

The Board of Directors are asked to;

Note the Trust's current performance to the end of January 2016, with particular regard to;

- The risks associated with the delivery of the emergency access target where performance remains challenging despite a range of actions taken.
- Risks against elective and outpatient activity volumes and contract performance.
- 18 week RTT where improved performance is dependent on delivery of at least the activity volumes identified in the recovery plan, particularly in light of the increased GP referrals and the ongoing need to resolve the waiting time issues within Community Paediatrics.

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

- The recovery plans in place to deliver the non-elective access target, particularly the implementation of SAFER.
- Ongoing work with the surgical division to improve the performance against the elective and outpatient programmes.
- The additional attention within the organisation being put on the 18 week RTT incomplete target to improve performance back to compliance from quarter one of 2016/17.

Mark Blakeman

Director of Informatics and Infrastructure

WUTH Integrated Performance Dashboard - Report on January 2016 for February 2016 BoD

Area	Indicator / BAF	Nov	Dec	Jan	Trend / Future Concern	Target (for 'Green')	Latest Period	Exec Lead	
Meeting Our Vision	Satisfaction Rates								
	Patient - F&F "Recommend" Rate	98%	97%	98%		>=95%	January 2016	GW	
	Patient - F&F "Not Recommend" Rate	1%	2%	1%		<=2%	January 2016	GW	
	Staff Satisfaction (engagement)	3.83	3.83	3.83		>=3.69	Q2 2015/16	JM	
	First Choice Locally & Regionally								
	Market Share Wirral	85.7%	86.2%	88.0%		>= 85%	April to Oct 2015	MC	
	Demand Referral Rates	1.5%	1.4%	1.0%		>= 3% YoY variance	Fin Yr-on-Yr to Jan 2016	MC	
	Market Share Non-Wirral	9.5%	9.3%	9.4%		>=8%	April to Oct 2015	MC	
	Strategic Objectives								
	Harm Free Care	96%	96%	96%		>= 95%	January 2016	GW	
HIMMs Level	5	5	5		5	January 2016	MB		
Operational Excellence	Key Performance Indicators								
	A&E 4 Hour Standard	88.02%	88.34%	82.31%		>=95%	January 2016	CO	
	RTT 18 Weeks Incomplete Position	92.0%	91.0%	90.1%		>=92%	January 2016	CO	
	Cancer Waiting Time Standards	On track	On track	On track		All met at Trust level	Q4 to Jan 2016	CO	
	Infection Control	0 MRSA; 29 C diff	1 MRSA; 31 C diff	1 MRSA; 35 C diff		0 MRSA Bacteraemia in month, and cdiff less than cumulative trajectory	January 2016	GW	
	Productivity								
	Delayed Transfers of Care	3.3	3.1	3.1		<= 4	12-mth ave to Jan 2016	CO	
	Delayed Complex Care Packages	47	48	55		<= 45	January 2016	CO	
	Bed Occupancy	93.9%	91.3%	94.8%		<=85%	January 2016	CO	
	Bed Occupancy Medicine	95.8%	93.5%	95.9%		<=85%	January 2016	CO	
	Theatre Utilisation	70.0%	68.0%	69.5%		>=85%	January 2016	CO	
	Outpatient DNA Rate	8.3%	8.4%	7.8%		<=6.5%	January 2016	CO	
	Outpatient Utilisation	82.3%	79.7%	80.4%		>90%	January 2016	CO	
	Length of Stay - Non Elective Medicine	7.4	7.1	7.1		<= 6.5	January 2016	CO	
	Length of Stay - Non-elective Trust	4.4	4.4	4.6		<=4.2	January 2016	CO	
	Contract Performance (activity)	-2.2%	-2.0%	-2.4%		0% or greater	January 2016	CO	
	Finance								
	Contract Performance (finance)	-1.6%	-1.7%	-1.7%		On Plan or Above YTD	January 2016	GL	
	Expenditure Performance	1.1%	0.9%	0.8%		On Plan or Above YTD	January 2016	GL	
	CIP Performance	-10.0%	-9.7%	-8.9%		On Plan or Above	January 2016	GL	
Capital Programme	14.8%	4.7%	-6.7%		On Plan	January 2016	GL		
Non-Core Spend	9.7%	9.7%	9.8%		<5%	January 2016	GL		
Cash Position	169%	140%	163%		On plan or above YTD	January 2016	GL		
Cash - working days	16.40	9.5	-19.8		> 10 days	January 2016	GL		
A. Healthy Organisation	Clinical Outcomes								
	Never Events	0	0	0		0 per month	January 2016	EM	
	Complaints	41.5	40	38.5		<30 per month	12-mth ave to Jan 2016	GW	
	Workforce								
	Attendance	95.6%	95.7%	95.8%		>= 96%	January 2016	JM	
	Qualified Nurse Vacancies	4.9%	5.2%	5.6%		<=6.5%	January 2016	GW	
	Mandatory Training	92.5%	91.8%	92.4%		>= 95%	January 2016	JM	
	Appraisal	82.28%	82.24%	84.28%		>= 85%	January 2016	JM	
	Turnover	9.5%	9.5%	9.4%		<10%	January 2016	JM	
	Nursing Agency Costs	2.7%	2.5%	2.3%		<=2.5%	January 2016	GW	
External Validation	National Comparators								
	Advancing Quality (not achieving)	3	3	5		All areas above target	November 2015	EM	
	Mortality: HSMR	90.53	89.01	89.23		Lower CI < 0.90	April to Oct 2015	EM	
	Mortality: SHMI	0.969	0.969	0.980		Lower CI < 90	July 2014 to June 2015	EM	
	Regulatory Bodies								
	Monitor Risk Rating - Finance CoS	2	2	2		4	January 2016	GL	
	Monitor Risk Rating - Governance	Red	Red	Red		Green	January 2016	CO	
	CQC	5	5	5		0	January 2016	EM	
	Local View								
	Commissioning - Contract KPIs	5	7	5		<=2	January 2016	CO	
Monitor enhanced monitoring									
A&E 4 Hour Standard	88.02%	88.34%	82.31%		>=95%	January 2016	CO		
Medical Outliers	5.23	4.1	6.71		<=5	January 2016	CO		
Bed occupancy	93.9%	91.3%	94.8%		<=85%	January 2016	CO		
Staff Friends and Family	62%	62%	62%		>= 75%	Q2 2015/16	CO		
Financial Recovery	Financial Recovery Plan								
	Contract / Inventory Management	0.8%	0.1%	-0.1%		0% (ie on plan) or greater	January 2016	MT	
	Income	-2.7%	-1.2%	-1.6%		0% (ie on plan) or greater	January 2016	MT	
	Workforce Value for Money	-4.8%	-6.3%	-2.5%		0% (ie on plan) or greater	January 2016	MT	
	Utilisation - Outpatients	-17.7%	-20.4%	-19.6%		0% (ie on plan) or greater	January 2016	MT	
	Utilisation - Theatres	-15.0%	-17.0%	-18.0%		0% (ie on plan) or greater	January 2016	MT	
Productivity - Patient Flow	2.2%	2.2%	-3.4%		0% (ie on plan) or greater	January 2016	MT		

Quarter	3
Period	01/10/2015 - 31/12/2015

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

Division		Tumour Group		Quarter 3 - Total							
				Breaches			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted		
Medicine	Haematology Lung Other	1	0	1	10	0	10	90.00%	90.00%		
		2	0	2	17.5	0	17.5	88.57%	88.57%		
		2	0	2	4	0	4	50.00%	50.00%		
Med & Surg	Upper GI	8	0	8	18.5	0	18.5	56.76%	56.76%		
Surgery	Breast Colorectal Head & Neck Skin Urology	0	0	0	38	0	38	100.00%	100.00%		
		2	0	2	25	0	25	92.00%	92.00%		
		2	0	2	5.5	0	5.5	63.64%	63.64%		
		0	0	0	60	0	60	100.00%	100.00%		
		13	0	13	50	0	50	74.00%	74.00%		
Women's	Gynaecology	6	0	6	16	0	16	62.50%	62.50%		
Total		36	0	36	244.5	0	244.5	85.28%	85.28%		

Division		Tumour Group		Quarter 3 - October							
				Breaches			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted		
Medicine	Haematology Lung Other	1	0	1	3	0	3	66.67%	66.67%		
		2	0	2	8	0	8	75.00%	75.00%		
		0	0	0	1	0	1	100.00%	100.00%		
Med & Surg	Upper GI	5	0	5	9	0	9	44.44%	44.44%		
Surgery	Breast Colorectal Head & Neck Skin Urology	0	0	0	9.5	0	9.5	100.00%	100.00%		
		2	0	2	8	0	8	75.00%	75.00%		
		0	0	0	1	0	1	100.00%	100.00%		
		0	0	0	18	0	18	100.00%	100.00%		
		9	0	9	23.5	0	23.5	61.70%	61.70%		
Women's	Gynaecology	2	0	2	3.5	0	3.5	42.86%	42.86%		
Total		21	0	21	84.5	0	84.5	75.15%	75.15%		

Division		Tumour Group		Quarter 3 - November							
				Breaches			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted		
Medicine	Haematology Lung Other	0	0	0	3	0	3	100.00%	100.00%		
		0	0	0	5	0	5	100.00%	100.00%		
		2	0	2	3	0	3	33.33%	33.33%		
Med & Surg	Upper GI	0	0	0	2.5	0	2.5	100.00%	100.00%		
Surgery	Breast Colorectal Head & Neck Skin Urology	0	0	0	16	0	16	100.00%	100.00%		
		0	0	0	9.5	0	9.5	100.00%	100.00%		
		1	0	1	2	0	2	50.00%	50.00%		
		0	0	0	23	0	23	100.00%	100.00%		
		4	0	4	11	0	11	63.64%	63.64%		
Women's	Gynaecology	2	0	2	5.5	0	5.5	63.64%	63.64%		
Total		9	0	9	80.5	0	80.5	88.82%	88.82%		

Division		Tumour Group		Quarter 3 - December							
				Breaches			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted		
Medicine	Haematology Lung Other	0	0	0	4	0	4	100.00%	100.00%		
		0	0	0	4.5	0	4.5	100.00%	100.00%		
		0	0	0	0	0	0	N/A	N/A		
Med & Surg	Upper GI	3	0	3	7	0	7	57.14%	57.14%		
Surgery	Breast Colorectal Head & Neck Skin Urology	0	0	0	12.5	0	12.5	100.00%	100.00%		
		0	0	0	7.5	0	7.5	100.00%	100.00%		
		1	0	1	2.5	0	2.5	60.00%	60.00%		
		0	0	0	19	0	19	100.00%	100.00%		
		0	0	0	15.5	0	15.5	100.00%	100.00%		
Women's	Gynaecology	2	0	2	7	0	7	71.43%	71.43%		
Total		6	0	6	79.5	0	79.5	92.45%	92.45%		

Integrated Performance Dashboard - Metric Thresholds				
Meeting Our Vision				
Indicator	Definition	Green	Amber	Red
Satisfaction Rates				
Patient Satisfaction - F&F "Recommend" Rate for Trust	Patient Satisfaction - Friends & Family "Recommend" Rate for Trust	>=95%	n/a	<95%
Patient Satisfaction - F&F "Not Recommend" Rate	Patient Satisfaction - Friends & Family "Not Recommend" Rate for Trust	<=2%	n/a	>2%
Staff Satisfaction (engagement)	Results from staff satisfaction survey	>=3.69	>=3.59 to <3.69	<3.59
First Choice Locally & Regionally				
Market share : Wirral	WJTH share of Wirral CCG GP Referred New OP Activity (rolling 3 months)	>= 85%	>= 80% to <85%	< 80%
Demand : Referral Rates	Outpatient referrals received from all GP/GPps - G&A specialities	>= 3% YoY variance	0% to <3% YoY	<0% YoY
Market share : Non-Wirral	WJTH share of West Cheshire GP Referred New OP activity	>=8%	>=6% to <8%	<6%
Strategic Objectives				
Harm Free Care	Compliance with Safety Thermometer definition of Harm Free Care	>= 95%	>= 93% to <95%	<93%
HIMMS Level	Current HIMMS level under Electronic Medical Record Adoption Model	5	n/a	<5
Organisational Excellence				
Indicator	Definition	Green	Amber	Red
Key Performance Indicators				
A&E 4-hour Standard	% of patients attending ED & ADHC treated within 4 hours	>=95%	n/a	<95%
RTT '18' Week Standard	RTT "Incompletes" standard met for the Trust as a whole	>=92%	n/a	<92%
Cancer Waiting Time Standards	All Cancer Waiting standards met for the Trust per quarter	All met at Trust level	n/a	Not all met at Trust level
Infection Control	MRSA Bacteremia CDIFF	0 MRSA Bacteremia in month, and cdiff less than cumulative trajectory	0 MRSA Bacteremia in month, and cdiff equal to cumulative trajectory	>= 1 MRSA Bacteremia in month or cdiff cases above cumulative trajectory
Productivity				
Delayed transfers of care	Average No of patients with a delayed transfer of care at month-end	<= 4	> 4 and < 6	>= 7
Delayed complex care packages	Average No of patients on the complex discharge list in the month	<= 45	>= 46 and <= 70	>= 71
Readmissions	% of patients readmitted non-selectively within 30 days of discharge	<= 7.5%	>7.5% and <= 10%	> 10%
Bed occupancy	Average % of General & Acute Beds occupied at midday	<=85%	>85% to <95%	>=95%
Bed occupancy - Medicine	Average % of Medial & Acute beds occupied at midday	>=85%	>=65% to <85%	<65%
Theatre utilisation	Average % of scheduled operating minutes utilised	>=85%	>=65% to <85%	<65%
Outpatient DNA Rate	Percentage of booked OP appointments that DNA (Med, Surg and W&C)	<= 6.5%	>6.5% and <= 9%	> 9%
Outpatient Utilisation	Percentage of OP appointments that DNA (Med, Surg and W&C)	>90%	>=80% to <90%	<80%
Length of stay - Non-elective Medical Division	Average length of stay per finished admitted spell (Medical Division)	<= 6.5	> 6.5 to 8.0	> 8.0
Length of stay - Non-elective Trust total	Average length of stay per finished admitted spell (Trust total)	<= 4.2	> 4.2 to 5.5	> 5.5
Contract performance (Activity)	Cumulative activity % variance against plan for all PODs combined	0% or greater	> -2.0% to <0%	< -2.0%
Finance				
Contract Performance (Finance)	Delivering both contracted volumes and values	On Plan or Above YTD	1% below plan YTD	>1%.below plan YTD
Expenditure performance	Delivering planned levels of expenditure	On Plan or Above YTD	1% below plan YTD	>1%.below plan YTD
CIP Performance	Delivering against the In-year CIP forecast.	On Plan or Above	10% below plan	>10% below plan
Capital Programme	A sound investment programme maintained & resourced appropriately	On Plan	+/- 15% against plan	+/- 25% against plan
Non-Core Spend	Non core as a % of total pay spend	<5%	>=5.0% to 6.5%	>=6.6%
Cash Position	Delivering against cash plan	On plan or above YTD	n/a	Below plan

