Wirral University Teaching Hospital NHS
NHS Foundation Trust

Board of Directors
Public Board

28th March 2018

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MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 28th MARCH 2018

COMMENCING AT 8.30AM IN THE BOARD ROOM
EDUCATION CENTRE, ARROWE PARK HOSPITAL

AGENDA

1	**Apologies for Absence** Chair	v
2	**Declarations of Interest** Chair	v
3	**Chair's Business** Chair	v
4	**Chief Executive's Report** Acting Chief Executive	v

5. Quality and Safety

5.1	**Patient Story** Acting Head of Patient Experience	v
5.2	**Learning From Improvement** Medical Director	d

6. Performance and Improvement

6.1	**Integrated Performance Report**	
	6.1.1 Integrated Dashboard and Exception Reports Chief Operating Officer	d
	6.1.2 Month 11 Finance Report Acting Director of Finance	d
6.2	**Strategic Planning Update** Director of Strategy and Sustainability	d

7. Workforce

7.1	**Draft Nursing & Midwifery Workforce Strategy** Interim Director of Workforce	d
7.2	**2017 National NHS Staff Survey** Interim Director of Workforce	d
7.3	**Gender Pay Gap** Interim Director of Workforce	d
7.4	**Proposed Workforce Assurance Committee** Interim Director of Workforce	d

8. Governance

8.1	**Board Assurance Framework** Acting Chief Executive	d
8.2	**Report of Finance Business Performance and Assurance Committee** Chair of Finance and Business Performance Assurance Committee	d
8.3	**Report of Audit Committee** Chair of Audit Committee	d
8.4	**Report of the Quality and Safety Assurance Committee** Chair of Quality and Safety Assurance Committee	d
8.5	**Board of Directors**	
	8.5.1 Minutes of the Previous Meeting – 28th February 2018	d
	8.5.2 Board Action Log Director of Corporate Affairs	d

9. Standing Items

9.1	**Items for BAF/Risk Register** Chair	v
9.2	**Items to be considered by Assurance Committees** Chair	v
9.3	**Any Other Business** Chair	v
9.4	**Date and Time of Next Meeting** Wednesday 25th April 2018	v

Board of Directors	
Agenda Item	5.2
Title of Report	Learning from Improvement
Date of Meeting	28 March 2018
Author	Howard Scott, Associate Director of Quality Governance
Accountable Executive	David Jago, Acting Chief Executive
BAF References	All
Level of Assurance	Identified gaps
Purpose of the Paper	Discussion
Review by Executive Committee	Discussed and developed with Executive Team
Data Quality Rating	Bronze – qualitative data
FOI status	Entire document is disclosable
Equality Impact Assessment Undertaken	N/A

1. Executive Summary

In November 2017 Kathy McLean, Executive Medical Director, NHS Improvement published 'Learning from improvement: special measures for quality A retrospective review'. The document pulls together the shared learning from several trusts who have been supported by NHSI in their move out of special measures as a result of a number of quality improvement initiatives. The purpose of the document is to share other trusts experiences, so that leaders and staff in other organisations, either currently in special measures or at risk, can benefit.

Given the acknowledged challenges facing the Trust it has been useful to use this document and a table contained within it to carry out a self-assessment about where the Trust is in relation to the improvement areas identified within the document – Leadership, Engagement, Culture, Governance and Quality Improvement. The output contained within the table is designed to provide the basis for further discussion.

2. Background

Since 2013, **37** trusts have entered special measures for quality and **21** have exited (three subsequently re-entered). The average time spent in special measures is **23 months**. Four years after the introduction of special measures, NHSI have reviewed the experience of trusts that exited the process.

The purpose of this review was to identify the practical actions trusts and others took that improved the quality of care for patients and helped trusts reach a point where they could exit from special measures. NHSI wanted these lessons to be available to help challenged trusts and boards that may be concerned about deterioration in quality of care.

NHSI's review identified **five themes** that were essential for improvement: **leadership, engagement** (internal and external), **culture, governance** and the trust's approach to **quality improvement**. A common message across these themes was the need to **communicate effectively**. The most successful trusts, which have been able to make the greatest improvement in the shortest time, have:

- quickly built an effective leadership team and board
- **ensured robust but lean governance, identifying problems locally and escalating those that cannot be resolved**
- reviewed and developed their vision and values, engaging staff in this process
- **given hope to the organisation that it could improve**
- engaged staff in improvement, and aligned clinical and managerial priorities around **patients**' needs
- **communicated effectively with all stakeholder groups**
- **used a quality improvement methodology to develop a quality improvement plan** that is more than a list of actions, with short- and long-term goals
- **identified some quick wins, and used their CQC report to identify 'must dos'.**

NHSI are now four years into their special measures programme that has provided trusts with dedicated support to address their specific challenges. It has included embedding improvement directors, funding for improvement programmes, monitoring improvement plans, building leadership capacity, facilitating change and providing intensive support on patient experience and staff engagement.

There is now significant learning to be gained from trusts that benefited from this dedicated support, and from understanding what helped them most in making the sustainable quality improvements that enabled them to exit special measures and continue to improve.

NHSI have reflected on this combined learning and on the challenges trusts face to sustain good practice and high quality patient care. They are clear that we must continue to learn and hone our understanding of which interventions and support have the most effective and long-lasting impact, to ensure a continuous cycle of learning and improvement.

NHSI key advice to a challenged trust is:

• acceptance: recognise when things are not as good as they should be and ask for support – this is the start of the improvement process

• be courageous about getting strong leadership on behalf of patients and staff

• place great importance on engaging and developing staff and supporting clinical leadership

• expect the work to be hard but stay with it, and seek and accept help

• it will be a long and difficult journey, but you will be successful; and this is ultimately what matters to patients.

The table below summarises the most important lessons by theme that trusts highlighted alongside an initial self -assessment of where the Trust is currently.

Leadership	Engagement	Culture	Governance	Quality improvement
Rapidly assess leadership capability and capacity	Build a **comprehensive engagement plan**	Genuine **visibility of whole board and moving beyond this to role-model expected behaviours**	Focus on **getting organisational structures right** early	There is **no single best meth**od for quality improvement
Make changes where necessary and put support in place	**Internal** Internal Structured programme of **staff engagement**	Refresh **vision, values behavioural standards and norms,** and **live them**	Clarity on **roles, responsibilities and accountability**	Using a **consistent, structured approach** yields quicker results
Establish a **stable and committed** leadership team	Re-engage staff in the improvement journey	**Link objectives** to staff appraisals	**Lean, transparent** governance processes	Improvement plans **must be more than a series of actions**
Build leadership at **all levels,** including **medical leadership**	**Medical engagement** can have the biggest impact, positive or negative	**Check people's actions/responses are in line with culture** – eg response when something goes wrong	**Decision-making** must be **agile**	It must be possible to **assess the impact** of the improvement plan
Collective board ownership of the issues	**Informal forums** often work well to engage staff	**Learn from mistakes**, avoid a **blame culture**	Governance should enable **consistent board oversight** of the trust	There must be a **clear understanding of the underlying issues and a vision for sustained improvement beyond special measures**
Clear roles in relation to improvement	**Embed staff** at all levels in the improvement programme	Champion the **maintenance of basic clinical standards** and safe clinical environment	Unitary board **challenging in a supportive way**	Buddying can be successful, **enhancing capability and capacity, and sharing what good looks like. There must be clear terms of reference and monitoring**
Visibility and **role modelling behaviours**	Engagement will take a **significant part of the leadership team's time**	Give the organisation **hope** and **celebrate success** along the way	Strengthening processes for **reporting and learning from incidents**	
A **clear strategy and priorities** for staff to understand	**External** Build **trusted relationships**		Collect and use data to **explain the problem, design the solution and show the improvement**	
Focus on **stakeholder management.**	**Don't overpromise,** push back on unrealistic expectations		Governance needs to be an **enabler**	

Significant amount of work to be undertaken	Started in some areas	Well established / implemented

3. Discussion

The table and the initial self-assessment by the Executive Team does not intend to be a stand-alone complete document, it is intended to provide a framework for further discussion around the challenges faced by the Trust as we move forward into a period of focussed quality improvement. The Board of Directors are asked to review the table and to engage in a discussion around where the assessment needs to be challenged and what further actions should be taken going forward.

In developing a High-Level Quality Improvement Plan for the Trust it should also be noted that some of the long-term issues like culture and engagement may take over two or three years before significant improvements can be evidenced fully. As Directors' will also be aware we are in the middle of a CQC Inspection and part of the High-Level Quality Improvement Plan will obviously include the subsequent CQC actions contained within the Final Report which should be published towards the end of June 2018.

Howard Scott
Associate Director of Quality Governance (Interim)
19 March 2017

Board of Directors	
Agenda Item	**6.1.1**
Title of Report	**Integrated Performance Dashboard**
Date of Meeting	**28th March 2018**
Author	**Anthony Middleton, Director of Ops / Deputy COO** **John Halliday, Assistant Director of Information**
Accountable Executive	**Janelle Holmes** **Chief Operating Officer**
FOI status	**Document may be disclosed in full**
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	**All Strategic Objectives (1 through 7)** **All Key Measures (1A through 7D)** **All Principal Risks**
Level of Assurance • **Positive** • **Gap(s)**	**Partial with gaps**
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	**Discussion**
Data Quality Rating	**Silver – quantitative data that has not been externally validated**
FOI status	**Document may be disclosed in full**
Equality Impact Assessment Undertaken • **Yes** • **No**	**No**

1. Executive Summary

This report provides a summary of the Trust's performance against agreed key quality and performance indicators. The Board of Directors is asked to note the performance to the end of February 2018.

2. Summary of Performance Issues

The key national priorities are the A&E four hour target and the financial position. These and other key targets noteworthy by exception are covered in the opening section.

3. Recommendation

The Board of Directors are asked to:

Note the Trust's current performance to the end of February 2018.

WUTH Metrics Summary
Performance for February 2018

Metrics	✓	!	✗	Not rated
	16	11	15	3

Headline Commentary

The key focus remains on the financial position and A&E 4-hour performance, followed by elective access standard performance (RTT and Cancer).

Performance against the A&E 4 hour standard had seen improvement, however the ongoing winter pressures have made sustaining that extremely challenging. This is reflected regionally and nationally.

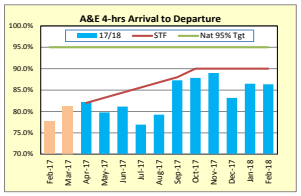
RTT incomplete validation and cleansing is complete, with increased activity now required to reduce waiting lists and times. The enforced cancellation of elective activity in January continued into February, with a natural detrimental effect on the RTT position. Very long waiters are being actively managed on an individual basis, and reviewed for possible harm.

Cancer standards are on track to be delivered for Q4. The financial position is detailed separately.

A&E : 4 Hours Arrival to Discharge ✗

Actual: 86.34% **Accountability:** J Holmes / A Middleton

Threshold: 95% (minimum) **Committee:** FPBAC



13 Months Trend: Feb 2017 to Feb 2018

Metric
The total time spent in A&E, measured from the time the patient arrives in A&E to the time the patient leaves the A&E Department, by discharge home, transfer to anther hospital or admission to a ward.

Key Issues
The Trust had agreed a trajectory to deliver the standard by March 2018, but this has now been superseded by a blanket national expectation of 90% for October through to February, with 95% to be delivered in March 2018.

Performance is now reported for Wirral at various levels :

Wirral-wide including all Walk-in-Centres & MIUs	86.34%
WUTH APH site including the ADHC	78.33%
WUTH APH ED only	70.49%

This performance reflects the pressure on urgent care services through Winter and that continued into February.

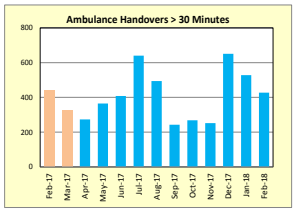
Inputs
Wirral wide capacity and demand modelling is now complete and there is a clear understanding of how demand, complexity and system configuration results in "overflow" into acute beds. The Trust has taken the decision to recruit substantively to previously tagged "unfunded" beds on 3 wards across both Arrowe Park and Clatterbridge sites. The focus remains on both SAFER work programmes as well as Stranded patients reviews which have now been extended to the Clatterbridge site on a weekly basis.

Progress
During March the elective beds used since January for winter demands have now been de-escalated

Ambulance Turnaround 30 Mins ✗

Actual: 427 **Accountability:** J Holmes / A Middleton

Threshold: 0 > 30mins **Committee:** FPBAC



13 Months Trend: Feb 2017 to Feb 2018

Metric
The standard is a maximum 30 minutes from the arrival of an ambulance to the handover of the patient to Trust staff in the Emergency Department (ED).

Key Issues
In the month of February there were 427 arrivals by ambulance that took longer than 30 minutes to handover.

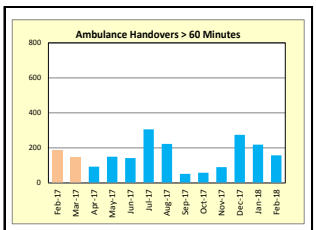
Inputs
The Trust is investing in additional nursing staff to aid in rapid handover, and when pressures increase ensure crews are not managing patients on "corridor queues". A programme of improvement in conjunction with NWAS continues and will be updated at the next A&E delivery board.

Progress
The programme which saw improvement over the autumn period but which was not resilient enough throughout winter will draw upon the lessons learnt and will adapt.

Ambulance Turnaround 60 Mins ✗

Actual: 158 **Accountability:** J Holmes / A Middleton

Threshold: 0 > 60mins **Committee:** FPBAC



13 Months Trend: Feb 2017 to Feb 2018

Metric
The guideline is that all handovers between ambulance and A&E must take place within 30 minutes - it is recoginsed that 60 minute handover waits are identified as a significant issue

Key Issues
In the month of February there were 158 arrivals by ambulance that took longer than 60 minutes to handover.

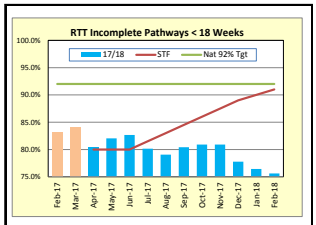
Inputs
The Trust is investing in additional nursing staff to aid in rapid handover, and when pressures increase ensure crews are not managing patients on "corridor queues". A programme of improvement in conjunction with NWAS continues and will be updated at the next A&E delivery board.

Progress
As part of the overall economy winter debriefs there will be specific inclusion of 60 min + handovers. Moving forward the national drive is to treat all breaches as formal incidents.

RTT - Incomplete ✗

Actual: 75.60% **Accountability:** J Holmes / A Middleton

Threshold: 92% (minimum) **Committee:** FPBAC



13 Months Trend: Feb 2017 to Feb 2018

Metric
The percentage of patients that have been referred to a consultant-led service and have not commenced treatment within 18 weeks from that referral, as measured at month-end.

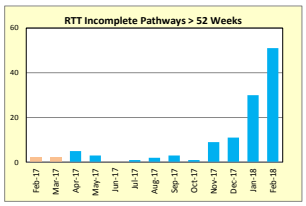
Key Issues
The Trust agreed a trajectory back to compliance across 2017/18 with NHS Improvement. This trajectory has not been acheved since June 2017. Performance for the end of February 2018 was 75.60%.

Inputs
The position has been markedly affected by the partial cessation of elective activities during quarter 4. Following the de-escalation of elective wards used for medical outliers the Trust has been able to fully restart its programme. The Trust has moved to centralise all the booking and administration of RTT from the 1st April.

Progress
As part of the 2018/19 planning round the Trust has developed a plan to redress the position by March 2019 and is discussing the affordability of the plan with commissioners. It should be noted that the national 2018/19 planning guidance moves away from 18 weeks as the key measure, rather focusing on total waiting list size.

RTT - 52 Week Waiters

Actual:	51	**Accountibility:**	J Holmes / A Middleton
Threshold:	0	**Committee:**	FPBAC



13 Months Trend: Feb 2017 to Feb 2018

Metric
In conjunction with the 92% standard for incomplete RTT pathways, there is the national expectation that all patients will commence treatment within 52 weeks of referral, as measured at month-end.

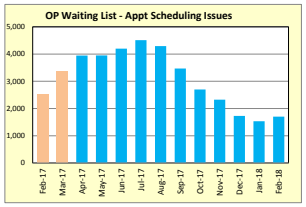
Key Issues
There were 51 patients at the end of February that had waited longer than 52 weeks for treatment to commence.

Inputs
Long waiting patients are being actively managed alongside the general waiting list and waiting time improvement actions. Any patients confirmed as having waited 52 weeks at month-end are reviewed to ensure no clincal harm has resulted from the long wait, and to understand the causes of the excessive waiting time.

Progress
Numbers have risen sharply during quarter 4 as the elective programme was impacted by emergency pressure, although the March forecast shows an improvement. Plans to address have been developed within the overall RTT plan for 2018/19. National guidance for 2018/19 expects at least a 50% reduction in breaches.

Outpatient Waiting List - Appointment Scheduling Issues (ASI)

Actual:	1703	**Accountibility:**	J Holmes / A Middleton
Threshold:	Zero	**Committee:**	FPBAC



13 Months Trend: Feb 2017 to Feb 2018

Metric
Number of eRS referrals on the Appointment Scheduling Issues (ASI) list at month-end

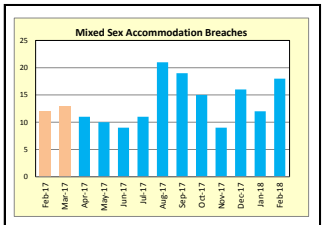
Key Issues
Direct bookings from GPs via the national eRS are unable to find an available appointment for the patient if there is limited capacity at the Trust. These referrals are then logged as an ASI, preveting the referal letter reaching the Trust, and the patient does not receive an appointment until capacity becomes available.

Inputs
The size of the ASI backlog increased slightly in February. Divisions are working through plans to reduce and minimise the number of ASI.

Progress
The ASI backlog is expected to continue to reduce across the remainder of 2017/18.

Mixed Sex Accommodation Breaches

Actual:	18	**Accountibility:**	J Holmes / A Middleton
Threshold:	Zero	**Committee:**	FPBAC



13 Months Trend: Feb 2017 to Feb 2018

Metric
Patients have a right to single-sex accommodation, to respect their privacy and dignity in an inpatient setting.

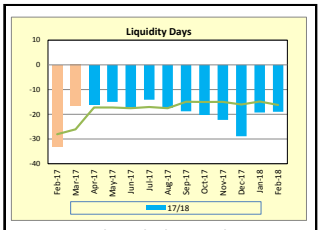
Key Issues
There were 18 breaches of the same sex accommodation standard in February. Thirteen related to patients waiting beyond the 24 hours allowed for patients transferring out of critical care areas, and 5 breaches occurred with a female patient admitted to a male bay on ACU.

Inputs
The delays in transferring out are discussed at all bed meetings and given high priority. The patients' privacy and dignity is maintained in the critical care areas, in a side room if possible, and all care given that would be provided on their destination ward. The delays are explained to the patients, and they are moved as soon as a bed becomes available in the right ward. The increased urgent care pressure on beds in recent months exacerbates the delays.

Progress
Options to increase the side rooms in critical areas are being assessed. Improving patient flow across the Trust will allow easier and more timely transfer back to general wards for those patients that no longer need augmented care.

Liquidity Days

Actual:	-19.00	**Accountibility:**	G Lawrence
Threshold:	Greater than planned liquidity	**Committee:**	FPBAC



13 Months Trend: Feb 2017 to Feb 2018

Metric
Days of operating costs held in cash-equivalent forms.
2016/17 plan and actual figures (to Feb 2017) appear worse than the 2017/18 metrics because they were compiled on a different basis. Due to changing instructions from the Department of Health and NHSI, working capital facility (WCF) borrowings were previously included within working capital balances, which made the liquidity metric more negative.

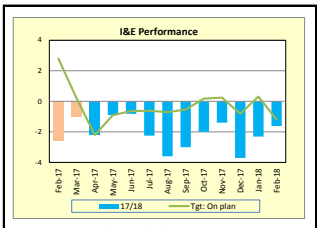
Key Issues
Since 2015/16, EBITDA deficits have consistently generated net cash outflows from operating activities, which in turn have deteriorated the Trust's working capital balances. The negative 'liquidity days' metric reflects this 'negative working capital' situation – the Trust's liabilities exceed its assets, including cash. This can be seen in the Trust's Statement of Financial Position.

Inputs
Loan arrangements are in place with the Department of Health and NHSI, which ensure that the Trust will not run out of cash.
Such borrowings are to cover day-to-day running costs, and are not ordinarily expected to be used to improve working capital balances.
Therefore, improvement in the liquidity metric primarily depends on improvement in the Trust's underlying EBITDA performance.

Progress
Improvement in the liquidity metric primarily depends on improvement in the Trust's underlying EBITDA performance.

I&E Performance

Actual:	-1.61	**Accountibility:**	G Lawrence
Threshold:	On plan	**Committee:**	FPBAC



13 Months Trend: Feb 2017 to Feb 2018

Metric
The actual monthly Trust financial position compared to the planned financial position.

Key Issues
Operational expenditure, in particular pay, continues to be significantly above plan due to workforce pressures as a result of the required escalation areas opened to manage non-elective demand and A&E pressures. Due to issues recruiting to medical gaps and the high levels fo nirsing vacancies there is high level use of non-core staffing. In addition there is the pressures from the pace of delivery on CIP schemes. The non-delivery of the operational plan has resulted in not being able to access the planned Sustainability & Transformation Fund (STF) since Q1.

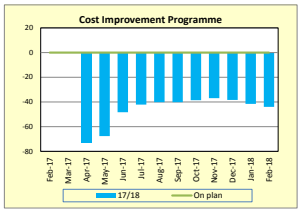
Inputs
A financial recovery plan is in place that will support the reduction of the current run-rate.

Progress
The financial recovery plan is reviewed at the Finance & Performance Group as well as the divisional finance reviews with the Director of Finance.

Cost Improvement Programme

Actual: -44.0 **Accountibility:** G Lawrence

Threshold: On Plan **Committee:** FPBAC



13 Months Trend: Feb 2017 to Feb 2018

Metric
The percentage of non-achievement of the in year CIP forecast against the £15m plan.

Key Issues
Pace of delivery of planned CIP schemes and the non-achievement to continue to find schemes to bridge the unidentified gap in the CIP plan.
The CIP forecast still has a potential delivery risk and the CIP mitigation risk reserve only partially offsets the current gap.

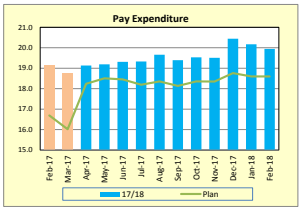
Inputs
The Transformation Steering Group (TSG) continues to review and approve new opportunities to deliver the CIP agenda and monitor plans in progress to delivery. Work is ongoing to look at the big transformational schemes for 18/19.

Progress
TSG continues to progress schemes when identified and has strong links to SSPG in order to realise benefits from proposed vertical and horizontal integration.

Pay Expenditure

Actual: 19.94 **Accountibility:** G Lawrence

Threshold: Plan **Committee:** FPBAC



13 Months Trend: Feb 2017 to Feb 2018

Metric
The actual monthly Trust pay spend compared to the pay plan.

Key Issues
Operational expenditure in particular pay continues to be significantly above plan due to workforce pressures as a result of increased non-elective demand, issues in recruiting to medical gaps and the high levels of nursing vacancies as well as the pace of delivery on CIP schemes. In addition the apprenticeship levy has impacted the December pay cost.
Use on non-core pay is still relatively high and represents c10% of pay spend.

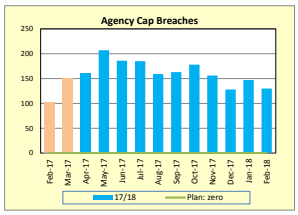
Inputs
The finance team review pay overspends and use of non-core on a regular basis with the budget managers and divisional teams.
There has been a vacancy freeze on all non-clinical posts implemented since early October and all vacancies remain under review.

Progress
As part of the financial recovery plan there are actions to look to reduce the run rate on pay expenditure.

Agency Cap Breaches

Actual: 130 **Accountibility:** J Holmes

Threshold: 0 **Committee:** FPBAC



13 Months Trend: Feb 2017 to Feb 2018

Metric
The target is set at zero breaches of the agency cap. Divisional target to reduce agency usage by 50%.

Key Issues
Use of unfunded or unestablished escalation wards is creating increased demands for bank and agency staff. The Divisional target to reduce agency usage by 50% is proving a challenge without direct impact on patient care.

Inputs
The Effective and Efficient Workforce transformation is reviewing Medical leadership roles to free up more time for patient contact, job planning for medical and non-medical staff to increase efficiency, and policies and procedures to reduce reliance on temporary staff.

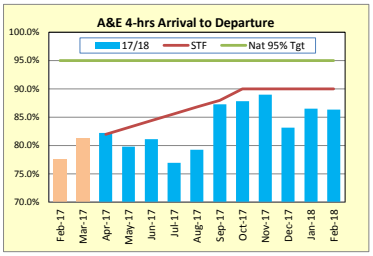
Progress
Policy amendments finalised Nov 2017. Revised workforce planning presented to WGG in Dec 2017. Collaborative agreements with other NHS organisations on agency rates are being considered for possible introduction from April 2018.

Access (Operations)

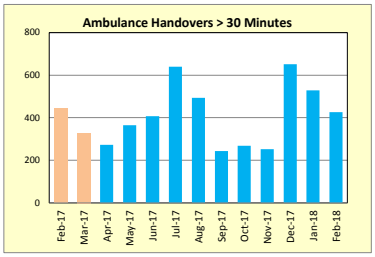
J Holmes / A Middleton

✓	!	✗	Not rated
9	4	9	

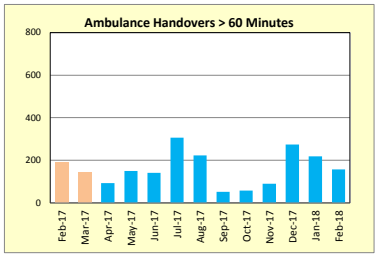
Access (Operations)



13 Months Trend: Feb 2017 to Feb 2018



13 Months Trend: Feb 2017 to Feb 2018



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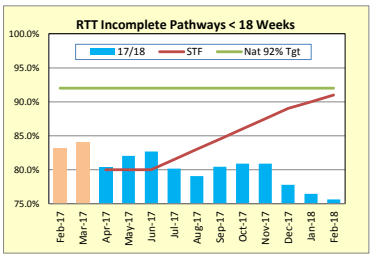

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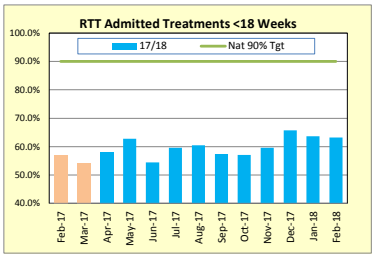

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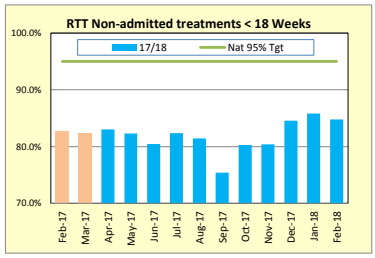

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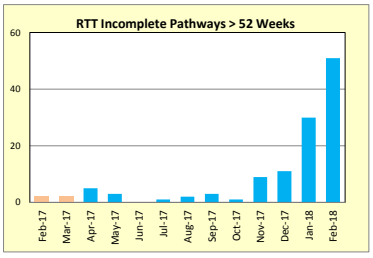

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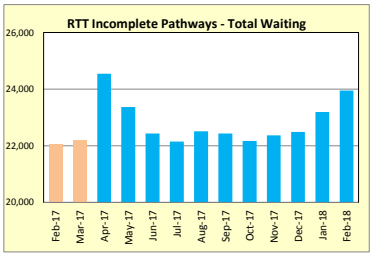

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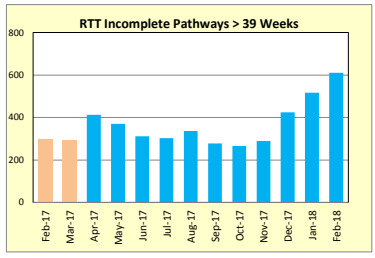

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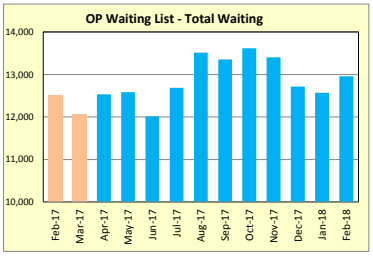

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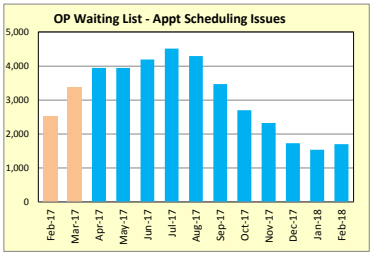

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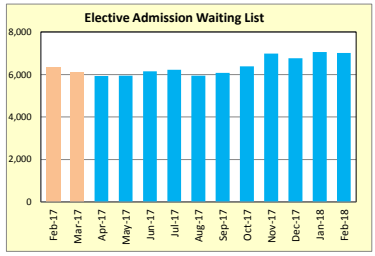

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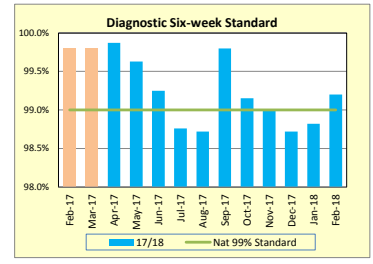

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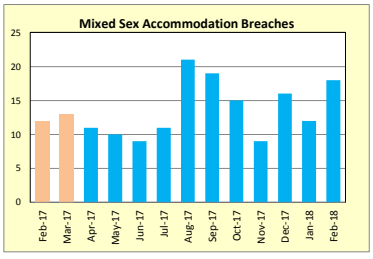
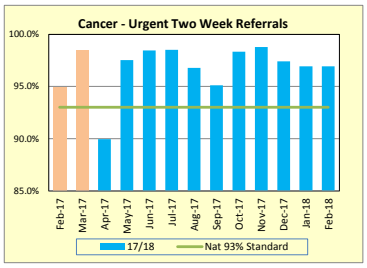


13 Months Trend: Feb 2017 to Feb 2018

Access (Operations)



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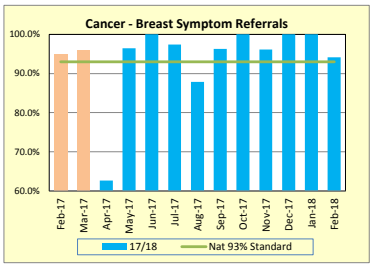

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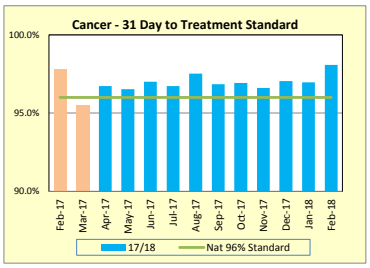

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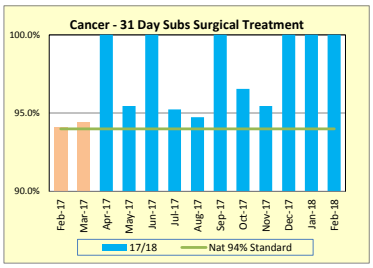

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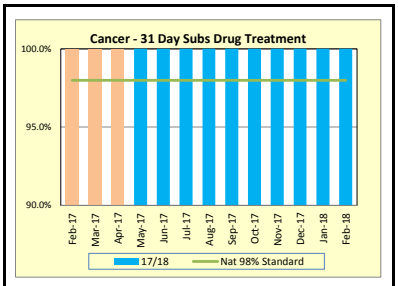

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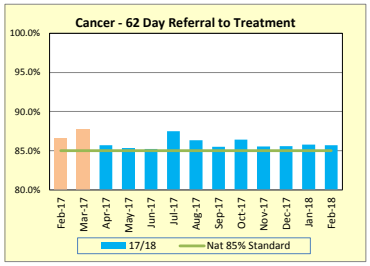

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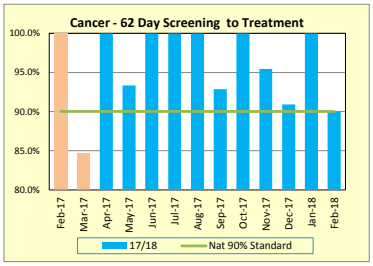

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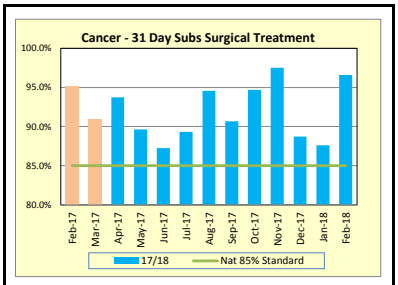


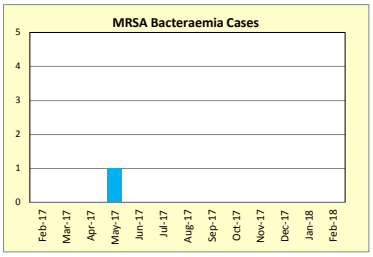
13 Months Trend: Feb 2017 to Feb 2018

Patient Experience

G Westray

✓	!	✗	Not rated
6	0	1	2

Patient Experience



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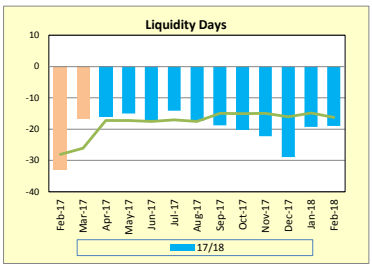
13 Months Trend: Feb 2017 to Feb 2018

Use of Resources

G Lawrence

✓	!	✕	Not rated
1	1	5	1

Use of Resources



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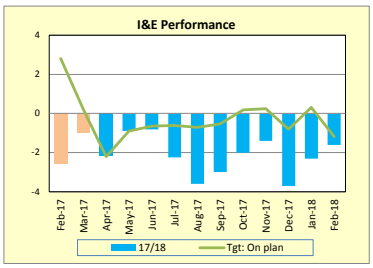

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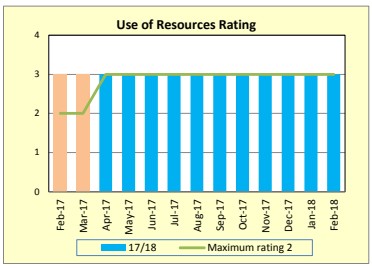

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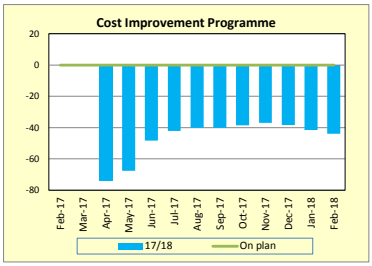

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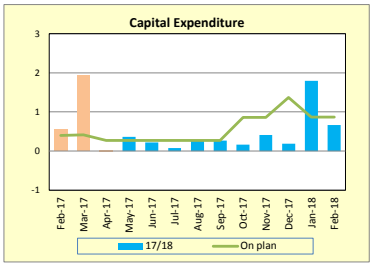

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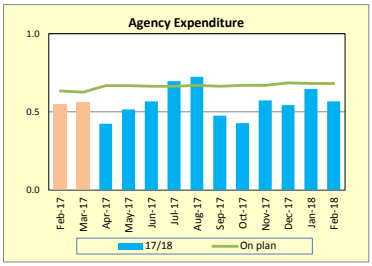

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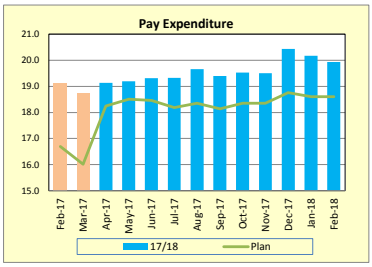

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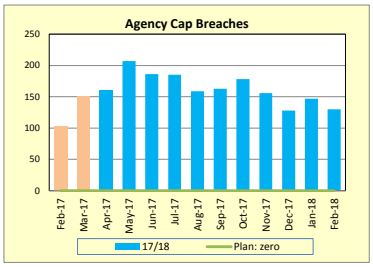


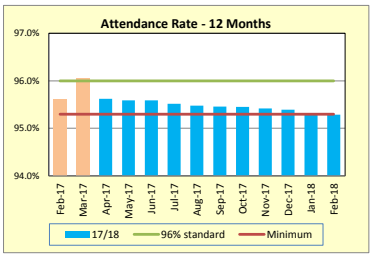
13 Months Trend: Feb 2017 to Feb 2018

Workforce

H Marks

✓	!	✗	Not rated
0	6	0	0

Workforce (HR)



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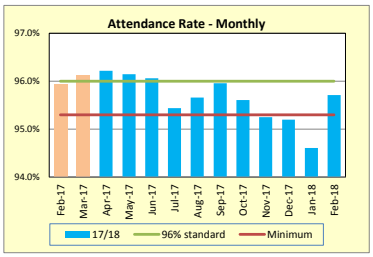

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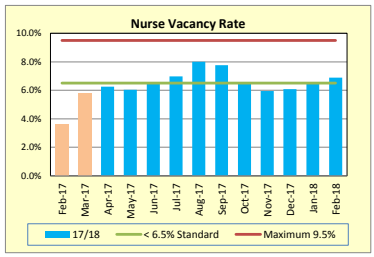

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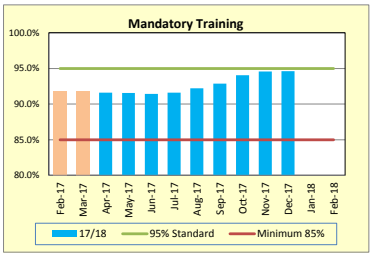

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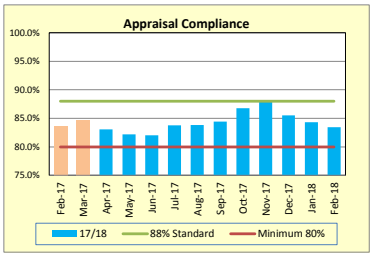

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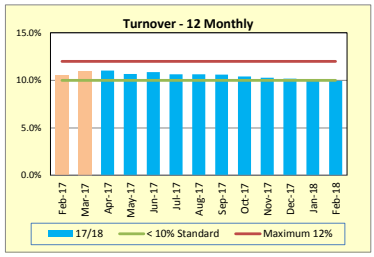


13 Months Trend: Feb 2017 to Feb 2018

Board of Directors	
Agenda Item	6.1.2
Title of Report	Month 11 Finance Report
Date of Meeting	28th March 2018
Author	Julie Clarke, Assistant Director of Finance
Accountable Executive	Gareth Lawrence, Acting Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	8 8c,8d
Level of Assurance • **Positive** • **Gap(s)**	Gaps: Financial performance below plan with consequent non delivery of STF funding.
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To discuss and note
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

Overview

This paper provides an update to the Board of Directors on the month 11 financial performance of the Trust for the 2017/18 financial year.

The Trust submitted a revised plan to NHS Improvement (NHSI) which agreed delivery of an operational deficit of (£0.4m) in line with the control total issued and agreed at Board in March 2017. Within this plan is the requirement to deliver a Cost Improvement Programme (CIP) of £15.0m and a requirement to deliver additional initiatives identified and agreed at Board in March to deliver further savings/initiatives of £6.6m (residual risk of £5.0m) profiled to the latter part of the financial year with a key element of this reliant on working with a formally appointed SEP.

At the end of February 2018 the Trust has reported an adjusted financial performance deficit (AFPD), excluding Sustainability and Transformation Funding (STF) of (£25.3m) against a plan of (£14.6m). As a result of the financial position the Trust has failed to meet the STF criteria has and has therefore not been able not been able to access £6.7m of the STF during the year.

In month, the Trust has delivered a (£1.7m) AFPD excluding STF compared to a planned AFPD of (£2.2m). The in-month favorable performance of £0.5m reflects the "year end" settlement with Wirral CCG, this has provided some mitigation against the operational pressures as well as ensuring no sanctions are applied in relation to the failure of CQUIN targets. In February there continued to be high levels of emergency activity presenting at the Trust. The Trust reduced Elective and Outpatient activity in line with National guidance issued during December 2017 in response to the increased operational pressure on Health and Social care resources. The reduced Elective performance has continued throughout February.
The elective program of activity has not "re-started" as intended, although the "settlement" with the CCG will alleviate some risk and ensure the year end position can be managed, there remains a residual risk of £1.6m in the treatment of Sepsis. Revised guidance has been issued by NHSE, in February 2018, both the Trust and CCG Information teams are working through the impact. The current reported position and forecast position assumes the Sepsis risk will not materialise.

The Trust disappointingly is reporting a (£5.7m) adverse variance performance in the CIP position having delivered £7.5m compared to the £13.2m target. The levels of savings within the plan represent c5% of Trust turnover which is c3% above the level nationally identified by NHSI in the planning guidance. Current delivery levels exceed the 2% level but fall short of the internal target required to achieve the operational plan and subsequent STF. The Trust sustainability challenge is key for 18/19 Planning and going forward.

The cash balance at the end of February was £3.5m, which is £1.1m above plan. This primarily reflects the closing 16/17 cash position being higher than plan, capital slippage, additional loan funding and the PDC cash received to support the Wirral Digital / Global Digital Exemplar (GDE) programme, offset by EBITDA performance. In February, additional cash support was drawn down in line with previous papers presented to the Board and FBPAC.

The Trust has agreed with the regional NHSI team a revised forecast AFPD of (£20.6m) in M10; this shows a year end AFPD excluding STF variance of (£12.5m) against the control total. The Trust is still in on target to achieve this forecast as a result of non-recurrent elements of the recovery plan being delivered throughout March.

The Trust has achieved an overall Use of Resources (UoR) Rating of 3 which is in line with plan. As in previous months, the Agency spend rating is preventing the overall UoR Rating from dropping to 4.

Table 1 Income and Expenditure Performance

Year ending 31 March 2018 Position as at 28th February 2018	Current Month			YTD			Year-end forecast		
	Plan £k	Actual £k	Variance £k	Plan £k	Actual £k	Variance £k	Board-approved Plan £k	Actual £k	Variance £k
Clinical income	24,820	25,301	481	277,465	269,066	(8,399)	303,692	293,777	(9,915)
Non-NHS clinical income	131	164	33	1,441	2,305	864	1,566	2,472	906
Other income	2,445	2,725	280	26,895	27,268	373	34,288	31,320	(2,968)
Total operating income before donated asset income	**27,396**	**28,190**	**794**	**305,801**	**298,639**	**(7,162)**	**339,546**	**327,569**	**(11,977)**
Pay	(18,616)	(19,943)	(1,327)	(202,560)	(215,613)	(13,053)	(221,376)	(235,521)	(14,144)
Other expenditure	(8,890)	(9,042)	(152)	(98,511)	(97,286)	1,225	(106,045)	(106,111)	(66)
Total operating expenditure before depreciation and impairments	**(27,506)**	**(28,985)**	**(1,479)**	**(301,071)**	**(312,899)**	**(11,828)**	**(327,422)**	**(341,632)**	**(14,210)**
EBITDA	**(110)**	**(795)**	**(685)**	**4,730**	**(14,260)**	**(18,990)**	**12,124**	**(14,063)**	**(26,187)**
Depreciation and net impairment	(715)	(565)	150	(7,638)	(6,013)	1,625	(8,353)	(6,578)	1,775
Capital donations / grants income	0	116	116	0	441	441	0	441	441
OPERATING SURPLUS / (DEFICIT)	**(825)**	**(1,244)**	**(419)**	**(2,908)**	**(19,831)**	**(16,924)**	**3,771**	**(20,200)**	**(23,971)**
Net finance costs and gains / (losses) on disposal	(363)	(366)	(4)	(3,985)	(4,016)	(31)	(4,340)	(204)	4,136
ACTUAL SURPLUS / (DEFICIT)	**(1,188)**	**(1,611)**	**(423)**	**(6,892)**	**(23,847)**	**(16,955)**	**(569)**	**(20,404)**	**(19,835)**
Reverse net impairment	0	0	0	0	0	0	0	0	0
SURPLUS / (DEFICIT) before impairments and transfers	**(1,188)**	**(1,611)**	**(423)**	**(6,892)**	**(23,847)**	**(16,955)**	**(569)**	**(20,404)**	**(19,835)**
Reverse capital donations / grants I&E impact	12	(99)	(111)	130	(276)	(406)	142	(259)	(401)
DEL net impairments *(damage, not revaluation)*	0	0	0	0	0	0	0	0	0
ADJUSTED FINANCIAL PERFORMANCE SURPLUS / (DEFICIT) (AFPD)	**(1,176)**	**(1,710)**	**(534)**	**(6,762)**	**(24,123)**	**(17,361)**	**(427)**	**(20,664)**	**(20,236)**
AFPD excluding STF	**(2,211)**	**(1,710)**	**501**	**(14,601)**	**(25,255)**	**(10,653)**	**(9,302)**	**(21,795)**	**(12,492)**

The table above details the current performance of the Trust in relation to the plan submitted to NHSI in March 2017 as well as the forecast. The detailed Income and Expenditure account can be viewed in Appendix 1. Due to the high levels of non-elective demand during the winter months operationally there has been a reduction to the surgical elective and day case activity programme and has resulted in c£1.8m lost elective income over the winter period.

The non-achievement of the control total and A&E performance since Q1 has meant that the Trust has had (£6.7m) of the STF fund withheld further deteriorating the income position. Non PbR excluded drugs is currently below plan by (£5.4m), this is offset within expenditure.

As a result of the increased levels of NEL activity the Trust has currently been penalised by c£3.0m greater than planned for in respect of the NEL marginal rate. The Trust continues to discuss the high levels of NEL activity with Health and Social partners in order to find a more sustainable level of support.

Due to the Trust signing up to the Control Total issued by NHS Improvement, the Trust has avoided financial sanctions of c£11.9m YTD due to A&E (£1.9m) and RTT (£10.1m) adverse performance to targets.

Operating expenditure is currently (£11.8m) above plan of which pay remains the significant driver and is overspent by (£13.1m). Within this pay position there are significant pressures which include: non delivery of the unidentified CIP of (£6.3m), additional costs incurred due to operational pressures whilst continuing to experience full capacity in winter of c (£2.3m), pressures in the emergency department of (£1.1m), vacancy factor pressure and further staffing pressures costs in relation to the use of non-core staff to cover medical gaps and nursing vacancies across the divisions. Agency costs are below the NHSI cap by c£1.2m. A number of operational overspends have been offset in Q1 by the release of the £1.2m CQUIN reserve and c£1.3m “savings” as a result of reviews undertaken on accruals and deferred income. There remains a number of bridging items in M12 to deliver the year end outturn including the Clatterbridge land sale.

The Trust continues to monitor the use of non-core spend and agency. The table overleaf shows the detail by non-core category:-

Table 2 Core and Non-Core Expenditure Analysis

	15/16 Average £000's	16/17 Average £000's	17/18 Average £000's	Apr £000's	May £000's	Jun £000's	Jul £000's	Aug £000's	Sep £000's	Oct £000's	Nov £000's	Dec £000's	Jan £000's	Feb £000's	YTD £000's
Plan				18,241	18,505	18,455	18,190	18,352	18,134	18,357	18,351	18,760	18,598	18,616	202,560
Pay Costs															
Substantive	**16,047**	**16,944**	**17,567**	**17,340**	**17,366**	**17,355**	**17,213**	**17,405**	**17,552**	**17,654**	**17,260**	**18,401**	**17,835**	**17,854**	**193,235**
Bank Staff	299	336	**434**	377	374	406	418	474	428	468	472	384	524	450	4,775
Agency Staff	723	591	**560**	424	515	568	696	724	477	429	574	543	647	567	6,164
Overtime	290	255	**286**	339	266	280	272	292	281	272	315	301	260	269	3,147
Medical Bank/Locum	357	462	**600**	486	506	558	546	629	541	582	626	710	770	645	6,599
WLI (In Year)	95	103	**154**	166	164	143	186	135	113	127	262	105	134	158	1,693
Non Substantive Total	**1,764**	**1,748**	**2,034**	**1,791**	**1,825**	**1,955**	**2,118**	**2,254**	**1,840**	**1,878**	**2,249**	**2,043**	**2,335**	**2,089**	**22,377**
Total Pay	17,811	18,692	19,601	19,131	19,191	19,310	19,331	19,659	19,392	19,532	19,509	20,444	20,170	19,943	215,612
Variance				(890)	(685)	(855)	(1,141)	(1,307)	(1,258)	(1,175)	(1,158)	(1,684)	(1,572)	(1,327)	(13,052)
Non-Core %	9.9%	9.4%	10.4%	9.4%	9.5%	10.1%	11.0%	11.5%	9.5%	9.6%	11.5%	10.0%	11.6%	10.5%	10.4%

The Trust will continue to review the operational pay spend via F&PG and FBPAC with a renewed focus on actions required to reduce the pay run rate currently being experienced. The Trust agency YTD spend in M11 was £6.2m compared to the "ceiling" of £7.4m issued by NHSI. Agency and Medical locum expenditure will continue to be closely managed given the premium adverse impact on the financial plan, alongside assessing the impact of a "freeze" imposed on non-clinical agency. The performance against the agency ceiling is ensuring that the Trust is currently delivering a UoR Rating of 3.

The YTD position includes the release of the £1.2m CQUIN risk reserve, as previously reported to the Board.

The YTD non recurrent support of £1.3m overall has been released in Q1. This is non recurrent mitigation and as previously reported to the Board of Directors is not available in future months to support any continuance of the current higher than planned expenditure run rate of the Trust.

The impact of the associated risks and non-recurrent adjustments to the current YTD position and the underlying position are demonstrated in the table overleaf.

