Wirral University Teaching Hospital NHS
NHS Foundation Trust

Board of Directors

Public Board

26th July 2017

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MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 26th JULY 2017
COMMENCING AT 9.00AM IN THE
BOARD ROOM
EDUCATION CENTRE, ARROWE PARK HOSPITAL

AGENDA

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

5. Quality and Safety

5.1	**Patient's Story/Learning** Director of Nursing and Midwifery	v
5.2	**Report of the Quality and Safety Committee** • **Emergency Preparedness Resilience & Response** Chair of the Quality &Safety Committee	d
5.3	**Nurse Staffing Report** Director of Nursing and Midwifery	d

6. Performance and Improvement

6.1	**Integrated Performance Report**	
	6.1.1 Integrated Dashboard and Exception Reports • **Progress against 9 Point A&E Action Plan** Chief Operating Officer	d
	6.1.2 Month 3 Finance Report Director of Finance	d
6.2	**NHS Improvement Quarterly Return** Director of Finance	d

7. Governance

7.1	**Report of Finance Business Performance and Assurance Committee** Chair of Finance and Business Performance Assurance Committee	d
7.2	**Research Annual Report** Medical Director	d

7.3	**Safeguarding Annual Report** Director of Nursing and Midwifery	d
7.4	**Board of Directors**	
	7.4.1 Minutes of the Previous Meeting – 28th June 2017	d
	7.4.2 Board Action Log Director of Corporate Affairs	d

8. Standing Items

8.1	**Items for BAF/Risk Register** Chairman	v
8.2	**Items to be considered by Assurance Committees** Chairman	v
8.3	**Any Other Business** Chairman	v
8.4	**Date and Time of Next Meeting** Wednesday 27th September 2017	v

Board of Directors	
Agenda Item	4
Title of Report	Chief Executive's Report
Date of Meeting	26 July 2017
Author	David Allison, Chief Executive
Accountable Executive	David Allison, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	ALL
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To Note
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

This report provides an overview of work undertaken and important announcements over the reporting period.

Internal

- **Global Digital Exemplar Programme**

The Global Digital Exemplar funding from NHS England which will help fund the programme has now been agreed along the following lines and the first amount of £3.9m is with the Trust

Date	Total	FY	Amount	Milestones
July 2017	£3861k	2017/18	£3861k Capital	Programme kick off. Signed off Funding Agreement
Jan 2018	£3860k	2017/18	£1125k Capital £2735k Revenue	TBA
August 2018	£2278k	2018/19	£456k Capital £1822k Revenue	TBA

We are currently in the process of re-planning and agreeing the two milestones in January 2018 and August 2018 since there has been slippage in providing the funding the dates and content for each milestone is being adjusted.

Plans will be submitted via the Digital Wirral Programme Board in August 2017.

Regulatory

- **NHS Improvement: Protocol for Changes to an In-Year Financial Forecast**

Guidance has been reissued by NHSI in respect of exceptional circumstances where it is necessary for an NHS Trust or foundation trust Board of Directors to reconsider its planned forecast outturn position.

The guidance notes “In this event, the provider Board’s primary focus must be the identification and delivery of a recovery plan that demonstrates the mitigating actions being implemented that ensure any proposed revision to forecast outturn is minimised, managed and fully recovered at the earliest possible time.”

The introduction of the protocol as in 2016/17 should not be taken By Boards of Directors as permission to deteriorate financial positions. For completeness and for the Board of Directors attention the protocol is set out below;

Protocol

Revisions to forecast outturns can only be made once a provider’s plan for the year has been agreed and only at the Quarterly reporting points in the year and can only be made through the standard quarterly reporting process.

However in advance of formally reporting a forecast outturn variance from plan, Trusts are required to have discussed the financial deterioration with the NHS Improvement Executive Regional Managing Director and Regional Director of Finance.

This engagement must be underpinned with a provider prepared detailed report that clearly exemplifies:

- The key financial drivers for the deterioration;
- The key financial drivers for the deterioration;
- An analysis of the underlying causes;

- The actions being taken to address the deterioration and evidenced confirmation that:

    - Relevant commissioners have been informed of the position and all opportunities for support have been explored and the recovery actions agreed;

    - The senior clinical decision making body with the provider has been engaged with and are party to the identification and delivery of the recovery actions;

    - NHS trust / foundation trust Executive Committee, Finance Committee and Board have considered and agree the proposed financial forecast revision and recovery actions.

This recovery plan described must explicitly reference:

- Details of the additional measures immediately implemented to improve financial control and working capital/cash management, including capital programme review. This will include all discretionary spend, agency/locum spend, supplies and consumable spend and delegated commitment range and levels.

- Details of how the provider is reviewing:

    - The affordability of planned investments to improve service quality and performance;

    - The acceleration of the delivery of productivity opportunities identified by the Carter Review;

    - The acceleration of proposals for sub-scale service consolidation or closure;

    - The impact on patient safety and experience of recovery actions;

- The demonstration of quarter on quarter improvement in income and expenditure run-rate from the point the revision is submitted and how Cost Improvement Programmes (CIP) delivery is being maximised.

When a formal revision to outturn forecast under this protocol is made through the national reporting process, it must be accompanied by an Assurance Statement signed by the NHS trust/ foundation trust Director of Finance, Chief Executive and Chair in respect of the organisation's adherence to this protocol and their commitment to the delivery of the recovery plan. This statement will be addressed to the Chair and Chief Executive of NHS Improvement and will be formally reported to NHS Improvement's Board.

Strategy

- **Accountable Care**

We continue to play a key role with partners in our Healthy Wirral work. The third and final 'Accelerating Accountable Care' workshop, facilitated by PWC took place on 29th June. The commissioners shared a high level timeline for forming a single integrated commissioner for all age health & care in Wirral. The expectation is that a Commissioning Prospectus will be published in November that outlines ambitions and expected outcomes. There is an opportunity for us, alongside other providers, to influence the content of this to

ensure that together we continue to move toward an Accountable Care System. There will be a final report and recommendations on next steps from PWC at the next Healthy Wirral Partners Board on 27th July. WUTH will host an Exec to Exec meeting with Wirral Community Trust on 27th July to continue discussion about how best providers organise themselves to respond to this prospectus. In the meantime, we continue to work in collaboration with partner providers on some of the building blocks of accountable care, most notably MSK service for which WUTH expect to be awarded the prime provider contract, and the Healthy Wirral Fifty Plus proof of concept which will trial new models of health & care delivery for the cohort of Wirral residents age 50+. Executive colleagues at WUTH and Countess of Chester held the first Wirral and West Cheshire Alliance Executive Steering Group meeting on 3rd July, which in addition to reviewing and agreeing some of the operational considerations for how our Alliance will work together in the coming months, agreed a handful of clinical and corporate priorities to be developed over the summer.

- **Sustainability and Transformation Plans STP**

Louise Shepherd, the Cheshire & Merseyside STP Lead and Richard Barker, NHSE Regional Director North, hosted a Cheshire & Merseyside Five year Forward View meeting on 6th July. At this session, senior colleagues from across our STP heard from KPMG about care system learning we might adopt from other systems, including examples of progress being made toward more accountable care systems. Colleagues also received a presentation from the CEO of West Cheshire CCG who described the very positive journey toward accountable care being undertaken by The West Cheshire Way. They too have been supported by PWC, and Healthy Wirral may well benefit from continuing to learn from and to a degree, follow the example being set by our nearest neighbours. Andrew Gibson, the newly appointed Independent Chair of the C&M STP spoke about the need to now make rapid progress toward delivery and some changes to the way in which the C&M STP will be governed. This included news that Louise Shepherd will be standing down as Senior Responsible Officer for our STP and a process for securing successor is now under way.

Celebrating Success

- **Proud Team of the Quarter**

A huge well done to the Neonatal Unit, who were announced as overall winners of the Team of the Quarter for Quarter 1 2017/18.

The divisional winners for this Quarter were as follows:

- Corporate Services: IT Technical Services Team
- Diagnostics and Clinical Support: Unplanned Care Therapy Team and Occupational Therapy Follow up
- Medical and Acute: Dialysis Unit

- **Excellence in Informatics**

I would like to say a big congratulations to our Informatics department, which includes Information Governance and Records Management, EBME, Information, IT and Clinical Informatics, as it has recently been awarded the Skills Development Network's Excellence in Informatics Level 1 accreditation.

Excellence in Informatics promotes the personal and professional development of Informatics staff, with the Level 1 standard being focussed on practices within the Informatics department.

The team will receive their accreditation award at the Skills Development Network's Connect Conference in September.

David Allison
Chief Executive
July 2017

Board of Directors	
Agenda Item	5.2
Title of Report	Report of the Quality & Safety Committee – 12 July 2017
Date of Meeting	26 July 2017
Author	Cathy Maddaford, Chair of the Quality and Safety Committee
Accountable Executive	Gaynor Westray, Director of Nursing and Midwifery Dr Susan Gilby, Medical Director
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**	Discussion
Data Quality Rating	N/A
Review by Assurance Committee	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

This report provides a summary of the work of the Quality and Safety Committee which met on the 12 July 2017. Key focus areas are those which address the gaps in assurance/control in the Board Assurance Framework.

Quality and Safety Committee Terms of Reference Review

The Committee reviewed the Quality and Safety Committee Terms of Reference (ToR) which had been updated to include amendments requested by the Committee in late 2016 and changes to the Committee membership to ensure ongoing quoracy, as agreed by the Board of Directors at its June 2017 meeting.

Following review of the ToR, the Committee requested the following further amendments:
- Inclusion of the Head of Patient Experience as a Committee member;

- Clarification regarding the Committee role on reviewing Clinical Audit effectiveness rather than processes;
- Reference to the Committee role in respect of receiving and monitoring strategies which focus on staff engagement and performance.

The Committee recommended that, subject to the above detailed amendments, the revised ToR (appendix 1) be approved by the Board of Directors.

The Committee noted that the Quality and Safety Committee ToR would be subject to further review on receipt of the final recommendations of the Quality Governance Review.

Board Assurance Framework

The Committee reviewed the Board Assurance Framework (BAF) and gave consideration to the following key points:

- Revision of Risk 10 (Referral to Treatment Target (RTT)) for which the risk rating has been reduced to reflect the effectiveness of the Trust's implemented mitigating actions. The risk descriptor has also been revised to remove referral to the 'loss of Sustainability and Transformation Fund funding' as the Trust would not receive financial penalties for failure to achieve the NHS Improvement agreed trajectory targets for 2017/18.
- An upcoming review of Risk 12 (C.diff) which, following review by the Senior Management Team at its meeting of 30th June 2017, would be reviewed by the Chief Operating Officer in view of the upward trend in instances of C difficile.

The Committee noted that strategic Risks 13, 14 and 15 would be subject to review by the new Director of Strategy and Sustainability ahead of the Board meeting in July 2017. The Executive Teams of the Trust and the Countess of Chester had agreed to share BAFs in order to identify, as part of work programmes, where recruitment/collaboration would be an option. Such information would be captured within applicable risk templates going forward.

The Committee reviewed and approved Risk 3095, with a risk score of 15, which pertained to Trust potential non-compliance with the requirements of the NHS Cervical Screening Programme. The Committee received an update in respect of the counter measures taken to address the issues identified and were provided with assurance that this could not happen again in the future in this area or in any other areas. The Risk will remain at this level until full assurance against all the actions being taken has been received.

The Committee voiced support of the outlined changes to the Trust's governance meeting structure in respect of replacement of the Operations Risk Management Team with an expanded Senior Management Team which would result in the realisation of enhanced risk review processes.

Workforce & OD Dashboard

The Committee reviewed the Workforce & OD Dashboard which highlighted the following key points:

- A sickness rate of 3.85% for May 2017, which was better than the Trust target of 4%
- Nursing and Midwifery workforce vacancy rates were reported as 6.04%, which remains low compared to other organisations however a particular concern is the division of Medicine & Acute where the vacancy rate for Band 5 in inpatient areas is 10%. In response a Nurse Recruitment Plan has been developed and work continues to support Nursing managers in the successful recruitment of staff.
- Medical workforce vacancy rates were reported as 6.76%. It was expected that the recent appointments in hard to recruit to areas will improve the overall situation.
- The appraisal compliance rate for March 2017 had decreased to 82.20%, which remained below the Trust target of 88%
- Mandatory training compliance was reported at 91.57% (Block A) and 86.98% (Block B) for May 2017 which was below the Trust targets of 95%.

The Committee was disappointed to note the continued deterioration of appraisal compliance and was apprised of the ongoing collaborative work of the HR Team with individual departments to

address areas of concern. The Committee requested that future reports provide a breakdown of appraisal compliance by area to better facilitate identification of hotspots and trends across the Trust.

The Committee received and in-depth presentation in respect of the Organisational Development Plan 2017-20 which would see the Trust improve staff engagement through reinvigoration of the Trust values and behaviours to positively influence working culture. The Committee noted the importance of divisional and departmental ownership of implementation of the Organisational Development Plan, with assistance from the HR Team, in order to fully realise Trustwide improvements in staff engagement. The Committee supported the proposed approach to implementation and monitoring of the Organisational Development Plan and welcomed future progress updates.

Quality Dashboard

The Committee reviewed the further enhanced Clinical Quality Dashboard which provided an overview of performance in respect of the following key areas:

- Patient Safety (Medical);
- Patient Experience (Nursing);
- Access (Operations);
- Workforce (HR) ; and
- Regulations (Finance and Governance).

Following review of the dashboard, the Committee requested that:

- The content of the report be reviewed to minimise the utlisation of acronyms to ensure appropriate understanding of the information provided by all members of the Committee;
- The format of quantitative data be amended where necessary to enable timely interpretation;
- Qualitative explanations may need to be provided to indicate whether performance is positive or negative.

The Committee was disappointed to note that the Trust had reported a Never Event in 2017/18. Compliance with internal and external governance processes in respect of reviewing the incident and disseminating learning following the Never Event were confirmed.

The Committee reviewed data in respect of agency spend and noted the continued zero tolerance of the Trust in respect of non-core spend breaches. The Committee requested that individual reviews of each recurrent and non-recurrent breach be undertaken going forward to ascertain the overall impact of these breaches.

The Committee noted the continued high level of reporting in respect of medicines management and related incidents. Consequently the Committee requested that future reports distinguish the proportion of low harm medicines management incidents to evidence that high levels of incident reporting did not reflect poor quality of care.

CQC Compliance and Action Plan Progress Update

The Committee received the CQC Compliance and Action Plan Progress Update and noted that a project group was to be established to support the Trust in preparation for the next CQC inspection and would focus particularly on compliance with the Well-Led and Safety domains. The Committee noted that the Trust neared completion of the initial Care Quality Inspection schedule which included all clinical areas. Re-inspection of areas previously allocated a rating of 'Requires Improvement' had commenced and would continue over the coming period.

The Committee was disappointed to note the medicines management issues and was advised of the mitigating actions to be implemented with a view to improving Trust compliance with medicines management requirements. The Committee therefore requested that a deep dive be undertaken by the Clinical Governance Group to determine the timescales for improvement in respect of medicines management and other key areas.

The Committee welcomed the imminent relaunch of the SAFER initiative which would enhance patient experience through improved patient flow.

Outpatients Improvement Programme Update

The Committee received an in-depth presentation in respect of the Outpatients Improvement Programme which focused on four key aspects:

- Space Utilisation – which included relocation of services to alternative provider facilities in order to realise cost efficiencies whilst maintaining service provision within the same geographical area for patients in the community.
- Outpatient Workforce – a review of the nursing skill mix within outpatients was conducted to ensure best utilisation of staff skills and experience. Further work was underway to explore centralisation of some service functions to enable standardisation of working practices.
- IT Enablers – work had commenced to explore technological functionality in order to decrease follow-ups through the implementation of patient self-health management programmes and expansion of the text reminder service and introduction of partial booking would be undertaken to reduce patient non-attendance.
- Clinic Utilisation – successful progress of this aspect of the project would enable full use of clinics with minimum hospital cancellations.

The Committee noted that the Outpatients Improvement Programme would be conducted in such a manner as to ensure the continued and uninterrupted provision of high quality services to patients.

The Committee was pleased to note that staff had demonstrated receptiveness to the above detailed initiatives and the Committee stated the importance of continued staff involvement as projects progress to ensure refreshed approaches are embedded in everyday practice.

Mortality Review Process

The Committee received a progress update in respect of the implementation of revised mortality review processes in line with local guidelines. The Trust had established a Mortality Steering Group which would act a key forum for review and monitoring of mortality review processes and dissemination of learning outcomes. The Committee raised concerns that only 41% of reviews had been undertaken during the reporting period. The Trust had made changes to the process to enable greater attendance by staff to attend reviews and undertake these in a timely manner.

The Committee noted that training in the use of the Structured Judgement Review process is yet to be put in place nationally and was alerted to the publication by the National Quality Board of the "National Guidance on Learning from Deaths – a framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigation and Learning from Deaths in Care". The guidance describes key actions the Trust would need to take to provide assurance that care given is examined, lessons are learnt from deaths and concerns of bereaved relatives are acted on. To encourage openness, Board level reporting in an open forum is a key requirement. Quarterly reports will be provided to the Board from quarter 3.

Emergency Preparedness, Resilience and Response (EPRR) Annual Report

The Committee recommended to the Board of Directors the approval of the EPRR Annual Report for 2016/17 (as circulated separately by email to the Board of Directors).

Clinical Audit Annual Report and Forward Plan

The Committee noted that the Trust had played an active role in national clinical audits during 2016/17 and would continue to do so throughout the coming year. The Trust had also conducted a number of internal audits over the reporting period, the outcomes of which had contributed to improvements in patient experience. A key challenge for the coming year was highlighted as the further utilisation of technology in order to simplify audit processes.

The Committee was provided with an outline of the internal audit selection procedure and stated the importance of standardising Divisional processes for the identification of controls, outcomes and reporting in order to realise work efficiencies.

Safeguarding Annual Report 2016/17

The Committee received the comprehensive Safeguarding Annual Report 2016/17 which gave an overview of Trust performance in respect of safeguarding compliance and processes throughout the reporting period with particular focus on Protecting Vulnerable People Training and Mental Capacity Assessments. Although there had been significant improvement in mandatory training, there was still much more work to do.

The Committee was pleased to note safeguarding performance to date and recommended to the Board of Directors the approval of the Safeguarding Annual Report for 2016/17.

Assurance Reporting

The Committee received Chair's reports from the following Working Executive Committees:

- Clinical Governance Group,
- Patient and Family Experience Group,
- Workforce and Communication Group.

Issues for escalation to the Board of Directors

The Committee agreed to escalate to the Board the requirements from Quarter 3 for reporting on mortality reviews; the concerns with compliance with appraisals rates and the need to increase at pace compliance with mandatory training for safeguarding.

Cathy Maddaford
Chair of Quality and Safety Committee

Appendix 1

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Quality and Safety Committee

Terms of Reference

Authors Name & Title: Gaynor Westray, Director of Nursing and Midwifery Susan Gilby, Medical Director Carole Self, Director of Corporate Affairs	
Scope: Trust Wide	**Classification: Terms of Reference**
Replaces: N/A	
To be read in conjunction with the following documents: **Board Assurance Framework** **Standing Financial Instructions**	
Document for public display? Yes	

Unique Identifier:	**Review Date: January 2018**	
Issue Status: Draft	**Issue No: 4.1**	**Issue Date: June 2017**
Authorised by: Board of Directors	**Authorisation Date:**	
After this document is withdrawn from use it must be kept in an archive for 10 years		
Archive: Document Control	**Date added to Archive:**	
Officer responsible for archive: Document Control Administrator		

1 Constitution

The Committee is established as an Assurance Committee of the Board of Directors in order to provide the Board with assurances in respect of delivery of the Trust's Quality Improvement Strategy and service delivery in respect of clinical effectiveness, safety, and patient and staff experience. This will assess the impact of performance and compliance with national and local requirements.

2 Authority

The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek information it requires of any employee (or contractor working on behalf of the Trust) and all employees (or contractor working on behalf of the Trust) are directed to cooperate with any request made by the Committee. The Committee is authorised to obtain legal advice or other professional advice from internal or external sources.

The Committee has authority delegated by the Board of Directors to ratify and review policies and procedures within its remit, and where appropriate delegate responsibility for this to associated committees or groups.

3 Objectives

The Committee will deliver the following objectives, along with any others that are assigned by the Board of Directors during the course of the year:

3.1 Risk

3.1.1 To assess, receive and monitor risks above 15 relating to quality and safety in accordance with the Risk Management Strategy.

3.1.2 To receive and monitor Serious Untoward Incidents including never events, and the outcome of external reviews to gain assurance that actions plans effectively mitigate the concerns identified, and are implemented.

3.1.3 To receive assurance that potential impact of cost improvement programmes upon the future quality of care has been risk assessed and actions taken to mitigate recognised risks in advance of implementing the programme to monitor and evaluate ongoing assessment of risk.

3.1.4 To receive and assess post evaluation reviews for all cost improvement programme initiatives to obtain confirmation of benefits realisation.

3.1.5 To ensure that gaps in controls and/or assurance are reported to the Board by exception, with recommendations to update the Board Assurance Framework where necessary.

3.2 Clinical Effectiveness and Safety

3.2.1 To support the development and oversee the delivery of the Trust's Quality Improvement Strategy and be assured the associated actions are being implemented.

3.2.2 To seek assurance that clinical performance is of acceptable quality and improving through use of selected KPIs / quality dashboard, this will include external benchmarking data and measures linked to continuous improvement in patient and staff experience as outlined within the Quality Improvement Strategy.

3.2.3 To seek assurance that Divisional Quality Performance is meeting the requirements of the Quality Improvement Strategy and demonstrates continuous improvement using available intelligence.

3.2.4 To ensure effective arrangements for monitoring and continually improving the quality of healthcare provided through use of NHS Improvement's Well Led Governance Framework.

3.2.5 To seek assurance that there is ongoing compliance with CQC Fundamental Standards of Care and that all actions plans arising from CQC inspections are monitored and progressed promptly.

3.2.6 To receive assurance of actions arising from complaints, claims and incidents or Ombudsman's recommendations and consider trends, appropriateness of actions taken and impact of organisational learning as outlined within the Clinical Governance Group Chair's Report.

3.2.6 To seek assurance on Clinical Audit effectiveness and progress against the Trust Clinical Audit Plan, including receipt and ratification of the Clinical Audit Annual Report and Forward Plan, based on the Quality Improvement Strategy .

3.3 Patient Experience

3.3.1 To monitor performance from our "learning with patients" systems including the friends and family test.

3.3.2 To receive assurance via the Clinical Governance Group Chair's Report of review and monitoring of Divisional performance against delivery plans for patient experience as set out in the Quality Improvement strategy

3.3.3 To oversee the delivery of the Patient Experience Strategy to embed a patient and family centred approach to care delivery.

3.3.4 To receive a summary of national patients' surveys and seek assurance that any action plans required to drive improvement are delivered.

3.4 Workforce

3.4.1 To review and monitor performance against the Workforce and OD Strategy, with particular focus on workstreams pertaining to staff engagement and recruitment.

3.4.2 To receive assurance on the safe staffing of all clinical areas.

3.5 Staff Satisfaction and Engagement

3.5.1 To monitor Divisional performance against key metrics relating to staff experience and engagement.

3.5.2 To receive the results of the national staff survey and seek assurance that improvement plans are identified and delivered.

3.5.3 To ensure investigation, learning and communication from concerns raised by staff and report upon concerns reported directly to CQC.

3.6 Governance

3.6.1 To receive and be assured that the Trust has responded appropriately to the findings and recommendations from the CQC and Healthwatch, as required.

3.6.2 Receive and ratify the following annual reports and forward plans on an annual basis:
- Safeguarding Adults and Children,
- Accountable Officer Controlled Drugs,
- Emergency Planning and Business Continuity,
- Clinical Audit, annual report and forward plan.

3.6.3 Consider and ensure appropriate response / implementation of relevant national guidance and external reviews, including directives from CQC, DH, NHS Improvement and external inquiries where there is an impact on patient care, quality or safety.

3.6.4 To undertake annual review of Trust Compliance against the NHS Constitution.

3.6.5 Approve the establishment, work plans, duration and ensure the effectiveness of Groups reporting to the Committee.

3.6.6 Refer actions to, and respond to actions referred by, the Audit Committee.

3.6.7 To receive and recommend the Annual Quality Account.

3.6.8 To undertake 'deep dives' as appropriate.

4 Equality and Diversity

The Committee will have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

5 Integration

The Committee will support the integration of clinical, organisational and financial risk management with that of the business planning process.

It will promote a holistic approach to managing risk that will encourage all staff to provide safe, effective, timely and efficient care to patients.

The Committee Chair will work with the Executive Team and Board to integrate clinical, financial and organisational governance and risk management processes and systems.

The Committee will work with other Committees including the Audit Committee to provide assurances required to support the Annual Governance statement.

The Committee will identify areas of duplication and ensure that reports are received by exceptions from those groups reporting to it.

6 Membership

- Nominated Non-Executive Director (Chair)
- Two additional Non-Executive Directors (one of whom shall be Vice Chair of the Committee – each member shall be a member of either the Audit Committee or the Finance Business Performance and Assurance Committee)
- Medical Director (Nominated Deputy - Deputy Medical Director)
- Director of Nursing & Midwifery (Nominated Deputy – Deputy Chief Nurse)
- Director of Workforce
- Chief Operating Officer
- Associate Director of Risk
- Director of Finance
- Head of Patient Experience
- Nominated Governor
- Nominated Patient Representative (Healthwatch)

7 Attendance

- *Director of Corporate Affairs*
- *Divisional Representation*

Other officers of the Trust will be invited to attend on an ad hoc basis to present papers or to advise the committee.

All members are expected to attend all meetings with attendance being reviewed annually; attendance below 80% will be discussed with the Committee Chairman at the earliest opportunity.

8 Quorum and Frequency

The quorum shall be four members, to include at least two Non Executive Directors, one of whom must be the Chair or Vice Chair and either the Medical Director or the Director of Nursing & Midwifery or their nominated deputy.

The Committee shall meet at least 6 times a year, in accordance with a planned business cycle that is agreed at the start of each year (April).

9 Reporting

The Committee will report to the Board following each meeting via a Chair's report which will include an annual review of the Terms of Reference.

Chair's reports will be circulated to Board Members by email as soon as is practicable following the meeting.

The Committee will receive reports from the following:

- Clinical Governance Group (monthly) – Chair's report and annual review
- Patient & Family Experience Group (quarterly) – Chair's report and annual review
- Workforce and Communication (bi-monthly) – Chair's report and annual review

10 Conduct of Committee Meetings

The lead Executive Director, in liaison with the Chair of the Committee will ensure that the appropriate processes are followed:

- An annual work plan reflecting the Committee's business cycle will be prepared by the end of March each year for the forthcoming year

- Minutes and action log will be kept by the Committee Secretary on behalf of the Chair

- The agenda will include the following standing items:
  - Minutes of last meeting
  - Action Log
  - Risk
  - Enhanced Patient Experience
  - Workforce
  - No Avoidable Harm
  - Consistent and Reliable Care
  - Group Chair's Reports
  - Items for Escalation
  - Evaluation of Meeting and Papers
  - Date of next meeting

- The agenda and supporting papers will be sent out 4 working days prior to the Committee, unless there are exceptional circumstances authorised by the Chair.

- Authors of papers must use the standard template and indicate the purpose of the paper – e.g. decision, discussion, assurance, approval.
- Presenters of papers can expect all committee members to have read the papers and should keep to a verbal summary outlining the purpose of the report and its recommendations. Committee members may question the presenter.
- Distribution of minutes and archiving of documentation will be managed by the Committee Secretary in accordance with standard procedures.

Board of Directors	
Agenda Item	5.3
Title of Report	Nurse Staffing Report May / June 2017
Date of Meeting	26th July 2017
Author	Clare Pratt, Deputy Director of Nursing Johanna Ashworth-Jones, Senior Analyst Tracey Lewis, Head of Clinical Excellence & Organisational Development
Accountable Executive	Gaynor Westray, Director of Nursing and Midwifery
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	1, 3
Level of Assurance **Positive** **Gap(s)**	**Positive** • Vacancy rates remain significantly below the national average • Introduction of Specialty reporting of staffing fill rates and CHPPD allows for easier comparison of staffing data • An Associate Director of Nursing Report has been introduced to provide an auditable trail which provides details from Ward Sisters/Charge Nurses and Matrons on mitigating actions taken to address staffing shortfalls **Gaps** • Medicine and Acute have a significantly higher vacancy rate than Surgery, Women's and Children's
Purpose of the Paper **Discussion** **Approval** **To Note**	For discussion
Reviewed by Executive Committee	
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 the Board of Directors with information on Registered Nurse / Midwives and Clinical Support Workers staffing data including vacancy rates and staffing related incidents for May & June 2017. The report also includes the details of the Trust's monthly

submission of Care Hours per Patient Day (CHPPD) and information published within the National Model Hospital Portal.

2 Recruitment Strategy

A key priority at Wirral University Teaching Hospital is to ensure appropriate nurse staffing levels are established and maintained. The previous investments in nurse staffing, as well as a robust recruitment plan, has ensured that the Trust has a stable nursing and midwifery workforce, however as the National Nursing shortage continues this is now impacting on registered nurse staffing levels.

The total Trust vacancy rate for the registered nursing and midwifery workforce in May was 6.04% (92.28 WTE) which increased in June to 6.46% (98.72 WTE). Our vacancy rate remains significantly better than the national average of 10% however additional strategies are being developed to support reducing vacancy rates.

When reviewing the vacancy rate for in-patient and Emergency Department (ED) Band 5 posts the Trust's electronic staff records (ESR) data identified a vacancy rate of 8.80% in June 2017 which equates to 59.51 WTE. The vacancies have reduced from the previous month and the establishment has increased due to agreed permanency of ward 33.

Table 1 - Band 5 Vacancies Inpatient and Emergency Department Registered Nurses

	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017
Establishment	674	674	675	666	665	665.8	676
Actual Numbers	634	634	634	619	613	598.4	616.4
Vacancies	40	40	41	47	52	67.36	59.51
Vacancies %	5.94	5.92	6.08	7.03	7.89	10.12	8.80

Table 2- Current Band 5 vacancy position by Division

Division	March 2017	April 2017	May 2017	June 2017
Surgery, Women and Children's	5.09% 11.1WTE	3.80% 8.3 WTE	8.80% 19.19 WTE	5.13% 11.19WTE
Medicine and Acute	7.99% 35.71 WTE	9.89% 44.26 WTE	10.76% 48 .17WTE	10.55% 48.32

Medicine and Acute Division continue to look at the ward establishment and support roles. NHSP have trained an additional 10 CSWs these are working on wards and will work on WUTH bank. Critical care have recruited 5 RNs – 4 from external organisations. Ward 38 and ward 36 are the largest wards with highest number of RN vacancies. They have recruited into additional band 3 post and these will support RNs in teams performing admissions, observations, bloods, ECGs etc. The first pharmacy technician is currently in training and will be working on ward 32. The EU 10 recruits are due to start on the 14th August and have all been allocated to Medicine and Acute Division. The trainee Nursing Associates have just completed their first placement of their pilot and this has been a great success.

The Trust has commenced phase 2 of International recruitment with Placement Group. A project plan had been agreed that facilitates monthly recruitment events as demonstrated with nurses starting in cohorts from August 2017.