Cash - working days	Liquidity Days: The number of days the Trust could support it's pre EBITDA expenditure with it's liquid assets i.e.((Current Assets - Inventories - Current liabilities) / Pre EBITDA expenditure) x number of days elapsed in financial year	> 10 days	>= 7 days to 9 days	< 7 days
A Healthy Organisation				
Indicator	Definition	Green	Amber	Red
Clinical Outcomes				
Never Events	Number of occurrences of "Never Events"	0 per month	n/a	>= 1 per month
Complaints	Number of occurrences of formal complaints	<30 per month	30 to 50 per month	> 50 per month
Workforce				
Attendance	Monthly staff attendance rate	>= 96%	>=95.3% to <96.0%	< 95.3%
Qualified Nurse Vacancies	% vacant posts	<=6.5%	>6.5% to 9.5%	>9.5%
Mandatory Training	Rolling 12-month staff mandatory training rate	>= 95%	>= 85% to <95%	< 84.9%
Appraisal	Rolling 12-month staff appraisal rate	>= 85%	>= 80% to <85%	<80%
Turnover	Rolling 12-month staff turnover rate	<10%	>= 10% to <12%	>=12%
Nursing Agency Costs	Nursing agency costs as a percentage of total nursing costs	<=2.5%	>2.5% to <3.0%	>=3.0%
External Validation				
Indicator	Definition	Green	Amber	Red
National Comparators				
Advancing Quality (not achieving)	Number of areas not achieving	All areas above target	1 area below target	> 1 area below target
Mortality : SHMI	SHMI	Lower CI < 0.90	Lower CI 0.90 to 0.99	Lower CI >= 1.0
Mortality : HSMR	HSMR	Lower CI < 90	Lower CI 90 to 99	Lower CI >= 100
Regulatory Bodies				
Monitor Risk Rating - Finance	Monitor Risk Assessment Framework - Continuity of Service rating	4	3 or 2*	2 or 1
Monitor Risk Rating - Governance	Monitor Risk Assessment Framework - Governance rating	Green	n/a	Red
CQC	Number of concerns raised by CQC following inspection	0	1 to 2	>2
Local View				
Commissioning - Contract KPIs	Number of Quality KPIs in the contract not being achieved	<=2	3 to 4	>=5
Monitor Enhanced Monitoring				
A&E 4-hour Standard	% of patients attending ED & ADHC treated within 4 hours	>=95%	n/a	<95%
Medical Outliers	Average daily medical outliers in non-medical beds	<=5	>5 to 10	>10
Bed occupancy	Average % of General & Acute Beds occupied at midday	<=85%	>85% to <95%	>=95%
Staff Friends and Family	Recommend Trust to work	>= 75%	>= 50% to <75%	<50%
Financial Recovery Plan				
Contract / Inventory Management	Total non pay expenditure against plan, excluding CNST premium and high cost drugs	>=0%	<0% to -5%	<-5%
Income	Total income against plan	>=0%	<0% to -5%	<-5%
Workforce Value for Money	Total pay expenditure against plan	>=0%	<0% to -5%	<-5%
Utilisation - Outpatients	Percentage of available resource utilised against scheduled resources	>=0%	<0% to -5%	<-5%
Utilisation - Theatres	Percentage of available resource utilised against scheduled sessions	>=0%	<0% to -5%	<-5%
Productivity - Patient Flow	Reduction in non-elective length of stay against plan	>=0%	<0% to -5%	<-5%

Board of Directors	
Agenda Item	7.1.2
Title of Report	Month 10 Finance Report
Date of Meeting	24 th February 2016
Author	Shahida Mohammed, Assistant Director of Finance
Accountable Executive	Gareth Lawrence, Acting Director of Finance
BAF References <ul style="list-style-type: none"> • Strategic Objective • Key Measure • Principal Risk 	7
Level of Assurance <ul style="list-style-type: none"> • Positive • Gap(s) 	Positive
Purpose of the Paper <ul style="list-style-type: none"> • Discussion • Approval • To Note 	To note
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken <ul style="list-style-type: none"> • Yes • No 	No

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1. Executive Summary

Overview

Operationally January was a challenging month for the Trust, reflecting the increasing demand on non elective services, compounded with the effects of the junior doctor's industrial action. Within the context of this environment the Trust delivered a deficit of £1.3m during the month. Although this is some £0.5m worse than the original planned

deficit of £0.7m for the month, it is an improved position when compared to the summer months.

The cumulative position is showing an actual deficit of £12.7m, against a plan of £11.3m. Despite the in month deterioration the Trust is still on track to deliver the revised forecast outturn of £15.0m assuming the risks identified are not realised.

Actual cash held continues to show a positive position, reflecting cash preservation initiatives continuing throughout the year. As at the end of January the cash balance held was £5.4m, this is some £2.1m better than the initial plan, which included the £4.8m cash resilience injection planned in December 2015. The Trust is forecasting to conclude the year with a year-end balance of c£2.3m, without the need for any resilience funding in 15/16. However it has to be noted the Trust will require resilience funding in the first quarter of 16/17, following notification from NHS England that they will not permit CCG's to make quarterly payments in advance to providers.

The financial performance in month translates into a Financial Sustainability Risk Rating (FSRR) score of 2, which remains in line with plan.

Income and Expenditure Performance

	Month 10			Year to Date			Full Year Forecast		
	In Month			Year to Date			Plan	Actual	Variance
	Plan	Actual	Variance	Plan	Actual	Variance			
£k	£k	£k	£k	£k	£k	£k	£k	£k	
NHS Clinical Income	23,790	23,239	(551)	232,845	228,951	(3,894)	279,420	275,949	(3,471)
Other Income	2,307	2,493	186	22,906	24,682	1,775	27,535	29,495	1,960
Employee Expenses	(17,253)	(18,185)	(933)	(172,643)	(176,887)	(4,244)	(206,305)	(212,546)	(6,241)
All Other Operational Expenses	(7,700)	(8,034)	(334)	(75,904)	(77,926)	(2,022)	(91,071)	(93,868)	(2,797)
Reserves	(745)	328	1,073	(6,672)	(269)	6,403	(8,827)	(455)	8,372
EBITDA	399	(159)	(558)	533	(1,449)	(1,981)	752	(1,425)	(2,177)
Post EBITDA Items	(1,197)	(1,155)	42	(11,826)	(11,297)	529	(14,220)	(13,612)	607
Net Surplus / (Deficit)	(798)	(1,314)	(516)	(11,294)	(12,746)	(1,452)	(13,468)	(15,038)	(1,570)
EBITDA %	1.5%	(0.6%)	(2.1%)	0.2%	(0.6%)	(0.8%)	0.2%	(0.5%)	(0.7%)

Specifically the table highlights;

- In-month NHS clinical income under-performed by (c£0.6m) against plan, increasing the cumulative deficit to (£3.9m). The underperformance was driven by value and volume.
- Other income continues to over perform largely at the current run rate; half the over-recovery is one off income gains and the other half offsets overspends in expenditure.
- Pay costs overspent by (c£0.1m) reflecting the increased pressure on staffing in the Emergency Department, particularly in relation to medical and nursing staff required to manage the level of demand and acuity.
- Non-pay costs are some £0.1m higher than plan reflecting the continuing cost pressures on clinical supplies.
- The EBITDA position is currently behind plan as a result of operational pressures mentioned above, but is being supported by savings in PDC as a result of the stronger cash balances and a marginal saving on depreciation as a result of capital timing differences.

Cash position and Financial Sustainability Risk Rating (FSRR)

The cash position is £5.4m, £2.1m better than plan.

Capital expenditure (on accruals basis) to month 10 is (£0.5m) below plan, reflecting underspends on the Pharmacy robot, and Cerner IT project. The capital programme is expected to remain within plan in year as long as c£0.4m unallocated resource is sufficient enough for unexpected urgent capital requirements.

It is anticipated that the majority of the cash timing differences resulting in the higher cash balance will unwind in the coming months and the Trusts cash position will reduce. The Trust is forecasting to finish the financial year with a c£2.3m cash balance, without any injection of resilience funding however support will be required in the first quarter of 2016/17.

The overall position returns a FSRR of 2, which is in line with plan.

Cost Improvement Programme (CIP)

The 2015/16 plan assumed delivery of £13m of CIP with £11m of identified opportunities at the time of the Plan submission. These plans were extracted according to the profile of the schemes identified, with the unidentified balance of £2m extracted in a flat profile (12 ths).

Year to date the Trust has delivered through a combination of cost improvements and revenue generation initiatives of c£8.9m, against a plan of £9.8m.

Under performances in coding, patient flow and theatre productivity workstreams have been offset by over performances in other areas including outpatients.

The latest forecast outturn position is showing a marginal improvement from the previous month to c£11.8m.

Recurrently schemes are expected to deliver c£11.5m against a plan of £16.4m. The Trust is mindful of the pressure this places on plans going into 2016/17 and has reflected this in the draft operational plan submitted to Monitor in February. It is therefore imperative that, whilst maintaining the focus on CIP delivery in 2015/16 the emphasis is clearly on the identification and planning of schemes to meet the challenges required in delivering the operational plan requirement for 2016/17.

Risks inherent in the CIP plans had been identified as part of the planning process, some mitigation is also available within reserves; this is applied on a monthly basis.

2. Non-Core Spend

Non-core spend has been identified nationally as one of the main drivers in explaining the deterioration in Trusts finances. Nursing agency guidance and thresholds have already been issued and the Trust continues to work towards reducing its non-core expenditure. The table below analyses the current Pay expenditure within the Trust in comparison to the average last financial year.

Detail	14/15 Average £k	April £k	May £k	June £k	July £k	August £k	September £k	October £k	November £k	December £k	January £k	YTD £k
Budget		17,634	17,878	17,763	17,725	17,725	17,609	17,743	17,715	17,758	17,873	177,421
Pay Costs												
Substantive	15,875	15,911	15,990	15,937	15,868	16,046	15,696	16,006	15,971	16,218	16,159	159,802
Bank Staff	319	306	291	295	293	289	278	281	239	326	347	2,945
Agency Staff	518	698	712	605	683	606	747	694	804	779	825	7,152
Overtime	224	343	278	282	263	276	388	281	289	298	217	2,915
Locum	362	299	264	332	356	410	300	405	340	368	334	3,408
WLI (In Year)	155	52	88	126	100	91	98	56	72	126	76	884
Non Substantive Total	1,577	1,698	1,633	1,640	1,695	1,672	1,811	1,717	1,744	1,897	1,798	17,305
Total Pay	17,451	17,609	17,623	17,577	17,563	17,718	17,507	17,723	17,715	18,115	17,957	177,107
Variance		24	255	186	162	7	102	20	(1)	(357)	(85)	315

In January 2016 c£1.8m has been spent on non-core pay categories as detailed in the above table which is an improved position compared to December. As part of the winter plan the Trust had planned for non-core spend to increase to enable the operational teams to flex the bed base at times of increased demand and the support the winter escalation wards.

The Trust continues to submit agency information to Monitor on a weekly basis which is reviewed at the Senior Management Team on a weekly basis. There is continued focus on the non-core spends across the divisions and they are a part of the performance dashboards at the divisional performance reviews to identify opportunities to improve the run-rate going forward. These opportunities will then be fed through the transformation steering group(TSG) as potential saving opportunities.

The Trust still remains under the nursing agency cap of 3%, with the Nursing agency costs in January equating to 2.5% of the substantive nursing wage bill.

While the increase in non-core spend is disappointing and largely stepped up due to the winter escalation areas it also gives the Trust an opportunity to improve the overall run-rate of the Trust by identifying relevant staff strategies to reduce this spend. These opportunities are currently being identified and will be fed through TSG as potential saving opportunities.

3. Risks/Mitigations

The Trust is currently forecasting a year end deficit of (£15.0m). The following risks have not been reflected in the forecast position therefore any of these risks becoming realised would lead to a further deterioration in the forecast outturn.

3.1 Health Economy affordability

The Trust has had discussions with the CCG with regards to a reaching a year-end settlement, with the aim of minimising risk for both the Trust and CCG. Unfortunately the offer from the CCG was not better than the Trust internal forecast outturn.

Furthermore following recent instruction from Monitor/NHSE with regards to the re-investment of sanctions, the Trust has assumed this will be made to support the Trusts position, and will not be retained by the CCG for their bottom line, this has not yet been confirmed by the CCG.

3.2 Delivery of activity

- Although elective/daycase activity in Surgery during January achieved the anticipated recovery plan.

- Outpatients attendances were significantly below plan in Surgery, Women's and Children's Division and in Medicine and Acute.
- Impact of further industrial action.