Table 3 Underlying Deficit

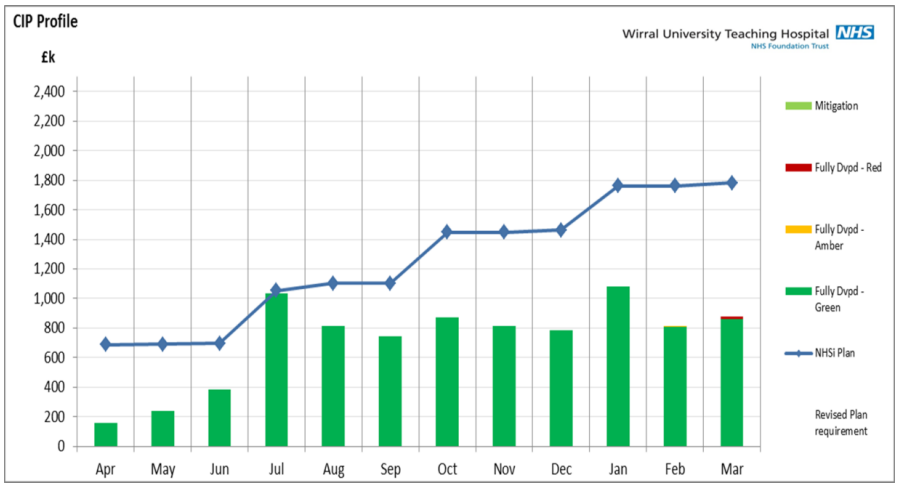
	YTD Plan £k	YTD Actual £k	YTD Variance £k
Adjusted financial performance surplus / (deficit) (AFPD)	**(6,762)**	**(24,123)**	**(17,361)**
AFPD exc STF	(14,601)	(25,254)	**(10,653)**
AFPD Exc STF & Non - Recurrent Support Q1	(14,601)	(26,554)	**(11,953)**
AFPD exc STF/NR/Winter Fund	(14,601)	(27,979)	**(13,378)**
Underlying Deficit	**(14,601)**	**(27,979)**	**(13,378)**

The underlying position has been reflected in the Draft Operational Plan submitted to NHSI for 2018/19.

Cost Improvement Programme (CIP)

The CIP for 2017/18 is £15m (c5%), this is allocated as a target both divisionally and workstream led. As at the end of the Month 11 the Trust is behind the YTD target of £13.2m by £5.7m.

Table 4 CIP Performance



The table below details the month 11 position for CIP by Division.

Divisional Summary	YTD			In Year			FYE		
	Target	Actual	Variance to NHSi Plan	Target	Forecast	Variance to NHSi Plan	Target	Forecast	Variance to NHSi Plan
Division	£k	£k	£k	£k	£k	£k	£k	£k	£k
Medicine and Acute	3,701	895	(2,806)	4,200	1,004	(3,196)	4,200	1,057	(3,143)
Surgery	3,111	2,442	(668)	3,530	2,702	(828)	3,530	2,435	(1,095)
Women and Children	1,295	570	(725)	1,470	640	(830)	1,470	666	(804)
Diagnostics and Clinical Support	2,115	998	(1,117)	2,435	1,119	(1,316)	2,435	1,158	(1,277)
Corporate	2,996	2,060	(936)	3,365	2,326	(1,039)	3,365	1,013	(2,352)
Central			0	0	610	610	0	1,500	1,500
TBC		559	559	0	0	0	0	0	0
TOTAL FULLY DEVELOPED PRE ADJUSTMENT FOR RISK	13,218	7,525	(5,693)	15,000	8,401	(6,599)	15,000	7,830	(7,170)
Adjustment for Risk					(33)	(33)		1,270	1,270
TOTAL FULLY DEVELOPED AFTER RISK	13,218	7,525	(5,693)	15,000	8,369	(6,631)	15,000	9,100	(5,900)

The year to date position as at the end of February is £7.5m, £5.7m short of the NHSI Plan requirement. £5.6m of this variance is as a result of the unidentified gap against the NHSI Plan requirement with a further £0.1m underperformance on developed schemes. Planned CIP mitigation of £1.4m is attributable up to the end of February to partially offset this shortfall.

The in-year forecast for fully developed schemes at the end of January is £8.4m; this is £0.4m lower than the position reported in M10. Application of the CIP mitigation reserve of £1.5m (not shown in the figures above) would leave in year CIP forecast at £9.9m. This position is reflected in the full financial forecast.

The focus of planning has now moved to 2018/19 with work underway to identify opportunities and develop robust plans to ensure the delivery of these opportunities.

Statement of Financial Position (SOFP), cash position and Use of Resources (UoR) Rating

The Trust's Balance Sheet is detailed at Appendix 2 – *Statement of Financial Position (SOFP).*

Capital assets variances to plan (£2.2m) are primarily due to actual brought forward balances for 2017/18 exceeding those in plan and depreciation savings, offset by the transfer of part of the Clatterbridge site to *Assets held for sale*, and a year-to-date capital underspend. Depreciation savings have been delivered by extending the asset life of the Cerner EPR system. While this has had a benefit to the Income & Expenditure position, it increases risks to the Trust's ability to fund its future capital programme without additional external support.

Capital expenditure is currently behind plan (inclusive of Digital Wirral (GDE) scheme) by £3.2m. Forecast public dividend capital to be received in respect of the GDE scheme in year (£5.1m) must be spent before 31 March 2018. To enable utilisation of the capital funding available, the Trust is bringing forward capital schemes from the 2018/19 programme.

February's working capital variances are due to controlled variations in the working capital cycle, in addition to temporary processing delays due to an upgrade of the Trust's financial system. In month 11, movements and variances in non-current borrowings are primarily attributable to the in-month draw-down of the Trust's revenue support *uncommitted loan* facility (£2.2m).

The February closing cash balance was £3.5m, which is £1.1m above plan. This variance comprises a number of factors: 16/17 closing cash position being higher than plan (£3.6m), capital underspend (£2.9m), the additional PDC cash received to support the Digital Wirral (GDE) programme (£3.9m), and above-plan loan draw-down (£9.9m), offset by working capital movements (£0.4m) and adverse EBITDA performance (£19.0m). Further detail of the Trust's cash position is at Appendix 3 – *Statement of Cash Flows*.

The Trust has achieved an overall Use of Resources (UoR) Rating of 3 which is in line with plan. As previously noted, the *Agency spend* rating is preventing the overall UoR Rating dropping to 4.

Conclusion

The Trust is currently reporting an YTD adverse variance (excluding STF) to plan of c(£10.7m) as at the end of February and as a consequence of this has not received the associated STF payments of £6.7m. The February position was £0.5m better than the planned AFPD primarily due to the year- end settlement agreed with Wirral CCG. This has ensured the Trust's income position with regards to its main commissioner contract and mitigated previous risks in relation to delivering CQUIN targets. There remains a residual risk of c£1.6m on the agreed treatment of Sepsis.

The underlying deficit position of the Trust continues to be reviewed and has been reflected in the 2018/19 Draft Plan submitted in March. Going forward the Trust Sustainability Challenge will look at the improving the underlying operational pressures over a longer term recovery plan.

Recommendations

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

Gareth Lawrence
Acting Director of Finance
March 2018

Appendix 1
Income & Expenditure

Year ending 31 March 2018 Position as at 28 February 2018	February Plan £k	February Actual £k	February Variance £k	YTD Plan £k	YTD Actual £k	YTD Variance £k	Year-end forecast Board-approved Plan £k	Year-end forecast Actual £k	Year-end forecast Variance £k
NHS clinical income									
Elective	1,822	1,031	(791)	20,568	19,172	(1,396)	22,534	22,304	(230)
Daycase	2,189	2,229	39	24,552	24,365	(187)	26,899	26,183	(716)
Elective excess bed days	86	49	(37)	970	787	(183)	1,063	937	(126)
Non-elective	7,159	8,020	861	82,696	89,446	6,750	90,511	97,637	7,126
Non-elective excess bed days	174	193	19	2,001	2,269	268	2,191	2,503	312
A&E	990	980	(10)	11,372	11,843	471	12,453	13,030	577
Outpatient	2,781	2,634	(147)	31,169	30,257	(912)	34,148	33,333	(815)
Diagnostic imaging	201	206	5	2,257	2,236	(20)	2,472	2,452	(20)
Maternity	431	399	(32)	5,145	4,733	(412)	5,622	5,167	(455)
Non PbR	5,790	7,432	1,642	63,935	63,245	(690)	69,801	67,863	(1,938)
HCD	1,707	1,192	(515)	18,778	13,393	(5,385)	20,485	14,588	(5,897)
CQUINs	433	938	505	5,965	6,023	58	6,398	5,941	(457)
Other income	20	4	(16)	216	165	(51)	240	193	(47)
STF	1,035	0	(1,035)	7,839	1,131	(6,708)	8,875	1,131	(7,744)
Total clinical income	**24,819**	**25,306**	**487**	**277,465**	**269,066**	**(8,398)**	**303,692**	**293,777**	**(9,915)**
Non-NHS clinical income									
Private patients	54	5	(49)	594	332	(262)	647	358	(289)
Other non-NHS clinical income	77	159	82	847	1,973	1,126	919	2,114	1,195
Total non-NHS clinical income	**131**	**164**	**33**	**1,441**	**2,305**	**864**	**1,566**	**2,472**	**906**
Other income									
Education & training	815	877	62	8,965	9,149	184	9,780	9,955	176
R&D	34	37	3	374	445	71	408	480	72
Non-patient services to other bodies	773	788	15	8,503	8,021	(482)	9,277	8,750	(527)
Other income	823	1,139	316	9,053	10,093	1,040	14,824	12,576	(2,248)
Total other income	**2,445**	**2,841**	**396**	**26,895**	**27,709**	**814**	**34,288**	**31,761**	**(2,527)**
Total operating income	**27,395**	**28,311**	**916**	**305,801**	**299,080**	**(6,720)**	**339,546**	**328,010**	**(11,536)**
Pay costs	(18,616)	(19,943)	(1,327)	(202,560)	(215,613)	(13,053)	(221,376)	(235,521)	(14,144)
Drug costs	(2,786)	(1,938)	848	(26,664)	(22,055)	4,609	(29,220)	(24,107)	5,113
Clinical supplies	(2,575)	(2,627)	(52)	(28,276)	(31,847)	(3,571)	(30,933)	(34,510)	(3,577)
Other costs	(3,529)	(4,477)	(948)	(43,571)	(43,384)	187	(45,893)	(47,495)	(1,602)
Depreciation and net impairment	(715)	(565)	150	(7,638)	(6,013)	1,625	(8,353)	(6,578)	1,775
Total operating costs	**(28,221)**	**(29,550)**	**(1,329)**	**(308,709)**	**(318,911)**	**(10,203)**	**(335,775)**	**(348,210)**	**(12,435)**
Operating surplus / (deficit)	**(826)**	**(1,239)**	**(413)**	**(2,908)**	**(19,831)**	**(16,923)**	**3,771**	**(20,200)**	**(23,971)**
Operating surplus / (deficit) %	**-3.02%**	**-4.38%**		**-0.95%**	**-6.63%**		**1.11%**	**-6.16%**	
Net finance costs and gains / (losses) on disposal	(363)	(366)	(4)	(3,985)	(4,016)	(31)	(4,340)	(204)	4,136
Actual surplus / (deficit) per annual accounts	**(1,189)**	**(1,606)**	**(416)**	**(6,893)**	**(23,847)**	**(16,954)**	**(569)**	**(20,404)**	**(19,835)**
Reverse net impairment	0	0	0	0	0	0	0	0	0
Surplus / (deficit) before impairments and transfers	**(1,189)**	**(1,606)**	**(416)**	**(6,893)**	**(23,847)**	**(16,954)**	**(569)**	**(20,404)**	**(19,835)**
Reverse capital donations/grants I&E impact	12	(99)	(111)	130	(276)	(406)	142	(259)	(401)
DEL net impairments *(damage, not revaluation)*	0	0	0	0	0	0	0	0	0
Adjusted financial performance surplus / (deficit) (AFPD)	**(1,177)**	**(1,705)**	**(527)**	**(6,763)**	**(24,123)**	**(17,360)**	**(427)**	**(20,664)**	**(20,236)**
AFPD excluding STF	**(2,212)**	**(1,705)**	**508**	**(14,602)**	**(25,254)**	**(10,653)**	**(9,302)**	**(21,795)**	**(12,492)**

Appendix 2
Statement of Financial Position (SOFP)

Actual as at 01.04.17 £k		Actual as at 31.01.18 £k	Actual as at 28.02.18 £k	Variance (monthly) £k	Plan as at 28.02.18 £k	Actual as at 28.02.18 £k	Variance (to plan) £k	Forecast 31.03.18 £k	Plan 31.03.18 £k
	Non-current assets								
145,789	Property, plant and equipment	145,680	145,821	141	144,776	145,821	1,045	149,933	145,166
12,216	Intangibles	11,522	11,479	(43)	10,321	11,479	1,158	14,666	10,080
950	Trade and other non-current receivables	867	871	4	1,612	871	(741)	881	1,612
158,955		**158,069**	**158,171**	**102**	**156,709**	**158,171**	**1,462**	**165,480**	**156,858**
	Current assets								
3,881	Inventories	4,117	4,101	(16)	4,051	4,101	50	4,101	4,051
16,389	Trade and other receivables	27,503	30,084	2,581	22,437	30,084	7,647	24,271	20,760
0	Assets held for sale [1]	595	595	0	0	595	595	0	0
5,390	Cash and cash equivalents	2,424	3,458	1,034	2,312	3,458	1,146	7,884	2,257
25,660		**34,639**	**38,238**	**3,599**	**28,800**	**38,238**	**9,438**	**36,256**	**27,068**
184,615	**Total assets**	**192,708**	**196,409**	**3,701**	**185,509**	**196,409**	**10,900**	**201,736**	**183,926**
	Current liabilities								
(31,059)	Trade and other payables	(42,362)	(43,368)	(1,006)	(34,029)	(43,368)	(9,339)	(42,016)	(32,172)
(3,341)	Other liabilities	(4,033)	(6,187)	(2,154)	(3,696)	(6,187)	(2,491)	(2,783)	(3,696)
(1,015)	Borrowings	(1,074)	(1,074)	0	(1,015)	(1,074)	(59)	(1,073)	(1,014)
(668)	Provisions	(668)	(668)	0	(664)	(668)	(4)	(668)	(664)
(36,083)		**(48,137)**	**(51,297)**	**(3,160)**	**(39,404)**	**(51,297)**	**(11,893)**	**(46,540)**	**(37,546)**
(10,423)	**Net current assets/(liabilities)**	**(13,498)**	**(13,059)**	**439**	**(10,604)**	**(13,059)**	**(2,455)**	**(10,284)**	**(10,478)**
148,532	**Total assets less current liabilities**	**144,571**	**145,112**	**541**	**146,105**	**145,112**	**(993)**	**155,196**	**146,380**
	Non-current liabilities								
(9,154)	Other liabilities	(8,869)	(8,841)	28	(8,841)	(8,841)	0	(8,813)	(8,812)
(26,708)	Borrowings	(41,536)	(43,731)	(2,195)	(33,634)	(43,731)	(10,097)	(49,257)	(27,627)
(2,221)	Provisions	(2,063)	(2,047)	16	(1,982)	(2,047)	(65)	(2,031)	(1,969)
(38,083)		**(52,468)**	**(54,619)**	**(2,151)**	**(44,457)**	**(54,619)**	**(10,162)**	**(60,101)**	**(38,408)**
110,449	**Total assets employed**	**92,103**	**90,493**	**(1,610)**	**101,648**	**90,493**	**(11,155)**	**95,096**	**107,972**
	Financed by								
	Taxpayers' equity								
72,525	Public dividend capital	76,416	76,416	0	72,525	76,416	3,891	77,575	72,525
4,575	Income and expenditure reserve	(17,662)	(19,272)	(1,610)	(3,545)	(19,272)	(15,727)	(15,829)	2,779
33,349	Revaluation reserve	33,349	33,349	0	32,668	33,349	681	33,350	32,668
110,449	**Total taxpayers' equity**	**92,103**	**90,493**	**(1,610)**	**101,648**	**90,493**	**(11,155)**	**95,096**	**107,972**

[1] The Trust is selling part of the Clatterbridge site, to complete in March 2018.

Appendix 3
Statement of Cash Flows

	Month			Year to date			Full Year	
	Actual	Plan	Variance	Actual	Plan	Variance	Forecast	Plan
	£k	£k	£k	£k	£k	£k	£k	£k
Opening cash	**2,424**	**1,963**	**461**	**5,390**	**1,752**	**3,638**	**5,390**	**1,752**
Operating activities								
Surplus / (deficit)	(1,611)	(1,190)	(421)	(23,842)	(6,893)	(16,957)	(20,404)	(568)
Net interest accrued	89	83	6	962	906	56	1,073	982
PDC dividend expense	277	277	0	3,047	3,049	(2)	2,924	3,326
Unwinding of discount	1	3	(2)	6	33	(27)	6	35
(Gain) / loss on disposal	0	0	0	0	0	0	(3,800)	0
Operating surplus / (deficit)	(1,244)	(827)	(417)	(19,828)	(2,905)	(16,930)	(20,202)	3,775
Depreciation and amortisation	565	715	(150)	6,013	7,638	(1,625)	6,578	8,353
Impairments / (impairment reversals)	0	0	0	0	0	0	0	0
Donated asset income (cash and non-cash)	(116)	0	(116)	(441)	0	(441)	(441)	0
Changes in working capital	309	1,118	(808)	(2,098)	(1,699)	(390)	(6,124)	(270)
Other movements in operating cash flows	0	0	0	0	0	0	0	0
Investing activities								
Interest received	6	7	0	36	75	(39)	44	82
Purchase of non-current (capital) assets [1]	(680)	(664)	(16)	(4,431)	(7,301)	2,870	(5,095)	(7,964)
Sales of non-current (capital) assets	0	0	0	0	0	0	4,395	0
Receipt of cash donations to purchase capital assets	0	0	0	40	0	40	40	0
Financing activities								
Public dividend capital received	0	0	0	3,891	0	3,891	5,050	0
ITFF loan principal drawdown	0	0	0	0	0	0	0	0
Support funding [2] principal drawdown	2,200	0	2,200	17,334	7,434	9,900	23,373	9,600
ITFF loan principal repaid	0	0	0	(508)	(508)	0	(1,015)	(1,014)
Support funding [2] principal repaid	0	0	0	0	0	0	0	(7,666)
Interest paid	0	0	0	(502)	(510)	9	(1,113)	(1,064)
PDC dividend paid	0	0	0	(1,373)	(1,663)	290	(2,924)	(3,326)
Capital element of finance lease rental payments	(5)	0	(5)	(55)	0	(55)	(59)	0
Interest element of finance lease rental payments	(1)	0	(1)	(11)	0	(11)	(12)	0
Total net cash inflow / (outflow)	**1,034**	**348**	**686**	**(1,932)**	**560**	**(2,491)**	**2,494**	**505**
Closing cash	**3,458**	**2,312**	**1,147**	**3,458**	**2,312**	**1,147**	**7,884**	**2,257**

[1] Outflows due to the purchase of non-current assets are not the same as capital expenditure due to movements in capital creditors.
[2] Support funding currently comprises a working capital facility, and 'uncommitted loans', issued by DHSC and administered by NHSI.

BOARD OF DIRECTORS	
Agenda Item	6.2
Title of Report	Strategic Planning Update
Date of Meeting	28th March 2018
Author	Terry Whalley
Accountable Executive	David Jago
BAF References	Risks 13, 14, 15
Level of Assurance	N/A
Purpose of the Paper	Discussion
Reviewed by Assurance Committee	None
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken	Not required

1. **Executive Summary**

   This paper serves to provide the Board with an update on Strategy for discussion at March's board. Board colleagues are invited to discuss this paper and ask any questions or confirm further assurances that may be required.

2. **Background**

   Previously, we agreed our Big 5 priorities.

   1. Our People
   2. Clinical Leadership, Quality & Safety
   3. Improving our Standards, doing our basics brilliantly
   4. Place Based Collaboration (Healthy Wirral)
   5. Acute Care Collaboration (Wirral & West Cheshire Alliance)

   The first three relate to areas within our own gift. The last two relate to broader collaboration vertically with partners in Wirral and horizontally with acute partners across Cheshire & Merseyside with particular emphasis on Countess of Chester.

3. 2018/19 Planning

The national planning guidance, received on 2nd February, required first draft operating plans and accompanying plan narrative to be submitted to NHSI by 8th March with final Board approved plans to be submitted by 30th April. We are required to submit a narrative on *updates* to the two year plan together with a full suite of operating plan submissions to the deadlines in the published national timetable as set out in Refreshing NHS plans for 2018/19, and also adhere to the contract variation deadlines and processes. While it is not necessary to provide a revised version of the full two-year operational plan narrative that was produced last year, we agreed at February Board that it would be beneficial for us to refresh our plan narrative to ensure relevance going into next year, but with additional focus on providing clarity on key changes in terms of activity, quality, workforce and finance.

Appendix 1 contains the operating plan narrative that we submitted to NHSI on 8th March alongside required detailed template submissions.

This plan narrative will be updated in line with revisions to operating plan details based in part on emerging detail from divisional planning, in part from contracting discussions with Wirral CCG and in part on discussions with NHSI regarding our control total. See Appendix 2 for reminder of key dates ahead of April 30th submission deadline.

Board members are requested to discuss the draft operating plan submission, and confirm any additions or changes that may be required ahead of final draft coming to Public Board in April for Board approval.

4. 2018/19 Strategy

We recognise that the Trust needs a clear strategy. The Trust last produced a strategy back in 2015, covering the period 2016-2021. This was updated in the publication *'Locally Focussed, Regionally Significant: an updated on our strategy (2016-2021)'*, published early in 2017.

Based on this extant strategy and body of work, and perhaps given the circumstances of the last few months, we discussed and agreed at February Board, that our identifier, used to underpin our external narrative, would continue to be ***Wirral University teaching Hospital, #PROUD to care for you.***

We also agreed that our PROUD Values going into 2018/19 would remain unchanged, but that we will focus on the first two in particular;

- **Patient Focus**
- **Respect**
- Ownership
- Unity
- Dedication

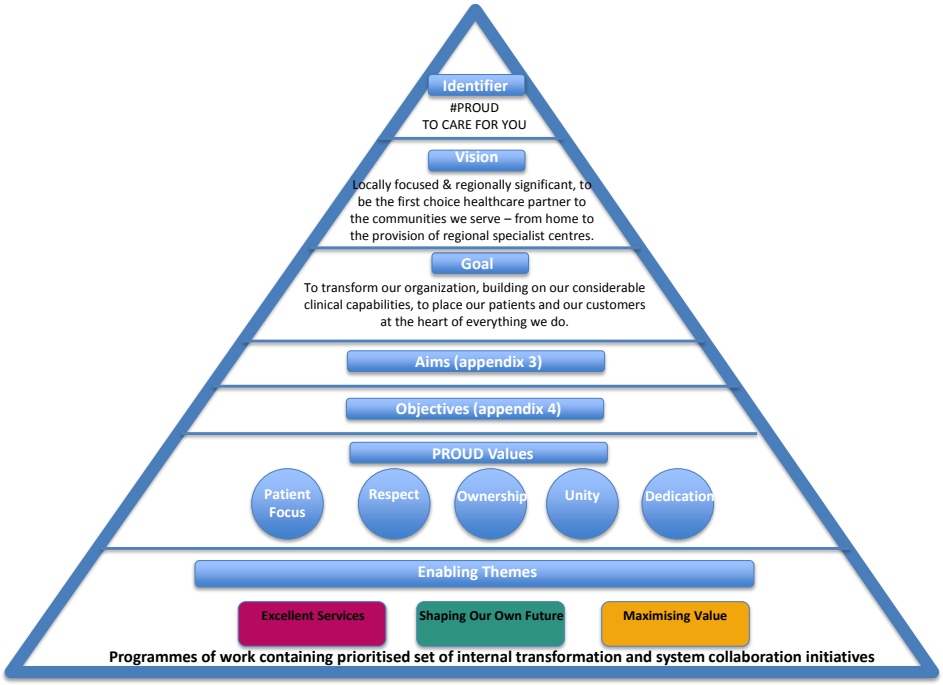
We also agreed that our vision going into 2018/19 would remain unchanged;

Our Vision is to be locally focused and regionally significant and '**to be the first choice healthcare partner to the communities we serve – from home to the provision of regional specialist centers'**

- **Locally focused**, we are committed to our community and working with our partner organisations to provide the best possible care.
- **Regionally significant**, we aspire to be the hospital of choice for patients.

Finally, we agreed our goal going into 2018/19 remains unchanged; '*Over the next 5 years we will work together to transform our organisation, building on our considerable clinical capabilities, to place patients and our customers at the heart of everything we do*'.

While recognising that we need a strategy, we must be clear about what that means. Our strategy should be a coherent set of actions with a reasoned chance of achieving the outcomes we might describe as being true in our compelling future state vision. It might be said that we have lacked the space, time, appetite and even permission to really explore what our future state vision is. At the same time, following publication of five year forward view, the C&M Sustainability & Transformation Plan with associated Local Delivery System Plans, the recently published Wirral CCG Strategy, the 2017 relaunch of Cheshire & Merseyside Health & Care Partnership, the emerging Wirral Place focus and divergence of 'Lock Ins' from extant Healthy Wirral governance, there has been much shift in the landscape around us.



We must now though recognise the urgency to clarify our vision for the future and the coherent set of actions with a reasoned chance of achieving. The picture above shows how we intend to create a golden thread to link our (current) vision and goal through a series of aims and objectives to well defined programmes of work within the 3 enabling themes 'Excellent Services', 'Shaping our Future' and 'Maximising Value', these being the themes set out in the 2017 strategy update and which currently underpin much of the communication we undertake with colleagues.

While these overarching elements may not have changed, we have agreed a refreshed set of strategic aims which we believe better frame our priorities going into 2018/19. It might be helpful to consider these as being the outcomes we believe would be true if our future state vision were true. This approach may a) help to build out the detailed programmes of work that will drive us forward from given reality of today, and b) help to inform a revised and more compelling / engaging vision.

Our strategic aims are listed below, and **appendix 3** sets these out alongside a set of 'indicators' which will serve to illustrate if we are making progress against these aims. Each indicator will have a starting position based on 17/18 performance, a target for

18/19 which will be our definition of what good likes like over next 12 months, and a '2020 aim' which will be our aspiration when our future state vision is real. We will use the integrated performance dashboard to provide a view to the Board of performance.

1. **We are** rated the best NHS Trust in the region, because our staff, and the patients who use our services, say we are
2. **We consistently deliver** safe, high quality, locally accessible services with health outcomes that compare with the best.
3. **We provide** safe, high quality, locally accessible services in partnership with primary, social and community care, now and in the future
4. **We put** our people first so they can put our patients first, and we **create** our workforce of tomorrow by investing in the workforce of today
5. **We excel** in a quality improvement / learning culture that allows us all to reduce unwarranted variation and constantly improve our services
6. **We are** a national exemplar for transforming care through innovation and technology
7. **We make** the best use of the public resources we have to deliver high quality, locally accessible services that are clinically & financially sustainable

These aims will frame a set of SMART objectives which will inform our priority work programmes sitting within the 3 areas 'Excellent Services', 'Shaping Our Own Future' and 'Maximising Value'. These draft objectives are described in **appendix 4**.

Finally, the aims and objectives will be triangulated with a refreshed Board Assurance Framework, allowing a comprehensive and effective link between our strategic aims, our most significant risks and the detailed in-year objectives and programme of work.

5. Wirral & West Cheshire Alliance

Previously, we reconfirmed some fundamental principles which we aim to use to guide our Wirral & west Cheshire Alliance work going forward-

- We will behave and act like one organisation delivering services in two locations
- We aim to share leadership, clinical and managerial, where appropriate
- We strive to ensure we can continue to deliver high quality, locally accessible, clinically & financially sustainable services

On that basis, we agreed some high level Goals -

- We will co-design care delivery for the next 70 years, delivered in a setting relevant to patient and service need
- We will reduce unwarranted duplication and variation and maximise resilience
- We will enable highest levels of public, clinical & commissioner engagement

West Cheshire & Wirral CCGs have now formally commissioned WUTH and COCH to produce a joint Wirral & West Cheshire Clinical Strategy, see **appendix 5** for this commission and our initial response. **Appendix 6** sets out the draft proposal we intend to go back to the CCGs with as part of a fuller response.

6. Recommendation

Board colleagues are invited to discuss this paper and ask any questions or confirm further assurances that may be required.

Appendix 1 – 18/19 Operating Plan Narrative (DRAFT submitted 8th March)

Appendix 2 – 18/19 Planning Timetable

Key actions & milestones for 18/19 planning and contracting processes	Date	Notes
Planning Guidance Published	2nd Feb	
TSG review planning guidance	6th Feb	
SPPG review planning guidance, revised 18/19 planning timetable and strategic initiative development	9th feb	Use to prioritise those schemes which should be included in 18/19 sustainability plan with indicative opportunity
Feedback from divisional ideas generation and budget review sessions to be fed into sustainability plans	By 14th Feb	To be incorporated in paper to FBPAC which will need to go 16th Feb
Finance/ STT agreement of which of sustainability programmes can be badged as CIP	By 14th Feb	To be incorporated in paper to FBPAC which will need to go 16th Feb
Opportunities to be agreed with all exec programme sponsors/ leads	By 14th Feb	To be incorporated in paper to FBPAC which will need to go 16th Feb
F&PG review operational plans and budgets	21st Feb	
FBPAC review of 18/19 operating plans	23rd Feb	Get confirmation of CIP requirement to be shown in NHSI plan
Board first review of draft 18/19 operating plans	28th Feb	
Exec review of strategic priorities and draft operating plan	1st Mar	Use for Exec check and challenge session of sustainability plan for inclusion in NHSI return?
First draft NHSI efficiency tab completed	2nd March	In to support bridges etc. in rest of template subject to change post TSG review
TSG Review 18/19 Transformation Hopper	6th Mar	Use for sign off of first draft submission to NHSI?
Draft 18/19 Organizational Operating Plans submitted to NHSI	8th Mar	
Draft 18/19 STP triangulation template submitted	8th Mar	
SSPG review of strategic / transformational initiatives	9th Mar	
Exec review of strategic priorities, operational plan narrative, POAPS and 18/19 operating plans	15th Mar	
F&PG review operational plans and budgets	21st Mar	
National deadline for signing 18/19 contract variation and contracts	23rd Mar	
FBPAC review of strategic priorities, operational plan narrative, POAPS and operating plans	23rd Mar	
Board review of strategic priorities, operational plan narrative, POAPS and operating plans	28th Mar	
Exec review of strategic priorities, operational plan narrative, POAPS and 18/19 operating plans	29th Mar	
Governors review of strategic priorities, operational plan narrative, POAPS and 18/19 operating plans	10th Apr	
Exec review of strategic priorities, operational plan narrative, POAPS and 18/19 operating plans	12th Apr	
SSPG review of strategic priorities, operational plan narrative, POAPS and 18/19 operating plans. Sign off operational plan narrative.	13th Apr	
F&PG review of strategic priorities, operational plan	18th Apr	

narrative, POAPS and 18/19 operating plans. Sign off operational plan.		
TSG review of strategic priorities, operational plan narrative, POAPS and 18/19 operating plans	19th Apr	
FPBAC approval of strategic priorities, operational plan narrative, POAPS and 18/19 operating plans	20th Apr	
Board sign off of strategic priorities, operational plan narrative, POAPS and 18/19 operating plans	25th Apr	
Final Board or Governing Body approved Organisation Operating Plans submitted	30th Apr	

Appendix 3 – Strategic Aims and Indicators

Strategic Aims		Key Indicators		Board Director Ownership
1	**We are** rated the best NHS Trust in the region, because our staff, and the patients who use our services, say we are	1A	Friends & Family Test IP recommendation	Director of Nursing & Midwifery
		1B	Friends & Family Test IP Non Recommendation	Director of Nursing & Midwifery
		1C	RTT - Incomplete 18 weeks	Director of Operations
		1D	RTT - 52 Week Waiters	Director of Operations
		1E	RTT Admitted < 18 weeks	Director of Operations
		1F	RTT non-admitted < 18 weeks	Director of Operations
		1G	Outpatient Appointment Scheduling Issues	Director of Operations
		1H	Outpatient Waiting List - Total Waiting	Director of Operations
		1I	Diagnostic six-week standard	Director of Operations
		1J	Elective admission waiting list	Director of Operations
		1K	Complaints received	Director of Nursing & Midwifery
		1L	Complaints response time	Director of Nursing & Midwifery
		1M	Stage 2 Complaints	Director of Nursing & Midwifery
		1N	Mixed Sex Accommodation Breaches	Director of Nursing & Midwifery
		1O	Staff satisfaction score	Director of Workforce
2	**We consistently** deliver safe, high quality, locally accessible services with health outcomes that compare with the best	2A	Health Outcomes (Key Measures from Quality Dashboard)	Medical Director
		2B	Cancer 62 day referral to treatment	Director of Operations
		2C	Cancer 62 day screening to treatment	Director of Operations
		2D	Cancer 31 day to treatment standard	Director of Operations
		2E	Cancer - Urgent 2 week referral	Director of Operations
		2F	Cancer - Breast symptom Referrals	Director of Operations
		2G	Ambulance Turnaround > 30 minutes	Director of Operations
		2H	Ambulance Turnaround > 60 minutes	Director of Operations
		2J	4 Hour standard	Director of Operations
		2K	MRSA bacteraemia bloodstream infection (BSI)	Director of Nursing & Midwifery
		2L	Escherichia coli (E. coli) bacteraemia bloodstream	Director of Nursing & Midwifery
		2M	C Difficile Avoidable Cases	Director of Nursing & Midwifery
		2N	Breast Feeding rate	Director of Nursing & Midwifery
		2P	Avoidable Pressure Ulcers (Grade 2 and above)	Director of Nursing & Midwifery
		2Q	Avoidable Falls with Moderate / Greater Harm	Director of Nursing & Midwifery
		2R	WUTH Harm Free Care - Safety Thermometer	Director of Nursing & Midwifery
		2S	Hospital Standardised Mortality Rate (HSMR)	Medical Director
		2T	Summary Hospital Mortality Indicator (SHMI)	Medical Director
3	**We provide** safe, high quality, locally accessible services in partnership with primary, social and community care, now and in the future	3A	Unplanned admissions for chronic conditions	Director of Operations
		3B	emergency admissions for acute conditions	Director of Operations
		3C	Non elective admissions	Director of Operations
		3D	Avoidable readmissions	Director of Operations
		3E	Admissions from nursing homes	Director of Operations
		3F	Unplanned / Emergency admission during last year of Life	Director of Operations
		3G	Medically Optimised Patients	Director of Operations
		3H	Delayed Transfers of Care	Director of Operations
		3J	Stranded Patients	Director of Operations
		3K	Patient Streaming	Director of Operations
		3L	Length of Stay	Director of Operations
		3M	ED attendances	Director of Operations
4	**We put** our people first so they can put our patients first, and **we create** workforce of tomorrow by investing in the workforce of today	4A	Staff Attendance rate	Director of Workforce
		4B	Number of Managers trained in Coaching	Director of Workforce
		4C	Number of Leadership Courses	Director of Workforce
		4D	Completion of Equality Delivery System goals 1-4	Director of Workforce
		4E	Turnover rates	Director of Workforce
		4F	Substantive Medical Vacancy Rate	Director of Workforce
		4G	Sustantive Nurse Vacancy rates	Director of Workforce
		4H	Non core staff usage	Director of Workforce
		4J	Mandatory Training	Director of Workforce
		4K	Appraisal Rate	Director of Workforce
		4L	Appraisal Quality	Director of Workforce
		4M	Bullying and Harrassment Training	Director of Workforce
		4N	Bullying and harrasment experienced	Director of Workforce
		4P	Wellbeing Indicator	Director of Workforce
		4Q	Staff Mood Indicator	Director of Workforce
		4R	Staff satisfaction scores	Director of Workforce
5	**We excel** in a quality improvement / learning culture that allows us all	5A	Pathway variations (Sepsis, FNoF, Stroke)	Medical Director
		5B	Number of evidence based clincial pathways	Medical Director
6	**We are** a national exemplar for transforming care through innovation and technology	6A	EPR Digitization	CIO
		6B	HIMMS Level	CIO
		6C	Paperless metric	CIO
		6D	Population Health registries	CIO
		6E	LTC Health care record exceptions	CIO
		6F	Data Quality Kitemark	CIO
		6G	R&D Metrics	Medical Director
		6H	Digital Maturity Index	CIO
7	**We make** best use of the public resources we have to deliver high quality, locally accessible services that are clinically & financially sustainable	7A	Liquidity Days	Director of Finance
		7B	I&E Performance	Director of Finance
		7C	CIP	Director of Finance
		7D	Pay Expenditure	Director of Finance
		7E	Agency Expenditure	Director of Finance
		7F	Agency Cap Breaches	Director of Finance
		7G	NHSI Single Oversight Framework (SOF) Segment	Chief Executive Officer
		7H	NHSI Use of Resources Rating (UoR)	Director of Finance
		7J	Capital Expenditure	Director of Finance
		7K	CQC Quality Rating	Medical Director
		7L	Surplus / Deficit	Director of Finance

Appendix 4 – 18/19 Objectives

Ref	Link to Aim	Owner	2018 SMART Objective Description	Link to BAF
1	1, 2, 3	Medical Director	We deliver safe & timely care with a focus on continuous improvement to ensure we always deliver safe high quality care.	1, 2
2	2, 3	Medical Director	We continue our programme to reduce unwarranted variation in clinical services based on a risk based set of priorities.	1, 6
3	1,4	Medical Director	We will change how the Trust is led & managed to ensure that clinicians lead service design and delivery and that other professionals at all levels are developed to maximise their strengths and our collective ability to deliver safe services in a semi-autonomous way that enables our journey to more accountable care.	15, 19
4	3	Director of Strategy & Sustainability	Establish a robust, cohesive governance & accountability framework with associated programme of work that effectively links place based integrated care, collaboration (vertical & horizontal) and Trust specific initiatives into Cheshire Merseyside Health & Care Partnership plans.	13
5	3	Director of Strategy & Sustainability	In partnership with Healthy Wirral partners, create a credible plan to deliver placed based integrated care system in Wirral	14
6	3	Director of Strategy & Sustainability	Establish and embed the Wirral & West Cheshire Alliance in partnership with Countess of Chester Hospital, defining a unitary Wirral & West Cheshire Clinical Strategy and delivering health, care and value benefits in 18/19	13
7	6	Director of Informatics	Deliver current GDE work programmes according to NHS Digital agreed programme plan.	16, 20
8	7	Director of Finance	Reduce unwarranted variation to safely release costs, establish sustainable clinical networks and provide a framework for the WUTH team to deliver transformational change.	6, 8
9	7	Director of Finance	Reduce our Estates non clinical footprint and meet ERIC benchmark & other Carter targets	5, 17
10	7	Director of Finance	Achieve clinical productivity efficiencies/targets in line with Model Hospital and GIRFT	5, 6
11	2, 5	Medical Director	We will improve the quality of acute care across surgical and medical specialties, using evidence based practice such as the national Getting It Right First Time (GIRFT) programme to determine specialty specific plans.	1, 5
12	1	Director of Nursing & Midwifery	As part of a defined Patient Engagement Strategy, we will increase the quantity & quality of patient feedback, especially in areas with high volumes of patient contacts, so that we can learn what matters to patients and identify opportunities for improvement.	2
13	2	Director of Nursing & Midwifery	We deliver safe care with no avoidable harm to patients.	1
14	2	Medical Director	We review 100% of hospital mortalities and we always undertake a more detailed structured review where warranted so that we can identify any learning and imporvement opportunities and so reduce the risk of future lapses in care.	1
15	2	Director of Nursing & Midwifery	We avoid harming patients through avoidable infections such as MRSA, C-difficil, CPE, VRE and MSSA by always detecting rapidly, isolating effectively and doing the infection prevention basics brilliantly	1, 12

Ref	Link to Aim	Owner	2018 SMART Objective Description	Link to BAF
16	1	Director of Nursing & Midwifery	We have an open and easy to access mechanism for complaints. We always acknowledge, respond, resolve and learn in a timely way. We avoid the need for level 2 complaints to Ombudsman.	2
17	2	Director of Operations	We will deliver safe & timely care, meeting performance agreed against all NHS constitutional standards for access & quality, including waiting times in A&E, referral to treatment time and cancer care throughout the year	9, 10, 11
18	2, 5	Medical Director	We use our review of our compliance with the 4 national clincial standards for 7 day working to agree & execute a credible and sustainable plan to close gaps.	15
19	3, 6	Director of Informatics	We will implement new models of integrated care, building on respiratory and diabetes models, to include additional pathways supported by Healtheintent platform.	14
20	2, 3	Chief Operating Officer	We will implement a Wirral & West Cheshire Urology Service to enable patients to access high quality, local and sustainable urology services	14
21	7	Director of Finance	Develop a credible plan for utilising clatterbridge estate more effectively based on a 3-5 year 2 site strategy. In doing so, reduce variation with Clatterbridge becoming a colder site focused on elective, day case and rehab activity enabling Arrowe Park to reconfigure effectively in support of safe timely emergency / non elective work.	15
22	3, 7	Director of Strategy & Sustainability	Clinical and non-clinical support services: We will define the opportunity and associated roadmap for consolidating corporate services within Wirral, and for potentially extending elements of consolidation beyond Wirral	13
23	3	Director of Strategy & Sustainability	**The Wirral health and social care system:** We will agree with our local partners plans for the integrated planning and delivery of primary, community, social and hospital services. In particular, we will develop closer strategic and operational links with primary care.	14
24	4	Director of Workforce	**Creating a Compassionate Culture:** We will have defined and established a set of behaviours that support the organisation's values and allows high levels of engagement with the workforce ensuring every voice counts. We will have created a culture where innovation flourishes and effective team work is the norm.	3
25	4	Director of Workforce	**Securing a Sustainable Workforce:** We will have in place a programme of recruitment events to appoint high calibre employees as well as introducing modern recruitment practices. We will also have a plan of retention activities that include supporting newly qualified professionals to undertake their roles in the organisation and creating clear career pathways from apprentice to professional and continue to make better use of roles such as ANP and Associate Physician	3, 7
26	4	Helen Marks	**Creating a Learning Organisation:** We will have designed and implemented an education strategy that is patient centred incorporating the use of E-learning and the effective use of practice educators. The trust will also be promoting research across the organisation.	3
27	4	Director of Workforce	**Compassionate leadership:** We will have shaped compassionate leaders at every level of the organisation, cultivated coaching conversations across the organisation and supported mentoring and buddying activities throughout the trust	3
28	7	Director of Finance	Define and implement an estates plan to meet our service development plans and/or enable our corporate / divisional transformation agenda.	17
29	7	Director of Finance	Prioritise finite capital resources to minimise risk to the Trusts estate, focussing in particular on the things that keep colleagues and patients safe, and address concerns raised in previous CQC inspection.	17
30	7	Director of Finance	As part of Healthy Wirral, we will develop "One Public Estate" principles across Wirral to enable definition of future state vision to maximise ues of public assets	

Ref	Link to Aim	Owner	2018 SMART Objective Description	Link to BAF
31	7	Director of Finance	We will work with local partner agencies to maximise the use of NHS and local authority premises.	17
32	6	Director of Informatics	Hospital will achieve HIMSS7 acreditation by 2019. GDE payments continue to provided resulting from delivery of the progrmme	16, 20
33	3, 6	Director of Informatics	Current work programmes will deliver according to programme plan. - full data sets from GPs, WCT and WUTH by 31/3/2018. - first round of reports to HWEDG to agreed community wide KPIs delivered - 5 pathways live in Millennium - WCR in use in new care models for Diabetes, COPD and Asthma and 5 new registries in place	14, 16, 20
34	6	Director of Informatics	**IT Infrastructure -** Ensuring capabable, resilient IT infrastructure and services. Proof of security provided by audit. Business continuity and Disaster recovery tested. Compliance with GDPR.	16 & 20
35	6	Director of Informatics	once COCH has signed up to Cerner, we will start to work on bringing the IT and Informatics service together across the two hospitals	13, 14, 16 & 20
36	4	Director of Finance	Deliver new agile ways of working to ensure a more sustainable workforce model that improves staff experience and minimises non-clinical space.	
37	3, 7	Director of Strategy & Sustainability	We will establish a Wirral & West Cheshire Pathology Service with a clear roadmap for improvement across all pathology services that is a significant part of the North 4 Pathology Network.	
38	1, 2, 3	Medical Director	We will establish a Wirral & West Cheshire Women & Children's service in collaboration with Countess of Chester, and with local Wirral providers in primary & secondary care, that transforms provision of services and that influences NHS Cheshire & Merseyside regional models of care	
39	5	Medical Director	We embed a safety culture with a focus on always events to avoid never events, and on making it easy to do the right thing and really hard to do the wrong thing.	
40	4	Director of Workforce	**Healthy working environments.** We will have defined a framework that promotes the health and wellbeing of our employees, our patients and our communities. Every employee will be supported to improve their health and wellbeing and to make every contact count in relation to discussions with our patients in relation to health and wellbeing. We will be role models to our communities through involvement with the health and wellbeing agenda	
41	4	Director of Workforce	**An Inclusive organisation.** We will demonstrate commitment to Equality, Diversity and Human Rights legislation to ensure that it gives due regard to meeting the Public Sector Equality Duties (PSED) both generally and specifically	
42	1, 2, 3	Chief Operating Officer	We deliver Arrowe Park Urgent Treatment Centre by April 2019 in line with agreed Wirral Urgent Care Plan	
43	3	Director of Strategy & Sustainability	We will, in conjunction with Healthy Wirral Partners, define and agree a credible plan to enable delivery of integrated care systems.	
44	1, 2, 3, 7	Medical Director	Together with colleagues at Countess of Chester and in line with requirement from Commissioners, we create a single integrated Wirral & West Cheshire Clinical Strategy	

Appendix 5 – Wirral and West Cheshire Clinical Strategy

Commission from CCG

Appendix 6 – Wirral and West Cheshire Clinical Strategy

Provider Proposal (draft for discussion)

Operational Plan Narrative 2018/19

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1. Trust Summary

2017/18 was a challenging year for the Trust. While making strong progress on patient safety and quality agenda and developing closer collaborative working relationships within our health economy and the broader Cheshire & Merseyside Health & Care Partnership, the Trust's financial performance was materially adverse to plan and there were concerns raised about leadership, behavioural, governance and cultural issues at the Trust. Subsequently, both the CEO and the Chair left the Trust and the Trust now has in place an Interim Chair and Acting CEO.

Following these concerns, The Trust commissioned an independent listening exercise with colleagues in our Emergency Department, and in parallel, NHSI undertook an independent review into leadership, behaviour, governance and culture which was published early March 2018, just prior to submission of this initial plan narrative.

The review, commissioned by NHS Improvement, examined issues raised about the trust during 2017 and NHS Improvement's handling of these concerns when they were raised with NHS Improvement's regional team. The Trust has welcomed the findings of the independent investigation by NHS Improvement, and also the report into culture in our Emergency Department.

This has been a challenging period for the Trust. The Trust's immediate priority and focus going into 2018/19 is to now work through both reports so collectively an action plan can be produced on how we take any required positive steps forward. Much of this work has already started, as described in this plan narrative, and much further action will be identified as we go through these reports.

Our 2018/19 plans build on the following key elements.

Our identifier, used to underpin our external narrative, continues to be ***Wirral University Teaching Hospital, #PROUD to care for you.***

While our PROUD Values going into 2018/19 remain unchanged, our intention will be to focus on the first two in particular;

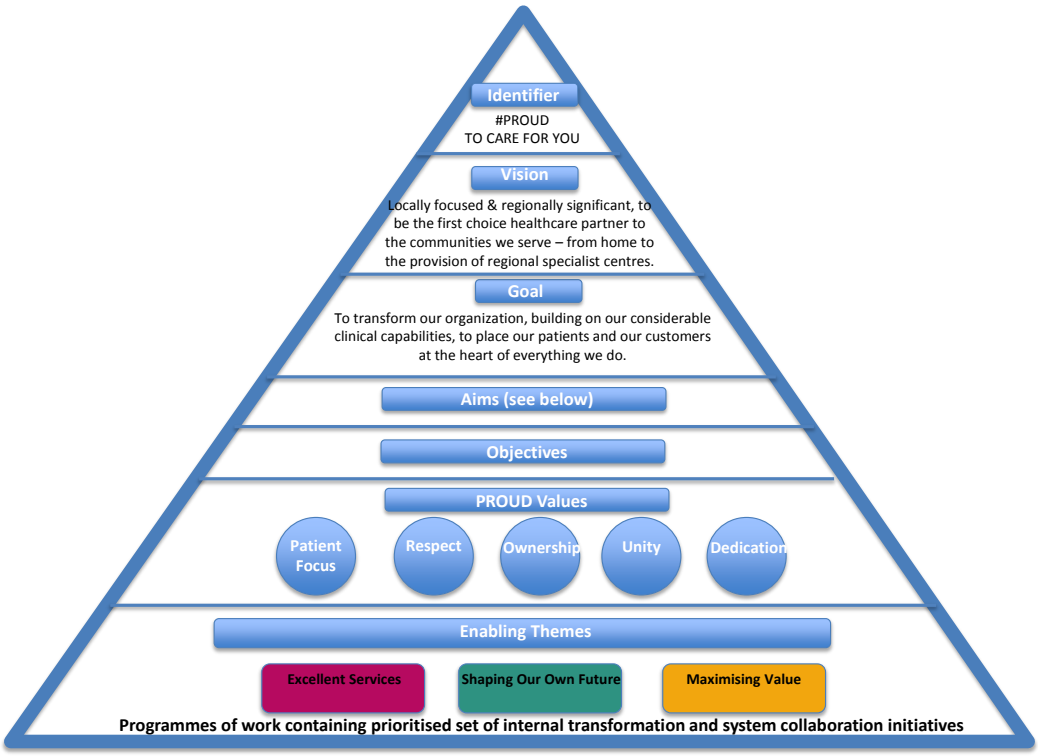
- **Patient Focus**
- **Respect**
- Ownership
- Unity
- Dedication

Our vision going into 2018/19 remains unchanged; **Our Vision is to be locally focused and regionally significant** and '**to be the first choice healthcare partner to the communities we serve – from home to the provision of regional specialist centres'**

- **Locally focused**, we are committed to our community and working with our partner organisations to provide the best possible care.
- **Regionally significant**, we aspire to be the hospital of choice for patients.

Our colleagues, and the services we provide, are helping us to achieve that Vision.

Our goal going into 2018/19 remains unchanged; 'Over the next 5 years we will work together to transform our organisation, building on our considerable clinical capabilities, to place patients and our customers at the heart of everything we do'.



While these overarching elements have not changed, we have agreed a refreshed set of strategic aims which we believe better frame our priorities going into 2018/19.

1. **We are** rated the best NHS Trust in the region, because our staff, and the patients who use our services, say we are
2. **We consistently deliver** safe, high quality, locally accessible services with health outcomes that compare with the best.
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5. **We excel** in a quality improvement / learning culture that allows us all to reduce unwarranted variation and constantly improve our services
6. **We are** a national exemplar for transforming care through innovation and technology
7. **We make** the best use of the public resources we have to deliver high quality, locally accessible services that are clinically & financially sustainable

We recognise that we start from a different place against some of these aims. For example, number 6, we are already recognised as a Global Digital Exemplar, and so our focus is on going further, faster enabling new care models through use of technology. Whereas for number 1, we start from a position based on 2017 staff engagement of below average so we have more work to do to achieve this aim and the journey will take more than a year.