Table 3 – EU recruitment programme

Recruitment events 2017	Offered posts at WUTH	Offered re - interview	Commencement dates	Placement areas
10-12 May	10	2	14th August 2017	Priority Medicine – allocation to be confirmed by 21/7/17
5-6th July	9	1	October 2017	
20th July				
Sept TBC				

3 Temporary Staffing

2016/17 annual review of NHSP contract and service provision has demonstrated a productive and collaborative partnership with key highlights relating to the nursing workforce.

- Agency decreased by 15%
- Bank fill rate increased by 11%
- Nursing and Midwifery represent the highest number of new starters on NHSP

National and regional benchmarking identified WUTH having the lowest nursing agency fill rate at 4.4% against a national average of 20.8% fill rate

4 Model Hospital Portal, Staff Retention and Care Hours Per Patient Day (CHPPD)

The latest data available for staff retention is March 2017; this demonstrates staff retention for registered nurses is above national and regional average. However turnover in Midwifery is higher at WUTH, which is a reflection of the outcomes of the cultural review and performance management. We anticipate that this position will improve with a regular review at Senior Nursing and Midwifery Team meeting

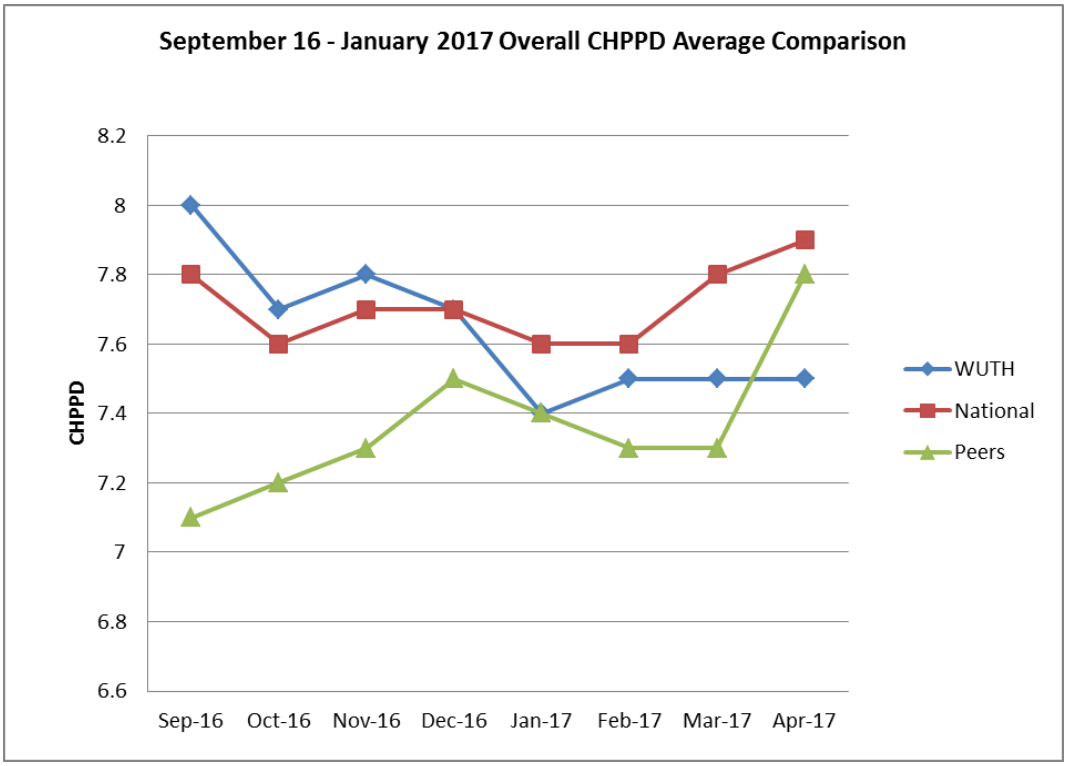
Staff Retention Data			
March 2017 data	WUTH	Regional Peers	National
Registered Nurses	90.7%	87.5%	87.4%
Midwifery	87%	90.5%	88.6%
Clinical Support workers	89.8%	87.5%	83.5%

The Department of Health Efficiency Centre has developed a Model Hospital Portal to allow comparison of hospital data across the range of Carter recommendations. The latest data available for CHPPD is April 2017. During April WUTH's CHPPD was slightly lower than the National and Regional peers averages.

April 2017 data	WUTH	Regional Peers	National
Total CHPPD	7.5	7.8	7.9
RN CHPPD	4.3	4.6	4.8
CSW CHPPD	3.2	3.2	3.1

The line graph below displays the average CHPPD from September 2016 to April 2017 for WUTH compared with the National Average and regional peers. Since December 2016

WUTH has fallen slightly below the National Average CHPPD and during April, WUTH was also lower than the regional average, this is due to a combition of National and regional CHPPD hours increasing but also in WUTH's CHPPD reducing. It should be noted that the National average will consist of a variety of different types of hospital trusts which will range significantly in their local CHPPD.



Local monitoring of CHPPD continues. The last six months of overall staffing fill rates and CHPPD are displayed in the tables below. Fill rates that have been rated as red and denoted with a # symbol indicate that although staffing rates are below funded establishment levels, the Board have received previous reports to demonstrate that appropriate mitigation had been put in place .

Orthopaedics	CHPPD information	Indicators	January	February	March	April	May	June
Ward 10 **7.6**	Average: **6.4** Range 6-8.8	CHPPD	6.5	6	5.9	6.6	6.5	7.3
		Fill Rate	92%	91%	90%	93%	92%	94%
Ward 11 **9.6**	Average: **8.4** Range 7.6 - 10	CHPPD	7.6	7.9	9.4	9.7	9.3	8.9
		Fill Rate	106%	103%	99%	119%	113%	114%
Ward 12 **12.8**	Average: **8.6** Range 8 - 12.5	CHPPD	8.8	8	8	8.7	8.9	8.7
		Fill Rate	87%	80%	89%	81%	77%	79%
M1 **13.4**	Average: **11.5** Range 9 - 14.2	CHPPD	9	14.2	11	11.2	12.3	11.4
		Fill Rate	82%	# 79%	82%	# 71%	83%	78%

Ward M1 and Ward 12 are elective Orthopedic wards which flexes the capacity against demand. The division reviews this on a daily basis and provides assurance that there is sufficient staffing for patient acuity

Surgical	CHPPD information	Indicators	January	February	March	April	May	June
Ward 17 **6**	Average: **6.1** Range 5.7 - 6.6	CHPPD	5.8	6.1	5.9	5.9	6.9	6
		Fill Rate	107%	110%	107%	106%	106%	96%
Ward 18 **5.9**	Average: **5.9** Range 5.7 -6.2	CHPPD	5.7	6.2	5.9	5.8	5.8	6.1
		Fill Rate	93%	95%	95%	94%	93%	94%
Ward 20 **6**	Average: 5.8 Range 5.6 - 6.7	CHPPD	5.6	5.8	5.7	5.6	5.7	7.1
		Fill Rate	97%	105%	98%	99%	99%	98%
ESAU **14.5**	Average:**13.4** Range 13 - 17.3	CHPPD	13.3	12.6	12.6	12.5	11.9	12.4
		Fill Rate	100%	97%	97%	99%	98%	97%
M2 **42.9**	Average: 26.1 Range 12 - 35.4	CHPPD	23	12	16.1	21.2	23	18.4
		Fill Rate	100%	100%	95%	94%	100%	100%
Dermatology **10.7**	Average: **11.5** Range 8.5 - 16	CHPPD	8.5	8.6	8.7	11.1	9.2	9.3
		Fill Rate	100%	100%	100%	100%	93%	100%

Women's & Children's	CHPPD information	Indicators	January	February	March	April	May	June
Children's **10.1**	Average: **10.8** Range 8.1 - 14.9	CHPPD	9.9	12.2	10	11.4	10.9	11.4
		Fill Rate	95%	97%	103%	107%	105%	108%
Maternity **7**	Average: 7.9 Range 5.7 - 10.9	CHPPD	6.6	7.6	10.9	6.8	5.2	5.2
		Fill Rate	98%	100%	98%	93%	98.50%	96%
Delivery Suite **36.6**	Average: **38.5** Range 30.8 - 45.5	CHPPD	37.9	41.3	37.7	36.6	32	34.6
		Fill Rate	108%	106%	102%	101%	98%	99%
Ward 54 **7.8**	Average: 6.7 Range 6.4 - 9.1	CHPPD	6.3	6.6	4.7	7.5	6.9	7
		Fill Rate	# 75%	# 71%	97%	92%	89%	84%
Neonatal **12.5**	Average: **12.6** Range 10.9- 14.4	CHPPD	12.3	13.4	14.4	12.5	11.6	15.4
		Fill Rate	103%	90%	96%	99%	84%	82%

DME / Rehab	CHPPD information	Indicators	January	February	March	April	May	June
Ward 21 **6.3**	Average: **5.6** Range 5.1 - 6.4	CHPPD	6.3	6.3	6.1	6.4	6.2	6.3
		Fill Rate	109%	107%	105%	104%	105%	107%
Ward 22 **5.7**	Average: 5.9 Range 5.4 - 6.6	CHPPD	5.4	5.5	5.6	5.6	6.3	5.6
		Fill Rate	96%	97%	99%	98%	99%	98%
Ward 23 **7.3**	Average: **7** Range 6.7 - 7.8	CHPPD	6.7	7	6.8	7.2	7.3	7.2
		Fill Rate	97%	98%	99%	105%	108%	103%
Ward 27 (Ward 24) **7.5**	Average: **6.7** Range 5.8 - 9.4	CHPPD	5.7	5.7	5.8	5.9	5.5	6.2
		Fill Rate	89%	91%	91%	96%	92%	96%
M2 Rehab **5.5**	Average: **5.6** Range 5.2 - 6	CHPPD	5.2	5.3	5.7	4.9	5.3	5.1
		Fill Rate	97%	96%	97%	92%	93%	99%
CRC **6**	Average: **6.4** Range 5.6 - 6.8	CHPPD	6.2	6.5	6.6	6.1	5.9	6
		Fill Rate	107%	114%	113%	98%	99%	99%

Staffing establishments have been reviewed with DME / Rehab and therefore the average and the standarised CHPPD will be recalculated for all wards in the next report to reflect these changes.

Medicine	CHPPD information	Indicators	January	February	March	April	May	June
Ward 26 **6.6**	Average: **6.1** Range 5.6 - 6.7	CHPPD	5.9	6.4	6.6	6.2	5.8	7.4
		Fill Rate	94%	102%	108%	96%	94%	103%
Ward 30 **8.1**	Average: **7** Range 6.2 - 7.5	CHPPD	6.2	6.3	6.6	6.3	6.5	6.8
		Fill Rate	87%	91%	97%	92%	97%	92%
Ward 32 **6.7**	Average: 5.9 Range 5.6 - 10.5	CHPPD	5.6	5.8	5.9	6	6	5.9
		Fill Rate	91%	94%	97%	95%	94%	94%
CCU **14.9**	Average: **12.5** Range 12.1 - 16.3	CHPPD	12.8	12.3	12.6	12.1	13.9	13
		Fill Rate	86%	89%	95%	91%	92%	97%
Ward 33 Changed to winter November 2016	Average: 6.**2** Range 5.8 - 6.9	CHPPD	6	6.2	6.2	6.9	5.8	7.5
		Fill Rate	92%	95%	92%	97%	90%	94%
Ward 36 **6**	Average: **5.5** Range 5.2 - 6	CHPPD	5.2	5.3	5.7	5.5	5.7	5.7
		Fill Rate	90%	92%	95%	91%	94%	94%
Ward 37 **7.5**	Average: 6.4 Range 5.8 - 7.9	CHPPD	6.7	5.8	6.1	6.1	5.4	5.4
		Fill Rate	94%	100%	100%	101%	99%	100%
Ward 38 **5.7**	Average: **5.5** Range 3.2 - 5.9	CHPPD	5.7	5.3	5.4	5.5	5.9	5.6
		Fill Rate	99%	97%	103%	101%	105%	104%
Ward 25 **9.4**	Average: 9 Range7.5 - 11.4	CHPPD	7.5	7.1	10.4	9.1	9.4	9.4
		Fill Rate	122%	115%	110%	107%	111%	109%
Ward 24 (IPC)	Average : 6.5 Range 5.6 -7.2	CHPPD	6.8	7	5.6	5.8	5.6	6.3
		Fill Rate	92%	98%	101%	93%	93%	100%

Acute Care	CHPPD information	Indicators	January	February	March	April	May	June
MSSW **8.2**	Average: 6.6 Range 5.9 - 8.8	CHPPD	6.3	7	6.9	6.4	6.4	6.4
		Fill Rate	84%	91%	90%	85%	88%	85%
AMU **10.6**	Average: 11.4 Range 9.5 -14.9	CHPPD	14.2	10.3	10.5	9.9	9.7	10.1
		Fill Rate	97%	102%	105%	100%	99%	101%
EDRU **9.6**	Average: **9.4** Range 7.7 -10.7	CHPPD	7.7	9.6	9.2	8.9	8.6	8.9
		Fill Rate	101%	99%	100%	105%	100%	103%
ITU **35.8**	Average: 29.4 Range 26.8 -41.6	CHPPD	29.6	33.9	28.3	28.5	29.6	28.1
		Fill Rate	89%	# 72%	# 73%	# 64%	66%	81%
HDU **27.6**	Average: **24.5** Range 21.1 -36.3	CHPPD	23.7	21.6	24.3	21.1	22.6	22.7
		Fill Rate	96%	95%	95%	91%	94%	91%

During May ITU reported a fill rate of 66% as reported in March and April report staffing was safe with the unit monitoring and recording patient acuity levels in line with staffing levels on duty. There is a supernumerary Ward Sister on every shift with level 3 patients always supported with 1:1 nursing care.

As confidence has grown in the CHPPD data Senior Nursing teams can now use this to help further inform correct establishment levels. The next stage in using CHPPD to support this is too review the difference in Registered Nurse to CSW ratios and compare a breakdown of CHPPD for Registered Nurses and CSWs across the clinical specialties.

The Divisional Triumvirate has requested that a divisional average for CHPPD is included in future reports and this is displayed below.

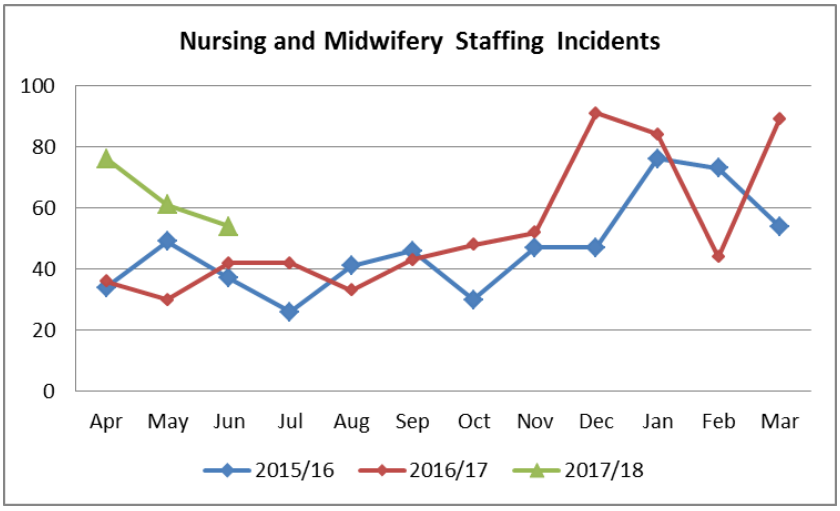
Division	May 2017			June 2017		
	RN	CSW	Total	RN	CSW	Total
Medical Specialties	3.7	3.2	7	3.8	3.4	7.2
Surgical , Women's and Children's Division	5.2	3.1	8.3	5.5	3.2	8.7

It is noted that there is a variation in the RN ratio, with medical specialties being lower than surgery, women and childrens, this information has been triangulated with data relating to vacancies , attendance and incidents and further work is planned including ensuring medical specialties is a priority within all recruitment , retention and reward initiatives.

Details of the CHPPD ratios for each ward for RN and CSW have been shared with the ADNs to help further inform divisions regarding their agreed establishments and will form part of a full staffing review report September 2017.

5 Reported Staffing Incidents

The number of recorded Incidents during May and June 2017 were significantly higher than compared to previous years as displayed in the chart below however significantly lower than the number of incidents reported in March and April 2017. WUTH is proud to have a positive culture of incident reporting and whilst there has been an increase in the number of incidents reported these did not results in any patient harms.



A monthly summary report highlighting themes and trends is reported to the Senior Nursing and Midwifery Team each month highlighting the areas with the most frequent number of incidents. On review of June's incidents it was identified that there were cases of several incidents forms being completed regarding the same time period / incident but completed by different members of staff and therefore are actually duplicates within the system. There was no single area that consistently featured as a high reporter during May and June 2017.

6 Conclusion

- Benchmarking WUTH performance for Care Hours per Patient Day (CHPPD) with other acute hospitals using Model Hospital Portal allows us to provide further assurance that safe staffing levels are in place and this can be used to address staff perception that staffing levels are low. This comparison work will be taken forward once real time reporting is available on the Model Hospital Portal

- The Trust continues to ensure all mitigating actions are in place to ensure that there are safe and appropriate nurse staffing levels at WUTH
- The Trust will continue with monthly Trust wide recruitment for registered nurses in tandem with the new initiatives outlined in this report
- A full Staffing review is currently under way and will be presented September 2017

7 Recommendations

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

Board of Directors	
Agenda Item	**6.1.1**
Title of Report	**Integrated Performance Dashboard**
Date of Meeting	**26th July 2017**
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 June 2017.

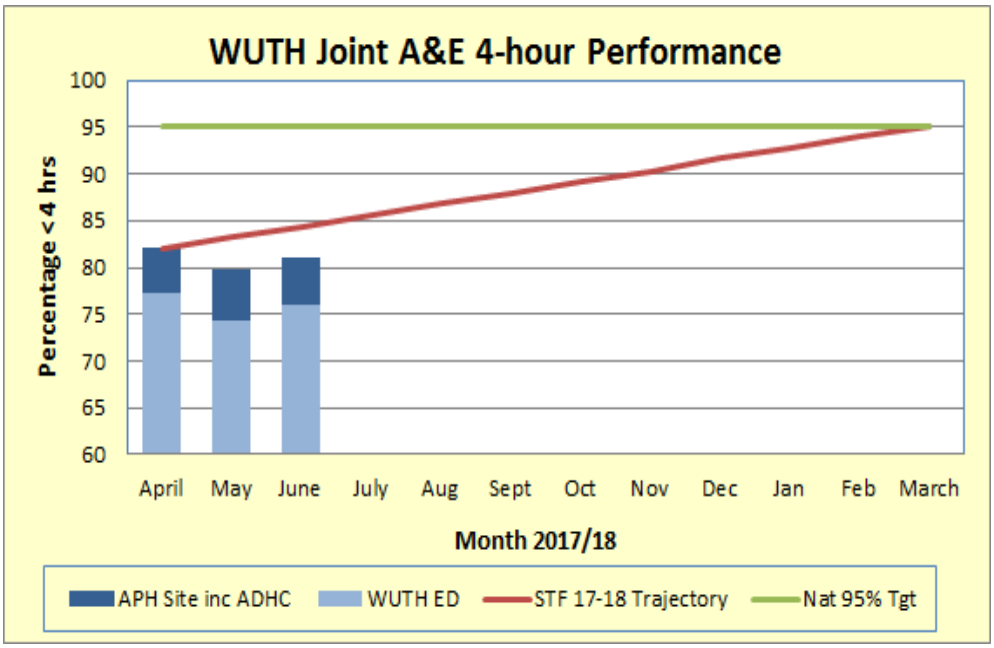
2. Summary of Performance Issues

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

3. Detailed Explanation of Performance and Actions

a. A&E 4 Hour Target

Against the A&E standard of a minimum 95% of patients to be admitted, transferred or discharged within four hours, the month of June was 81.14% as measured across a combined ED and All Day Health Centre performance at the Arrowe Park site. ED alone was 76.08%. The performance in June therefore did not achieve the regulatory compliance level of 95% or the Sustainability and Transformation Fund (STF) trajectory as illustrated below. For Quarter 1 the regulators have determined that half of the transformation monies will be attributable to the delivery of primary care screening – as the Arrowe Park ED has demonstrated close working with the All Day Health Centre to this effect we are confident that remuneration will follow accordingly.



The remaining half of the Q1 STF monites has been linked to the delivery of 90% based upon an A&E delivery board footprint – This would include all the

Walk in centre's based in the community, however even with that addition the % performance would stand at 88%. The Trust is discussing with NHSI whether the original submitted STF should stand and if so how the delivery of May's standard would be treated. Furthermore the Trust is pushing to understand what the rational will be for future STF monies. At the time of writing the intelligence would suggest that the primary care streaming element will remain for Q2 but there is uncertainty on how the performance element will be based.

It is clear from the current pressures being experienced at the Trust that the usual seasonality expected around the summer months does not appear to be manifesting itself. Indeed in the past 4 weeks has seen growth of over 7% in attendances which put alongside the annual growth of 3% is stark.

Whilst there is an extensive programme of improvement schemes there is a burning need to bring forward the implementation of these to meet the current pressures. One such element is the newly designed arrangements for discharges where there is an on going need for care at home or in the community, and where WUTH, the Local authority and the community Trust have collaborated closely with benefits now expected to be realised at the end of August as opposed to October.

The economy is struggling to bring forward many of the other schemes and therefore WUTH is exploring options to bring additional ward capacity on line at the earliest opportunity to aid in the short term.

NHSI has recently informed the Trust that it has been successful in its bid to access capital monies linked to the development of primary care screening solutions at the Arrowe Park site. The original bid was £1.4m for a redesigned entrance encompassing the ED and All day health centre with additional assessment and treatment areas. The monies secured are £0.99m and the estates team are now assessing whether the scheme can be revisited to reduce the overall costs as well as developing a robust construction timeline.

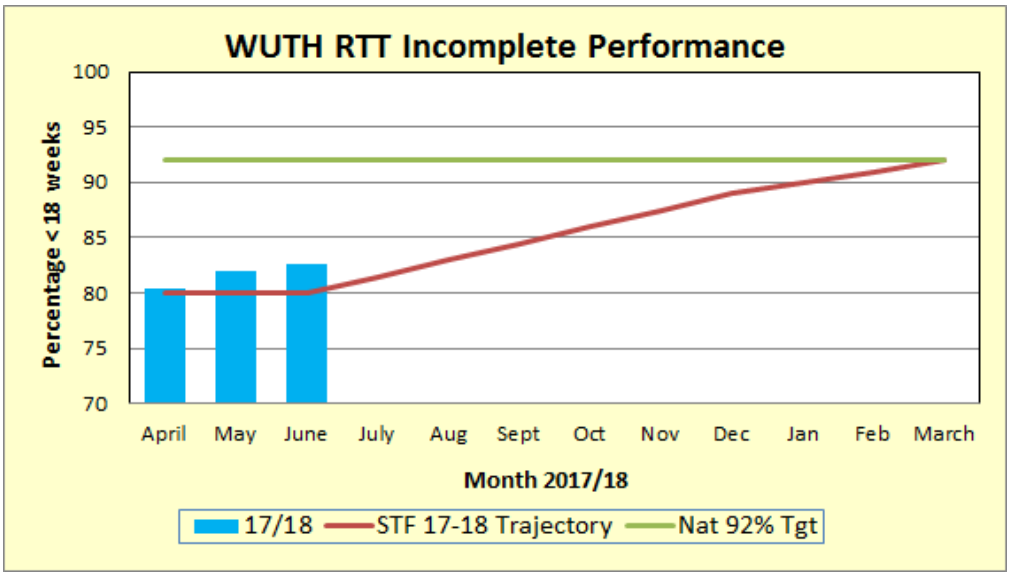
18 Weeks Referral To Treatment (RTT)

The focus of RTT is now solely on the incomplete standard, with the threshold set at a minimum 92% of patients waiting to be seen at 18 weeks or less.

In line with continuing expectations, the Trust did not achieve the national standard at the end of June; however there was again a slight improvement on the previous month with the final position being reported at 82.67%, above the STF trajectory.

There were no patients that had waited more than 52 weeks at the end of June.

The data issues are being addressed and there is economy wide transparency in this process under the newly formed RTT strategic group.



The objective remains to achieve the requisite 92% standard no later than March 2018. The Trust is currently delivering its elective plan and has developed robust plans to address the backlog as a combination of additional internal working and utilisation of independent sector capacity. Discussions around the affordability of this are being discussed with the CCG, with both NHSI and NHSE sighted.

b. Diagnostic Six Weeks Wait

Although a supportive measure for RTT, the standard that patients should wait less than six weeks for a diagnostic test is a key performance metric in its own right. Waiting times against a subset of 15 diagnostic investigations are measured at the end of every month. The threshold standard is that a minimum of 99% of patients waiting should have waited less than 6 weeks. At the time of this report the final position was still undergoing validation, but the expectation is that the end of June will be above the minimum 99.0%.

c. Cancer

For Cancer access targets, the 62-day standard continues to be the most difficult to achieve, and this is reflected in performance levels at a national level. This particular standard also has an explicit line in STF trajectories, with the expectation the 85% standard will be achieved each month. Cancer waiting time performance is only finalised many weeks after month-end due to the time required to confirm diagnosis and share patient pathways between providers.

The current performance against the 62-day Cancer standard for the current quarter is detailed in the dashboard. Although challenging the Trust expects full compliance with this cancer waiting time standard.

As previously detailed, the Trust will not achieve the symptomatic breast standard of 93% of all referrals seen in an outpatient setting within two weeks, although this standard was met for the months of May and June, and there is confidence about ongoing stable delivery.

d. Infection Control

For C Difficile, there have been two avoidable hospital acquired cases in the month of June. Hospital Infection Control Team reviewed the post infection review summary and identified a number of issues relating to lapses in care on busy wards, on standards of environmental cleaning including interruptions to HPV rounds, gaps in robust assurance around the basics (e.g. hand hygiene, isolation delays, infection alert monitoring) and continued stretch on IPC resource due to recent change in staff. We need to refocus on our IPC Strategy; Detect Rapidly, Isolate Effectively and Do the Basics Brilliantly, with initial focus on the latter, and an additional HICT will take place in August to review our high risk priorities and drive action to recover our grip.

4. Recommendation

The Board of Directors are asked to:

Note the Trust's current performance to the end of June 2017.

WUTH Integrated Performance Dashboard - Report on June for July 2017 BoD

Area	Indicator / BAF	April '17	May	June	Trend / Future Concern	*Target (for 'Green')*	Latest Period	Exec Lead
Meeting Our Vision	**Satisfaction Rates**							
	Patient - F&F "Recommend" Rate	99%	99%	99%		*>=95%*	June 2017	GW
	Patient - F&F "Not Recommend" Rate	0%	1%	0%		*<=2%*	June 2017	GW
	Staff Satisfaction (engagement)	3.78	3.78	3.78		*>=3.69*	Q4 2016/17	JM
	First Choice Locally & Regionally							
	Market Share Wirral	81.4%	81.6%	82.5%		*>= 85%*	Jan to March 2017	AM
	Demand Referral Rates	-43.7%	-34.4%	-28.5%		*>= 3% YoY variance*	Fin Yr-on-Yr to June 2017	AM
	Market Share Non-Wirral	7.8%	6.6%	6.0%		*>=8%*	Jan to March 2017	AM
	Strategic Objectives							
	Harm Free Care	96%	96%	97%		*>= 95%*	June 2017	GW
	HIMMs Level	5	5	5		*5*	June 2017	PC
Operational Excellence	**Key Performance Indicators**							
	A&E 4 Hour Standard	82.21%	79.80%	81.14%		*>=95%*	June 2017	AM
	RTT 18 Weeks Incomplete Position	80.34%	82.05%	82.67%		*>=92%*	June 2017	AM
	Diagnostics 6 Week Standard	99.81%	99.63%	99.25%		*>=99%*	June 2017	AM
	Cancer Waiting Time Standards	Concern 1 standard	Concern 1 standard	Concern 1 standard		*All met at Trust level*	Q1 to June 2017	AM
	Infection Control (c Diff cumulative YTD)	0 MRSA; 2 C diff	1 MRSA; 5 C diff	0 MRSA; 7 C diff		*0 MRSA Bacteraemia in month, and cdiff less than cumulative trajectory*	June 2017	GW
	Productivity							
	Delayed Transfers of Care - % of beddays	4.58%	4.54%	6.43%		*< 3.5% of occupied beddays*	June 2017	AM
	Medically Optimised Inpatients			240		*New metric - tbc*	June 2017	AM
	Bed Occupancy	87.7%	90.7%	90.5%		*<=85%*	June 2017	AM
	Bed Occupancy Medicine	91.5%	94.5%	94.9%		*<=85%*	June 2017	AM
	Theatre Utilisation	92.8%	90.9%	88.6%		*>=85%*	June 2017	AM
	Outpatient DNA Rate	8.0%	8.5%	8.4%		*<=6.5%*	June 2017	AM
	Outpatient Utilisation	81.4%	81.2%	79.8%		*>90%*	June 2017	AM
	Length of Stay - Non Elective Medicine	5.2	5.7	5.5		*<= 5.0*	June 2017	AM
	Length of Stay - Non-elective Trust	4.8	5.3	5.2		*<=4.2*	June 2017	AM
	Contract Performance (activity)	3.5%	3.2%	2.7%		*0% or greater*	June 2017	AM
	Finance							
	Contract Performance (finance)	-2.6%	-1.3%	-1.6%		*On Plan or Above YTD*	June 2017	DJ
	Expenditure Performance	2.2%	1.1%	0.4%		*On Plan or Below YTD*	June 2017	DJ
	CIP Performance	-73.5%	-67.6%	-48.1%		*On Plan or Above*	June 2017	DJ
	Capital Programme	89.1%	28.5%	25.3%		*On Plan*	June 2017	DJ
	Non-Core Spend	9.4%	9.4%	9.7%		*<5%*	June 2017	DJ
	Cash Position	296.0%	218.0%	55.0%		*On plan or above YTD*	June 2017	DJ
	Cash - liquidity days	-16.1	-15.0	-17.2		*> 0 days*	June 2017	DJ
A Healthy Organisation	**Clinical Outcomes**							
	Never Events	0	0	1		*0 per month*	June 2017	SG
	Complaints	19	20	30		*<30 per month*	June 2017	GW
	Workforce							
	Attendance	95.62%	95.59%	95.59%		*>= 96%*	June 2017	JM
	Qualified Nurse Vacancies	6.25%	6.04%	6.46%		*<=6.5%*	June 2017	GW
	Mandatory Training	91.62%	91.57%	91.41%		*>= 95%*	June 2017	JM
	Appraisal	83.06%	82.20%	82.01%		*>= 85%*	June 2017	JM
	Turnover	11.04%	10.68%	10.88%		*<10%*	June 2017	JM
	Agency Spend	36.5%	29.8%	24.7%		*On plan*	June 2017	GW
	Agency Cap	161	207	186		*0*	June 2017	JM
External Validation	**National Comparators**							
	Advancing Quality (not achieving)	2	3	2		*All areas above target*	June 2017	SG
	Mortality: HSMR	89.61	86.91	89.46		*Lower CI < 0.90*	April 2016 to March 2017	SG
	Mortality: SHMI	0.966	0.966	0.966		*Lower CI < 90*	Oct 2015 to Sept 2016	SG
	Regulatory Bodies							
	NHSI - Use of Resources (UoR) Rating	3	3	3		*1 or 2 (NHSI amended Oct 2016)*	June 2017	DJ
	CQC	Amber	Amber	Amber		*Overall CQC rating Requires Improvement*	June 2017	SG
	Local View							
	Commissioning - Contract KPIs	7	8	9		*<=2*	June 2017	AM