3.3 CQUINs

- Achievement of the quarter 4 target is a challenge particularly as certain targets are weighted higher in this quarter. Early indications show three targets are a pressure, plans are in place to ensure appropriate actions are taken, and discussions with the CCG continue to minimise the risk.

4. Conclusion

The overall I & E position as at the end of January is a £0.5m deterioration to the plan. The Trusts cash position continues to be stronger than plan and the forecast cash position will not require the injection of resilience funding this financial year. The Trust has achieved its FSRR of 2 as planned.

It is imperative that the Trust continues to deliver its activity plans in the remaining months of the year; specifically from a planned care perspective and that this is facilitated through improved patient flow across the organisation.

The forecast full year CIP is £11.8m which is a marginal improvement from the previous month. The current recurrent forecast will mean that the Trust will be able to deliver the planned deficit for 2016/17 as per the financial improvement plan.

From a risk perspective the key considerations include the requirement to ensure planned activity for the remainder of the year is achieved, in addition to improve patient flow, our assumptions in relation to the re-investment of financial penalties are confirmed by the CCG and CQUIN targets are delivered.

In addressing these issues divisions are closely monitoring activity levels and seeking opportunities to maximize capacity, developments in patient flow have been supported to ensure the swiftest and most clinically appropriate transition of patients into and out of the organisation and weekly review of CIP development and delivery is undertaken at an executive level, which will also be used to inform the 16/17 requirement.

At an aggregate level the Trust is forecasting to be £1.6m below plan recognising that further risks on delivering activity/income, continued cost improvement and the application of contract penalties. Close management of cash and working capital balances continues to afford the Trust a stronger cash position than planned.

5. Recommendations

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

Gareth Lawrence
Acting Director of Finance
February 2016

Board of Directors	
Agenda Item	8.1
Title of Report	Equality & Diversity Annual Report 2015
Date of Meeting	24 February 2016
Author	Michael Chantler, Head of Patient Experience
Accountable Executive	Gaynor Westray, Director of Nursing and Midwifery
BAF References • Strategic Objective • Key Measure • Principal Risk	1A Risk 2835 1B Risk 1908 4A Risk 1909
Level of Assurance • Positive • Gap(s)	Gaps
Purpose of the Paper • Discussion • Approval • To Note	To note
Data Quality Rating	Gold – externally validate Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • Yes • No	Note for Report Writers – if your report relates to a service change of any kind, you will need an EIA. For further guidance on EIA contact Associate Director of Governance or Head of Patient Experience

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

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- Understanding experience
- Accessible Information Standard
- Workforce Race Equality Scheme
- Workforce composition
- Training and Development

It also includes an overview of the Equality Delivery System 2 (EDS 2) and the process for developing Equality & Diversity objectives based on the assessment of the EDS 2 standards.

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 under the Act as follows:

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

3. Equality Delivery System 2

The Trust has an established Equality and Diversity Action Plan which is monitored at the Patient and Family Experience Group and reportable to the Clinical Commissioning Group as part of the Quality Contract Schedule. The introduction of the Equality Delivery System 2 across the NHS in 2015 has provided a framework for self-assessment across a range of indicators. The self-assessment for WUTH has been completed by a group including staff from different services/functions as well as staff side colleagues. The next step will be for Healthwatch and other patient representative groups to verify these assessment results in March 2016.

The self-assessment gradings are as follows:

Goal 1 - Better Health Outcomes		Assessment Rating (subject to verification) Undeveloped/Developing/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.	Developing
1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed.	Developing
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.	Developing
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.	Undeveloped
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.	Developing
4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination.	Developing

The main area for focus is in relation to Goal 4 – Inclusive Leadership, with one indicator undeveloped and two as developing. This will require a structured programme of improvement and the leadership team will need to consistently demonstrate their development and capability in this area and that their considerations and decisions are being made regardless of any bias, conscious or otherwise.

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.

In addition to the standard process for completing an Equality Analysis, a full audit of the 2015/16 CIP schemes was completed to assess any impact on groups with protected characteristics.

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.

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 service providers in place to meet interpretation and translation guidelines. 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 April 2014 and March 2015.

	April 2014- March 2015
Action on Hearing Loss	£41,752.97
Language Line	£1,595.10
Beacon Languages	£45,291.17
Total Exc VAT	£88,639.24

The Trust is currently tendering for a single provider of interpretation and translation services and this will be completed by the start of the 2016/17 financial year. This will improve access and usage of these services.

Improving care for patients with Learning Disabilities

This has been a significant area of focus for the Trust since 2010 and over the last five 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.

An electronic flag has been developed for patients with a learning disability and an Electronic Daily Records is now produced which enables senior nurses to check that reasonable adjustments have been put in place for the patient. This has been a significant step forward to providing consistent quality care for this patient group. In addition, a retrospective flagging exercise has been completed for patients under the care of Cheshire and Wirral Partnership NHS Foundation Trust to ensure they are identified on Wirral Millennium.

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.

Accessible Information Standard

The Accessible Information Standard was included as a statutory requirement for NHS Trusts in the Health and Social Care Act 2012. The guidance issued by NHS England in 2015 details that NHS Trust will have to have electronic means of recording patient's preferred communication and information requirements as well as having the supporting processes in place to meet their needs. A steering group has been established, reporting into the Information Governance Group and CERNER have completed an initial assessment of the requirements against the capability of Wirral Millennium to meet the standard. The Accessible Information Standard has to be implemented by 31/7/16 and is reportable to the Clinical Commissioning Group as part of the Quality Contract Schedule.

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 provides an opportunity to discuss any issues arising from their members.

Some of the most prominent activities throughout 2015 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 Healthwatch 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 varied demographical data.

		WUTH		Female		Male		BRM		Disability		16-30		31-64		65+		LGB			
		n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%		
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	Previous insufficient data to run report			
	2012-13	8435	76	4050	77	2849	77	37	70	2063	71	560	77	4009	78	3538	76	Previous insufficient data to run report			
	2013-14	5368	74	1848	76	1437	73	41	73	1187	67	320	72	764	74	1808	74	Previous insufficient data to run report			
	2015	5385	80	2658	81	1706	80	162	78	1268	74	476	82	2156	82	581	85	47	64		
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	Previous insufficient data to run report			
	2012-13	8307	98	4009	98	2834	99	35	100	2053	98	555	96	3979	98	3494	99	Previous insufficient data to run report			
	2013-14	3954	94	1710	94	1338	94	41	81	1144	93	301	91	616	93	1593	96	Previous insufficient data to run report			
	2015	4523	95	2231	95	1403	96	127	92	1110	93	451	90	1778	95	431	97	45	87		
I got the care that mattered to me	2011 -12	3291	98	434	97	365	96	33	91	869	97	161	93	1377	98	1333	98	Previous insufficient data to run report			
	2012-13	8021	98	3925	97	2735	99	27	100	1963	97	551	95	3926	98	3335	98	Previous insufficient data to run report			
	2013-14	5376	98	1864	97	1482	99	45	100	1185	97	317	97	761	96	1828	98	Previous insufficient data to run report			
	2015	5487	98	2715	97	1745	98	165	98	1286	96	468	97	2174	97	610	100	50	94		
I would recommend this hospital to my friends & family	2011 -12	3324	96	434	92	375	95	35	97	885	93	151	95	1374	97	1357	96	Previous insufficient data to run report			
	2012-13	8050	96	3912	95	2763	97	37	89	1982	94	542	93	3885	95	3397	96	Previous insufficient data to run report			
	2013-14	5020	97	1709	96	1322	97	41	98	1114	92	282	95	692	95	1695	97	Previous insufficient data to run report			
	2015	6169	98	2728	97	1721	99	158	98	1292	96	461	97	2159	97	608	99	48	96		

Overall, patient's experiences are generally positive from a demographic perspective and many scores have improved in comparison to 2013/14. For the first time this data includes patients who have stated that they are Lesbian, Gay or Bisexual which is a positive step as in previous years this demographic group have been reluctant to provide the data. This group will require some targeted engagement as their experience of being involved in decisions about care and treatment is a significant variance from the overall WUTH figure.

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 31/12/15

Gender	Total
Female	4629
Male	1272
Grand Total	5901

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	439	98	537
Band 2	1079	287	1366
Band 3	420	117	537
Band 4	297	64	361
Band 5	1066	161	1227
Band 6	639	113	752
Band 7	342	65	407
Band 8A	93	33	126
Band 8B	28	12	40
Band 8C	16	5	21
Band 8D	4	2	6
Band 9	1		1
M&D	191	298	489
Other	14	17	31
Grand Total	4629	1272	5901

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

Ethnic Origin	Total
White - British	5295
White - Irish	39
White - Any other White background	46
White English	1
White Greek	4
White Irish Traveller	1
White Italian	1
White Mixed	1
White Other European	20
White Polish	7
White Turkish	2
White Unspecified	2
White Welsh	1
Asian British	1
Asian East African	1
Asian Mixed	4
Asian or Asian British - Any other Asian background	20
Asian or Asian British - Bangladeshi	6
Asian or Asian British - Indian	180
Asian or Asian British - Pakistani	21
Asian Sri Lankan	4
Asian Unspecified	3
Black Nigerian	1
Black or Black British - African	30
Black or Black British - Any other Black background	2
Black or Black British - Caribbean	4

Chinese	16
Filipino	1
Malaysian	1
Mixed - Any other mixed background	8
Mixed - Asian & Chinese	1
Mixed - Black & Asian	1
Mixed - Chinese & White	1
Mixed - Other/Unspecified	1
Mixed - White & Asian	6
Mixed - White & Black African	7
Mixed - White & Black Caribbean	1
Not Stated	105
Other Specified	26
Any Other Ethnic Group	29
Grand Total	5901

The Workforce Race Equality Standard (WRES) was mandated across the NHS in 2015 and all NHS Trusts were required to publish a baseline assessment on their websites. The WRES is intended to improve the representation of black and minority ethnic (BME) staff in the workforce, especially in senior management and board level appointments. The assessment did not show any significant variance for BME staff compared with white staff with the exception of a higher likelihood of BME staff who have reported personal discrimination in the last 12 months from colleagues or manager/team leader. In addition, the requirement for the board to be representative of the community they serve is highlighted as there is no BME representation at board level. These issues are also highlighted in the EDS 2 assessment and will require action to progress.

Disabled	Total
No	2028
Not Declared	394
Undefined	3414
Yes	65
Grand Total	5901

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 the Trust were appropriate the governments Access to Work scheme is used to fund any necessary adjustments in the workplace.

Sexual Orientation	Total
Bisexual	16
Gay	29
Heterosexual	2549
I do not wish to disclose my sexual orientation	522
Lesbian	14
Undefined	2771
Grand Total	5901

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 522 staff have chosen to not to disclose their sexual orientation when being recruited to the organisation.

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 Trusts 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.

10. Supporting young people into work

Apprenticeships

The Trust's Apprenticeship programme continues to receive national recognition and has recently been runner up in the UK in the HSJ Value Awards in the Learning & Development category which recognises the work it does with young people and in leading this initiative across the region. In the past year the Trust has invested in twenty-five 16-23year old apprentices across a range of specialisms to support patient care. Individual successes range from apprentices progressing into Band 3 and 4 job roles in Emergency Care and Pharmacy as well as taking their first steps into attaining Institute of Leadership and Management qualifications and our first apprentice being accepted for the School of Nursing in September 2016. The benefit all our apprentices have is the gaining of Level 2 English and Mathematics alongside a vocational qualification linked to gaining a permanent post with the Trust which supports our 'Grow your Own' initiative.

Traineeships

The Trust has supported other Trusts in Cheshire and Merseyside in the past 12 months to develop Traineeship programmes which give young people aged 16-24 to enhance their social skills, job readiness, gain experience in the workplace and achieve their Level 2 English and Mathematics. With mentoring and support the Trainees have grown and this year we have seen four of them progress into our apprenticeship programme working with patients. In partnership with Wirral Metropolitan College we have also seen numbers applying for our programme rise and the participants gaining employment within the local community. This reflects our Trust's strategy to be 'Locally Focused, Regionally Significant' and helps grow our workforce of the future based on skills, experience and values.

Supported Internships

The success of our Merseyside Pilot has engaged a range of employers across the county in supporting 16-24 year olds with significant learning difficulties to gain experience in the workplace. The programme has developed communication skills, working with colleagues and provided all participants with confidence to travel independently. A celebration with parents, families and friends along with Trust colleagues highlighted how each intern had developed over the year within the Trust. Some interns worked directly with patients in Day case Surgery and Dermatology as well in Outpatients using the Trust's state of the art Patient Cerner IT system. Some of the interns have now progressed to college and are studying for additional qualifications however we were pleased to see two of them gain permanent employment within our Estates department and Surgical Division.

11. Key Issues

The EDS 2 assessment, although subject to verification has identified gaps in meeting the goals and outcomes which in turn will lead to the development of new Equality and Diversity Objectives. There are two principles issues that require considered action prior to the EDS verification as follows:

- Development of an Inclusive Leaders programme to improve Goal 4 of the EDS 2
- Planning for a one off programme to refresh workforce composition data, particularly in relation to disability and sexual orientation

12. Next Steps

The Board of Directors is asked to note this report. It is recommended that a further report is submitted in April 2016 detailing the results of the EDS verification along with draft objectives for approval.

Trust Board	
Agenda Item	8.2
Title of Report	Community Paediatrics Update
Date of Meeting	24 th February 2016
Author	Maureen Wain – Divisional Director
Accountable Executive	Chris Oliver – Acting Director of Operations
BAF References Strategic Objective Key Measure Principal Risk	7C Monitor Green Governance Rating 2832
Level of Assurance Positive Gap(s)	
Purpose of the Paper Discussion Approval To Note	To note
Data Quality Rating	Bronze – qualitative data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken Yes No	No

1. Executive Summary

This paper is to provide an update on the Community Paediatrics service to the Trust Board.