To evidence progress, these aims connect to a series of **indicators** which we aim to provide visibility on through our integrated dashboard. They will also frame a set of **objectives** which will inform our priority work programmes sitting within the 3 areas 'Excellent Services', 'Shaping Our Own Future' and 'Maximising Value'**.**

All of this will then provide a line of sight link between our Trust vision, aims, objectives and our prioritised programme of work to meet our clinical & financial sustainability challenge.

2. Activity Planning

The Trust recognises that a fundamental requirement of the 2018/19 planning round is for providers and commissioners to have realistic and aligned activity plans, and that these are in turn consistent with broader Cheshire & Merseyside Health & Care Partnership (formerly Cheshire & Merseyside STP) planning assumptions. Our approach this planning round has sought to support this.

2.1 Elective Planning

For elective activity planning the Trust has adopted the use of the national benchmarking data available via the Model Hospital portal, NHS Interim Management and Support (IMAS) capacity and demand tool. The use of this model has been jointly agreed with our main commissioner (NHS Wirral CCG), and identifies areas of over/under capacity and supports the divisions in maximising operational productivity. This has been assessed against 18 week trajectories to ensure capacity is in place for any contracted key performance indicators.

The approach using the IMAS tool has been:

- An initial internal validation of the IMAS tool by comparing outputs from the tool to previous annual activity outputs to ensure no major or significant discrepancies
- Using the IMAS tool to model elective capacity at individual specialty level (reflecting Consultant job planning level) with clinical and managerial engagement
- Using the IMAS tool to ensure capacity is modelled at each point of delivery, e.g. first outpatient attendance, follow up outpatient attendance, outpatient procedure and elective spell (inpatient or day case)
- Clinical and Managerial specialty “sign off” of outputs of the model
- Divisional “check and challenge” of IMAS outputs with Finance and the Service Transformation Team
- Executive “check and challenge” of IMAS outputs

Following this approach the capacity outputs have provided the Trust with realistic data in order to inform the contracting round, specifically considering additional capacity that may be required in specialty areas to support any activity backlog to deliver 18 week Referral To Treatment (RTT) compliance, adhering to national planning guidelines.

The work done on IMAS will allow more accurate planning with commissioners in order to consider any future growth, changes in referrals due to commissioning intentions (e.g. procedures of limited clinical priority) and compliance with national elective standards (18 weeks RTT and Cancer targets). This approach will allow an understanding for contracting with commissioners to deliver agreed levels of activity in line with constitutional standards.

Most of the improvements have focussed on effective theatre utilisation and productivity of theatre teams. A theatre dashboard has been developed and uses information to drive prospective planning of theatre sessions and retrospective review to inform future planning. A newly established Theatre Resource Group is the mechanism for delivering and monitoring elective care reform and improvements.

2.2 Non Elective Planning

The Trust continue to use several approaches as part of the wider health and social care economy to ensure greater success as part of non-elective planning. This will also reference the new planning guidance for elective which concentrates on zero growth in waiting list size from March 18 to 19 as opposed to achieving RTT. We will determine with our Commissioners the extent to which we maintain current performance versus closing the gap. As a current outlier on RTT, we need to ensure we get the balance right on this.

Internally as part of a wider patient flow work stream a specific bed modelling programme has been refreshed to review bed capacity related to non-elective demand. This work is supported by the Trusts Service Transformation Team and takes into account recommendations made from the Emergency Care Intensive Support Team (ECIST) and the SAFER flow bundle.

Externally the Trust continue to work in partnership with NHS Wirral CCG and the wider health and social care economy in order to better understand non elective demand and capacity on a whole system footprint via:

- Urgent Care and Elder Care Value Stream Analysis
- Health economy review of admission avoidance and discharge
- A series of strategic workshops to explore the potential for a system control total to enable system balance of the finances

2.3 Surge planning

The Trust is working with health and social care partners to align community and acute bed provision to ensure only those patients who require acute medical care remain within acute inpatient beds. As part of this work the economy will also ensure robust practice to manage any surge experienced with non-elective demand. This is in addition to our already established internal escalation plans and statutory resilience plans.

2.4 Winter Planning

Winter plans are being developed to ensure that the trust and the broader health economy are better placed than ever to cope with anticipated demand. Further detail will be included in final April 30th submission and following publication of Winter Planning Guidance, with final Winter Plan submission on 30th June.

2.5 Developing our planning capabilities further

Moving forward through 2018/19 the Trust, as a Centre for Global Digital Excellence will be seeking to develop ways of assessing and managing capacity and demand in real and predictive time in order to support elective and non-elective planning for the whole health and social care economy and be looking to share this learning system wide.

2.6 Key Operational Risks

The key operational risks to the delivery of the operational plan 2018/19 are summarized below. These would pose a risk to delivery of NHS Constitutional standards for urgent care and referral to treatment targets:

- Unplanned growth in demand (elective and non-elective). The Trust is reliant on partners implementation of demand management schemes, e.g. reducing non elective attendances and admissions in line with Right Care and Emergency Care Pathway, the failure of implementation of procedures of limited clinical value at commissioner level will impact on planned activity levels
- Managing the loss of intermediate care capacity and any further unplanned reductions
- Market vulnerability of independent sector of domiciliary care, care homes and detox provision
- Unplanned events, e.g. Junior Doctor Industrial action, Flu, Major incidents, Infection Prevention and Control issues
- Challenges with lack of system wide implementation of Better Care Fund which impacts on out of hospital care and reablement.
- Consultant workforce challenges in specific specialities and gaps in Junior Doctor rotas across Medicine as a whole.
- Bandwidth and leadership to manage internal and external system wide transformation.

The Trust hosts the Chair role of the A&E Delivery Board and as such will have opportunity to proactively manage key operational risks. Furthermore the Trust is working with health and social care partners towards the creation of an Accountable Care Organisation in order to increase operational accountability and whole system strategic planning.

3. Quality planning

3.1 Approach to quality improvement

The Lead Executive for Quality Improvement is the Medical Director.

The Trust is currently implementing the GIRFT recommendations for Obstetrics and Gynaecology following from the presentation received in October 2017. Specific areas of focus include 'new to follow up' ratios and improved use of clinical techniques that reduce length of stay. In April 2018 the Trust will receive its GIRFT report for Paediatric surgery and will produce an action plan to address any issues raised. The Surgery Division has action plans in place for T&O, ENT and Urology following the most recent GIRFT visits. The actions identified have been further enhanced by a priority matrix review of clinical variation at a more granular level. The outputs of the priority matrix review are scheduled for presentation to the Divisional Triumvirate at the end of March and will inform more detailed plans for 18/19 improvement. Since the last General Surgery GIRFT visit, we have introduced an Emergency Surgical Assessment Unit employing 5 Emergency Surgeons. Improvements on performance include a reduction in length of stay, admission avoidance with patients being redirected in to the Surgical Ambulatory Service. The service is currently participating in the national Surgical Ambulatory Emergency Care Network programme.

Our Maternity services were one of the highest performing in the country in the 2017 CQC inpatient survey, and we have an action plan for areas identified for improvement. We have a programme in place to work with NHS Resolution Safer Maternity guidance to aim for a £700k reduction in CNST premium by improving quality. Our GIRFT report identified our Gynaecology service as having the lowest length of stay nationally for abdominal hysterectomy rates and we have been identified as one of the best teaching unit in northwest deanery. In line with the better births national review as members of the Cheshire and Mersey Local Maternity System partnership we are piloting in 2018 the first freestanding community midwifery lead unit in the country.

The T&O Directorate work programme includes achieving best practice tariff for fractured neck of femur. The Directorate have established WAFFU; Wirral Acute Femoral Fracture Unit to ensure the delivery of BPT and achievement of the Advancing Quality Metrics. The Directorate of Perioperative Medicine have progressed many quality improvements this year across the operative spectrum from preoperative assessment to reducing length of stay and compliance with the basket of day case procedures. This work will continue into 18/19.

The organisation uses a number of quality improvement methodologies, and has embedded an approach to safety culture and quality improvement based on weekly safety summits. The main purpose of these events is to identify rapid learning or actions following serious incidents for the wider organisation. They also enable clinical senior leaders across the organisation to have a shared knowledge and understanding of the Trust's most serious incidents. There is an opportunity for all attendees to contribute issues to explore during the summit, and attendance is open to all. Following each summit, a 'Safety Bites' update is issued throughout the trust summarising the topics covered together with any associated learning. Depending on the topic, items are often followed up by an evidence based research article from the Library team in an 'Evidence Bites' update.

The Trust subscribes to the Advancing Quality Alliance (AQuA) which supports our quality improvement work from ward to Board. During 2018/19, we will continue to work with AQuA to develop a training programme for quality improvement to further develop staff across the organisation and engage them in local quality improvement work. The Trust has a programme of work to develop our IT system (Cerner Millennium) that includes decision support and clinical pathways that will support safer, high quality care. As a Global Digital Exemplar (GDE) we will continue to work with our local health economy partners to develop enable new models of care underpinned by population health management, shared care records and interoperable systems.

Quality Improvement work is aligned to the specialty and divisional priorities that in turn are related to the Trust priorities as defined in the Quality Improvement Strategy, incorporating the Quality Account priorities. Projects are agreed through the relevant divisional or corporate group and are performance managed at this level. Concerns about quality improvement work are escalated to the Clinical Governance Group who in turn provides assurance to the Quality & Safety Committee. The Quality & Safety Committee reports on levels of assurance about the Quality Improvement work to the Board. In line with recommendations from the Well Led Governance Review the Trust has enacted a revision to

its governance structures to ensure that a greater degree of review and monitoring is undertaken at executive working group level. The assurance committees thereafter determine whether the assurance provided by the executive working group is sufficient to mitigate any potential risks or aid the Trust to achieve its strategic objectives.

In support of the Cheshire & Merseyside Health & Care Partnership and in line with developments across the wider NHS in England, the Trust will accelerate its work on minimising clinical variation. This will be done through the Getting It Right First Time (GIRFT) and other nationally accepted quality indicators, and embedding them into our Cerner Millennium Information System in order that the Trust obtains top quartile length of stay in these conditions. A number of extant clinical pathways have now enabled digitally through Millennium (Sepsis, FNoF and Stroke pathways). These have been implemented on a risk based priority basis within the Trust, and are showing good signs of enabling a reduction in unwarranted variation. We have committed to a rolling programme to digitally enable more pathways in 18/19. The Trust has also implemented a number of Healthcare Registries as part of the roll out of Cerner's HealtheIntent, branded locally as the Wirral Care Record, and which is live in all 51 GP practices. Data coming from initial Diabetes, Asthma, COPD and Respiratory healthcare registries are showing a direct correlation between proactive self-care and primary care interventions and a reduction in emergency / unplanned attendances at A&E for cohorts with long term conditions. We plan to go further in partnership with our CCG, Primary Care and other local health economy partners rolling out further registries and enabling more proactive use by GPs.

3.2 Wirral & West Cheshire Clinical Strategy

With the development of the Cheshire & Merseyside Health and Care Partnership, and in particular, the acute sustainability programme, we plan to seek out the potential opportunities that such a programme affords. We will in 2018 examine closer workings in respect of acute services ourselves and our nearest acute neighbour, The Countess of Chester NHS Foundation Trust. From national evidence and benchmarking data we believe there is much that can be done locally to improve standards, reduce variation, and stabilise the system. Drivers such as the Model Hospital, Get it Right First Time (GIRFT), NHS Right Care, Public Health Outcome data and qualitative reports such as the AQ programme, indicate that there are significant opportunities that are beholden upon us to explore.

Whilst the focus will be on acute sustainability, we will work with commissioner and other parties to consider the whole system dependencies and impacts. There are strong interfaces with primary care, community services, and social care, and the integration of this project's work with the local system strategy as a whole will be crucial for the transformation of acute care services (Integrated Care partnerships).

The scope of work will seek to determine the necessary acute care services required for the population of West Cheshire and Wirral and how, when considering this larger population, this will be undertaken in such a way as to assure services that are clinically and financially sustainable. More specifically we consider the following questions as key lines of enquiry within which to frame our proposals. How will such an approach:

- Demonstrate improved outcomes for patients, including delivery of NHS constitutional standards and a reduction in unwarranted variation.
- Demonstrate financial sustainability, including efficient use of resources with a reduction of unnecessary duplication.
- Demonstrate the delivery of safe services within the context of a clinically sustainable workforce.
- Demonstrate the delivery of safe services within the alignment of activity and `critical mass` with the accreditation of services.
- Demonstrate the connections and integrations with other services to support demand management and the delivery of care closer to home.

This work will result in an outline framework able to demonstrate clinical engagement at the very outset and connections with key partners as a means of effectively managing pathways. In summary we expect the framework to demonstrate / consider:

- A case for change

- The delivery of clinical and patient standards
- Clinical co-dependency framework
- Gap analysis – current state
- New model of care
- Clinical support and call to action

We anticipate that our respective commissioners will support with communications, business intelligence and information as required, and that they will also provide, as required, engagement with member GP practices, scrutiny and health and well-being boards as this project matures.

The Trust aims to obtain a 'Good' CQC rating when re-inspected in 2018, albeit recognising the challenge this will present, and a rating of 'Outstanding' in 2019. The Trust has a comprehensive work programme in place in order to achieve this with a focus on:

- Implementing our Quality Strategy and complying with the recommendations of our 2015 inspection
- Continuing our Care Quality Inspections and the Ward Accreditation Programme
- Developing a programme for the minimisation of clinical variation in collaboration with other hospitals in Cheshire
- Creating a Quality Governance Team supporting Divisional clinical governance arrangements

The Trust quality objectives in support of the Trust vision are agreed in collaboration with Governors and the Board of Directors. Each Executive Director thereafter takes responsibility for these objectives.

The Trust has a robust appraisal system whereby all staff are appraised against core values and behaviours, contribution towards organizational objectives and are required to demonstrate that they have undertaken appropriate mandatory training and continuous professional development. Appraisal rates are reported formally to the Trust Board along with a range of quality measures via our Integrated Dashboard. Additionally, our Quality Dashboard is scrutinised by the Board Quality & Safety Committee on a regular basis so they can be assured we have a grip on quality & safety matters.

3.3 Quality Account

The Quality Account outcomes linked to the Quality Strategy are reported using the below milestones and performance indicators.

Implement the SAFER bundle to improve patient flow and ensure safe discharge • The Trust will aim for 25% of all medical discharges from base wards to be before noon • The Trust will aim to improve compliance within specialty care ('right patient right bed') so that no more than 10% of patients are admitted to the 'wrong' bed.
Ensure patients are supported with eating and drinking based on their individual needs • 85% of patients will report receiving appropriate assistance with eating, and 90% with drinking • Where appropriate, patients' nutritional and fluid input will be recorded within their electronic record of care
Reduce harm to patients, in particular from newly formed pressure ulcers • Zero tolerance of avoidable hospital-acquired pressure ulcers at grades 3 and 4 • The Trust will will aim for a 50% reduction in avoidable hospital-acquired grade 2 pressure ulcers,
Reduce the frequency of missed medication events • The Trust will aim for no more than 3% of critical medication doses to be missed, and; • an appropriate care score of 70%
Improving End of Life Care • Launch of Wirral Palliative and End of Life Care Strategy to ensure we are clear about PEOLC outcomes that matter most to us and have a credible plan to enable those outcomes to be achieved.

• The Trust has added 'Care in the Last Days of Life' to corporate induction for all new staff, to 75% of existing nurses and clinical support workers in the Acute and Medical Division, and to 75% of doctors in training Trust-wide • The Trust will roll out the 'Record of Care for Patients in the Last Days of Life' • The Trust will increase the staffing resource allocated to Specialist Palliative Care
Reduce emergency readmissions within 30 days • The Trust will aim to achieve a 1% reduction on overall readmissions, with no more than 10% readmissions being potentially avoidable

3.4 Quality Improvement Plan

A summary of the quality improvement plan including compliance with national quality priorities is provided below, and this table contains relevant references to our Quality Improvement Plan in order to highlight the approach to key developments for 2018/19

National Clinical Audits	National audits are prioritised in the Trust to ensure the Trust has robust benchmarking data. All audit reports are reviewed in their clinical area and an action plan developed based on the findings. These are presented within the divisions and approved through the governance structure. Action plans are monitored through the divisional teams and reported in the annual audit report. In the coming year the Trust will continue to monitor completion of audits on a quarterly basis; highlighting and acting on any delays. The Audit Committee reviews the clinical audit programme and the methodology as part of its review of internal control.
Safe staffing care hours per patient day	The Trust has a robust process for recording and reporting safe staffing per patient day. The Trust uses the benchmark CHPPD with national data held on the Safer Hospitals Portal
Actions from better births review	The Trust will work collaboratively with alternative providers in order to improve the quality of care that women have said that they want by the sharing of best practice in order to improve outcomes. In addition the Trust will also implement the recommendations of NHS E "Including Safer Maternity Care" which incorporates a Board member sponsoring these recommendations.
Compliance with the 4 priorities of the 7 day standards for hospital services.	The Trust is currently delivering standards 5 and 6. Exploratory indicators and a local dashboard has shown no difference in length of stay, readmissions or risk adjusted death rates based on day of admission or discharge. The Trust is currently establishing the additional resource requirements to deliver standards 2 and 8.
Improving the quality of mortality review and Serious Incident Investigation and subsequent learning into action.	The HSMR for the Trust remains significantly below that expected for the population the Trust serves. The mortality review process has been in place for a number of years and is currently being reviewed to ensure it remains robust and current. Lessons are learnt through meetings, newsletters and also through changes to policy and guidelines. The new Executive led Serious Incident Review Group oversees the approval of root cause analysis reports and provides assurance to the Trust Board regarding the quality of reports submitted and robustness of actions to prevent recurrence. Learning is shared via weekly news bulletins as well as via divisional and corporate governance meetings. Root cause analysis training is now available for Trust staff to access; this has been very successful and the quality of investigations has improved. The Trust has implemented actions from 'Learning from Deaths' report, undertaking structured clinical reviews to ensure we learn from any indications of areas for improvement in delivery of care. All mortality reviews are triangulated with complaints and Serious

	Incident reviews.
Anti-microbial resistance	The Trust will be developing further the antimicrobial stewardship in the Trust through 2018/19 with a dedicated named consultant leading this work.
Infection Prevention and Control	Maintaining the programme of work to ensure compliance with the health and social care act is a priority. The Trust has a CPE strategy involving triple cohorting. Our C-Diff strategy includes a full ward decontamination programme involving HPV. Our MRSA strategy will continue including daily review of all MRSA patients to prevent clinical investigation. Effective use of the isolation unit is regularly assessed
Falls	The Trust has seen a reduction on falls through Ward education using our dementia matron and clear assessment on admission. The Trust continues to develop new methods of assessment e.g. sensory pads
Sepsis	For 2018 and beyond the 4 areas of focus are: Senior review of most seriously ill septic patients, IV fluid administration for septic patients, Consistency in care for septic referrals from Primary Care and sepsis screening on ambulance transfer.
Pressure Ulcers	The Trust continues to see a year on year reduction with a zero tolerance of avoidable hospital-acquired pressure ulcers at grades 3 and 4. The Trust will aim for a 50% reduction in avoidable hospital-acquired grade 2 pressure ulcers Pressure Ulcers are Part of the sign up to safety programme
End of Life Care	The Trust has in conjunction with CCG, Hospice, Primary Care, Community Trust and other key voluntary and patient stakeholders a palliative and end of life strategy and plan. This includes a record of care for patients who are in the last stages of life. The Trust has increased the capacity of the service by appointing additional consultants, 2 end of life of life educators and administrative support. The record of care will be revised through clinical audit which demonstrates substantial improvements in documented care and reduction in unnecessary interventions. The Trust intends focussed work on training, the MDT process and advanced care planning over the coming year in line with our plan to ensure a high quality, evidence based service. The Trust is also part of NHSI system change through transformational leadership programme focusing on EOL.
Patient experience	In support of the Trust aim for the best levels of patient satisfaction the Trust will continue to achieve a Friends & Family Test recommendation score above 95% and a non-recommendation score of below 2%.To achieve this the Trust will introduce new mechanisms for obtaining feedback in areas with of high volumes of patient contacts (e.g. A&E and Outpatients) and implement formal performance management arrangements for inpatient areas identified as requiring improvement. The Trust will continue to make it easier for complaints to be raised where there is a need or wish to, improving accessibility and initial response times. We don't aim to deliver a year on year reduction in the number of complaints as this may lead to suppression of complaints when we want the opportunity to learn and improve and so welcome complaints being made. Instead, we aim for a year on year improvement in response times and a reduction in the number of level 2 complaints being referred to Ombudsman. The Trust will introduce Matron Clinics to drive local ownership of the resolution of complaints. The Trust is opening a new communications hub providing patients, members of

	the general public and staff with support in the management of concerns and complaints.
National CQUINS	The Trust provides quarterly progress reports to the CCG via the joint Quality and Contract monitoring meeting. This forum allows both CCG and the Trust to propose to NHSE any local quality variations which would suit the local patient population.

As part of a refresh of our quality strategy through 2018/19 the Trust will factor in the direction of travel from the Cheshire and Mersey Partnership Health & Care Partnership.

3.5 Quality impact assessment process

Both Cost Improvement Plans (CIP) and Service Improvement Plans are developed with clinical teams at speciality, divisional and corporate levels. Programme and plans are reviewed and signed off at Transformation Steering Group with Executive representation. Individual projects are subjected to Quality Impact Assessment (QIA) using a standard form incorporating national guidance. Building on work from 2017/18 the QIA process for 2018/19 and beyond will incorporate the wider five CQC domains (safe, effective, responsive, caring and well led), allowing insight into staff impact.

Completed forms are scrutinised, challenged as appropriate and approved by the Medical Director and the Director of Nursing & Midwifery. If a project requires an Equality Impact Assessment, this is supported by the Divisional Associate Directors of Nursing. The Trust's Service Transformation Team (STT) is responsible for warehousing QIAs. The overall process is overseen by the Clinical Governance Group which reports to the Quality & Safety Committee (QSC) of the Board. QSC's work programme is designed to receive assurance on patient safety, clinical outcomes, and patient experience and workforce indicators. This is signed off by MD and DoN with option to review at 3, 6, 9 months as required.

In addition for 2018-19 an agreement has been reached with NHS Wirral CCG Clinical Senate representing the whole health economy whereby individual organizations share proposed efficiency plans to allow for impact analysis across the whole health economy.

3.6 Triangulation of quality with workforce and finance

We have developed and implemented a monthly Integrated Quality Governance Report (Dashboard) aligned to the five CQC domains – Safe, Caring, Responsive, Effective and Well Led. The purpose of this dashboard is to provide 'one version of the truth' that is used to support internal and external quality meetings. Within the Trust the Dashboard is reviewed and scrutinised monthly by the Clinical Governance Group and bi-monthly at the Board Quality & Safety Committee. Externally it supports the monthly Wirral Clinical Commissioning Group's Quality & Clinical Risk Meeting. Divisional integrated quality dashboards are currently in production and will be rolled out in 2018.

Specifically for workforce building on existing work from 2017/18 the Trust Board will receive monthly information relating to safe staffing and care hours per patient day for all inpatient areas. On a six monthly basis a robust analysis of funded establishment, patient acuity and dependency and nurse sensitive indicators is produced to ensure that funded establishments enable delivery of high quality safe care.

The key indicators uses in this process are:

- Professional Judgement model
- Shelford Group Safer staffing tool
- Use of nurse sensitive indicators such as pressure ulcers, falls and medication errors.

The Trust Board will use this information to inform decisions relating to future workforce models, skill mix and funded establishment.

4. Workforce

The Trust is facing some significant challenges in relation to the culture across the Trust. The issues of bullying and harassment, lack of engagement and the questioning of the trust's values and behaviours have surfaced following independent reviews, as mentioned in the summary. Therefore, over the coming 12 months the Workforce and OD strategy will significantly focus on the following areas:

- Culture – redefining the trust's values and behaviours and shaping a compassionate organisational culture from board to ward.
- Leadership – developing compassionate leaders at every level of the organisation.
- Healthy working environments – creating healthy working environments for all our workforce which are free from bullying and harassment and promotes the health and wellbeing of our employees
- Learning organisation – supporting our workforce to grow and learn that are based on quality conversations about individuals development needs and aspirations.
- Engagement – ensuring our workforce have a voice and our actively engaged in the business of the trust and its direction of travel
- Valuing our staff – that we recognise the contributions that are staff make to the trust on daily basis and celebrate their successes
- Inclusivity - securing a diverse workforce enables us to deliver a more inclusive service and improve patient care.

The trust will be reviewing its Workforce and Organisational Development strategy over the coming months to ensure that it underpins the strategic direction of the organisation. The strategy will focus on shaping the culture of the trust and in particular detailing the required behaviours that will create a compassionate organisation from board to ward. In addition the trust will be securing compassionate leaders at every level of the organisation particularly focusing on the newly established clinical leadership teams.

Conversations will be cultivated across the organisation to engage the workforce in shaping discussions on quality ideas that may subsequently positively impact on the trust finances. As well as introducing recruitment and retention activities that incorporate the development of career pathways, supporting newly qualified members of staff from education to profession.

The Trust will commit to ensure that we have the right numbers of staff in the right place with the right skills at the right time. Trust leaders will maintain a strategic forward view, anticipating and managing required organisational change. In the period 2017–19 workforce numbers and structures at WUTH will be impacted by increased cross working with the Countess of Chester Hospital (COCH) and closer co-operation with primary and social care in a move towards an Integrated Care System.

IT developments will increase the effectiveness of the workforce. The outcomes of these changes on staffing levels will inevitably be impacted by increased demand, increased acuity and a drive for improved quality (e.g. ensuring safe staffing levels through management of KPIs such as Care Hours per Patient Day, meeting waiting time targets etc.).

The Trust currently has a 4.69% sickness rate, over a rolling 12 month period. Reductions in sickness allows extra staff days for the care of our patients as well as reducing the reliance on bank and agency staff. The organisation is committed to creating a health and wellbeing framework with a view to supporting the health and wellbeing of our workforce, our patients and our communities. As a minimum the Trust ensures a very high number of our staff receives the Flu Vaccination; this year 81.3% employees were vaccinated.

The Trust has a total vacancy rate of 4.9%. For our nursing staff it is 6.09% and for our medical and dental workforce 4.98%. However, for consultant medical staff we have a vacancy rate of 7.71%. The trust is committed to reduce vacancy rates part of which will be nurturing new talent. The trust has plans to expand the numbers participating in its already successful apprenticeship program (in line with national guidance). Further progress will be made in our multidisciplinary workforce planning including a particular focus on the integration of new roles. New roles, job planning and skills development particularly in key groups such as our Advanced Nurse Practitioners and Associate Physician will assist in maintaining a stable workforce.

Key to the delivery of workforce efficiency savings and to maintaining high quality services will be a reduction in reliance on and cost of non-core staffing. Progress has been made in ensuring that the skill mix of substantive staff is optimised to reduce the need for agency and bank staffing. The further development of e-Roster, currently underway, will also support this.

5. Finance

The Trust's draft financial plan has been developed in line with the annual planning timetable set out by NHS Improvement. The underlying financial position of the Trust has been reported throughout the year to the Finance Business Performance & Assurance Committee (FBPAC) and Trust Board with initial draft plan being discussed by the Board of Directors at the February Board Meeting. The overarching financial strategy principles agreed by the Board of Directors is to create a long-term financially stable organisation with the:

- Ability to invest in patient care and facilities, delivering maximum value from the deployment of the Trust's estate with a longer term estates strategy based on a more joined up approach to care on the Wirral and between hospitals.
- Capacity to secure internally a transition from delivering transactional efficiencies to a focus on delivering sustainable service transformation through our newly established Service Transformation Team supported by enhanced governance structures and processes.
- Ability to survive structural changes in the financial flows in the NHS and wider health and social care economy.
- Capacity to cope with short term financial shocks.
- Deployment of the Wirral Millennium platform and Global Digital exemplar status to transform the delivery of care to patients on the Wirral. Patients will benefit from evidence based electronic care pathways. These pathways will be continuous across all health and social care settings.

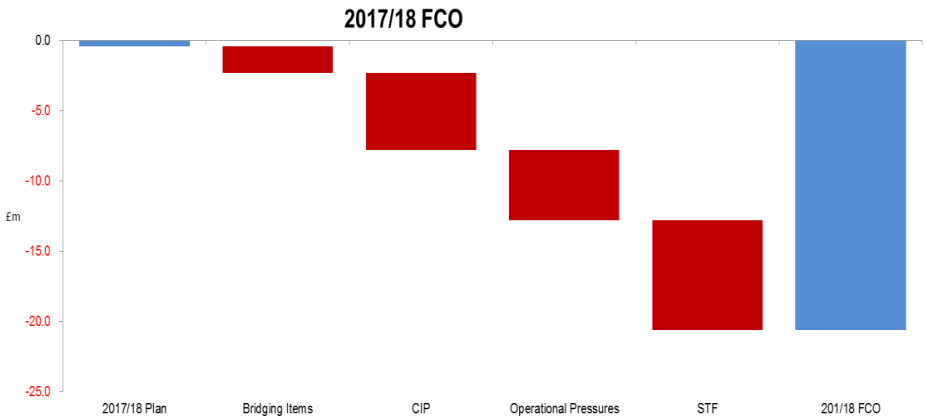
In the short term;

- Maintain a Use of Resources rating of level 3
- Balanced approach to delivering on the money, safety and quality in 2018/19
- A requirement for cash support going into 2018/19

The Trust whilst cognisant of the historical financial challenges it has faced (and recognises the continuing challenge in the short term) is of the belief that opportunities exist to significantly re-shape and transform the provision of health and social care on the Wirral through some form Integrated Care Partnership (ICP), this is consistent with the intent set out within our CCG's draft commissioning strategy to more toward a Place Based Collaboration System (PBCS), although the timeframe for this journey is a live discussion as we continue to respond to the CCG consultation on this strategy.

5.2 2016/17 Financial Plan Performance

The Trust is currently forecasting to finish the 2017/18 financial year with a deficit of c£20m. This is worse than the planned control total of a £0.4m deficit. The key drivers behind the Trusts normalised forecast outturn deficit is set out in the bridge chart below;



As set out in correspondence with NHSI/NHSE and the Wirral Health and Social care system the main drivers of the adverse plan are;

- While the Trust will deliver a CIP of 3% in 2017/18 which is 1%more than the National target it will fall below the 5% target included within the plan.
- Loss of STF funding as a result of non-achievement of the control total since Q1 - £7.8m
- Operational pressures as a result of continued escalation beds opened throughout the year, loss of Elective activity due to National directions around winter pressures and increased costs as a result of National intervention around A&E performance - £5m
- Non achievement of bridging items set in plan to enable acceptance of control total - £1.9m

As can be seen the failure to deliver the financial plan is not as a consequence of loss of "financial grip", the Trust has embedded robust governance processes and structures ensuring a focussed approach on controlling the cost base and managing delivery of financial and non-financial key performance indicators during the course of 2017/18.

The 2017/18 position has been supported by non-recurrent benefits of c£7.5m that will not be available to support the Trust during 2018/19. These non-recurrent benefits have been reported throughout the year to the FBPAC and Board as part of the underlying position.

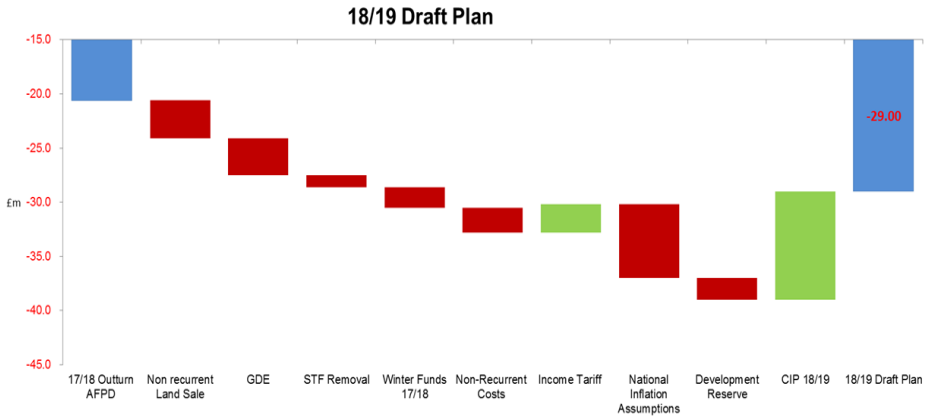
5.3 Key Planning Assumptions

WUTH is facing a considerable challenge in the second year of this planning cycle. The Trust continues to see significant growth in Non-Elective Activity and is currently having c£5.5m withheld by Wirral CCG under marginal rate rules. Despite the Health economy investing in excess of the mandated requirement in the Better Care Fund, the Trust continues to have significant pressures around Non-Elective activity. The CCG has so far failed to show where the marginal rate income is being reinvested and as a result the Trust will be entering into Mediation with the CCG to request that the Non-Elective baseline is moved to 2017/18 levels.

Included within the plan are the national planning assumptions identified within the 2017/18 planning guidance. The Trust has allocated resource for a 1% pay award although no confirmation has yet been received on how the lift on public pay awards will be allocated for 2018/19. We've also made assumptions around the level of CIP that is achievable, and how our GDE programme will use resources during the period.

The Trust's overarching financial strategy is to maintain a minimum level 3 Use of Resources rating throughout the planning period under the current Single Oversight Framework. To deliver upon this objective, the Board of Directors at WUTH recognises the need to robustly plan and secure delivery of increasingly challenging efficiency requirements moving from an historical transactional delivery to one which delivers truly transformational programmes of efficiency both within the acute hospital setting but increasingly aligned to the Cheshire & Merseyside Health & Care Partnership, Place Based Collaboration System (Healthy Wirral) and our Wirral & West Cheshire Acute Care Alliance. We are though dependent upon collaboration from CCG and other Wirral partners, and our current planning assumptions are based on the current realistic prospect of change in partnership with those parties.

The movement from the 2017/18 outturn position to the operational plan for 2018/19 is demonstrated in the bridge graph below.



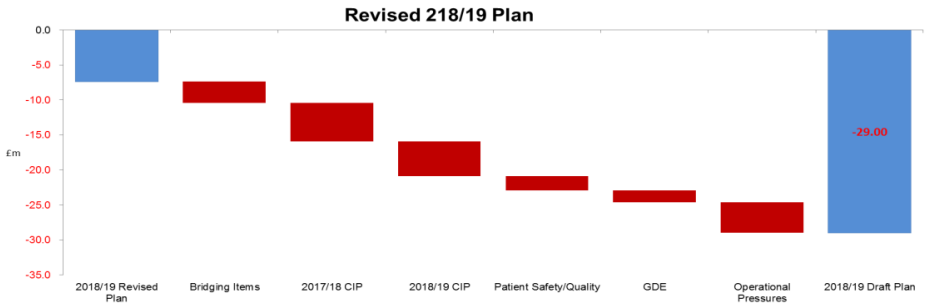
Agency Rules: WUTH will continue with the range of measures introduced in 2017/18 that will see successful delivery of the agency cap to ensure on going compliance with the £7.5m cap from April 2018. The Trust will continue to build upon its robust approach to workforce planning to minimise the use of agency staffing in 2018/19 reflecting on its forecast outturn for 2017/18 of circa £7m.

Procurement: The Trust is actively engaged with Countess of Chester NHS Foundation Trust on moving toward a shared Procurement function and aligning / harmonising contract arrangements to enable increased purchasing power and other synergies. The Trust actively reviews the opportunities available to it from the Purchasing Price Index Benchmarking (PPIB) tool. We continue also to work with other trusts across Cheshire & Merseyside to explore opportunities to buy better together and achieve some of the Carter at Scale benefits that may be available.

Movement from Initial Plan

The Trust did not accept the control total for 2018/19 as a result of the non-recurrent elements including in the bridging items for 2017/18 and the significant stretch that would be required to deliver a £6.1m surplus from a £0.4m deficit. As a result of the not accepting the control total the subsequent STF was removed for the 2nd year of the plan as were the non-recurrent bridging items.

Due to the significant challenges that the Trust has encountered during 2017/18 some of the initial assumptions included in the 2nd year plan are no longer viable. The bridge below demonstrates the movement from the plan submitted last March to the current draft plan.



The Trust does not believe that a 5% CIP is deliverable given the national historical challenge in delivering this level of saving through 2017/18 and in all previous years. The Trust has reduced the savings target to 3% which is still 1% more than the National target as per the guidance.

5.4 Transformation Agenda & Sustainability Programme

The indicative requirement for achieving overall financial sustainability is circa £30 million. As noted previously, planning guidance assumes 2% efficiency is realistic and so a challenge in the region of 9% is wholly unrealistic based on traditional CIP approach.

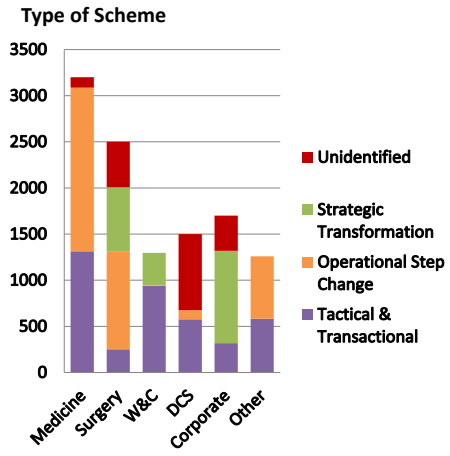
However, given the challenges in getting anywhere near close to 5% in the 17/18 year and with little visible prospect of a fundamental shift in health economy collaboration at this stage, we believe that 9% is not achievable for the 18/19 year, and the risk to quality and safety of attempting to do so would be highly undesirable and not aligned to the Board of Directors view that while we challenge ourselves to make best use of resources and deliver financial sustainability, this cannot be at the expense of patient safety and quality.

We have taken the view that rather than a traditional CIP, which frankly is a barrier to real clinical engagement and tired approach which colleagues have become weary of, we will identify opportunities to enable long term financial (and clinical) sustainability in each of the three areas described below.

- **Tactical & Transactional** – the result of operational grip, low level cash releasing efficiencies and short term decisions that will enable us to achieve a baseline efficiency saving in the region of 2% per planning guidelines. In other words, '*doing the things we do today more efficiently tomorrow*.'
- **Operational Step Change** – additional more fundamental changes to what we do and / or how we do it within our operations. In other words, *'doing different things and/or doing things differently, where it is within the trust's gift to do so'*. These items will enable us to stretch beyond 2% and get to the 3% plus target we have set as described above, potentially even a little beyond.
- **Strategic Transformation** – these rely heavily and wholly on collaboration outside the hospital walls. New models of care, either as part of place based collaboration within Wirral (vertical) or as part of acute care alliance working (horizontal). In other words, *'doing different things and/or doing things differently, where it is NOT within the trust's gift to do so'*. These items will enable us to stretch beyond 3% and start to close the gap on the kind of 9-10% challenge we are facing.

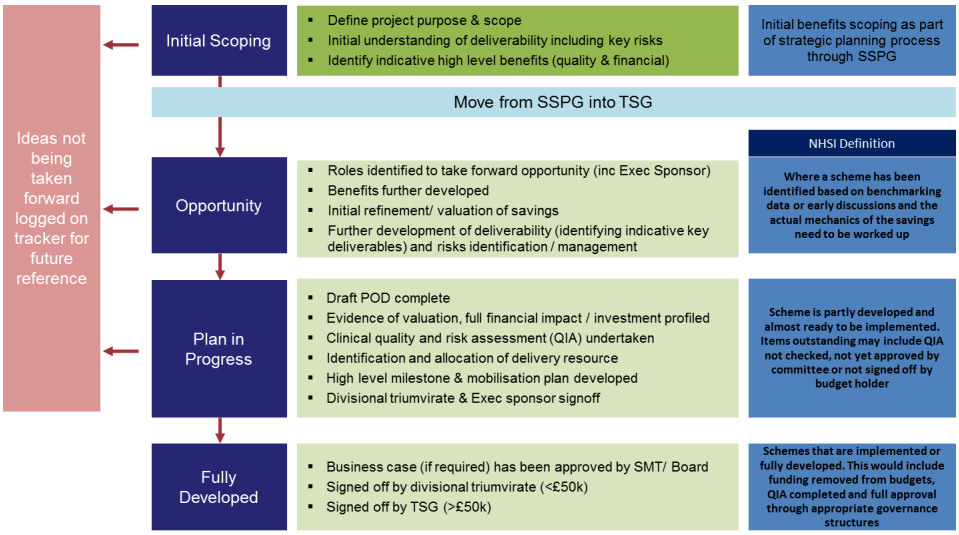
Current modelling assumes that the Trust will deliver a £9.8m through the first two categories, which translate into traditional CIP; i.e. c3% of turnover and 1% higher than the planning guidance target of 2%. The Trust had, when submitting plans a year ago, assumed a further 5% CIP target within the 2018/19 plan.

Against the 2018/19 efficiency target of £10m planning work undertaken by the Trust's Service Transformation Team have identified work streams to support the delivery of £7.2m of the overall requirement with a further £2.5m identified as opportunities. See tables below for how this breaks down across the 3 categories.

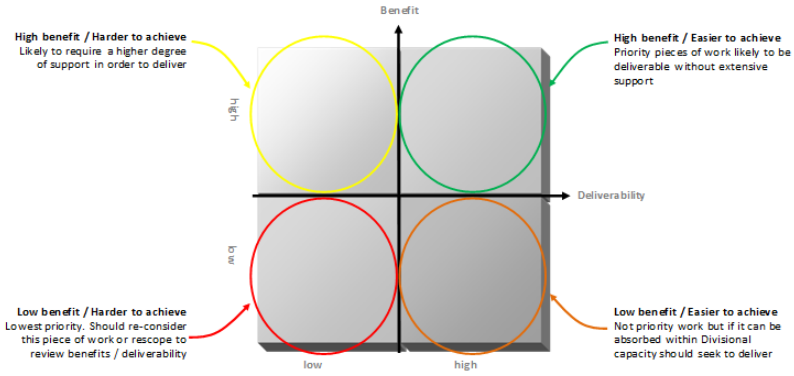


2018/19 In Year Position Programme View	Sustainability Plans Opportunity £k	Plan in Progress £k	Fully Developed £k	Total IYE £k
Operational Step Change				
Patient Flow and Bed Reconfiguration	0	1,500	0	1,500
Theatre Improvement Programme	300	0	743	1,043
Outpatient Improvement Programme	600	0	0	600
Workforce Transformation	125	83	39	247
Clinical Variation	220	0	0	220
Operational Step Change	**1,245**	**1,583**	**782**	**3,610**
Strategic Transformation				
Collaboration - Healthy Wirral	100	500	52	652
Collaboration - Wirral & West Cheshire	400	0	0	400
Other Strategic - IT	0	0	1,000	1,000
Other Strategic - Site Strategy	0	0	0	0
Strategic Transformation	**500**	**500**	**1,052**	**2,052**
Tactical and Transactional				
Procurement and Non Pay	589	0	561	1,150
Pharmacy and Meds Management	0	0	234	234
Divisional and Departmental	175	1,269	1,156	2,600
Tactical and Transactional	**764**	**1,269**	**1,952**	**3,984**
Unidentified				**354**
Total				**10,000**

To enable us to influence and take a leading role in identifying strategic transformation opportunities, we have established a Strategy & Sustainability Planning Group (SSPG). Chaired by the Director of Strategy & Sustainability, this senior leader group representing all divisions and corporate services and including clinical, nursing and operational / management colleagues, this group provides the capacity & capability to identify and 'shape' opportunities and determine actions to progress within and without the Trust. The table below shows how 'ideas' move from this SSPG into well-defined pieces of work which then become managed through our extant Transformation Steering Group and associated governance. This also shows how schemes translate into NHSI definitions for purposes of reporting 'CIP'.

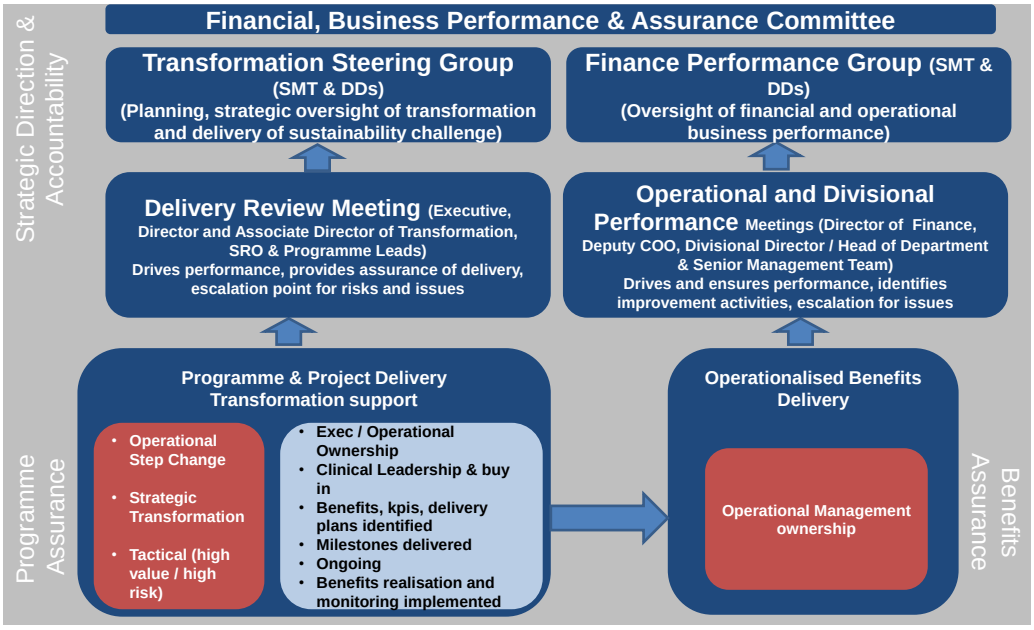


Recognising that there is limited bandwidth for change given the hot and busy nature of acute hospital environments in 2018, we have developed an approach to prioritising ideas based on quantum of benefit (better health, better care and better value) and on practical consideration of deliverability.



The diagram below demonstrates the governance arrangements for the Transformation agenda:

Portfolio Governance Assurance Arrangements



The Transformation Steering Group (TSG) operates as a strategic group and is chaired by the Chief Operating Officer and reports into the Finance, Business, Performance and Assurance Committee (FBPAC). The group oversees all significant change and improvement projects within the Trust, and each programme has an Executive lead and the appropriate meeting structure to support delivery. The group have a holistic view at a portfolio level to ensure that all interdependences are highlighted; approved programmes/projects align with the Trust's vision, and deliver the specified benefits such as achieving value for money and whilst sustaining quality and safety. The diagram below shows the current portfolio of work within scope of TSG.

Quality Healthcare, Sustainable Future Transformation Portfolio		
Programme & Aim	**Ownership & Accountability**	**Service Transformation Programmes & Projects**
Operational Step Change		
Patient Flow and Bed Reconfiguration To free up beds in the hospital and community by ensuring that we have the right patients in the right beds at the right time supported by the most appropriate staff to ensure patients receive the best care	SRO: Anthony Middleton Programme Lead: Shaun Brown	Achievement of internal ED targets Redesign of ACU pathways Primary Care Streaming Embed SAFER Assessment Area flow and reconfiguration Transformation of discharge services
Theatre Productivity To improve theatre efficiency to enable us to reduce waste and treat more patients in a timely way	SRO: Gareth Lawrence Programme Lead: Jo Keogh	Theatre utilisation Pre-op pathway
Outpatient Improvement Programme To improve our outpatient services to enable us to see more patients in a timely way and improve patient experience	SRO: Anthony Middleton Programme Lead: Nicola Davidson	Clinic Productivity Nursing skills mix Clinic supoport staff including IT enablers
Workforce Transformation To reduce our total workforce costs by continuously improving our ways of working	SRO: Janelle Holmes/ Helen Marks Programme Lead: Ann Lucas	Medical Staffing Nursing Corporate Clinical A&C
Clinical Variation To reduce variation in patient outcomes, care and experience, and reduce variation in costs of delivery through implementation of consistent care practices	SRO: Susan Gilby Programme Leads: Various	Clincial pathways GIRFT Demand management
Strategic Transformation		
Collaboration - Healthy Wirral To reshape health & social care services to ensure quality patient care is delivered in the appropriate setting, enhancing the experience of our patients whilst offering best value for money	SRO: Terry Whalley Programme Leads: Various	Collaboration - Women's & Children's Place Based MSK Urgent Care
Collaboration - Wirral & West Cheshire To reshape acute healthcare services enhancing the experience of our patients whilst offering best value for money	SRO: Terry Whalley Programme Leads: Various	Collaboration - Urology Collaboration - Women & Children Acute Services
Other Strategic - IT To provide our patients with the best care supported by world leading technology	SRO: Paul Charnley Programme Lead: Sheila Stewart	GDE
Other Strategic - Site Strategy To ensure our space is fully utilised and enhances the experience of our patients, whilst offering the best value for money	SRO: Gareth Lawrence Programme Lead: Dave Sanderson	Site utilisation
Tactical and Transactional		
Procurement and Non Pay To provide high quality, clinically appropriate products and services at the best possible prices and reduce waste and inefficiencies in the supply chain	SRO: Gareth Lawrence Programme Lead: Jane Christopher	Comprehensive spend analysis Contract review Product standardisation
Pharmacy and Meds Management To safely reduce our drug and prescribing spend and ensure efficient use of our pharmacy services	SRO: Pippa Roberts Programme Lead: Sue Robinson	Comprehensive spend analysis Reduced medicines waste Pharmacy collaboration
Divisional and Departmental	Programme Leads: Divisional Directors	Tactical schemes

In addition, it ensures that any new projects are assessed to the agreed methodology and makes recommendations as appropriate to the Senior Management Team (SMT) or Finance, Business, Performance and Assurance Committee (FBPAC).

To ensure visibility of progress and provide assurance on ability to deliver against plan, we have developed a heat map approach to inform TSG view of where to seek further detail, early snapshot below.

5.5 Capital Planning

The capital allocation for 2018/19 is based on receipts from the Clatterbridge Land Sale received during March 2018, nationally funded Global Digital Exemplar and on internally generated resources. The Trust has a rigorous, fair and risk adjusted process in selecting agreed capital developments but recognises the challenges it faces in meeting all of its needs in respect of capital expenditure. The financial plan caters for capital expenditure of some £11.3m with the following key areas of planned expenditure;

- GDE

- Medical Equipment
- Backlog Maintenance

The above planned investments represent a risk based approach to capital investment within the Trust predicated on eliminating backlog risk and risk re medical equipment obsolescence to ensure delivery of safe and sustainable services within an appropriate environment.

5.6 Cash

The Trust has had a challenging year in 2017/18 in respect of cash as a result of the operational performance. The Trust will require continued cash support throughout 2018/19 as a result of the deficit plan.