Quarter	1
Period	01/04/2017 - 30/06/2017

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

Quarter 1 - Total

Division	Tumour Group	Breaches			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted
Medicine	Haematology	0	0	0	12	1	13	100.00%	100.00%
	Lung	2	0	2	9.5	1.5	11	78.95%	81.82%
Other	Other	1	1	2	2.5	1	3.5	60.00%	42.86%
Med & Surg	Upper GI	4	0	4	8.5	1.5	10	52.94%	60.00%
Surgery	Breast	1	0	1	46	0	46	97.83%	97.83%
	Colorectal	4	0	4	23.5	2	25.5	82.98%	84.31%
	Head & Neck	3.5	0	3.5	6	0	6	41.67%	41.67%
	Skin	1.5	0	1.5	70.5	1	71.5	97.87%	97.90%
	Urology	14.5	0	14.5	41.5	0	41.5	65.06%	65.06%
Women's	Gynaecology	1.5	0	1.5	3.5	2	5.5	57.14%	72.73%
	Total	**33**	**1**	**34**	**223.5**	**10**	**233.5**	85.23%	85.44%

Quarter 1 - April

Division	Tumour Group	Breaches			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted
Medicine	Haematology	0	0	0	3	0	3	100.00%	N/A
	Lung	0	0	0	3.5	0	3.5	100.00%	N/A
Other	Other	0	0	0	0.5	0	0.5	100.00%	N/A
Med & Surg	Upper GI	0	0	0	1	0	1	100.00%	N/A
Surgery	Breast	1	0	1	18.5	0	18.5	94.59%	N/A
	Colorectal	2	0	2	6	0	6	66.67%	N/A
	Head & Neck	1.5	0	1.5	2	0	2	25.00%	N/A
	Skin	0	0	0	18.5	0	18.5	100.00%	N/A
	Urology	5.5	0	5.5	16.5	0	16.5	66.67%	N/A
Women's	Gynaecology	0	0	0	0.5	0	0.5	100.00%	N/A
	Total	**10**	**0**	**10**	**70**	**0**	**70**	85.71%	N/A

Quarter 1 - May

Division	Tumour Group	Breaches			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted
Medicine	Haematology	0	0	0	5	0	5	100.00%	N/A
	Lung	1	0	1	3	0	3	66.67%	N/A
Other	Other	0	0	0	1	0	1	100.00%	N/A
Med & Surg	Upper GI	2.5	0	2.5	6	0	6	58.33%	N/A
Surgery	Breast	0	0	0	11.5	0	11.5	100.00%	N/A
	Colorectal	2	0	2	11	0	11	81.82%	N/A
	Head & Neck	1	0	1	1.5	0	1.5	33.33%	N/A
	Skin	0	0	0	28	0	28	100.00%	N/A
	Urology	3.5	0	3.5	8.5	0	8.5	58.82%	N/A
Women's	Gynaecology	1.5	0	1.5	3	0	3	50.00%	N/A
	Total	**11.5**	**0**	**11.5**	**78.5**	**0**	**78.5**	85.35%	N/A

Quarter 1 - June

Division	Tumour Group	Breaches			Treatments			Compliance	
		Actual	Predicted	Total	Actual	Predicted	Total	Actual	Predicted
Medicine	Haematology	0	0	0	4	1	5	100.00%	100.00%
	Lung	1	0	1	3	1.5	4.5	66.67%	77.78%
Other	Other	1	1	2	1	1	2	0.00%	0.00%
Med & Surg	Upper GI	1.5	0	1.5	1.5	1.5	3	0.00%	50.00%
Surgery	Breast	0	0	0	16	0	16	100.00%	100.00%
	Colorectal	0	0	0	6.5	2	8.5	100.00%	100.00%
	Head & Neck	1	0	1	2.5	0	2.5	60.00%	60.00%
	Skin	1.5	0	1.5	24	1	25	93.75%	94.00%
	Urology	5.5	0	5.5	16.5	0	16.5	66.67%	66.67%
Women's	Gynaecology	0	0	0	0	2	2	N/A	100.00%
	Total	**11.5**	**1**	**12.5**	**75**	**10**	**85**	84.67%	85.29%

Board of Directors	
Agenda Item	6.1.2
Title of Report	Month 3 Finance Report
Date of Meeting	26th July 2017
Author	Gareth Lawrence, Deputy Director of Finance
Accountable Executive	David Jago, Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	8 8c,8d
Level of Assurance • **Positive** • **Gap(s)**	Positive
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 3 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 £0.426m 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 £15m 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 £5m) 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 June 2017 the Trust has delivered an overall deficit of £3.9m which is £0.2m above plan. This adverse performance to plan relates to the non-achievement of the A&E performance trajectory and the corresponding reduction of Sustainability and Transformation Funding (STF).

The Trust is reporting a £1.3m adverse variance to the profiled CIP plan having delivered £0.2m in month and £0.75m for the year compared to the planned £2.1m. The Trust continues to review all transformational schemes via the Transformational Steering Group (TSG) in order to support sustainable delivery of the savings target. This level of performance at the end of quarter one is a key risk going forwards to delivery of the overall financial plan if the pace of identification and execution of CIP schemes does not increase significantly in quarter two.

The cash balance position at the end of June was £3.0m which is £1.1m above plan. This positive variance is driven by the 2016/17 closing cash balance being higher than plan, and a year to date capital cash underspend.

The month 3 position includes the full Sustainability and Transformation funding available relating to achievement of the financial plan (70%) and the value attributable to progressing GP streaming (15%), this equates to a total of £1.1m compared with the £1.3m in total which was available.

The year-end forecast in line with plan as noted in Table 1 overleaf is at risk if pace of change in respect of identification and execution of CIP does not significantly increase, additional capacity costs for the remainder of the year staying in line with that catered in the financial plan and the agreement to release of risk reserve by commissioning colleagues.

As noted in the CEO briefing NHSI colleagues have re-introduced the “Protocol for Changes to an In-Year Financial Forecast”. The protocol notes in exceptional circumstances it may be necessary for a foundation trust board to reconsider its planned forecast outturn position. The key steps to be taken are outlined including timing of any required revision which has to be at the quarterly reporting point and through the standard quarterly reporting process.

The Trust has achieved an overall Use of Resources (UoR) Rating of 3 which is in line with plan.

Table 1 Income and Expenditure Performance

Income and expenditure summary

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Year ending 31 March 2018 Position as at 30 June 2017	YTD Plan £k	YTD Actual £k	YTD Variance £k	Year-end forecast Board-approved Budget £k	Year-end forecast Actual £k	Year-end forecast Variance £k
Clinical income	74,860	73,680	(1,181)	303,692	303,692	0
Non-NHS clinical income	393	594	201	1,566	1,566	0
Other income	7,335	7,393	58	34,288	34,288	0
Total operating income	82,588	81,667	(921)	339,546	339,546	0
Pay	(55,202)	(57,633)	(2,431)	(221,376)	(221,376)	0
Other expenditure	(28,040)	(25,310)	2,730	(106,045)	(106,045)	0
Total operating expenditure before depreciation and impairments	(83,242)	(82,943)	299	(327,422)	(327,422)	0
EBITDA	(654)	(1,276)	(622)	12,124	12,124	0
Depreciation and net impairment	(2,027)	(1,561)	466	(8,353)	(8,353)	0
OPERATING SURPLUS / (DEFICIT)	(2,680)	(2,836)	(156)	3,771	3,771	0
Net finance costs and gains / (losses) on disposal	(1,064)	(1,069)	(5)	(4,340)	(4,340)	0
ACTUAL SURPLUS / (DEFICIT) per annual accounts	(3,745)	(3,906)	(161)	(569)	(569)	0
Reverse net impairment	0	0	0	0	0	0
SURPLUS / (DEFICIT) before impairments and transfers	(3,745)	(3,906)	(161)	(569)	(569)	0
Reverse capital donations/grants I&E impact	36	(4)	(40)	142	142	0
DEL net impairments *(damage, not revaluation)*	0	0	0	0	0	0
ADJUSTED FINANCIAL PERFORMANCE SURPLUS / (DEFICIT) (AFPD)	(3,709)	(3,910)	(201)	(427)	(427)	0
AFPD excluding STF	(5,040)	(5,040)	(0)	(9,302)	(9,302)	0

The table above identifies the current performance of the Trust in relation to the plan submitted to NHSI in March 2017. The detailed Income and Expenditure account can be viewed in Appendix 1.

PbR activity is currently above plan by £1.3m YTD as a result of over performance in Elective/Day case, Non Elective and A&E activity. This has been offset with under performance in Non-PbR, (£0.7m) relates to a difference in the treatment of penalties within the main CCG contract offer, this is offset within expenditure, a further (£0.3m) relates to various underperformance in areas such as Neonates and ICU. Non PbR excluded drugs is currently behind plan by (£1.4m), this is offset within expenditure.

As a result of signing up to the Control Total issued by NHS Improvement the Trust has avoided financial sanctions of c£2.8m YTD due to A&E and RTT performance. The Trust has had £0.2m withheld from the STF at the end of Q1 as a result of not achieving the A&E trajectory.

Operational expenditure is currently materially above plan as a result of non delivery of CIP (£1.3m) and operational overspends across the Trust partially mitigated by the deployment of non-recurrent initiatives.

The Trust continues to experience high levels of non-core spend, 10.2% of the pay bill being spent this way in June as demonstrated in the table overleaf:

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	YTD £000's
Plan				18,241	18,506	18,455	55,202
Pay Costs							
Substantive	**16,047**	**16,944**	**17,351**	**17,340**	**17,366**	**17,346**	**52,052**
Bank Staff	299	**336**	386	**377**	**374**	406	1,157
Agency Staff	723	**591**	502	**424**	**515**	568	1,507
Overtime	290	**255**	295	**339**	**266**	280	885
Medical Bank/Locum	357	**462**	517	**486**	**506**	558	1,550
WLI (In Year)	95	**103**	161	**166**	**164**	152	482
Non Substantive Total	**1,764**	**1,748**	**1,860**	**1,791**	**1,825**	**1,964**	**5,580**
Total Pay	17,811	18,692	19,211	19,131	19,191	19,310	57,632
Variance				(890)	(685)	(855)	(2,430)
Non-Core %	9.9%	9.4%	9.7%	9.4%	9.5%	10.2%	9.7%

The Trust will continue to review the operational pay bill via FSPG and FBPAC. The Trust continues to perform well in controlling agency costs with £1.5m spent YTD compared to the "ceiling" of £2m issued by NHSI. While this is a positive position agency has increased in month and will continue to be closely managed given the premium adverse impact of agency costs on the financial plan. This continued performance ensures that the Trust continues to deliver a UoR Rating of 3.

The Trust is currently discussing with Health and Social care partners potential opportunities of supporting excess escalation costs (£0.4m) in the short term albeit initial response received is not positive.

As a result of the adverse performance in expenditure and CIP delivery the position includes as previously reported to the Board the release of £1.2m from the CQUIN risk reserve that was built into the financial plan. This remains a risk to the Trust as this funding stream has not yet been released by the CCG. The Trust continues to be in discussions with NHSI so that they can authorise the transfer of the funds.

Further non recurrent support of £1.2m has also been released at the end of June after reviewing year end accruals. This non recurrent support will not be available in future months to support any continuance of the current higher than planned 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 below.

Table 3 Underlying Deficit

	YTD Plan £k	YTD Actual £k	YTD Variance £k
Adjusted financial performance surplus / (deficit) (AFPD)	**(3,709)**	**(3,910)**	**(200)**
AFPD excluding STF	(5,040)	(5,041)	**0**
AFPD excluding Non-Recurrent Support	(5,040)	(6,241)	**(1,200)**
AFPD excluding CQUIN Risk	(5,040)	(7,441)	**(2,400)**
AFPD Underlying Position (exc STF & CQUIN Risk)	**(5,040)**	**(7,441)**	**(2,400)**

Cost Improvement Programme (CIP)

The CIP for 2017/18 is £15m (4.5%) that is split as a target both divisionally and workstream led. As at the end of the Month 3 the Trust is behind the YTD target of £2.1m by £1.3m.

Table 4 set out below details the month 3 position for CIP.

Table 4 CIP Performance

Summary as at Month 3	YTD		In Year		
	Actual		Forecast		Trend
NHSi Plan (Target)	£2,076k		£15,000k		
Fully Developed TSG approved schemes	£941k		£7,791k		
Overperformance/ (Gap) v NHSi Plan	-£1,135k	-54.7%	-£7,209k	-48.1%	
Latest Forecast performance on TSG approved schemes	£746k		£7,756k		⇧
Over/ (Under)performance compared to TSG approved schemes	-£195k	-20.7%	-£34k	-0.4%	
Latest Forecast including mitigation	£746k		£7,756k		⇧
Performance Variance (Latest Forecast to NHSi Plan)	-£1,330k	-64.1%	-£7,244k	-48.3%	
Latest Forecast adjusted for risk	£746k		£6,083k		
Performance Variance (Latest Forecast to NHSi Plan)	-£1,330k	-64.1%	-£8,917k	-59.4%	

The above table excludes the identified "stretch" initiatives required to deliver the agreed control total.

The table below further analyses CIP performance by Division.

Table 5 Divisional CIP analysis

£k	In Year (IYE)					FYE		
	Target	TSG Approved Schemes Signed off at TSG	Variance to NHSi Plan	Forecast	Variance to NHSi Plan	Target	Forecast	Variance to NHSi Plan
Division	£k	£k	£k	£k	£k	£k	£k	£k
Medicine and Acute	**4,200**	1,563	(2,637)	**1,521**	**(2,679)**	4,200	2,196	(2,004)
Surgery	**3,530**	2,807	(723)	**2,795**	**(735)**	3,530	1,880	(1,650)
Women and Children	**1,470**	482	(988)	**513**	**(957)**	1,470	518	(952)
Diagnostics and Clinical Support	**2,400**	1,006	(1,394)	**966**	**(1,434)**	2,400	1,281	(1,119)
Corporate	**3,400**	1,432	(1,968)	**1,461**	**(1,939)**	3,400	1,341	(2,059)
Central	**0**	0	0	**0**	**0**	0	0	0
TBC		500	500	**500**	**500**		0	
TOTAL FULLY DEVELOPED PRE ADJUSTMENT FOR RISK	**15,000**	**7,791**	**(7,209)**	**7,756**	**(7,244)**	**15,000**	**7,216**	**(7,784)**
Adjustment for Risk				**(1,674)**	**(1,674)**		(2,164)	(2,164)
TOTAL FULLY DEVELOPED AFTER RISK	**15,000**	**7,791**	**(7,209)**	**6,083**	**(8,917)**	**15,000**	**5,052**	**(9,948)**

The in-year forecast on fully developed schemes is £7.8m, £7.2m behind the NHSI requirement. The graph showing the profile of this is included in appendix 4.

It is imperative that the pace of conversion of opportunities needs to be accelerated in order to reduce the gap between the plan requirement and the value of fully developed schemes.

Work is underway with the divisional and corporate leads to move these schemes into fully developed plans with the individual portfolio review meetings chaired by the Director of Operations and STT providing in depth challenge and support across progress on both the transformation agenda and CIP performance. CIP performance has also been escalated to EMT with particular focus on the delivery of the corporate directorate targets and again it is anticipated that there will be a significant advance within this area this month.

It should however, be recognised that there is risk associated with this and the challenge to deliver the £15m target in year has previously been highlighted to the Board of Directors.

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 variances to plan (£2.6m) are primarily due to actual brought-forward balances for 2017/18 exceeding those in plan, and depreciation savings. Depreciation savings have been delivered in line with extending the asset life of the Cerner EPR system, while this has had a benefit to the Income & Expenditure position it increases the risk of the Trust funding the current capital programme without cash support. Capital expenditure is £0.3m under plan during June as a result of slippage to some capital projects.

June's working capital variances to plan are all within acceptable tolerances, and are due to controlled variations in the working capital cycle. The significant month-on-month increase in *Trade and other receivables* is materially attributable to a contract prepayment to Cerner which covers the full financial year.

The June cash position was £3.0m, which is £1.1m above plan. This variance is primarily due to 2016/17 closing cash exceeding planning assumptions (£3.6m) and the cash effects of capital slippage (£0.8m), offset by the adverse effects of the operational trading deficit and working capital movements (£3.3m). All movements and variances in borrowings are attributable to finance lease balances rather than treasury activity. Further detail of the Trust's cash position is at Appendix 3 – *Statement of Cash Flows*.

Overall financial performance returns a UoR Rating of 3, which is in line with plan.

Conclusion

The Trust has delivered a deficit position in line with plan (excluding STF) but only as a result of releasing the CQUIN risk reserve and utilising non recurrent initiatives. The underlying deficit position of the Trust at the end of quarter 1 as set out in table 3 is of concern but reflective of the underlying deficit position the Trust entered the current financial year at circa £23.0m. Overall operational financial plan performance at the end of quarter one is disappointing with key material risks centering on delivery of CIP going forwards and avoidance of escalations costs over and above those catered for within the financial plan. It is imperative that the expenditure run rate and specifically the pay run rate is robustly managed back in line with plan in order to support both the delivery of the CIP and overall financial plan.

The cash position remains positive with a continued focus on delivering cash preservation initiatives and robust management of working capital. Whilst the Trust has delivered a UoR of 3 in line with planned assumptions as noted above adverse operational financial plan performance has been mitigated by release of risk reserve(£1.2m) and deployment of non-recurrent initiatives(£1.0m).

Recommendations

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

David Jago
Director of Finance
July 2017

Appendix 1
Income & Expenditure

Income and expenditure statement (SoCI)

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Year ending 31 March 2018 Position as at 30 June 2017	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	5,455	5,655	200	22,534	22,534	0
Daycase	6,532	6,488	(45)	26,899	26,899	0
Elective excess bed days	258	219	(38)	1,063	1,063	0
Non-elective	22,240	23,381	1,141	90,511	90,511	0
Non-elective excess bed days	538	682	144	2,191	2,191	0
A&E	3,088	3,221	132	12,453	12,453	0
Outpatient	8,321	8,190	(131)	34,148	34,148	0
Diagnostic imaging	605	585	(19)	2,472	2,472	0
Maternity	1,402	1,301	(101)	5,622	5,622	0
Non PbR	17,406	16,413	(993)	69,801	69,801	0
HCD	5,121	3,718	(1,403)	20,485	20,485	0
CQUINs	2,503	2,519	16	6,398	6,398	0
Other income	60	175	115	240	240	0
STF	1,331	1,131	(200)	8,875	8,875	0
Total clinical income	**74,860**	**73,680**	**(1,181)**	**303,692**	**303,692**	**0**
Non-NHS clinical income						
CRU / RTA / ICR income	162	132	(30)	647	647	0
Other income	231	462	231	919	919	0
Total non-NHS clinical income	**393**	**594**	**201**	**1,566**	**1,566**	**0**
Other income						
Education & training	2,445	2,413	(32)	9,780	9,780	0
R&D	102	99	(3)	408	408	0
Non-patient services to other bodies	2,319	2,733	414	9,277	9,277	0
Other income	2,469	2,148	(321)	14,824	14,824	0
Total other income	**7,335**	**7,393**	**58**	**34,288**	**34,288**	**0**
Total operating income	**82,588**	**81,667**	**(921)**	**339,546**	**339,546**	**0**
Pay costs	(55,202)	(57,633)	(2,431)	(221,376)	(221,376)	0
Drug costs	(6,499)	(6,038)	461	(29,220)	(29,220)	0
Clinical supplies	(7,819)	(8,407)	(588)	(30,933)	(30,933)	0
Other costs	(13,722)	(10,865)	2,857	(45,893)	(45,893)	0
Depreciation and net impairment	(2,027)	(1,561)	466	(8,353)	(8,353)	0
Total operating costs	**(85,269)**	**(84,504)**	**765**	**(335,775)**	**(335,775)**	**0**
Operating surplus / (deficit)	**(2,680)**	**(2,836)**	**(156)**	**3,771**	**3,771**	**0**
Operating surplus / (deficit) %	**-3.25%**	**-3.47%**		**1.11%**	**1.11%**	
Net finance costs and gains / (losses) on disposal	(1,064)	(1,069)	(5)	(4,340)	(4,340)	0
Actual surplus / (deficit) per annual accounts	**(3,745)**	**(3,906)**	**(161)**	**(569)**	**(569)**	**0**
Reverse net impairment	0	0	0	0	0	0
Surplus / (deficit) before impairments and transfers	**(3,745)**	**(3,906)**	**(161)**	**(569)**	**(569)**	**0**
Reverse capital donations/grants I&E impact	36	(4)	(40)	142	142	0
DEL net impairments *(damage, not revaluation)*	0	0	0	0	0	0
Adjusted financial performance surplus / (deficit) (AFPD)	**(3,709)**	**(3,910)**	**(201)**	**(427)**	**(427)**	**0**
AFPD excluding STF	**(5,040)**	**(5,040)**	**(0)**	**(9,302)**	**(9,302)**	**0**

Appendix 2
Statement of Financial Position (SOFP)

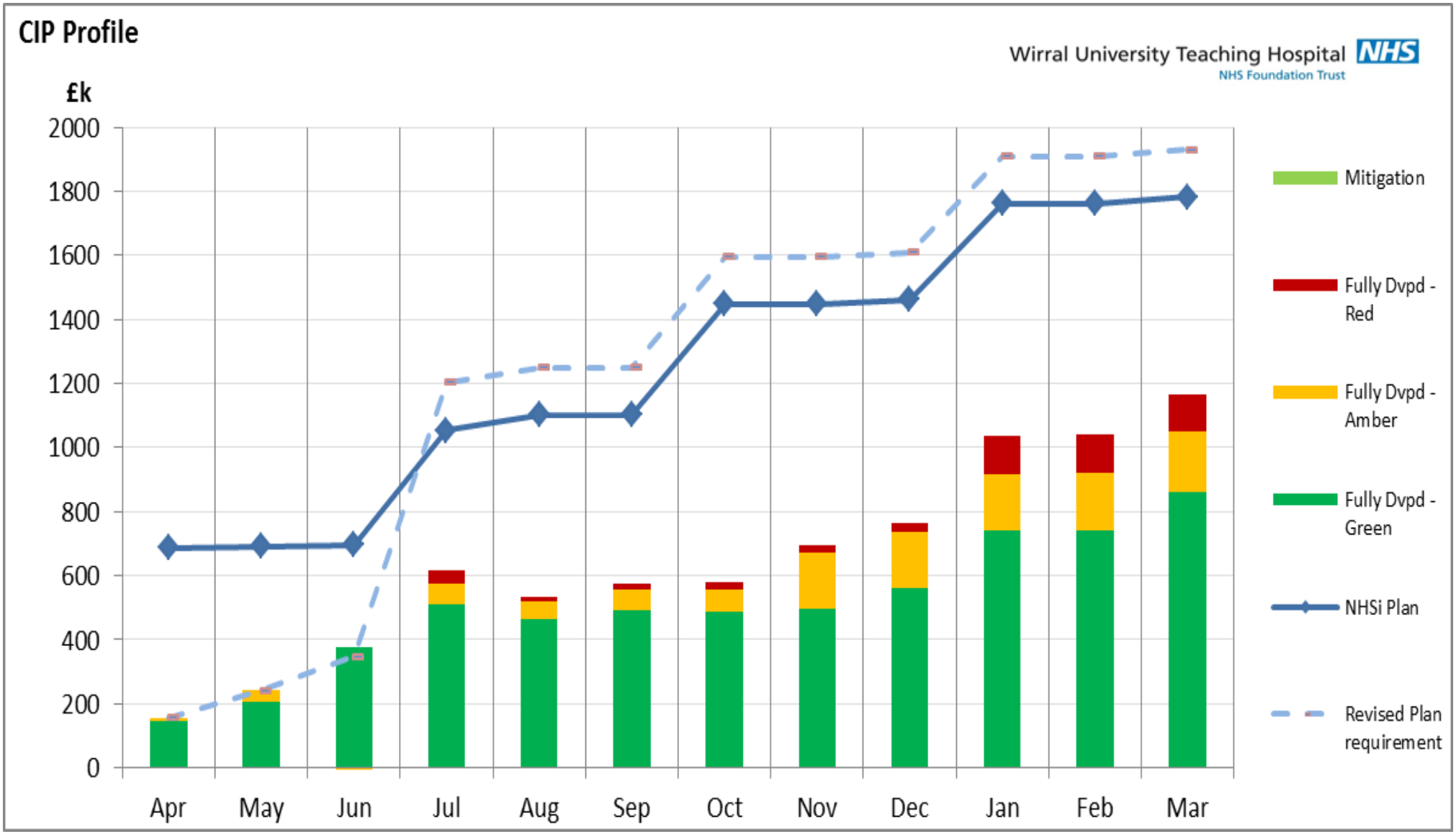
Actual as at 01.04.17 £k		Actual as at 31.05.17 £k	Actual as at 30.06.17 £k	Variance (monthly) £k	Plan as at 30.06.17 £k	Actual as at 30.06.17 £k	Variance (to plan) £k	Plan 31.03.18 £k
	Non-current assets							
145,789	Property, plant and equipment	145,252	145,638	386	143,358	145,638	2,280	145,166
12,216	Intangibles	11,822	12,049	227	11,701	12,049	348	10,080
950	Trade and other non-current receivables	859	859	0	1,612	859	(753)	1,612
158,955		**157,933**	**158,546**	**613**	**156,671**	**158,546**	**1,875**	**156,858**
	Current assets							
3,881	Inventories	3,627	3,937	310	4,051	3,937	(114)	4,051
16,389	Trade and other receivables	18,028	20,368	2,340	20,437	20,368	(69)	20,760
0	Assets held for sale	0	0	0	0	0	0	0
5,390	Cash and cash equivalents	6,480	3,013	(3,467)	1,939	3,013	1,074	2,257
25,660		**28,135**	**27,318**	**(817)**	**26,427**	**27,318**	**891**	**27,068**
184,615	**Total assets**	**186,068**	**185,864**	**(204)**	**183,098**	**185,864**	**2,766**	**183,926**
	Current liabilities							
(31,059)	Trade and other payables	(33,241)	(34,154)	(913)	(32,660)	(34,154)	(1,494)	(32,172)
(3,341)	Other liabilities	(3,441)	(3,204)	237	(4,068)	(3,204)	864	(3,696)
(1,015)	Borrowings	(1,086)	(1,073)	13	(1,015)	(1,073)	(58)	(1,014)
(668)	Provisions	(668)	(668)	0	(664)	(668)	(4)	(664)
(36,083)		**(38,436)**	**(39,099)**	**(663)**	**(38,407)**	**(39,099)**	**(692)**	**(37,546)**
(10,423)	**Net current assets/(liabilities)**	**(10,301)**	**(11,781)**	**(1,480)**	**(11,980)**	**(11,781)**	**199**	**(10,478)**
148,532	**Total assets less current liabilities**	**147,632**	**146,765**	**(867)**	**144,691**	**146,765**	**2,074**	**146,380**
	Non-current liabilities							
(9,154)	Other liabilities	(9,097)	(9,069)	28	(9,069)	(9,069)	0	(8,812)
(26,708)	Borrowings	(28,980)	(28,979)	1	(28,742)	(28,979)	(237)	(27,627)
(2,221)	Provisions	(2,189)	(2,174)	15	(2,088)	(2,174)	(86)	(1,969)
(38,083)		**(40,266)**	**(40,222)**	**44**	**(39,899)**	**(40,222)**	**(323)**	**(38,408)**
110,449	**Total assets employed**	**107,366**	**106,543**	**(823)**	**104,792**	**106,543**	**1,751**	**107,972**
	Financed by							
	Taxpayers' equity							
72,525	Public dividend capital	72,525	72,525	0	72,525	72,525	0	72,525
4,575	Income and expenditure reserve	1,492	669	(823)	(401)	669	1,070	2,779
33,349	Revaluation reserve	33,349	33,349	0	32,668	33,349	681	32,668
110,449	**Total taxpayers' equity**	**107,366**	**106,543**	**(823)**	**104,792**	**106,543**	**1,751**	**107,972**

Appendix 3
Statement of Cash Flows

	Month			Year to date			
	Actual	Plan	Variance	Actual	Plan	Variance	Plan
	£k	£k	£k	£k	£k	£k	£k
Opening cash	**6,480**	**2,037**	**4,443**	**5,390**	**1,752**	**3,638**	**1,752**
Operating activities							
Surplus / (deficit)	*(823)*	*(591)*	*(232)*	*(3,906)*	*(3,646)*	*(260)*	*(568)*
Net interest accrued	*82*	*25*	*57*	*236*	*89*	*147*	*982*
PDC dividend expense	*277*	*277*	*(0)*	*832*	*832*	*0*	*3,326*
Unwinding of discount	*1*	*3*	*(2)*	*2*	*42*	*(40)*	*35*
(Gain)/loss on disposal	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Operating surplus / (deficit)	(463)	(286)	(177)	(2,837)	(2,684)	(153)	3,775
Depreciation and amortisation	237	676	(439)	1,561	2,027	(466)	8,353
Impairments / (impairment reversals)	0	0	0	0	0	0	0
Donated asset income (cash and non-cash)	(17)	0	(17)	(45)	0	(45)	0
Changes in working capital	(2,986)	(219)	(2,767)	(1,775)	924	(2,699)	(270)
Other movements in operating cash flows	0	0	0	0	0	0	0
Investing activities							
Interest received	3	7	(4)	6	20	(14)	82
Purchase of non-current (capital) assets [1]	(239)	(275)	36	(1,321)	(2,134)	813	(7,964)
Sales of non-current (capital) assets	0	0	0	0	0	0	0
Receipt of cash donations to purchase capital assets	17	0	17	17	0	17	0
Financing activities							
Public dividend capital received	0	0	0	0	0	0	0
ITFF loan principal drawdown	0	0	0	0	0	0	0
Support funding [2] principal drawdown	0	0	0	4,200	4,200	0	9,600
ITFF loan principal repaid	0	0	0	0	0	0	(1,014)
Support funding [2] principal repaid	0	0	0	(2,166)	(2,166)	0	(7,666)
Interest paid	0	0	0	1	0	1	(1,064)
PDC dividend paid	0	0	0	0	0	0	(3,326)
Capital element of finance lease rental payments	(15)	0	(15)	(15)	0	(15)	0
Interest element of finance lease rental payments	(3)	0	(3)	(3)	0	(3)	0
Total net cash inflow / (outflow)	**(3,467)**	**(98)**	**(3,369)**	**(2,377)**	**187**	**(2,564)**	**505**
Closing cash	**3,013**	**1,939**	**1,074**	**3,013**	**1,939**	**1,074**	**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, issued by DH and administered by NHSI.

Appendix 4
CIP Profile



Board of Directors	
Agenda Item	6.2
Title of Report	NHSI Quarterly Letter - Month 3 NHSI Commentary
Date of Meeting	26th July 2017
Author	Shahida Mohammed - Assistant Director of Finance
Accountable Executive	David Jago, Executive Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	8 8c,8d
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To note
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

Month 3 2017/18 Financial Commentary for NHS Improvement

The following commentary details the Trust's financial performance during June (Month 3) and the cumulative outturn position for FY18 against plan.