The Community Paediatric service continues to experience long waiting times for first appointments with a significant number of patients breaching the 18 week constitutional standard. As of 8th February, the number waiting for a first appointment is 733, of which 381 have been waiting over 18 weeks. This has reduced from 474 since September 15.

It should be noted that all statutory standards within the service are met.

The CCG has undertaken a Community Paediatric Service review which identifies a number of short term recommendations and long term transformation options. In addition, the CCG has agreed the use of non-recurrent slippage funding to start to address the immediate waiting list pressures.

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The Trust has identified the next steps with timescales in place. The Trust Board is asked to note the contents of the paper and approve recommendations for next steps.

2. Background

The waiting time from referral to treatment (RTT) for children referred to community paediatrics is 46 weeks. However, the length of wait varies from 4 weeks to 46 weeks; with 381 patients waiting over 18 weeks for a first appointment. This position is contributing to difficulties in the Trust's ability to meet its 18 week constitutional standard.

David Allison, Chief Executive and representatives of the Trust met with Wirral Clinical Commissioning Group (WCCG) in November 2015 to identify a solution to this issue, with WCCG undertaking an external review of the service in response to the Trusts request for additional recurrent resource above and beyond the block contract value to address the shortfall in capacity.

3. Key Issues/Gaps in Assurance

WCCG completed the Community Paediatric Review at the end of December 2015. The report¹ was shared with the Trust in early January 2016. Christine Campbell, Head of Partnerships WCCG and Nesta Hawker, Director of Commissioning presented the review to the divisional management and community paediatric teams on 21st January 2016.

The review contained a number of both short-term recommendations and medium to longer term transformational options. It should be noted that the key findings (see below) from the review conducted by the CCG are not necessarily all supported by the Division or Community Paediatric Service and that none of the short-term recommendations from the CCG fully alleviate the pressure within the service.

Key findings of the CCG review:

- All professionals involved in the review have in common a passion to improve services locally
- Concern was raised regarding the service commission with no agreed specification or desired outcomes agreed
- Agreement that statutory functions are being delivered
- Criteria for following up children need to be urgently developed
- Movement towards an aspirational staffing model with a higher nursing resource
- Recommendation for the Trust to undertake an internal review of the operational delivery of the service
- The CCG and Local Authority to develop a Wirral parenting 'offer' as a medium to longer term solution with a short term solution for 2016/17
- Joint commissioning of Speech and Language Therapy (SLT) in line with statutory requirements
- Child Development Service model approach
- WCCG indication that it may give consideration to initiating a tender for service in future
- No evidence to suggest that the core service is underfunded, and that the service requires an increase in core funding. The Trust does not agree with this finding of the report.

It was agreed the Trust will aim to respond with factual inaccuracies and provide a formal response to the review by 12th February. The factual inaccuracies have been collated and Senior Management Team has had the opportunity to review the document and contribute to the response. The Trust has responded to the CCG and await any further feedback.

It is expected that any impact from implementation of the review recommendations will take a significant amount of time before the full affects are felt by the service. At such time, the Trust and CCG will be in a position to determine if transformation has been achieved which adequately addresses the long waiting times for new appointments, capacity for follow-up appointments and availability of other first line options (e.g. parenting / early intervention offer).

The risk to the Trust is an on-going shortfall in capacity and associated long waiting times while the review recommendations are implemented. However, as the CCG review contains no implementation timescales for the medium term recommendations WUTH are unable to assess the impact.

In addition to the review, the CCG asked the Trust to put together a proposal for slippage within the Future in Mind (CAMHS Transformation) monies in 15/16 to support reducing the waiting list. The monies need to be invested in both patients waiting for a first appointment and those waiting for a follow up, otherwise this will cause further problems in the future.

A proposal³ for approximately £120,000 was submitted to the CCG for additional Consultant (Existing and Locum), Registrar, Nursing and Administration hours to support an increase in capacity. This proposal was agreed by the CCG on 29th January 2016.

The Trust has secured one locum consultant and are currently engaging with further locum agencies for additional capacity, with additional SLT services are being considered. There is regular reporting to the CCG so underspent resources can be redirected to other services and a request to the CCG for the Trust to be allowed to manage the skill mix against the proposal as is felt clinically appropriate.

This will maximise the available resources and appointments to reduce the waiting list for first appointments by an anticipated 90 patients and corresponding reduction in waiting time to 37 weeks.

The risks, mitigations and next steps will be monitored within the divisional team meeting

It should also be noted that the slippage money offered supports making a reduction in waiting times for the period of February and March. It is expected that additional monies would be required to support the gap between the position at the end of March and the timescales associated with the impact of some of the Review Recommendations. This will form part of our formal feedback to the CCG.

4. Next Steps

Implementation of agreed slippage funding proposal (February and March 2016)

Action plan in response to the Review findings (February 2016)

An internal operational review of the service (29th February 2016)

Formal meeting with CCG to finalise review and address gap analysis due to implementation of review recommendations

5. Conclusion

The Trust has made progress and has successfully reduced the longest waits for the community paediatric service. It is anticipated that further progress will be made following the publication of the CCG review and the Trust's own operational review, which is due by the end of February. The CCG review has identified a number of short term recommendations and longer term transformation options to address the long waiting times and compliance with the 18 week constitutional standards within community paediatrics. However, this is the view of the CCG and an operational review is required to ensure WUTH ability to deliver the service is captured and addressed.

The full impact from implementation of the review recommendations will not be felt for some time and hence WUTH will remain with existing pressures for the waiting times unless additional resources post March are also funded.

Short term financial support from the CCG to address the long waiting times has been agreed and implementation of this has a number of associated risks, particularly around the availability of suitable locum consultant resource, although initial indications are positive. However, it should be noted that a longer term model may not necessarily require additional consultant resource. Benchmarking may indicate the need for greater nursing involvement.

6. Recommendations

It is recommended that the Trust Board note the contents of this paper and awaits a further update on waiting time reduction and the outcome of the Trust's operational review. A update will be provided to the Trust Board in early March.

Board of Directors	
Agenda Item	8.3
Title of Report	Care Quality Inspections
Date of Meeting	24 February, 2016
Author	Louise Taylor, CQC Compliance Manager Dr Melanie Maxwell, Associate Medical Director
Accountable Executive	Dr Evan Moore, Medical Director
BAF References • Strategic Objective • Key Measure • Principal Risk	Strategic Objective 7 – Supported by financial, commercial and operational expertise Key Measure 7a – Fully comply with our registration with the Care Quality Commission
Level of Assurance Positive	Positive
Purpose of the Paper	Approval
Data Quality Rating	Not applicable, no data included
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken	Not needed

1. Executive Summary

The Trust 'Board Walkabout' was established in September 2013, in part as a response to the NHS Institute for Innovation and Improvement toolkit '15 steps challenge'. The purpose of the Trust 'Board Walkabout' was to help staff, patients, service users and others to work together to identify improvements that could enhance the patient or service user experience. It provided a way of understanding patients' and service users' first impressions more clearly and a method for creating positive improvements and dialogue about the quality of care. The Trust 'Board Walkabout' was a committed team of Board Directors and Governors, asking open and engaging questions to the patient and/or carer so that they could express their thoughts. The discussion provided qualitative information that helped teams understand what worked and where improvement was required.

Building on further to the 'Board Walkabout' and the Care Quality Commission (CQC) mock inspections that took place last year and as part of the Trusts commitment to the provision of safe, effective care in a well led, caring and responsive organisation, the Trust is now implementing systematic Care Quality Inspections across the organisation in all patient areas, as an everyday way to monitor quality and standards of care within the Trust. These aim to triangulate compliance information to provide assurance against assessed compliance within a ward / clinical location. Results will be reported to the Quality & Safety Committee through the Clinical Governance Group, with a summary paper of the outcomes of the Care Quality Inspections presented to both the Board of Directors and the Council of

Governors on a regular basis. The Board of Directors as well as interested members of the Council of Governors will continue to play an invaluable role in this future model by being key members of each core team in an observational capacity. This change will result in the cessation of the current format of 'Board Walkabout' and the integration into the Care Quality Inspections.

1. Background

Between January & August 2015 the Trust undertook a programme of Care Quality Commission mock inspections, which involved a wide range of multi-disciplinary staff across the trust, including Healthwatch, trust volunteers, nursing and medical staff. The mock inspections were useful for identifying issues and an impetus for service improvement, and now the formal inspection is over we are keen to continue with this work stream. As part of the mock inspections all clinical areas in the Trust were assessed using a sample of CQC standards.

The corporate nursing team undertakes a patient focused care audit which is primarily based on the review of documentation and notes. The corporate nursing team proposes to expand this work stream into a Ward Accreditation Standard.

The newly designed Care Quality Inspections are different as they are broader in scope, and provide a multi-disciplinary approach, but they will provide useful information that can support the ward accreditation scheme and provide quality assurance.

The Care Quality Inspections will be enhanced by the support of the Board of Directors and Governors in an observational capacity

2. Key Issues

The mock inspection programme in its previous form was not sustainable long term. Care Quality Inspections will be performed less frequently but covering all five key lines of enquiry as set out by the CQC. A standard operating procedure (SOP) for the Care Quality Inspection's (CQI's) has been established which was piloted in December 2015, and resumed in January 2016 as a permanent bi-monthly inspection process . (Appendix 1)

The questionnaires have been restructured and a simplified approach based on the five key lines of enquiry has been taken, (Appendix 2). Specialty questionnaires will be developed for specific areas i.e. theatres, ED, children's services.

For those areas where concerns and recommendations are highlighted we are proposing a response report from the divisional team. The ward inspections will be monitored through Quality & Safety Committee and Clinical Governance Group.

3. Next Steps

The bi-monthly inspections will include a morning and afternoon session for each date planned. It is important that staff recognise the CQI's as a permanent internal approach to monitoring quality and standards of care across the trust. Further work will now be undertaken to align both the Care Quality Inspections with the ward accreditation programme. Raising awareness of the CQI's is essential to engage and encourage staff to be part of the inspection team.

4. Conclusion

We have developed an approach which maintains the key elements of the successful Trust Board Walkabout and mock CQC inspection programme whilst also recognising there are fewer resources available. It is key that as a Trust we provide accurate information about quality services and patient experience without creating an excessive burden for staff in the clinical areas or duplication of other quality improvement work streams such as the nursing and midwifery patient focused audit.

5. Recommendations

The Board is asked to note the SOP and proposed plan going forward for CQI's

Appendix 1.

Standard Operating Procedure: Care Quality Inspections

Following on from the Mock Inspection programme the Trust is now implementing Care Quality Inspections across the organisation in all patient areas, as an everyday way to monitor Quality and Standards of care within the trust. These aim to triangulate compliance information to provide assurance against assessed compliance within a location. Results will be reported to the Quality & Safety Committee through the Clinical Governance Group. Participation in the inspection teams is voluntary, with core team members to include as observers a member of the Board and a public Governor

Underpinning Principles:

Visits:

- Inspections will ensure that we are delivering CQC fundamental standards.
- Inspections will focus on validating other information sources about the location in line with the CQC framework Safe, Caring, Effective, Well Led and Responsive.
- Inspections will rate each area in line with the CQC rating system and identify good practice as well as service improvement.
- Inspections will provide timely feedback to the location manager.
- Inspection may be suspended if there is an emergency in the location at the request of the location manager or team leader.
- Inspections will take place bi-monthly, an allocated inspection day will include identified morning and afternoon sessions.
- The number of areas inspected at any one time will be dependent on the number of volunteers in the inspection teams.
- Inspections will be performed in all areas at least once per year.
- Inspections for EOL care will be incorporated into the standard inspection programme.

Teams:

- Inspection teams will be multi-disciplinary, all grades of staff are invited to take part, including students. Teams will be predominantly clinical and have up to five members
- Volunteers, Members of Health Watch and CCG will be invited to join staff as part of the inspection team
- Inspection teams will be led by someone outside of the speciality/division to reduce bias wherever possible, however it will be recognised that when inspections are taking place in specialist areas i.e. theatres key members of staff with specialist knowledge may need to be on the inspection team
- Any member of the inspection team who is concerned about a patient's safety during the course of the inspection should report this immediately to the location manager and the inspection lead that day. Risks will be managed in line with the Trust risk management policy and incident policy.
- Inspection teams are expected to be present throughout the course of the inspection session for a 3 hour period, unless there is an emergency.
- Inspection teams must not divulge patient identifiable information they receive during the course of the inspection.

Process:

Set-up:

1. The Quality & Safety assistant will circulate a bulletin with planned inspection dates to the Board of Directors, Medical Director, Director of Nursing & Midwifery, Council of Governors, Divisional Triumvirates, and to the Trust wide communications team
2. Dates will be set for the year with a reminder sent 8 weeks prior to the inspection and again at 7 weeks prior to the inspection.

3. 6 weeks prior to the inspection, documentation will be provided in advance for inspectors to familiarise themselves with the contents.
4. Along with the quality & safety assistant the CQC Compliance Manager will develop a programme of inpatient and outpatient areas to visit.
5. The Head of Assurance and the CQC Compliance Manager will use developed documentation based on the CQC Key Lines of Enquiry to provide assessors with an understanding of what compliance with the standard means.
6. The inspection leader will arrange volunteers into suitable inspection teams.