5.7 Summary Income and Expenditure

We will include a summary of income & expenditure in the final April submission.

6. Digital

During 2018/19 the Digital Wirral programme, funded in part with NHS Digital Global Digital Exemplar funding, will deliver new developments within the Trust in the areas of;

- Medicines management – extending into maternity and neonates, chemotherapy trials, antimicrobial stewardship, and the more complex areas of prescribing and administration. We will be aiming to improve safety when administering drugs so that we do the "closed loop" checks of the rights (Right patient, right medication, right dose, right route, right time, right documentation, and right situation) easily on the system. We will also introduce prescribing in the outpatient setting.
- Device Integration – of a range of equipment from vital signs, and ECGs to infusion pumps will be integrated making it easier to add information to the patient record.
- Incorporating digital images - from medical photography and "oscopies" so they can be found as part of the overall record
- Clinical Pathways - The introduction of electronic support for a range of clinical pathways which will help to manage unwarranted variation
- Patient Flow - The development of a capacity management capability to be included as part of the introduction of a command centre to assist with patient flows into, through and beyond Wirral Hospital
- Pathology Services - The migration of microbiology system from an externally managed system to be part of our integrated Laboratory Information System in Wirral Millennium. We are also in discussion with the Countess of Chester Hospital about this being the first part of bringing the pathology services in both hospitals together onto the one system
- Patient portal – We will be enhancing and expanding the patient portal which has been piloted to develop a range for digital services for patient to provide them with more convenient access to services
- Becoming paperless – ultimately the combination of all these things along with digital dictation and voice to text technologies deployed in the outpatient setting should allow us to reduce and eventually eliminate the cost of paper consumption, printing, storage and the people required to move paper around the system

Informatics is working with the Transformation Team and the Divisions to establish plans for the systematic and methodical realisation of benefits from these new features which will contribute to quality improvement and in some cases cost reductions. We will also aim to ensure that governance for developments within the current programme and beyond is led by clinicians and the divisions.

Of course the majority of what is done in Information and IT and Information governance and Medical Records is business as usual and will be the subject of continuous improvement and cost management attention during the course of the year. Under the heading of Information Governance the main focus will be on ensuring that the Trust is compliant with the General Data Protection Regulations which come into effect in May 2018.

The information management team has also been working on new interactive, self-service website with dashboard of information collated for the divisions and executive management to modernise reporting and access to data for operational management. This will be rolled-out and continue to develop throughout the year.

Behind the scenes the Digital Wirral programme is helping to develop infrastructure improvements including continuing the ongoing process of ensuring cyber security against evolving threats. We have also been able to expand our workforce and skill sets to ensure we can support our systems in future years.

In the wider system digital services will be expanded and linked both "vertically" in Wirral and "horizontally" with the Countess of Chester Hospital

- Communication between organisations - Move to electronic data flows between our organisations within Wirral and further afield speeding up communications and reducing printing and postal costs.
- Building the Wirral Care Record and Registries - Wirral has a unique opportunity as the first place outside the USA to adopt a system which allows the combination of records from different systems into one which will support new care models and population health management. All 51 GP practices are providing data to be merged with the hospital data and Wirral community will be adding more data over time. 5 registries have been developed in Diabetes and respiratory care and there are 6 more in development Cardiovascular Disease: AF, HF; Substance Misuse; Wellness; Mental health; Frailty and End of Life. We also aim to have social care connected into our shared systems during 2018/19.
- Linking systems - we are also enabling the visibility of the patient records from each of the main providers in Wirral to clinicians regardless of which organisation they work for
- Digital Partners - We are also working with Countess of Chester who will become digital partners in our hospital system (a Fast Follower in NHS Digital terms). The plan is for them to be live on the same instance as Wirral towards the end of 2019 so much of the planning and technical work will begin and we will be in full flow by the end of 2018/19. Work will also begin to bring the two Trust's informatics and IT functions together as they begin to work on the one system
- Cheshire and Merseyside health and care partners - in line with wanting to be part of the wider health and care system we are also fully involved with the digital plans in Cheshire and Merseyside to review services and share work in areas such as interoperability, cyber security, shared infrastructure and support for urgent care and patient flow.

7. Collaboration beyond WUTH

7.1 Links to the Cheshire and Merseyside Health & Care Partnership (formerly C&M STP)

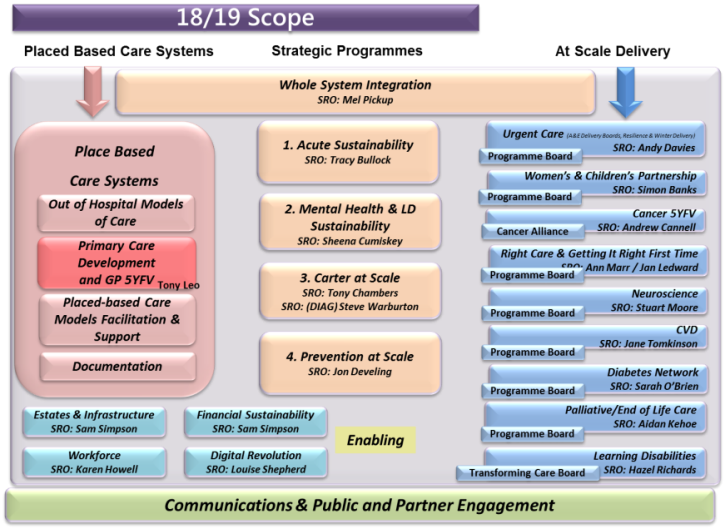
The Cheshire & Merseyside STP submitted to NHS England in October 2016 was based on three 'Local Delivery System Plans' (LDSP). WUTH was included within the LDSP for Cheshire & Wirral. The STP represented "the design stage of a programme [of change]". The underpinning vision – improving the health of the Cheshire & Merseyside population, improving the quality of care in hospital settings, optimising direct patient care – remains clear and compelling. But the way in which the STP and LDSPs were progressed did not work.

In the summer of 2017 the STP recruited a new Chair and SRO (Andrew Gibson and Mel Pickup), and 'reset' the STP. Relaunched as **Cheshire & Merseyside Health & Care Partnership**, there is much more emphasis and focus on Place Based Care, and a recognition that the majority of 'work' to deliver sustainable services will need to happen through 'Place', building on ever increasing Integrated Care Systems. This is a welcome approach, and is consistent with the content of the recently published CCG Strategy, and the aspiration that underpins Healthy Wirral Partnership.

It follows from this that a key objective for 2018/19 is to work with Cheshire & Merseyside Health & Care Partners and Healthy Wirral partners to develop the work streams and projects to a position where a detailed change programme is in place and can be delivered. WUTH has committed to play a material role in the development of both. Project management and governance arrangements are currently being put in place. The Trust will continue to provide resources to support implementation and to invest in the development of closer relations with partners.

The Cheshire & Merseyside Health & Care Partnership sets out four key areas of work, each made up of a number of discrete programmes & projects as summarised below and in the diagram that follows:

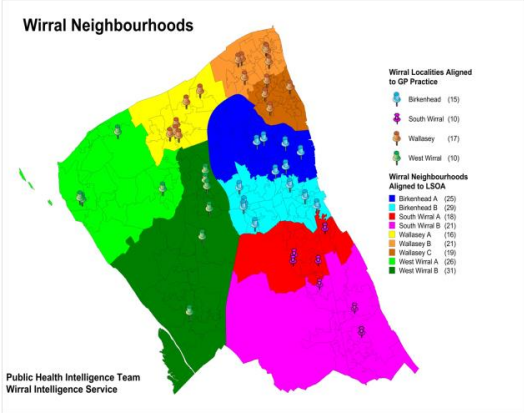
1. Place Based Care Systems, which for us is the Healthy Wirral Place Based Integrated Care System work
2. Strategic Programmes enabling Whole System Integration, including most notably Acute Sustainability for which our Medical Director is the Clinical Lead, and Carter at Scale which we actively support and influence through initiatives such as procurement, payroll, pathology and pharmacy.
3. At Scale Delivery across a number of significant areas.
4. Enabling, cross cutting themes such as workforce, digital, estates & infrastructure, communications & engagement.



We are clear, in line with C&M Health & Care Partnership thinking, that 80% of the solutions to how we ensure clinically and financially sustainable services will come from Place Based Collaboration, and how we achieve Integrated Care Systems / Partnerships. And, as described in Finance section previously, this is essential to our ability to get closer to the overall financial sustainability challenge we face. We are very committed therefore in 2018/19 to progressing Healthy Wirral in partnership with Wirral CCG, Wirral Community Trust, Cheshire & Wirral Partnership, Primary Care Federations and other public, third and voluntary organisations.

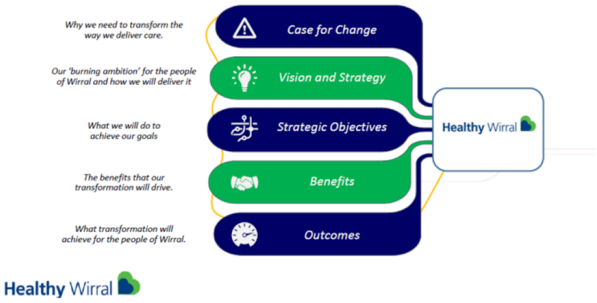
7.2 Healthy Wirral

We continue to develop asset based new models of care, building on recognition that in Wirral there are 4 localities, 9 neighbourhoods, 51 general practices and a single district centre for acute care. This '51-9-4-1' model will underpin new models of integrated care, developed within various strands of Healthy Wirral and consistent with the now published draft Wirral Integrated Commissioning (WIC) Strategy 2018-2021.

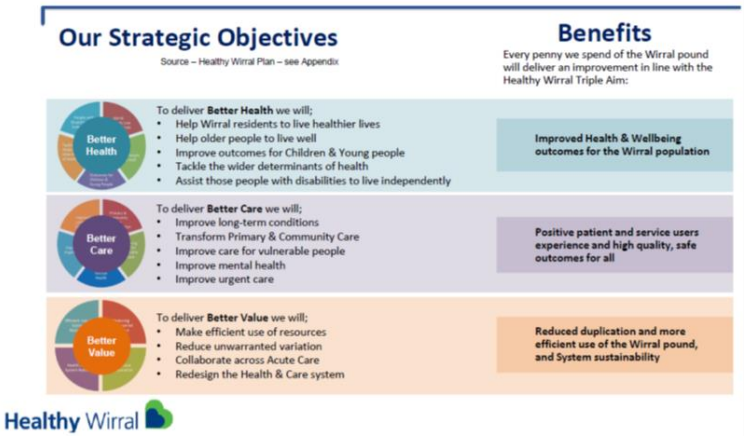


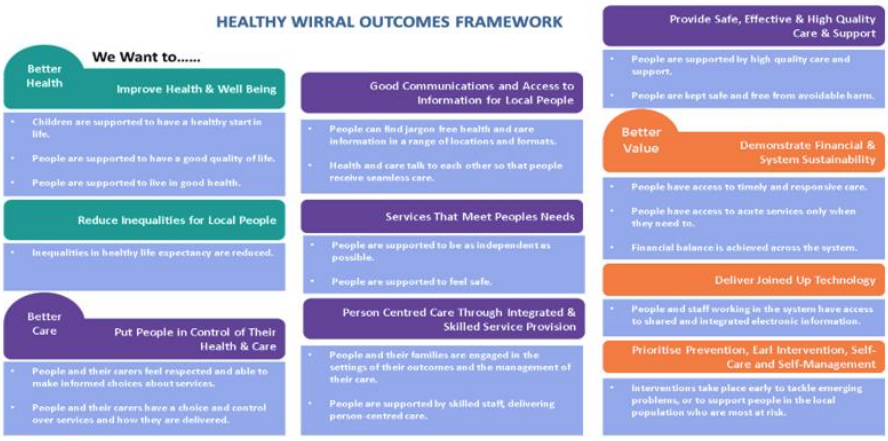
This WIC strategy document outlines intent from 2020/21 to undertake place based commissioning to improve population health outcomes in Wirral. The document outlines WIC's vision, how they will move towards the commissioning of high level population based health and care outcomes, and the timeline for achieving this change. This Commissioning & Transformation Strategy is intended by WIC to be a living document which will change and develop as the new system evolves, and we have already provided some quite detailed feedback to the commissioners as part of early consultation on the draft document.

Our Healthy Wirral Plan is built around a 'Golden Thread', one that connects our case for change to specific initiatives we plan.



The initiatives are described in the context of delivering Better Health, Better Care and Better Value, and are linked to a series of agreed outcomes against which we will measure progress.





The ambition of the WIC is to commission on a place based care basis, with a capitated budget in place by 2021. In order to achieve this goal and to ensure development of a sustainable health and care system, it is proposed that a gradual approach be adopted, as indicated below:

- 2019/20 – older people (50+)
- 2020/21 – all adults
- 2021/22 – all age population

During the next two years WIC plan to commission services in a different way and have identified opportunities to facilitate the development of a PCBS. These enablers are identified below, and they have indicated that they will seek to develop formal contracts only with Providers who are working in appropriate collaborative arrangements and are the most capable to deliver the required outcomes.

- Muscular Skeletal Services
- Drug and Alcohol Services
- Diabetes Pathway
- Respiratory Pathway
- Urgent Care Service
- Older People Living Well
- Obesity
- Mental Health – (IAPT, crisis care and integration with physical health

To support the approach described above by WIC, we will at the invitation of WIC work with all stakeholders in the period to October 2018, to co-produce a prospectus. This will include wide engagement and consultation with local people to ensure that they are involved in how services and pathways are transformed. This prospectus will define placed based commissioning requirements for the older people (50+) population and outline what is expected from providers to meet the requirements of the particular pathways to be agreed for inclusion within this segment of PBCS. The prospectus will identify populations needs and the outcomes that are important to the people we serve in their particular place, and this will include defining what success looks like. While supportive of the intent, and as previously described, the prospect of a 3 year phased approach does not directly show how we will close the financial sustainability challenge in 18/19 and we continue to seek to influence more pace.

7.3 Acute Care Alliance

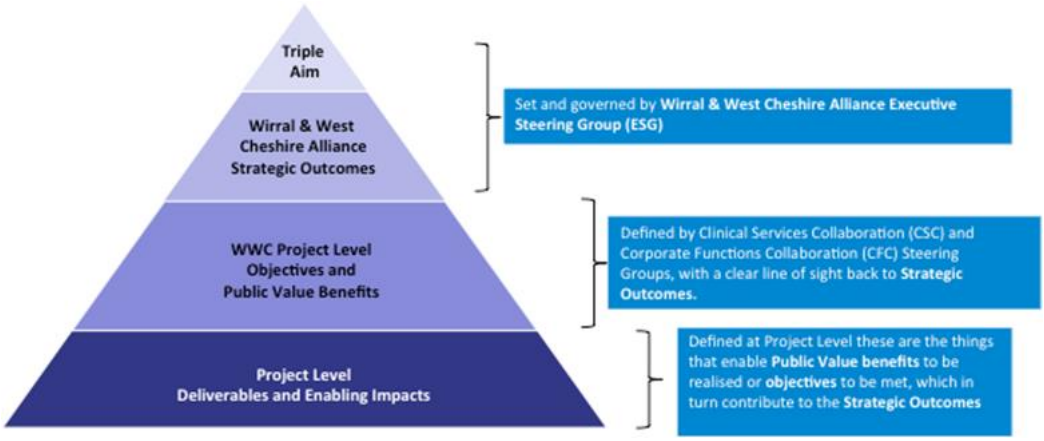
As referenced in Quality Section of this plan, we will in 2018 examine closer workings in respect of acute services between ourselves and our nearest acute neighbour, The Countess of Chester NHS Foundation Trust.

Our two organisations have a track record of successful collaboration; joint ownership of microbiology shared service, shared HR / Payroll services, clinical collaboration on a vascular hub, joint interventional radiology, human milk bank and other services to name but a few. We plan to collaborate in a number of additional areas;

- Digital enablement (Countess of Chester expect to become the first 'Fast Follower' to the WUTH / Cerner GDE model)
- Lord Carter Model Hospital collaboration, taking forward procurement and payroll opportunities in corporate functions and exploring a range of clinical opportunities as part of the clinical strategy work.
- Immediate opportunities for collaboration in areas such as Urology, Pathology and Women's and Children's Services. Pathology collaboration will build on extant shared microbiology service, meet the extant timetable for MES renewals and contribute to emerging dialog across North 4 Pathology Network which both Trusts are committed to supporting while remaining open minded about the future stave vision / target operating model options appraisal that will be required.

The WWC Alliance is in place to enable both Trusts to work together on some carefully selected things that will enhance the clinical and financial sustainability of services delivered by both Trusts. To do this and to provide a public narrative that our colleagues and the general public can get behind, the WWC Alliance has, at its heart, a 'triple aim'

1. Improve Health Outcomes for the half million or so people in the Wirral & West Cheshire path served by the two Partner Trusts
2. Improve the experience of Healthcare, not just for the people we serve but for our colleagues who deliver healthcare services
3. Better use of resources for health and care – Financial Sustainability



8. Trust Membership and Elections

The Trust holds Governor Elections each year for both public and staff seats on the Council of Governors. The Trust held an election in summer 2016 for 5 seats, both staff and public, which were all successfully filled. Elections in summer 2017 also successfully filled 5 public and staff governor seats.

In December 2017 the Trust held an additional by-election for the role of staff governor for the Medical and Dental Constituency.

The Trust continues to hold Council of Governors Workshops which includes visits to particular areas of the hospital to increase Governor Knowledge of, and insight into key areas of the Trust's operations. The majority of topics and areas for workshops are selected by governors themselves and have recently been expanded to include the participation of Ambassadors. The Governor role in the internal Care Quality inspections will remain pivotal in 2018 and beyond as this expands upon the concept of Board Walkabouts making these more meaningful and structured for all parties. The role of Ambassadors introduced during 2015/16 was a means of retaining the knowledge of ex-Governors who have reached the end of their tenure and using this to support new Governors. This has proven to be very successful, seeing more governors at the end of their natural tenure wishing to return as Ambassadors.

The Trust has continued with its active engagement of Governors via its Strategy & Sustainability Advisory Committee, the Committee reviews strategic themes and objectives and the programme for completion of the annual plan.

The Membership Strategy was revised and updated to take into account the evolving needs of the Trust, aiming to have wider links with the community. It was developed with the involvement of the Membership and Engagement Committee and approved by the Council of Governors in July 2017.

The Trust has always worked with established groups on the Wirral such as HealthWatch and the Older Peoples Parliament as a way of engaging with members and drawing upon a limited resource. Our Governors and Ambassadors play a huge role in the promotion and execution of our Annual Members' Meeting and with the content of our joint staff and public Newsletter.

The Trust continues to have a membership that is a good representation of the population it serves.

NHS
West Cheshire
Clinical Commissioning Group

NHS
Wirral
Clinical Commissioning Group

7th March 2018

Sent via email

Private & Confidential
Mr T Chambers and Mr D Jago

Dear Tony and David,

RE: NHS West Cheshire Clinical Commissioning Group and NHS Wirral Clinical Commissioning Group Acute Care Commission

With the development of the Cheshire & Merseyside Health and Care Partnership, and in particular, the acute sustainability programme, our respective Clinical Commissioning Groups (CCG) would like to commission from you a framework that seeks out the potential opportunities that such a programme affords.

As commissioners of the Countess of Chester NHS Foundation Trust and Wirral University Teaching Hospitals NHS Foundation Trust respectively, we are writing to request from you an exploratory `commission` that will examine, in the first instance, closer workings in respect of acute services between the two organisations. This commission will form part of the 2018/19 contract terms.

From national evidence and benchmarking data we believe there is much that can be done locally to improve standards, reduce variation, and stabilise the system. Drivers such as the Model Hospital Get it Right First Time (GIRFT), NHS Right Care, Public Health Outcome data and qualitative reports such as the AQ program, indicate that there are significant opportunities that are beholden upon us to explore.

Whilst the focus is on acute sustainability, we will work with you to consider the whole system dependencies and impacts. There are strong interfaces with primary care, community services, and social care, and the integration of this project's work with the local system strategy as a whole will be crucial for the transformation of acute care services. (Integrated Care partnerships)

The Scope
This scope will seek to determine the necessary acute care services required for the population of West Cheshire and Wirral and how, when considering this larger population, this will be undertaken in such a way as to assure services that are clinically and financially sustainable.
More specifically we would like to you to consider the following questions as key lines of enquiry within which to frame your proposals.

How will such an approach:

- Demonstrate improved outcomes for patients, including delivery of NHS constitutional standards and a reduction in unwarranted variation.

Chair - Dr Sue Wells
Chief Officer – Simon Banks

- Demonstrate financial sustainability, including efficient use of resources with a reduction of unnecessary duplication.
- Demonstrate the delivery of safe services within the context of a clinically sustainable workforce.
- Demonstrate the delivery of safe services within the alignment of activity and `critical mass` with the accreditation of services.
- Demonstrate the connections and integrations with other services to support demand management and the delivery of care closer to home.

The commission will result in an outline framework able to demonstrate clinical engagement at the very outset and connections with key partners as a means of effectively managing pathways.

In summary we expect the framework to demonstrate / consider:

- A case for change
- The delivery of clinical and patient standards
- Clinical co-dependency framework
- Gap analysis – current state
- New model of care
- Clinical support and call to action

For our part, commissioners will support with communications, business intelligence and information as required. We will also provide, as required, engagement with member GP practices, scrutiny and health and well-being boards as this project matures.

Commissioners are able and willing to support you in any we can as this project develops and we look forward to working with closely over the coming months. We would also expect a communications and engagement plan from yourselves outlining how you will engage our respective organisations in this work as it develops.

If you have any queries or points of clarity please do not hesitate to contact us.

Yours faithfully

Alison Lee
Chief Executive Officer
NHS West Cheshire Clinical Commissioning Group

Simon Banks
Chief Officer
NHS Wirral Clinical Commissioning Group

Wirral University Teaching Hospital NHS
NHS Foundation Trust

NHS
Countess of Chester Hospital
NHS Foundation Trust

David Jago
Acting Chief Executive
Arrow Park Hospital
Arrowe Park Road
Upton
Wirral, CH49 5PE

Tony Chambers
Chief Executive
The Countess of Chester Health Park
Liverpool Road
Chester
CH2 1UL

12th March 2018

By E-mail
Simon Banks, Wirral CCG
Alison Lee, West Cheshire CCG

Dear Simon and Alison

Many thanks for your recent letter.

Recognising the development of the Cheshire & Merseyside Health and Care Partnership, and in particular, the acute sustainability programme, we are delighted to be commissioned to produce a framework that seeks out the potential opportunities that such a programme affords.

As you know, the Countess of Chester NHS Foundation Trust and Wirral University Teaching Hospitals NHS Foundation Trust have a long history of close workings in respect of acute services, and we too believe there is much that can be done locally to improve standards, reduce variation and ensure stability of acute services, and that there are significant opportunities we must explore together.

We have asked our respective Medical Directors to work with their colleagues to determine our approach to this commission, and we expect to be able to provide you with a more detailed proposal before the end of March.

We also welcome your offer of support with communications, business intelligence and information as required, and in respect of engagement with member GP practices, scrutiny and health and well-being boards.

We look forward to working with closely over the coming months.

David Jago
Acting Chief Executive

Tony Chambers
Chief Executive

Wirral & West Cheshire
Proposal for Clinical Strategy Summit

Context & Background

With the development of the Cheshire & Merseyside Health and Care Partnership, and in particular, the Acute Sustainability Programme, our respective CCGs have commissioned the Countess of Chester NHS Foundation Trust and Wirral University Teaching Hospitals NHS Foundation Trust to explore the potential opportunities that such a programme affords. They have requested from us an exploratory `commission` that will examine, in the first instance, closer workings in respect of acute services between the two organisations. This commission will form part of the 2018/19 contract terms.

From national evidence and benchmarking data we believe there is much that can be done locally to improve standards, reduce variation, and stabilise the system. Drivers such as the Model Hospital Get it Right First Time (GIRFT), NHS Right Care, Public Health Outcome data and qualitative reports such as the AQ program, indicate that there are significant opportunities that are beholden upon us to explore.

This scope will seek to determine the necessary acute care services required for the population of West Cheshire and Wirral and how, when considering this larger population, this will be undertaken in such a way as to assure services that are clinically and financially sustainable. More specifically we are required to consider the following questions as key lines of enquiry within which to frame our proposals.

How will such an approach:

- Demonstrate improved outcomes for patients, including delivery of NHS constitutional standards and a reduction in unwarranted variation.
- Demonstrate financial sustainability, including efficient use of resources with a reduction of unnecessary duplication.
- Demonstrate the delivery of safe services within the context of a clinically sustainable workforce.
- Demonstrate the delivery of safe services within the alignment of activity and `critical mass` with the accreditation of services.
- Demonstrate the connections and integrations with other services to support demand management and the delivery of care closer to home

The remainder of this document together with appendices outlines how we propose to approach this commission.

Proposed Participants (not exhaustive)

- Exec Team
- Divisional Chairs / Directors
- Clinical Directors
- Clinical Service Leads
- Heads of Nursing
- Associate Directors of Nursing
- Heads of other clinical services e.g. Physio
- Divisional General Managers
- AD for Estates & Facilities
- Representatives from key corporate functions e.g. Finance, HR
- 1 or 2 Non-execs
- Governors / Patient Representatives / Healthwatch

Output

A discussion document outlining key strategies which will cover:

- A case for change
- The delivery of clinical and patient standards
- Clinical co-dependency framework
- Gap analysis – current state
- New models of care
- Clinical support and call to action

Proposed Process

1. Preparatory meetings (2 hours) to identify perceived Strengths, Weaknesses, Opportunities & Threats (SWOT) within the groups in **appendix 1**:
2. Preparation of agenda, participants, materials, logistics by a small Steering Group;
3. A one-day workshop, offsite, designed to be highly participative, enlivening, varied in format, intensive and productive **(appendix 2**, strawman agenda);
4. Production of the discussion document, circulation & feedback;
5. A further one-day workshop to bring back by clinical group proposed strategies;
6. Prioritising & initiating further work required.

Workshop format

Based on the SWOT analyses generated in the preparatory meetings, workshop participants will be invited to generate strategies of four kinds, arising from the interactions of the SWOT quadrants as illustrated below:

Title of Service:	**Strengths:**	**Weaknesses:**
Opportunities:	Exploitation (which of our strengths will we exploit, to take advantage of the opportunities?):	Internal development (which of our weaknesses can we overcome, to take advantage of the opportunities?):
Threats:	External development (how will we make our strengths more visible to clients?):	Survival/Exit strategies (for which services?):

Timing - Proposed schedule:

See attached timeline **appendix 3**

Medicine (unplanned / non elective)	Accident & Emergency	ED MAU SAU Resus	
	In Patient (bed holding)	General Medicine	Acute Medicine DME / Elderly medicine Palliative / EoL Stroke
		Other Medicine Specialties	Gastro Endoscopy / Bronchoscopy Cardiology Respiratory Haematology Rheumatology Diabetes & Endocrinology Nephrology Dermatology
	Rehab	Elderly Care	
		Specialist	
Surgery (planned / elective)	In Patient	Trauma & Orthopaedics	
		General & Specialist Surgery	Vascular Urology ENT Oral Max GI, Upper & Lower
		General Surgery	Opthalmology
	Outpatients / Day case / Ambulatory		
	Peri-operative medicine (Theatres)		
Women's & Children's	Paediatrics		
	Women's services		
Clinical Support	Radiology		Interventional Radiology
	Pathology	Cellular Pathology	
		Blood Sciences	
		Microbiology	
	Pharmacy		
	Other	Anaesthetics	
		Critical Care	
		Therapies	

NHS
Countess of Chester Hospital
NHS Foundation Trust

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Clinical Summit

10th May 2018

Wirral & West Cheshire
South Of The Mersey

Agenda

09.00 Coffee and Networking

09.30 Welcome

09.45 Plenary 1: National & Regional Context (CCG)

10.30 Breakout 1: Patient Centred Outcomes

11.15 Coffee & Networking

11.30 Plenary 2: Our Story (Women & Children's Services)

11.45 Breakout 2: Celebrating our Strengths, Recognising our Gaps

12.30 Lunch & Networking

13.15 Plenary 3: Our Story (Urology)

13.30 Breakout 3: Our Priorities

14:30 Coffee & Networking

15:00 Plenary 4: Our Story (Pathology)

15:15 Breakout 4: Our Approach

16.15 Panel Q&A

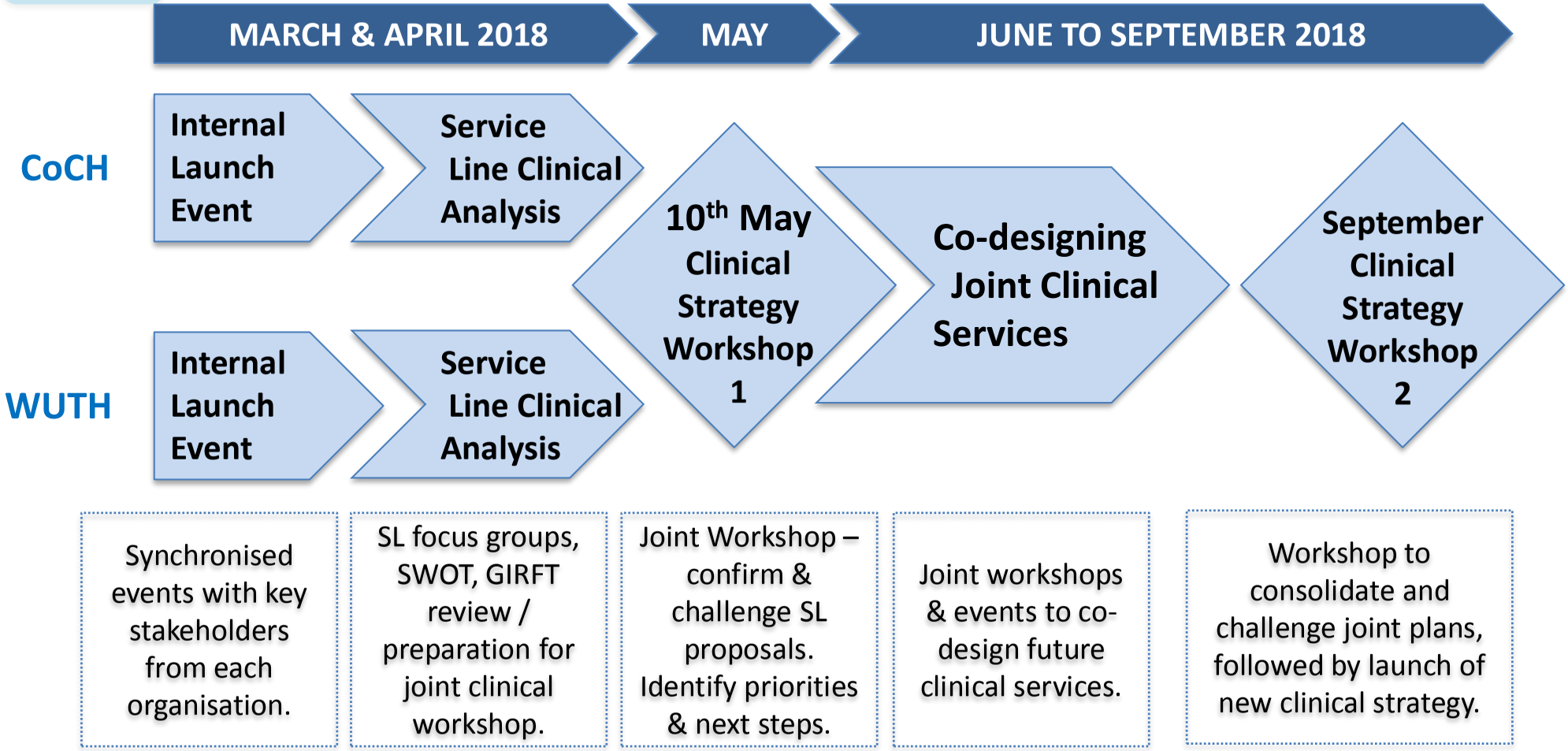
16.45 Closing Remarks, what's next?

17:00 Close (Networking time)

W&WC ALLIANCE

CLINICAL SERVICES STRATEGY DRAFT

From WHAT to HOW and WHERE ?



Board of Directors	
Agenda Item	7.1
Title of Report	Draft Nursing & Midwifery Workforce Strategy
Date of Meeting	28 March 2018
Author	Helen Marks, Director of Workforce
Accountable Executive	Helen Marks, Director of Workforce
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Strategic Objective – 1 "To be the top NHS Trust in the North West for patient and staff satisfaction"
Level of Assurance • **Positive** • **Gap(s)**	
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion
Data Quality Rating	
FOI status	
Equality Impact Assessment Undertaken • **Yes** • **No**	No

1. Executive Summary

The following document is a draft nursing and midwifery strategy that has been produced in order to address recruitment and retention challenges facing the Trust.

2. Background

The nursing and midwifery workforce makes up 40% of the Trust's total headcount. Over the past 12 months the turnover amongst band 5 nurses has doubled (particularly within inpatients and the emergency department). In addition the Trust has also seen a significant rise in sickness absence amongst the nursing and midwifery workforce.

At the February 2018 Trust Board a commitment was made to develop a nursing and midwifery workforce strategy that would address the areas of concern experienced by the organisation.

3. Nursing and Midwifery Workforce Strategy

The attached strategy will present a vision for our nursing and midwifery workforce and has been shaped around the following key headings:

- What our patients can expect from our nursing and midwifery workforce
- What our nursing and midwifery workforce can expect from us
- What our communities can expect from the trust
- What our approach is to research

Under each of these headings are a number of initiatives to enhance and raise the Trust's profile in relation to the recruitment of nurses and a number of interventions that will assist with retention as well as address sickness absence. There will be a 'golden thread' from the corporate organisational development themes, as identified in the Trust Board report about the national staff survey, to the plans detailed in the document to ensure that all programmes are joined up and there is one direction of travel.

The strategy is currently in draft format as it is proposed that the document will be circulated for consultation. The first stage of that consultation is to present it to Board for discussion and comments. It is then envisaged that the final document will come to Trust Board for May 2018 for approval.

It is proposed that the Trust will hold its first nursing and midwifery conference in early summer of 2018 to launch the strategy.

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4. Recommendation

It is recommended to Trust Board:

- To receive the draft strategy and provide comments
- To receive and approve the final document in May 2018

Helen Marks
Interim Director of Workforce

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Nursing and Midwifery Workforce Strategy

2018 - 2020

EXCELLENT SERVICES | SHAPING OUR OWN FUTURE | MAXIMISING VALUE

#PROUD TO CARE FOR YOU WUTHstaff wuth.nhs.uk

Our Director of Nursing & Midwifery

Wirral University Hospital Trust believes that our patients deserve the very best care and places the patient at the heart of the services the trust provides. Nursing and Midwifery is the largest part of our workforce and therefore the trust recognises that they are fundamental in delivering compassionate, safe and high quality care.

Our dedicated, highly skilled and knowledgeable workforce ensure that our patients receive safe and effective care and have the most positive experience whilst receiving services from us.

Nursing is facing it's greatest challenges with the increasing demand on our services, the lessons detailed in the Francis report, the changes in the education for nursing and national recruitment difficulties. Therefore, it is vital that Wirral University Teaching Hospitals sets the strategic direction with a clear way forward for addressing these challenges, particularly in relation to recruiting and retaining a highly skilled nursing workforce.

I am proud to lead this dedicated workforce who invest so much of themselves every day with enthusiasm and professionalism and wish to support them in their careers to make this trust one of the best.

Gaynor Westray

DRAFT

Vision for Nursing

The 6 Cs

The 6Cs are embedded into everything nursing, midwifery and care staff do here at Wirral University Teaching Hospital. The 6Cs are:

Care:

Caring is what I do – I am proud when I have cared for patients and their carers really well and I have made a difference.

Compassion:

I am kind, thoughtful, a good listener and anticipate my patients' needs – I will go the extra mile for my patients and their carers.

Competence:

I am knowledgeable and competent. I am responsible for finding out about my patients' care and I will always ask for help if I am unsure because my patients' safety matters to me.

Communication:

I will introduce myself to patients and visitors, establishing eye contact and smile. I will use the patients' preferred name. I will not talk over patients and will be polite, calm and approachable.

Courage:

I will speak out and be responsible for taking action if my patients' care is being compromised. I will adhere to my Code of Conduct at all times.

Commitment:

I will come to work and be focused on the patients in my care and the needs of my team members. I will be fit and well to care. I will inspire confidence through my professional appearance and I am proud to wear my uniform.

DRAFT

Background

This strategy builds on the vision of our previous five year Nursing and Midwifery strategy that was launched in December 2013 – modern, patient focused nursing and midwifery based on traditional values.

Over the past five years nursing and midwifery at Wirral University Teaching Hospitals have based their care on traditional values – the 6 Cs - Caring, Compassionate, Competencies, Communication, Courage and Commitment. In 2016 Professor Jane Cummings, Chief Nursing Officer, NHS England launched a new framework, building on the 6Cs, which encourages the nursing & midwifery workforce to get into the driving seat to lead transformational change in the health and care sector. The ten commitments are designed to support all staff to understand the leadership role they all play to deliver the challenges and outcomes described in the Five Year Forward View. The commitments cover the following areas:

1. We will promote a culture where improving the population's health is a core component of the practice of all nursing, midwifery and care staff
2. We will increase the visibility of nursing and midwifery leadership and input in prevention
3. We will work with individuals, families and communities to equip them to make informed choices and manage their own health
4. We will be centred on individuals experiencing high value care
5. We will work in partnership with individuals, their families, carers and others important to them
6. We will actively respond to what matters most to staff and colleagues
7. We will lead and drive research to evidence the impact of what we do
8. We will have the right education, training and development to enhance our skills, knowledge and understanding
9. We will have the right staff in the right places and at the right time
10. We will champion the use of technology and informatics to improve practice, address unwarranted variations and enhance outcomes

This Nursing and Midwifery Workforce Strategy describes what our nursing workforce can expect from us, how they will develop, be supported and listened to in order to deliver the best possible care for our patients and the communities we serve.

DRAFT

Our Patients

Our patients deserve the best care and therefore they can expect the following:

1. Patients will receive compassionate individualised care. In addition the promotion of our patient's health and wellbeing will be in every discussion ensuring that they are treated as an individual instead of a diagnosis.

2. The recruitment of high quality staff, which means that we will attend a programme of recruitment events where we will be in attendance as well as running our own.

3. That all our nursing staff regardless of whether qualified or non-qualified will have completed all of their mandatory, essential and clinical skills training as a core kite mark of patient safety and clinical effectiveness.

4. That all our qualified nursing staff will be actively involved in continuous professional development in order to enhance their nursing skills.

5. We will work towards reducing avoidable harm such as pressure ulcers hospital acquired infections, medication errors and reducing falls.

6. We will continue to improve the discharge experience

7. That our patients receive excellent care at the end of life.

8. The outcomes from the Friends and Family Test will be feedback into the nursing leadership teams in order to engage the wider nursing workforce to make any necessary changes.

9. That our patients will be cared for in a harm-free environment.

DRAFT

Our nursing workforce

Our nursing workforce can expect the following:

1. Work with university partners to increase the capacity of our nursing workforce that meet the values and behaviours of Wirral University Hospital Trust.

1. Building on our existing preceptorship and development programmes to support newly qualified nurses to make the transition from training to practice

2. To have practice educators in every nursing area.

3. To continually review our clinical skills programmes meet the needs of modern nursing practice

4. That all senior nurses will have access to compassionate leadership and coaching programmes that will assist in creating a pipeline for future roles such as Matrons, Nurse Consultants Heads or specialist nursing positions

5. Clinical support workers will have a development programme in place that will support them into different roles such as Nursing Associates and to help them to consider registered roles.

6. Develop clear career pathways that facilitate the journey from apprenticeships to professional roles within the trust and continue to make better use of workforce modernisation roles.

7. That employer supported bursaries or apprenticeships will be offered to assist in non-registered employees becoming qualified as a way of 'growing our own' talent.

8. Create working environments that support health and wellbeing of nursing workforce and to build resilience.

9. Develop the skills of our nursing workforce to support our patients who have mental health difficulties and learning disabilities more effectively

10. To actively facilitate and support concerns being raised, with the assurance that they will be addressed effectively and promptly.

11. The trust will align training with all patient safety and quality indicators to ensure learning from incidents and complaints to improve the quality of care and the patient experience.

12. An increase the effectiveness of e-roster for nurses

13. To routinely seek feedback from our nurses leaving the trust and to act on this

14. To adopt approaches that recognise and value our nursing and midwifery workforce

15. To be activity engaged in positively shaping the services we provide.

DRAFT

Our communities

As a major health care provider on the Wirral our communities can expect:

1. A workforce that reflects the diversity of the community we serve

2. No barriers for people from any background (and from any of the protected characteristics) from joining or progressing in the Trust.

3. Us to provide work experience and volunteering opportunities in non- registered roles or registered roles for the appropriately qualified either on a part-time or flexible basis.

4. To create links with schools and colleges in order to raise the awareness of nursing roles, which include offering taster days

5. To develop an approach to traineeships, apprenticeships and work experience linked to increasing employment opportunities as a first step into a health care career.

6. Increase the scope of volunteering programme across the Trust through working with third sector partners.

7. Us to play a key role to work with our stakeholder, partners and other agencies in working towards the creation of a healthy Wirral.

DRAFT

Our research

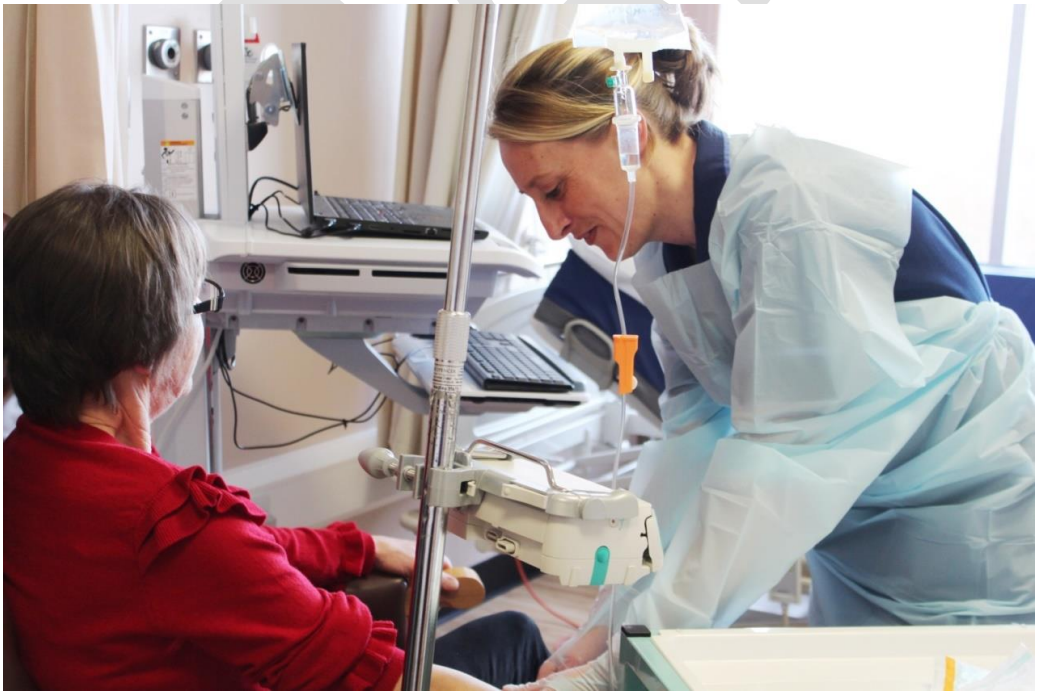
We want to ensure that our nursing workforce, are facilitated to take part and contribute to research through:

1. The encouragement of our nurses to publish papers with a view to write for publications and achieving trust publications in peer reviewed professional, research and management journals

2. To work in collaboration with universities to develop clinical research career for nurses and supporting secondment and/or sabbaticals to facilitate nursing to take on research which will feedback into the trust.

3. To optimise the use of technology and informatics to address clinical variance and to ensure that we deliver safe evidence based nursing care.

4. To encourage oversea links with universities and the nursing workforce to encourage overseas nurses to come and work in the trust.



Trust Board	
Agenda Item	7.2
Title of Report	NHS 2017 National Staff Survey Results for Wirral University Teaching Hospital
Date of Meeting	28.3.2018
Author	Cathy McKeown, Assistant Director of OD
Accountable Executive	Helen Marks, Director of Workforce (interim)
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	*Strategic Objective – 1 "To be the top NHS Trust in the North West for patient and staff satisfaction"* *Risk Ref 3 - Staff Engagement – There is a risk that the challenging NHS Environment impacts on staff engagement.*
Level of Assurance • **Positive** • **Gap(s)**	*Gaps*
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	*To Note*
Data Quality Rating	Gold – Quantitative data that has been externally validated but low response rate
FOI status	
Equality Impact Assessment Undertaken • **Yes** • **No**	*No*

1. Executive Summary

This paper highlights the outcome of the National Staff Survey results 2017 as well as explaining the next steps to address the areas of concern. Appendix 1 is the summary of findings of the National Survey 2017.

2. Background

The National Staff Survey was undertaken between September and December 2017. It was distributed to a random sample of 1250 staff across all roles and divisions. For the first time, the Trust had increased its distribution via NHS email to 70% of invitees, with 30% who received it in hard copy format. Multiple reminders were sent.

The Trust's response rate was the lowest seen in several years at 31% (382 respondents). The national average for acute trusts administered by Quality Health was 45%. Our response rate in 2016 was 46%.

3. Findings of the 2017 Staff Survey

As can be seen from the attached summary, although there are some positive areas, overall the results of the survey are disappointing.

Positive areas are:

- Staff experiencing harassment, bullying or abuse from patients, relatives and the public
- Staff experiencing discrimination at work
- Staff working extra hours or attending work when unwell

The biggest areas of concern are, which were in the lowest 20% are:

- Staff engagement
- Appraisals, both quantity and quality
- Lack of training and development
- Lack of effective team working
- Recognition and valued by managers and the organisation
- Staff ability to contribute to improvements at work
- Staff witnessing potentially harmful errors, near misses or incidents
- Staff confidence and security in reporting unsafe clinical practice
- Staff satisfaction with the quality of work and care they are able to deliver
- The degree to which staff agree that their role makes a difference to patients/services users
- Effective use of patient/service user feedback
- Staff experiencing harassment bullying or abuse

4 Next Steps

The Staff Engagement work programme for 2018 will take a new approach and focus on key themes delivered though a refreshed Organisational Development Plan. Additionally, these key themes will take into consideration feedback from staff on the low or most deteriorated areas within the 2017 National Staff Survey. Themes will include:

- Culture
- Leadership
- Engagement
- Healthy Working Environment
- Learning Organisation
- Valuing our workforce

- Inclusivity

A programme of work will underpin each of these themes. These work programmes will be presented to the board for approval in April 2018. Quarterly updates on progress will be brought to the board. There is also a paper on the March 2018 Trust Board agenda proposing the establishment of a workforce committee, as a sub-committee of the board. If approved, one of the main purposes of the committee will be to ensure delivery of the overall programme. The board will then receive updates from the committee to provide assurance.

5 Recommendations

The Trust Board is asked to:

1. Note the contents of the report and attached national summary report.
2. Support the next steps highlighted in section 4 and the proposed governance arrangements to oversee progress
3. Note that the quarterly Staff Friends & Family Test will continue to be used throughout the year to provide a temperature check on the workforce staff engagement levels.

Cathy McKeown
Assistant Director of OD
March 2018

NHS

2017 National NHS staff survey

Brief summary of results from Wirral University Teaching Hospital NHS Foundation Trust

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2: Overall indicator of staff engagement for Wirral University Teaching Hospital NHS Foundation Trust 5

3: Summary of 2017 Key Findings for Wirral University Teaching Hospital NHS Foundation Trust 6

4: Full description of 2017 Key Findings for Wirral University Teaching Hospital NHS Foundation Trust (including comparisons with the trust's 2016 survey and with other acute trusts) 15

1. Introduction to this report

This report presents the findings of the 2017 national NHS staff survey conducted in Wirral University Teaching Hospital NHS Foundation Trust.

In section 2 of this report, we present an overall indicator of staff engagement. Full details of how this indicator was created can be found in the document ***Making sense of your staff survey data***, which can be downloaded from www.nhsstaffsurveys.com.

In sections 3 and 4 of this report, the findings of the questionnaire have been summarised and presented in the form of 32 Key Findings.

These sections of the report have been structured thematically so that Key Findings are grouped appropriately. There are nine themes within this report:

- Appraisals & support for development
- Equality & diversity
- Errors & incidents
- Health and wellbeing
- Working patterns
- Job satisfaction
- Managers
- Patient care & experience
- Violence, harassment & bullying

Please note, two Key Findings have had their calculation changed and there have been minor changes to the benchmarking groups for social enterprises since last year. For more detail on these changes, please see the ***Making sense of your staff survey data*** document.

As in previous years, there are two types of Key Finding:

- percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions

- scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5

A longer and more detailed report of the 2017 survey results for Wirral University Teaching Hospital NHS Foundation Trust can be downloaded from: www.nhsstaffsurveys.com. This report provides detailed breakdowns of the Key Finding scores by directorate, occupational groups and demographic groups, and details of each question included in the core questionnaire.

Your Organisation

The scores presented below are un-weighted question level scores for questions Q21a, Q21b, Q21c and Q21d and the un-weighted score for Key Finding 1. The percentages for Q21a – Q21d are created by combining the responses for those who “Agree” and “Strongly Agree” compared to the total number of staff that responded to the question.

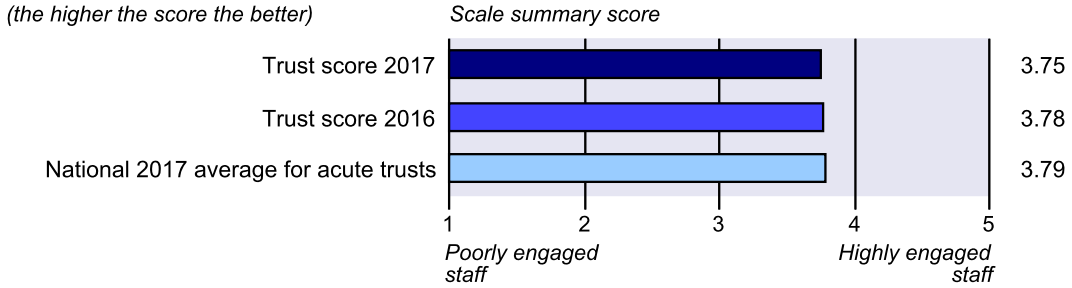
Q21a, Q21c and Q21d feed into Key Finding 1 “Staff recommendation of the organisation as a place to work or receive treatment”.