The year to date performance excluding STF shows an actual deficit of (£5.0m), which is in-line with plan. The Trust has delivered £1.1m of STF compared to the plan of £1.3m which has improved the YTD deficit to £3.9m. The Trust continues to forecast a planned deficit of £0.4m. During Q2 the Trust will continue to review the proposed outturn. While the Trust has delivered the financial plan element of the STF and the element relating to GP streaming it is currently not achieving the A&E trajectory. Significant work is on-going to recover this position within the Trust and in collaboration with the wider Health Economy as part of the A&E Delivery Board.

The Trust continues to experience an increase in demand for its Non Elective services with A&E activity significantly higher than the same period in 2016/17.

Pay costs exceed plan by c(£2.4m) as at the end of June, reflecting operational pressures in supporting Non Elective activity levels and Better Care fund challenges within the health and social care economy as well as non-delivery of CIP and other operational pay pressures. To maintain patient safety the Trust has had to increase internal escalation areas as a result of higher than planned demand for non elective patients within the system.. The Trust still has a high number of "medically optimised" patients within the bed base as a result of a reduction of alternatives within the health and social care system. For 17/18 the CCG and L/A have agreed to share BCF programmes of work and KPIs and ensure system wide "sign off" of additional resources and key metrics, so all stakeholders are aware of progress and action plans. The Trust has utilised the 0.5% CQUIN risk reserve within the YTD position, this has yet to be paid over by the CCG, the non-payment of this allocation could result in a deterioration of the YTD position.

The CCG notified the Trust of their intentions to undertake a review of the provision of Urgent Care Treatment in Wirral, including, Accident and Emergency services, Walk in Centres and Minor Ailment Centres in March 2017. The aims of the review include improving the patient journey, outcomes, wait times, and achieve the 4 hrs. standard, and reinvest the current urgent care spend in new ways of working, this review commenced in May 2017.

The cumulative cash position at the end of June is £3.0m, which is some £1.1m above plan. This comprises of two elements, the closing 16/17 cash position being higher than plan and a capital cash underspend being offset by movements in working capital and EBITDA performance.

The table below details the year to date performance against the Trust control total.

SUMMARY FINANCIAL STATEMENT							
	PLAN	MONTH 3			YTD		
	Full Year	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000	£000
NHS Clinical Income	303,693	25,318	24,765	(553)	74,857	73,680	(1,177)
Other Income	35,854	2,576	3,023	447	7,728	7,987	259
Employee Expenses	(221,376)	(18,455)	(19,310)	(855)	(55,201)	(57,633)	(2,432)
All Other Operational Expenses	(106,045)	(9,050)	(8,707)	343	(28,040)	(25,310)	2,730
EBITDA	**12,125**	**389**	**(229)**	**(618)**	**(656)**	**(1,277)**	**(621)**
Post EBITDA Items	(12,693)	(1,031)	(596)	434	(3,091)	(2,630)	461
Net Surplus/(Deficit) incl STF	**(568)**	**(642)**	**(826)**	**(184)**	**(3,747)**	**(3,907)**	**(160)**
Remove capital donations/grants I&E impact	142	12	(4)	(16)	36	(4)	(40)
Adjusted Performance including STF	**(426)**	**(630)**	**(830)**	**(200)**	**(3,711)**	**(3,911)**	**(200)**
Less: STF	(8,875)	(443)	(243)	200	(1,331)	(1,131)	200
Adjusted Performance excluding STF	**(9,301)**	**(1,073)**	**(1,073)**	**0**	**(5,042)**	**(5,042)**	**0**
Control Total Excl STF	(9,300)	(1,072)	(1,072)	0	(5,042)	(5,042)	0
EBITDA %	**3.6%**	**1.4%**	**(0.8%)**	**(2.2%)**	**(0.8%)**	**(1.6%)**	**(0.8%)**

NHS Clinical Revenue

Cumulatively all PODs are over performing in terms of actual activity delivered against the initial plan, with the exception of EL excess bed days, OP Follow Up and OP diagnostic imaging. This predominantly reflects the increase in emergency demand and patient acuity levels. Non PbR activity achieved plan, although HCD income is below plan, this is offset by a reduction in drugs.

Performance against CCG contracts is broadly balanced with the exception of NHS England specialised commissioning reflecting the under recovery in drug "pass through" costs.

Operating Expenditure

In June (Month 3) operating expenditure is £(0.5)m above plan by with a favorable YTD variance of £0.3m.

Pay costs exceeded plan in June by (£0.8m), and are showing a cumulative overspend of (£2.4m). The issues driving the current cumulative adverse performance in pay are:

- Pressures relate to internal capacity continuing and increased demand and costs within A&E to deal with increased levels of acuity and attendances. The Trust is working with external partners via the A&E Board and the System Wide Recovery group. The impact of these escalation costs beds are c(£0.4m). Medical staffing gaps in the Emergency department are resulting in a £(£0.2m) pressure.

- Non–delivery of cost improvement plans in relation to pay work-streams of c (£1.0m)

- Other operational pressures in medical staffing costs and high levels of qualified nurse vacancies have resulted in the use of non-core spend of (£2.7m) on bank staff with a further (£0.9m) on overtime to cover gaps and vacancies.

- Use of WLIs to support delivery of RTT and cancer targets has resulted in c(£0.5m) ytd spend which were partially planned.

- Agency spend was £1.5m as at the end of June which is c£0.5m lower than the required ceiling. This reflects the work the Trust is undertaking on managing agency costs across the organisation.

Non pay costs are below plan by £ 0.3m in June and cumulatively below plan by £2.7m.

- In June £0.2m of non-recurrent accrual review has supported the financial position in other operating expenses.; ytd this is c£0.6m.

- High Cost pass through drugs is a further £1.4m underspent ytd and £0.3m in-month that is offset in NHS Clinical income.

- The CQUIN risk reserve was fully utilised last month and (£1.2m) is supporting the YTD position. This is a further risk to the position if this CQUIN income is not received.

Achievement of the 2017/18 Cost Improvement

The 2017/18 plan assumed the achievement of £14.0m of cost improvement programs and £1.0m revenue generation schemes through the year, delivering a combined total of £15.0m.
The Trust currently has £7.8m of fully built up schemes with opportunities and plans of a further £4.8m leaving a current shortfall of £2.5m.

The CIP position for 2017/18 (including non-recurrent schemes) can be summarised as follows:

Summary as at Month 3	YTD		In Year		
	Actual		Forecast		Trend
NHSi Plan (Target)	£2,076k		£15,000k		
Fully Developed TSG approved schemes	£941k		£7,791k		
Overperformance/ (Gap) v NHSi Plan	-£1,135k	-54.7%	-£7,209k	-48.1%	
Latest Forecast performance on TSG approved schemes	£746k		£7,756k		⇧
Over/ (Under)performance compared to TSG approved schemes	-£195k	-20.7%	-£34k	-0.4%	
Latest Forecast including mitigation	£746k		£7,756k		⇧###
Performance Variance (Latest Forecast to NHSi Plan)	-£1,330k	-64.1%	-£7,244k	-48.3%	
Latest Forecast adjusted for risk	£746k		£6,083k		
Performance Variance (Latest Forecast to NHSi Plan)	-£1,330k	-64.1%	-£8,917k	-59.4%	

The in-year forecast on fully developed schemes is £7.8m, £7.2m behind the NHSI requirement. Whilst this shortfall is of concern, there are plans in progress with an estimated in year value of £2.3m expected to be approved during July 17, with a further £2.5m of opportunities identified. It is recognised that the pace of conversion of opportunities needs to be accelerated in order to reduce the gap between the plan requirement and the value of fully developed schemes. Work is underway with the divisional and corporate leads to move these schemes into fully developed plans with the individual portfolio review meetings chaired by the Director of Operations and Service Transformation Team providing in depth challenge and support across progress on both the transformation agenda and CIP performance. CIP performance has also been escalated to the weekly Executive Management Team meeting with particular focus on the delivery of the corporate directorate targets and again it is anticipated that there will be a significant advance within this area during July and August 2017.

The challenge continues into 17/18 in the conversion of ideas and opportunities into expenditure releasing recurrent schemes. The Trust continues to focus its attention on managing performance against schemes identified and milestones agreed through the Transformation Steering Group (TSG).

The Trust is mindful of the financially challenging environment and the need to maintain pace and focus in the identification of initiatives and subsequent delivery. The Service Transformation team continues to work closely with the Divisions to secure plans for 17/18 and provide support in the subsequent delivery.

Statement of Financial Position for the period ending 31st March 2017

Post EBITDA Items

For month 3, the year-to-date variance to plan for ITDA items totals £0.5m, due to depreciation savings based on the realignment of the Cerner contract..

Statement of Financial Position

Total taxpayers' equity equals £106.5m. The main variances on actual balances against plan are explained below.

a) Non-current assets

Total capital assets are above plan by £2.6m at month 3. This variance is detailed in the table below.

Capital variances	£m
17/18 brought forward balances above plan	1.7
Capex underspend, not including finance lease recognition	-0.6
Depreciation below plan	0.5
Finance lease recognition / derecognition	0.9
Total variance of capital assets to plan	**2.6**

b) Current assets

Current assets are above plan by £0.9m. Current trade and other receivables are below plan by £0.1m, and inventories are below plan by a further 0.1m. The remaining variance is due to cash balances being above plan by £1.1m. This cash variance is split out in the table below.

Cashflow variances	£m
17/18 brought forward cash balance exceeded plan	3.6
EBITDA below plan	-0.7
Working capital movements	-2.7
Capital expenditure (cash basis) behind plan	0.8
Total variance of cash to plan	**1.1**

c) Current liabilities

Current liabilities are above plan by £0.7m. This is attributable to minor variances in the working capital cycle.

d) Non-current liabilities

Non-current liabilities exceed plan by £0.3m, primarily due to the recognition of a new finance lease liability within the Trust's borrowings balance.

Use of Resource (UoR) Rating

The Trust has achieved an overall UoR Rating of 3, which is in line with plan.

	Planned Rating	Actual Rating
Liquidity	4	4
Capital service capacity	4	4
I&E margin	4	4
Distance from financial plan	1	2
Agency spend	1	1
Overall UoR Rating	**3**	**3**

Control Total and Sustainability and Transformation Fund (STF)

The Trust has delivered £1.1m of the £1.3m available vis the STF. While the Trust has delivered the financial plan and GP streaming element the A&E performance is currently below trajectory. The Trust continues to work with the Health Economy to improve this position and has also brought in external support to aid improvement.

Conclusion

The Trust has delivered the year to date plan as submitted in March 2017, as part of the planning process. Going forward there continues to be significant risks within the health and social care economy that will impact the Trust. These risks are being managed through the A&E Delivery Board where it is anticipated that the system will take ownership for the overall pressures that are being incurred internally and externally to the Trust.

The Trust will continue to submit 13 week cash flows in line with NHSI processes to support the requirement of future cash draw downs in line with plan.

The Trust is working closely with all partners across the health economy to support the delivery of a sustainable health service within the Cheshire and Wirral LDSP.

David Jago
Director of Finance
July 2017

Board of Directors	
Agenda Item	7.1
Title of Report	Report of the Finance, Business Performance and Assurance Committee – 21 July 2017
Date of Meeting	26 July 2017
Author	Andrea Hodgson, Chair of the Finance, Business Performance and Assurance Committee
Accountable Executive	David Jago, 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

This report provides a summary of the work of the Finance, Business Performance and Assurance Committee (FBPAC), which met on the 21 July 2017. Key focus areas are those, which address the gaps in assurance/control in the Board Assurance Framework.

Board Assurance Framework

The Committee noted the key changes to the Board Assurance Framework (BAF) during the reporting period, including:

- The risk scores associated with Risk 5 (Sustainability) had been revised and increased to accurately reflect the anticipated challenges and risk associated with delivery of the Financial Plan for 2017/18.

- The tolerable risk score for Risk 6 (Efficiency) had been increased to illustrate a Trust willingness to explore innovative and pioneering initiatives in order to realise efficiency gains.
- The risk descriptor for Risk 10 (RTT) had been amended to remove reference to 'loss of STF funding' as the Trust would not incur any financial penalties for failure to achieve the NHS Improvement (NHSI) agreed trajectory targets for 2017/18. The current score for the risk had also been reduced to reflect the effectiveness of the implemented mitigating actions.
- Although not reflected within the BAF at the time of the meeting, it was confirmed that the risk score for Risk 12 (C.diff) would be increased to reflect the upward trend in instances of avoidable cases of C.difficile reported in Q1 of 2017/18. The Committee noted that the trend had been discussed by the Hospital Infection Control Team who would work to address issues identified and as such the Committee requested that an update in respect of the progress against the mitigating action plan be presented to the next Quality and Safety Committee.

The Committee accepted the two presented 15+ risks which were:

- Risk 3076 which pertained to performance against the 4 Hour A&E Standard; and
- Risk 3089 which related to potential limited access to transfusion data contained within the Triple G computer system.

The Committee was provided with a progress update in respect of the mitigating steps taken in relation to risk 3089 and requested that a further update on progress be provided at a future meeting. It was agreed by the Committee that future presentations of 15+ risks would outline mitigating management plans to address the risks raised.

The Committee requested that the potential risks associated with changes to the General Data Protection Regulation, as discussed at the Board of Directors meeting of 28 June 2017, be reflected within the BAF.

M3 Financial Position

The Committee reviewed M3 financial position, which reported an actual deficit of £3.91m which was a £0.2m adverse variance. The cause for the variance was identified as loss of Sustainability and Transformation Fund (STF) funding following Trust non-achievement of the Q1 STF trajectory for the 4 Hour A&E Standard. The Committee noted the Trust would challenge any non-achievement (and consequent loss of A&E performance STF monies) of the 2017/18 trajectory proposed by NHSI for future quarters and was pleased to note confidence in the Trust ability to deliver GP streaming in line with required deadlines.

The Committee was alerted to the potential increase in the forecast underlying deficit (at circa £23.0m) for 2017/18 as a consequence of CIP slippage, current non-delivery of the Trust vacancy plan and above plan pay costs as a consequence of unplanned staffing of escalation areas and risk to delivery of planned deficit. The Committee explored opportunities to ensure the Trust remained in line with the financial forecast for 2017/18 and was pleased to be advised of negotiations with the Local Authority in order to reach an agreement whereby the Trust was in discussions with the Local Authority to secure reimbursement of escalation costs, through the relocation of medically optimised patients to the Clatterbridge site.

The Committee was advised that the Trust cash position was above forecast at £3m which was a positive variance of £1.1m. The Trust continued to benefit from the higher than budgeted closing cash balance from 2016/17 of £3.6m, partially offset by negative movements on working capital (£2.7m). The Committee noted that deterioration in the Trust Income and Expenditure position would impact the projected drawdown requirement and requested that a flash report be issued to the Board of Directors should the position change.

The Use of Resources (UoR) rating was reported at level 3, which was in line with the Trust plan.

The Committee was disappointed to note that Trust had fallen short of the circa £2m Q1 CIP target for 2017/18 by £1.3m delivering efficiencies of £0.7m (compared to £1.7m in Q1 2016/17). The Committee recognised the significant work undertaken to fully develop a number of substantial initiatives but stated the importance of realising delivery of such schemes.

The risks and appropriate mitigations were outlined and debated by the Committee in relation to income, expenditure, CIP and cash. The Committee discussed escalating to Board the potential risks associated with the underlying forecast deficit for 2017/18, non-achievement of Q1 CIP targets and the importance of realising a reduction in overall pay costs following appointment to substantive posts across the Trust.

Q4 Service Line Report Update

The Committee was presented with a summary of service line performance for Q4 of 2016/17 and was pleased to note the robustness of the data presented although further information was sought on how the information would be utilised to realise service efficiencies and quality improvements. It was confirmed that subject to an additional piece of work to determine the primary causes for service inefficiencies, further evaluation the service line data would be used to inform theatre session utilisation and consultant job planning.

Capital Plan – Evaluation of Total Demand

The Committee reviewed the capital requirements which remain outstanding as a consequence of current restrictions of funding. Concerns were raised in respect of the lack of funding for aging equipment and it was suggested by the Committee that the introduction of a periodic in-year risk evaluation be considered in order to support in-year re-prioritisation of capital expenditure.

The Committee requested that future capital plan evaluation reports detail changes to risk scores of proposed schemes over time. The Committee also requested that a comparative report be presented at the September 2017 considering the value for money alternatives of leasing material equipment noting the adverse impact that leasing would have on the I&E position of the Trust.

Better Care Fund – Funding Allocation and Work Stream Progress

The Committee received a verbal update in respect of the progress of the allocation of the £2m innovation funding, as part of the externally focused Better Care Fund (BCF), which was to be spread over 15 initiatives. It was confirmed that spending guidance had been received and the key performance indicators for each work stream had been compiled however further work by the Better Care Fund Steering Group would be required to determine the effectiveness of the monitoring metrics over time.

The Committee was pleased to note Trust representation on the Better Care Fund Steering Group which would enable the Trust to inform the focus of future initiatives and influence the redirection of funding.

Reference Costs Process

The Committee received an update in respect of changes to the annual reference costs submission which would see the incorporation of education and training into an overarching national mandatory return which would be used to inform the ratings of the Reference Cost Index. The Committee supported delegation of approval of the final submission to the Chairman and Director of Finance. The Committee was advised that the Trust would not receive any feedback in respect of its reference costs until Autumn 2017. The Trust had previously received a positive rating in this area, and continued to perform at the similarly reported levels, however it was acknowledged that the rating is reflective of national performance and as such could be subject to change.

Performance Report for Period Ending 30 June 2017

The Committee noted that the Trust had reported an improved compliance against the 4 Hour A&E Standard of 81.10% for June 2017 although this remained below the national target of 95% and trajectory submitted to NHSI. It was confirmed that continued improvement had been compromised by challenges associated with patient flow. The Committee was apprised of the mitigating actions to be applied to ensure the embedding of process changes at pace to sustain a continued improvement in 4 Hour A&E Standard performance. This would be further supported by

the work that had commenced in collaboration with Ernst & Young, in order to identify high impact process changes for the A&E Department over the coming month.

The Committee noted that the Trust had reported performance of 82.67% compliance against the Referral to Treatment Target (RTT) standard for June 2017 which was below the national standard of a minimum 92% and confirmed that the Trust was in a strong position to realise improvements of RTT performance over 2017/18 as a consequence of continued delivery of the elective activity plan. The Committee was pleased to note the refreshed enthusiasm of the divisional specialties to address the current RTT backlog through the use of internal capacity and resources and welcomed future progress reports in respect of this area.

The Committee noted that the Trust RTT improvement trajectory would be subject to further review as a consequence of renewed internal support for the purposes of clearing the current RTT backlog. It was confirmed that work was underway in collaboration with Divisional colleagues in order to better determine the dynamics of the recovery plan.

The Committee received confirmation that the Trust continued to deliver against the Cancer targets for 2017/18, with the previously raised issue in respect of delivery against the symptomatic breast standard having been successfully resolved.

The Committee was disappointed to note that the Trust reported 2 cases of avoidable C.diff during June 2017 which increased the cumulative position to 7 which was above the in-year trajectory.

A&E Delivery Board – 9 Priorities Review

The Committee reviewed the RAG rated 9 Point Plan return and requested that future iterations of the report include a heat map in order to illustrate Trust performance against the projected trajectories. It was confirmed that performance against the 9 Point Plan would be incorporated into future iterations of the Integrated Board Report.

Transformation Portfolio and Cost Improvement Programme at M3 including MSK Overview

The Committee was disappointed to note that the Trust had reported significant below plan performance of £1.3m for M3 against the CIP. It was confirmed that performance analysis had been conducted in order to identify areas of poor performance and work had commenced to support the progress of stalled initiatives. It was explained that although a further tranche of fully developed schemes would be subject to approval at the July 2017 Transformation Steering Group (TSG), work was required to identify additional projects which would enable the Trust to reach its £15m target for 2017/18. The Committee was however pleased to note that of the fully developed schemes, they were projected to generate circa £9.8m of recurrent savings. It was stated that the August 2017 TSG would review future schemes for 2018/19 and beyond in order to enable the Trust to allow sufficient lead in time so that benefits would be realised at the most opportune point.

The Committee received an overview of the progress of the MSK project which outlined:

- Potential benefits and risks;
- Work undertaken to date;
- Next steps and mobilisation plans; and
- The proposed governance structure.

Non-Core Spend Report

The Committee received the Non-Core Spend Report which confirmed that the Trust continued to perform comparatively well nationally in respect of agency costs to that of peer NHS organisations and remained on track to deliver £1m below the NHSI threshold of £8.1m for 2017/18.

The Committee noted that the Trust had reported no breaches in respect of IR35 legislation for the reporting period.

The Committee requested that future iterations of the report include:

- Workforce numbers, profile and forecast substantive and agency costs to inform strategic workforce planning.
- A trend line to illustrate the number of agency breaches over a rolling period.

Business Case Review – Orthopaedic Trauma Products

The Committee received an update in respect of the performance of the Orthopaedic Trauma contract, following Committee approval of the contract award in December 2016. The Committee was pleased to note the benefits realised as a result of the positive performance against the contract.

Sub-Group Terms of Reference

The Committee was pleased to note the construction of the Terms of Reference (ToR) for the following proposed sub-groups of the FBPAC:

- Finance and Performance Group;
- Strategy and Sustainability Planning Group.

As the Committee had had little time to review the proposed ToR, it was agreed that feedback would be provided to the authors of the ToR after the meeting in respect of their content.

NHS Improvement – Monthly Return

The Committee noted the content of the NHSI Month 13 financial commentary, which detailed the financial position at the end of June 2017 and cumulatively against the 2017/18 plan.

Assurance Reporting

The Committee received Chair's reports from the following Working Executive Committees:

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

The Committee agreed that the report of the Finance, Strategy and Planning Group would be adapted to produce a standard template for all sub-group reporting.

Andrea Hodgson
Chair of Finance, Business Performance and Assurance Committee

BOARD OF DIRECTORS	
Agenda Item	7.2
Title of Report	Research Department Annual Report 2016/17
Date of Meeting	26 July 2017
Author	Paula Brassey, Research Manager
Accountable Executive	Dr Susan Gilby
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	**Strategic Objective** - To maximise innovation and enabling technologies. **Key Measure** - Participate in research and ensure patients are notified of opportunities to participate in suitable studies. **Principal risk -** There is a risk that participation in research reduces because of limited capacity. This will reduce research income and incur staffing cost pressures. It may impact on patient choice. In the long term, the ability to recruit high caliber staff is likely to reduce and quality indicators may deteriorate**.**
Level of Assurance **Positive** **Gap(s)**	Positive
Purpose of the Paper **Discussion** **Approval** **To Note**	Discussion
Reviewed by Assurance Committee	Presented to Clinical Governance Group on 21 July 2017
Data Quality Rating	Bronze – qualitative data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken **Yes** **No**	No

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

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

3. Key Issues/Gaps in Assurance
The report addresses national research targets and the Trust's ability to meet these targets; failure to meet targets may impact upon future research funding. During 2016/17 the Trust continued to exceed two national KPI's and has improved significantly in another KPI over the past three years.

4. Next Steps
The Research Department will work towards continual improvement on national KPI's. This will be achieved by continuing to seek out potentially higher recruiting studies in an attempt to increase the Trust's overall recruitment. The Research Nurses will continue work closely with consultants in actively seeking out participants for studies to ensure studies are able to recruit the agreed study aim within the agreed timescales.

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

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

Research Annual Report 2016/17

Paula Brassey, Research Manager

June 2017

Contents **Page**

Appendix

1. Introduction

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

The research core team consists of a Manager, 2 administrative posts, 11 Research Nurses and a Research Midwife. The majority of these posts are funded by National Institute of Health Research and some are partially funded from commercial research or the Trust.

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

2. Research Governance

During 2015/16 the Health Research Authority (HRA) significantly changed how research is approved throughout England. HRA Approval is the new process for the NHS in England that brings together the assessment of governance and legal compliance, undertaken by dedicated HRA staff, with the independent Research Ethics Committee opinion provided through the UK Health Departments' Research Ethics Service. It replaces the need for local checks of legal compliance and related matters by each participating organisation in England. Participating organisations instead need to assess, arrange and confirm their capacity and capability with the study sponsor prior to starting recruiting. The Research Department liaises with appropriate Trust departments for all new studies prior to issuing confirmation of capacity and capability. The final roll-out of these changes was implemented 1 April 2016.

In addition to implementing new studies the Research Department is also responsible for processing in approximately 150 amendments to on-going studies each year.

It is the responsibility of each individual member of staff to inform the Research Department about any research they wish to undertake and it is a requirement that all staff involved in research must have up-to-date Good Clinical Practice (GCP) Training. GCP is the ethical and practical standard to which all clinical research is conducted. This should be undertaken every two years.

3. National Institute of Health Research

The National Institute for Health Research (NIHR) is a national organisation funded through the Department of Health. The NIHR Clinical Research Network consists of 15 Clinical Research Networks; this Trust's local network is North West Coast Clinical Research Network (NWC CRN). The NWC CRN is responsible for ensuring the effective delivery of research in the Trusts, primary care organisations and other qualified NHS providers throughout the North West Coast area.

3.1.1 NIHR Studies

Approximately two thirds of the research undertaken within the Trust has been adopted onto the NIHR portfolio of studies. During 2016/17 the Trust confirmed capacity and capability for 33 new NIHR adopted studies:

- 6 Clinical Trials of Investigational Medicinal Products (CTIMPs)
- 2 Clinical Investigation or other study of a medical device
- 6 Clinical trials to study a novel intervention or randomised clinical trial to compare interventions in clinical practice.
- 11 Studies administering questionnaires / interviews.
- 2 Research Database / Data only studies
- 1 Qualitative studies
- 2 PIC study (The Trust acts as a Participant Identification Centre)
- 3 Other

Nine of these new studies are commercial studies and these bring additional income to the Trust. See appendix 1 for details of NIHR studies the Trust confirmed capacity and capability during 2016/17. (See section 4 for information on studies that have not been adopted on the NIHR portfolio).

One of the changes to research within England that the HRA have introduced is for some simple, non-interventional studies not to require Trusts to confirm capacity and capability. The Trust is just notified about the research. During 2016/17 this has applied to three new studies; see appendix 2 for more information.

3.1.2 NIHR Recruitment

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

Recruitment is very dependent on the type of studies the Trust has open. Some studies are highly complex Clinical Trials of Investigational Medicinal Products (CTIMPs) and individual recruitment aims for these studies is low (typically max. 10 per study). Simpler observational or questionnaire studies by contrast are much easier to recruit to and have much higher recruitment numbers. See appendix 3 for recruitment information by speciality.

3.1.3 Expressions of Interest

The Research Department is responsible for disseminating and supporting 'expressions of interest' regarding potential new studies for the Trust to participate in. These expressions of interest are received in a variety of ways: from the NWC CRN, directly from study sponsors to the Research Department or directly to the specialty concerned. During 2016/17 the Research Department received in excess of 100 expressions of interest for potential new studies.

3.1.4 NIHR Taskforce Staff

In order to help increase recruitment throughout the whole of the North West Coast Network the NWC CRN has a team of Taskforce Research Nurses and administrators who are able to work across Trusts to provide support. During 2016/17 this Trust has had a Taskforce Research Nurse for 3-4 days per week to cover a variety of studies. The NWC CRN also provided cover for one of our Research Nurses who was on long-term sick leave.

3.1.5 Cancer Recruitment

In previous years cancer recruitment has been predominately to malignant haematology studies; this year sees a big increase in other cancer research. During the preceding 3 years recruitment had averaged at 34 cancer patients recruited per year. During 2016/17 the Trust recruited 60 cancer patients to studies (21 to malignant haematology and 39 to other cancers). This is an increase of 76% in cancer research in the last year.

Cancer patients diagnosed at this Trust are frequently referred to specialist cancer centres for routine treatment. Some of these patients are subsequently recruited onto a study by the specialist cancer centre. See appendix 4 for information.

3.1.6 National Cancer Patient Experience Survey

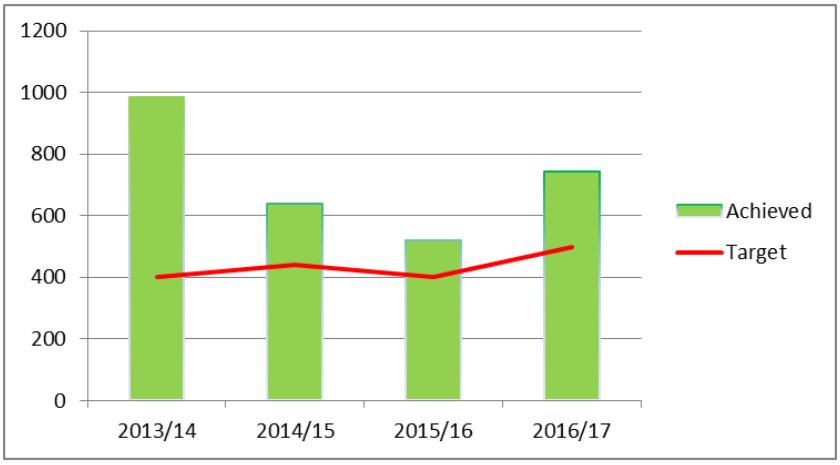
The National Cancer Patient Experience Survey in 2014 highlighted that few patients had seen information about cancer research around the hospital and that few patients had cancer research discussed with them. There are now specific noticeboards at various locations throughout the Trust providing information about research. This and the significant increase in patients being recruited to cancer studies should hopefully see an improvement in research related questions on the next National Cancer Patient Experience Survey.

3.2 NIHR High Level Objectives

The NIHR has a number of high level objectives (HLO); the main HLOs applicable to this Trust are:

- To achieve annual recruitment target. (Since 2013/14 this Trust has exceeded its target).
- For 80% of non-commercial studies to recruit to time and target. (A notable area of improvement for the Trust since 2013/14 is the increase in the number of non-commercial studies closing that achieved their recruitment target).
- For 80% of commercial studies to recruit to time and target. (Since this data was recorded in 2015 the Trust has exceeded this target).