Inspection:

1. At the start of the inspection, the team will meet with the Associate Medical Director, Associate Director of Risk, the CQC Compliance Manager or the Head of Assurance for a briefing session lasting no longer than 15 minutes.
2. Each group will need to identify a team leader; this person will manage the inspection. The Team Leader will:
 - a. Allocate the work load
 - b. Introduce the inspection team to the location lead
 - c. Explain/remind the location leads why they are there.
 - d. Thank the location leads as they depart
 - e. Ask the location lead to arrange for their line manager to be present at an agreed time for verbal feedback if possible
 - f. Complete the feedback matrix
3. The environment will be reviewed at each visit, using the Quality Ward Assessment document.
4. The inspection team should be able to speak to any member of staff, patients and visitors in the location to gain an understanding of the culture and environment.
5. The inspection team may access the case records to check activities have taken place (audit purposes); they may not remove any patient identifiable data from the location. (Ensure a member of the team has Cerner access).
6. If a team member is concerned about patient safety they should escalate this to the location manager at the time and inform the Team Leader. Further action will depend on the assessed risk to patients.
7. If a patient or member of the public raises a concern, the inspector should establish if the patient and/or carer has formally raised this before; should endeavour to address the issue, or escalate the concern to the location manager.
8. The inspector may make observations that fall outside of the remit of the standards that require reporting back (positive or negative). This can be raised in the feedback session.
9. The inspection is expected to last up to two hours.
10. Assessors will receive a briefing outlining the process, identifying the location and the standards for investigation. All supporting materials will be provided on the day
11. Every location should be inspected at least once per year. Any areas for concern will be revisited within an appropriate timeframe in line with findings, and referred to the team appropriate

Feedback

1. All team members will reconvene to discuss their finding and agree feedback to the location; captured on the feedback form
2. The feedback form will cover the five questions Safe, caring, Responsive, Effective and Well Led, and each question will be rated.
3. An overall rating of the ward / department will then be given.
4. The CQC Compliance Manager will ensure the location manager, Divisional Quality & Safety Manager and Associate Director of Nursing receive a scanned copy of the feedback form within 5 working days
5. The location should produce a response to the report within 14 days; agreed with the triumvirate. **(under discussion)**
6. The report and planned actions will be managed within the divisions with reporting by exception to Clinical Governance Group.
7. Clinical Governance Group will regularly receive a summary document of inspections and their impact.

8. The Quality & safety team will produce a report on common trust wide themes, and identify any trust wide quality improvement initiatives
9. Concerns effecting safety and quality of care highlighted during the inspection will be reported to the relevant triumvirate member by the CQI coordinator leading that session.
10. Highlighted concerns will be followed up within three days by a member of the Quality & Safety team.

Dr M J Maxwell, Associate Medical Director 17 April 2015

Updated Louise Taylor, CQC Compliance Manager 19 November 2015

Updated Gaynor Westray, Director of Nursing & Midwifery 14 February 2016

Appendix 2.

Care Quality Inspections: Caring

Question	Source of Information & Response
Patient Centred Care	
Are staff observed performing patient rounding & wearing rounding tabards? If not performed at time of inspection, is rounding documentation completed?	Observe
Do patients have easy access to call bells, drinks, bedside tables and walking aids?	Observe
What is the response time for a call bell?	Observe
Has the dementia screening question been asked for patients over the age of 75?	Ask staff / ward manager & review Nurse Worklist
Is the "forget me knot" symbol being used appropriately on the ward board? (i.e. for pts with a formal diagnosis of dementia only)	Ask staff
If there are any patients identified with a diagnosis of dementia has the "Dementia Care Bundle" been initiated?	Ask staff / check nursing documentation in IView
Has the "This Is Me" booklet been completed?	Ask staff / observe
<i>End of Life care: Are there any patients on the ward receiving end of life care? If so, refer to the end of life supplementary questions, if not continue below</i>	
Are staff aware of how to make referrals to the palliative care team?	Ask staff
Do staff know how to contact the palliative care team out of hours? (<i>via hospice</i>)	Ask staff
Are staff aware of the End of Life Care bundle in millennium & have they used it?	Ask staff
How do staff support family of dying pts / support bereaved relatives?	Ask staff
Are staff aware of individual cultural and religious beliefs of patients and how it may change delivery of care?	Ask staff
Are staff aware of how to contact the chaplaincy team during day time & night time hrs?	Ask staff
Are staff aware of the role of the chaplaincy team in contacting other faith leaders / priests?	Ask staff
Are staff aware of how to access interpretation & translation services, and in what circumstances to use them?	Ask staff
Are staff familiar with the term reasonable adjustment and what it means?	Ask staff
Dignity & Respect	
Are the hygiene needs of the patients being	Observe / ask pts.

Question	Source of Information & Response
met?	
Are patients dressed in a way that maintains their dignity?	Observe
Is the service compliant with delivering same sex accommodation?	Observe / ask ward manager
Are there a suitable number of toilets and showering facilities?	Observe / ask ward manager
Is chaperoning available and are patients aware of this?	Ask pts. / is there any signage on display
Are bed curtains long enough?	Observe
Is there a quiet private space available for pts to use?	Ask staff
Communication	
Are staff speaking to patients in a courteous and respectful way and addressing them as they wish to be addressed?	Observe
Do staff introduce themselves by name to the patient?	Observe / pts.
Is patient's confidentiality respected?	Observe / pts.
How are staff interacting with patients? (are lower tones used for private or sensitives conversations?)	Observe
Are patients informed about their condition & plans of care?	Ask pts.
Do pts know which nurses are looking after them today?	Ask pts.
How do staff enable communication for relatives who are unable to visit?	Ask staff / pts.
Documentation	
Is there documented evidenced of communication to patients & explanation of plans of care in the patients notes / electronic notes?	Check clinical notes
Are entries into written notes dated / timed and signed?	Check clinical notes
Are written notes legible?	Check clinical notes
Patient Feedback	
Are friends and family results on display?	Observe
Do patients feel they can approach staff / ward manager with any concerns?	Ask pts.

Care Quality Inspections: Effective

Question	Source of Information & Response
Nutrition & Hydration	
Is the patient nutrition board completed and up to date and meal time co-ordinator identified?	Observation
Is MUST screening completed for all patients?	Ask staff / ward manager & review Nurse Worklist
If a pt. has a score >2 has the pt. been referred to the dietician?	Check in millennium in "Orders" for referral
Is there a dietetic plan in place and is there evidence the plan is being followed i.e. daily weight, food chart, supplements etc.?	Ask staff & check documentation; food chart, weight chart
Are red trays / beakers / adapted cutlery and sectioned plates available as required?	Observe if at meal time, /ask staff & pts.
Are patients offered assistance with feeding where indicated?	Observe if at meal times / ask pts.
Are pts. prepared appropriately for meal times; suitable position, hand wipes provided?	Observe if at meal time / ask pts.
Are pts. relatives supported / encouraged to assist at mealtimes if appropriate?	Ask staff & relatives if appropriate
Does the ward operate protected meal times?	Ask staff
Are food & fluid balance charts completed accurately?	Observation, check documentation. Confirm with ward whether paper or electronic records in use
Are there any pts on the ward receiving Naso Gastric Feeding? If so, is the Naso Gastric Feeding Tube Pathway (Adult) being used?	Ask staff & check clinical notes (paper)
Are snacks and biscuits offered to patients?	Ask pts. & staff
Are staff aware of how to obtain meals out of hours or for specific dietary requirements?	Ask staff
Do pts. always receive the meal they ordered?	Ask pts.
Are pts. satisfied with the choice & quality of food provided?	Ask pts.
Pain Relief	
Are patients regularly assessed for pain?	Check patient rounding documentation & nursing documentation. Ask pts.
Do patients receive pain relief in a timely manner?	Ask pts.
Is pain managed effectively? i.e. evidence of review / discussion with patient regarding analgesia	Observe in clinical notes & ask pt.
Are there adequate pain relieving measures available for patients i.e. simple comfort measures including support to reposition & pillows	Ask pt.
Discharge Planning & Multidisciplinary Working	
What actions do staff take to ensure that the discharge process is performed smoothly & in a	Ask staff

Question	Source of Information & Response
timely manner? i.e. TTH's prescribed / dispensed, transport booked, care packages in place, use of discharge centre etc	
Are regular MDT board rounds held?	Ask staff
Do staff know how to access the Integrated Discharge Team / Discharge Co-ordinators?	Ask staff
Has discharge planning been discussed with the pt. ?	Ask pt.
Does the ward provide information about how to access external advocacy services if they are needed?	Ask staff
Safeguarding	
How do you refer to the Safeguarding Team in the hospital? Where would find safeguarding information? <i>Web Incident Safeguarding</i>	Ask staff
Are staff aware of the 5 categories of abuse? <i>Physical, sexual, financial, emotional/psychological and neglect</i>	Ask staff
In the event they suspect abuse (including domestic abuse) or abuse is disclosed, whether it be child or adult are staff aware what they should do? <i>Ensure immediate safety and refer to the Safeguarding Team</i>	Ask staff
Even when the patient states they do not want staff to tell anyone? <i>Ensure immediate safety and refer to the Safeguarding Team</i>	Ask staff
In the event a confused patient wishes to make a specific decision that may seem unwise and place them at risk, are staff aware what assessment should take place? <i>Mental Capacity Assessment</i>	Ask staff
Are staff aware in what situations is it appropriate to restrain a patient? <i>Lack of Capacity, putting self or others in danger, committing a criminal offence or under MH section</i>	Ask staff
You are caring for a confused patient who wanders around the ward/department. They have never attempted to leave or request to leave the ward. You have also been asked to make sure you are aware of the patients whereabouts at all times. What do you need to consider? <i>Deprivation of Liberty Application</i>	Ask staff
What significant change has the Care Act brought for Adult Safeguarding? <i>First ever statutory framework for Safeguarding Adults - LAW</i>	Ask staff
In the event a patient is deemed unable to make a decision for themselves and it is not a life threatening situation, who should be consulted	Ask staff

Question	Source of Information & Response
before the decision is carried out? <i>Those interested in the person welfare / relatives</i>	
You have concerns with regard to a patient's increase in extreme comments to other patients of a religious or racist nature, would this constitute a safeguarding referral? Yes – PREVENT	Ask staff
At what age does a child become an adult in safeguarding? 18	Ask staff
A mother is admitted with a self-induced minor laceration to her arm following a verbal argument. Would you refer to the Safeguarding Team, if so who? Yes – DAC, Safeguarding Children Team	Ask staff
What would you do if you had concerns regarding a patient's ability to parent safely? <i>Make a referral to the Safeguarding Children Team. Professional Consultation with Social Worker at Central Advice Duty Team (CADT)</i>	Ask staff
What would you do if you had concerns regarding a patient's ability to parent safely? <i>Make a referral to the Safeguarding Children Team. Professional Consultation with Social Worker at CADT</i>	Ask staff
Can you identify the 3 categories of Harmful Practice? <ul style="list-style-type: none"> • <i>Female Genital Mutation (FGM)</i> • <i>Honour Based Violence (HBV)</i> • <i>Forced Marriage (FM)</i> 	Ask staff
Comments & Notes	

Care Quality Inspections: Responsive

Question	Response
Meeting Peoples Individual Needs	
Are risk all assessments (Braden, Falls, Manual Handling etc) completed on all pts?	Ask staff / ward manager & review the Nurses Worklist for completed assessments. (Assessments should be completed at least weekly unless clinical change indicates further assessment)
Is the nursing & midwifery documentation completed and does it include a response to the question re. alcohol and substance misuse?	Check documentation in millennium
Ask staff/ward manager to identify any pts. with pressure ulcers; Is SKIN assessment completed in IView?	Check documentation on millennium
Has the SSKIN bundle been completed for pts with a pressure ulcer?	Paper document
Are patient information leaflets available on the ward and in correct trust format and up to date?	Observation
Meeting the needs of patients and speciality care	
Are there any outliers on the ward? If so, is there a specified reason why?	Ask ward manager / staff
If there are any outlying pts; have patients had a daily medical review?	Observe in clinical notes
Are staff able to access specialist nurse services / specialist support timely and appropriately?	Ask staff
Are there any pts. under joint care? If so, are staff able to contact teams easily and plans of care communicated effectively?	Ask staff / observe in clinical notes
Learning from Complaints & Concerns	
Is there information on display about the patient relations team and how to raise a concern / complaint?	Observe
Are pt. information leaflets available about how to raise a concern/ complaint?	Observe
Do staff know where to access the complaint policy?	Ask staff
Are staff aware of the process they should follow if a concern is raised to them by a pt. or relative?	Ask staff
How many complaints has the ward had in the last month?	Ask ward manager / information should be on display at the ward entrance board
Are staff informed made aware of any ongoing complaints about the ward?	Ask staff
Has the ward implemented any changes / shared learning from a complaint?	Ask staff
Do pts feel able to raise a concern they have regarding there care?	Ask pts.
Good Governance	
Has there been any shared learning from	Ask staff

Question	Response
incidents within the department and how have these been communicated to the team?	
How is the Learning with Patients questionnaire distributed?	Ask staff
Are staff aware of results of the most recent Friends & Family test for their ward?	Ask staff
Have staff completed their Equality & Diversity training or read the Trusts commitment to equality & diversity?	Ask staff
Comments / Notes	

Question	Response

Care Quality Inspections: Safe

Question	Response
Environment	
Use Ward Quality Assessment list to assess environment and ward areas.	Observe
Infection Control & Cleanliness	
Are staff compliant with good hand hygiene practice? Are staff decontaminating hands in-between pts and tasks?	Observe
Is Personal Protective Equipment used & disposed of appropriately?	Observe
Does the ward appear clean & tidy?	Observe
Is there any visible dust or dirt, including clinical equipment?	Observe
Is multiple use equipment cleaned and decontaminated in between uses?	Observe
Where infection control notices are in place, are instructions followed? i.e. keep door closed	Observe
Is rubbish / soiled linen disposed of appropriately and not visible in the ward area?	Observe
Risk Management	
Are staff aware of how to report an incident on the web based reporting tool?	Ask staff
Have staff been involved in any Root Cause Analysis? Did they receive feedback when the investigation was complete?	Ask staff / ward manager
Are staff familiar with the term Never events?	Ask staff
Are staff aware of any of the Never Events that have actually happened in this Trust?	Ask staff
Safe Care and Treatment	
Does the ward entrance board / dashboard have current information on display? (up to one month behind is acceptable)	Comment on data recorded: Falls: Pressure Sores:
Are staff aware of the number of pressure sores and falls on the ward for the previous month and whether any learning or actions have taken place?	Ask staff
Are there any patients identified as having an allergy on the ward? If so, are these patients wearing red wrist bands?	Ask staff
Are staff aware that the red wrist band is for allergies only? (i.e. not used for pts. at risk of falls etc.)	Ask staff
Are allergies documented in millennium for those pt. with red wrist bands?	Ask staff to identify pts. with allergies and check records.
Ask staff to identify any pts going for planned procedures where formal consent is required i.e. theatre, endoscopy etc.	Ask staff