		Your Trust in 2017	Average (median) for acute trusts	Your Trust in 2016
Q21a	"Care of patients / service users is my organisation's top priority"	69%	76%	71%
Q21b	"My organisation acts on concerns raised by patients / service users"	66%	73%	70%
Q21c	"I would recommend my organisation as a place to work"	59%	61%	62%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	69%	71%	69%
KF1.	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.70	3.76	3.73

2. Overall indicator of staff engagement for Wirral University Teaching Hospital NHS Foundation Trust

The figure below shows how Wirral University Teaching Hospital NHS Foundation Trust compares with other acute trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.75 was below (worse than) average when compared with trusts of a similar type.

OVERALL STAFF ENGAGEMENT



This overall indicator of staff engagement has been calculated using the questions that make up Key Findings 1, 4 and 7. These Key Findings relate to the following aspects of staff engagement: staff members' perceived ability to contribute to improvements at work (Key Finding 7); their willingness to recommend the trust as a place to work or receive treatment (Key Finding 1); and the extent to which they feel motivated and engaged with their work (Key Finding 4).

The table below shows how Wirral University Teaching Hospital NHS Foundation Trust compares with other acute trusts on each of the sub-dimensions of staff engagement, and whether there has been a significant change since the 2016 survey.

	Change since 2016 survey	Ranking, compared with all acute trusts
OVERALL STAFF ENGAGEMENT	• No change	! Below (worse than) average
KF1. Staff recommendation of the trust as a place to work or receive treatment *(the extent to which staff think care of patients/service users is the trust's top priority, would recommend their trust to others as a place to work, and would be happy with the standard of care provided by the trust if a friend or relative needed treatment.)*	• No change	! Below (worse than) average
KF4. Staff motivation at work *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)*	• No change	• Average
KF7. Staff ability to contribute towards improvements at work *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)*	• No change	! Lowest (worst) 20%

Full details of how the overall indicator of staff engagement was created can be found in the document ***Making sense of your staff survey data***.

3. Summary of 2017 Key Findings for Wirral University Teaching Hospital NHS Foundation Trust

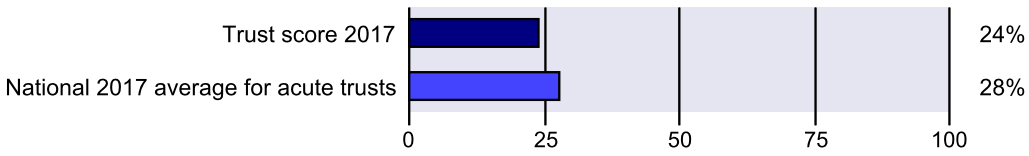
3.1 Top and Bottom Ranking Scores

This page highlights the five Key Findings for which Wirral University Teaching Hospital NHS Foundation Trust compares most favourably with other acute trusts in England.

TOP FIVE RANKING SCORES

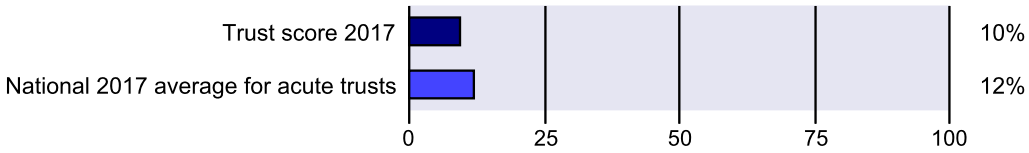
✓ KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

(the lower the score the better)



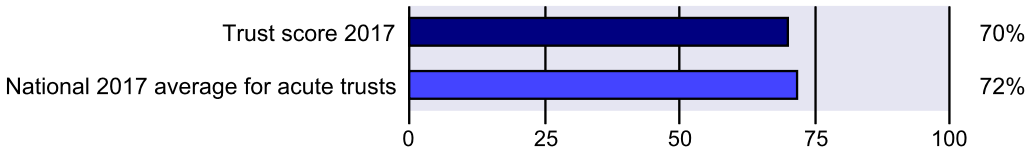
✓ KF20. Percentage of staff experiencing discrimination at work in the last 12 months

(the lower the score the better)



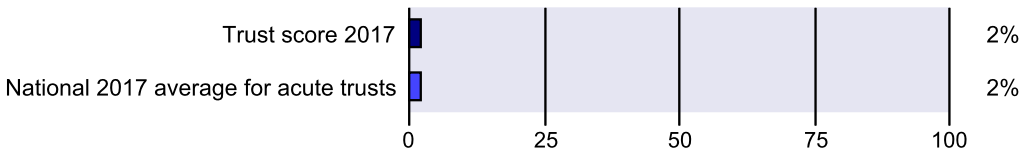
✓ KF16. Percentage of staff working extra hours

(the lower the score the better)



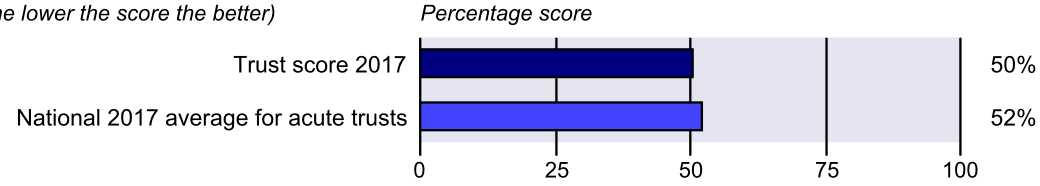
✓ KF23. Percentage of staff experiencing physical violence from staff in last 12 months

(the lower the score the better)



✓ KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves

(the lower the score the better)



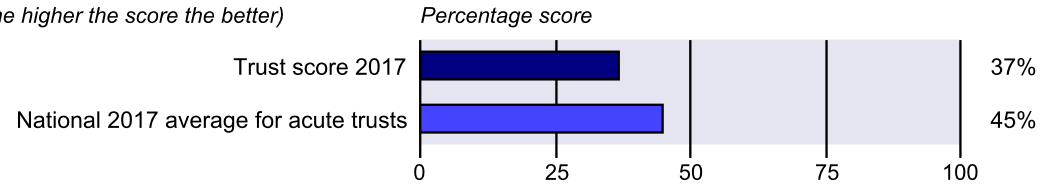
For each of the 32 Key Findings, the acute trusts in England were placed in order from 1 (the top ranking score) to 93 (the bottom ranking score). Wirral University Teaching Hospital NHS Foundation Trust's five highest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 1. Further details about this can be found in the document ***Making sense of your staff survey data***.

This page highlights the five Key Findings for which Wirral University Teaching Hospital NHS Foundation Trust compares least favourably with other acute trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

BOTTOM FIVE RANKING SCORES

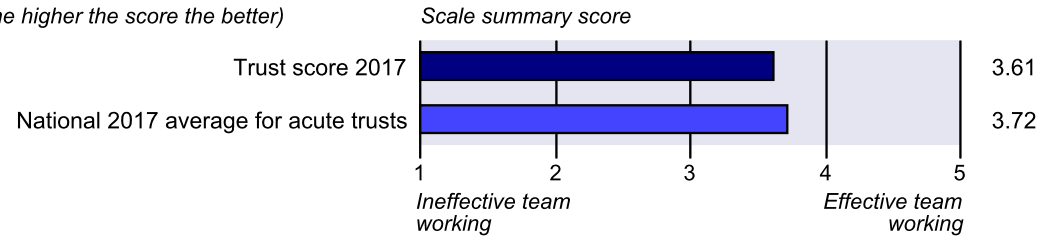
! KF27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse

(the higher the score the better)



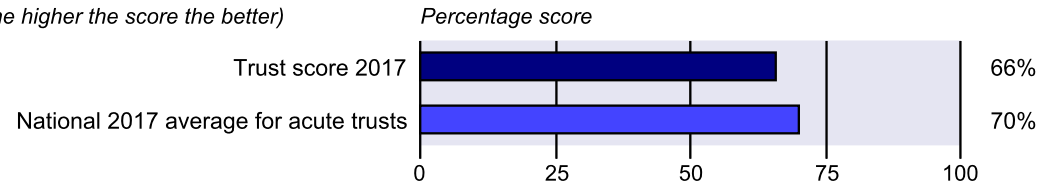
! KF9. Effective team working

(the higher the score the better)



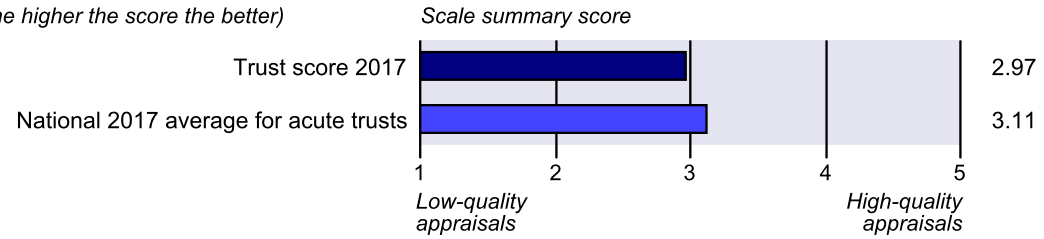
! KF7. Percentage of staff able to contribute towards improvements at work

(the higher the score the better)



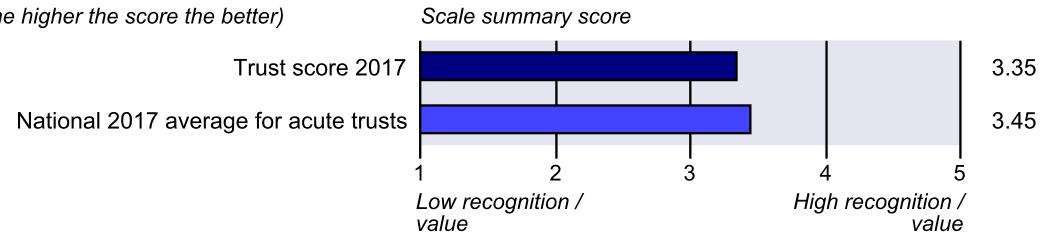
! KF12. Quality of appraisals

(the higher the score the better)



! KF5. Recognition and value of staff by managers and the organisation

(the higher the score the better)



For each of the 32 Key Findings, the acute trusts in England were placed in order from 1 (the top ranking score) to 93 (the bottom ranking score). Wirral University Teaching Hospital NHS Foundation Trust's five lowest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 93. Further details about this can be found in the document ***Making sense of your staff survey data***.

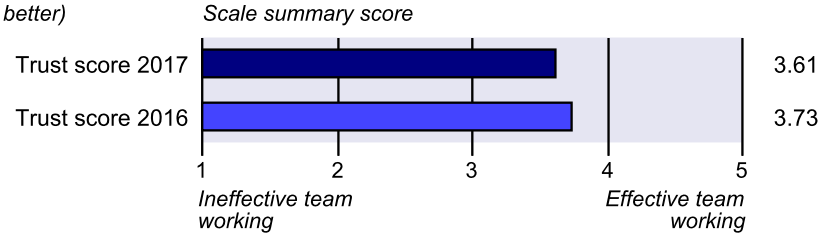
3.2 Largest Local Changes since the 2016 Survey

This page highlights the two Key Findings where staff experiences have deteriorated since the 2016 survey. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

WHERE STAFF EXPERIENCE HAS DETERIORATED

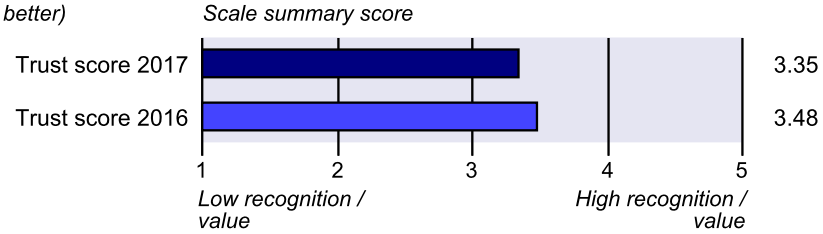
! KF9. Effective team working

(the higher the score the better)



! KF5. Recognition and value of staff by managers and the organisation

(the higher the score the better)



Because the Key Findings vary considerably in terms of subject matter and format (e.g. some are percentage scores, others are scale scores), a straightforward comparison of score changes is not the appropriate way to establish which Key Findings have deteriorated the most. Rather, the extent of 2016-2017 change for each Key Finding has been measured in relation to the national variation for that Key Finding. Further details about this can be found in the document ***Making sense of your staff survey data***.

3.3. Summary of all Key Findings for Wirral University Teaching Hospital NHS Foundation Trust

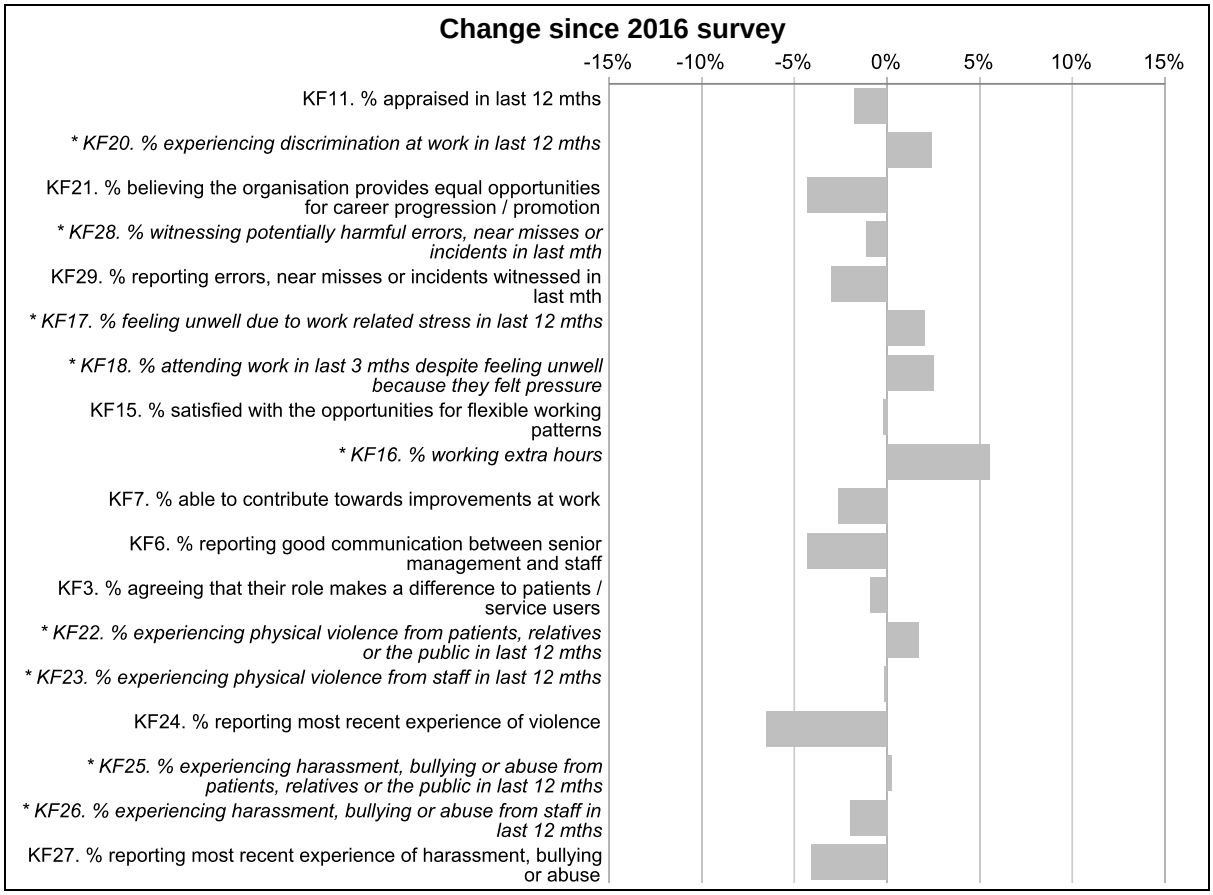
KEY

Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2016 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2016 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2016 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.3. Summary of all Key Findings for Wirral University Teaching Hospital NHS Foundation Trust

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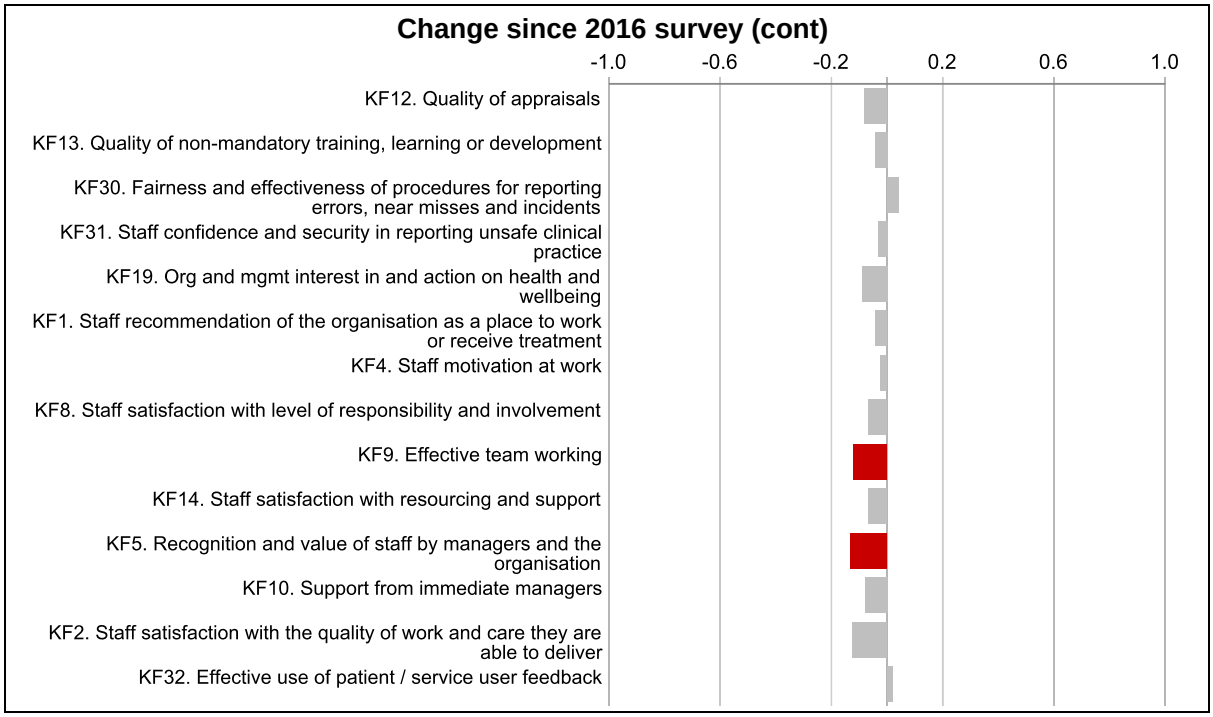


3.3. Summary of all Key Findings for Wirral University Teaching Hospital NHS Foundation Trust

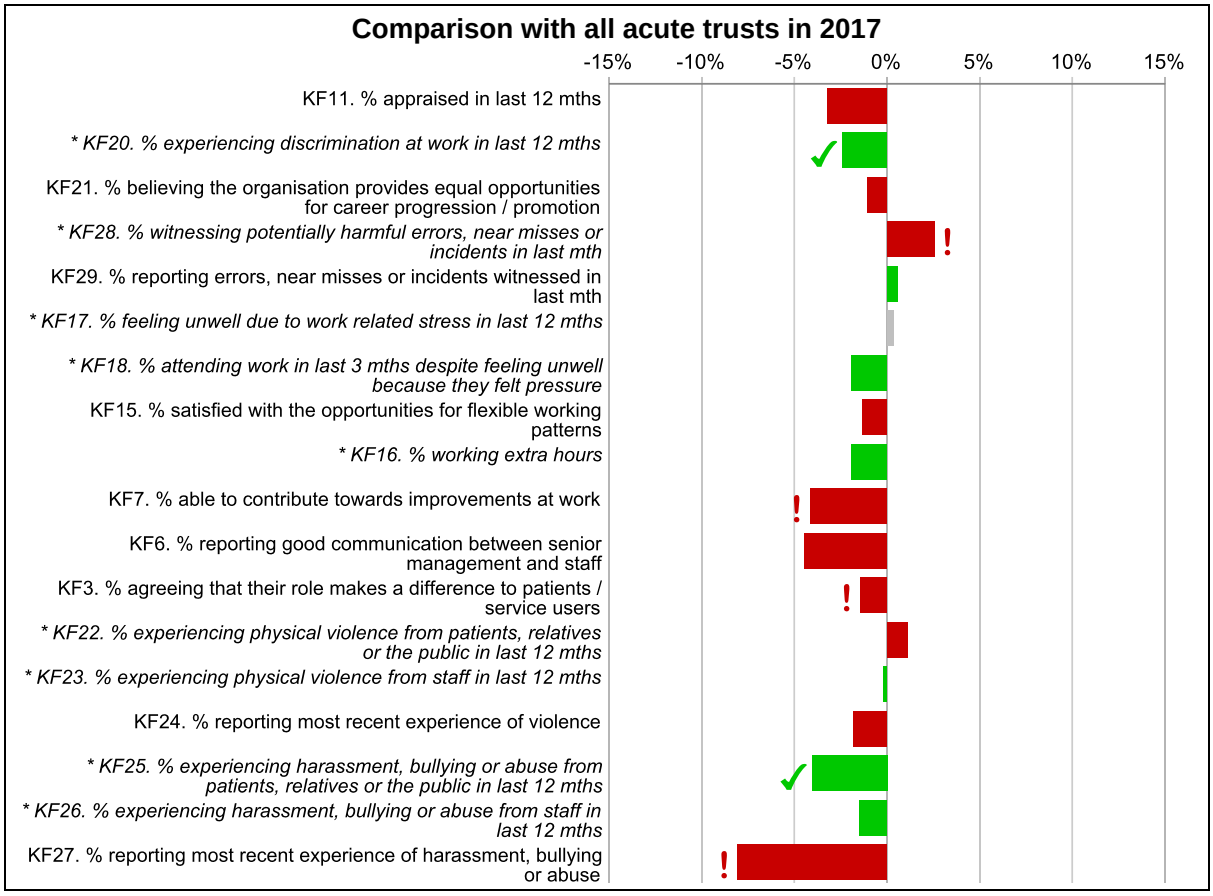
KEY

Green = Positive finding, e.g. better than average. If a ✓ is shown the score is in the best 20% of acute trusts

Red = Negative finding, i.e. worse than average. If a ! is shown the score is in the worst 20% of acute trusts.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.3. Summary of all Key Findings for Wirral University Teaching Hospital NHS Foundation Trust

KEY

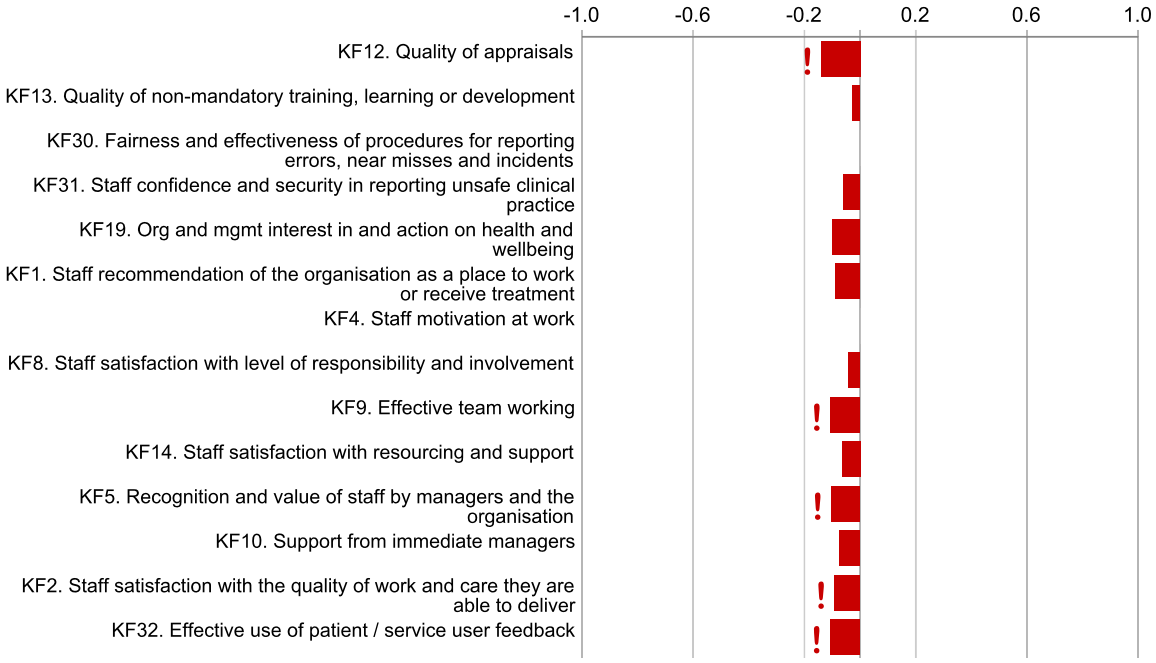
Green = Positive finding, e.g. better than average. If a ✓ is shown the score is in the best 20% of acute trusts

Red = Negative finding, i.e. worse than average. If a ! is shown the score is in the worst 20% of acute trusts.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

Comparison with all acute trusts in 2017 (cont)



3.4. Summary of all Key Findings for Wirral University Teaching Hospital NHS Foundation Trust

KEY

✓ Green = Positive finding, e.g. in the best 20% of acute trusts, better than average, better than 2016.

! Red = Negative finding, e.g. in the worst 20% of acute trusts, worse than average, worse than 2016.

'Change since 2016 survey' indicates whether there has been a statistically significant change in the Key Finding since the 2016 survey.

-- No comparison to the 2016 data is possible.

* For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

	Change since 2016 survey	Ranking, compared with all acute trusts in 2017
Appraisals & support for development		
KF11. % appraised in last 12 mths	• No change	! Below (worse than) average
KF12. Quality of appraisals	• No change	! Lowest (worst) 20%
KF13. Quality of non-mandatory training, learning or development	• No change	! Below (worse than) average
Equality & diversity		
* *KF20. % experiencing discrimination at work in last 12 mths*	• No change	✓ Lowest (best) 20%
KF21. % believing the organisation provides equal opportunities for career progression / promotion	• No change	! Below (worse than) average
Errors & incidents		
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	• No change	! Highest (worst) 20%
KF29. % reporting errors, near misses or incidents witnessed in last mth	• No change	✓ Above (better than) average
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	• No change	• Average
KF31. Staff confidence and security in reporting unsafe clinical practice	• No change	! Below (worse than) average
Health and wellbeing		
* *KF17. % feeling unwell due to work related stress in last 12 mths*	• No change	• Average
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	• No change	✓ Below (better than) average
KF19. Org and mgmt interest in and action on health and wellbeing	• No change	! Below (worse than) average
Working patterns		
KF15. % satisfied with the opportunities for flexible working patterns	• No change	! Below (worse than) average
* *KF16. % working extra hours*	• No change	✓ Below (better than) average

3.4. Summary of all Key Findings for Wirral University Teaching Hospital NHS Foundation Trust (cont)

	Change since 2016 survey	Ranking, compared with all acute trusts in 2017
Job satisfaction		
KF1. Staff recommendation of the organisation as a place to work or receive treatment	• No change	! Below (worse than) average
KF4. Staff motivation at work	• No change	• Average
KF7. % able to contribute towards improvements at work	• No change	! Lowest (worst) 20%
KF8. Staff satisfaction with level of responsibility and involvement	• No change	! Below (worse than) average
KF9. Effective team working	! Decrease (worse than 16)	! Lowest (worst) 20%
KF14. Staff satisfaction with resourcing and support	• No change	! Below (worse than) average
Managers		
KF5. Recognition and value of staff by managers and the organisation	! Decrease (worse than 16)	! Lowest (worst) 20%
KF6. % reporting good communication between senior management and staff	• No change	! Below (worse than) average
KF10. Support from immediate managers	• No change	! Below (worse than) average
Patient care & experience		
KF2. Staff satisfaction with the quality of work and care they are able to deliver	• No change	! Lowest (worst) 20%
KF3. % agreeing that their role makes a difference to patients / service users	• No change	! Lowest (worst) 20%
KF32. Effective use of patient / service user feedback	• No change	! Lowest (worst) 20%
Violence, harassment & bullying		
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	• No change	! Above (worse than) average
* *KF23. % experiencing physical violence from staff in last 12 mths*	• No change	✓ Below (better than) average
KF24. % reporting most recent experience of violence	• No change	! Below (worse than) average
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	• No change	✓ Lowest (best) 20%
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	• No change	✓ Below (better than) average
KF27. % reporting most recent experience of harassment, bullying or abuse	• No change	! Lowest (worst) 20%

4. Key Findings for Wirral University Teaching Hospital NHS Foundation Trust

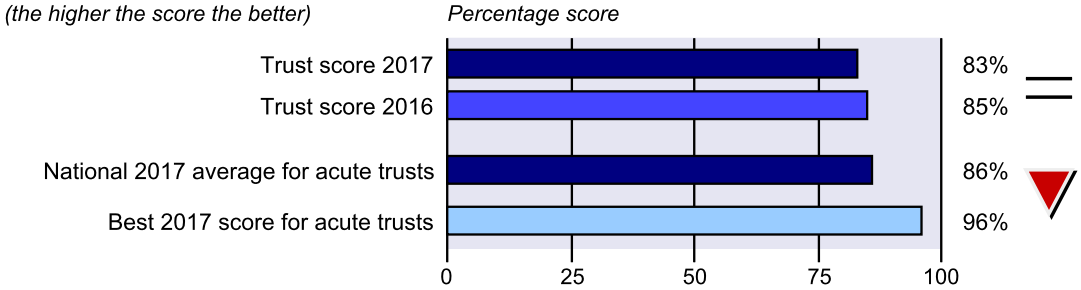
Wirral University Teaching Hospital NHS Foundation Trust had 382 staff take part in this survey. This is a response rate of 31%[1] which is in the lowest 20% of acute trusts in England (44%), and compares with a response rate of 46% in this trust in the 2016 survey.

This section presents each of the 32 Key Findings, using data from the trust's 2017 survey, and compares these to other acute trusts in England and to the trust's performance in the 2016 survey. The findings are arranged under nine themes: appraisals and support for development, equality and diversity, errors and incidents, health and wellbeing, working patterns, job satisfaction, managers, patient care and experience , and violence, harassment and bullying.

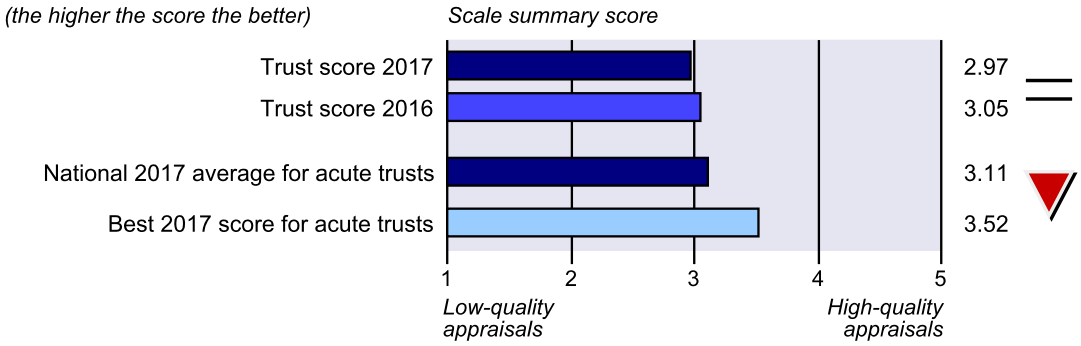
Positive findings are indicated with a green arrow (e.g. where the trust is in the best 20% of trusts, or where the score has improved since 2016). Negative findings are highlighted with a red arrow (e.g. where the trust's score is in the worst 20% of trusts, or where the score is not as good as 2016). An equals sign indicates that there has been no change.

Appraisals & support for development

KEY FINDING 11. Percentage of staff appraised in last 12 months



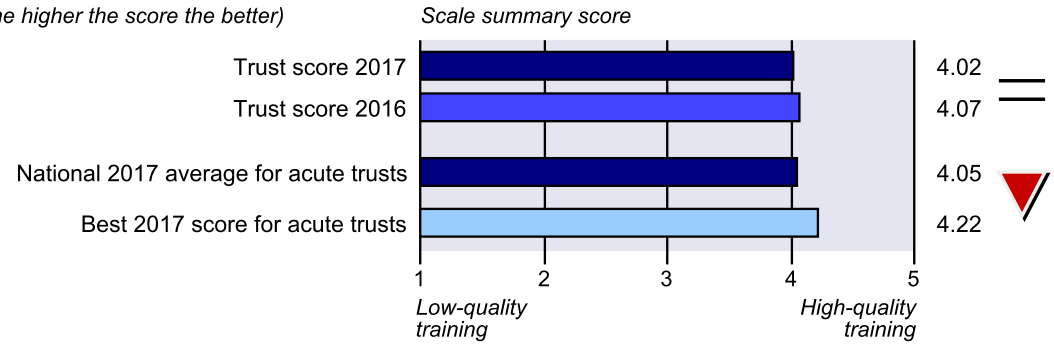
KEY FINDING 12. Quality of appraisals



[1]At the time of sampling, 5943 staff were eligible to receive the survey. Questionnaires were sent to a random sample of 1232 staff. This includes only staff employed directly by the trust (i.e. excluding staff working for external contractors). It excludes bank staff unless they are also employed directly elsewhere in the trust. When calculating the response rate, questionnaires could only be counted if they were received with their ID number intact, by the closing date.

KEY FINDING 13. Quality of non-mandatory training, learning or development

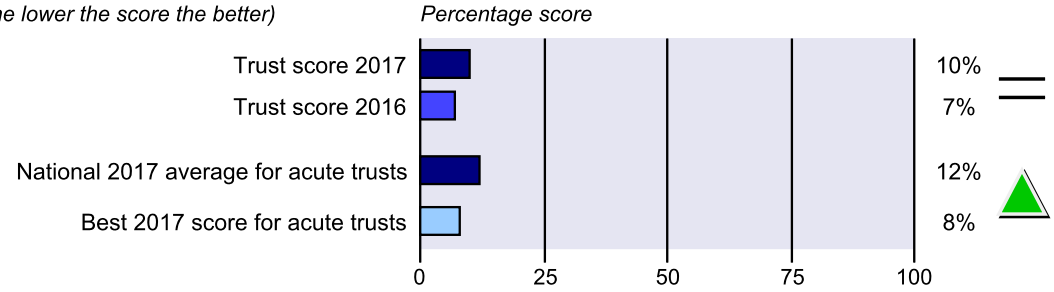
(the higher the score the better)



Equality & diversity

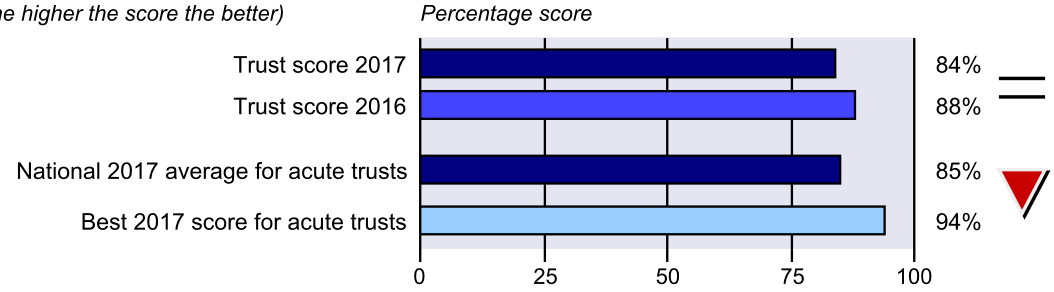
KEY FINDING 20. Percentage of staff experiencing discrimination at work in the last 12 months

(the lower the score the better)



KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

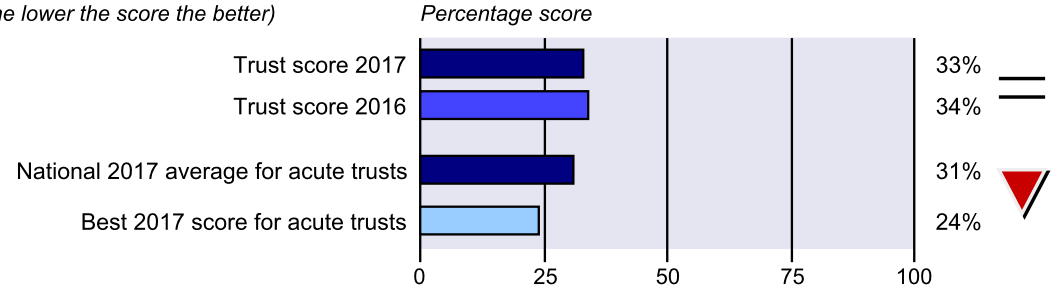
(the higher the score the better)



Errors & incidents

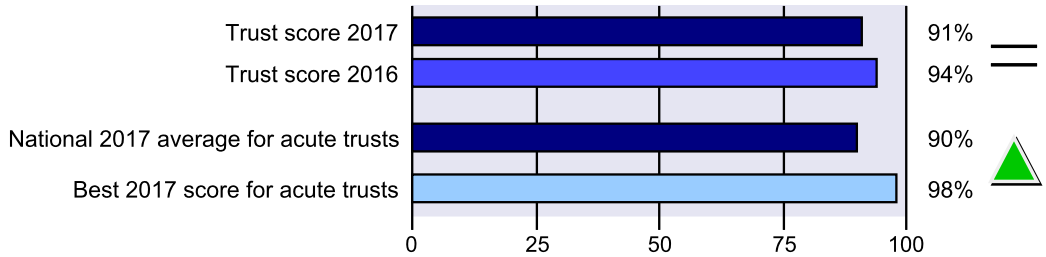
KEY FINDING 28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)



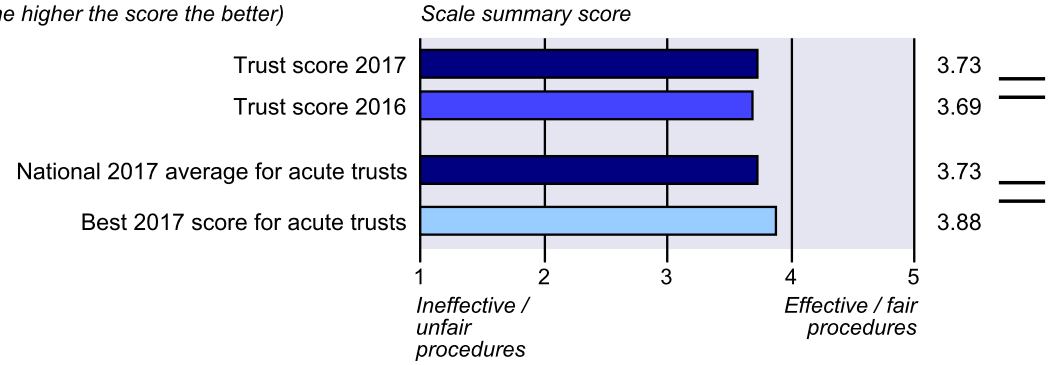
KEY FINDING 29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)



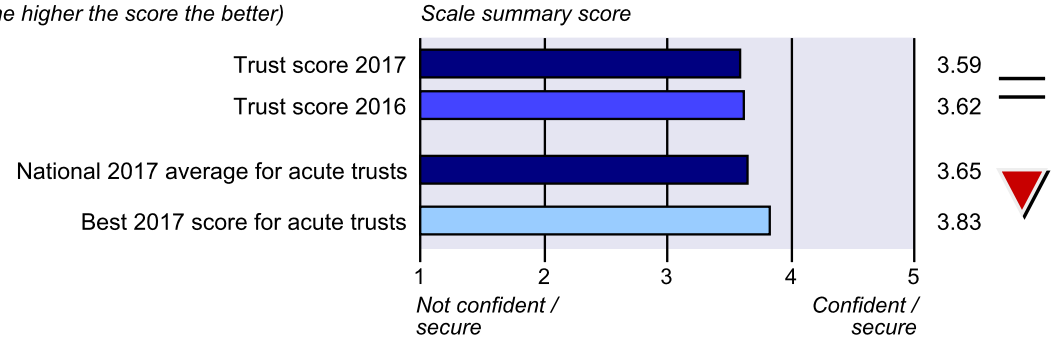
KEY FINDING 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents

(the higher the score the better)



KEY FINDING 31. Staff confidence and security in reporting unsafe clinical practice

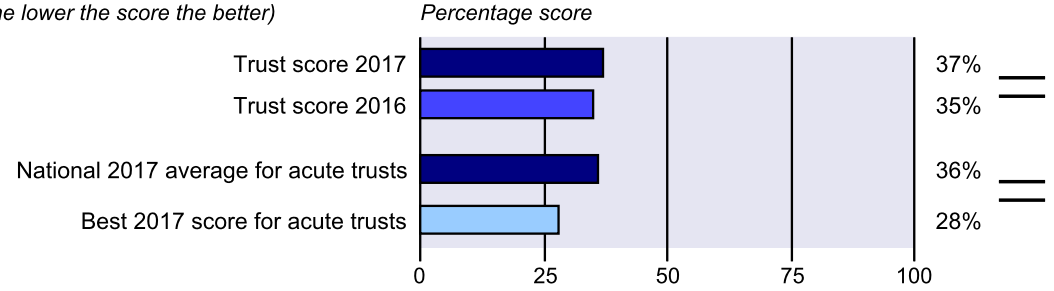
(the higher the score the better)



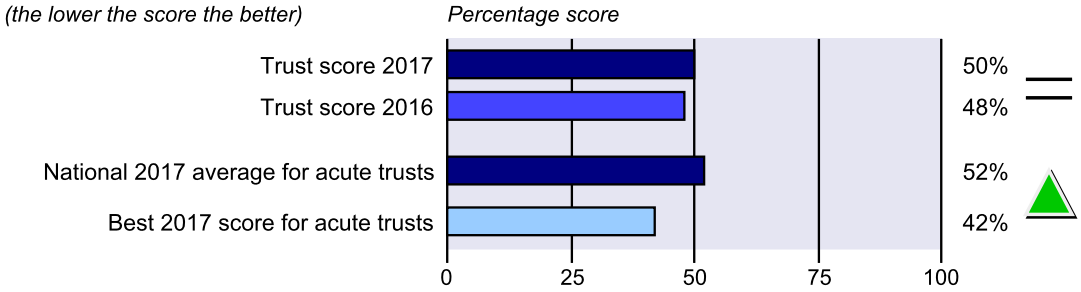
Health and wellbeing

KEY FINDING 17. Percentage of staff feeling unwell due to work related stress in the last 12 months

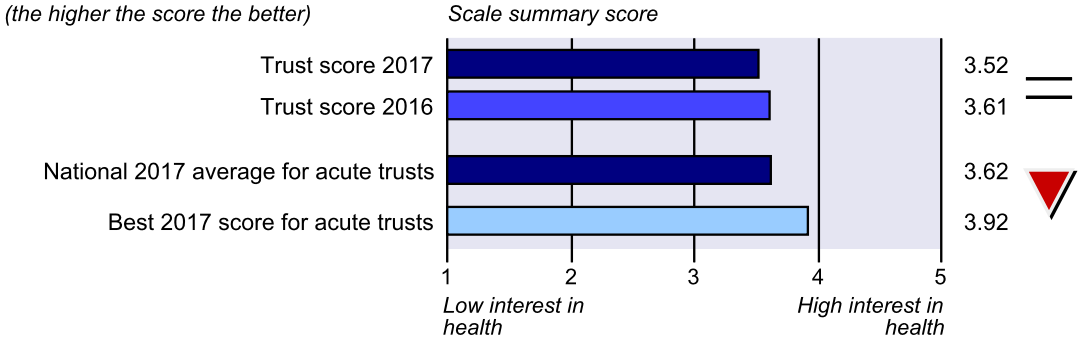
(the lower the score the better)



KEY FINDING 18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves

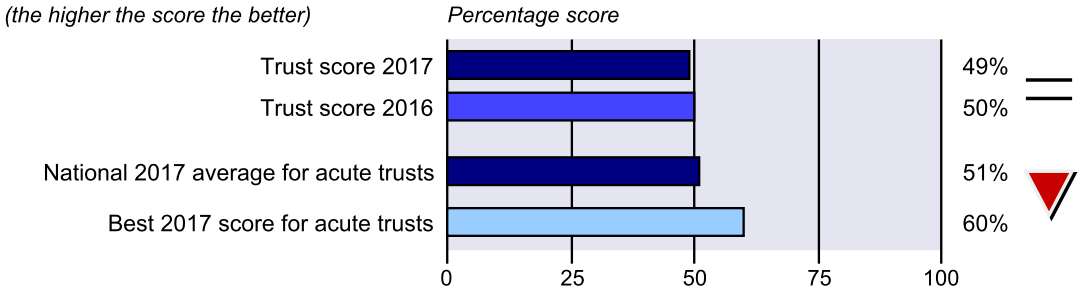


KEY FINDING 19. Organisation and management interest in and action on health and wellbeing

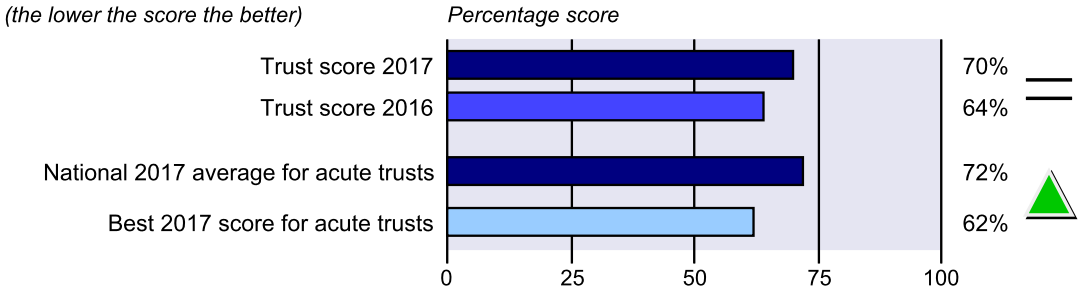


Working patterns

KEY FINDING 15. Percentage of staff satisfied with the opportunities for flexible working patterns



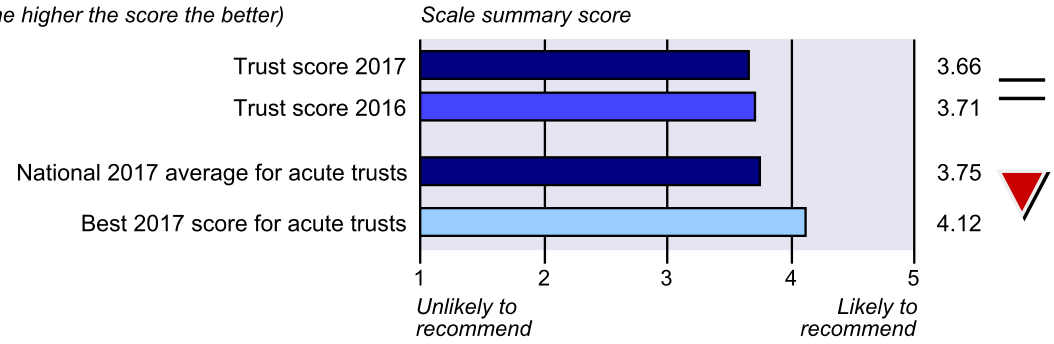
KEY FINDING 16. Percentage of staff working extra hours



Job satisfaction

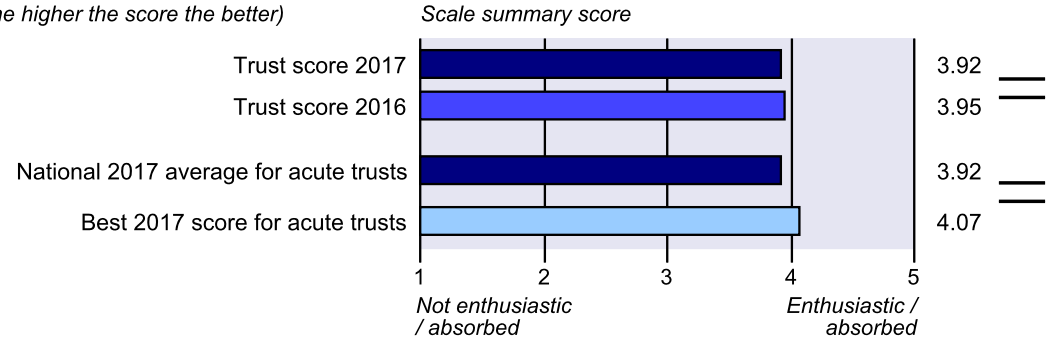
KEY FINDING 1. Staff recommendation of the organisation as a place to work or receive treatment

(the higher the score the better)



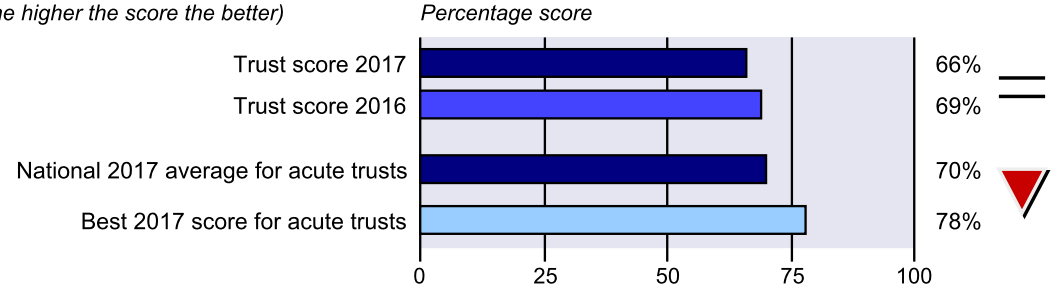
KEY FINDING 4. Staff motivation at work

(the higher the score the better)



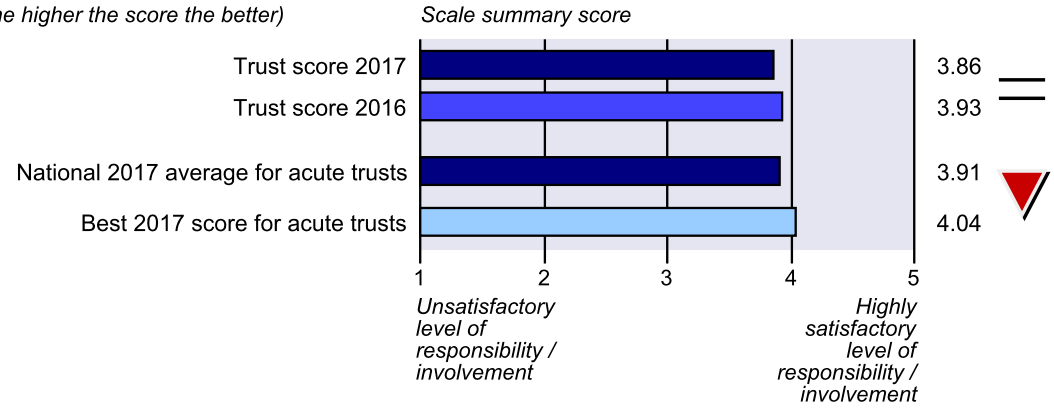
KEY FINDING 7. Percentage of staff able to contribute towards improvements at work