NIHR Recruitment Target



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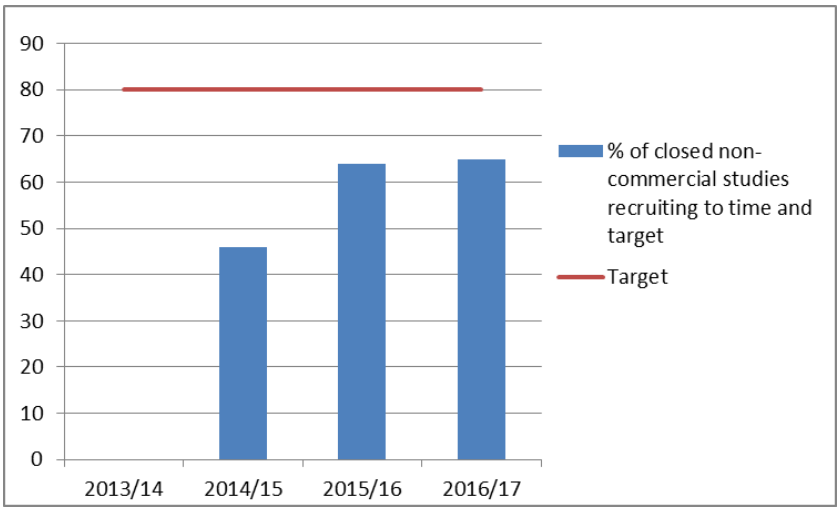
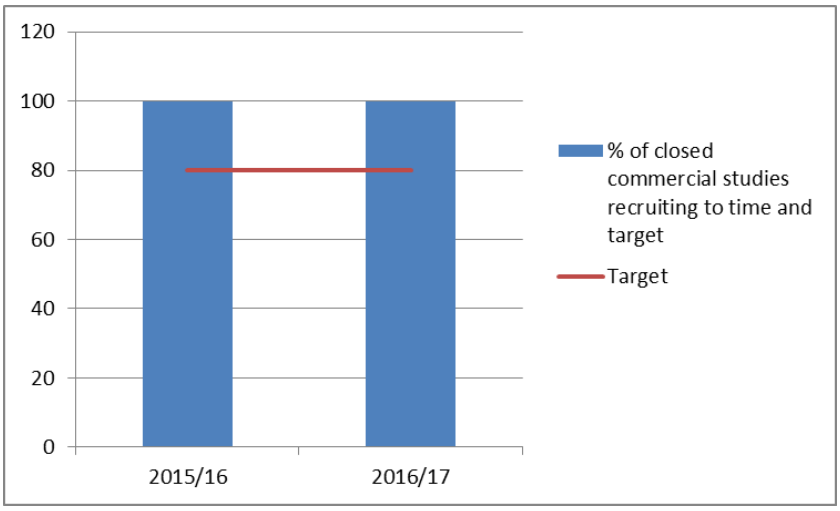
Non-Commercial Closed Studies



Commercial Closed Studies



Due to the changes in the HRA approval process the metrics since 2016 have been amended and research departments throughout England are now required to record and report increasing amounts of information in relation to study set up times and recruitment.

4. Non NIHR Research

In addition to NIHR portfolio research the Trust undertakes non-NIHR portfolio research. This is generally single site studies led by Trust consultants, Trust staff undertaking research modules within masters or PhD qualifications or external researchers undertaking research across several sites. During 2016/17 the Trust granted NHS permission for 24 non-NIHR adopted studies.

See appendix 5 for full list of non NIHR studies.

5. Collaborative Working

5.1 Clatterbridge Cancer Centre

The Trust continues to work in conjunction with Clatterbridge Cancer Centre (CCC). Some of the commercial studies opened at CCC require this Trust to undertake some research specific activities, e.g. Ophthalmology tests that CCC is not able to perform. During 2016/17 the Trust agreed 9 new sub-contracts relating to this work. The Trust receives income for this work.

5.2 Research Passports

Under the NIHR Research Passport Scheme during 2016/17 the Trust issued 16 Letters of Access to allow researchers from other Trusts or universities to undertake research related activities within the Trust.

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

5.3 Key-Service Support

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

Departments to cover costs for any research related activity for NIHR adopted studies. (Also see Finance 6.1 below).

5.3.1 Pharmacy

The Trust pharmacy department continues to support clinical trials involving Investigational Medicinal Products (IMPs) and provides a dispensing and aseptic preparation service for all IMPs. During 2016/17 6 trials involving IMPs were opened and 3 closed down, leading to an increase in the total number of active trials requiring pharmacy input from 34 at the start of the financial year to 37 at the end.

During 2016/17 the pharmacy haematology clinical team have been involved in the project to introduce electronic chemotherapy prescribing in line with national recommendations. Electronic chemotherapy prescribing went live in January 2017. All prescribing regimens for new haematology trials will be built on Wirral Millennium and work is continuing to transfer the prescribing regimens for all existing haematology trials onto the electronic system.

The pharmacy clinical trials team has continued to work closely with Principal Investigators, Research Nurses and the Research Department to ensure trial set up and initiation is as smooth and efficient as possible. There has been representation from the trust at both the North West Clinical Trials Pharmacist meetings held in 2016/17. A report listing ongoing IMP trials is provided to the Wirral Drugs and Therapeutics Committee on a quarterly basis by the pharmacy clinical trials team.

5.3.2 Pathology

The Pathology Department supports research within the Trust by providing a wide-range of clinical services, including histopathology, cytology, blood sciences and microbiology. During 2016/17 seven of the non-commercial studies the Trust confirmed capacity and capability on also required pathology approval. In addition to undertaking research related activity for the Trust, the Pathology Department also provides a service to Clatterbridge Cancer Centre for some of their research related activity.

5.3.3 Radiology

The Radiology Department supports research within the Trust by offering a full range of imaging including MRI, CT and plain films. For some studies the department provides investigations for outside review; other studies rely on diagnosis and interpretation by sub-speciality radiologists. During 2016/17 two of the non-commercial studies the Trust confirmed capacity and capability also required radiology approval. The Radiology

Department occasionally provides a service to Clatterbridge Cancer Centre for some of their research related activity.

5.4 Junior doctors supporting research

Many doctors below consultant level contribute to research within the Trust. Eight doctors have been added to the study delegation logs of nine separate studies to enable them to participate in research; they will all have undertaken NIHR Good Clinical Practice (GCP) training (4 CPD points). See Appendix 6 for a list of doctors, below consultant level, working on NIHR studies.

5.5 National Institute for Health Research - Collaboration for Leadership in Applied Health and Research Care - North West Coast: NIHR CLAHRC NWC

In 2015 the Trust entered into a partnership agreement with CLAHRC NWC; the other parties are:

- The NHS Liverpool Clinical Commissioning Group
- The University of Liverpool
- University of Central Lancaster
- Lancaster University

The aim of the partnership is for the parties to work collaboratively to deliver a research programme designed to decrease health inequalities and improve the health of the population of the North West Coast.

5.5.1 Care After Presenting with Seizure to Emergency Services (CAPS)

As part of the CLAHRC NWC partnership agreement the Trust has been participating in the CAPS research study. The aim of the research is to determine whether the wide, and unacceptable, variability in care given to patients presenting with a seizure can be improved by implementation of the new care pathway and whether this can be enhanced further with implementation of a research nurse. 99 Participants have been recruited to this study.

6. Funding

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

6.1 NIHR funding

The Trust receives income from North West Coast Clinical Research Network to cover the costs of working on NIHR adopted studies; breakdown below of recent funding:

	2013/14 Funding from Merseyside and Cheshire Comprehensive Local Research Network	2014/15 Funding from North West Coast Clinical Research Network	2015/16 Funding from North West Coast Clinical Research Network	2016/17 Funding from North West Coast Clinical Research Network
Research Nurses	£313,136	£331,329	£297,594	£289,951
Pharmacy key-service support	£39,956	£60,791	£40,791	£39,868
Pathology key-service support	£20,000	£40,000	£20,000	£12,377
Radiology key-service support	£20,000	£20,000	£20,000	£5,000
Research Management & Governance	£29,700	£20,974	£19,147	£13,564
Data Support	£13,239	£19,455	£19,954	£24,060
PA Allocation	0	£50,000	0	0
TOTAL	**£436,031**	**£542,549**	**£417,486**	**£384,820**

6.2 Research Capability Funding

During the past few years the Department of Health have allocated £20,000 Research Capability Funding (RCF) to research active Trusts if they recruited more than 500 participants to non-commercial NIHR studies in the previous year.

In March 2015 the NIHR announced that it was rewarding all Trusts additional Network Research Capability Funding (nCRF) funding for commercial studies that had recruited to time and target. The allocation allowance per qualifying study has changed and reduced since its introduction.

	2013/14	2014/15	2015/16	2016/17
Research Capability Funding	Nil	£20,000	£20,000	£20,000

Network Research Capability Funding	Payments first made in 2015/16	£31,000 (based on 2013/14 performance – 4 qualifying studies)	£12,056 (based on 2014/15 performance - 4 qualifying studies)

6.3 Commercial Income

The Trust receives income from commercial sponsored research; the majority of which goes directly to the speciality undertaking the research though the Research Department does keep a proportion to cover costs and also for capacity building. Breakdown below of current and previous year's commercial income:

	2013/14	**2014/15**	**2015/16**	**2016/17**
Divisions	£85,025	£93,229	£95,108	£95,259
Research Department	£40,971	£39,769	£32,612	£21,259
Total	**£125,996**	**£132,998**	**£127,720**	**£116,518**

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

In April 2015 the NIHR introduced new guidelines regarding the allocation of income from commercial studies and a new Research Commercial Income Policy has been ratified to ensure the Trust complies with these new requirements. It is too early to say yet what effect this new policy will have on the overall research income.

6.4 Contracts

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

7. Library

7.1 Publications

The Library and Knowledge Service (LKS) records all publications that have been publicised via the Library Blog. The criteria for inclusion are that the articles have been listed on PubMed, Medline or EMBASE and have been written by members of WUTH staff. The Research Department have display space within the library including a list of these articles. See appendix 7 for list of articles added to the blog from 1 April 2016 to 31 March 2017. Over the past couple of years the number of articles published by WUTH staff has significantly decreased (2014/15 = 106; 2015/16 = 58; 2016/17 = 25).

The LKS achieved a compliance score of 99% in their external quality assessment, the Library Quality Assurance Framework (LQAF) for health libraries, which includes an assessment of how well they support research activity within the Trust.

To encourage publication and help develop research skills the LKS invests in BMJ Case Reports to enable WUTH staff to publish case reports (avoiding the usual publication fee).

7.2 HEE Funding Bid

The Library and Knowledge Service is undertaking a study entitled “Knowledge Mobilisation in Critical Care” in partnership with the University of Liverpool. This study will establish the knowledge requirements of critical care staff and patients, then pilot and evaluate a model of LKS support.

8. Additional Information

8.1 Advice and support

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

8.2 Future Research Annual Reports

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

Paula Brassey	Research Manager Ex 8471 Paula.Brassey@nhs.net
Dr Melanie Maxwell	Associate Medical Director Ex 2212 Melanie.Maxwell@nhs.net

APPENDIX 1

List of NIHR adopted studies this Trust confirmed capacity and capability 01/04/16 – 31/03/17

Study Title	Type of Study	Principal Investigator / Speciality
PREGLEM: A prospective, multi-national, multicentre, non-interventional study to evaluate the long term safety of Esmya, in particular the endometrial safety, and the current prescription and management patterns of Esmya in a long term treatment setting	Basic science study involving procedures with human participants Commercial Study	Mr Ash Alam / Reproductive Health
LUCID: Lung Cancer Indicator Detection	Clinical Investigation or other study of a medical device	Dr Andrew Wight / Cancer
STOPPIT 2: An open randomised trial of the Arabin pessary to prevent preterm birth in twin pregnancy, with health economics and acceptability	Clinical Investigation or other study of a medical device	Mrs Stella Mwenchanya / Reproductive Health
A Phase 3, Multicentre, Randomised, Double-blind, Placebo-controlled Study Evaluating the Efficacy and Safety of Ustekinumab in the Treatment of Anti-TNFα Refractory Subjects With Active Radiographic Axial Spondyloarthritis	Clinical trial of an investigational medicinal product Commercial Study	Dr Emmanuel George / Rheumatology
ALFIE 2: Anticoagulants for Living FoEtuses in women with recurrent miscarriage and inherited thrombophilia	Clinical trial of an investigational medicinal product	Mr Mike Ellard / Reproductive Health
CF START: The cystic fibrosis (CF) anti-staphylococcal antibiotic prophylaxis trial (CF START); a randomised registry trial to assess the safety and efficacy of flucloxacillin as a longterm prophylaxis agent for infants with CF.	Clinical trial of an investigational medicinal product	Dr David Lacy / Paediatrics

ECLIPSE - Emergency Treatment with Levetiracetam orPhenytoin in Status Epilepticus in Children – an open label randomised controlled trial	Clinical trial of an investigational medicinal product	Dr Mark Buchanan / Paediatrics
GALACTIC: GA101 (obinutuzumab) monocLonal Antibody as Consolidation Therapy In CLL	Clinical trial of an investigational medicinal product	Dr Ranjit Dasgupta / Haematology
M13-542: Phase 3 ABT-494 study in Mod/Severe RA with Bio-IR	Clinical trial of an investigational medicinal product Commercial Study	Dr Yee Ho Chiu / Rheumatology
AFFINITE: Two linked cluster randomised trials to evaluate feedback interventions embedded within a national audit of transfusion practice	Other	Dr David Galvani / Haematology
Achilles Tendinopathy Management (ATM): A multi-centre placebo controlled randomised controlled trial comparing Platelet Rich Plasma (PRP) to placebo (imitation) injection in adults with Achilles tendon pain.	Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice	Mr Mike Hennessy / Trauma and Orthopaedics
BOOST: Better Outcomes for Older People with Spinal Trouble (BOOST) Randomised Controlled Trial	Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice	Carole Burton / Physiotherapy
LORIS: A Phase III Trial of Surgery versus Active Monitoring for Low Risk Ductal Carcinoma in Situ (DCIS)	Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice	Mr Raman Vinayagam / Cancer

MAMMO-50: Mammographic surveillance in breast cancer patients aged 50 years or older	Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice	Mr Raman Vinayagam / Cancer
POSNOC: POsitive Sentinel NOde: adjuvant therapy alone versus adjuvant therapy plus Clearance or axillary radiotherapy. A randomised controlled trial of axillary treatment in women with early stage breast cancer who have metastases in one or two sentinel nodes	Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice	Mr Raman Vinayagam / Cancer
PURE: The clinical and cost effectiveness of surgical interventions for stones in the lower pole of the kidney: The Percutaneous nephrolithotomy, flexible Ureterorenoscopy and Extracorporeal shockwave lithotripsy for lower pole kidney stones Randomised Controlled Trial	Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice	Mr Snahel Patel / Renal
EMBARC: The European Bronchiectasis Registry	Research Database	Dr Nicola Stevenson / Respiratory
BeST-SE (iBeST) Evaluating the impact of implementing the Back Skills Training Programme (BeST) for people with low back pain. Evaluated within NHS services as a routine service evaluation. BeST-SE	Service evaluation	Dr Beth Fordham / Physiotherapy
Assessment of STELARA® (Ustekinumab) and Tumour necrosis factor alpha inhibitor therapies in patients with Psoriatic Arthritis in standard health-care practice: A prospective, observational cohort study.	Study administering questionnaires / interviews for quantitative analysis, or using mixed quantitative / qualitative methodology Commercial Study	Dr Emmanuel George / Rheumatology

PGRx Information System for Epidemiological Research	Study administering questionnaires / interviews for quantitative analysis, or using mixed quantitative / qualitative methodology Commercial Study	Dr Ruth Davies / Stroke
ARIADNE: Assessment of Real LIfe cAre – Describing EuropeaN Heart FailurE Management	Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology Commercial Study	Dr Antonios Benopoulos / Cardiology
ETNA VTE: Non-Interventional Study on Edoxaban Treatment in Routine Clinical Practive in Patients with Venous Thromboembolism in Europe.	Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology Commercial Study	Dr Nicola Stevenson / Respiratory
IVIS Impact of visual impairment after stroke	Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology	Miss Victoria Smerdon / Stroke
Monitoring Patient-Reported 6-point Mayo Scores, Quality of Life and Work Productivity in Golimumab Treated Ulcerative Colitis Patients Over Time.	Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology Commercial Study	Dr Paul Flanagan / Gastroenterology

ORENCIA - Evaluation of the effectiveness of the abatacept (ORENCIA®) intravenous and formulation Patient Alert Cards in patients with rheumatoid arthritis in a sample of European Economic Area countries	Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology Commercial Study	Dr Emmanuel George / Rheumatology
PQIP: Perioperative Quality Improvement Programme Database	Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology	Dr Kathryn Brodbelt /
SNAP 2: The Second UK Sprint National Anaesthesia Project: Epidemiology of Critical Care provision after Surgery (SNAP-2: EpiCCS)	Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology	Dr Suresh Singaravelu / Critical Care
SPEAK: Surveying People Experiencing young Adult Kidney failure	Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology	Dr Tom Ledson / Renal
NOVEMBR: Non-invasive ventilation for the management of children with bronchiolitis: a feasibility study.	Study involving qualitative methods only	Dr David Lacy / Paediatrics
RAFT – iHYPE – Research & Audit Federation of Trainees – A study of Intraoperative hypotension in elder patients	Study limited to working with data (specific project only)	Dr Natasha Permall / DME

Development and validation of a new instrument and assessment protocol for assessing social communication/ autism in young children with severe visual impairment (DAiSY Project)	Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology	N/A
Eculizumab in Shiga-Toxin producing E. Coli Haemolytic Uraemic Syndrome (ECUSTEC): A Randomised, Double-Blind, Placebo-Controlled Trial	Clinical trial of an investigational medicinal product (WUTH is a Participant Identification Centre (PIC Site)	Dr Lil Breen
Cloudy with a chance of pain	Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology (WUTH is a Participant Identification Centre (PIC Site)	Prof Will Dixon

APPENDIX 2

List of studies not requiring Trust Confirmation of Capacity and Capability

Study Title	**Type of Study**	**Study Sponsor**
Consultants perceptions on the determinants of adoption and diffusion of innovation in cancer treatment	Study involving qualitative methods only	Imperial College London
Evaluating the ten year impact of the Productive Ward at the clinical microsystem level in English acute trusts	Study administering questionnaires / interviews for quantitative analysis, or using mixed quantitative / qualitative methodology	Kings College London
G-PATH SUPPORT: Gastrostomy feeding and psychosocial support	Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology	N/A

APPENDIX 3

Total NIHR Recruitment Data since 2013/14

	Number of participants recruited			
Speciality	**2013/14**	**2014/15**	**2015/16**	**2016/17**
A&E	0	0	38	64
Acute Care	0	0	0	123
Anaesthetics	0	126	0	218
Blood Transfusion	0	0	0	1
Cancer	36	35	32	60
Cardiovascular	19	10	0	0
Critical Care	546	164	0	30
Dementia	21	22	1	0
Dermatology	15	10	4	0
Diabetes	0	7	4	0
Gastroenterology	0	0	8	7
Health Services	0	0	128	0
Microbiology	17	47	15	4
No Local Investigators	10	0	0	0
Ophthalmology	21	3	0	0
Paediatrics	95	88	76	59
Physiotherapy	0	0	0	3
Renal	0	2	7	30
Reproductive Health	48	93	111	23
Respiratory	4	10	7	20
Rheumatology	22	10	35	24
Stroke	3	13	49	75
Surgery	3	0	6	0
TOTAL	**860**	**640**	**521 ***	**741**

*This figure is slightly higher than reported in last year's annual report due to late additional data becoming available.

APPENDIX 4

Referring Cancer Data

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

	2012/13	2013/14	2014/15	2015/16	2016/17
Aintree University Hospitals NHS					
Head and Neck Cancer Group	16	24	1	1	2
Upper Gastrointestinal	0	0	0	1	0
Aintree Total	**16**	**24**	**1**	**2**	**2**
Royal Liverpool & Broadgreen					
Children's Cancer and Leukaemia	0	1	0	0	0
Genetics	0	1	0	0	2
Haematology	4	1	1	1	6
Upper Gastrointestinal	0	0	0	1	0
Royal Liverpool & Braodgreen Total	**4**	**3**	**1**	**2**	**8**
Clatterbridge Cancer Centre					
Bladder	2	1	2	1	3
Breast	3	12	4	3	2
Colorectal	14	0	0	0	0
Gastrointestinal	6	5	2	3	0
Genetics	1	1	0	0	0
Gynaecological	5	3	3	2	2
Head & Neck	0	0	0	0	2
Lung	2	2	5	10	9
Melanoma	2	0	1	0	0
Prostate	22	37	28	9	2
Renal	11	1	0	2	2
Palliative	0	0	1	0	0
Teenage & Young Adults	0	0	1	0	0
Upper GI	0	0	0	0	4
Urology	0	0	0	1	0
Multiple	28	3	0	9	0
Clatterbridge Cancer Centre Total	**96**	**65**	**47**	**40**	**26**
GRAND TOTAL	**116**	**92**	**49**	**44**	**36**

APPENDIX 5

List of non-NIHR adopted studies granted Trust approval.
01/04/16 – 31/03/17

Study Title	**Type of Study**	**Principal Investigator / Name of University if applicable**
Exploring non-technical skills in surgical trainees	Study involving qualitative methods only	Paul Sutton/ University of Liverpool
A national population-based case-control study of the genetic, environment and behavioural causes of breast cancer in men	Other	Mr Raman Vinayagam
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders and barriers to communication: the perception of senior medical staff in the acute care setting, a qualitative study.	Study involving qualitative methods only	Lisa Delaney / University of Chester
Evaluation of a Coaching Workshop	Study involving qualitative methods only	Dr June Keeling / University of Chester
Pre- and post-operative bladder function in women undergoing excision of endometriosis	Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology	Mr Vasileios Minas

What are the experiences of midwives in managing a nuchal cord	Study involving qualitative methods only	Jill Blakey / University of Chester
Exploring the wellbeing of doctors in training during workplace transitions (Exploring Doctors' wellbeing)	Study involving qualitative methods only	Iliana Makri / University of Liverpool
Fetal blood Sampling of Scalp pH,	Study administering questionnaires / interviews for quantitative analysis, or using mixed quantitative / qualitative methodology	Alison Campion / University of Chester
Vision Screening Tool	Basic science study involving procedures with human participants	Victoria Smerdon / University of Liverpool
Ophthalmic manifestations of Behcet's Disease **(PIC Site)**	Study limited to working with data (specific project only)	N/A
Surgical management of high risk prostate cancer in the era of pre-biopsy multiparametric MRI	Study limited to working with data (specific project only)	Mr Chirag Patel

Healthcare professionals' knowledge towards antimicrobial prescribing	Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology	N/A
Implementation, impact and costs of policies for safe staffing in acute trusts.	Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology	N/A
A quantitative reasoned action approach to employees' social media misconduct	Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology	John Bentham / Liverpool John Moores University
Knowledge, attitudes and perceptions of 1. General practitioners 2. Junior Doctors 3. Antimicrobial prescribing in England.	Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology	Oliver Harvey / University of Sussex
Incontinence Sling Trial	Clinical Investigation or other study of a medical device	Mr Mark Doyle
Survey on the use of ESAs in patients with CKD and cancer	Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology	

Emergency Laparotomy and Frailty- a national multi-centre study of frail older surgical patients undergoing emergency laparotomy (ELF)	Study limited to working with data (specific project only)	Mr Jeremy Wilson
What are the perceptions of orthopaedic nurses on the topic of "do not attempt cardiopulmonary resuscitation" (DNACPR) discussions?	Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology	Charlotte Walker / University of Chester
An explorative study on perceptions of undertaking drugs calculation tests from the prospective of nurses whose first language is not English	Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology	Christinah Makondo / University of Chester
Sleep quality before and after total knee arthoplasty	Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology	Mr Stylianos Papalexandris
Availability of Custom Made Nipple Prosthesis	Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology	Stacey Evans / Cardiff Metropolitan University

In relation to continuing professional development, what educational support is provided within a secondary care northwest hospital trust, for advanced nurse practitioners following completion of medical prescribing course?	Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology	Helen D'Arcy / University of Chester
Early Mobilisation After Thrombolysis: Current UK Physiotherapy Practice and the Perceived Benefits and Harms - An Exploratory Study using Semi-structured Interviews.	Study involving qualitative methods only	Nicola Turner / Cardiff University

APPENDIX 6

Junior doctors supporting research – added to delegation logs between 01/04/2016 – 31/03/2017

Name	Position	Research Title
Dr Debashis Sarkar	Registrar	**ADD ASPIRIN -** A phase III, double blind, placebo controlled, randomised trial assessing the effects of aspirin on disease recurrence and survival after primary therapy in common non-metastatic solid tumours
Dr Lamees Salom	F2, Cardiology	**ARIADNE -** Assessment of real life care-describing European heart failure management
Dr Valerie Gott	Associate Specialist, Stroke	**TARDIS -** Safety and efficacy of intensive versus guideline antiplatelet therapy in high risk patients with recent ischaemic stroke or transient ischaemic attack: a randomised controlled trial
		TICH 2 - Tranexamic acid for IntraCerebral Haemorrhage TICH2
		GLORIA AF - Global Registry on Long-Term Oral Anti-thrombotic Treatment in Patients with Atrial Fibrillation - Feasability Questionnaire
Dr Rachel Tildesley	Registrar, Reproductive Health	**PREGLEM-** A prospective, multi-national, multicentre, non-interventional study to evaluate the long term safety of Esmya, in particular the endometrial safety, and the current prescription and management patterns of Esmya in a long term treatment setting
Miss Caroline Lever	Foot Fellow, Trauma & Orthopaedics	**ATM-** Achilles Tendinopathy Management: A multi-centre placebo controlled randomised controlled trial comparing Platelet Rich Plasma (PRP) to placebo (imitation) injection in adults with Achilles tendon pain.
Mr Joseph	Academic Fellow, Trauma &	

Alsousou	Orthopaedics	
Mr Ashtin Doorgakant	Registrar, Trauma & Orthopaedics	
Dr Imna Rahiman	Registrar, Rheumatology	**M13 542-** Phase 3 ABT-494 study in Mod/Severe RA with Bio-IR
		CNT01275- A Phase 3, Multicentre, Randomised, Double-blind, Placebo-controlled Study Evaluating the Efficacy and Safety of Ustekinumab in the Treatment of Anti-TNFα Refractory Subjects With Active Radiographic Axial Spondyloarthritis

APPENDIX 7

Trust Publications (see inclusion criteria in Library section 7)

Title of article	**Citation**	**Author**
A retrospective study of seven-day consultant working: reductions in mortality and length of stay	The Journal of the Royal College of Physicians of Edinburgh. 2015, 45(4), 261-7	Leong KS, Titman A, Brown M, Powell R, Moore E, Bowen-Jones D
An ethical dilemma: malignant melanoma in a 51-year-old patient awaiting simultaneous kidney and pancreas transplantation for type 1 diabetes	The British Journal of Dermatology. 2016, 175(1), 172-4	Kirby LC, Banerjee A, Augustine T, Douglas JF
Atypical Chronic Ankle Instability in a Paediatric Population Secondary to Distal Fibula Avulsion Fracture Non-union	The Journal of Foot & Ankle Surgery. 2016 Jun 14 (epub)	El Ashry SR, El Gamal TA, Platt SR
Changes to the law on consent following Montgomery vs	British Journal of Hospital Medicine.	Clearkin L

Lanarkshire Health Board	2016, 77(6), 355-7	
Critical care in the Emergency Department: organ donation	Emergency Medicine Journal. 2016 Aug 18	Gardiner DC, Nee MS, Wootten AE, Andrews FJ, Bonney SC, Nee PA
Diagnostic Imaging of Diabetic Foot Disorders	Foot and Ankle International. 2016 Oct 12	Peterson N, Widnall J, Evans P, Jackson G, Platt S
Endometriosis of the liver	British Journal of Hospital Medicine. 2016, 77(5), 310-1	Adishesh M, Hawarden A, Rowlands D
Functional Connectivity with the Default Mode Network Is Altered in Fibromyalgia Patients	PloS one 2016, 11(7)	Fallon N, Chiu Y, Nurmikko T, Stancak A
Helping parents / carers to give medicines to children in hospital	Archives of disease in childhood. 2016, 101(9), e2	Williams L, Caldwell N, Collins E
Initial UK experience with transversus abdominis muscle release for posterior components separation in abdominal wall reconstruction of large or complex ventral hernias: a combined approach by general and plastic surgeons	Annals of the Royal College of Surgeons of England. 2016 Aug 11:1-6	Appleton ND, Anderson KD, Hancock K, Scott MH, Walsh CJ
Laparoscopic Management of a Ruptured Interstitial Pregnancy Associated With Massive Haemoperitoneum and History of Ipsilateral Salpingectomy	Journal of minimally invasive gynecology. 2015, 22(6S), S147	Minas V, Ashraf K
Nomograms for calculating drug doses in obese adults	Anaesthesia. 2016, 71(8), 977-8	Callaghan LC, Walker JD, Williams DJ

On-scene treatment of spinal injuries in motor sports	European Journal of Trauma and Emergency Surgery. 2016 Dec 22	Kreinest M, Scholz M, Trafford P
Peritoneal amyloidosis with myopathy in primary systemic (AL) amyloidosis	BMJ Case Reports. 2017 Feb 10	Al-Adhami A, Steiner K, Ellis S
Rare case of gallbladder agenesis presenting with pancreatitis	BMJ Case Reports. 2016, Aug 8.	Thornton L, Goh YL, Lipton M, Masters A
Robotic gynaecologic surgery: a tool or a toy?	BJOG. 2017, 124(2), 344	Minas V
Scaling Hemodialysis Target Dose to Reflect Body Surface Area, Metabolic Activity, and Protein Catabolic Rate: A Prospective, Cross-sectional Study	American Journal of Kidney Diseases. 2016 Sep 20.	Sridharan S, Vilar E, Davenport A, Ashman N, Almond M, Banerjee A, Roberts J, Farrington K
Screening for cardiovascular risk factors in patients admitted for acute coronary syndrome	International Journal of Clinical Practice. 2014, 68(7), 929-30	Banerjee M, White A, Pearson R, Balafsan T, Hama S, Yadav R, France M, Kwok S, Younis N, Soran H
Severe co-trimoxazole-induced hypoglycaemia in a patient with microscopic polyangiitis	BMJ Case Reports. 2017 Mar 16	Conley TE, Mohiuddin A, Naz N
Skin lesions in calciphylaxis	British Journal of Hospital Medicine. 2016, 77(6), 371	Kirby LC, Abdulnabi K
Specific mutations in KRAS codon 12 are associated with worse overall survival in patients with advanced and recurrent colorectal cancer	British Journal of Cancer. 2017, Feb 16	Jones RP, Sutton PA, Evans JP, Clifford R, McAvoy A, Lewis J, Rousseau A, Mountford R, McWhirter D, Malik HZ

The current status of prophylactic femoral intramedullary nailing for metastatic cancer	Ecancermedicalscience. 2016 Dec 1	Ormsby NM, Leong WY, Wong W, Hughes HE, Swaminathan V
The Introduction of "Mini-Touch" Microwave Endometrial Ablation in an Outpatient Setting in a UK District General Hospital	Journal of minimally invasive gynecology. 2015, 22(6S), S225-S226	Alam MA, Steele G, Jones KE
The UK Neovascular AMD Database Report 3: inter-centre variation in visual acuity outcomes and establishing real-world measures of care	Eye. 2016, Jul 15	Liew G, Lee AY, Zarranz-Ventura J, Stratton I, Bunce C, Chakravarthy U, Lee CS, Keane PA, Sim DA, Akerele T, McKibbin M, Downey L, Natha S, Bailey C, Khan R, Antcliff R, Armstrong S, Varma A, Kumar V, Tsaloumas M, Mandal K, Egan C, Johnston RL, Tufail A
The United Kingdom Diabetic Retinopathy Electronic Medical Record Users Group, Report 1: baseline characteristics and visual acuity outcomes in eyes treated with intravitreal injections of ranibizumab for diabetic macular oedema	The British Journal of Ophthalmology, 2017, 101(1), 75-80	Egan C, Zhu H, Lee A, Sim D, Mitry D, Bailey C, Johnston R, Chakravarthy U, Denniston A, Tufail A, Khan R, Mahmood S, Menon G, Akerele T, Downey L, McKibbin M, Varma A, Lobo A, Wilkinson E, Fitt A, Brand C, Tsaloumas M, Mandal K, Kumar V, Natha S, Crabb D, UK AMD and DR EMR Users Group

Wirral University Teaching Hospital

NHS Foundation Trust

Arrowe Park Hospital, Wirral, CH49 5PE

wuth.nhs.uk

Board of Directors	
Agenda Item	7.3
Title of Report	Safeguarding Annual Report
Date of Meeting	26 July 2017
Author	Susan Fogarty – Head of Safeguarding
Accountable Executive	Gaynor Westray – Director of Nursing and Midwifery
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	1, 2
Level of Assurance **Positive** **Gap(s)**	Positive – Protecting Vulnerable People Training strategy meets statutory guidance launched September 2016 Gap – Protecting Vulnerable People Training Compliance continues to increase, however not in line with the 8% predicted trajectory to ensure the Trust reaches 95% compliance by end of September 2017. Lack of assurance of staff knowledge and completion of Mental Capacity Assessments
Purpose of the Paper **Discussion** **Approval** **To Note**	Discussion and approval
Reviewed by Executive Committee	Quality and Safety Committee – 12 July 2017
Data Quality Rating	Silver
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken **Yes** **No**	No

1. Executive Summary

This annual report provides a summary of key issues and safeguarding activity in relation to the Wirral University Teaching Hospital (WUTH) Safeguarding Team during 2016/17. It provides assurance to the Board of Directors and external agencies that evidences how WUTH discharges its statutory duties in relation to safeguarding children and young people, Children Looked After and Adults at risk of compliance with statutory and contractual requirements, national and local safeguarding guidance.