Question	Response
Have consent forms been completed?	Check clinical notes
Have pre- procedure checklists been completed accurately?	Check clinical notes
Can staff explain the process for transferring pts. to another hospital?	Ask staff
Are discharge summaries produced promptly and to the required standard?	Ask ward clerk / ward manager
Are staff aware of and understand the phrase "Duty of Candour"	Ask staff
Are staff able to contact medical staff timely?	Ask staff
Medicines Management	
To be completed as a separate document, if no pharmacist on group to be completed as part of the Ward Quality Assessment	Check Quality Ward Assessment if no pharmacist on group
Staffing	
Does the level of staff on duty correspond with planned staffing?	Check staffing board outside of ward
Is the ward up to full establishment?	Ask ward manager
Is there an appropriate skill mix of staff on duty?	Ask ward manager
Are all staff wearing I.D badges?	Observe
Mandatory / Essential Training	
Are staff compliant with mandatory training?	Ask ward manager and review matrix if appropriate?
How many staff have attended Dementia training?	Ask ward manager
Comments & Notes	

Question	Response

Care Quality Inspections: Safe, Medicines Management

Question	Response
Safe and appropriate storage of medicines	
Is the key reconciliation form being completed after every shift change?	Observe
Are all of the medicine cupboards locked and in good order (i.e. no loose strips of tablets/ vials or syringes left in cupboard)	Observe
Are all medicines locked away i.e. no medicines left out on the benches?	Observe
Are returns / expired stock stored securely and in a separate cupboard? (usually in a green box located in a locked cupboard)	Observe
Are pharmacy bags empty?	Observe
Is air tube cupboard locked?	Observe
Are CD balance checks undertaken daily?	Observe
Are the CD registers locked away ie in CD cupboard?	Observe
IV Fluids	
Stored in a separate area within locked room?	Observe
Are fluids containing >40mmol/L potassium stored in the CD cupboard?	Observe
Stored in original boxes or dedicated defined and clearly labelled area if stock a few bags e.g. Isoplex.	Observe
Stored on shelves and not on the floor?	Observe
Are all IV fluids clearly segregated i.e. not mixed?	Observe
Fridges	
Are they locked?	Observe
Is the temp within range?	Check documentation
Is the temp measured with min/max thermometer?	Check documentation
Is the temp recorded daily?	Check documentation
Do they only contain medicines and are they in date?	Observe
Emergency Medicines	
Is the anaphylaxis kit on the ward/clinic?	Observe
Is a hypobox on the ward?	Observe
Is an emergency box in the ward?	Observe

Question	Response
Are they readily accessible i.e. on emergency trolley or in medicines room?	Observe
Bedside Lockers	
Are the lockers locked (suggest check a sample eg 5 lockers from selection of bays)	Observe
Are medicines stored in the computer nursing cart drawers when unattended (ie at any time other than medicine admin rounds)	Observe
Administration of medicines in a way that balances independence and safety	
Do staff check whether 'PRN' medicines are required eg assess pain control before offering analgesia/ sickness before offering antiemetics?	
Do staff check allergy status before administering medicines (both wrist band and on Cerner?)	
Do nursing staff observe and/or check whether or not medicines have been taken? Do they remind patients of purpose/side effects, is information tailored to the individual?	
Do nursing staff offer information about medicines e.g. information leaflets to patients?	
Management of medicines on admission	
Has the medicines reconciliation form been completed? <i>(Either yellow form or as part of pre-admission booklet/ acute clerking booklet/ actual medical record eg on NNU. Note for paediatrics, a yellow form will only be completed if the child takes regular medication, if they don't take any it will be stated in actual medical record)</i> If yes was it commenced by the clerking professional? Has the med rec form been signed off by a pharmacist?	Observe / check sources as listed
Explanation/information provided when prescribing medication –	
If any medical ward rounds/ nursing/ pharmacy interaction observed during the inspection: Is any explanation of purpose and potential side effects offered or information about dosage and how to take the medication?	Observe
Have any medications been missed? If so, is the reason stated on Cerner and does it appear valid?	Check millennium
Have patients who are suitable for self-medication been identified (if not, what is the	Observe

Question	Response
reason for this?) If yes, is it being carried out in accordance to Trust policy?	
Are discharge summaries produced promptly (ie prior to discharge) and contain medication related information regarding meds started or stopped during admission?	Observe / check discharge summaries
Patient Group Directives (PGDs)	
Are there any medication PGDs in use within the area? If so, is there a copy of the current PGD in the clinical area? Is it in date and is it signed by the staff authorised to use it	Observe
Comments & Notes	

Question	Response

Care Quality Inspections: Well Led

Question	Response
Operational Management	
What are the 3 main priorities / areas for concern on the ward?	Ask ward manager
Have these concerns been raised escalated & any actions planned?	Ask ward manager
Are there any vacancies at present on the ward?	Ask ward manager
Have these vacancies been approved and is recruitment in progress? If not is there a reason why?	Ask ward manager
Are issues relating to sickness absence, capability, disciplinary being managed effectively?	Ask ward manager
Has the ward experienced any incidents in relation to staffing shortages?	Ask ward manager
Are bank or agency staff used on the ward?	Ask ward manager / staff
When they are used, are they given a local induction?	Ask ward manager / staff
Are staff / ward manager aware of their responsibilities in relation to maintaining professional registration and are they ready for revalidation?	Ask ward manager / staff
Do newly qualified staff receive preceptorship?	Ask ward manager / staff
Are staff given the opportunity to develop and attend specialist training / courses?	Ask ward manager / staff
Are staff up to date with mandatory training?	Ask ward manager
What evidence is there that staff have been trained to use clinical equipment?	Ask ward manager
Are staff aware where to access Major Incident Plan?	Ask staff
Are staff aware of the Raising Concerns Policy?	Ask staff
Do staff know about the role of the Staff Guardians and how they can be contacted?	Ask staff
Are staff compliant with the uniform policy, i.e. bare below the elbows, no excessive jewellery, no nail varnish etc.	Observe
Governance	

Question	Response
When was the last serious incident that has happened on your ward?	Ask ward manager
What learning occurred following this incident?	Ask ward manager
How was learning shared with staff?	Ask ward manager
Are medical records stored safely?	Observe
Are there any loose episodes of care waiting to be filed?	Ask ward manager / ward clerk
Are computer screens locked when not in use?	Observe
Do staff know where to find trust policies?	Ask staff
Staff Engagement	
How do you communicate changes and learning to keep staff up to date with trust information?	Ask ward manager / staff
Do you have regular ward huddles?	Ask ward manager / staff
Do you communicate with night staff in the same way as discussed above?	Ask ward manager
Are staff able to name the Medical Director and Nursing Director?	Ask staff
Are staff able to name any of Divisional Associate Directors of Nursing / Deputy Associate Directors of Nursing / Matrons?	Ask staff
Do staff see them on walkabouts / visiting the ward?	Ask staff
Does the ward have a "Board Buddy"? If so, do staff know who they are? When was the last time they visited the ward?	Ask staff
Innovation & Improvement	
What are you proud of about your ward or your team?	Ask staff / ward manager
Has the ward been involved in any quality initiatives?	Ask ward manager
Has the ward undertaken any clinical /service audits?	Ask ward manager
Has the ward made any improvements to the ward or services they offer to improve patient care and patient experience?	Ask ward manager / staff
Comments & Notes	

Question	Response

Area: Date:	Ward / Department Quality Assessment	Notes
Ward Entrances	Is the Information presented displayed in current Trust format?	
	Does the display look professional – are the posters laminated?	
	Is the entrance free from clutter?	
	Are Hand Gels available for use and in working order?	
	Is there an odour as you enter the ward? What does your sense of smell tell you?	
Ward Corridors	Are they free from clutter?	
	Are there any Health & Safety issues apparent? Trailing wires , trip hazards, incomplete works etc	
	Are doors with key coded locks closed?	
	Are rooms labelled with signs – “keep door closed” actually closed?	
	Are Patient Records on public view?	
	Signage – up to date and laminated?	
	Are patient names covered / protected on the white boards?	
	Are glove & apron dispensers stocked?	
Bathrooms	Is the bathroom being used as a storeroom? If so is it identified as such?	
	Is the bath being used to store kit? – If so ask about Legionella water testing – are taps run – is it practical to do so?	
	Are the floors free from clutter and kit to enable mopping of 100% of the area?	
	Are bath aids clean? – look underneath and examine	
	Ask yourself - would you bathe in this room?	
	Are there any call bells that could be used as ligature points? (are these easily breakable if weight applied)	
Kitchens	Clean and tidy / free from clutter?	
	Food fridges – do they contain patient foods – check use by dates on sandwiches / yoghurts / milk etc	
	Are staff and patient foods stored separately?	
	Are fridge temperature checks consistently monitored and documented – are there variances and gaps in recording?	
Sluice Rooms	Clean and tidy – free from clutter? –	
	Tristal – evidence of when the solution was made / monitoring sheets?	
	Used sharps bins – signed / dated / labelled correctly and closed properly?	
	Has dirty laundry been removed for processing?	
Mattresses	Where are they stored on the ward?	
	Are they clean? – How do you know? – labelled as decontaminated?	
	Are there any beds stored outside the ward? ? Are they labelled, clean, have a reason for being there?	

Medicines & Clinic Room	If access controlled is the door locked?
	Ensure no keypad numbers written on wall/woodwork around the lock
	Are staff wearing red tabards for medicine administration?
	Have key reconciliation records completed?
	Have drug fridge temperatures been monitored? Consistently every day?
	Has room temperature been monitored? Consistently every day?
	Are there drugs in the drawer below Computer on Wheels when no drug round in process?
	IV fluids – are they stored off the floor, stored in correctly labelled area and in date? (if not in original box)
	Randomly select a storage drawer to check the use by date of a disposable item. Is the item selected in date?
	Are worktops clean & tidy?
	Are medicines stored appropriately & cupboards tidy? (no loose strips of medicines or injections in drawers)
	Is the CD order book locked away?
	Are CD book balance checks undertaken daily?
	Are medicines left in pots on patient bed tables?
General Environment	Any visible paintwork repairs needed? Bare wood visible? Unpainted plaster?
	Are there any outstanding jobs that need completing from estates? Ask ward manager / ward clerk
	Are patient call bells audible? If so – how long are they sounding for before being answered?
	Do patients have to wait too long for care?
	Is clinical equipment clean and labelled and stored appropriately
Emergency Equipment	Has emergency equipment check been completed and equipment in date? Consistently every day? <ul style="list-style-type: none"> • Hypo box • Anaphylaxis box • Emergency box
Comments & Notes	Document to be adapted for specialist areas / units.

Board of Directors	
Agenda Item	9.1
Title of Report	Report of the Finance Business Performance & Assurance Committee 19 February 2016
Date of Meeting	24 February 2016
Author	Graham Hollick, Chair of Finance Business Performance and Assurance Committee
Accountable Executive	David Allison, Chief Executive
BAF References <ul style="list-style-type: none"> • Strategic Objective • Key Measure • Principal Risk 	5A, Risk 2718, 6B, 7B, Risk 1927 and 2550, 7C Risk 2328, 7D, Risk 2689
Level of Assurance <ul style="list-style-type: none"> • Positive • Gap(s) 	Gaps with mitigating actions
Purpose of the Paper <ul style="list-style-type: none"> • Discussion • Approval • To Note 	Discussion
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken <ul style="list-style-type: none"> • Yes • No 	N/A

Chairman's Business

An overview of the visit by Monitor in the week commencing 15th February was provided with specific feedback on the work undertaken on the savings plans; demand and capacity planning; the forecast out-turn for 16/17 and the review of performance against access targets.

Board Assurance Framework (BAF)

The Committee reviewed the BAF which focused on the 3 key risks that had reduced; these were all in relation to staff satisfaction, staff morale and the NHS staff survey. The reason for the decrease was attributed to the evidence that the impact from the work in this area had been successful. The Committee also focused on a significant number of risks that had increased, these were associated with activity levels, referral to treatment time targets, Community paediatrics, C difficile incidents, A & E performance and End of

Life Care. The Committee recognized that many of these risks were not within the Trust's gift to mitigate on its own and agreed therefore to concentrate its efforts on reducing those aspects which were within its control.

The Committee, as recommended by the Audit Committee, reviewed its risk profile as at 13th January and again at 12th February to understand the level of change as a result of key factors such as the receipt of the draft CQC report; performance against the RTT target for January; the commissioners review into community paediatrics and the M10 financial position.

M10 Financial Position

The Committee reviewed in detail the cumulative year to date deficit position at M10 which was reported as £12.7m against the plan of £11.3M. The Committee noted that the Trust was now forecasting to achieve a year end deficit out-turn of £15m recognizing however that this still had considerable risks associated with it, namely health economy affordability; the stance taken by the CCG to impose ambulance fines of £600k and the need to undertake a revaluation of the Trust's estate. The Committee raised concerns over the difficulties experienced with consultant recruitment and the emerging risks with junior doctor training and succession planning. The Committee requested that the Director of Workforce focus on the work being undertaken to address these concerns and report this to the next Quality and Safety Committee.

The cash position was reported as £2.1M above plan. The Capital programme was confirmed as on track. The Financial sustainability Risk Rating was reported at 2 as per the plan.