(the higher the score the better)



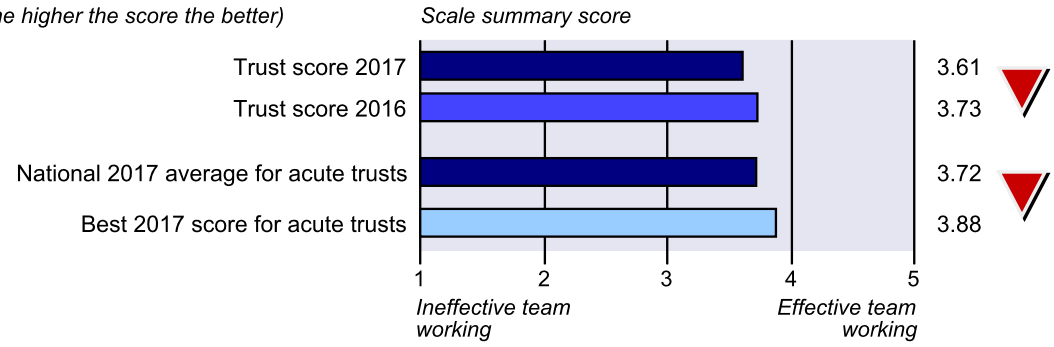
KEY FINDING 8. Staff satisfaction with level of responsibility and involvement

(the higher the score the better)



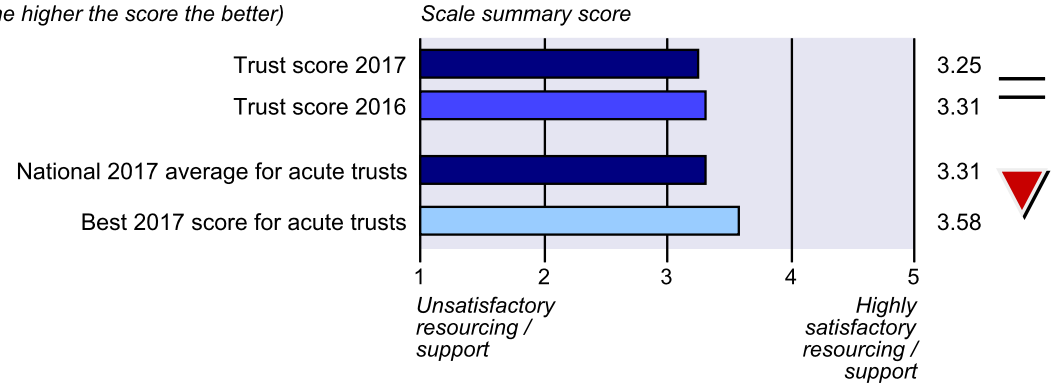
KEY FINDING 9. Effective team working

(the higher the score the better)



KEY FINDING 14. Staff satisfaction with resourcing and support

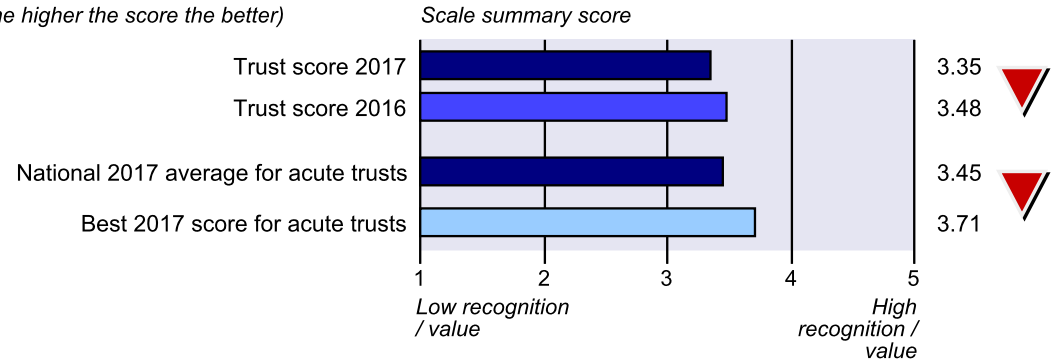
(the higher the score the better)



Managers

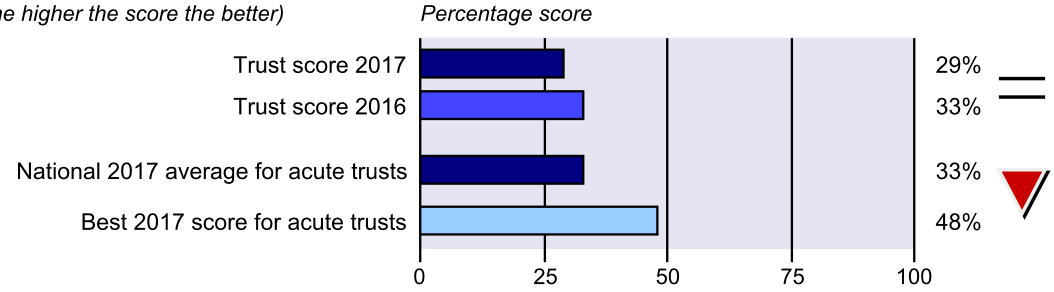
KEY FINDING 5. Recognition and value of staff by managers and the organisation

(the higher the score the better)



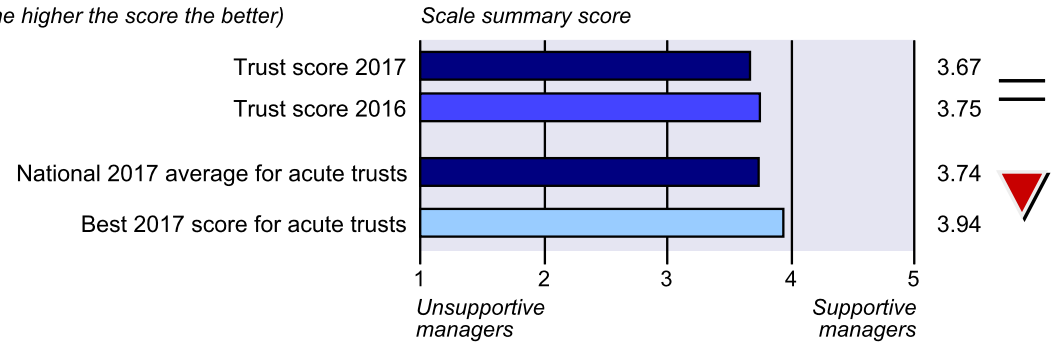
KEY FINDING 6. Percentage of staff reporting good communication between senior management and staff

(the higher the score the better)



KEY FINDING 10. Support from immediate managers

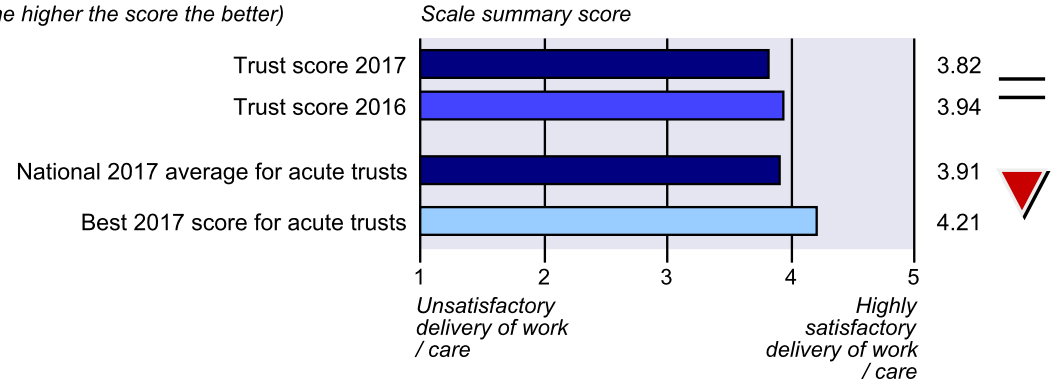
(the higher the score the better)



Patient care & experience

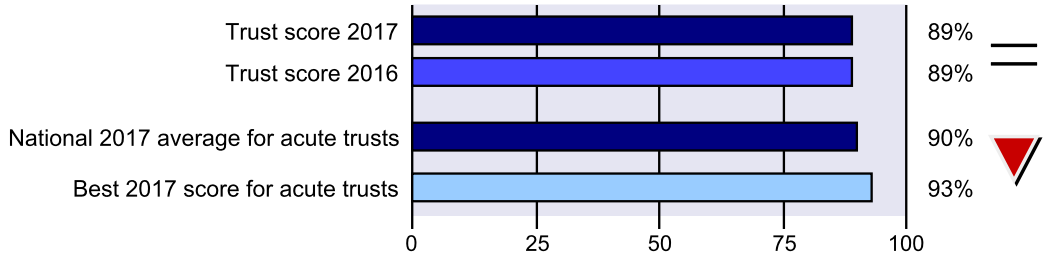
KEY FINDING 2. Staff satisfaction with the quality of work and care they are able to deliver

(the higher the score the better)



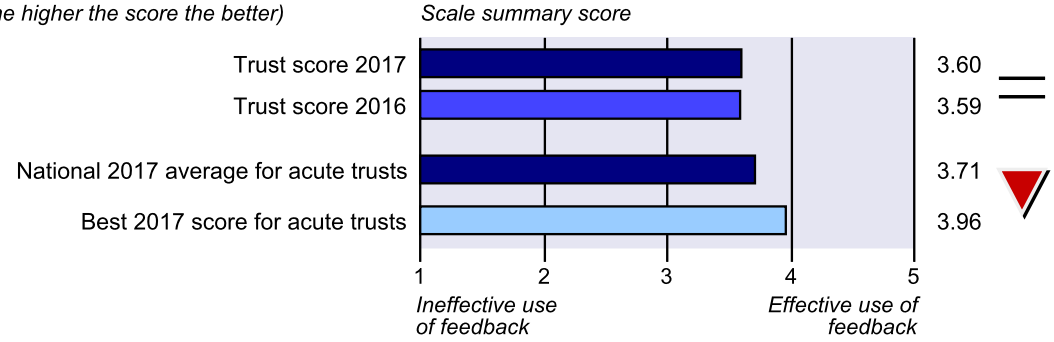
KEY FINDING 3. Percentage of staff agreeing that their role makes a difference to patients / service users

(the higher the score the better)



KEY FINDING 32. Effective use of patient / service user feedback

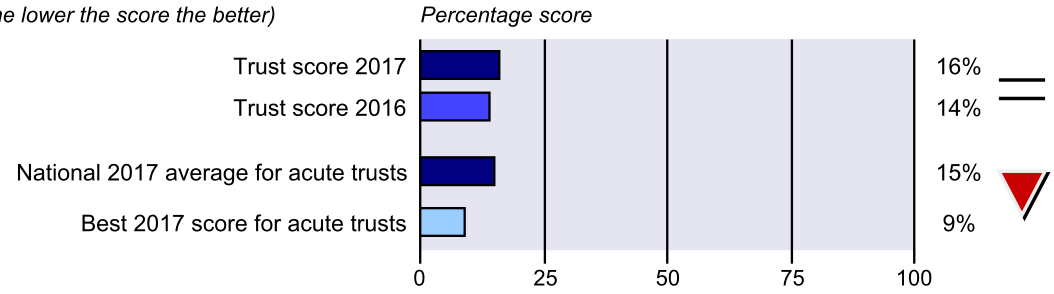
(the higher the score the better)



Violence, harassment & bullying

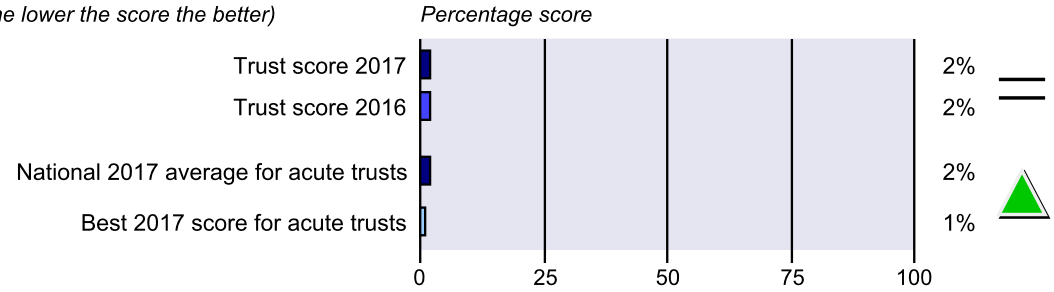
KEY FINDING 22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(the lower the score the better)



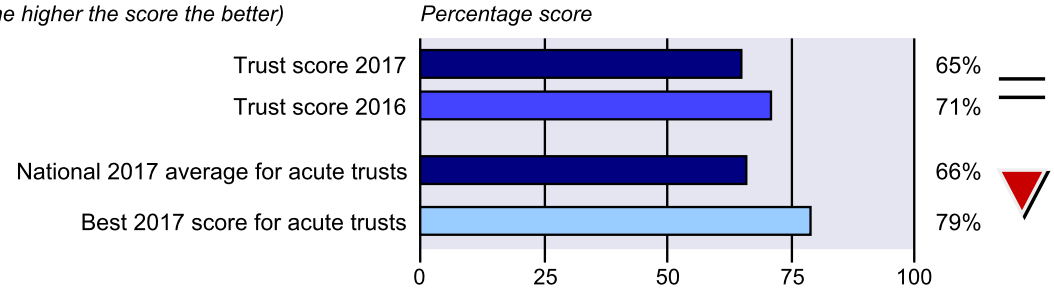
KEY FINDING 23. Percentage of staff experiencing physical violence from staff in last 12 months

(the lower the score the better)



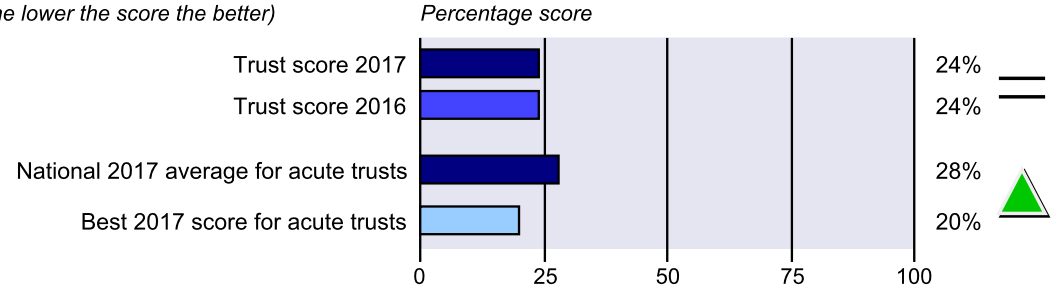
KEY FINDING 24. Percentage of staff / colleagues reporting most recent experience of violence

(the higher the score the better)



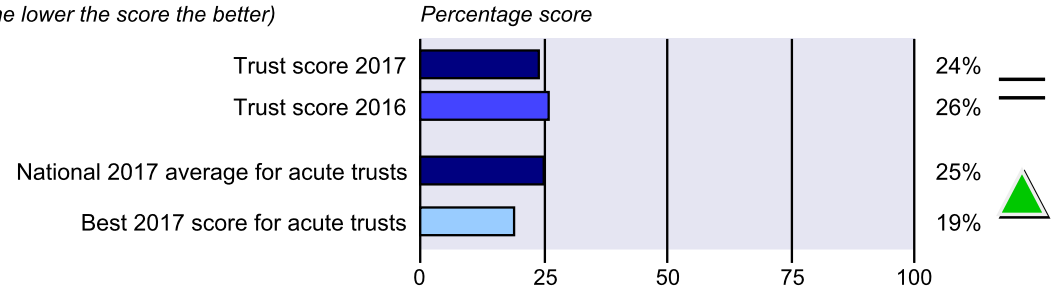
KEY FINDING 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

(the lower the score the better)



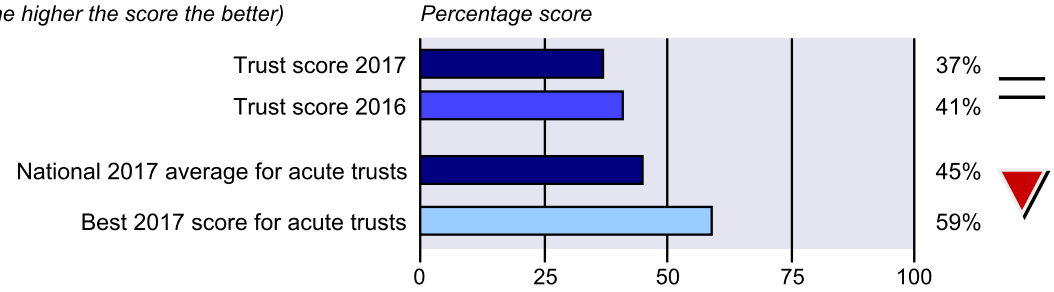
KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

(the lower the score the better)



KEY FINDING 27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse

(the higher the score the better)



BOARD OF DIRECTORS	
Agenda Item	7.3
Title of Report	Gender Pay Gap Report
Date of Meeting	28 March 2018
Author	Sharon Landrum, Equality & Diversity Adviser
Accountable Executive	Helen Marks, Director of Workforce
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	2, 3
Level of Assurance	Submission of this report and subsequent upload of data and report to Government portal will ensure Trust compliance
Purpose of the Paper	To note data and themes arising and potential actions required for improvement.
Reviewed by Executive Committee	N/A
Data Quality Rating	Silver
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken	Yes, attached at Appendix B

1. Background

The gender pay gap legislation introduced in April 2017 requires that UK employers with 250 employees or more publish data about their gender pay gap on an annual basis (based on a snapshot date of 31st March each year for the public sector). This is therefore Wirral University Teaching Hospital's first gender pay gap report and falls in line with national reporting requirements. Data is based on the snapshot date of 31st March 2017.

The full report is attached at Appendix A.

1. Key Issues

The report identifies a mean gender pay gap of 23.9% in favour of male employees, with a mean bonus pay gap of 7.8% and proportionality of bonus difference of 5.6% both in favour of males (0.6% of females receive bonus and 6.2% males).

Breakdown of data identifies that most pay bands show similar minimal pay gaps, with the exception of 3 pay bands having a gender pay gap of over 6% (pay bands 1, 8d and "other").

This first data capture has identified some themes that need further exploration and consideration of positive action to support improvements.

Themes identified are:

1) Low levels of male employees overall, particularly in lower middle and upper middle quartiles, with a larger gender pay gap in pay band 1 in favour of females
2) Lower levels of female employees in the highest quartile positions
3) Lower levels of female employees in Consultant positions
4) Bonus pay gap in favour of males (6.2%) and low proportionality of females accessing bonus payments (0.6%)

2. Next Steps

- The attached report will be uploaded to the Trust's staff and public webpages
- Required data will be uploaded to the Governments reporting portal along with a link to the attached report on the Trust's website
- A further gender pay gap report will be issued followed review of the data from the impending snapshot date of 31 March 2018 and more detailed actions confirmed to move forwards for 2018 / 19
- Plans to address the issues identified in the report will be presented and approved at the proposed Workforce Assurance Committee

3. Recommendations

- The Board are asked to note and acknowledge the gender pay gap reporting data and the themes identified.
- The Board are asked to acknowledge the submission of data to the Government reporting portal and publication of the attached report on Trust staff and public webpages

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Appendix A

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Gender Pay Gap Report

2017

Author: Sharon Landrum, Equality & Diversity Adviser

Date: March 2018

Contents

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1.0 Executive Summary 2
2.0 Background and Introduction – reporting requirements 3
2.1 Staff included in the gender pay gap data 3
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4.0 Wirral University Teaching Hospital's gender pay gap 4
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6.0 Bonus pay gender gap 5
7.0 Bonus pay proportions 6
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Foreword

In September 2017 new Equality Act Regulations were published that required public sector organisations to publish their gender pay gap by 31st March 2018. This requirement makes up one of the Equality Act's 2010 Public Sector Equality Duties. Instruction on how to undertake the calculation was issued from Central Government and guidance developed for public sector bodies from ACAS. In December 2017 an ESR module was launched that enabled Trusts to enter their data into a pre-built system that would calculate the Gender Pay Gap in a way that could be benchmarked across the NHS.

This report fulfils the Gender Pay Gap requirements for Wirral University Teaching Hospitals. The calculation is based on all staff, including bank staff, on their net pay.

Helen Marks

Helen Marks
Director of Workforce

March 2018

1.0 Executive Summary

The gender pay gap legislation introduced in April 2017 requires that UK employers with 250 employees or more publish data about their gender pay gap on an annual basis (based on a snapshot date of 31st March each year for the public sector). This is therefore Wirral University Teaching Hospital's first gender pay gap report and falls in line with national reporting requirements.

The report identifies a mean gender pay gap of 23.9% in favour of male employees, with a mean bonus pay gap of 7.8% and proportionality of bonus difference of 5.6% both in favour of males (0.6% of females receive bonus and 6.2% males).

Breakdown of data identifies that most pay bands show similar minimal pay gaps, with the exception of 3 pay bands having a gender pay gap of over 6%.

1) Pay band 1 – gender pay gap is -7.3% a gap in favour of female employees, therefore the average hourly rate of females within this band are higher than male employees. That said, there are only 2 pay points within this band and approximately 5 times more females than males.
2) Pay band 8d – gender pay gap of 6.4% in favour of males, therefore the average hourly rate for male employees is higher than that of females, that said however, only 5 staff are included in this pay band.
3) Other – gender pay gap of 37.7%. This category contains only 10 staff with varying roles and salaries and so this has caused a significant difference in the overall results.

The number of female employees (79%) significantly outweighs the number of males (21%) therefore positive action is required to support male employees in recruitment and retention processes and to understand if there are any particular barriers affecting them.

The ratio of female employees is higher in all pay quartiles, except the highest. Specifically, it is noticeable within this quartile that the ratio of female consultants is significantly lower (178 males and 77 females). The percentage of female employees accessing bonus pay is also extremely low 0.6% (compared with 6.2% of males), and a difference in bonus pay of 7.8% in favour of males, which is largely related to clinical excellence awards and discretionary points.

Further work should therefore be focussed on the recruitment and retention of males overall and on consultants and with a view to understanding any barriers or impacts on females and application of positive action to support where necessary.

As reporting data will again be available on the snapshot date of 31st Match 2018, full action plans will not therefore be produced until the next set of reports have been reviewed. Work will however commence to further explore the areas identified above and to further aid more detailed understanding in the next report.

2.0 Background and Introduction – reporting requirements

The gender pay gap legislation introduced in April 2017 requires that UK employers with 250 employees or more publish data about their gender pay gap on an annual basis (based on a snapshot date of 31st March 2017 for the public sector).

The gender pay gap shows the difference between the **average** (mean or median) earnings of men and women and is expressed as a percentage of men's earnings.

This report is therefore based on the snapshot date of 31st March 2017 and is based on six calculations as required under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 applicable to the public sector:

1. Median gender pay gap in hourly pay
2. Mean gender pay gap in hourly pay
3. Mean bonus gender pay gap
4. Median bonus gender pay gap
5. Proportion of male and female employees in each pay quartile
6. Proportion of male and female employees receiving a bonus payment

Wirral University Teaching Hospital WUTH) is committed to ensuring that the principles of the Public Sector Equality Duty (PSED) are upheld and that we eliminate discrimination and ensuring working towards advancing opportunities and fostering good relations. This report is therefore vital not only to ensure compliance with national requirements, but to support the Trust in identifying where any gaps my lie and what actions are required to create improvements.

The Trust views analysis of any gaps in gender pay as a valuable tool in identifying levels of equality in the workplace, female / male participation and how effectively talent is being maximised.

The gender pay gap differs from equal pay (which deals with the pay difference between men and women who carry out the same or similar jobs, or work of equal value). Wirral University Teaching Hospital pays staff of different genders equally if they perform the same job or work of similar value.

2.1 Staff included in the gender pay gap data

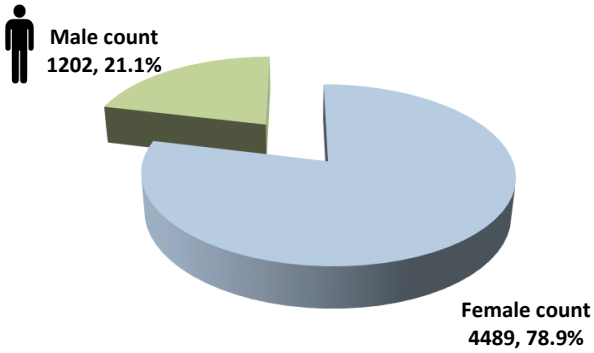
Data is based on full-pay relevant employees at the snapshot date of 31st March 17.

2.2 What counts as pay?

The gender pay gap **includes** basic pay, paid leave, allowances, pay for any piecework and bonus pay and **excludes** overtime pay, expenses, pay in lieu of notice, the value of salary sacrifice, redundancy or termination payments, arrears of pay, shift premiums and benefits in kind

3.0 Wirral University Teaching Hospital Demographics

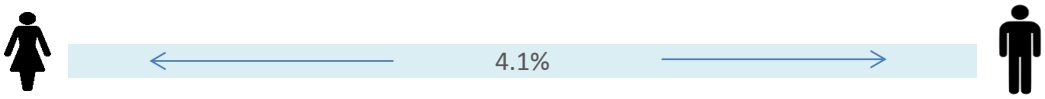
The overall gender split within WUTH is shown below. The number of female employees significantly outweighs the number of male employees.



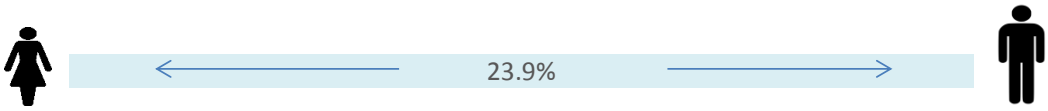
4.0 Wirral University Teaching Hospital's gender pay gap

Gender pay gap calculations are based on the reporting requirements listed above and include bonus pay.

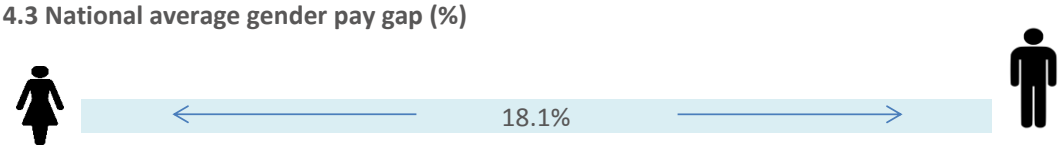
4.1 Median gender pay gap (%)



4.2 Mean gender pay gap (%)



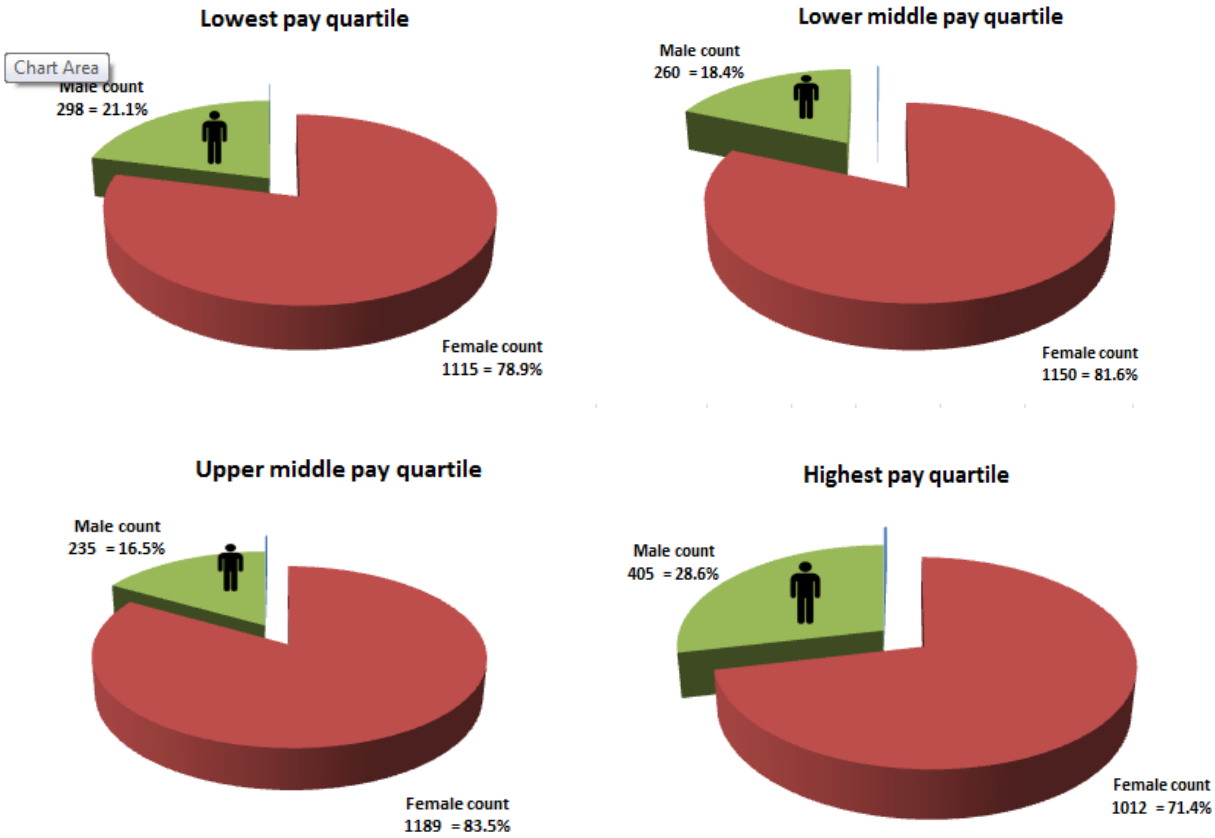
4.3 National average gender pay gap (%)



5.0 Salary

WUTH salary quartiles

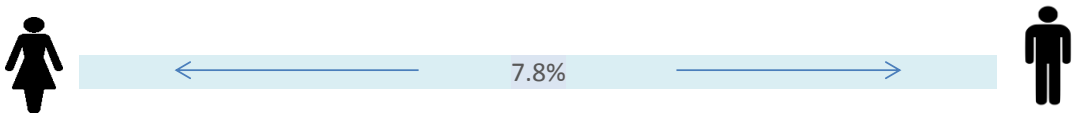
Females are in the majority in all pay quartiles; however there is a lower proportion of females in the highest pay quartile and the lowest proportion of men in the upper middle quartile.



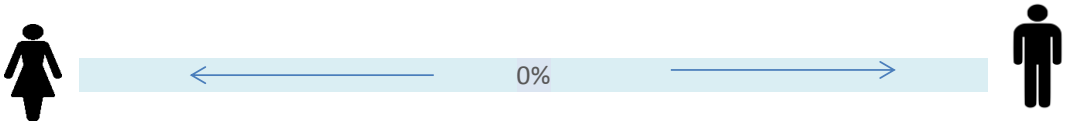
6.0 Bonus pay gender gap

Bonus pay includes clinical excellence awards and discretionary points.

6.1 Mean bonus gap (%)



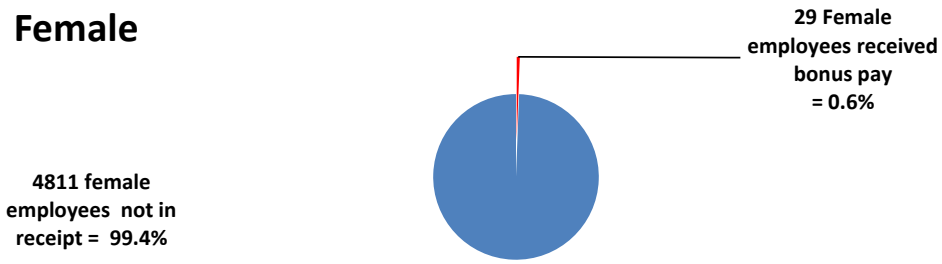
6.2 Median bonus gap (%)

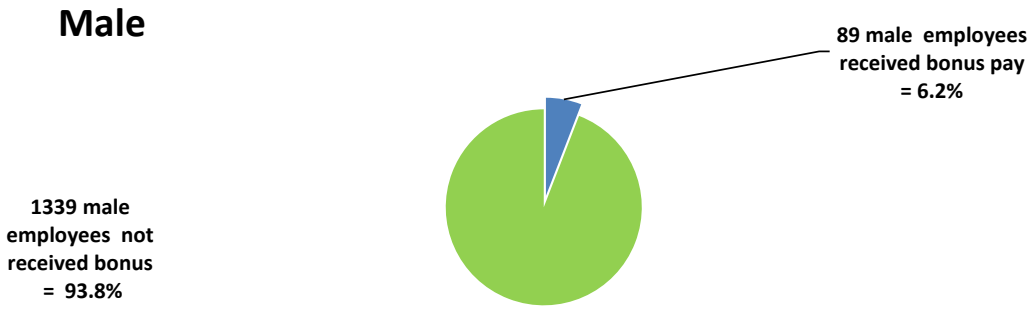


Clinical excellence award payments increase up an agreed framework as service continues. The Trust has a number of male employees with long-service that will therefore receive a higher scale of award.

7.0 Bonus pay proportions

The proportion of staff receiving bonuses is low overall, however extremely low for female employees with only 0.6% receiving bonus pay and a 5.6% difference between male and female employees.



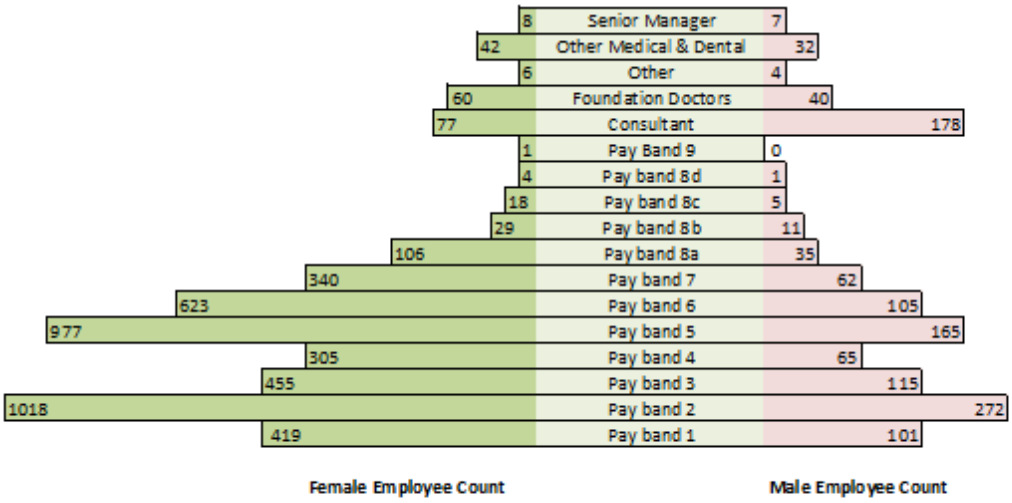


8.0 Additional Data

In addition to the legislative requirements and in order to further analyse data and seek improvements, WUTH have decided to further breakdown data collected per pay bands as follows:

Gender count and mean averages per pay grade

	Female Average of Hourly Rate (£)	Count of Employee Number	Male Average of Hourly Rate (£)	Count of Employee Number	Pay Gap %
Pay Band 1	9.6	419	8.9	101	-7.3
Pay band 2	9.8	1018	9.6	272	-2
Pay band 3	10.1	455	10.5	115	3.7
Pay band 4	11.2	305	11.6	65	3.7
Pay band 5	14.8	977	14.4	165	-2.7
Pay band 6	17.8	623	16.9	105	-5.1
Pay band 7	20.3	340	20.4	62	0.6
Pay band 8a	23.2	106	23.2	35	-0.1
Pay band 8b	27.5	29	27.9	11	1.6
Pay band 8c	32.8	18	33.5	5	2.2
Pay band 8d	39.5	4	42.2	1	6.4
Pay band 9	50.1	1			0
Consultant	47.2	77	47.43	178	0.5
Foundation Drs	17.4	60	17.5	40	0.8
Other	6.7	6	10.8	4	37.7
Other Medical & Dental	28.5	42	28.9	32	1.5
Senior Manager	55.1	8	55.8	7	1.2
Grand Total	**14.4**	**4489**	**19**	**1202**	**23.9**



9.0 Key Findings

1) The number of female employees significantly outweighs the number of male employees.
2) The Trust has identified that whilst there is only a median gap of 4.1%, there is however a mean gender pay gap of 23.9% in favour of male employees which is also higher than the national average of 18.1%.
3) WUTH employs a significantly higher number of female employees in all pay quartiles with the highest proportion of females being in the upper middle quartile and the highest number of males in the highest quartile. Lower levels of males in lower middle and upper middle quartiles.
4) A small number of employees receive bonus pay and this proportion is higher for male employees in certain roles within the highest quartile
5) There are more female employees in all grades except within Consultant grades whereby there are only 77 females and 178 males.
6) The mean gender pay gap appears most significantly within the "Other" category at a level of 37.7% in the favour of male employees. This category includes a variety of roles including Clerical Apprentices, Non-Executive staff and Clinical Scientists and Psychotherapists. Whilst the % is high this is greatly skewed by the fact there is only a small number of employees (10).
7) The second band with the high gender pay gap is band 1 with a gender pay gap of 7.3% in favour of female employees. There are only 2 pay points within pay band 1 and also approximately five times more females than males in this band.

10.0 Summary

This first data capture has identified some themes that need further exploration and consideration of positive action to support improvements.

Themes identified are:

5) Low levels of male employees particularly in lower middle and upper middle quartiles, with a larger gender pay gap in pay band 1 in favour of females
6) Lower levels of female employees in the highest quartile positions
7) Bonus pay gap in favour of males and low levels of females accessing
8) Lower levels of female employees in Consultant positions

11.0 Action planning and next steps

This report will be circulated via all necessary Trust reporting structures and findings noted and published as required on the internal and external equality and diversity pages of the Trust's website.

As this report is currently based on data from 31 March 2017 and now required on an annual basis, whilst themes have arisen and will be examined further and actions considered going forwards; a full detailed action plan will not be produced until data is received relating to 31 March 2018. Reports and analysis will be conducted as soon as practicable and will ensure that all actions identified are based on contemporary data and then reported and monitored accordingly.

Equality Analysis (EA) Form

Title	Gender Pay Gap Report			
Agenda Item/Policy Reference	Gender Pay Gap Report – Board reports			
Lead Assessor	Sharon Landrum E&D Adviser			
Date Completed	15.03.18			
What groups have you consulted with? Include details of involvement in the EA process	Staff in area concerned	☐	Staff side colleagues	☐
	Service users	☐	HR	☒
	Other	☐	Other	☐
What is being assessed? Please provide a brief description and overview of the aims and objectives				
The production of the Trust's first Gender Pay Gap report				
Who will be affected (Staff, patients, wider community?)				
Current and potential workforce may be interested in the contents of the report and its findings.				

Section 1 – Initial analysis

What is the impact on the equality groups below?		
Equality Group	**Any potential impact?** **Positive, negative or neutral**	**Comments / Evidence** (For any positive or negative impact please provide a short commentary on how you have reached this conclusion)
Disability (inc physical and mental impairments)	**Positive**	Whilst data not appearing to directly relate to some characteristics, it provides greater openness, transparency and opportunities to identify areas to improve or areas of strength. Whilst the results may create some questions, queries and even concerns for some, particularly with regards directly to gender and indirectly to others; the overall aim is to highlight areas for improvement and plan to improve. This is therefore an overall positive advancement which will also be reviewed and monitored.
Age	**Positive**	
Race (all ethnic groups)	**Positive**	
Religion or belief	**Positive**	
Sexual Orientation	**Positive**	
Pregnancy & Maternity	**Positive**	
Gender	**Positive**	
Gender Re-assignment	**Positive**	
Human Rights	**Positive**	
Other e.g. Carers	**Positive**	

Section 2 – Full analysis not applicable

Board of Directors	
Agenda Item	7.4
Title of Report	Proposed Workforce Assurance Committee
Date of Meeting	28 March 2018
Author	Helen Marks, Director of Workforce
Accountable Executive	Helen Marks, Director of Workforce
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Strategic Objective – 1 "To be the top NHS Trust in the North West for patient and staff satisfaction"
Level of Assurance • **Positive** • **Gap(s)**	
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To Approve
Data Quality Rating	
FOI status	
Equality Impact Assessment Undertaken • **Yes** • **No**	*No*

1. Executive Summary

The following paper seeks the approval of trust board to establish a Workforce Assurance Committee, which will be a sub-committee of the board.

2. Background

One of the Trust's biggest assets is its workforce and it spends 72% of its income on pay. There is significant research that demonstrates that the culture of an organisation impacts on an engaged, motivated and healthy workforce. Without a well-led, engaged and developed workforce the Trust will experience high levels of sickness, increased employee relation cases, an increase in turnover and difficulties in recruitment. Therefore, workforce is one of the highest risks for the trust.

In addition, the Trust has had a number of reports that have highlighted concerns in relation to the culture of the organisation and the significant lack of engagement. The Trust has also had a disappointing national staff survey.

Currently workforce discussions focus on the HR key performance indicators and take place in a number of forums such as Workforce & Comms meeting, Quality and Safety Committee, Clinical Governance Group, Finance & Performance Group, Finance and Performance Committee and Trust Board. All of these groups consider the same data.

3. Workforce Assurance Committee

It is proposed that a new Workforce Assurance Committee is established to take forward the strategic workforce agenda for the trust. **Appendix 1** details the proposed terms of reference for the committee. The committee will take responsibility for seeking assurance about the progress of the workforce agenda and the HR key performance indicators. The chair of the committee (a non-executive director) will provide an update report to the board and the minutes will be available to the board for information. This committee would be the one forum (in addition to the board) where workforce issues are considered.

4. Recommendation

It is recommended to Trust Board:

To establish a Workforce Assurance Committee
To agree the terms of reference as detailed in Appendix 1

Helen Marks
Interim Director of Workforce

Wirral University Teaching Hospital
NHS Foundation Trust

WORKFORCE ASSURANCE COMMITTEE
TERMS OF REFERENCE

Constitution: The Board hereby resolves to establish a Committee of the Board to be known as the Workforce Assurance Committee (the Committee).

Membership: The Committee shall consist of the following:

- Non-Executive Director (Chair)
- Non- Executive Director
- Non-Executive Director
- Director of Workforce
- Director of Nursing & Midwifery
- Medical Director
- Chief Operating Officer
- Director of Strategy

In Attendance

- Deputy Director of Workforce
- Equality and Diversity lead
- Assistant Director of OD
- Assistant Director of Workforce Effectiveness
- Partnership Forum Representative
- Governor representative

At least one Non-Executive Director shall attend the Committee as Chair. The Director of Workforce or the Deputy of Workforce shall normally attend meetings. Additional invitations for attendance will be in agreement within the Chair of the Committee.

Quorum: A quorum shall be 4 members, with at least one Non-Executive Director & one Executive Director present.

Deputies: Members shall attend a minimum of three meetings per year and shall nominate deputies to attend meetings on their behalf when required.

Frequency: Meetings shall take place bi-monthly.

Authority: The Committee is authorised by the Board to investigate any activity within its Terms of Reference.

Purpose: The overall purpose of the Committee is to advise the Board on the strategic direction and priorities of the Trust in relation to people and organisational development issues. The committee will review performance against the Workforce & Organisational Development Strategy and it will make decisions on behalf of the Board on people and organisational development issues.

Duties: The duties of the Committee can be categorised as follows:

1. To inform the direction and priorities for the development of workforce strategies, including approval of the Trust's Workforce & Organisational Development Strategy and monitoring its effectiveness on an ongoing basis.

2. To develop, support and review recruitment and retention strategies for all staff groups to address future workforce supply and demand requirements.

3. To ratify new and existing HR/OD policies and procedures, ensuring that these are notified to the Board via the appropriate minutes, following development at other committees (e.g. Partnership Forum) and reflect the Trust's Workforce & Organisational Development Strategy.

4. To monitor internal workforce performance indicators on behalf of the Board of Directors and report to the Board via the integrated performance report and on an exception basis.

5. To oversee the development of new roles in relation to the workforce modernisation agenda and seek assurance on the benefits and impact for the trust

6. To monitor pay, including variable pay and provide updates at each meeting and report to the Board.

7. To review the annual staff survey report against the Trust's Workforce Strategy and OD plans, monitor progress and outcomes, and advise the Board.

8. To receive minutes from sub-committees and to resolve issues which have been referred from these committees.

9. To receive and monitor the implementation of Equality and Delivery statutory delegations under the single Equality Duty (2011). These include annual review of the Equality Delivery system, Equality Duty Assurance Report, Workforce Race Equality Standard (WRES) and other relevant reports. This will include receiving periodic updates and minutes from the Equality and Diversity Strategy Group. The Committee is to act as the Trust's champion for all Equality and Diversity issues.

10. To receive the annual report from the Freedom to Speak Up Guardian.

11. To oversee the progression of nursing and midwifery training and education

12. To receive periodic updates from Director of Medical Education and the Medical Staffing Team, providing an overview of medical education and medical staffing plans and monitor risks identified through the BAF.

13. To monitor progress on the Internal Audit Report actions that are relevant to workforce – related risks and provide progress updates to Audit Committee.

14. To review and update the Committee's work plan, to support agenda planning and regular review of key workforce related issues and risks.

15. To review how the Trust considers and uses evidence of new HR/OD and modernisation practices, which will have an impact on patient and staff experience, quality and efficiency resulting in benefits realisation.

16. To review and monitor the development, implementation and evaluation of leadership/management development across the Trust, in line with the Trust Values and Behavioural Standards.

17. To develop and nurture the concept of learning as an integral part of the Trust's processes and objectives.

18. To review and analyse the experiences of our staff and how we engage with them, as part of the work to support organisational and cultural change with particular focus on the Trust Values and Behavioural Standards. This will include assessing how we are developing clinical engagement and clinical leadership, as part of the Model Hospital and the Trust's Strategy.

19. To review and monitor the integrated workforce agenda working with our partners across the health economy

Circulated Papers: The Committee Papers will be circulated no later than 5 working days prior to the meeting date.

Reporting: The minutes of Workforce Assurance Committee meetings shall be formally recorded and submitted routinely to the Board of Directors. Minutes will be issued up to 10 working days for the date of the Committee meeting.

Risks: The Committee has delegated responsibility from the Board of Directors for managing workforce-related risk, and providing/obtaining assurances against that risk as documented in Board Assurance Framework (BAF).

Review: The constitution, terms of reference and progress of the Committee shall be reviewed annually.

Document Owner:

Director of Workforce is responsible for maintaining both these terms of reference and the record keeping of any minute authorising their variation.

Board of Directors	
Agenda Item	8.1
Title of Report	Board Assurance Framework
Date of Meeting	28th March 2018
Author	Howard Scott, Associate Director of Quality Governance (Interim)
Accountable Executive	David Jago Acting Chief Executive
BAF References	All
Level of Assurance	Gaps with mitigating action
Purpose of the Paper	Discussion
Review by Executive Committee	Not applicable
Data Quality Rating	Bronze – qualitative data
FOI status	Full Disclosure
Equality Impact Assessment Undertaken	N/A

1. Executive Summary

The attached report includes the following:

- **Appendix 1** - An overview of the risks and their associated risk scores in the Board Assurance Framework (BAF)
- **Appendix 2** – A profile of the risks detailed within the BAF
- **Appendix 3** - A detailed analysis of each risk and the associated actions to mitigate these

2. Change in risk score/Update to Board of Directors

This is a refresh of the BAF previously considered at Assurance Committee level presented to the Board of Directors at its March meeting to fully consider key risks, assurances and mitigating actions and to provide a framework going into 2018/19 on a revised BAF.

Risk 16 -Cerner system – The Trust is heading towards May when GDPR comes into effect – we are working through the implementation requirements with MIAA and report progress to our Information and IG group monthly with oversight from FBPAC .There is a risk that the legislation removes the cost of access and will lead to a rapid increase in the need for us to release records for which we do not have the resources, particularly because the time limit to respond is halved.
The Trust is also working on a Mandatory Training scheme for Wirral Millennium.

Risk 20 -Data Quality – The position on RTT continues to be improved, There is a continual issue with clinical coding capacity as we train coders and they then leave for better paid roles in other organisations. Benchmarking information will be sought to assess nature if any of outlier banding issues.

3. Top 4 risks in the Trust

Through review at assurance committee level it was agreed that the top 4 risks for the organisation are set out below;

1. **Workforce** – ability to recruit and retain the workforce of the future. Undertaking OD work to enact a cultural change
2. **Quality and Safety** – this includes infection prevention and control and medicines management
3. **Access** – this includes all access standards but principally the 4 hour A & E standard and noting 18/19 planning guidance re RTT and patient waiting numbers
4. **Finances** – includes the financial plan for 2017/18 and thereafter which includes the need for cash, shortage of capital and the current situation re our estate

4. Recommendations

The Board of Directors is asked to consider the following:

- Whether the methodology of updating, review and escalation of the BAF provides adequate assurance.