The Trust recognises that safeguarding is integral part of its core business. The Safeguarding Annual Report (Appendix 1) sets out how the Trust remains committed to provision of the highest standards to ensure effective patient care which in relation to safeguarding requires the Trust provide a safe environment to protect patients from harm and the knowledge that its workforce are aware of their roles and responsibilities in respect of safeguarding.

The Annual Report provides an update following the launch of the Protecting Vulnerable People Strategy in September 2016. This followed a fundamental review of safeguarding training which was undertaken in May 2016 to ensure that the workforce was equipped with the correct level of knowledge, skills and competencies to protect service users from harm and abuse.

The Annual Report provides evidence which demonstrates that safeguarding is firmly embedded as a priority across all service areas. The report also includes an update in respect of Trust compliance with the application of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) as well as assurance in relation to risk management, activity, compliance with standards and safeguarding governance.

The Board of Directors is asked to receive and approve the Safeguarding Annual Report for 2016/17.

2. Background

The Annual Report provides a summary of the key issues, activity and performance of the Safeguarding Team, and the wider Trust, during 2016/17 in order to evidence to the Board of Directors and external agencies how WUTH discharges its statutory duties in respect of the below legislation:

- Statutory requirement under Section 11 of the Children Act (1984, 2004) to safeguard and protect children and families who access care.
- Safeguarding Vulnerable Adults in line with Care Act 2014.
- Mental Capacity Act 2005 and Deprivation of Liberty Safeguards amended in 2007.
- Working Together to Safeguard Children (2015).

- Policies and Procedures of Local Safeguarding Children Board.
- CQC Regulation 13: Safeguarding service users from abuse and improper treatment.
- CQC Regulation 12: Safe care and treatment.
- Looked After Children: Knowledge, skills and competences of health care staff (Intercollegiate Role Framework March 2015).

3. Key Issues/Gaps in Assurance

3.1 Protecting Vulnerable People Training

In May 2016 a review of safeguarding training was undertaken to measure compliance against safeguarding measures to ensure that the Trust and its staff are fully equipped with the skills and competencies to protect all users from harm and abuse, and to ensure it is meeting the required legislation standards.

The Trust launched its Protecting Vulnerable People (PVP) Training Strategy on 30 September 2016 which will provide assurance that all staff have received, or are scheduled to receive, the appropriate level of training. This is monitored by Learning and Development and data evaluations from training to Safeguarding Strategic Team.

The Trust Workforce and Communications Group approved the proposal in July 2016 which recommended that staff would have until September 2017 to attend the Protecting Vulnerable People training. Performance against the training compliance trajectory for PVP is reported as part of the monthly Trust Mandatory Training reports. From September 2017 the formal reporting of this subject will commence against the Trusts agreed key performance indicator of 95%. The following Annual Report provides an update in respect of the Trust's current compliance for each level of training against the planned trajectory, which has been calculated in order to reach full compliance by the end of September 2017. Failure to demonstrate compliance within the required timescales may result in the Trust breaching CQC Regulation 13 - Safeguarding service users from abuse and proper treatment. A breach could result in enforcement by the regulator.

Progress against compliance trajectories is reported on a monthly basis to the Clinical Divisions and Corporate Services alongside their mandatory training compliance data to enable senior managers to monitor and action training plans in order to improve compliance with PVP training in line with the Trust plan.

PVP training is also monitored internally via the Safeguarding Strategic Team and Trust Risk Register as well as being subject to external scrutiny via the Clinical Governance and Clinical Commissioning Group via the Safeguarding Assurance Framework.

3.2 Lack of assurance in the knowledge and completion of Mental Capacity Assessments

The Safeguarding Team has identified a lack of awareness and knowledge from the workforce, specifically in relation to the completion of Deprivation of Liberty. This is also evidenced within Serious Incident Review Group following Root Cause Analysis.

MCA and DoLs training is included as part of PVP training in order to improve knowledge in line with current guidance. The monthly 'Little Gem' newsletter is cascaded within clinical areas and the NHS Safeguarding booklet, which includes information on MCA and DoLs, has been issued to all staff within the Trust. The Trust also utilises "Safely Does It" articles which are drafted following on from Root Cause Analysis in order to effectively disseminate shared learning recommendations relating to MCA.

To ensure that all areas of the organisation receive relevant and effective MCA and DoLs training, the Safeguarding Team continue to offer bespoke training sessions to specific areas where training or process gaps have been identified.

Staff knowledge within the MCA arena, for Deprivation of Liberty has been added to the Trust risk register and monitored by Clinical Governance Group.

To provide assurance to the Board that the workforce have the correct knowledge and skills required to undertake and document MCA, the safeguarding team has plans to develop quarterly audits of completed Mental Capacity Assessments, which have been undertaken by staff. This will assess staffs knowledge within the MCA arena and identify any gaps through quality assurance of MCA. Areas identified as good practice and areas requiring improvement will be identified allowing the Trust to apply focused improvements and good practice recognition.

4. Next Steps

The key next steps for 2017/18 are:

- Ensure that PVP training reaches 95% compliance by September 2017.
- Further embed MCA/DoLs awareness and processes throughout the Trust.
- Continue to promote safeguarding as a responsibility of all Trust staff to safeguard all patients and staff.

5. Conclusion

Safeguarding children and adults at risk continues to have a high profile within the Trust. Although robust safeguarding structures and processes are embedded in Everyday practice across the Trust and it remains key that the Trust meet its statutory requirements and continue to safeguard its most vulnerable patients.

6. Recommendations

The Board of Directors are requested:

- To approve the report for information and assurance.
- Consider whether there are any areas within the Annual Report which require further assurance.

Appendix 1

Safeguarding Annual Report - 2016/2017

Key Facts

3833 Causes for concern referrals responded to by Safeguarding Team

302 Maternity causes for concern responded to – increase 21%

798 Adult cases for concern responded to – 9% increase

1989 Safeguarding Children causes for concern responded to – 43 % increase

447 Domestic Abuse causes for concern responded to – 2% increase

297 Deprivation of Liberty Safeguard referrals received – 16% increase

156 Deprivation of Liberty Safeguard applications made – 29% increase

Development of Wirral Pre Birth Liaison Group

36 Trust staff trained as Common Assessment Framework (CAF) Champions by the Safeguarding Children Board

Launch of Protecting Vulnerable People Training Strategy in September 2016 incorporating Children, Adults, Domestic Abuse, Child Sexual Exploitation, Harmful Practices, FGM, Mental Capacity and Deprivation of Liberty Safeguards, Modern Slavery and the PREVENT agenda

Protecting Vulnerable People training evaluation data

Monthly Safeguarding Little Gems published to enhance staff knowledge and development

100% Named Professionals receiving Safeguarding Supervision

Mental Capacity Assessment tool is now embedded within Cerner Millennium

Both adult and children "Referrals into the Social Care" have been developed and embedded into Cerner Millennium

Contents:

Appendices:

Patient Focus **R**esponsibility **O**wnership **U**nity **D**edication

1. Introduction

Safeguarding is a shared responsibility with the need for effective joint working between partner agencies and professionals that have different roles. In order to achieve effective joint working there must be constructive relationships at all levels, promoted and supported by:

- The commitment of senior managers and board members to safeguarding children and adults at risk
- Clear lines of accountability within the organisation for work on safeguarding
- Service developments that take account of the need to safeguard all service users, and is informed, where appropriate, by the views of service users
- Safeguarding training and continuing professional development so that staff have an understanding of their roles and responsibilities, and those of other professionals and organisations in relation to children, adults and looked after children
- Safe working practices including recruitment and vetting procedures
- Effective interagency working, including effective information sharing.

The report provides evidence that safeguarding is firmly embedded as a priority across all service areas. Safeguarding children and adults at risk is core to the business of Wirral University Teaching Hospital and is embedded in the Trust Nursing and Midwifery Strategy 2016-2018.

The Trust is committed to safeguarding and this is evident from “Ward to Board” with strong culture of safeguarding vulnerable patients of any age that come into contact of our services, either as patients, carers, staff or members of the public.

As outlined in the Safeguarding Strategy 2015-2017 “Safeguarding is everyone’s responsibility” and reflects the “One chance Rule is embedded in all divisions across the Trust. Discharging safeguarding duties effectively is based upon five key priority outcomes within the strategy. The priorities defined by the local children and adult safeguarding boards.

The key priorities and objectives are:

- Domestic Abuse, Neglect, Child Sexual Exploitation, Early Help and Mental Capacity Assessment and Deprivation of Liberty
- Effective safeguarding, leadership, structure and processes
- Learning and improvement through experience, audit and partnership working
- Continuing the development of a caring, safe and effective workforce including compliance with Protecting Vulnerable People Training Strategy
- Engaging with service users and external agencies

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

2. Safeguarding Leadership and Accountability

The structure provides clear lines of accountability and governance within the Trust. In addition the Safeguarding Strategic Team, which reports into the Clinical Governance Group, provides external scrutiny from the Designated Professionals to whom the Trust provides evidence of compliance within the statutory and contractual framework. This provides assurance for Safeguarding Children and Adults at Risk within the Trust.

The report will cover how the Trust has responded to the ever changing safeguarding agenda at a Trust Wide level, then focus on how the Trust has discharged its statutory functions. Section 11 of the Children Act 2004 outlines the requirement for a clear line of accountability within NHS organisations in respect of safeguarding, thus promoting the welfare of children and young people is embedded within the organisation. The NHS Safeguarding and Accountability Assurance Framework support this requirement have extended it to include adults at Risk.

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

Mrs. Gaynor Westray, Director of Nursing and Midwifery has Executive Responsibility for Safeguarding in her portfolio and are supported by highly dedicated and motivated safeguarding team.

The Head of Safeguarding who takes strategic responsibility to ensure governance systems and maintaining organisation focus on safeguarding. The Team consists of:

- Head of Safeguarding/Named Nurse for Safeguarding Children and Young People 1.0 WTE
- Named Midwife 0.4WTE
- Named Nurse for Adults at Risk & Mental Capacity Act/Deprivation of Liberty Safeguards 1.0 WTE
- Lead Specialist Nurse for Domestic Abuse, Female Genital Mutilation (FGM), Forced Marriage (FM), Honor Based Violence (HBV) 1.0 WTE
- Safeguarding Practitioner for Children and Young People 1.0 WTE
    - Safeguarding practitioner for Adults at Risk1.0 WTE
    - Safeguarding Practitioner 1.0 WTE
    - Safeguarding Administration 1.0 WTE

The Team is supported internally by:

- Named Doctor for Safeguarding Children and from July 2017 the Trust will be appointing a Named Doctor for Children Looked After.

The Named professionals have a key role in promoting good professional practice within the Trust, providing advice and expertise for fellow professionals and undertake duties to safeguard children and adults in line with the guidance and legislation (Working Together 2015 and the Care Act 2014).

Safeguarding activity across the Trust continues to increase in volume and complexity. Causes for concern are recognised more frequently across clinical areas causing additional pressures within the team. The Director of Nursing has agreed to recruit a further Safeguarding Practitioner in a secondment role for a period of six months. This will then be reviewed and a business case will be submitted to secure funding for a permanent position.

Due to the increase in data collection, assurance and audit the team is supported by further administration support. This was identified in MIAA report during 2015. The Director of Nursing has agreed to recruit a further support in a secondment role for a period of six months. This will then be reviewed and a business case will be submitted to secure funding for a permanent position.

The Named professionals have a key role in ensuring a safeguarding training strategy is in place and delivered across the organsiation. They lead on safeguarding audits, carrying out regular audits focusing on process and outcomes.

3. Safeguarding Governance Arrangements and Assurance

The Safeguarding service is required to evidence assurance and compliance through various domains, nationally and locally.

3.1 Safeguarding Strategic Team (SST)

This forum is chaired by the Director of Nursing and Midwifery and held quarterly. This enables Named Professionals from the Safeguarding Team, alongside the Named Doctor for Safeguarding to meet with Designated Health Professionals from the Clinical Commissioning Group who provide scrutiny and oversight of the Trust's compliance with safeguarding standards, including the Safeguarding Assurance Framework.

Terms of reference outlined below have been reviewed and key areas have been identified:

- To ensure that safeguarding is at the forefront of service planning
- To provide assurance in respect of safeguarding all vulnerable people

- To ensure that the agreed systems, standards, protocols are in place to effectively work together within a clear framework of managerial supervision and multi-agency procedures

- To ensure that concerns related to safeguarding are escalated appropriately and in a timely manner

- Contracts and service specifications, including Safeguarding Assessment Framework which has a red, amber, green rated audit tool is completed and subsequent action plan formulated. To ensure the Trust meets its statutory requirements in relation to Safeguarding Boards Section 11 audit.

- To monitor and review action plans, and audit tools

- To monitor compliance in Protecting Vulnerable People Training including MCA

The Wirral Pre Birth Liaison Group from Women's Services and the Emergency Department Safeguarding Meeting provide assurance into the Safeguarding Strategic Team of the effectiveness of safeguarding, within those key areas.

3.2 Quarterly Safeguarding Performance Report presented at Clinical Governance Group

A quarterly Safeguarding Performance Report is presented and discussed at Clinical Governance Group which is accountable for overseeing the Trust's responsibilities to the adult and children safeguarding agenda (including Children Looked After and Domestic Abuse). Any areas of concern are escalated by the Director of Nursing to Quality and Safety Committee.

3.3 – Quarterly Safeguarding Assurance Frameworks for Children, Adults and Children Looked after presented at Quality Contract Meeting

The safeguarding team submits a quarterly Safeguarding Performance Report which includes the Safeguarding Assurance Framework Data with key performance indicators are monitored by the Designated Health Professionals. The Safeguarding Assurance Framework is embedded within the WUTH Quality Schedule and is submitted as part of the Trusts Quarterly contractual assurance.

3.4 Section 11 Audits – Self Assessment against Commissioned Service Standards for Safeguarding and Children and Adults at Risk

The Safeguarding Board Section 11 of the Children Act 2004 outlines to all agencies who deliver services to children, young people under the age of 18 are required to assure the Safeguarding Board that they have effective arrangements in place to safeguard and promote the welfare of children and young people.

The annual self- assessment audit in now embedded within the Section 11 audit which provides a self-assessment of arrangements provided to safeguard all vulnerable people within their organisation and the effectiveness of safeguarding arrangements across the partnership. The assessment tool is Rag rated - Red, Amber Green against all standards which is monitored by the Designated Nurse in the CCG who establishes a baseline against the standards and the action plan is then monitored via the Safeguarding Strategic Team. Areas of concern are escalated to Clinical Governance Group.

The Trust completed the Section 11 audit tool within expected timescale. The following actions were generated and monitored via an action plan with timescales.

- 10 standards of which there were 99 key indicators
- 75 – GREEN
- 19 AMBER
- 5 not applicable to the Trust
- 0- RED.

The 19 AMBER rated standards have been included into an improvement plan – 13 were related to Children Looked After and agreed actions with the Designated Nurse for Children Looked After are currently being implemented.

3.5 Merseyside Internal Audit (MIAA)

In May 2016 – MIAA undertook review of the arrangements for Safeguarding Children and Adults within the Trust. The outcome of the report is of **Significant Assurance**. This level of assurance reflects improvements made to the safeguarding service since 2014.

3.6 Safeguarding Incident Reporting

Safeguarding incident referrals are now integrated into the Trust Safeguard database to record all safeguarding incidents. The system automatically raises the issue of an incident. Following receipt of the incident documentation received by the Safeguarding Team, it is recorded in Cerner Millennium system to ensure all staff has access to all safeguarding information.

The Safeguard system then automatically reports relevant safeguarding incidents to the National Reporting and Learning System (NRLS).
Any escalations are alerted to Clinical Commissioning Group and Care Quality Commission as required.

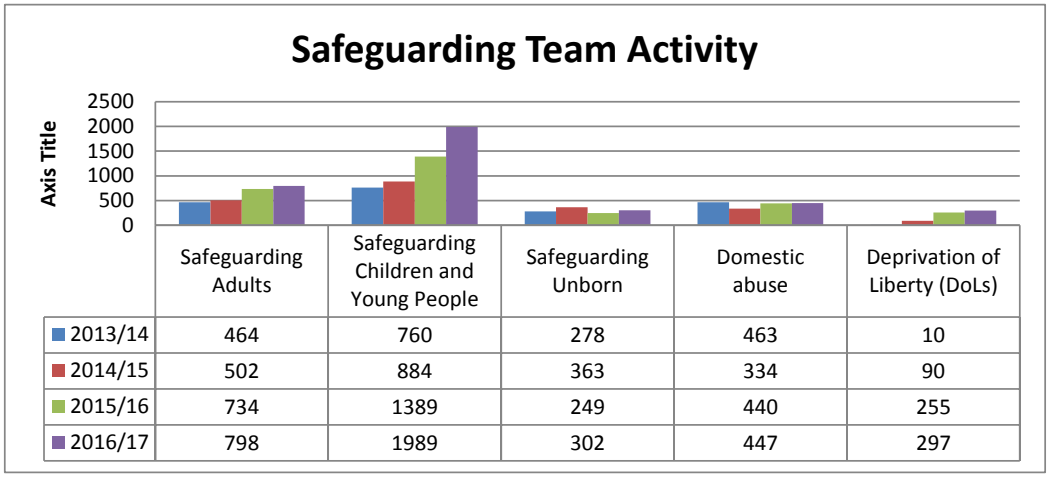
The Trust has escalated four serious incidents of children and adults.

3.7 Safeguarding Team Activity and Performance

During April 2016 to March 2017, the Safeguarding Team has seen an overall general increase in activity and complexity.

Table 1 below details the activities and compares this with the activity of previous years.

The increase in referrals can also be attributed to rise in awareness of safeguarding since the implementation of the Protecting Vulnerable People Training Strategy which outlines that safeguarding is "Everybody's Business" and promotes the "One Chance Rule". Workforce is becoming more autonomous in acknowledging their roles and responsibilities in the safeguarding arena and has a greater awareness of their training responsibility.



	Safeguarding Adults	Safeguarding Children and Young People	Safeguarding Unborn	Domestic abuse	Deprivation of Liberty (DoLs)
2013/14	464	760	278	463	10
2014/15	502	884	363	334	90
2015/16	734	1389	249	440	255
2016/17	798	1989	302	447	297

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

Currently on Wirral, the threshold has been met for a Serious Case Review (SCR). Frontline and managerial meetings have been held with multiagency partners regarding a young person. The independent reviewer has completed her initial draft and once finalised will then be shared with the Safeguarding Board and partner agencies. Subsequent action plan will be developed and monitored externally by the Safeguarding Board and any WUTH actions will be monitored by the Safeguarding Strategic Group.

Two further cases did not meet the threshold for SCR and a Multi-Agency Review has been completed with practitioners and their managers which identified key lines of enquiry. The reviewer is currently compiling her report and the Trust will monitor any subsequent recommendations via the Trust Safeguarding Strategic Group (SSG)

There has also been a Single Agency Health Review, the reviewers have met with practitioners and the Trust is awaiting the final report. Any subsequent recommendations will be monitored via the Trust SSG

There have been no Serious Case Reviews for adults in this period; however three cases were discussed for consideration at Serious Case Review sub group: two of these have subsequently been escalated to LSAB for consideration.

There have been no Domestic Homicide Reviews or OFSTED inspections during 2016-2017.

3.9 Inspections/Reviews

There has been no internal inspection or reviews within the last year. WUTH have been represented at a Reflective review with Knowsley Safeguarding Board following the death of a child. A multi-agency review meeting was held as this case did not meet the threshold for a Serious Case Review.
The Trust is awaiting the recommendations/learning points which will strengthen multi-agency systems and processes to protect children.

4. Partnership Working

Wirral University Teaching Hospital is a key partner agency in the safeguarding arena on Wirral. This is achieved through:

- Membership of Safeguarding Children and Adult Boards

- Active contribution to:
  - Serious Case Reviews (adults and children)
  - Multi agency and single agency reviews
  - Domestic Abuse – Fast task Meetings
  - Domestic Homicide reviews

  - Bi monthly attendance at Multi Agency Risk Assessment Conferences (MARAC) – sharing appropriate information and ensuring actions are subsequently completed and relevant flag is uploaded onto Cerner Millennium

  - Bi monthly attendance at Multi Agency Child Sexual Exploitation (MASCE) meetings - sharing appropriate information and ensuring actions are subsequently completed and relevant flag is uploaded onto Cerner Millennium

  - Submit mandatory reporting into the CCG supporting the PREVENT agenda

  - Participates in multi-agency audit with Safeguarding Children Board

  - Providing data to Board via Safeguarding Dataset.

- Quarterly attendance at Wirral Safeguarding Children Forum. The meeting is chaired by Designated Doctor and Nurse for Wirral and is attended by partner agencies within the health economy of Wirral.

In July 2016 OFSTED carried out a single agency inspection of Wirral Local Authority and also reviewed the effectiveness of the Safeguarding Children Board. The inspection report was published in September and the Judgement was that both the Board and Children's services were rated inadequate.

Recommendations for the authority and the Board were made and have developed an improvement plan with clear actions and intended outcomes which will be closely monitored by OFSTED by quarterly monitoring visits.

Director of Nursing and Head of Safeguarding from WUTH have attended improvement meetings alongside other partner agencies to meet with the Department of Education to discuss progress made against recommendations

In supporting partnership working the Trust Safeguarding Team members participate in various multi-agency forums and delegates from the Trust attend.

Forum	Responsibility
WSCB	Director of Nursing & Midwifery
Serious Case Review	Named Nurse Adults at Risk
Improving Outcomes Meeting	Head of Safeguarding/Named Nurse for Safeguarding Children & Young People
Learning & Development	Safeguarding Practitioner
Performance	Head of Safeguarding
Child Sexual Exploitation Committee	Head of Safeguarding/Named Nurse
Communications	Named Nurse Adults at Risk
Domestic Abuse	Specialist for Domestic Abuse
Wirral MARAC Steering Group	Head of Safeguarding
Wirral Health Safeguarding Children Forum	Head of Safeguarding/Named Midwife and Specialist in Domestic Abuse

5. Children and Young People Safeguarding Liaison /Child Death Overview Panel (CEDOP)

The post holder assists in the effective discharge of health economy duties in relation to sharing information of attendances within the Emergency Department and participates in the national requirements regarding Child Death Overview Panel process. Within WUTH, this has been embedded into the role of the Children and Young

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

There have been thirty four child deaths in Wirral during2013-2017. Seven of these were Sudden Unexpected Death of Child (SUDiC's). All of the deaths were reviewed at the Merseyside Child Death Overview Panel.

6. Safeguarding Supervision and Support

The Trust is required to provide safeguarding supervision to all health practitioners who case load safeguarding cases. The Safeguarding Supervision, states that safeguarding supervision is offered to all professionals who hold a caseload with safeguarding children concerns, and staff/departments that have direct involvement with safeguarding children and young people cases.

Following recommendations from the Care Act 2014, the policy has been amended to include practitioners who support adults. Safeguarding Supervision is provided by members of the Safeguarding Team who have undertaken the accredited NSPCC Safeguarding Supervisors course.

The Trust has **20** Safeguarding Supervisors who ensure that all staff who case load receive quarterly safeguarding supervision apart from midwifery colleagues. The Trust has made decision that midwifery colleagues receive safeguarding supervision six weekly, due to the potential escalation of safeguarding concerns which may occur within the pregnancy.

As part of the Safeguarding Assurance Framework, a KPI is that staffs who require safeguarding supervision are receiving supervision in accordance with policy and national guidance. This data is collated quarterly and is provided to the CCG. During Quarter 3 and 4 respectively, the Trust has ensured that 94% and 97.5% of staffs have received supervision which is above the KPI of 90%.

As nine midwives have received the NSPCC safeguarding supervision training, the supervision of the safeguarding case loading midwives is within their remit. The Named Midwife, Specialist Lead for Domestic Abuse will then supervise the nine midwives in accordance with guidance.

The Named Nurse for Safeguarding Children has previously provided group supervision for all Emergency Department (ED) staff and this will now be undertaken by the Children and Young People Safeguarding Liaison Manager.

Moving forward he Trust will ensure that group supervision for acute services and paediatric wards will be completed on an informal basis due to the fact that staffs do not carry caseload.

Funding to train a further **3** members of the safeguarding team to undertake the NSPCC Safeguarding Supervision training in July 2017.

The Named Nurse, Named Midwife, Named Nurse for Adults at Risk, and Named Doctors all access safeguarding supervision from Designated Nurses and Doctor.

7. Safe Recruitment and Vetting Procedures

Following the publication of the Lampard report 2015 into lessons learnt in the aftermath of Jimmy Saville, the Trust has considered changing the DBS frequency to three years.

The Trust reviewed these arrangements through the Senior Management Team and concluded that this Trust would remain consistent with other Trust's in the region which means that we will not introduce the undertaking of 3 yearly DBS checks. The Trust will however amend our HR policies to ensure that all staff are clear as to the need to self-declare should they have any criminal convictions, we will also commit to undertaking annual communications to ensure staff are clear of this requirement.

8. Child Protection Information Sharing

Child Protection - Information Sharing (CP-IS) project is an NHS Digital sponsored work programme dedication to developing an information sharing solution that will deliver a higher level of protection to children who attend NHS unscheduled care settings.

WUTH has previously signed a letter of agreement and acceptance, which has been acknowledged as a commitment to CP-IS implementation within the Trust.

The information sharing focuses on three specific categories of child:

- Children on Child Protection Plan
- Children with Looked after status (children with full care orders and voluntary care agreements)
- Pregnant women whose unborn child has a pre-birth protection plan

Several meetings have taken place to implement the CP-IS on Wirral. There is overall general consensus to implement child protection information sharing within each health organisation and the local authority, however it was also recognised that there remains a number of barriers were assistance is needed to help progress this programme of work.

Further meetings to be scheduled by NHS Digital on Wirral to progress this project on Wirral.
From a Trust perspective, identified leads from Safeguarding and informatics have been identified. Cerner Millennium is expected to have their CP-IS functionality available in January 2018, however the Trust is scoping into the feasibility of full connection to the spine with no final decision on timescales.

WUTH have worked proactively to ensure all children on Child Protection Plans and Children Looked After are flagged on the Trust IT systems. The CP-IS project will complement and enhance current processes in place.

9. Risk Register

Current identified risks on the Trust risk register March 2017:

Regulation 13 –Safeguarding service users from abuse and proper treatment Safeguarding training did not meet the requirements of Royal Children's Paediatric Child Health Guidance. (RPCG 2014) 2016

Wirral University Teaching Hospital commenced a review of its safeguarding programs to ensure that the Trust and its staff are fully equipped with the skills and competencies to protect all users from harm and abuse, and to ensure it is meeting the required legislation standards.

The Trust has launched Protecting Vulnerable People Training Strategy on 30th September 2016 which will provide assurance that all staff receives the appropriate level of training.

The Trust approved that staff would have until September 2017 to attend the Protecting Vulnerable People training, with a working towards compliance figures reported as part of the monthly Trust mandatory Training reports. From September 2017 the formal reporting of this subject will commence in line with the Trusts KPI of 95%.

The Trust may be at risk of illegally depriving patients of their liberty when urgent/extended urgent authorisations expire. This is due to failure/delay of the local authority (supervisory body) completing granted or not granted authorisations following the application by WUTH within timescales.

The Trust continually provide care to patients to ensure they are being cared for in their best interests as per MCA 2005 whilst awaiting authorization from the supervisory body

Safeguard board are fully aware of the risk. This risk is monitored via the Safeguarding Assurance Framework to the Clinical Commissioning Group.

There is a lack of knowledge on the application of DoLs and MCA

The Trust may be at risk of breaching outcome 7 of the CQC standard leading to potential damage The Trust may unlawfully detain patients due to Mental Capacity Assessments being completed in a timely manner, therefore application for Deprivation of Liberty cannot be completed by the Safeguarding team.

The Trust has included MCA/DoLs within the Protecting Vulnerable People training strategy which included the knowledge and skills to undertake Mental Capacity Assessments. Compliance is being monitored via monthly completion reports.

Safeguarding team undertake daily visibility walkabouts to all areas across the Trust to support and guide staff to enhance their knowledge in relation to MCA.

All staff have been provided the NHS England Safeguarding booklet which included MCA guidance. Safeguarding newsletter – Little Gem dedicated for MCA and DoLs and a "Safely Does It" article which has been cascaded to clinical areas.

The Trust not routinely screening for Female Genital Mutilation (FGM) apart from maternity services

Acute Trusts have a mandatory duty to report known cases of FGM, as routine screening is not undertaken throughout key areas within the Trust there may be gaps in reporting this data to NHS Digital.

Further developments with Cerner Millennium to introduce key screening questions with identified areas.

10. Women's and Children's services

Maternity services within the Trust have provided care for **3211** women delivering at between April 2016 and March 2017.

Midwives provide a process of care which allows early identification of potential safeguarding causes for concern. Multi agency working remains high priority within the Trust ensuring mothers and babies are safeguarded throughout their pregnancy and post-natal period.

302 cases that have supplementary safeguarding cause for concern provided has provided further operational challenges for the Directorate. Causes for concern arise from working with a wide variety of services and agencies including Children's Social Care, social workers, health visitors and others. As such, multi-agency safeguarding for maternity services remains a key priority to promote the health and wellbeing of women, their babies and their families.

Midwives are now being empowered to take responsibility for managing safeguarding cases in line with national and local policies and procedures. The number and complexity of referrals is increasing particularly for families with previous involvement with the local authority, domestic abuse, drug and alcohol use and mental health issues and as such safeguarding is becoming increasingly challenging.