As requested by the Board, the Committee undertook a "deep dive" into the financial forecast to the end of 15/16 to fully understand the risks to achievement in greater detail and the level of granularity and monitoring undertaken on a weekly basis within the Trust. The projected income and expenditure for the final two months were reviewed and understood by members. Further work was requested on the potential "upsides" these being the initiatives in the surgical division. The cash position and the prudent assumptions taken within this forecast were reviewed.

Lord Carters Report

The Committee reviewed the Trust's approach being adopted following the final release of the Lord Carter report on the 5th February 2016. The Committee was advised of the level of opportunity estimated in the Trust as a result of this work however this was caveated with the understanding that this did not take into account where the Trust was already successful in specific areas. The Committee reviewed the key recommendations in the report and the Trust's response in each case. It was reported that the greatest opportunity for saving was thought to be in the area of collaboration which the Trust was exploring. The full extent of the opportunity would be articulated in the Trust Procurement Transformation Plan due to be completed by April 2016.

The Committee reviewed the Trust's performance against the procurement framework and sought to understand how it could support the procurement team to deliver much more on this agenda as opposed to simple compliance. The visibility of the team was felt to be very important with plans in place to improve this significantly.

Review of Service Levels Agreements (SLAs)

The Committee was pleased with the work undertaken in this area to improve the rigour and governance both in income and expenditure. The Committee recommended that in view of the number of contracts held by the Trust that the priority be on income contracts

in the first instance. The Committee also recommended that good practice be shared more widely in the Trust.

Change in Banking arrangements

The Committee was updated on the change following a tender process and the reduction in future risk associated with any electronic downtime as the Trust now dealt with two different banking providers.

Service Line Reporting Update

The Committee was provided with an update by Division on service line reporting. The Committee requested that future reporting include the level of analysis and consideration being undertaken by each Division to ensure that services were being considered not only from a quality and access perspective but also from a sustainable basis. The appointment of the Deputy Medical Director as the Chair of the SLR Steering Group was reported as a positive move as this individual could be much more objective in this review.

Progress Report on the Recovery Plan 2015-16

The Committee reviewed progress of the CIP programme at M10. The programme reported a positive variance of £200k in- year and £400K year to date with a full year effect forecast of £13.4m. The recurrent position was reported at £4.9M behind plan.

Areas of concern were reviewed; these included theatres, patient flow, coding and outpatients which albeit was over plan was reducing. The Committee requested that the outcome of the review into coding to establish whether the underperformance was attributable to acuity or volumes be reviewed by the Committee.

The progress made with the planning for 2016/17 was outlined with confirmation that there were no longer any opportunities that required identification in the plan which was a significant improvement on previous years. The status of the schemes, as defined by Monitor, was outlined and the Committee requested that this verbal update be provided in written form in future reports.

Performance Report

Key points from the performance report included:

- Achievement of all cancer targets.
- The non-achievement of the RTT target for both December and January with plans forecast for delivery focussed on April 2016 as accepted by Monitor. The Committee requested the trajectory by speciality for its next meeting.
- C difficile remained a concern although the action plan was deemed to be successful as the Trust could now begin to justify reported cases as unavoidable as the HPV programme had been in place for 3 months.
- A & E 4 hour standard – the impact of SAFER was outlined together with the improving achievements against the metrics set by Monitor which focussed on medical outliers and discharge. The significantly increased number of ambulance attendances was highlighted as a key risk which was currently the subject of discussion between the Chief Executives and Director Operations from both this Trust and NWS.

NHSP Contract

The Committee reviewed the options as presented for extending the current contract with NHSP. Although the feedback from the Senior Management Team was positive, the

Committee raised a number of concerns which would need to be addressed before it recommended the extension to the Board for approval. These included the risks associated with the procurement process and specific confirmation on NHSP's performance against the key performance indicators.

Graham Hollick
Chair of Finance Business Performance and Assurance Committee

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF MEETING

27 JANUARY 2016

**BOARDROOM
 EDUCATION CENTRE
 ARROWE PARK HOSPITAL**

Present	
Michael Carr	Chairman
David Allison	Chief Executive
Cathy Bond	Non-Executive Director
Jill Galvani	Director of Nursing and Midwifery
Andrea Hodgson	Non-Executive Director
Graham Hollick	Non-Executive Director
Gareth Lawrence	Acting Director of Finance
Cathy Maddaford	Non-Executive Director
Evan Moore	Medical Director
Jean Quinn	Non-Executive Director
In attendance	
Carole Self	Director of Corporate Affairs
Mark Blakeman	Director of Informatics and Infrastructure
Gaynor Westray	Deputy Chief Nurse
Chris Oliver	Interim Director of Operations
Mike Coupe	Director of Strategy Apologies
Apologies	
John Sullivan	Non-Executive Director

Reference	Minute	Action
BM15-16/237	Apologies for Absence Noted as above	
BM15-16/238	Declarations of Interest None	
BM15-16/239	Patient Story The Director of Nursing and Midwifery presented a patient story as outlined on NHS choices, the patient gave thanks for their care which started in the Emergency Department but included long and short stay support. Thanks were given to cleaners, porters, catering staff, AHPs, nurses and doctors for the amazing care given.	
BM15-16/240	Chairman's Business The Chairman welcomed members of the public to the meeting. He gave recognition for the extraordinary pressure the hospital was facing and for all the hard work of the Trust's staff. The Board was updated on the appointment of consultants, 2 in dermatology these being Dr Farrar and Dr Hashim, one in gastroenterology, this being Kia and one in palliative care – Dr Latum. The Board debated the difficulty with consultant recruitment in specific	

Reference	Minute	Action
	<p>areas and sought and received assurance that all the necessary steps were being taken to ensure the Trust maximised all opportunities.</p>	
<p>BM15-16/241</p>	<p>Chief Executive’s Report</p> <p>The Chief Executive presented the report and highlighted the following:</p> <p>Clinical Commissioning Group CCG – the Chief Executive advised that the contract closure discussions for 2015/16 remained a challenge, as did the negotiations for 2016/17 with the national expectation that these were concluded by the end of March 2016. The real challenge associated with the Sustainability and Transformation Plan was outlined in particular in relation to the determination of the single “footprint” for providers. The Board was advised that Wirral Partners had agreed that the overarching “footprint” should be Cheshire and Merseyside within which would be a Liverpool “footprint” and a Cheshire/Wirral/Warrington “footprint”. The process for final “sign off” was not yet clear although the meeting on Friday with NHSE may provide clarity. The Board sought to understand whether the “footprint” included public health as well as the local authority. The Chief Executive confirmed that it did; he further advised that Wirral Local Authority was likely to align itself for health on the Cheshire and Merseyside “footprint” and for regeneration with the Liverpool “footprint”.</p> <p>The Board sought to understand whether the CCG had given any early indication of any changes in the contract or identified any areas of risk. The Chief Executive advised that the initial discussion suggested a 3.5% cut in funding to enable the CCG to deliver a 1% surplus and associated contingencies. The CCG was seeking to use its original 15/16 contract value for the 16/17 contract value, and as the Trust had predicted additional demand and volume this was much higher. The Board debated the progress on the Alliance contract and the value of this although it was concerned that this could see the risk transferring from the Commissioner to Providers although the symbolic nature of working in an integrated way was welcomed.</p> <p>The Board was advised that the Memorandum of Understanding for the Vanguard project was signed by all partners on Friday 22nd January 2016.</p> <p>SAFER update – following previous briefings the Board recognised the significant beneficial impact the initiative had had in the first week of January. There was recognition however that the last few days had been very challenging.</p> <p>Community Paediatrics – The Chief Executive confirmed that the situation with this service remained a significant concern to the Trust in terms of waiting times for assessments and the impact on the 18 week target. Although partners were working to resolve the situation, the long waits remain. The Director of Childrens’ Services had been alerted to the situation which had motivated all to address the situation. Although the overall position of the CCG was to commission a new service, action was required now to ensure children did not wait any longer. The Board was</p>	

Reference	Minute	Action
	<p>advised that some funding had been provided to address the situation and whilst compliance with waiting times was being progressed in line with expectations by the end of March 2016, this was hugely ambitious. The Chief Executive confirmed that the list had been analysed and triaged to ensure that the risk to children was reduced wherever possible.</p> <p>The Interim Director of Operations confirmed that the Trust had secured additional locum resource and moved some children to CAMHS where appropriate. The position of the CCG was that some of these children should be seen in primary care. Restrictions on the additional non-recurrent monies were outlined which prevented this being used anywhere else other than in CAMHS who still had to identify the necessary resource. Concerns were raised with children being referred into primary care without any framework or agreement from GPs. The Chief Executive shared these concerns and advised that the Trust was currently trying to establish what cohort of GPs could undertake this work as this didn't appear to be evidence based. The Board also raised concerns about the additional support resource that would need to be identified if further locum work was undertaken and suggested a full capacity review be undertaken.</p> <p>The Interim Director of Operations confirmed that the Division was currently considering what service the Trust could deliver now it was in receipt of the commissioning review.</p> <p>The Board debated the position on the Wirral in terms of being an outlier for Looked after Children and those medicated which was attributed to the financial support which was associated with a diagnosis. The Board sought further clarification on the actions being taken by the Trust which was confirmed as a full review of the waiting list to ensure that children who could be referred back to their GP were; all parents written to with a view to establishing the current position with the child and a review of the referral criteria to ensure children were not being disadvantaged. The Medical Director confirmed that all urgent and statutory cases were being seen. The Board requested a monthly progress report until the situation was resolved.</p>	CO
BM15-16/242	<p>Vanguard Programme Update</p> <p>The Chief Executive provided an update on the elements of Healthy Wirral that were being funded by NHSE. This included the contract signing with Cerner on New Year's Eve and the rigour now being applied to structures and reporting mechanisms although this was felt to be still too process orientated.</p> <p>The Director of Strategy advised the Board that the ambition of the Vanguard PMO was to have the same report for every Board. The appointment of a new Head of PMO was seen as a benefit although it would take time for this individual to work through all the work streams, project plans and reporting mechanisms. The Board raised concerns over the lack of demand, capacity and financial modelling which was felt to be fundamental to the programme. The Board supported the programme at a high level but raised concerns about the model, substance and</p>	

Reference	Minute	Action
	<p>significance in terms of articulating the effective delivery of progress from the current state to the future planned state.</p> <p>The Chief Executive advised that this project was seen nationally as ahead of the game with the MOU having been drafted and agreed, the establishment of the PMO and the discussions on alliance contracting, although he shared concerns with regards to the rigour being applied.</p> <p>The Board agreed that the message should be supportive as the Trust wanted to respect the decisions and position of partners. However more rigour was required; the inclusion of a roadmap with benefits and critical milestones would be useful in the future. The Board urged caution with committing resources ahead of understanding the full impact. The Board also requested that future reports linked into the Trust’s Board Assurance Framework as this had been omitted.</p>	MC
<p>BM15-16/243</p>	<p>Integrated Performance Report</p> <p>The Director of Infrastructure and Informatics presented the Integrated performance dashboard and Executive Directors expanded on areas of focus as follows:</p> <p>7.1.1 Integrated Dashboard and Exception Reports</p> <p>A & E 4 hour standard – the interim Director of Operations confirmed that the SAFERstart initiative had led to improvements however the pressures on the hospital still exist. He confirmed that this was not confined to this Trust but was being evidenced in the NHS as a whole. The Board was advised of the high number of ambulance conveyances which equated to an increase of 500 per month compared to the same time last year. This was thought to be attributable to the launch of the 111 service on the Wirral as the Trust had not seen the same rise in admissions. The Board was advised that the Chief Executive and the Interim Director of Operations were due to meet with the ambulance service to discuss this further with a view to securing a resolution. The Board sought to understand whether other Trusts had seen the same level of increase and was advised that this was not the case and therefore the Trust was an outlier. The Interim Director of Operations outlined the improvement made in weekend discharges although there was recognition that further work was required with discharges earlier in the day. A points of prevalence review had been undertaken and the Local Authority had been supportive by commissioning additional spot purchase beds and packages of care. The issue with availability of domicillary care on the Wirral was highlighted which was associated with the rates of pay being offered. The additional beds at Charlotte House were seen to be a success which had allowed good throughput into the community. The Board questioned why the A & E position deteriorated so soon after the end of the SAFERstart initiative and was advised that the pressure on the hospital had increased. The Chief Executive outlined the differences in care and patient experience from the previous year as a result of the decision not to open any unplanned escalation beds; not to cancel any elective activity and to continue with the HPV programme. This had undoubtedly however had an</p>	

Reference	Minute	Action
	<p>impact on the A & E 4 hour standard as patient flow was affected. The Board sought to understand whether the introduction of an Alliance Contract would improve the situation. The Chief Executive advised that in theory it should however it wouldn't until other community settings were commissioned to take medical presentations. The Interim Director of Operations assured the Board that the actions agreed as part of the SAFERstart initiative were still being progressed. This included the boardrounds etc, however the level of activity over the last 7-10 days had increased significantly. The Board requested a weekly update in light of current performance.</p> <p>RTT- the interim Director of Operations confirmed that the performance in December of 91.02% against the target of 92% was disappointing. He confirmed that this was in the main attributable to community paediatrics; the initiative to reduce capacity at Christmas and the junior doctors strike. He confirmed that all services were working through their demand and capacity plans to ensure they can deliver the RTT target on a sustainable basis. He outlined the good work being undertaken with Trauma and Orthopaedics with the focus on activity in outpatients from theatre to re-balance the waiting list and maximise the efficiency of theatres. The financial impact was estimated at circa £150K.</p> <p>C difficile – the Deputy Chief Nurse provided assurance to the Board that the robust action plan continued uninterrupted. She confirmed that in December the Trust reported 31 cases against the target of 29 with a further 3 cases under investigation. As of the previous night 2 additional avoidable cases were reported, and if confirmed, would take the total number up to 33. The Board was reminded of the 3 month post infection period which was impacting on the Trust's performance. The Deputy Chief Nurse confirmed that the Trust was taking all the right action to mitigate the risk of further infections along with the full infection prevention control agenda.</p> <p>The Board agreed that the presentation and information being reported in the integrated performance report had improved as the triangulation between finances, activity and performance had improved. Further work was recommended to ensure that the anticipated impact of planned action was captured, together with the risks, which would aid with future evaluation and analysis.</p> <p>7.1.2 Month 9 Finance Report</p> <p>The Acting Director of Finance confirmed that the operational performance had translated into the financial position as a result of increased cancellations, industrial action and an increased emphasis on discharges. Despite this, the Trust delivered an in month position of £1.7m which was £300k adverse to the original profile used within the Monitor plan and £600k worse than the latest forecast. The cumulative deficit as at the end of December was reported at £11.4m which was a £900k adverse variance to the plan of £10.5M. Compliance with the nursing agency cap was reported positively. Cash continued to be better than plan at £6.8M. The variances were outlined and attributed to the early progression of ward</p>	<p>CO</p> <p>MB</p>