Quality of Care

Strategic Objective:			**We are** the best NHS Trust in the region, because our staff, and the patients who use our services, say we are **To deliver:** consistently high quality secondary care services enhanced through the provision of regional specialist services within available resources	**Key Measures:**	2a – Continue to deliver our quality strategy and build on the recommendations of our September 2015 CQC inspection		
				Linked Risks/ collaboration opportunities	Risks 2, 3, 9, 10, 12		
Risk ID:	1	**Risk:**	**Quality and Safety:** The Trust does not promote a culture of quality and safety resulting in patient harm, poor patient experience, poor staff engagement and failure to meet statutory fundamental standards of care	**Board Lead:**	Medical Director	**Date last reviewed:**	February 2018
				Audit Committee Position	MIAA Safe Staffing (nursing) – limited assurance – Feb 17 MIAA Mandatory Training audit – significant assurance – July 17		

Risk Rating: (Likelihood x Consequence)		**Controls:** (How are we managing this risk?)	**Aligned Risks on Trust Corporate Risk Register (15 or above)** **13 Risks in total**
Current Risk Score:	4 x 5 = 20	• Quality and Safety Committee commissions "deep dive" reports • Weekly safety summits followed by a review of serious incidents (real time learning) • Weekly Safety Bites bulletin • Review of Integrated quality dashboard & identification of key action required • Using CQC Insight to prioritise intervention • Harm care reviews in place for long waiters • Availability of 7 day consultant – agreed respiratory business case at SMT and since appointed • Safeguarding committee • Nutrition steering group • Incident reporting and learning feedback	• Failure to receive 'Good' or better in next CQC Inspection (16) • MCA/DOLs not always being completed on admission (16) • Best Interests Assessments by partner agency not always been carried out meaning Trust is in breach of DOL Law (16) • AMU Overcrowding (16) • Replacement of the MARS system (16) • Ability to remove CPE from the Environment (15) • Medicine Storage (15) • Storage and Security of medicines – Staff behaviour (15) • Inadequate Medicines procurement – not being able to supply other legal entities (15) • Discharge Summaries inadequately completed (15) • Prescribing and administration of infusion and fluids & other continuous infusions (15) • Certain Defibrillators will become unsupported during 2018 (15) • Blood Traceability (15)
Tolerable Risk Score:	1 x 5 = 5		
Direction of Travel:	↔		

Assurances (How do we know if the things we are doing are having an impact?)	**Key Performance Indicators**
• Audits and Patient Feedback indicate improvements in End of Life Care • Maternity cultural review – positive patient and staff feedback through FFT • Safety thermometer targets compliant • HSMR and SHMI data better than national expectations • Increased awareness of MCA/Dols – although still more work to do • A and E cultural review – positive outcome from A and E action plan • Improved assurance to board relating to safe staffing from Hard truths meeting • Accurate timely articulation of validated harms in Integrated dashboard / supporting narrative	Cross reference to integrated quality dashboard
Gaps/rationale for current risk score/emerging risks	**Mitigating actions:** (What further mitigating action could be taken?)
1. Trust wide safety culture – concerns with Never Events 2. Safe staffing – Nursing in Medicine & Acute and Junior Medical Staff Trust wide 3. Medicines storage audit (clinical areas) – 59% compliant in Sept deterioration from Aug 4. Clinical handover flagged as a risk by CQC following serious incident review/audit of electronic handover indicates non-compliance – July 17 5. Protecting Vulnerable People training behind trajectory although increasing 6. Access to good quality data that aids decision making 7. Current compliance against all CQC fundamental standards 8. 2 out of 5 standards for 7 day working not met 9. Compliance with Nutrition and hydration standards and the MUST tool 10. Mortality reviews figure requires improvement, 11. A and E culture review- raises concerns, action plan commenced February 18.	1. Introduction of safety summits and OD interventions - ongoing 2. Nurse recruitment campaigns & development of hybrid roles and development of workforce plan 3. Meds Storage – Non- compliant areas to provide update to next CGG 4. Closer monitoring of audit compliance with electronic handover 5. Trajectory of improvement in place for MCA/Dols training 6. Improving Integrated Quality Dashboard , developing improved supportive narrative to aid triangulation 7. CQC inspection preparation group in place, updates to Q & S 8. Future changes to assessment units and medical ward based consultant teams will address this. 9. Trust-wide Nutrition & Hydration Meeting established to monitor and support management. 10. Deputy Medical Director to ensure electronic solution implemented w/c 27/11/17 11. Introduction of Hard truths assurance meeting, ensuring collaboration with HR / Nursing to mitigate safe staffing risks, 12. Harm free care assurance meeting 13. Introduction of fit for purpose RCA for harms / weekly validation panels supported by SMEs to enable timely validation of risks (March 18)

Quality of Care

Strategic Objective:			**We are** the best NHS Trust in the region, because our staff, and the patients who use our services, say we are **To deliver:** consistently high quality secondary care services enhanced through the provision of regional specialist services within available resources	**Key Measures:**	1a – Deliver an FFT recommend score of above 95% and a non-recommend score of below 2% 1b – Deliver a year on year reduction in the number of complaints and a year on year improvement in response times 2b – Deliver the Harm Free Care programme and ensure that the Trust Harm Free Care score is no lower than 95% 2c – Deliver a Hospital Mortality Rate that is better than expected 7c – Look to improve our Research and Development Metrics		
				Linked Risks/ collaboration opportunities	Risk 9 - 4 hour A & E Standard Risk 10 - RTT		
Risk ID:	2	**Risk:**	**Patient Experience:** The challenging NHS environment impacts on patient satisfaction impacting on clinical outcomes & public confidence	**Board Lead:**	Director of Nursing and Midwifery	**Date last reviewed:**	February 2018
				Audit Committee Position	MIAA previous Limited Assurance report on water safety – High risk recommendations completed Mar 17.		

Risk Rating: (Likelihood x Consequence)		**Controls:** (What are we currently doing about the risk?)	**Aligned Risks on Trust Corporate Risk Register (15 or above)** **0 Risks in total**
Current Risk Score:	3 x 3 = 9	• Monthly Integrated Quality Dashboard • Revised QIA process for all CIP schemes with post implementation review • Harm free care meeting (relaunch March 18)	
Residual Risk Score:	2 x 3 = 6		
Tolerable Risk Score:	2 x 2 = 4		
Direction of Travel:	⟷		

Assurances (How do we know if the things we are doing are having an impact?)	**Key Performance Indicators**
• Positive QIA process review undertaken by CCG – August 17 • Safety thermometer targets compliant – October 17 • HSMR and SHMI data better than national expectations • Bereavement survey – 100% recommend rate Sep 17 from 57% in 2014	Cross reference to integrated quality dashboard

Gaps/rationale for current risk score/emerging risks	**Mitigating actions:** (What more should we do?)
1. Complaints response times show levels outside of acceptable timescales 2. FFT scores in ED and outpatients deteriorating 3. PLACE survey – food scores lower than expected following CIP initiative although Trust responded by making further changes 4. 1 Reg 28 notice/2 Inquest conclusions – accidental death to which neglect contributed during financial reporting year 5. Deterioration in timely completion of death certificates in Aug and Sept 17 6. Harm free care below 95% lack of timely validated data to ensure effective reporting of risk	1. Short term resource identified to respond to longstanding complaints 2. Find workable solutions to gathering data for FFT- look for good practice examples and review approach. 3. Further action being considered by the Trust as escalated as concern from QSC 4. Learning from Inquests to be linked to safety summits 5. Trust to continue to raise awareness of the need to undertake on a timely basis 6. Introduction of fit for purpose RCA for harms / weekly validation panels supported by SMEs to enable timely validation of risks (March 18)

Quality of Care

Strategic Objective:			**We** put our people first so they can put our patients first, and we create the workforce of tomorrow by investing in the workforce of today **To ensure:** our people are aligned with our vision	**Key Measures:**	1c - Deliver a year on year improvement in our staff satisfaction survey score 5a – Continue the on-going delivery of the Workforce and OD Strategy to deliver (i) healthy organisational culture (ii) sustainable and capable workforce (iii) effective leaders and managers 5b – Work to deliver absence rates below 4%, appraisal rates of 88% and continued improvement in our NHS Staff Survey 5c – Increase the number of staff attending LiA events by 20%		
				Linked Risks/ collaboration opportunities	Linked risks 1, 2, 9, 10, 12		
Risk ID:	3	**Risk:**	**Workforce:**. failure to attract and retain safe staffing levels will impact on our ability to deliver high quality safe care in a sustainable manner	**Board Lead:**	Director of Workforce	**Date last reviewed:**	February 2018
				Audit Committee Position	MIAA – payroll/human resources – significant assurance – Sept 16 MIAA – mandatory training – significant assurance – July 17		

Risk Rating: (Likelihood x Consequence)		**Controls:** (How are we currently managing this risk?) • Integrated Quality Dashboard • Finance Committee Workforce Dashboard • Workforce & Organisational Development Dashboard • Bi-annual review of the Workforce & Communication Dashboard • NHS Staff Survey	**Aligned Risks on Trust Corporate Risk Register (15 or above)** **2 Risk in total** • High Numbers of Registered Nurse Vacancies within Medicine and Acute Specialities (16) • Levels of therapy staff on Ward 33 (15)
Current Risk Score:	4 x 4 = 16		
Tolerable Risk Score:	1 x 4 = 4		
Direction of Travel:	↑		

Assurances (How do we know if the things we are doing are having an impact?)	**Key Performance Indicators**
• Delivery against Workforce metrics targets (e.g. vacancy rate, attendance, appraisal, staff satisfaction, mandatory training) • Clear workforce strategy 0-5 years	See Integrated Quality Governance Dashboard
Gaps/rationale for current risk score/emerging risks	**Mitigating actions:** (What further mitigating action could be taken?)
1. Workforce metrics benchmark well but below Trust target 2. Staff FFT Recommend the Trust as a place to work – 52% Q2 17/18 deteriorating 3. Staff FFT Overall staff engagement score per NHS staff survey – 3.76 4. High nursing vacancy rate, particularly within Medicine and Acute 5. A and E culture review – Action plan commenced February 18	1. Workforce & Organisational Development Strategy in place with actions to be agreed by WCG and then Quality & Safety Committee. 2. Better visibility of Workforce Information throughout the organisation to help support delivery.to be reviewed at the next Workforce Group 3. Improved Workforce Planning approach with dedicated lead nominated from within HR&OD to work with the Divisions. 4. Further assurance via hard truths meeting ensuring traction on key workstreams linked to safe staffing / retention / workforce plans 5. Leadership development / career pathways for nursing

Quality of Care -MERGED WITH RISK 1 (THIS WILL BE REMOVED FROM THE FRAMEWORK)

Strategic Objective:			**To be:** the top NHS Trust in the north west for patient and staff satisfaction **To deliver:** consistently high quality secondary care services enhanced through the provision of regional specialist services within available resources	**Key Measures:**	1a – Deliver a FFT recommendation score of above 95% and a non-recommendation score of below 2% 2b – Deliver the Harm Free Care programme to ensure that our harm free care score is no lower than 95%		
				Linked Risks/ collaboration opportunities	Risk 1 Quality and Safety Countess of Chester – Vascular/Urology/Renal/haematology/Womens and Childrens/diagnostics		
Risk ID:	4	**Risk:**	**Improving Clinical Outcomes:** The Trust is unable to ensure consistent delivery of evidenced based practice 7 days per week as a result of failure to provide consultant review of all emergency admissions in 14 hours	**Board Lead:**	Medical Director	**Date last reviewed:**	August 2017
				Audit Committee Position			

Risk Rating: (Likelihood x Consequence)		**Controls:** (How are we mitigating this risk?)	**Aligned Risks on Trust Corporate Risk Register (15 or above)** **O Risks in total**
Current Risk Score:	2 x 4 = 8	• Monthly Integrated Quality Dashboard • Weekly safety summit • Weekly serious incident review • Weekly Safety Bites Bulletin – Trust-wide • Embedded clinical pathways and protocols • Embedded clinical escalation policy	
Tolerable Risk Score:	2 x 4 = 8		
Direction of Travel:	⟷		

Assurances (How do we know if the things we are doing are having an impact?)	**Key Performance Indicators**
• HSMR and SHMI data better than national expectations • Safety Thermometer targets are compliant – July 17 • 3 out of the 5 standards for 7 day working are being met	See integrated quality governance dashboard

Gaps/rationale for current risk score/emerging risks	**Mitigating actions:** (What are we doing to mitigate this risk further?)
1. Number of RCAs with action plans overdue 2. 2 out of 5 standards for 7 day working not met 3. 1 Reg 28 notice/2 Inquest conclusions – accidental death to which neglect contributed during financial reporting year 4. Never Events – see risk 1	1. Action as part of quality governance review process 2. What action has been agreed for 7 day working? 3. Learning from Inquests to be included as part of safety summit work 4. The wider learning from the RCA review of Ophthalmology to be used Trust-wide 5. Implementation of learning from deaths Policy – Q3 2017/18

Finance and Use of Resources

Strategic Objective:			**We make** the best use of the public resources we have to deliver high quality, locally accessible services that are clinically and financially sustainable	**Key Measures:**	8d – We will deliver a Use of Resources (UoR) rating of level 3		
				Linked Risks/ collaboration opportunities	CoCH – collaboration on finance function and strategic estates work		
Risk ID:	5	**Risk:**	**Sustainability:** The Trust is unable to deliver financial performance in line with agreed control total with consequent adverse impact on ability to manage capital & cash with further risks centring on inability to cover financial obligations	**Board Lead:**	Director of Finance	**Date last reviewed:**	February 2018
				Audit Committee Position	The Committee requested that FBPAC review the Trust's responsibilities in relation to the Better Care Fund		

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	4 x 5 = 20
Tolerable Risk Score:	3 x 5 = 15
Direction of Travel:	⟷

Controls: (How are we currently managing this risk?)

- Divisional financial review meetings in place to monitor and where required identify potential risk mitigations to delivery of financial plan and CIP.
- TSG governance structure & process re identification & delivery of CIP work programme.
- Business as usual process initiated in areas where substantive recruitment has taken place thereby releasing interim support
- Contract negotiations concluded with main commissioners and control re cash payments of contractual performance
- Rolling 13 week cash flow forecasting
- Reviewing trade creditor payment terms and conditions

Aligned Risks on Trust Corporate Risk Register (15 or above)
1 Risk in total

- Failure to Meet CIP Targets (16)

Assurances (How do we know if the things we are doing are having an impact?)

- Cash support agreed & drawn down with capital cash team presently in line with plan.
- Cash preservation initiatives deployed to protect year end cash balances.
- The Trust achieved an overall Use of Resources Rating of 3 in line with plan.
- The cash position at end of M10 was £2.4M above plan by £0.4M with the variance primarily due to receipt of the GDE capital funding.

Key Performance Indicators

Liquidity

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
4	4	4	4	4

Gaps/rationale for current risk score/emerging risks

1. Overall deficit of £25.3m excluding STF at end of M11. £10.6m above planned deficit.
2. CIP delivery remains above National targets but below the Trusts Internal Target.
3. Concerns with the BCF, additional innovation resource deployment and impact of trust escalation capacity
4. Board approved uncommitted loan of £21.7M (worst case scenario) in October 17 and delegated arrangements for drawdown
5. Underlying deficit position at month 11 standing at c£30M.
6. At month 11 loss of STF at £6.7m. With forecast outturn being at £7.8m
7. Go forwards risk re interest payable on borrowings

Mitigating actions: (What further mitigating action could we take?)

1. Financial recovery plan in place with actions agreed by FBPAC and Board of Directors.
2. Non delivery of CIP mitigated (at month 3) by deployment of non-recurrent initiatives but not available going forwards.
3. Better visibility on BCF and initiatives to help support delivery of escalation facilities to financial plan funded levels
4. Working capital management to support cash balances and forecasting and cash preservation initiatives being progressed (ongoing)
5. Additional cash drawdown facilities to manage cash and liquidity challenges.
6. Plan feedback will incorporate interest rates payable on borrowings

Finance and Use of Resources

Strategic Objective:			**We make** the best use of the public resources we have to deliver high quality, locally accessible services that are clinically and financially sustainable	**Key Measures:**	8c – Implement relevant recommendations of Lord Carter's review of hospital performance and productivity to deliver an Adjusted Treatment Cost figure putting WUTH in top 10% of NHS Trusts in England		
				Linked Risks/ collaboration opportunities	CoCH as per risk 4		
Risk ID:	6	**Risk:**	**Efficiency:** The Trust is unable to remove unwanted variation resulting in an inability to reduce costs	**Board Lead:**	Director of Finance	**Date last reviewed:**	February 2018
				Audit Committee Position			

Risk Rating: (Likelihood x Consequence)		**Controls:** (How are we currently managing this risk?)	**Aligned Risks on Trust Corporate Risk Register (15 or above)** **0 Risks in total**
Current Risk Score:	4 x 4 = 16	• Workforce and non-pay work streams governed through TSG • Recovery plan governance structure and processes initiated and monitored on a weekly basis • Monitoring of implementation of Carter recommendations • Robust Pharmacy Hospital Transformation plan	
Tolerable Risk Score:	3 x 5 = 15		
Direction of Travel:	⟷		

Assurances (How do we know if the things we are doing are having an impact?)

- ATC currently at 0.91
- Performing well against pharmacy model hospital metrics
- Procurement efficiency work stream aligned to Carter report recommendations

Key Performance Indicators

Headline Metrics	As reported in dashboard
Cost per Weighted Activity Unit (WAU)	£3,289
Potential savings opportunity	7.0%
Surplus/ deficit as % of expenditure	-0.1%
Total pay cost per WAU	£2,213
Total non-pay cost per WAU	£1,076

Gaps/rationale for current risk score/emerging risks

1. Carter figures based on annual reference costs
2. Pay cost per WAU identified as outlier and opportunity for productivity improvement
3. Absence of plan to implement GS1

Mitigating actions: (What further mitigating action could we take?)

1. Workforce plan being developed with Divisions
2. STT to differentiate from data quality issues to absolute opportunity
3. Refreshed IT strategy to include GS1 implementation
4. Recovery action plan agreed with specific focus on reducing pay run rate.

Finance and Use of Resources

Strategic Objective:			**We make** the best use of the public resources we have to deliver high quality, locally accessible services that are clinically and financially sustainable	**Key Measures:**	8d – We will deliver a Use of Resources (UoR) rating at level 3		
				Linked Risks/ collaboration opportunities			
Risk ID:	7	**Risk:**	**Controls:** The Trust is unable to manage its agency spend and meet its agreed agency control total resulting in loss of STF funding and regulatory intervention	**Board Lead:**	Director of Finance	**Date last reviewed:**	February 2018
				Audit Committee Position			

Risk Rating: (Likelihood x Consequence)		**Controls:** (How are we currently managing this risk?) • Agency compliance report received and reviewed by EMT weekly • Divisional authorisation controls in place • Workforce & Communications Group governance	**Aligned Risks on Trust Corporate Risk Register (15 or above)** **0 Risks in total**
Current Risk Score:	2 x 5 = 10		
Tolerable Risk Score:	2 x 5 = 10		
Direction of Travel:	⟷		

Assurances (How do we know if the things we are doing are having an impact?)	**Key Performance Indicators**
• Trust is currently below its month 11 agency trajectory expenditure plan by c£1m • Continued reduction on 2016/17 • Continued low absence rates	As at month 11 agreed expenditure plan agency control total stood at £7.4m with actual expenditure at £6.2m.
Gaps/rationale for current risk score/emerging risks	**Mitigating actions:** (What further mitigating action could we take?)
1. Minimal retrospective authorisation 2. Breaches in respect of wage, price cap and framework 3. CIP behind plan 4. Increasing run rate on agency noting material improvement in October expenditure level.	1. Ensure minimal retrospective authorisation (ongoing) 2. Review case of need for non-clinical agency and innovative recruitment and retention initiatives – Reviewed on weekly basis by EMT. EMT "deep dive" into the total number of vacancies and high areas of spend – August 17 3. Re-looking at the role of TSG/Finance & Performance & SSPG to ensure enables the Trust to focus on achievement of the plan at the right level 4. Recovery plan actions with focus on impact of agency freeze in place for all non-clinical staffing and risk assessment

Finance and Use of Resources

Strategic Objective:			**We make** the best use of the public resources we have to deliver high quality, locally accessible services that are clinically and financially sustainable	**Key Measures:**	8d – We will deliver a Use of Resources rating of level 3		
				Linked Risks/ collaboration opportunities			
Risk ID:	8	**Risk:**	**Value for Money:** Inability to demonstrate proper arrangements for securing economy, efficiency and effectiveness in the Trust's use of resources	**Board Lead:**	Director of Finance	**Date last reviewed:**	February 2018
				Audit Committee Position			

Risk Rating: (Likelihood x Consequence)		**Controls:** (How are we currently managing this risk?)	**Aligned Risks on Trust Corporate Risk Register (15 or above)** **0 Risks in total**
Current Risk Score:	3 x 4 = 12	• Transformational Team governance adhering to NHSI guidance delivering safe, sustainable cost improvement plans • Budgetary Control • Core Financial controls • Service Line Reporting • Divisional Performance review process • Annual Plan	
Tolerable Risk Score:	3 x 3 = 9		
Direction of Travel:	⟷		

Assurances (How do we know if the things we are doing are having an impact?)	**Key Performance Indicators**
• MIAA Core financial systems • External assessment against Well Led Framework • Regulatory risk rating • NHSI Review of Annual Plan • ATC index • External audit opinion • Delivered CIP at £11.2m in 2016/17 • Reference Cost Index	Overall UoR detailed within Risk 5 New use of resources guidance
Gaps/rationale for current risk score/emerging risks	**Mitigating actions:** (What further mitigating action could we take?)
1. Improve adoption of SLR through new clinical leadership structure	1. Action plan re-launched SLR with focus on three service lines

Operational Performance

Strategic Objective:			**We consistently** deliver safe, high quality, locally accessible services with health outcomes that compare with the best	**Key Measures:**	8a – Ensure delivery of the NHS Constitution access standards: 18 week RTT, improvement on the A & E 4 hour standard in year and delivery of national cancer standards		
				Linked Risks/ collaboration opportunities			
Risk ID:	9	**Risk:**	**4 Hour A&E Standard:** Failure to achieve the trajectory targets agreed with NHSI for 2017/18 resulting in poor patient experience, reduced clinical quality, regulatory action and loss of STF funding	**Board Lead:**	Chief Operating Officer	**Date last reviewed:**	February 2018
				Audit Committee Position			

Risk Rating: (Likelihood x Consequence)		**Controls:** (How are we currently managing this risk?)	**Aligned Risks on Trust Corporate Risk Register (15 or above)** **1 Risks in total**
Current Risk Score:	4 x 5 = 20	• Continuous senior management overview • Full improvement plan in place to deliver sustainable improvements signed off by ED delivery Board and regulators • Internal monitoring arrangements in place with mitigation plans	• Failure to meet ED Standards and subsequent overcrowding (20)
Tolerable Risk Score:	2 x 4 = 8		
Direction of Travel:	⟷		

Assurances (How do we know if the things we are doing are having an impact?)

- Evident improvement in performance since 28th August 2017
- EY engaged between September and December with robust improvement programme and analytics
- Comparable position with other economy's significantly improved

Key Performance Indicators

Feb 17	July	Feb 17	Mar 17	Aug 17	Sept 17	Oct 17
79.80%	81.14%	76.9%	79.2%	87.5%	87.84%	

Nov 17	Dec 17	Jan 18
85.73%	80.44%	86.47%

Gaps/rationale for current risk score/emerging risks

- Health Economy improvement plan agreed –not all actions completed
- Demand and acuity has outstripped economy plan during quarter 4
- Adverse impact on RTT re winter planning for 17/18 and cessation of non-urgent elective programme

Mitigating actions: (What further mitigating action could we take?)

- Agreed health economy action plan to deliver sustainable improvement is being tracked to ensure delivery to agreed timescales
- Identification and recording of early warning signs re risk on 52 week breaches

Strategic Objective:	We consistently deliver safe, high quality, locally accessible services with health outcomes that compare with the best	Key Measures:	8a – Ensure delivery of the NHS Constitution access standards: 18 week RTT, improvement on the 4 hour A & E standard in year and delivery of national cancer standards
		Linked Risks/ collaboration opportunities	

Risk ID:	10	Risk:	RTT – Failure to achieve the trajectory targets agreed with NHSI for 2017/18 resulting in poor patients experience and regulatory action	Board Lead:	Chief Operating Officer	Date last reviewed:	February 2018
				Audit Committee Position	Audit committee requested that FBPAC review the impact on the Trust's provider licence as a result of the failure of RTT. The specific licence requirement is as follows "are clear systems in place for notifying individual patients about choice re "18 week" breaching when arranging alternative care		

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	4 x 5 = 20
Tolerable Risk Score:	2 x 5 = 10
Direction of Travel:	↔

Controls: (How are we currently managing this risk?)

- RTT Improvement Board in place
- Full Recovery Action Plan in place
- Weekly Access and Performance meeting established
- Development of data quality and patient tracking reports
- Compliance with Access Policy
- Reporting via Finance and Operational Group
- Full patient tracking in place with live PTL
- CCG Contract Monitoring meeting
- Data Quality monitoring in place
- Elective Intensive Support Team (IST) review of Trust action plan complete.

Aligned Risks on Trust Corporate Risk Register (15 or above)
1 Risks in total

- Failure to meet ED Standards and subsequent overcrowding (20)
- Failure to achieve 62 Day Cancer Target – Urology (16)

Assurances (How do we know if the things we are doing are having an impact?)

1. RTT Strategic Group provides oversight of improvement work

Key Performance Indicators

May 17	Jun 17	Jul 17	Aug 17	Sept 17	Oct 17
82.05%	82.67%	80.15%	79.07%	80.4%	80.91
Nov 17	Dec 17	Jan 18			
80.91%	77.77%	76.43%			

Gaps/rationale for current risk score/emerging risks

1. Data quality – gaps in assurance (Actions 1 and 2)
2. Long waits in some specialties for first out-patient appointment (Actions 3 & 4)
3. Additional capacity to clear backload no robustly available
4. Mismatch between NHS constitutional standard/Single Oversight Framework and STF trajectories agreed with regulators and commissioners

Mitigating actions: (What further mitigating action could we take?)

1. Clean up of PTL
2. Full roll out of 18 week training
3. Intensive Support Team supporting the improvement work
4. Full recovery action plan in place

Strategic Objective:			**We consistently** deliver safe, high quality, locally accessible services with health outcomes that compare with the best	**Key Measures:**	8a – Ensure delivery of the NHS Constitution access standards: 18 week RTT, improvement on the 4 hour A & E standard in year and delivery of national cancer standards	
				Linked Risks/ collaboration opportunities		
Risk ID:	11	**Risk:**	**Cancer:** Failure to deliver the National Cancer Standards for 2016/17 resulting in poor patient outcomes, regulatory action & loss of STF funding	**Board Lead:**	Chief Operating Officer	**Date last reviewed:** February 2018
				Audit Committee Position	MIAA – Activity Data Capture report – 31 day cancer – significant assurance/62 day cancer – limited assurance	

Risk Rating: (Likelihood x Consequence)		**Controls:** (How are we currently managing this risk?) • Cancer tracking and monitoring weekly • Escalation policies in place • Full divisional overview • Review via Finance & Performance Group and FBPAC • CCG Contract Monitoring meeting	**Aligned Risks on Trust Corporate Risk Register (15 or above)** **1 Risks in total** • Failure to achieve 62 Day Cancer Target – Urology (16)
Current Risk Score:	2 x 5 = 10		
Tolerable Risk Score:	2 x 5 = 10		
Direction of Travel:	⟷		

Assurances (How do we know if the things we are doing are having an impact?)

- Compliance with cancer standards regularly achieved with adherence to agreed pathways
- Capacity in line with current demand

Key Performance Indicators

Apr 17	May 17	Jun 17	July 17	Aug 17	Sep 17
Concern 1 Standard	Concern 1 Standard	Concern 1 Standard	Delivered	Delivered	Delivered
Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	March 18
Delivered	Delivered	Delivered	On track Q4	On track Q4	On track Q4

Gaps/rationale for current risk score/emerging risks

- National awareness campaigns drive demand and not always pre-warned which can increase demand & mismatch capacity (no mitigating actions applicable)
- Overall compliance reliant on good performance in dermatology
- Data quality concerns following MIAA Audit

Mitigating actions: (What further mitigating action could we take?)

- Audit Committee review management actions to MIAA Audit Report. EMT agreed to have Christie undertake a peer review

Operational Performance

Strategic Objective:	We **consistently** deliver safe, high quality, locally accessible services with health outcomes that compare with the best	Key Measures:	8b – Deliver national infection and prevention control targets for C.diff
		Linked Risks/ collaboration opportunities	

Risk ID:	12	Risk:	**C.diff:** There is a risk that the Trust fails to keep a grip on infection, prevention & control resulting in harm to patients, poor patient experience and potential regulatory action & loss of STF funding associated with exceeding the permitted cumulative number of C.diff cases for 17/18	Board Lead:	Director of Nursing and Midwifery	Date last reviewed:	February 2018
				Audit Committee Position	Internal Audit – Water Safety – Significant assurance report received August 17		

Risk Rating: (Likelihood x Consequence)	
Current Risk Score:	4 x 4 = 16
Tolerable Risk Score:	2 x 3 = 6
Direction of Travel:	⟷

Controls: (How are we currently managing this risk?)

- Rapid detection, effective isolation & doing the basics brilliantly
- HPV Programme and use of Ultra Violet Light Machines (UVLM) to be operationally delivered without interruption, together with effective environmental cleaning
- Isolate effectively; use Ward 25 and side rooms in the best way possible based on agreed protocols
- Doing the basics brilliantly; Daily & weekly MDT of patients with IPC concerns, Antimicrobial stewardship and prescribing audits
- Reconfiguration of beds within medicine and acute to support an extension to the isolation facilities on ward 24/25

Aligned Risks on Trust Corporate Risk Register (15 or above)
1 Risks in total

- Ability of Trust to remove CPE from the environment (15)

Assurances (How do we know if the things we are doing are having an impact?)

- Full HPV and UVLM Programme in place
- Agreed protocols for isolation and step down
- Robust assurance on hand hygiene
- PIRs completed and lessons learned / actioned effectively

Key Performance Indicators - Year to Date Cumulative

May 17	Jun 17	July 17	Aug17	Sep 17	Oct17
5 C.diff	7 C diff	8 C diff	14 C diff	16 C diff	19 C diff
Nov 17	**Dec 17**	**Jan 18**			
20 C diff	22 C diff	23 C diff			

Gaps/rationale for current risk score/emerging risks

- Challenges associated with cohort nursing on Ward 25 (isolation unit)
- Absence of effective MDT / daily specialist nurse reviews and prompt action
- No follow up on discharged patients to reduce reoccurrence / readmissions
- Insufficient assurance on doing the basics brilliantly; hand hygiene, environmental cleaning, admin/data, monitoring alerts, step up/down from isolation
- Failure to follow up Post Infection Reviews to learn lessons
- Gaps in team and lack of ownership engagement across the trust beyond IPC.
- Recent external peer reviews highlighted a range of recommendations

Mitigating actions: (What further mitigating action could we take?)

- Review the operational management of wards 24 and 25 to ensure high risk cohorts are maintained (positive CDiff and CPE) with appropriate staffing levels are in place
- Formalise the weekly MDT to include all patients with CDiff infection
- interim Leadership support from November in place, substantive recruitment in process
- Delivery of the IPC improvement plan on time, mitigating actions as required, in particular to CPE management and high risk patients, cleaning provision and approach to screening. Review of all estates priorities/work that directly impacts onto patient areas
- Matrons, Ward Sisters and IPCNs to identify equipment on wards labelled as Ward 19 to be returned
- Doors to be erected on Ward 19 (decant ward) to secure equipment on the ward

Strategic Change

Strategic Objective:			**We provide** safe, high quality, locally accessible services in partnership with primary, social and community care, now and in the future	**Key Measures:**	3b – Work with acute/secondary, primary, community and social care partners on 'end to end' redesign of the unscheduled care system and services for older people 3c – Work with CoCH to deliver an agreed model for future development of services 4a – Progress the integration of back office & clinical support functions with CoCH 6a – Contribute proactively to the development of the NHS for C&M (STP) Cheshire and Mersey footprint ensuring that the needs of Wirral citizens and the Wirral pound are fully considered		
				Linked Risks / collaboration opportunities	C&M Health & Care Partnership solutions may negatively impact provision of services in Wirral. The pace of delivery of Wirral solutions may be impacted by complexity of working with multiple organisations. Lack of intellectual and/or financial headroom may reduce delivery pace		
Risk ID:	13	**Risk:**	**Cheshire &Merseyside Health & Care Partnership (STP):** There is a risk that we are unable to work effectively in collaboration with organisations within our C&M footprint to implement agreed plans in a timely way that inhibits our ability to provide clinically & financially sustainable, locally accessible high quality services.	**Board Lead:**	Director of Strategy and Sustainability	**Date last reviewed:**	February 2018
				Audit Committee Position			
Risk Rating: (Likelihood x Consequence)			**Controls:** (How are we currently managing this risk) • Engagement in C&M Health & Care Partnership emerging governance arrangements (Q1 2018) • Avoid distraction of LDS, which is now largely superseded by refreshed C&M Health & Care Partnership and 'Place Based Collaboration System' care by accelerating progress on WWC Alliance, defining a handful of clinical and corporate services we can rapidly take forward (Q1 2018) and planning to develop a Wirral & West Cheshire Clinical Strategy (Q3 2018). • Proactively design future configuration of Women & Children's services for Wirral and West Cheshire as an exemplar solution for C&M Health & Care Partnership (Q1 2018) • Work fully with 'North 4' Pathology footprint in line with NHSI direction to move toward 29 consolidated pathology networks across England without impeding further value from building further on extant WWC collaboration (Q1-4 2018) • Provide effective Leadership of elements of C&M Health & Care Partnership macro plans, e.g. reducing variation and high quality hospital care	**Aligned Risks on Trust Corporate Risk Register (15 or above)** **0 Risks in total**			
Current Risk Score:	4 x 5 = 20						
Tolerable Risk Score:	3 x 5 = 15						
Direction of Travel:	⟷						
Assurances (How do we know if the things we are doing are having an impact?)				**Key Performance Indicators**			
Critical success factors (improved health outcomes, healthcare experience and better use of resources) will be defined prospectively to ensure best use of resources and limited capacity to deliver change as we prioritise work programme. Tangible, SMART key performance measures and indicators agreed to enable effective assurance of progress / escalation of impediments / exceptions.				1. Fully defined C&M Health & Care Partnership governance available and endorsed by WUTH Board 2. WWC Alliance governance & change delivery framework & 2018 programme of work available / endorsed by WUTH Board. 3. WWC solution for Women & Children's services available/endorsed by WUTH/CoCH and embedded in C&M Health & Care Partnership macro plans 4. WWC pathology proposals form core of North 4 pathology planning & delivery timeline reflects pace required by WWC Alliance 5. C&M Health & Care Partnership plans agreed for reducing variation & enabling high			

	quality hospital care
Gaps/rationale for current risk score/emerging risks	**Mitigating actions:** (What further mitigating action could we take?)
1. C&M Health & Care Partnership governance arrangements lack clarity and/or direct grip 2. Acceptance of proposed solution for Women & Children's Services is uncertain 3. Absence of capacity & capability to prioritise strategic change over short term delivery of standards (4 hour, access, financial balance)	1. Focus further on Wirral & West Cheshire Alliance ahead of C&M Health & Care Partnership provider network 2. Create additional capacity / capability to drive strategic priorities that directly improve short term delivery of standards (4 hour, access, financial balance) 3. Work more closely with colleagues, patients, citizens, volunteers, third & private sector

Strategic Change

Strategic Objective:			**We provide** safe, high quality, locally accessible services in partnership with primary, social and community care, now and in the future	**Key Measures:**	3a – Continue to support the roll out of the Healthy Wirral Programme 4b – Develop and implement a strategy to support a closer working relationship with primary care services 6a – Contribute to the development of the STP for the period 2021 across the Wirral, South Mersey and Cheshire and Mersey footprints and achieve all 2016/17 milestones		
				Linked Risks/ collaboration opportunities	CCG / LA Integrated Commissioning Strategy and/or Healthy Wirral solutions may negatively impact provision of sustainable services by WUTH through unintended consequences. The pace of delivery of Healthy Wirral solutions may be impacted by absence of intent and / or consensus on route to Place Based Collaboration System care and / or lack of intellectual and / or financial headroom to move quickly. Timeframe for CCG strategy delivery (3 year) is incongruent with regulator's drive for 12 month turnaround.		
Risk ID:	14	**Risk:**	**Healthy Wirral:** Failure to work collaboratively with partners & implement agreed plans inhibits our ability to improve the quality & sustainability of services for our patients	**Board Lead:**	Director of Strategy and Sustainability	**Date last reviewed:**	February 2018
				Audit Committee Position			

Risk Rating: (Likelihood x Consequence)		**Controls:** (How are we currently managing this risk?) - Definition of governance arrangements supporting Healthy Wirral (HWPB, HWEDG, HW50+, GDE Board) - Agreed roadmap / programme of work to deliver better heath, better care & better value in line with published commissioning strategy - Effective Wirral Integrated Provider Partnership established to provide cohesion and grip on provider collaboration - Clarity on resolving contradiction between delivery of financial balance via Commissioner Strategy delivery (3 year) and Regulator drive for surplus in 18/19.
Current Risk Score:	4 x 5 = 20	
Tolerable Risk Score:	3 x 5 = 15	
Direction of Travel:	⟷	

Aligned Risks on Trust Corporate Risk Register (15 or above)
0 Risks in total

Assurances (How do we know if the things we are doing are having an impact?)	**Key Performance Indicators**
Critical success factors (improved health outcomes, healthcare experience and better use of resources) will be defined prospectively to ensure best use of resources and limited capacity to deliver change as we prioritise work programme. Tangible, SMART key performance measures and indicators agreed to enable effective assurance of progress / escalation of impediments / exceptions.	• reduction in the level of unplanned hospitalisation for chronic ambulatory care sensitive conditions bringing Wirral nearer to the NHSE average • Reduction in the level of emergency admission for acute conditions not usually requiring hospital admission bringing Wirral nearer to the NHSE average • A year on year reduction in ED attendances/non-elective admissions/avoidable readmissions (as a % of all admissions) admissions from nursing homes • A reduction in ALOS bringing WUTH in line with best quarter performance
Gaps/rationale for current risk score/emerging risks	**Mitigating actions:** (What further mitigating action could we take?)
1. Governance arrangements for Healthy Wirral lack definition and grip 2. There is no clearly defined roadmap to enabling place based accountable care	1. New Model of care (52-9-4-1)to be piloted within HW50+ programme, with a MOU 2. Delivery MSK Prime Provider contract let by CCG & secured by WUTH in partnership with WCT & PC 3. Further Wirral Leaders Lock-In session in March 2018 to reach agreement on roadmap and timetable 4. Wirral Integrated Provider Partnership established 5. Primary & Acute Care collaboration being piloted with Primary Care Wirral 6. Acceleration of recent urgent care solutions to continue to improve system delivery of 4 hour standard 7. HWPB TOR redeveloped, MOU to be established, independent Chair and Programme Director to be appointed

Strategic Change

Strategic Objective:			**We provide** safe, high quality, locally accessible services in partnership with primary, social and community care, now and in the future	**Key Measures:**	All impacted if trust is not sustainable		
				Linked Risks/ collaboration opportunities	• Focus on the short term / urgent may impact delivery of future state • Lack of resource may constrain our ability to take forward all we wish / need to • Inability to effectively prioritise may lead to missed opportunity to maximise value		
Risk ID:	15	**Risk:**	**Operational Step Change & Internal Transformation:** Failure to prioritise strategic change & implement agreed plans inhibits our ability to improve the quality & sustainability of services for our patients	**Board Lead:**	Director of Strategy and Sustainability	**Date last reviewed:**	February 2018
				Audit Committee Position			
Risk Rating: (Likelihood x Consequence)			• **Controls:** (How are we currently managing this risk?) Establish Strategy & Sustainability Planning Group (SSPG) to complement and link effectively with F&PG, FBPAC, TSG, WWC Alliance, Healthy Wirral and C&M HCP • Establish 18/19 operational planning timetable to connect divisional planning to the SSPG • Establish Governor Strategy and Sustainability Advisory Committee • Establish a diagonal change agent network • Develop a robust approach to enable priorities to be set, and to linked to to trust vision	**Aligned Risks on Trust Corporate Risk Register (15 or above)** **0 Risks in total** •			
Current Risk Score:	4 x 5 = 20						
Tolerable Risk Score:	3 x 5 = 15						
Direction of Travel:	⟷						
Assurances (How do we know if the things we are doing are having an impact?)				**Key Performance Indicators**			
• Comprehensive operational plan for 18/19 that links and prioritises strategic system change with operational step change with low level 'bau' cash releasing efficiencies / tactical savingss. • Clear strategic roadmap for 2018 initially and then beyond to 2020 • Critical success factors (improved health outcomes, healthcare experience and better use of resources) will be defined prospectively to ensure best use of resources and limited capacity to deliver change as we prioritise work programme.				• Improved performance against CSFs, KPMs and KPIs (will form part of updated performance reports to the Trust board)			
Gaps/rationale for current risk score/emerging risks				**Mitigating actions:** (What further mitigating action could we take?)			
• Bandwidth to effectively manage all of the priorities				• Encourage, recognise & reward broader engagement in making real our strategic ambitions. Provide a more accessible vision for our future to enable more colleagues to connect fully and understand their role in enabling. • Prioritisation process underway as part of sustainability challenge			

Strategic Change

Strategic Objective:			**We are** a national exemplar for transforming care through innovation and technology	**Key Measures:**	7a – Work towards full digitization of the Electronic Patient Record 7b – Work towards the achievement of HIMMS level 7 7d – Look to improve our digital maturity index score		
				Linked Risks/ collaboration opportunities			
Risk ID:	16	**Risk:**	**IT:** Failure to realise the benefits of Cerner through the various work streams resulting in poor patient outcomes, reputational damage & future investment	**Board Lead:**	Director of IT and Information	**Date last reviewed:**	February 2018
				Audit Committee Position	Internal Audit Report – IT Service Continuity Review – Limited Assurance – Committee reviewed findings and proposed actions and requested that a re-audit was undertaken before the end of the financial year in view of the seriousness of the matter. A report was taken to Trust Board in January and progress will be reported on a quarterly basis. Remaining actions nearing completion and a new audit programme for 2017/18 is in progress MIAA Critical Application Review – JAC – Pharmacy – Limited assurance		

Risk Rating: (Likelihood x Consequence)		**Controls:** (How are we currently managing this risk?)	**Aligned Risks on Trust Corporate Risk Register (15 or above)** **1 Risk in total**
Current Risk Score:	3 x 4 = 12	• The Trust uses a standardised implementation methodology to engage and involve users in the system design and testing. • All staff receive classroom based training prior to receiving a user name & password. • Progress with the programme is managed through the Informatics governance structure and reported to the Digital Wirral Programme Board. • All major go lives are signed off by the CEO and Medical Director.	• No Access to Child Health System – Women & Children's (20)
Tolerable Risk Score:	2 x 4 = 8		
Direction of Travel:	⟷		

Assurances (How do we know if the things we are doing are having an impact?)	**Key Performance Indicators**
• Post implementation reviews completed at major milestones • External review of GDE programme by representative of NHS Digital	A new benefits programme is being developed under Digital Wirral programme which will develop a set of metrics for the benefits of the programme published in September 2017
Gaps/rationale for current risk score/emerging risks	**Mitigating actions:** (What further mitigating action could we take?)
1. Training required for clinical staff (inc locum and bank staff) to ensure appropriate use of Cerner system following successful implementation of phase 3 (Action 1) 2. Limited Assurance received following the MIAA IT Service Continuity Review (Actions 2 and 3) 3. Delays in receiving GDE funding (Action 4) although funding now received 4. Additional work require to prepare for implementation of renewed General Data Protection Regulations (GDPR) (Action 5) 5. Lack of tracking system to determine "real time" bed state and patient flow (Action 6)	1. Undertaking review of training e.g. drugs administration refresher and will produce proposal for on-call training service for locums and bank staff (to include associated costs) (Date TBC) 2. Work underway to complete IT Service Continuity action plan to address limited assurance assigned by Internal Audit. A report was taken to Trust Board in January and progress will be reported on a quarterly basis 3. 'Snapshot' audit to confirm achievement of improved assurance in combination with cyber security and system resilience work – outcomes reported to Audit Committee in March 2017 and further audit in Q2 4. GDE benefits realisation plan for GDE (Statement of Planned Benefits) has been signed off by NHS Digital and Divisions are working through it through TSG This will contribute to a refreshed business case. To be previewed by Trust Board once the financial details are settled planned for March 18 5. Information, IG & CG to oversee implementation of GDPR action plan through active engagement with the Clinical Divisions and Corporate Services – March 2018 6. Continue with the Capacity Management Solution but develop business case for "real time" tracking system for future investment

Strategic Change

Strategic Objective:			**We provide** safe, high quality, locally accessible services in partnership with primary, social and community care, now and in the future	**Key Measures:**	4a – Progress (i) the development of a VAT efficient Special Purpose Vehicle for service delivery (ii) A SEP with a third party		
				Linked Risks/ collaboration opportunities			
Risk ID:	17	**Risk:**	**Estates:** Failure to develop & implement a strategic estates strategy impacts on patient & staff experience; collaborative working and clinical service strategies and financial sustainability	**Board Lead:**	Director of Finance	**Date last reviewed:**	February 2018
				Audit Committee Position	• limited assurance report on water safety – reviewed before March 17 confirming high level recommendations completed • Full compliance review requested and undertaken in Estates against all the critical areas. This work should be aligned to the Health and Safety compliance and audit programme. • Internal Audit – Estates Maintenance Review – Significant assurance report received		
Risk Rating: (Likelihood x Consequence)			**Controls:** (How are we currently managing this risk?) • Experienced legal and financial partners have been contracted to ensure that the Trust follows the correct procurement process and avoid unnecessary legal challenges • Ongoing monitoring of compliance with Water Safety measures undertaken by IPORT • Glen Adams has been appointed chief engineer with specific duties concerning compliance.	**Aligned Risks on Trust Corporate Risk Register (15 or above)** **0 Risks in total**			
Current Risk Score:	3 x 5 = 20						
Tolerable Risk Score:	3 x 5 = 15						
Direction of Travel:	⟷						
Assurances (How do we know if the things we are doing are having an impact?)				**Key Performance Indicators**			
• To be developed as the programme progresses • Estates maintenance review – significant assurance report received • High risk areas in limited assurance report satisfactorily dealt with and acknowledged by MIAA • Initial Compliance assessment undertaken on all estates compliance and associated action plans produced.				See integrated quality dashboard			
Gaps/rationale for current risk score/emerging risks				**Mitigating actions:** (What further mitigating action could we take?)			
1. Inability to fully address backlog maintenance challenge 2. General capital investment demands vs capital resource and prioritisation requirement and residual risk 3. Authorised Person and Competent Person training needs to be undertaken 4. Procurement process for strategic estates partner as agreed at Board of Directors abandoned with adverse impact on a strategic estates plan for 2018/19				1. Prioritisation of maintenance issues in place. Further review undertaken by Executives to prioritise key items of work that would improve patient and staff experience 2. Strategic estates plans to be developed on a transitional basis using proposed six facet survey results. Six facet survey out to tender. 3. Authorised person and competent persons are undertaking the role, despite not having the written qualifications. Training in place for 2018/19. 4. Contingency planning proposals to be determined			

Leadership and Improvement

Strategic Objective:			**We make** the best use of the public resources we have to deliver high quality, locally accessible services that are clinically and financially sustainable	**Key Measures:**	8d – Deliver a Use of Resources (UoR) rating of level 3 8e – Work to improve our NHSI governance rating		
				Linked Risks/ collaboration opportunities	Risks 5,6,7,8,9,10		
Risk ID:	18	**Risk:**	**Enforcement Action** - Insufficient progress against agreed financial and access targets results in further regulatory action and enforcement of Section 111	**Board Lead:**	Chief Executive	**Date last reviewed:**	March 2018
				Audit Committee Position			

Risk Rating: (Likelihood x Consequence)		**Controls:** (How are we currently managing this risk?) • Quality review meetings with NHSI action points agreed • Monthly OSM meetings with NHSI • Monthly Board performance and financial reporting • Operational Task and Finish Groups for RTT and A & E • Full licence compliance review at Audit Committee	**Aligned Risks on Trust Corporate Risk Register (15 or above)** **0 Risks in total** •
Current Risk Score:	4 x 5 = 20		
Tolerable Risk Score:	2 x 5 = 10		
Direction of Travel:	⟷		

Assurances (How do we know if the things we are doing are having an impact?)	**Key Performance Indicators**
• Removal of enforcement actions in relation to requirement for interim support • Positive Well led Governance Review • Current review of financial undertakings and section 111 being undertaken by NHSI – Oct 17 Revised undertakings received from NHSI and action taken under S111(5)(a)re chair appointment	• Overall UoR (see Risk 5) • Liquidity (see Risk 5) • 4Hour A&E Standard (see Risk 9) • RTT (see Risk 10) • Cancer (see Risk 11) • C.diff (see Risk 12)
Gaps/rationale for current risk score/emerging risks	**Mitigating actions:** (What further mitigating action could we take?)
• Non-achievement of financial control total • Non-compliance with A & E and RTT standards	The actions being undertaken to mitigate the risks relating to RTT; A & E 4 hour standard and financial performance are outlined separately in the BAF as described under linked risks

Leadership and Improvement

Strategic Objective:			**We put** our people first so they can put our patients first, and we create the workforce of tomorrow by investing in the workforce of today **We excel** in a quality improvement/learning culture that allows us all to reduce unwarranted variation and constantly improve our services	**Key Measures:**	5a – Continue the on-going delivery of the Workforce and OD Strategy in order to deliver (i) a healthy organisational culture (ii) a sustainable and capable workforce (iii) effective leaders and managers		
				Linked Risks/ collaboration opportunities	1,2,3 & 4		
Risk ID:	19	**Risk:**	**Medical Engagement:** failure to improve medical leadership & engagement limits our ability to improve patient outcomes & results in loss of activity and increased costs	**Board Lead:**	Medical Director	**Date last reviewed:**	February 2018
				Audit Committee Position			

Risk Rating: (Likelihood x Consequence)		• **Controls:** (What are we currently doing about the risk?) Medical Engagement Strategy agreed • Medical Engagement Road Map – 3 Year Plan commenced April 17 • Consultant Recruitment Process focussed on values • 2 week bespoke induction programme for new consultants • 2 year consultant foundation programme • Clinical leaders' development programme • 'Later Years' Clinical Excellence Programme • Informal drop-in sessions run by Medical Director and Chief Operating Officer • Response to the medical engagement results • Structural change to enable clinically led services
Current Risk Score:	4 x 4 = 16	
Tolerable Risk Score:	3 x 4 = 12	
Direction of Travel:	↔	

Aligned Risks on Trust Corporate Risk Register (15 or above)
0 Risks in total

Assurances (How do we know if the things we are doing are having an impact?)	**Key Performance Indicators**
• Staff survey • Medical Director 1:1 with Senior medical leaders • Chief Operating Officer 1:1 with Divisional Medical Directors • Senior Medical Leaders Meetings (Monthly)	• Monthly Integrated Quality Dashboard • Attendance at weekly safety summit
Gaps/rationale for current risk score/emerging risks	**Mitigating actions:** (What more should we do?)
• High level focus on quality and safety from senior clinical leaders to junior and trainee medical staff. • Medical Engagement Survey results – Jun 17	• Developing new organisational structure to ensure services are clinically led. • Re-design medical leadership Job Descriptions and Personal Specifications to support the new structure, and to focus on values, professional leadership and patient safety. • Change programme Terms of Reference to be agreed ahead of undertaking Board development to ensure that there is an understanding on the effectiveness of the Board's role of setting and maintaining healthy organisational culture.