The Trust has a Named Midwife has brought extensive knowledge and skills who will be able to strengthen the strategic aspect of the role within the

Trust and has taken the lead in the safeguarding of vulnerable women and babies and is working closely with partner agencies to ensure a co-ordinated approach which meets local and national targets. The Named Midwife and safeguarding practitioner work closely with Substance Misuse Midwife, Teenage Pregnancy Midwife and Perinatal Mental Health Midwife team due to the high level of safeguarding issues with these cases.

10.1 New developments in maternity:

Following on from the launch of the Wirral Safeguarding Children Board Threshold Document in 2016, which outlines that all vulnerable unborn and children receive the Right level of support at the Right time, discussions were held with the local authority and Wirral University Teaching Hospital to scope the feasibility of launching a Wirral Pre-Birth Group Liaison Meeting. The Head of Safeguarding and Named Midwife for the Trust benchmarked other organisations in the North West and the formation of the Wirral Pre Birth Liaison Group (WPBLG) was formed. Multi-agency meetings were held and Terms of Reference agreed by partner agencies including Multi-Agency Safeguarding Hub (MASH), Wirral Community Trust, Early Help Services, WUTH midwives.

WLPBG is a pathway to share information with consent and knowledge of the client in order to develop a coordinated plan to safeguard children and unborn babies.

The aim of the meeting, held monthly within the Trust is chaired by Named Midwife for Safeguarding Unborn is to ensure that babies are adequately safeguarded, both pre-birth and immediately after birth, by either;

- Level 2 – Additional support when additional needs identified can be met through a single agency response.
- Level 3 – Targeted Support when multiple needs require a multi-agency co-ordinated response with a lead professional or
- Level 4 – Statutory Services when a high level of unmet and complex needs and the unborn is identified as a child in need or risk of suffering significant harm.

Key Achievements

- The development of Wirral Pre-Birth Liaison Group, multi-agency approach in line with WSCB “Right Service Right Time”
- Advances in Cerner Millennium, ensures staff are working from one electronic system to ensure continuity of care and enhances patient journey
- Regular monthly meetings with Named Midwife with Head of Midwifery to identify key themes and ensure all safeguarding processes are embedded to safeguard mothers and babies

- Improved communication between the midwifery services and Safeguarding, including information sharing with Local Authority.
- Empowering Midwives to manage safeguarding cases by developing knowledge and skill base.
- Cerner flagging system for unborns where there are safeguarding concerns.
- WUTH have **36** CAF Champions who have completed multi agency training from the WSCB– **12** from the maternity arena. This in turn will enable them to support their peers when completing CAF/TAF documentation and supporting them as Lead Professionals.
- Reduction in delay of providing early help to families and the unborn through more streamlined process of referral through the WPBLG
- Appropriate feedback from referral due to WPBLG
- Improvement of midwives liaising with Local Authority in relation to Discharge Planning Meetings.
- Improved working relations with Perinatal Mental Health Midwives and Substance Misuse Midwife

What difference has the Wirral Pre-Birth Liaison Group made to the protection of vulnerable women and babies?

Midwives alongside multi-agency partner agencies on Wirral ensure that vulnerable women and unborn are discussed monthly to ensure that they receive the "Right Service at the Right Time"
Due to the number and complexity of referrals is increasing, particularly for families with previous social care involvement, domestic abuse, substance misuse, mental health issues, safeguarding is becoming increasingly challenging.

Challenges/Priorities

•Further develop a comprehensive safeguarding Resource file for all areas within the Trust. This will contain all up to date relevant safeguarding information which will support and enable midwives with correct toolkit to support midwives in discharging their safeguarding responsibility

•Embed the Wirral Pre Birth Liaison Group meeting firmly within the Trust. Discussion surrounding adding Hospital Based Midwife to represent hospital based midwives

•Continue to develop further areas within the Cerner Millennium function to capture data in relation to safeguarding pregnant women and their unborn.

•Quality assure multi-agency birth plans

•To ensure that Key staff are aware of training sessions for 'Safer Families and Enhancing Futures' which will be implemented in October 2017

Strategic Goals

•Establish a live database to include referrals to Local Authority, with the outcome documented and plan for discharge.

•An audit is to be undertaken at six and 12 months since the formation of the Wirral Pre Birth Liaison Meeting to establish the effectiveness and to ensure that patients are receiving the "Right Service at the Right Time" to ensure that pregnant women and unborn are appropriately safeguarded

•Point Prevalence Audits to be undertaken

•Develop a Work Plan highlighting key priorities and objectives for the team

•Further scope of standalone Midwifery Safeguarding Policy

•Ensure appropriate governance and safeguarding processes are established in line with national and local frameworks within their sphere of responsibility

10.2 Safeguarding Children

The Named Nurse for Safeguarding Children continues to deliver a quality service that strives to ensure that every child and young person is provided with safe, high quality car. Flagging system within the health records assists the identification of children and young people who may be vulnerable and need of support, or they are at risk and need to be kept safe.

Key Achievement 2016-2017

- The team actively promotes the voice of the child, act as their advocate and when issues arise with parents or carers that present to the Trust with substance misuse, mental health concerns, the child is also of paramount importance and appropriate referrals are made to MASH for Early Help and Support to be offered**.**
- In response to CQC recommendation the Safeguarding team has now appointed a Registered Children's nurse
- The system for flagging electronic records for all children who are subject to Child Protection Plan and Looked After Children

- The system for flagging electronic records children and young people at risk of Child Sexual Exploitation to enable staff decision making
- Electronic flagging system for children and young people who are discussed at the Multi Agency Child Sexual Exploitation Meeting (MACSE)
- Regular attendance at MACSE meetings (monthly) to remain updated with progress of Vulnerable Children and Young people.
- WUTH have **36** CAF Champions who have completed multi agency training from the WSCB
- Development of Threshold document in ED department to ensure right service at right time in regards to referrals to social care. Including the needs of the adults with children who attend ED.
- Improved training to workforce around challenge/ escalation procedures to Local Authority.
- New PVP training which reflects the requirements of partner agencies. Private Fostering and CLA.
- Improved partnership with Local authority and partner agencies, such as Early Help Team, CAMHS, and Response.
- Continue to participate in SCR around CSE and to disseminate learning to WUTH staff through PVP training, Little Gems and multiagency posters.
- The Safeguarding Children's Policy reviewed and updated.
- Developed excellent relationships with wider areas of women and children's Division including NNU, Gynae Ward, Children's ward, Children' outpatients, CED/PAU.This has led to the uptake of Safeguarding link/ambassadors on each unit to help support staff with ongoing safeguarding issues/processes.
- Improved attendance by medical staff to attend Paediatric Peer review - KPI> 90%. Peer review has also involved staff from ED, wards and clinics to improve learning and reflection.
- Little gems – monthly production to include Safeguarding information in relation to Children and Young people, and to also signpost staff to multiagency teaching to enhance Safeguarding knowledge and development
- Quality assurance "Request for services form" to reduce the number of inappropriate referrals into the Local Authority.
- Visibility walks to all areas by the team to support staff in relation to their safeguarding responsibilities
- Regular Meetings and discussions with Children's ED Liaison manager and attendance at ED meetings to continue to enhance patient experience from admission to discharge.
- Improved communications and relationships with Cheshire Wirral Partnership concerning mental health of parents

Challenges and Priorities

- Increase awareness of MCA and consent for those young people 16 and 17 years old.
- Deliver bespoke training with Safeguarding links/Ambassadors in relation to safeguarding Children and Young people.
- Implementation of the threshold document in ED to improve appropriate referrals to the Local Authority.
- Capture the voice of the child at every opportunity
- Continue to disseminate key messages to raise awareness of CSE
- Implementation Of Child Protection Information Sharing (CP-IS)
- Development of referral process into Children's Liaison team from ED staff for low level concerns in relation to children and young people, to ensure they receive the "Right service at the Right Time"

Strategic Goals 2017 – 2018

- To further embed the service of CAF/TAF champions and Safeguarding Ambassadors.
- To ensure that staff are aware of training sessions for 'Safer Families and Enhancing Futures' which will be implemented in October 2017by the Safeguarding Board.
- Improve quality and accuracy of data management with the introduction of Databases for Children and young people who attend WUTH with safeguarding concerns, those who are discussed at MACSE, 16-19 years and the Unborn.
- Discuss with Pediatric Division in regards to identification and development of a Transitional Champion to bridge the gap for the 16-19 year group transitioning from Paediatric services to Adult services.

11 Safeguarding Adults

Safeguarding adults works to embed the principles of prevention, proportionality, protection, partnership working, empowerment and accountability. This work includes considering not only the individual affected but also embracing the concept of 'Think family' and to identify others who may be at risk. The Safeguarding Adults team consists of a statutory requirement of a Named Nurse for Adults and one safeguarding practitioner, who provide support and advice to the staff within the Trust and external agencies.

Key Achievements

- The safeguarding team saw a 9% increase in referrals for Adults at risk from 737 to 798 in comparison from last year. However not all of those referrals were in relation to true abuse and neglect concerns, however the safeguarding team were able to advise and direct staff to the most appropriate care and professionals and share information where appropriate

- 100% compliance in Named Professionals receiving safeguarding supervision

- The launch of an Adult Multi - Agency referral form for staff to use in WUTH acute care setting – this was launched on FAB change day in October

- Visibility walks to all areas by the team to support staff in relation to their safeguarding responsibilities

- Review of the safeguarding Adults training following the introduction of the intercollegiate document

- Strengthening of multi-agency partnership working introduced monthly meetings with the ALADO (Adults Local Authority Designated Officer) in relation to the management of allegations against Trust staff in line with the Care Act 2014

- Quarter 3 saw the Safeguarding team inclusion within the CLIPPE report to contribute towards the triangulation of themes and trends within the Trust

- Staff engagement development through the use of Safeguarding edition Little GEMS

- The safeguarding team supported the amalgamation of the behavioral management, restraint and mental capacity polices to produce one stand-alone positive handling policy

- The Protecting Vulnerable people strategy for the 1st time made provisions for Modern Slavery. Since this addition the Trust has identified 3 cases of human trafficking

Challenges / Priorities

- Introduce the Multi Agency Adult referral to the main hospital to allow staff to raise own concerns directly with the local authority and utilise the safeguarding team for support and advice.
- Launch safeguarding excellence ward's on each floor with a view to share and roll out good practice throughout the Trust.
- Identification of Safeguarding Ambassadors and provide bespoke single agency training to support all staff within the divisions.
- Complete a stand-alone PREVENT policy.
- Explore further inappropriate safeguarding referrals made by staff regarding care needs Vs abuse and neglect.
- Produce a stand-alone policy for Managing Allegations against staff.
- Introduce and provide good practice recognition cards to staff in relation to safeguarding work

Strategic Goals

- Looking forwards the team will continue to ensure that through Protecting Vulnerable People training and engagement with staff that the 'Think Family' remains at the forefront of every member of staffs thoughts when considering if individuals are at risk of harm or potential risk of harm
- Embed the new statutory proposals from the Law commission once agreed by government for Deprivation of Liberty recommendations
- Develop and complete regular clinical audit of safeguarding adults, mental capacity completion and deprivation of liberty referrals to ensure correct level of knowledge form staff and support areas in need
- Develop a robust mechanism of sharing good practice, clinical audit and serious case reviews within the Trust

12. Mental Capacity Act/Deprivation of Liberty Safeguards

The Mental Capacity Act (MCA) protects and empowers individuals who are unable to make decisions for themselves. The MCA applies to everyone working in health and social care providing support, care and treatment to people aged 16 and over who live in England and Wales. The Deprivation of Liberty Safeguards was an amendment of the MCA 2005, it is the procedure prescribed in law when it is necessary to deprive individuals of their liberty whom lack capacity to consent to their current care and treatment in hospital to keep them safe.

Key Achievements

- There has been an 29% increase in the number of Deprivation of Liberty Safeguarding applications made by the Trust compared to 2015/16 from 124 to 156
- Overall the team had a 16% increase in Deprivation of Liberty referrals to the team
- Quarter 4 saw the introduction of the visibility walkabouts which in
- Turn reflected just under a 100% increase in referrals to the safeguarding team in comparison to quarter 3 alone. This is felt to be due to an increase in staff knowledge and this increase is expected to continue into quarter 1 2017/18
- Mental Capacity Assessment tool embedded within Cerner Millennium in line with the requirements of Contemporaneous record keeping
- The Safeguarding team has been included in Terms of Reference and attends the Serious Incidents Review Group to further strengthen safeguarding integration internally. This has provided the safeguarding team oversight of any incidents/RCA that may involve safeguarding, MCA and DoLs and enabled the team to support the Divisions when required
- All advocacies within the Trust are now provided via n|compass northwest and have agreed to support the safeguarding team in providing figures of referrals made by staff. This is a requirement for the safeguarding Adults assurance framework for the CCG

The collection of safeguarding adult's data has been broken down into categories to identify where the concern has been escalated from and who the alleged perpetrator is. They are classified as follows and can be seen in the graph in appendix 2

- IE - Internally raised concerns in the hospital by WUTH staff about an external safeguarding concern
- EI - Externally raised concerns against WUTH to the local authority resulting as safeguarding section 42 enquiry
- II - Internally raised concerns regarding an internal safeguarding concern within WUTH
- EE - External concern however support is required from an external agency such as the police or social care as the victim has attended hospital as a result of the suspected abuse

Section 2 and other - These are the concerns raised internally by WUTH staff to the safeguarding team that are not true safeguarding cases, they may include patients that are self-neglecting and require care needs assessments or input form the mental health team. The team does however provide advice and support to direct the staff to the appropriate professionals and agencies. This category also records when advice only has been provided or any mental health referrals that the team has been made aware of due to self-harm and neglect. The safeguarding team will when appropriate share with the local authority for information sharing purposes only.

Challenges and Priorities

- To evidence the application of the Mental Capacity Act through clinical audit.
- To continue to increase staff awareness and knowledge and support staff in the completion of Mental Capacity Assessments, with a view of removing the risk from the Trust risk register in relation Deprivation of Liberty safeguards admission consent
- Continue to support and engage staff in their awareness of Mental Capacity Act and Deprivation of Liberty Safeguards
- Once the Law commissions review of Deprivation of Liberty Safeguards is approved ensure that the Trust is complaint with all statutory requirements set out under the Act
- Managing the volume of Deprivation of Liberty referrals within the team remains a challenge. Moving forwards the safeguarding team will utilise administration support and identify areas of high referrals to train key staff members in the completion of statutory applications
- Produce an Mental Capacity parody to support and engage the staff in relation to the principles of the act

13 Domestic Abuse/ Harmful Practices/FGM

Each year an estimated 1.9m people in the UK suffer some form of domestic abuse and with more than 100,000 people in the UK being at high and imminent risk of being murdered or seriously injured as a result of domestic abuse.

On Wirral it is estimated that the level of domestic abuse is higher than the national average for England. In 2015-16 the incident rates of high risk cases for Wirral were 27% while in England it is estimated that the incident rate is 20.4%.
Safe lives state that 1 in 5 high-risk victims reported attending A&E as a result of their injuries in the year before getting effective help.

To support the victims of domestic abuse who attend WUTH and disclose domestic abuse the Trust have a Lead Specialist for Domestic Abuse and Harmful Practice in post within the Safeguarding Team.
The aim of this service is to works across all areas of the Trust in both hospital and community and provides support, education and advice to all WUTH staff to ensure that victims who attend WUTH receive the appropriate support, advice and safety planning prior to discharge.

The Domestic Abuse Specialist also provides support to patients over the age of 16 and their families.

In 2016-2017 WUTH Safeguarding Team received a total of **445** referrals regarding domestic abuse.
287 of these referrals have been from patients attending WUTH and making a disclosure of domestic abuse to staff, with the highest proportion of referrals being received from A&E. Also 158 referrals were received from the police by the Safeguarding Team for any pregnant victim on Wirral.

Key Achievements

- All staff are empowered to take responsibility to aid and support patients when a disclosure of domestic abuse is made. Staff are expected to offer all patients a domestic abuse risk assessment following a disclosure of domestic abuse. This change of practice has been incorporated through the development of Domestic Abuse, FGM and Harmful Practice training in the PVP training.

- Key areas such as Maternity and the Emergency Department have also received additional bespoke training as these areas have been identified as the key areas for referrals.

- Developments within maternity department Cerner Millennium function ensures that all patients who attend WUTH or midwifery appointments are asked the routine screening questions in relation to domestic abuse and FGM.

- A new Domestic Abuse policy has been developed and launched in

May 2017 which includes harmful practice.

- The team has facilitated **24** referrals for victims at high risk of harm to MARAC within Wirral.

- The domestic abuse risk assessment is accessible on Cerner for all staff to complete.

- Additionally the safeguarding team have continued to support patients through partnership working with an attendance at MARAC every fortnight.

- All victims discussed at Wirral MARAC are flagged on Cerner to ensure that staff are aware of the safeguarding concerns and can liaise with the safeguarding team to discuss further actions/safety plans for the patient when the attend WUTH.

- The system for flagging electronic records for all pregnant women who have had FGM undertaken

Challenges and Priorities

- Further developments within Cerner to ensure that routine screening questions are implemented into all departments but specifically ED
- Further support to ED staff in completing the Domestic Abuse Risk Assessment as not all the staff is currently completing this. Audit is being completed to share with management regarding staff completion of the domestic abuse risk assessments. It is believed that once all staff are completing the domestic abuse risk assessments upon a disclosure that the referral to MARAC of high risk cases that have been identified through WUTH will be higher.
- To support staff with a hospital based IDVA. Currently a business case is being compiled to request funding for a hospital based IDVA to support victims who attend WUTH and disclose domestic abuse.

Strategic Goals 2017 - 2018

• Further development within Cerner to ensure that routine screening questions are implemented into all departments but specifically ED

• Audit quality of referrals received to ensure that all appropriate safeguarding procedures completed as stipulated in the Domestic Abuse Policy

• Continue to develop the routine screening questions in relation to FGM throughout the Trust as per Multi-agency Policy

14. Protecting Vulnerable People Training

In May 2016 a review into safeguarding training noted that due to significant changes to legalisation the current level of safeguarding training did not meet all of the statutory requirements for this subject. The review also noted that staff where required to complete different elements of safeguarding training which were completed separately in an ad-hoc manner, leaving gaps in level of assurance for this critical element of training.

The Safeguarding Team, with the support of Leadership and Development Team produced a revised programme entitled Protecting Vulnerable People, which would be delivered at Level 1 – 5, with the level of training attended by staff dependent on their role and exposure to safeguarding issues. The programme was designed to cover a number of competencies meaning staff will no longer have to attend additional sessions for subjects such as FGM, Domestic Abuse and MCA, giving the Trust greater assurance of competency. An assessment at the end of the training was also introduced.

Although the Trust already had a **high level** of compliance for its original safeguarding programme, it was felt that to give full assurance that all staff where up to date with all the new legislation and to act as a refresher for this critical area of patient care, that the Trust would start a fresher with its recording and reporting of safeguarding training compliance.

The Trust approved that staff would have until September 2017 to attend the Protecting Vulnerable People training, with a working towards compliance figures reported as part of the monthly Trust mandatory Training reports. From September 2017 the formal reporting of this subject will commence in line with the Trusts KPI of 95%

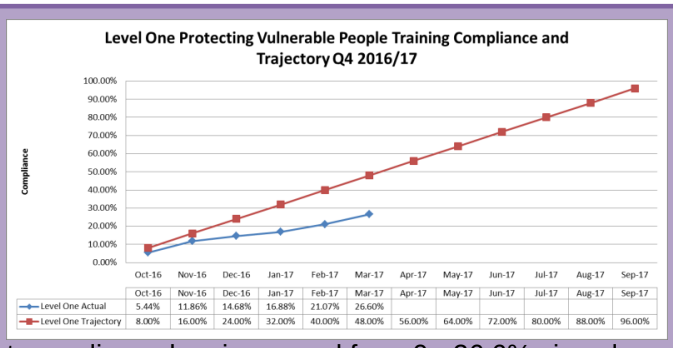
14.1 Protecting Vulnerable People Training Evaluation data

Following the launch of the PVP training programme, data collections from evaluation sheets are currently being processed. These include both Level 2 and Level 3 data from the face to face sessions held in the Lecture Theatre within the Education Department.
Initial data identifies:

- Over 95% of staff has stated that the training has improved knowledge within the safeguarding arena.
- Over 95% of staff felt the teaching sessions were clearly structured
- 90% of staff rated training as excellent or very good
- 95% strongly agreed that the training was well organised.
- 90% of trainees felt able to interact and ask questions.

Within the current format, the training sessions are didotic/PowerPoint and video clips approach and it has been recognised that the training style would benefit further interactive and practice focused approach to support and increase staff's knowledge and skill base within smaller groups. format. Below is compliance end March with trajectory to reach compliance of 95% by September 2017

14.2 Protecting Vulnerable People Training Compliance



Overall Trust compliance has increased from 0 - 26.6% since launch. However, this falls below the required target of 48%. In order to reach compliance target of 95% by end of September, a 12% trajectory is required. Divisions receive a monthly Compliance report to enable them to track which staff in their areas has already completed the required level, and which staff is still to complete

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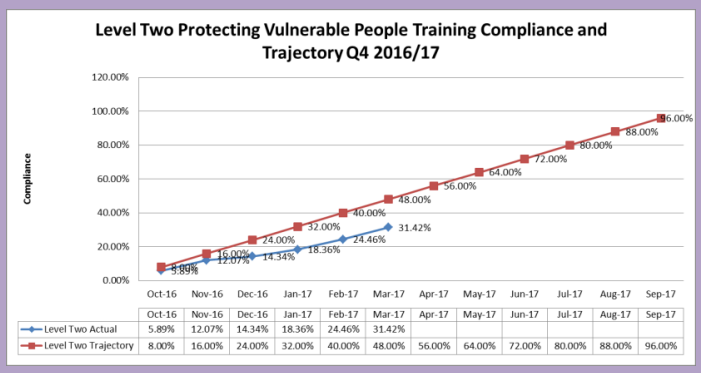
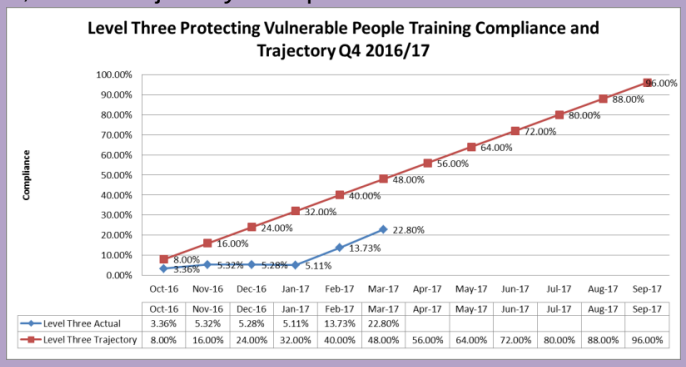


Overall the Trust compliance has increased from 0 - 31.42%. However, this falls below the required target of 48%. In order to reach compliance target of 95% by end of September, a 12% trajectory is required.



Overall the Trust compliance has increased from 0 - 22.80%. However this falls below the required target of 48%. In order to reach Compliance target of 95% by end of September, a 12% trajectory is required.

15. Children Looked After

During early 2017, discussions have taken place between WUTH and Wirral commissioners to discuss Service Level Agreement (SLG) for Initial Health Assessments

The SLG was developed in partnership with Wirral CCG and WUTH. The Trust is awaiting the draft service specification.

In the interim, the CLA service agreement is monitored by the standards and compliance indicators in the Safeguarding Assurance Framework.

The service is supported by the Designated Doctor for Children Looked After and the Trust has appointed a Named Doctor for CLA due to commence the Trust in July 2017.

16. PREVENT

Prevent awareness is included within the Corporate Induction and included within the newly launched Protecting Vulnerable People Training Strategy.

Following on from the launch of Protecting Vulnerable People Training Strategy in September 2016, mandatory training compliance is included within the compliance reporting of PVP specific to required skills and knowledge required.

As the Trust is not a priority site, the reporting mechanism is via the Safeguarding Assurance Framework to the Clinical Commissioning Group.

The Trust has two PREVENT leads – Head and the Deputy Head of Safeguarding

17. Child Sexual Exploitation (CSE)

Tackling Child Sexual Exploitation is a priority for Wirral University Teaching Hospital with the partnership. A high profile case on Wirral has highlighted the need for vigilance when the child or young person accesses our services.

The Director of Nursing and Head of Safeguarding has fully engaged with NHS England's managing of Wirral' s local investigation and has participated in tele conferences to provide updates when required. The Trust has identified a lead for CSE within the safeguarding team who co-ordinates information gathered from national and local reviews.

CSE is a mandatory reporting incident to the safeguarding to ensure that CSE toolkit is completed.

The Trust attends the bi-monthly Multi-Agency Child Sexual Exploitation Meeting (MACSE) meetings to ensure a multi-agency response.

Cascading of information to raise awareness of CSE, spotting the signs and reporting mechanisms within the Trust and staff can also access the Safeguarding Boards website to raise and enhance knowledge. Further awareness material including an online e-learning package. Themed updates from the Safeguarding Board are disseminated within the Trust and displayed in key areas within the emergency department, Women's and Children's division.

CSE training has been incorporated with the Trust new training strategy, Protecting Vulnerable People training which is mandatory for all levels of staff. Multi-agency CSE training aims to provide practitioners across all agencies with best practice principles for working with children and young people who have been or are at risk of being sexually exploited.

The Trust participated in the Safeguarding Boards CSE day including displaying of posters, engagement via twitter every day for a week before and after CSE including promotion of CSE pledges.

18. Key Objectives for 2017-18

Next Steps

Clinical Audit of all safeguarding services to provide assurance and quality monitoring

Safeguarding work plan highlighting priorities and objectives

Development of further safeguarding polices: Prevent, Allegations against Staff, Midwifery Safeguarding Policy and continue to update existing polices as required in line with legislative changes

Staff engagement ensuring that all groups of staff are included such as non-clinical

Further development of Cerner Millennium to improve data collection and recording

Achieve and maintain Protecting Vulnerable People training compliance

Utilise the E-Learning platform for safeguarding training once live within the Trust

Further development of Cerner Millennium in relation to CP-IS Information sharing system

Right service right time referral process development within emergency department

Further development of transitional processes for WUTH safeguarding for 16-19yr olds

Development of safeguarding databases to provide more detailed breakdown of safeguarding data to provide assurance internally and externally

Introduce the Multi Agency Adult referral to the main hospital to allow staff to raise own concerns directly with the local authority and utilise the safeguarding team for support and advice

Launch safeguarding excellence ward's on each floor with a view to share and roll out good practice throughout the Trust.

Identification of Safeguarding Ambassadors and provide bespoke multi agency training to support all staff within the divisions.

Embed the new statutory proposals from the Law commission once agreed by government for Deprivation of Liberty recommendations

Develop a robust mechanism of sharing good practice, clinical audit and serious case reviews within the Trust

Continue to support and engage staff in their awareness of Mental Capacity Act and Deprivation of Liberty Safeguards and review the completion of applications for DoLs

Complete a business case for a hospital based IDVA to support victims within the 'Golden Hour' when attending A&E with a disclosure of domestic abuse

19. Conclusion

Safeguarding children and adults at risk continues to have a high profile within the Trust. Although robust safeguarding structures and processes are embedded in everyday practice across the Trust and it remains key that the Trust meet its Statutory requirements and continue to safeguard its most vulnerable patients.