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Reference	Minute	Action
	<p>refurbishment and the new isolation ward refurbishment. The capital programme was still however expected to remain within plan in year.</p> <p>The Financial sustainability risk rating remained at 2 in line with the plan. The Acting Director of Finance advised that the forward look into Q4 highlighted significant challenges with the continued pressures on the emergency department. The deficit out-turn that was being forecasted was now circa £15m and the Acting Director of Finance confirmed that Monitor had been advised of the position. The Board debated the risks to achievement of the plan as outlined in the paper and the steps being taken to mitigate these which included negotiations with the CCG as to a year-end deal, although there was recognition that this would be difficult. The risk of affordability to the health economy of the activity plan was of concern however it was recognised that the Trust needed to achieve the plan, in the main, to ensure that the RTT targets were achieved. The activity forecast for February and March was reported as strong although the proposed strike would impact on this significantly.</p> <p>The Chief Executive advised the Board that if the Trust achieved the revised forecast deficit position of £15m that would be a good performance. He clarified that if industrial action did proceed as planned this would deteriorate the position by a further £1m- £2m. The Board debated the position of the CCG and the affordability concerns but could not see alternatives to undertaking the necessary activity required to deliver the 18 week target. The emphasis on the CCG and the health economy had to be on reducing the demand in the future.</p> <p>The Board sought clarity on the cash position at the end of March which was confirmed at £2m although this had been based on the lower end of the income figure of £221m which afforded the Trust a degree of tolerance.</p> <p>The Board debated the predictions for the year-end and sought to understand what deficit out-turn figure the cash position was based on. The Acting Director of Finance advised that the cash position was based on a deficit out-turn of £19m and the deficit forecast position was based on activity planned to the end of the quarter although the benefits of the trauma and orthopaedic initiative needed to be factored in. Although costs had increased the Board was assured that this was still in line with the plan. The Board agreed to submit the forecast deficit figure as part of the Q3 submission to Monitor at £15m although there was recognition of the level of risk with achievement of this. The Board requested that the Finance Business Performance and Assurance Committee undertake a “deep dive” into this at the meeting in February 2016.</p>	GL
BM15-16/244	<p>NHS Preparedness for a Major Incident</p> <p>The Interim Director of Operations provided the Board with the rationale for the need to provide assurance that the Trust was in a position to respond appropriately to a terror threat. The Board reviewed the role of NHSE in providing assurance and vice versa which had already been fed back to them.</p>	

Reference	Minute	Action
	<p>The Board was advised of the table top exercise undertaken in November 2016; the learning from the actual major incident resulting from an electrical failure and the plans for an out of hours exercise later in the month.</p> <p>The Interim Director of Operations advised the Board that the Trust had been asked to share its plans with neighbouring Trusts as these were considered to be robust. The Board was pleased to receive this feedback however it urged caution that the role of NHSE and that of the Trust did not become blurred.</p> <p>Thanks were extended to Mrs Nelson for her work in this area.</p>	
<p>BM15-16/245</p>	<p>Francis Report: Hard Truths Commitment: publishing of staffing data: 6 monthly report November Nurse Staffing December Nurse Staffing</p> <p>The Director of Nursing and Midwifery presented the 6 monthly report which covered the period November and December 2015. She confirmed that the 98% fill rate for both November and December reflected the impact of the recruitment strategy, however the Board recognised that the requirement notice for nurse staffing from the CQC still remained in force.</p> <p>The E-roster staffing system was confirmed as successfully transferring over to version 10 to allow more effective and efficient rostering of nursing staff in line with the recommendations in the Lord Carter Review. The future of the nursing workforce was debated in light of the potential changes to bursaries; the consideration of the Nurse Associate Role and the numbers of nurses that have the potential to retire at 55.</p> <p>The Board reviewed the changes in turnover rates from 8 to 12 per month as a result of nurses moving into specialist roles internally or as part of the Vanguard project.</p> <p>The Board debated the prospect of having “real time” data in relation to the acuity and dependency tool and although this was only available in the United States at present, the Trust planned to pilot this in the next 2 months. The Board agreed it would be of value to evaluate the level of investment in nursing versus the planned reduction in agency costs, sickness levels and the qualitative benefits of harm free care and improved staff satisfaction. The Board agreed to review capacity and capability of the nursing workforce in future reports by including a suite of indicators and metrics which focus on mentorship/preceptorship and safety.</p>	<p>GW</p> <p>GW</p>
<p>BM15-16/246</p>	<p>Nursing and Midwifery Strategy 2016-2018</p> <p>The Director of Nursing and Midwifery presented the updated Nursing and Midwifery Strategy 2016-18 as part of the handover to Mrs Westray.</p> <p>The Board noted the contents of the updated strategy, in particular the changes to the patient focussed actions.</p>	

Reference	Minute	Action
	The Board agreed to continue to review progress and impact through the Quality and Safety Committee	
BM15-16/247	<p>Director of Nursing and Midwifery – Handover Report to the Board of Directors</p> <p>The Director of Nursing and Midwifery presented the handover report to the Board which provided a summary of the progress of the nursing and midwifery agenda since 2013.</p> <p>The Board expressed its thanks for the helpful and informative report.</p>	
BM15-16/248	<p>Report of the Quality and Safety Committee – 13 January 2016</p> <p>Dr Quinn presented the report from the Quality and Safety Committee meeting held on 13th January 2016. The key highlights included the work undertaken on the BAF during the reporting period; the review of the NHS constitution; the progression of the Maternity Cultural review and key points from the CLIPPE report.</p> <p>The improvement in A & E triage times was reported positively. End of Life Care showed some improvements but the Committee still had a number of concerns and requested that a full review of the impact of the action plan be undertaken at its meeting in March 16. The Committee recommended that the necessary changes on Cerner in relation to recording of C difficile be given priority.</p> <p>The Committee undertook a full review of the web-holding file as recommended by the Audit Committee and concluded that further regular reviews would be required until the situation was resolved. Despite changes in the process, the overall number of incidents outstanding was not reducing which was a cause for concern (see also min BM15-16/250)</p> <p>The Chief Executive sought to understand whether the Trust needed to undertake any further analysis of its historic clinical claims and the learning in view of the significant increase in premiums. The Medical Director confirmed that this information was in the Annual Claims Report although the next review would determine any further next steps required.</p>	
BM15-16/249	<p>Financial Governance Review</p> <p>The Director of Corporate Affairs presented the key points from the Financial Governance Review undertaken by the Board as part of its development session in December 15. The report highlighted the key improvements made since the launch of the financial investigation and the areas for further consideration.</p> <p>The Board agreed to continually review performance and improvements to ensure continued improved decision making.</p>	

Reference	Minute	Action
BM15-16/250	<p>Report of the Audit Committee – 03 December 2015</p> <p>Mrs Bond presented the report of the Audit Committee from its meeting on the 3rd December 2015. The key points highlighted included the recommendations to the evaluation and process for the Tender of External Audit Services; the recommendation from the Committee for the Board to undertake a review of its risk appetite as part of one of its development sessions and the review of clinical audit which concluded with the recommendation that the learning needed to be spread more widely and the benefits made more explicit. The Board agreed to undertake a review of its risk appetite as part of its risk management review.</p> <p>The Committee reviewed its terms and reference and recommended these to the Board for approval. The Board approved the terms of reference.</p> <p>The Committee raised concerns with recommendations that were being rolled forward in relation to core legacy infrastructure and data quality migration and agreed to bring this to the attention of the Board. Mrs Bond was pleased to report that the Director of Infrastructure and Informatics had undertaken a full review of the recommendations and concluded that these had all in fact been completed. The review highlighted the need for clarity when providing the updates to the Auditors which had now been acted upon.</p> <p>Mrs Bond confirmed that because of concerns with the web-holding file the Committee agreed that a review of the process for incident reporting and adherence to it be included in the Internal Audit Plan for 2016/17.</p>	CS
BM15-16/251	<p>Monitor Quarterly Return Q3 – 2015/16</p> <p>The Board reviewed the draft submission in respect of Q3 and in particular the Board declaration. The Board agreed to include the % performance in relation to A & E in the declaration.</p> <p>The Board approved the submission based on earlier discussions.</p>	CS
BM15-16/252	<p>Board of Directors</p> <p>The Minutes of the Board of Directors Meetings held on 25 November 2015 were confirmed as an accurate record.</p> <p>Board Action Log The Board action log was updated as recorded</p>	
BM15-16/253	<p>Items for BAF/Risk Register</p> <p>Consideration to be given to the impact of financial penalties and links to the Board Assurance Framework.</p>	GL
BM15-16/254	<p>Any Other Business</p> <p>The Board noted the receipt of the draft CQC report which had separately been circulated to members and agreed to consider this further following</p>	

Reference	Minute	Action
	<p>the responses in factual accuracy and further determination by the Executives.</p> <p>The Chairman confirmed that the next meeting of the Board of Directors would take place on 24th February 2016 and the Council of Governors on the 16th March 2016.</p> <p>The Chairman gave recognition to the Director of Nursing and Midwifery, Mrs Galvani, on her last meeting for the Trust ahead of her retirement following over 30 years services in the NHS. The Chairman thanked her for her professionalism; for the difference she had made, as evidenced in the handover report to the Board, and the small changes implemented such as the uniforms which had had a huge impact. The Board expressed their thanks for the difference she had made.</p> <p>Mrs Galvani thanked the Chairman, the Chief Executive and the Board as a whole for its unstinting support and for the investment in nursing.</p>	
BM15-16/255	<p>Date and Time of Next Meeting</p> <p>Wednesday 24 February 2016 at 9.00 a.m. in the Boardroom, Education Centre, Arrowe Park Hospital.</p>	

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Chairman

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Date

ACTION LOG Board of Directors

Updated – February 2016

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 27.01.16						
1	BM15-16/241	Provide a monthly progress report on community paediatrics	CO	Included on the agenda for February 2016	February 2016	
2	BM15-16/242	Ensure future Vanguard reports link into the Board Assurance Framework	MC	ongoing	February 2016	
3	BM15-16/243	Provide a weekly progress report on A & E in light of current performance	CO	ongoing		
4	BM15-16/244	Further work recommended on the performance report to ensure that the anticipated impact of planned action was captured, together with the risks, which would aid with future evaluation and analysis	MB		March 2016	
5	BM15-16/243	The Board recommended that the Finance Business Performance and Assurance Committee undertake a “deep dive” into the revised forecast deficit of £15M	GL		February 2016	

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6	BM15-16/245	Evaluate the level of investment in nursing versus the planned reduction in agency costs, sickness levels and the qualitative benefits of harm free care and improved staff satisfaction	GW		March 2016	
7	BM15-16/245	The Board agreed to review capacity and capability of the nursing workforce in future reports by including a suite of indicators and metrics which focus on mentorship/ perceptorship and safety	GW		March 2016	
8	BM15-16/251	Include the % performance for A & E in the Board declaration on the Q3 submission	CS	Completed		
9	BM15-16/253	Consider the impact of financial penalties and any links to the BAF	GL		March 2016	
10	BM15-16/250	Undertake a review of the Board's risk appetite as part of the risk management review	CS		March 2016	
Date of Meeting 25.11.16						
11	BM15-16/193	Quality and Safety Committee to review the actions being undertaken to improve the AQ indicator for Fractured Neck of Femur	GW/MW	Included on the Agenda for Q & S – March 16	To be included in Chair's report March 16	
12	BM15-16/196	Provide an update on the benefits and successes of NHSP in relation to the agency cap	JG	Included in the Agency Cap Improvement Plan to be reviewed in the private part of the January Board - completed		
Date of Meeting 28.10.15						

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13	BM 15-16/163	Surgical Activity -The Board asked for consideration to be given to reporting routinely how and where beds were being protected as well as where these had been absorbed hence impacting on performance.	MB/SG		November 2015	
14	BM 15-16/163	RTT - The Board requested that further consideration be given to implementing an "early warning system" thus using the technology the Trust has.	MB/SG	Regular updates to the Board provided – next briefing due February 2016	November 2015	
15	BM 15-16/165	The Board asked that the monthly safe staffing appendix be reviewed to ensure this added value	GW	Completed	November 2015	
Date of Meeting 30.09.15						
16	BM 15-16/132	The Board requested that the actions being taken to address areas of under performance in the performance report ranked in terms of desired impact, where possible, to aid with review.	MB		October 2015	
17	BM 15-16/132	The Board requested that the Chief Executive reach a clear position with the CCG as soon as possible with regards to Community Paediatrics.	DA	This action has been superseded by action ref BM15-16/241 - completed	February 2016	
Date of Meeting 29.04.15						
18	BM 15-16/015	Provide the Board with a monthly update on CQC improvement against compliance	EM/CS	Ongoing	March 16	
19	BM 15-16/016	Consider adjusting the nurse staffing ratio targets when contingency wards used	JG	Completed	completed	
Date of Meeting 28.01.15						

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20	BM 14-15/165	Review the changes to Corporate Governance agreed at the Board in January 15 in 6 months time	CS	Completed	December 15	
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