Leadership and Improvement

Strategic Objective:			**We are** a national exemplar for transforming care through innovation and technology	**Key Measures:**	7a – Work towards the role of the Trust as a teaching institution 7b – Work towards the achievement of HIMMS level 6		
				Linked Risks/ collaboration opportunities			
Risk ID:	20	**Risk:**	**Data Quality:** failure to improve data quality results in loss of confidence; potential risk to patient safety and inability to manage capacity and demand	**Board Lead:**	Director of IT and Information	**Date last reviewed:**	February 2018
				Audit Committee Position	• May 2017 - Trust received qualified limited assurance on the Quality Account due to RTT data issues • Oct 17- MIAA activity data capture review – A & E significant assurance. 31 day cancer - significant assurance/ 62 day cancer – Limited assurance • IG Toolkit audited with significant assurance		

Risk Rating: (Likelihood x Consequence)		**Controls:** (How are we currently managing this risk?) • All staff receive training on their use of the IT system prior to receiving their usernames and passwords • There is significant validation built into the Trusts millennium system to ensure that only valid data can be collected • The Data Quality Group reporting to the Finance and Performance Committee • Where individual members of staff are found to be causing errors, this is escalated to line managers	**Aligned Risks on Trust Corporate Risk Register (15 or above)** **0 Risks in total**
Current Risk Score:	4 x 4 = 16		
Tolerable Risk Score:	2 x 4 = 8		
Direction of Travel:	⟷		

Assurances (How do we know if the things we are doing are having an impact?)	**Key Performance Indicators**
• Generally speaking there is a series of local and national audits which cover these areas and show that WUTH performs strongly compared with their peers. Individual issues raised by the reports will be dealt with by the Data Quality Group or Audit committee • MIAA significant assurance reports for 31 day cancer and A & E	A dashboard of issues such as completion and timeliness of coding is reviewed on a monthly basis
Gaps/rationale for current risk score/emerging risks	**Mitigating actions:** (What further mitigating action could we take?)
1. Lack of awareness of the clinical coding agenda (Action 1) 2. It is not always clear the provenance of data used in performance reports (Action 2) 3. Quality Account external audit review highlighted concerns with data quality in relation to RTT and A & E (Action 3) 4. Limited assurance report on 62 day cancer 5. MIAA report on ESR and E rostering highlighting 5 areas that require	1. Raise the profile of the clinical coding agenda by ensuring a senior clinical coding presence at key governance meetings, including the CGG and divisional governance meetings – Delays experienced as a consequence of open vacancies and maternity leave. Priority has been assigned to delivery of coding & a coding action plan was developed March 2017 in the dept & in collaboration with Divisions & is not in progress including resolving staffing issues 2. Introduce data quality kite-marks for all reported KPIs, a draft was to be prepared for January 2017 however introduction of kite-marks is proving difficult to implement and further assistance with this issue has been sought from MIAA

further investigation	3. Dedicated project led by operational team is improving the position on RTT and A&E 4 and 12 hour waiting data is now subject to routine audit for breaches and near misses 4. Audit Committee to reviewed management actions for these two limited assurance reports in Dec 17 5. HR undertaking investigation, Audit Committee reviewing outcomes.

Board Assurance Framework – Summary 21.03.18

Risk Ref	SMT Lead	Theme	Potential Risk	Current Score L x C	Tolerable Score L X C	Exec Comm	Assurance Committee
1	MD	Quality of Care	Quality and Safety – The Trust does not promote a culture of quality and safety resulting in patient harm, poor patient experience, poor staff engagement and failure to meet statutory fundamental standards of care	4 x 5 = 20 ↑	1 x 5 = 5 ↑	CGG	Board, QSC
2	DoNM	Quality of Care	Patient Experience – The challenging NHS environment impacts on patient satisfaction impacting on clinical outcomes & public confidence	3 x 3 = 9 ↔	2 x 2 = 4 ↔	PFEG	QSC
3	DoW	Quality of Care	Workforce – failure to attract and retain safe staffing levels will impact on our ability to deliver high quality safe care in a sustainable manner	4 x 4 = 16 ↑	1 x 4 = 4 ↓	WCG	Board, QSC
4	MD	Quality of Care	**MERGED WITH RISK 1**	2 x 4 =8	2 x 4 = 8	CGG	QSC
5	DoF	Finance & Use of Resources	Sustainability – The Trust is unable to deliver financial performance in line with agreed control total with consequent adverse impact on ability to manage capital & cash with further risks centring on inability to cover financial obligations	4 x 5 = 20 ↔	3 x 5 = 15 ↔	F & P	FBPAC
6	DoF	Finance & Use of Resources	Efficiency – The Trust is unable to remove unwanted variation resulting in an inability to reduce costs	4 x 4 = 16 ↔	2 x 5 = 15 ↔	F & P	FBPAC
7	DoF	Finance &Use of Resources	Controls – The Trust is unable to manage its agency spend and meet its agreed control total resulting in loss of STF funding and regulatory intervention	2 x 5 = 10 ↔	2 x 5 = 10 ↔	F & P	FBPAC
8	DoF	Finance &Use of Resources	Value for Money – Inability to demonstrate proper arrangements for securing economy, efficiency and effectiveness in the Trust's use of resources	3 x 4 = 12 ↔	3 x 3 = 9 ↔	F & P	FBPAC
9	COO	Operational Performance	4-Hour A&E Standard – Failure to achieve the trajectory targets agreed with NHSI for 2017/18 resulting in poor patient experience, regulatory action & loss of STF funding	4 x 5 = 20 ↔	2 x 4 = 8 ↔	F & P	Board, FBPAC
10	COO	Operational Performance	RTT – Failure to achieve the trajectory targets agreed with NHSI for 2017/18 resulting in poor patient experience and regulatory action	4 x 5 = 20 ↔	2 x 5 = 10 ↔	F & P	Board QSC FBPAC
11	COO	Operational Performance	Cancer – Failure to deliver the National Cancer Standards for 2017/18 resulting in poor patient outcomes, regulatory action & loss of STF funding	2 x 5 = 10 ↔	2 x 5 = 10 ↔	F & P	QSC
12	DoNM	Operational Performance	C.diff – There is a risk that the Trust fails to keep a grip on infection, prevention and control resulting in harm to patients, poor patient experience & potential regulatory action & loss of STF funding associated with exceeding the permitted cumulative number of C diff cases for 17/18	4 x 4 = 16 ↔	2 x 3 = 6 ↔	CGG	QSC
13	DoS&S	Strategic Change	NHS C & M – there is a risk that we are unable to work effectively in collaboration with organisations within our C & M footprint to implement agreed plans in a timely way that inhibits our ability to provide clinically & financially sustainable, locally accessible high quality services	4 x 5 = 20 ↔	3 x 5 =15 ↔	SSPG	Board,
14	DoS&S	Strategic Change	Healthy Wirral – failure to work collaboratively with partners & implement agreed plans inhibits our ability to improve the quality & sustainability of services for our patients	4 x 5 = 20 ↔	3 x 5 =15 ↔	SSPG	Board,
15	DoS&S	Strategic Change	Operational Step Change & Internal Transformation – Failure to prioritise strategic change and implement agreed plans inhibits our ability to improve the quality & sustainability of services for our patients	4 x 5 = 20 ↔	3 x 5 =15 ↔	SSPG	Board,
16	DoI&I	Strategic Change	IT – Failure to realise the benefits of Cerner through the various work streams resulting in poor patient outcomes, reputational damage & future investment.	3 x 4 = 12 ↔	2 x 4 = 8 ↔	IIT&MDG	FBPAC
17	DoF	Strategic Change	Estates – failure to develop & implement a strategic estates strategy impacts on patient & staff experience and financial sustainability	4 x 5 = 20 ↔	3 x 5 = 15 ↔	F & P	FBPAC
18	CEO	Leadership &Improvement	Enforcement Action – Insufficient progress against agreed financial and access targets results in further regulatory action and enforcement of Section 111	4 x 5 = 20 ↔	2 x 5 = 10 ↔	Board	Board
19	MD	Leadership & Improvement	Clinical Engagement – failure to improve clinical leadership & engagement limits our ability to improve patient outcomes & results in loss of activity & increased costs	4 x 4 = 16 ↔	3 x 4 = 12 ↔	CGG	Board QSC
20	DoI&I	Leadership & Improvement	Data Quality – failure to improve data quality results in loss of confidence; potential risk to patient safety and inability to manage capacity and demand	4 x 4 = 16 ↔	2 x 4 = 8 ↔	II&CG	FBPAC

Profile of risks on the Board Assurance Framework – March 2018

Consequence

Likelihood	1 = Insignificant	2 = Minor	3 = Moderate	4 = Major	5 = Catastrophic
1 = Rare					
2 = Unlikely					• **Controls (in part ie agency spend)** • **Cancer**
3 = Possible			• **Patient Experience**	• **Value for Money** • **IT Benefits**	
4 = Likely				• **Efficiency** • **C.diff** • **Data Quality** • **Clinical Engagement** • **Workforce**	• **Sustainability** • **Quality and Safety** • **4-Hour A&E Standard in part** • **NHS C&M** • **Operational step change & Internal transformation** • **Healthy Wirral** • **Estates** • **Enforcement Action (in part ie Board capability)** • **RTT in part**
5 = Certain					

Board of Directors	
Agenda Item	8.2
Title of Report	Report of the Finance, Business Performance and Assurance Committee – 23rd March 2018
Date of Meeting	28th March 2018
Author	Sue Lorimer, Chair of the Finance, Business Performance and Assurance Committee
Accountable Executive	Gareth Lawrence, Acting Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	4, 7, 8 4a, 7a, 7b, 7d, 8a, 8c, 8d, 5, 6, 7, 8, 9, 16, 17, 20
Level of Assurance • **Positive** • **Gap(s)**	Gaps with mitigating action
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion
Reviewed by Assurance Committee	Not applicable
Data Quality Rating	Not applicable
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	Not applicable

Report of the Finance, Business, Performance and Assurance Committee 23rd March 2018.

This report provides a summary of the work of the FBPAC which met on 23rd March 2018.Key focus areas are those which address the gaps in assurance in the Board Assurance Framework.

1. Chair's Business

Sue Lorimer introduced herself as the new chair of the committee and welcomed John Sullivan as the other NED member. She thanked Andrea Hodgson for her service as chair of the committee over a number of years. She also welcomed Sir David Henshaw, Trust Chairman who was in attendance.

Sir David Henshaw led a discussion on the purpose of the committee and how it might fulfil its function better. The volume of papers was too great and the content was too narrative-heavy currently. This did not help in supporting NEDs to provide appropriate challenge and it was difficult to identify accountabilities, particularly for transformation projects.

John Sullivan said it would be helpful to consider performance by division rather than across the whole organisation. The committee agreed that a change to shorter, more focussed papers based on dashboards of divisional performance would help it fulfil its role much better. This needed to be supported by an effective committee structure below Board level. Janelle Holmes agreed to take away an action to review and come back with a map of the supporting committees and some dashboards for consideration. A special meeting was to be arranged for 2 weeks' time.

2. Board Assurance Framework
The committee noted the contents of the BAF had now been brought up to date.

3. M11 Financial Position
The committee received the report and noted that performance is on course to achieve the revised forecast outturn deficit position. Janelle Holmes said that meetings had been held with all divisions who had confirmed that they saw no further risks to achieving their forecasts. Gareth Lawrence said that there had been circa £5m capital expenditure in March which meant that capital would outturn at some £0.4m below budget.

4. Going Concern
The committee reviewed a paper which set out the rationale for the organisation being able to declare itself a Going Concern and preparing its 2017/18 accounts on that basis. The reasons were that:

- The trust has not been notified of an intention for dissolution
- No major losses of commissioner income are anticipated
- NHSI and DH will have implicitly approved the borrowings required for 2018/19 by not rejecting the trust's plan.
- The trust has not identified any risk of an inability to repay borrowings as they fall due. If required, terms may be renegotiated.

The directors have identified the unapproved loans issue as a material uncertainty in line with DHSC guidance. However, this would not prevent the trust continuing to operate as a going concern for the foreseeable future.

The wording for the statement proposed by the trust has been agreed with its external auditors.

5. Draft Financial Plans 2018/19
The committee reviewed the draft financial plans for 2018/19 which had already been presented to a private session of the Board in February. It was noted that the plans were subject to the agreement on contract income with commissioners and that this had not been agreed. If the trust is successful in its negotiations the position is likely to improve. The plans include a CIP requirement of 3% or £10m. The planned deficit is significantly worse than the control total set by NHS Improvement and currently the trust is not in a position to accept it. This results in lost income and cash from the Provider Sustainability Fund of £12.5m. The committee supported the executive directors in pursuing a reasonable contract settlement which properly compensates the trust for the patient care activity it is undertaking, particularly in emergency and urgent care.

The committee noted that land sale proceeds had been included in the resources supporting the capital budget but there is a risk that the trust might be directed to use them in support of the cash position.

The draft budget results in a Use of Resources score of 3.

6. NHSI Compliance Report M11
The committee noted the report.

7. 2018/19 Contract with Wirral CCG – Mediation Position

The committee noted that the trust was unlikely to be able to sign contracts with its commissioners in the timescale required and that mediation discussions had started. The areas of disagreement between the trust and its commissioners amounted to £16m. The committee agreed that the Board has an obligation to reduce its deficit by being properly recompensed for its services and that regretfully, the team should continue through the dispute process.

8. Integrated Performance Dashboard

The committee noted the trust's performance to February. A&E and RTT performance continue to be key issues of concern. However, Janelle Holmes explained that the trust's relative performance on A&E is in the top quartile of trusts. RTT continues to be a concern and has worsened due to the national directive to cancel elective activity in order to support urgent demand.

9. CIP and Transformation Report M11

The committee noted the report and the projected achievement of £8.4m against a target of £15m. The CIP mitigation reserve brings this to £9.9m, a shortfall of £5.1m against the target.

10. Workforce Update Report

The committee noted the contents of the report. There was discussion about the format and presentation of information within the report and Helen Marks agreed it needed to be revised to a shorter, more focussed report. Gaynor Westray raised her concerns regarding the increase in the Nursing and Midwifery band 5 vacancy rate from 9.2% to 12.2% over 12 months. It was agreed that the workforce statistics would be more usefully presented by division.

11. Contract Award Recommendation Report

The committee received a report setting out the process undertaken to award a 3 year contract for the provision of prosthetic and technician services valued at £1.4 million to Otto Bock Healthcare PLC. The committee agreed that the process had been conducted appropriately and would recommend the contract award to the Board.

12. Assurance Reporting

The committee received reports from:

- Finance and Performance Group
- Digital Wirral Programme Board
- Information, Information Governance and Coding Group
- Strategy and Sustainability Planning Group.

The committee was pleased to see the significant assurance report received from MIAA on Information Governance. However mandatory training performance is still poor and the committee requested that Paul Charnley bring a plan of how training would be made more accessible to all staff and improve performance.

The Strategy and Sustainability report included plans for Transformation and CIP for 2018/19. This showed that while good progress has been made in identifying the £10m target, £2.5m of this is at the opportunity stage and £0.3m unidentified.

13. Escalation to the Board

- Risk that the capital receipt of £4.3m might not be available to support the 2018/19 capital programme
- The Going Concern statement is reliant on the Trust's plan not being rejected by NHSI
- CIP for 2018/19 still has £3.4m classed as opportunities or unidentified.
- The committee wished to recommend the award of the prosthetic and technician contract to Otto Bock Healthcare Ltd.
- Mandatory Training in Information Governance remains a concern

Sue Lorimer
Chair of Finance, Business Performance and Assurance Committee
28.3.2018

BOARD OF DIRECTORS	
Agenda Item	8.3
Title of Report	Chair of Audit Committee Report
Date of Meeting	28 March 2018
Author	Graham Hollick, Chair of the Audit Committee
Accountable Executive	Gareth Lawrence, Acting Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	All
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion
Reviewed by Assurance Committee	Not applicable
Data Quality Rating	Not applicable
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	Not applicable

Board Assurance Framework (BAF)
The committee noted that the Board Assurance Framework needed to be fully updated and reviewed in order to give assurance to the members that the risks were being fully articulated and mitigated.

Financial Assurances Report
The committee reviewed the Financial Assurance report and sought and received further assurance regarding the historical VAT penalty that had been incurred in year. The committee also sought further assurance around the tender waiver for elements of refurbishments at the Clatterbridge site. It was noted that the aged debt had significantly reduced since the publishing of the papers as a result of payments received from the CCG.

NHS Improvement Licence
The committee reviewed the NHS Improvement Licence document and sought re-assurances around the recent investigation in to the trust and the potential impact this could have on the provider. It was not currently known how the recent events would affect the Licence but believed there would be potential implications. The committee agreed that the document reflected the current position of the Trust at the end of Q3.

Draft Financial Policies 2017/18
The committee reviewed the Draft Financial Policies for 2017/18. The committee noted that these could be subject to change if further guidance is issued but approved their adoption for the accounts.

Internal Audit Actions
The committee noted the internal audit progress thus far. The committee noted that while it was positive that there was assurance found in the areas tested, there was a potential for us to be reviewing similar areas. The committee took re-assurance from the fact that new areas had been discussed for the 2018/19 and that the BAF was reviewed in conjunction with their plan. The committee noted the request from FBPAC that there are certain metrics within the HR department that would need review; this was requested of MIAA who confirmed that this had been built in to the work plan for 2018/19.

Anti-Fraud Progress Report
The committee reviewed the work undertaken by the Counter Fraud Specialist. A trend has been identified in that there has been a significant increase in people working while off sick. Communication plan was being formed to highlight this issue to all staff. The committee sought assurance around the number of cases that were being reported, while the cases were still low they were higher than in previous years which could demonstrate greater awareness.

The committee reviewed the audit plan presented by the external auditors. Assurances were sought that they had sufficient resources in place to complete the Audit which was confirmed by Grant Thornton. The Auditors confirmed that they would be testing the outcomes raised in the recent NHSI commissioned review on the Trust Governance. The committee noted the contents of the report.

The committee then requested the Acting CEO to attend the meeting for questions to be raised under AoB. The committee members sought assurances on the following issues:

- The arrangements for covering the Director of Finance role post April.
- The arrangements for supporting the Corporate Secretary given the challenges on the BAF and pending Annual Report.
- Reputational damage regarding recent media reports.
- Effect of recent events on Operational Morale
- The arrangements for the HR Director vacancy

The Acting Chief Exec confirmed that plans were in place for the DoF role and that Helen Marks has accepted a 6 month contract as interim Director of HR. Options had been pursued over Corporate Secretary support and he hoped to have further confirmation in the coming weeks.
While reputational damage was a risk there had been no adverse impacts on recent recruitment for Senior Clinical and Operational posts.

Morale would be a challenge none more so than for the Operational pressures that are staff are operating under. Leader's forum was recently changed to have a more interactive approach and further developments are planned in the future.

Graham Hollick
Audit Committee Chair

Board of Directors	
Agenda Item	8.4
Title of Report	Chairs Report – Quality & Safety Committee
Date of Meeting	28 March 2018
Author	John Sullivan
Accountable Executive	Susan Gilby Medical Director Gaynor Westray Director of Nursing
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	 1, 2, 4, 5, 7 1a, 1b, 2a, 2b, 2c, 4a, 5a, 5b, 5c, 7a, 7b, 7c, 7d 1, 2, 3, 16, 17, 19
Level of Assurance • **Positive** • **Gap(s)**	Gaps with mitigating action
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Discussion
Data Quality Rating	Gold – externally validate Silver – quantitative data that has not been externally validated Bronze – qualitative data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

Executive Summary

This report provides a summary of the work of the Quality and Safety Committee which met on the 14 March 2018

The group reviewed the following reports as part of the agenda:

Board Assurance Report (BAF)

The committee agreed that the current BAF presented is in need of a full refresh and update. The Executive Directors present will lead and complete an update and present the outcomes to the March 2018 Trust Board meeting.

Deep Dives

The committee were reminded of upcoming 'deep dives' into Hydration & Nutrition and Infection Prevention and Control (IPC). Both reports will be presented to the next meeting of the Q&S Assurance Committee (May 2018).

IPC and Safeguarding

These will both report directly to the Quality & Safety Committee in future.

2017 Staff Survey Results

The 2017 NHS Staff Survey results were discussed. The committee agreed that the results should be analysed alongside the other recent reports and investigations on engagement and culture. The proposed refresh of an Organisation Development programme was discussed and supported.

Annual Statutory Reports

In future these reports will go to the WUTH Clinical Governance Group for review with a summary presented to the Q&S Assurance Committee.

The Q&S Assurance Committee will be presented with an annual work plan (including statutory annual reports) at its next meeting (May 2018).

Unannounced CQC Inspection

The current unannounced CQC inspection day 1 was discussed. The committee were also reminded of the CQC Well Led Review booked for 1-3 May 2018. A list of participants will be distributed and briefing panels scheduled in advance of the review. The Trust Board will be consulted on the preparations for the Well Led Review at the March 2018 Trust Board meeting.

Action Log

The committee's action log is out of date and a thorough update will be distributed with the next meeting's pre reads (May 2018).

Items to escalate to the Trust Board

- Risks associated with WUTH infrastructure condition and the future prevention of incidents as a result of losses of containment from fluid pipe work and drains.

- Risks associated with delays in reaching 95% compliance with Protecting Vulnerable People Safeguarding mandatory training. In particular in the Emergency Department where compliance is 76.92% with 27 staff remain non-compliant

- A proposal for a separate Workforce subcommittee of the Trust Board. Proposed terms of reference will come to the Trust Board for support and approval.

- The proposed Organisation Development programme (in response to recent investigations, reports and the 2017 staff survey results) will come to the Trust Board for discussion and agreement.

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF PUBLIC MEETING

28th FEBRUARY 2018

BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL

Present

Andrea Hodgson	Non-Executive Director, Deputy Chair
David Jago	Acting Chief Executive
Susan Gilby	Medical Director
Graham Hollick	Non-Executive Director
Janelle Holmes	Chief Operating Officer
Gareth Lawrence	Acting Director of Finance
Sue Lorimer	Non-Executive Director
Cathy Maddaford	Non-Executive Director
Anthony Middleton	Director of Operations and Performance
John Sullivan	Non-Executive Director

In attendance

Mike Baker	Head of Communications
Dr John Fry	Public Governor
Jayne Kearley	Member of the Public
Frieda Rimmer	Public Governor
Nigel MacLeod	PA to CEO and Chairman (Minutes)

Apologies

Gaynor Westray	Director of Nursing and Midwifery

*denotes attendance for part of the meeting.

Reference	Minute	Action
BM 17-18 /236	**Apologies for Absence** Noted as above.	
BM 17-18 /237	**Declarations of Interest** None	
BM 17-18 /238	**Chairman's Business** The deputy Chair welcomed all to the meeting. Members and those in attendance were reminded that the meeting, whilst held in public, was not a public meeting. Having resigned as Trust Chairman 27 February 2018, the Deputy Chair recorded thanks to Michael Carr for service to the Trust as both Non-Executive Director and Chairman, and wished him every success for the future. The Board received confirmation that Mr Carr's resignation had been communicated to all staff and key stakeholders. Board members welcomed the Council of Governors appointment of Sir David Henshaw as Interim Chair and very much looked forward to working with Sir David once a formal commencement date had been agreed. In concluding Chair's Business, the Board received confirmation of two Respiratory and one ENT Consultant appointments; Dr Alison Hufton, Dr David Tarpey and Mrs Helen Beer respectively.	

Reference	Minute	Action
BM 17-18 /239	**Chief Executive's Report** The Acting Chief Executive presented the report and highlighted the following areas: **NHSE Quality Surveillance Programme: Neonatal Critical Care Peer Review** - the Acting Chief Executive advised the Board that the report noted strong performance and good engagement across the unit. The report highlighted a number of areas for improvement, specifically pertaining to nurse staffing not being compliant with British Association of Perinatal Medicine [BAPM] standards. In order to discuss the main challenges of medical and nursing workforce and space, affecting all three level 3 units, and how a potential future network solution might be configured, the Acting Chief Executive advised the Board that he had met with the CEOs of Alder Hey and Liverpool Women's Hospitals. The networked approach would support the desire to maintain a level 3 unit for the population south of the Mersey and has the potential to compliment developing work with the Countess of Chester NHS Foundation Trust, regarding Women and Children's services. **Health Education England (HEE) Future Lead Employer Arrangements** - the Board heard that the North West Lead Employee Service Steering Group had reached agreement that it would like HEE to go out to tender, on behalf of all NW Provider organisations, for a 'single lead employer' for Doctors in training across the North West. To support the work being undertaken, the Board was appraised of the 'National Strategy for Staffing', a national system consultation document outlining a number of areas that will be consulted on to coincide with the NHS comprehensive health and workforce strategy. Andrea Hodgson sought and received confirmation that Professor James Barrett will work with the HEE to ensure any changes affecting the Trust, and especially Junior Doctors, will be minimised. The Acting Chief Executive concluded by reiterating the following sections of his written report: • Initial Operating Plans will be submitted to NHSI by the 8 March 2108 in line with 2018/19 Planning Guidance. Final plans will be submitted to Board for approval prior to the final submission date 30 April 2018. • The Trust will undertake a 'Use of Resources' assessment on 5 April 2018 following the recent submission of Provider Information Return to CQC. • The CQC had confirmed dates for the Trust Well Led Review; 3rd- 5th May 2018. An unannounced visit of at least one core service will take place prior to this. • The Department of Health had published 'Safer Maternity Care: Progress and Next Steps' that outlined new arrangements for investigations into maternity deaths and still births. The main points of the proposals had been summarised for Board members within the Acting Chief Executives written report. John Sullivan sought and received confirmation that the internal footprint and layout of Neonates is being discussed with the Acting Chief Executive bringing to the Board of Directors attention the positive working with	

Reference	Minute	Action
	IncuBabies to support reconfiguration to maximise the internal layout of the unit. Having noted that no further Winter Monies would be available, Cathy Maddaford sought confirmation that that Trust had included this within strategy plans being prepared. The Board heard that winter funding and staffing plans had been discussed with Wirral CCG in line with wider System working to formulate the Wirral Winter Plan. Confirmation was provided that People, Funding, Income and use of resources had all been considered. Dr Susan Gilby provided the Board with clarity that maternity deaths and still birth deaths are reported separately, as are paediatric deaths, and not via the mortality review process. Andrea Hodgson was provided with assurance that any cross learnings, via the reporting mechanisms, are triangulated and incorporated within the Patient Safety Summits.	
BM 17-18 /240	**Integrated Performance Report** • **Integrated Dashboard and Exception Reports** The Director of Operations and Performance presented the integrated performance dashboard and advised the Board as follows: **A & E 4 Hour Standard** – The Board was reminded of the national focus in this area particularly as this was an indicator as to how the NHS as a whole functioned. The Director of Operations and Performance advised the Board that January 2018 had reported at 86.4%. February 2018 month end position was expected to report at 86.6%.The Board was informed that this represented a comparable position compared to other Trust's within Cheshire & Merseyside and placed the Trust within the top third across the country. The Trust has not been below mid-point for over 3 months. The Board received confirmation that Ward 1 escalation has now been closed, with Ward 12 still having 16 outlying patients. The Trust is liaising with Wirral Community Trust to support 14 medically fit patients currently on Ward M2. Confirmation was provided that the elective programme is anticipated to recommence around 9th March 2018 subject to any further increase in urgent care. The Board discussed the importance of this so as to minimise and negate any 52 week breaches. The Director of Operations and performance highlighted a number of key metrics from the Performance Summary: • NWAS reporting had been included within the overall metrics summary. • RTT is anticipated to reduce to circa 75% by February 2018 month end. • 2018/2019 planning has commenced with RTT an integral element. RTT will now be assessed versus a comparable waiting list position; March 2019 waiting list position should not exceed the position March 2018. Discussions remain concurrent with the regulators. • An increase in mixed sex breaches had been evident pertaining to	

Reference	Minute	Action
	those patients who had returned to their base ward having spent time in the Critical Care Unit. The Board was advised that breaches had been reviewed, with a national acknowledgement of this issue due to the increased demand on the overall service. • Key focus is to reduce the number of week 52 breaches. Most recent instances have occurred as a result of the elective programme being stopped. Assurance was provided that before a procedure is cancelled Consultants have been reviewing patient notes in advance to ensure correct clinical procedures have been followed. • The C-difficille metric remained on threshold. • An increased volume of complaints in January had been associated with the action take to stop the elective programme. Graham Hollick accepted that A&E is being managed day to day, in the short term, but raised with the Board the importance of having a long term objective for A&E. The Board discussed the merits of this, from a long term perspective, noting that a number of initiatives had provided additional support in the short term; Patient Streaming, Front Door nurse triage, improved utilisation of the Walk in Centre and the plans for an Urgent Treatment Centre and Wirral CCG urgent care review The Board heard that Wirral CCG had gone to tender re the Urgent Treatment Centre, with ambitious plans for implementation by April 2019. Whilst welcoming the plans, the Board had some reservations in regards to timeframe and being able to secure the support of health economy partners to meet the required time frame; for example, Nursing Homes, Community support. Dr Gilby advised the Board that concurrent discussions are taking place internally at WUTH to engage with teams to understand that flow and demand becomes an integrated function across the wider hospital and not isolated to ED. Cathy Maddaford sought and received reassurance that other providers have been engaged to provide assistance, especially for patients nearing the 52 week timeframe. The Board heard that following the appointment of a new Hospital Manager, the Trust has re-engaged with Spire and have been discussing a number of short term options. John Sullivan sought information from the Acting Director of Finance pertaining to loss of PBR income and reduced RTT as elective activity was not being undertaken. It was outlined that the likely impact against the Income Recovery Plan was reduced revenue of circa £1.5M for the months of January and February 2018. Additional costs of referrals to Spire had still to be factored into the position. The Board received confirmation that medical staff had been utilised for clinical activity elsewhere, including ED. The Board heard that the additional staffing support had been reflected in improved outpatient feedback and productivity. Having concluded the report, the Deputy Chair sought assurance that future long term plans would incorporate the learnings and effects of ceasing the elective programme. In addition, the Director of Operations was asked to ensure Board members had sight of activity being undertaken when patients hit the 39 wait week mark in regard to RTT.	AM

Reference	Minute	Action
	• **M10 Finance and Cost Improvement Programme Report** The Acting Director of Finance presented the M10 Finance and Cost Improvement Report, indicating a YTD deficit of £22.4M, £16.8M adverse to plan. The position was primarily as a result of CIP delivery, loss of STF and Operational Pressures; including circa £2m loss of income pertaining to lack of elective activity. The Trust has adjusted the forecast deficit, as agreed with NHSI; this showed a year end variance of £20.6M. The cash balance at the end of January was £2.4M, £0.5M above plan, while cash is above plan this is a result of increased borrowings compared to the original plan submitted to NHSI. The Board was advised that the forecast positon may be effected by protracted progress pertaining to the Clatterbrbidge land sale and the ongoing discussions with the CCG re SEPSIS. The land sale is due to be concluded in the last week of March and the respective teams from the CCG and WUTH are currently working through the Sepsis guidance. Andrea Hodgson sought and received assurance that the current positon had been shared with NHSI and would be factored into the overall 2018/2019 planning cycle. Assurance was also provided that the positon would be reaffirmed at a forthcoming meeting with NHSI. Amongst other things, it was confirmed that both RTT and Marginal rates would be discussed at that time. The Use of Resources (UoR) rating was reported at 3 in line with the plan. As in previous months, the agency spend rating was preventing the overall UoR rating from dropping to a 4. The Acting Director of Finance drew the Boards attention to the Trust's underlying deficit position and reaffirmed the positon pertaining to the penalties attributable to the control total. |	YTD Plan £k	YTD Actual £k	YTD Vaiance £k
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Adjusted financial performance surplus/(deficit) (AFPD)	**(5,585)**	**(22,414)**	**(16,829)**
AFPD excluding STF	(12,389)	(23,545)	(11,156)
AFPD excluding Non-Recurrent Support inc Winter Funding	(12,389)	(25,797)	(13,408)
AFPD excluding SEPSIS Risk	(12,389)	(27,097)	(14,708)
AFPD Underlying Position (exc STF & CQUIN Risk)	**(12,389)**	**(28,297)**	**(15,908)** | John Sullivan sought and received assurance that the nursing pay bridge position had been reviewed. Board confirmation was provided that there had been a number of contributing factors, mainly associated with a lack of workforce availability with the required skill set. In terms of the Cost Improvement Programme (CIP), at the end of month 10 the Trust was behind on the CIP target and that it would outturn a delivery of c£9.5m against a plan of £15m. There was a general Board acceptance that the current CIP position was undoubtedly now a realistic year end positon. The Board discussed the importance of having an achievable and obtainable CIP to support the longer term Trust strategy. Accepting the current CIP is delivering in line with national guidelines, supported by a strong PMO	GL

Reference	Minute	Action
	and embedded, supported and well led Transformational Team, the Board discussed the overall merits of utilising internal resource and expertise versus engaging external support. There had been an acceptance that emphasis had to be aligned to overall system performance and not the Trust in isolation. Discussions pertaining to system finances held at the Wirral System 'Lock In' meetings had reiterated the importance of a collaborative approach. The Board agreed that external resource would not be engaged. Graham Hollick sought confirmation that any increase in interest rates was being factored into account, when considering the current rate of 3.5% on the deficit equates to circa £1.5M PA. The Acting Director of Finance confirmed that the hybrid/differing permutations of interest rates are driven by the regulators and the treasury and not directly affected by central banks rates.	
BM 17-18 /241	**Response to the Naylor Review** The Acting Director of Finance presented the report and confirmed to the Board it had been submitted to the recent Finance, Business Performance and Assurance Committee. The submitted paper addressed various elements associated with the Strategic Estate and the long-term vision, providing a Wirral University Teaching Hospital [WUTH] update by working with Partners to ensure, as a health economy, the most appropriate and effective facilities are being utilised. In order to establish a long term strategic work plan, for WUTH and the wider Wirral health economy, the Associate Director of Estates has gone to tender for the completion of a 6 Facet Survey. Graham Hollick raised the importance of having a long term, 5 -10-year, vision for the hospital that should be incorporated into the long term strategic work plan. The Board debated the importance of ensuring the long term strategic plan incorporates and reflects the many existing initiates that are concurrently in train; Accountable Care Organisation, Cheshire & Merseyside Sustainability, Acute Care Clinical Strategy and the long-term vision for a Strategic Estates Partnership. The Board also received confirmation that the long-term community needs of the Wirral, in addition to a Primary Care offering, is being incorporated into the vision. Dr Susan Gilby advised the Board that further support will be provided by two additional strategies; the launch of a joint acute clinical services strategy with the Countess of Chester NHS Foundation Trust and an improved urgent care paediatrics offering initially in Halton, Wirral and West Cheshire, prior to wider expansion.	
BM 17- 18 /242	**Report of Finance Business Performance and assurance Committee** The Board received the update from Andrea Hodgson, Chair of the Finance, Business Performance and Assurance Committee [FBPAC], who confirmed the update reflected month 10 financial position and recovery. FBPAC had noted the detailed element of the Board Assurance Framework [BAF] and advised the Board that a request had been made to ensure the full suite of key risk assessments are brought up to date.	

Reference	Minute	Action
	Having outlined the M10 Financial Position within the pre-circulated paper, the Board received updates pertaining to key aspect of the report. **Budget Planning Update** - FBPAC had been taken through the key themes of the Planning Guidance and Control total for 2018/19 and provided Board assurance that having discussed the Control total in line with the underlying financial position further updates would be reviewed prior to the 30 April 2018 submission deadline but at this point the control total set could not be agreed to. **Performance Report ending 31 December 2017** - FBPAC have requested more timely updates for future meetings. **Workforce Report** - The Board received confirmation that measures within the Workforce report are being reviewed for accuracy and that the Interim Director of Workforce has agreed to undertake validation of mandatory training data and fill rates. Once completed, this will be tested by Internal Audit to ensure the appropriate processes are consistently in place. **Assurance Reporting** - FBPAC has sought assurance from the Director of IT and Informatics to support the Trust's compliance with General Data Protection Regulation. It was agreed that MIAA have been invited to review the Trust's preparedness pertaining to the deadline of 18 May 2018. Discussion was held as to how the Trust might need to resource data access requests from patients. Having received a presentation from the Transformation Team, outlining how this could work in practice, it was agreed that this will be reviewed further to understand how the process can be dealt with quicker and the current blocks, impeding improved performance, can be minimised.	HM
BM 17- 18 /243	**Report of the Quality and Safety Committee** The Board received a verbal update from the Chair of the Quality and Safety Committee. **Board Assurance Framework** – assurance was given that the BAF would be updated for the next meeting. **Financial Recovery Plan – Quality Impact Assessment** - the Committee were assured of the formal process which is undertaken for the Cost Improvement Plans. Having identified no formal process for other schemes under the Transformation agenda, it was agreed that further work will be undertaken to revisit and adjust the programme of work. **Integrated Quality Dashboard** – The Committee received a full and comprehensive document and agreed recommendation to the Board. Having been advised that only a summary document would be provided at future meetings, assurance had been requested that sufficient information would be available to provide a clear position on challenges, areas of concern and good practice. Within the dashboard, a summary of the areas that had been discussed included:	DJ

Reference	Minute	Action
	• Improved compliance across all levels pertaining to safeguarding training. • The Risk Register had been updated to reflect deterioration across nursing 'fill rates'. It was reported that Paul Kavanagh-Fields, Head of Clinical Practice and Improvement, is supporting with a specific piece of work focused primarily around nurse workforce planning, recruitment, retention and nurse leadership. • The Committee had received a Medicine Management presentation of the 2016/17 annual medicines incident report, highlighting that the number of incidents reported by the Trust was lower than the national average. A reduced level of harm had also been reported. Having identified that last point prevalence audit errors and omissions were higher, the Director of Pharmacy had highlighted a number of actions derived at driving improvement; changing the delivery method of Wirral Millennium training, Medical Engagement and Accountability, Implementation of the Summary Care record and nurse education and accountability. • Having identified a deterioration of the 'Safety Thermometer', as a result of an increased number of pressure ulcers originating externally, the Trust did not meet the compliance target of 96% harm free care. The Tissue Viability Group is undertaking a review to be submitted to the Committee. • The Trust is reviewing the identified increase number of patient falls for review at Committee. • The Trust have commenced a review of nutrition and catering services. • The Board received confirmation that the Trust continues to achieve the highest performance for the Friends and Family Test, reporting 100% of responses were 'likely to recommend'. • Copies of a newly developed CQC 'Insight Analysis' report, monitoring the quality of care, will be received monthly going forward. **Mortality** – confirmation was provided that the mortality review process, and the associated training, continues to be embedded across the Trust. **Infection Prevention Control** – the Board received confirmation that the infection prevention and control improvement report had been presented, indicating two areas behind schedule; management of overall roles and inconsistent standards of cleaning. The Q&S Committee proposed that both the Infection Control group and Safeguarding group report directly to the Quality & Safety Committee going forward.	
BM 17- 18 /244	**Board of Directors** The minutes of the Board of Directors held 7 February 2018 were confirmed as an accurate record subject to an amendment pertaining to item BM 17-18 / 214. The Minutes have been amended to reflect that the Trust is currently 40% behind plan in relation to the CIP Programme. **Action Log** The Board agreed the Action Log will be reviewed and updated.	

Reference	Minute	Action
BM 17- 18 /245	**Items for the BAF/Risk Register** The Board agreed the Board Assurance Framework will be updated to reflect the following: • Identification and recording of early warning signs pertaining to any 52 week breaches. • Clarification specifically relating to working capital requirements and the associated interest rates. • Winter Planning and the associated impact against RTT. • Incident Reporting and associated learnings will be captured. • Associated risk relating to delays driven by the current Strategic Estates Programme to be included. The Board agreed that any high risk scoring BAF objectives will be incorporated into a regular update for Board members.	**DJ**
BM 17- 18 /246	**Items to be considered by the Assurance Committees** The Board agreed two items for consideration: • The Audit Committee to consider the Workforce report with specific scrutiny of mandatory training data and fill rates. • Cost Improvement Programme to be reviewed for robustness and implementation.	**GH**
BM 17- 18 /247	**Any Other Business** The Chairman sought any comments from the public on the meeting content. Having reflected on the comments made pertaining to Winter Pressures, Mr Fry sought assurance that Board members had taken the most appropriate action and that sufficient consideration had been given to bed capacity, A&E overall staffing/skills matrix, building infrastructure and completion of the Elective programme. Board assurance was provided, reflecting activity and action taken, highlighting the following: • The Wirral system wide winter plan, having received positive feedback from NHSI and NHSE, had incorporated bed capacity and fully tested escalation assumptions. • National patient increased acuity levels had been unprecedented, resulting in pressure across the planned additional bed capacity; 20 additional beds within both the hospital and community. • The decision to stop the elective programme was made in compliance with the mandate issued by the National Emergency Pressures Committee. • Assurance was provided that the skill set within the A&E Department was robust, supported well by Nurse Practioners, Rapid Response team and GP support via Streaming. • It had already been recognised that whilst the building footprint was not ideal it is being utilised to maximum effect. Clarification had already been given pertaining to investment to support improved infrastructure and improved patient flow.	

Reference	Minute	Action
	Frieda Rimmer sought and received confirmation that having confirmed the appointment of the Interim Chair, consideration will now be given to Non-Executive Director appointments, in addition to that of both the Chair and CEO.	
BM 17- 18 /248	**Date and Time of Next Meeting** Wednesday 28th March 2018 at 9.00am in the Boardroom, Education Centre, Arrowe Park Hospital.	

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Chairman

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Date

Board of Directors Action Log
Updated – February 2018

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 28.2.18						
1	BM 17-18/240	Board to have sight of activity being undertaken when patients hit the 39 wait week mark.	**AM**	Confirmed will be reported via Integrated Dashboard and Exception Reports		**Completed**
2	BM 17-18/240	Confirmation that Trust financial position and forecast has been shared with NHSI.	**GL**	Full position has been shared with NHSI colleagues and subsequent meetings have been held with Senior figures within the team		**Completed**
3	BM 17-18/242	Interim Director of Workforce has agreed to undertake validation of mandatory training data and fill rates.	**HM**	Met with internal Auditors (MIAA) and incorporated within work programme.		**Completed**
4	BM 17-18/243 & 245	BAF to be updated	**DJ**	Actioned and March Board agenda item	Monthly Board agenda item - Refresh needed for 18/19	
5	BM 17-18/245	The Audit Committee to consider the Workforce report with specific scrutiny of mandatory training data and fill rates.	**GL**	Workforce indicators have been included in the Internal Audit plan for 2018/19 which will report back to the Audit Committee		**Completed**
Date of meeting 7.2.18						
1	BM 17-18/210	1st review of 2018/19 Objectives to be developed for discussion at future Board meeting.	**TW**	Anticipate paper for April Board Meeting.	April 2018	
2	BM 17-18/211	Bi Monthly Nurse Staffing Report – Strategy to improve sickness absence to aid recruitment, retention and career development	**JH**	Work in progress and reporting timelines to Board noted.	March 2018	

3	BM 17-18/214	Integrated Dash Board & Exception Reports. Consider replicating NED Induction presentation pertaining to 'interpreting trends & performance' on a local level.	**AM**	AM has raised with BI team. Current dashboard is linked to SPC Analysis and tam are considering how can be developed further.		**Completed**
4	BM 17-18 / 216	FBPAC - The Committee have requested that future reports of the data quality, management of information and clinical coding review provides more assurance to the Committee relating to BAF risk.	**PC**		Ongoing	
5	BM 17-18/220	BAF to be reviewed and updated. Trust Financial position to be incorporated.	**All Directors.**	Update BAF to be presented to next assurance committee meetings for review. Board review through chairs assurance committee reports.	March 2018	
Date of Meeting 29.11.17						
1	BM17-18/172	CEO Report – Strategy. The Board also agreed to include the recommendation from the Non-Executives that the aims needed to be more explicit about meeting the future changing needs of the population.	**DA TW**	Will form part of operational plan narrative submission to NHSI	April 2018	
2	BM17-18/176	Ambulance Turnaround - The Board requested that all transfers over 1 hour is included in future reports.	**AM**	Update incorporated into February reporting		**Completed**
3	BM17-18/176	Workforce Metrics - The Chair of FBPAC reminded members of the request to split out short term and long term sickness and sought an update on this.	**JM**	Agreed and will be incorporated into future workforce reporting. Verbal update provided via FBPAC 23.2.2018.		**Completed**
4	BM17-18/176	Pressure Ulcers - The Board agreed that more work should be undertaken in this area and that the Safeguarding Board should review this also.	**JH/GW**	Agreed with reporting to March Quality &Safety Committee. Board review through chairs assurance committee reports.	April 2018	
5	BM17-18/176	M7 Finance and Cost Improvement Programme Report - The Board agreed and recommended that the Director of Finance and Executive colleagues articulate their forensic analysis of current performance as this would be useful ahead of any financial re-forecast required or as part of the improvement plan.	**DJ / GL**	Actioned as part of reporting on recovery plan progress and reforecast to Board. FBPAC to review at February meeting. Board review through chairs assurance committee reports and monthly finance report to Board of Directors.	March 2018	

6	BM17-18/176	M7 Finance and Cost Improvement programme Report - The Board agreed that the FBPAC should thoroughly review the Trust's progress in terms of reducing the monthly pay overspend in December in order to frame the discussion and decision making in the new year.	**DJ / GL**	Actioned. Ongoing review to link into capacity planning for 2018/19 budget setting round and use of benchmarking such as GIRFT, Model Hospital etc. Board to sign off operational plan submission including pay budgets April 2018.	March /April 2018	
7	BM17-18/178	Approval of Risk Management Strategy - The Board agreed to defer this item to the December meeting at the request of the Interim Quality Governance Consultant.	**SG**	To be agreed as part of 2018/19 Planning.	Ongoing	
8	BM17-18/182	Items for the BAF/Risk Register - The Board recommended that the recruitment of a high calibre HR replacement be included on the BAF	**CS**	Experienced interim recruited to role.	Ongoing	
9	BM17/18/183	Items to be considered by the Assurance Committees – Q & S Committee – focus on the new methodology for patient stories and the evaluation of learning from these together with the further work required in relation to exit interview analysis to inform future talent management policies. FBPAC - focus on monitoring the actions taken by the Trust to reduce the monthly pay overspend together with the developing the narrative ahead of any future financial re-forecast.	**JH/GW** **DJ/GL**	Actioned and ongoing Actioned and ongoing	March 2018 March 2018	
Date of Meeting 25.10.17						
1	BM17-18/148	Include the pay budget in the Use of Resources section of the new performance dashboard	**DJ**	Included in new Integrated dashboard - completed		**Completed**
2	BM17-18/148	Include the breach analysis in the A & E narrative	**JH**	Included in new integrated dashboard - completed		**Completed**
3	BM17-18/149	Articulate in the aims and objectives how the Trust would maximise value from developing an ACO or from horizontal integration as it was not clear where the savings or where the benefits might arise	**TW**	Long list of Healthy Wirral Initiatives being reviewed in terms of quantifiable benefits	Q1 2018/19	

4	BM17-18/154	Quality and Safety Committee to review the top 4 risks identified by SMT and review the risk ratings for risk 1 quality and safety and the risk for workforce	**CS**	Review undertaken in November 17- update included in Chair's report - completed		**Completed**
5	BM17-18/154	Quality and Safety Committee to review the work being undertaken on E Roster	**JM**	Work is progressing with Corporate Nursing regarding leading from a Nursing perspective. Completed January 2018.		**Completed**
6	BM17-18/154	Quality and Safety Committee to review the infection prevention control action plan	**DP**	Review undertaken in November 17 – update included in Chair's report – completed.		**Completed**
7	BM17-18/154	Quality and Safety Committee and Finance Business Performance and Assurance Committee to review the development of the new performance dashboard	**JH**	As agreed with assurance committees iterative improvements to dashboard agreed.		**Completed**
8	BM17-18/154	Finance Business Performance and Assurance Committee to review the potential savings/benefits from developing an ACO	**TW**		Q1 2018/19	
Date of Meeting 27.09.17						
9	BM17-18/112	Ensure future nursing reports focus on the action being taken to ensure that staff moves are appropriately managed	**DP**	Included in the nurse staffing report – Nov 17- Completed		**Completed**
10	BM17-18/116	The Board requested an update on the action being taken in relation to infection prevention and control in light of the increase in reported avoidable cases of C difficile	**DP**	Included on the agenda for October 17 - completed		**Completed**
11	BM17-18/119	Confirm the time commitment for Board members in undertaking the enhanced level 2 Equality, Diversity and Human Rights training	**DP**	The Board has agreed the training session will take place in Dec 17. Training session completed 20 December 2017		**Completed**
Date of Meeting 26.07.17						
12	BM217/18/096	Undertake a review of the Board Model Hospital portal	**DJ**	To be undertaken with members as part of work programme in September – completed.	Sept 17	
13	BM17-18/104	Quality and Safety Committee to review research work as part of their work plan	**SG**	Completed		**Completed**
14	BM17*18/105	Provide an update on future Care Quality Inspections to the CoG in September	**SG**	Also undertaken at COG 13.3.2018.		**Completed**
Date of Meeting 28.06.17						

15	BM17-18/068	Quality and Safety to receive assurance on CQC preparedness and overall compliance and provide regular reports on this to the Board	**SG**	Updated provided regularly at Board of Directors.		**Completed**
Date of Meeting 24.05.17						
16	BM17-18/039	Provide regular reports on the A & E 9 point action plan – specifically those areas that relate to the Trust	**JH**	9 point Action Plan superseded by Winter Preparedness. Regularly reported via FBPAC.		**Completed**
17	BM17-18/049	Review the IT risk on the BAF in relation to cyber security	**PC**	Work ongoing to implement further protections e.g. awaiting delivery of a new Internet circuit which is ordered but has a 90 day delivery time. Working with NHS Digital and GDE sites with Cerner to go through the Cyber Essentials plus framework funded by NHS Digital. WUTH is leading work on Cyber for Cheshire and Mersey STP. . Action taken regularly presented via Audit Committee		**Completed**
Date of Meeting 26.04.17						
18	BM17-18/013	Ensure Equality and Diversity is covered throughout the Trust's Mandatory training programme	**GW**	Level 1 now incorporated into ESR. Level 2 face to face programme rolled out with concurrent changes being made.		**Completed**
Date of Meeting 25.05.16						
19	BM16-17/036	Full review of the performance report to be undertaken to avoid this becoming unmanageable	**JH**	New dashboard included on the agenda for Nov 17 – completed.		**Completed**
20	BM16-17/037	Explore the impact of technology when reporting CHPPD in the future	**GW**	Director of IT and Information currently evaluating this work	April 17	