20. Recommendations

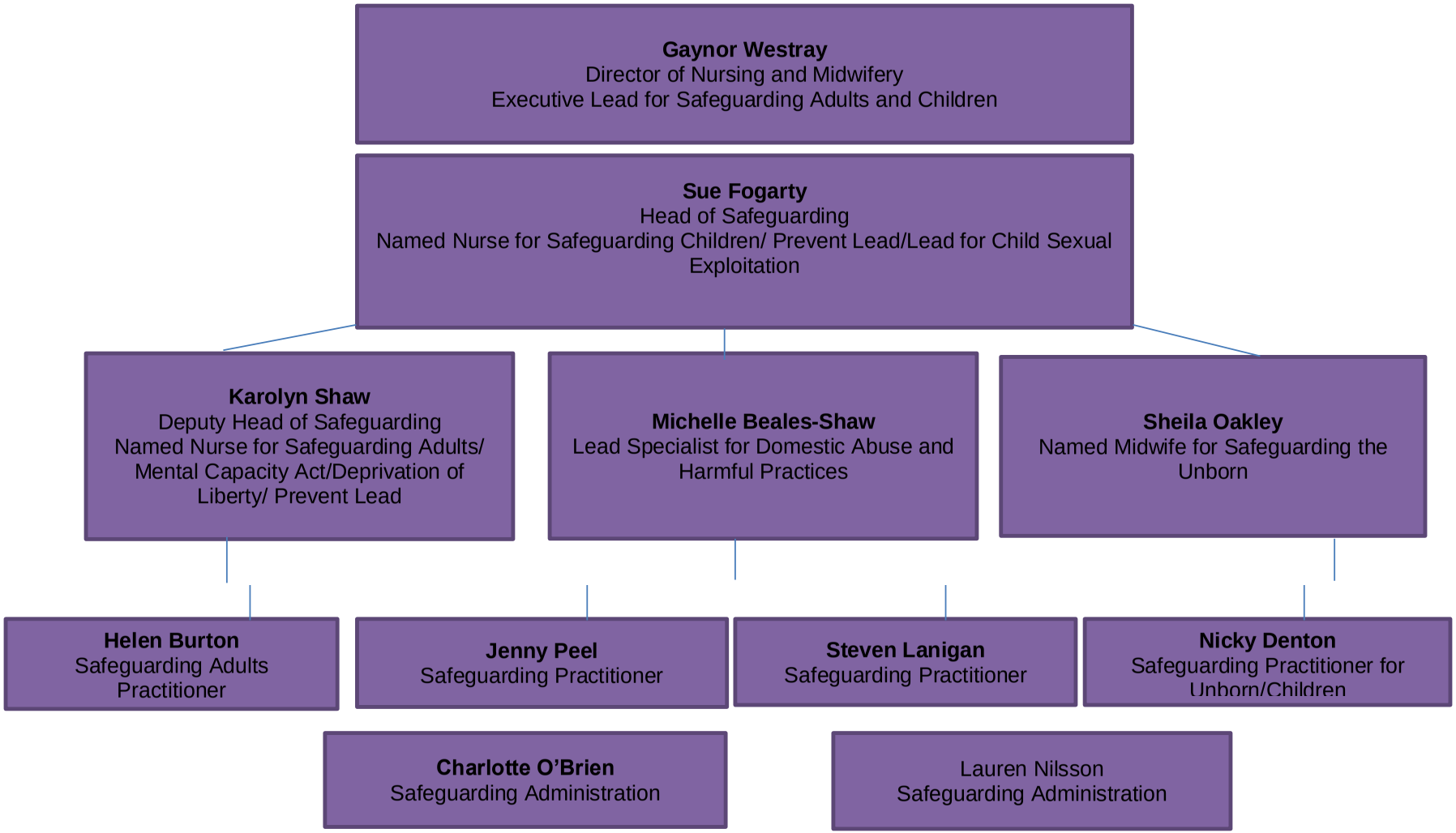
The Quality and Safety Committee is requested:

- To approve the annual report
- Quality and Safety Committee is asked to receive and support the next steps as listed

Appendix 1

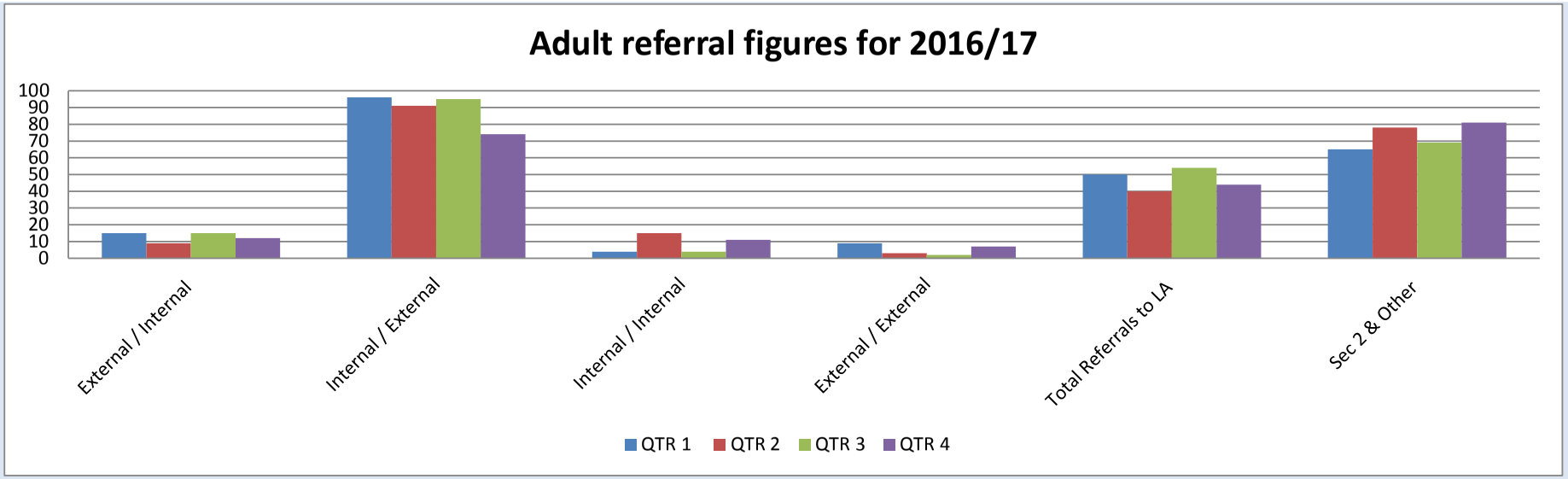
Wirral University Teaching Hospital NHS
NHS Foundation Trust

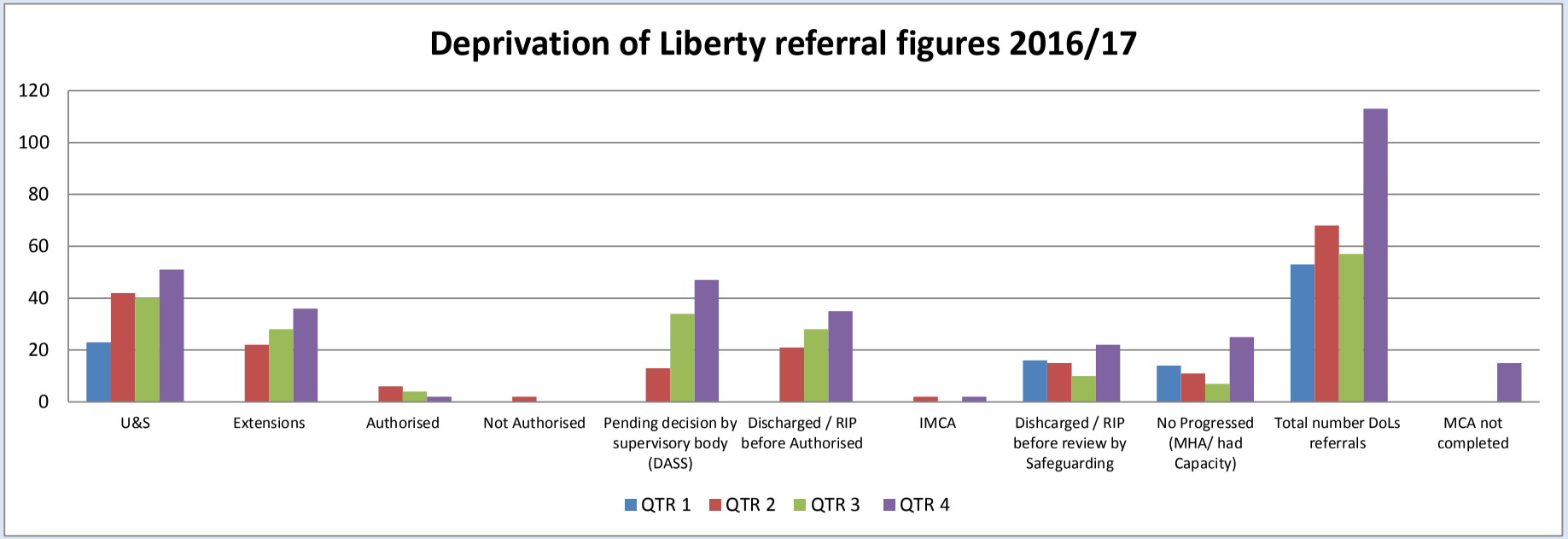
Safeguarding Structure



Wirral University Teaching Hospital NHS
NHS Foundation Trust

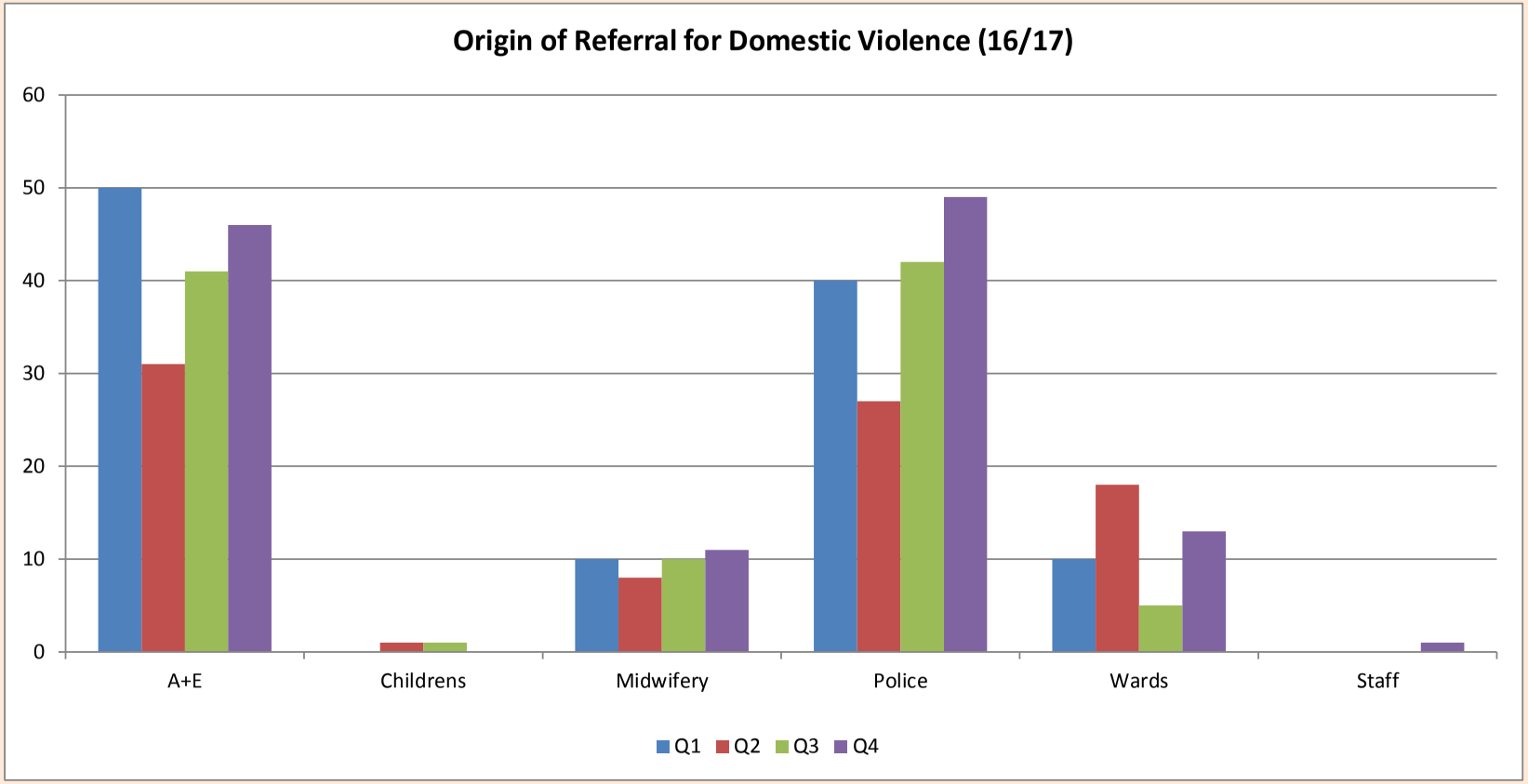
Adult Safeguarding Statistics Dashboard





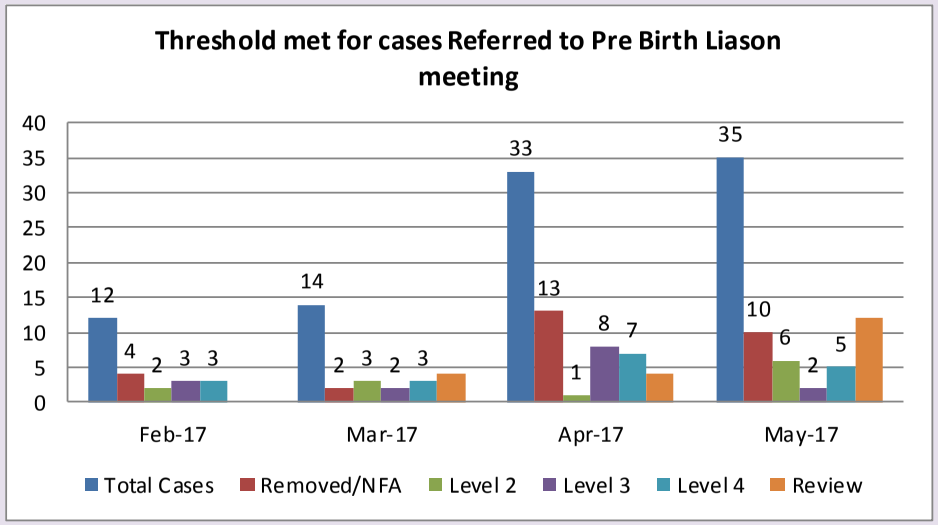
Appendix 3

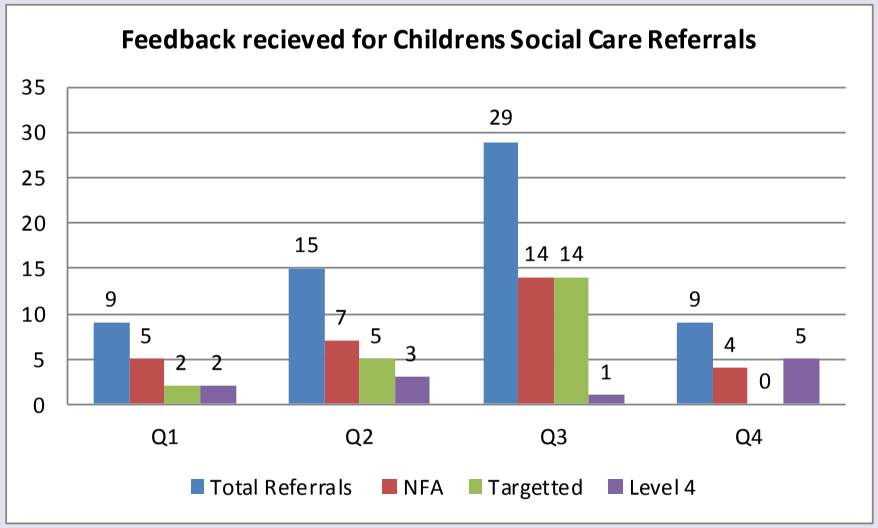
Domestic Violence Statistics Dashboard



Appendix 4

Pre Birth and Unborn Safeguarding statistics Dashboard





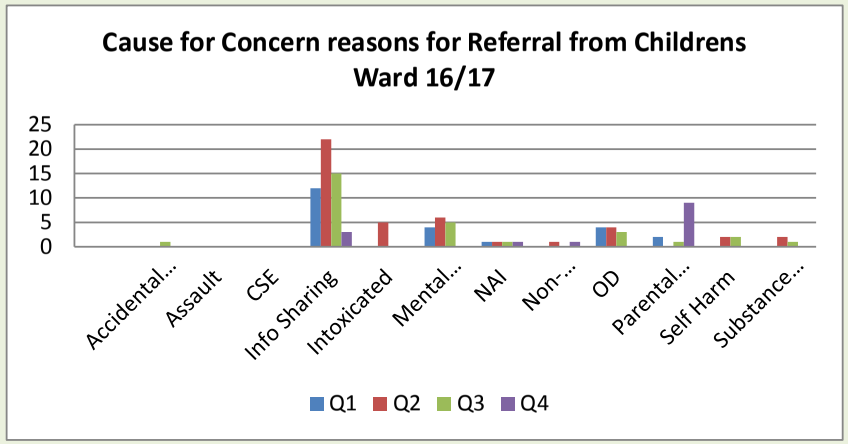
The Wirral Pre Birth Liaison Group Meetings commenced as of January 2017 and so no previous data has been collected.

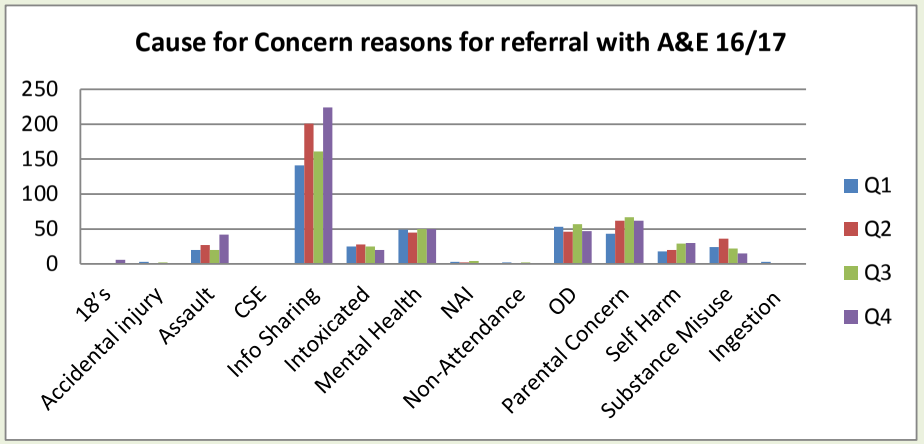
During Quarter 4, no feedback from social care has been received by safeguarding for the month of January. This has been escalated to social care by the team

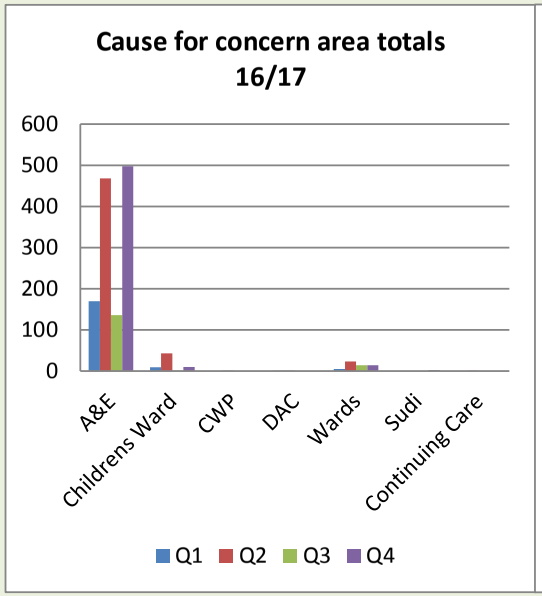
Appendix 5

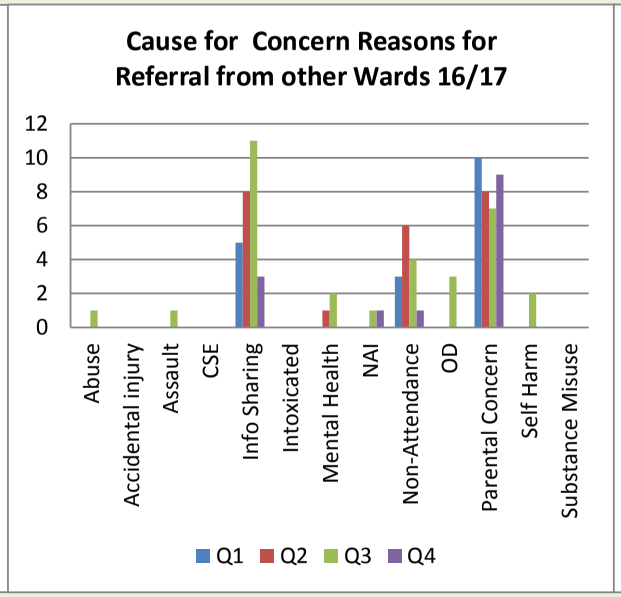
Wirral University Teaching Hospital NHS
NHS Foundation Trust

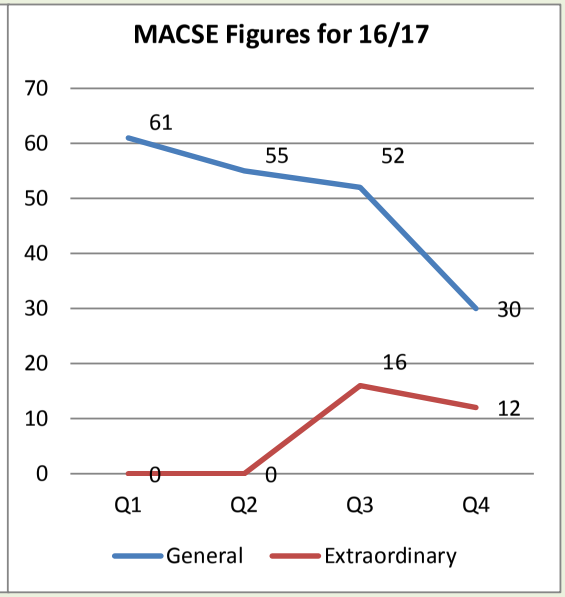
Safeguarding Young Children and Young people statistics Dashboard











In Q3, Safeguarding developed a Threshold group to discuss cases of High Priority for CSE, and remove any inappropriate referrals into MACSE

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF PUBLIC MEETING

28 JUNE 2017

BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL

Present

Michael Carr	Chairman
David Allison	Chief Executive
Cathy Bond	Non-Executive Director
Susan Gilby	Medical Director
Andrea Hodgson	Non-Executive Director
Graham Hollick	Non-Executive Director
Janelle Holmes	Chief Operating Officer
David Jago	Director of Finance
Cathy Maddaford	Non-Executive Director
Jean Quinn	Non-Executive Director
John Sullivan	Non-Executive Director

In attendance

Carole Self	Director of Corporate Affairs
Jayne Kearley	Member of the Public

Apologies

Gaynor Westray	Director of Nursing and Midwifery

*denotes attendance for part of the meeting

Reference	Minute	Action
BM 17-18/063	**Apologies for Absence** Noted as above	
BM 17-18/064	**Declarations of Interest** None	
BM 17-18/065	**Chairman's Business** The Chairman extended his congratulations to the Director of Workforce and his team following the recent announcement that they had been successful in being named the Human Resources and Organisational Development Team of the Year by the Healthcare People Management Association HPMA. The Chairman advised the Board that the Volunteers summer lunch was a huge success and that they were very appreciative of the hamper the Board had donated.	
BM 17-18/066	**Chief Executive's Report** The Chief Executive presented the report and highlighted the following areas for discussion: **Fire safety** – the Chief Executive advised the Board that following the terrible fire at Grenfell Tower, the Trust could confirm that it had no over-cladding on its building and that all other cladding was fire retardant in compliance with building regulations. He also confirmed that in view of this the Trust was not	

Reference	Minute	Action
	a priority for full inspection by the Fire Service. The Director of Finance confirmed that the Trust was continuing with its usual safety measures and that the Associate Director of Estates was liaising on the national agenda and working closely with Cheshire and Merseyside Fire Service. The Board sought assurance that the Frontis building was compliant with fire safety. The Director of Finance advised that verbal confirmation had been received that the cladding was safe but were seeking this in writing from the legal owner. The Board sought and received assurance that the Trust's fire training and procedures were up to date and being undertaken as required. **Ascension –** the Chief Executive advised the Board that Ascension had now decided to partner with Ramsay Healthcare in Asia and were therefore no longer looking to undertake any UK work for 2 years. He confirmed that the Trust was now working at pace with partners in Chester and across the Sustainability and Transformation Plan STP footprint in this regard. **NHS Improvement** – the Chief Executive updated the Board on the purpose and outcome of the Progress Review Meeting on 1st June 2017. The focus was on compliance with the undertakings in the enforcement action in 2015 and the additional licence condition. The regulator was very pleased with the changes made to the Board; its governance processes; cost improvement plans CIP and the role of the service transformation team which was supported by 2 further visits to the Trust. The undertaking in relation to A & E was much more difficult as the regulator recognised that this was a health economy/system issue and not just an organisational issue. The Regulator agreed to share their recommendation for lifting of the undertakings ahead of this being progressed through the formal NHSI governance structure. The Chief Executive advised the Board that the Trust had agreed to share progress on the CIP plans on a monthly basis.	
BM 17-18/067	**Patient Story/Learning** The Director of Finance provided the Board with feedback from NHS choices of an endoscopy patient who received care in the Trust in May of this year. The feedback was very positive particularly in relation to timeliness of assessment and treatment; reassurance; friendliness and overall patient experience.	
BM 17-18/068	**CQC Compliance and Action Plan Progress Update** The Medical Director presented the Progress Update which outlined the Trust's compliance levels and state of inspection readiness. Although the internal auditors had provided an overall rating on their last audit of "significant assurance" there were still areas of improvement to be made in the domain of "safe" as highlighted in the Trust's own CQI inspections. The Medical Director confirmed that the focus of attention for the Trust was to improve this domain at pace through shared learning from incidents as well as sharing best practice. She advised the Board that the first Trustwide Safety Summit was due to take place the following day which would be followed up with a "Safety Bites" bulletin. The safety summit would be undertaken on a weekly basis.	

Reference	Minute	Action
	The Board was advised of the intention to amalgamate the best of the ward accreditation work and the CQIs to provide a "rich" picture of quality and safety in the Trust. The Medical Director advised the Board of 2 recent Never Events, the first in relation to part of a 2.5mm drill bit missing following a hip operation. The consultant checked the x-ray post op and confirmed that some of the drill bit was imbedded in the hip joint. The Trust observed duty of candour and the patient was made aware of this and the Consultant made the decision to take no further action. The Board was advised that this was a recognised risk and that the Medical Director agreed with the decision made. The 72 hour post incident review was currently being undertaken. The second Never Event was in the Breast Screening Unit and related to failure to comply with a safety check resulting in the patient not being able to have a single core biopsy undertaken. The 72 hour review was also taking place. The Medical Director confirmed that both of these Never Events would form part of the Safety Summit on the following day. The Board was disappointed with these Never Events especially in light of the good work being progressed in so many clinical areas and questioned how the Trust could sustain improvements made. The Medical Director highlighted the overall improvement in medicines storage to highlight that the focus needs to be on highlighting issues and seeking ownership and accountability for improvements as opposed to relying on inspections. The Board sought to understand how the work to prepare for an inspection therefore would aid with sustainability. The Medical Director confirmed that there was a specific piece of work required to prepare for an inspection from a practical perspective which the Trust was undertaking however the main focus for the Trust was embedding good practice and focussing on improving the safety culture. The Board agreed that in future the Quality and Assurance Committee would be provided with assurance on CQC preparedness and the overall compliance with the fundamental standards. The Board therefore would receive regular reports from the Quality and Safety Committee.	**SG**
BM 17-18/069	**Integrated Performance Report** • **Integrated Dashboard and Exception Reports** The Chief Operating Officer presented the integrated performance dashboard and highlighted the following: **A & E 4Hour Target –** the Board was advised that performance for May for the ED department alone was 74.36% and for the site 79.76%. The Chief Operating Officer advised the Board that the Trust had bid for £1M of capital funding to enact changes to the single front door; 4 rooms in the walk in centre were now being used to support the GP streaming process and the bed modelling work was progressing well as reported at the Transformation Steering Group. The Board was advised that the 9 point plan had been developed under the	

Reference	Minute	Action
	governance of the A & E Delivery Board although there were significant financial and operational challenges in its delivery many components of which needed to be brought forward to July from October. The Board raised concerns with the 9 point plan which required transformation at a strategic level if the most gains were to be made. The Board was advised that NHSI had accepted the improvement trajectory for A & E however the STF payments in relation to this had recently changed in line with national expectations which have been challenged by the Trust. Although disappointed that Q1 performance was not achieved, this mirrored the picture nationally and the change in STF funding to allow 50% payment if GP streaming put in place was seen by some Board members as a positive. The Board discussed how this would be enacted and how the Trust was utilising the skills of an ED consultant who was a GP by background to undergo some tests of change. The Board was advised that the focus was on primary care streaming as opposed to GP streaming and improved triage if the Trust was going to prevent patients re-entering A & E or assessment areas. The Chief Operating Officer advised of a meeting in the following week between the Community Trust and Commissioners to review funding of this initiative going forward. The Board also debated the impact of the recent closure of Eastham clinic because of community staffing issues as well as the SAFER initiative and the re-launch of this across non-elective wards in the first instance supported by the service transformation team. **Referral to Treatment Time RTT** – the Board was advised that the Trust had met the improvement trajectory for May as planned and that the Improvement Board had now been established with attendance confirmed from the regulator and the CCG. The Chief Operating Officer confirmed that the Trust was currently negotiating with private providers with a view to improving the trajectory even further. **Diagnostics 6 weeks wait** – the Board was advised that performance was on track as at the end of May 17. **Cancer -** the Board was advised that although challenging the Trust expected full compliance with the waiting time standard. **Infection Control** – the Chief Operating Officer confirmed that Ward 19 closed last month and that the HPV programme was back on track. The Board was advised of the outcome of the post infection review in relation to the single hospital acquired MRSA bacteraemia case in May which identified a lapse in care. The Board was advised that the learning from the review had been shared across clinical areas. The Board was advised of the proposal to align the infection control team with microbiology and the line insertion team to strength relationships between services. **M2 Finance and Cost Improvement Programme Report** The Director of Finance presented the M2 finance and cost improvement report and highlighted the following areas:	

Reference	Minute	Action
	• The overall deficit at the end of May 17 was reported at £3.1M which was in line with the profile of the financial plan submitted. Above planned expenditure of £1.8M was reported driven by non-delivery of CIP and escalation costs of £500K above plan. The Board was advised that this had been mitigated with the use of CQUIN reserve recognising that this was a risk as it was assumed a level of anticipated income from the CCG that had not, as yet, been confirmed as this needed regulatory approval. The Board sought to establish the level of financial risk if not approved and this was confirmed as £1.2M • The Cost Improvement Plan (CIP) reported a £1M variance having delivered £0.2M in month and £0.4M for the year against the plan of £1.4M • Cash was reported at £6.5M which was £4.4M above plan, the variance being primarily due to the 2016/17 closing cash being higher than plan and the capital cash underspend • Use of Resources was reported at 3 which was in line with the plan The Board was pleased to note that Payment by Results PBR activity was above plan by £1.1M year to date as a result of over performance in elective/day case, non-elective and A & E activity. This however had been offset with under performance in non-PBR activity of £0.9M and PBR excluded drug (£1.1M matched by expenditure). The Director of Finance confirmed that the Transformation Steering Group had earlier in the week approved a further £3M of savings schemes which now needed to be implemented at pace. This now brought the overall gap against the annual plan down to £2.2M although this was still considered to be significant especially in light of the need to release two 12ths of CQUIN reserve already. Mr Sullivan, the Non-Executive member of the TSG confirmed that the meeting that took place earlier in the week was very encouraging in terms of the schemes being put forward and the level of input and accountability displayed. The Director of Finance also advised the Board that if the Trust was successful at negotiating the Cerner Contract that there would be a depreciation gain to the value of £1.2M which was currently not in the figures. He advised however that this would put a further risk on the availability of capital. The Board sought to establish whether the £3M of savings schemes approved were recurrent or non-recurrent, the Director of Finance agreed to confirm. The Board raised concerns with the pay costs which were increasing and sought to understand the drivers of this. The Director of Finance confirmed that this was associated with the cost of supporting the escalation beds which required the Trust to pay premium costs particularly in the Emergency Department.	**DJ**
BM 17-18/070	**Sustainability and Transformation Plan Funding** The Chief Executive presented the paper which required the Board to	

Reference	Minute	Action
	approve the Trusts allocation of funding to support the Sustainability and Transformation Plan STP through 2017/18. He reminded the Board of the original request from partners of £7M which was not supported by members. The request now is for £2M however due to the part year effect this equates to £1.6M across the whole STP membership. Members agreed to fund this as part of the national requirement. The Chief Executive confirmed that the Trust's share of this was based on the following methodology – 50% of the cost was split equal across all members with the other 50% being based on the size of the organisation. The total cost for this Trust was confirmed as £57K. The Board was advised that £600K would be used to support the workstreams required with the remaining £1M being used to draw down external resource as required by the STP. The Board was supportive of the funding on the understanding that the STP was clear about the intended outcomes. The Board formally approved this.	
BM17-18/071	**Board of Directors** The Minutes of the Board of Directors held on the 24th May 2017 were confirmed as an accurate record. **Action Log** The Board accepted the action log as presented	
BM17-18/072	**Items for the BAF/Risk Register** The Board requested that the risk relating to the CQUIN monies being used ahead of formal approval be included on the BAF	**DJ**
BM 17-18/073	**Items to be considered by the Assurance Committees** The Board agreed the following focus areas for the assurance committees: **Quality and Safety Committee** – the Board agreed that in future the full CQC preparedness and compliance review would be undertaken at the Quality and Safety Committee and formally reported through to the Board.	**SG**
BM17-18/074	**Any Other Business** The Director of Corporate Affairs requested a change to the terms of reference of the Quality and Safety Committee ahead of the meeting in July. The Board was asked to amend the membership to note that the nominated deputy for the Medical Director was the Deputy Medical Director and that the quoracy included nominated deputies for both the Medical Director and the Director of Nursing and Midwifery. The Board approved these changes. The Board expressed their thanks to Cathy Bond following the end of her	

Reference	Minute	Action
	tenure as a Non-Executive. Cathy had always been noted for her pertinent questions, which were well times, well thought out and thought provoking. She was particularly congratulated for her role as Audit Chair.	
BM 17-18/075	**Date and Time of Next Meeting** Wednesday 26th July at 9.00am in the Boardroom, Education Centre, Arrowe Park Hospital.	

……..……
Chairman

……..
Date

ACTION LOG
Board of Directors
Updated – July 2017

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 28.06.17						
1	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**	**Ongoing**	July 2017	
2	BM17-18/069	Confirm whether the £3M of saving schemes identified were recurrent or non-recurrent	**DJ**		July 2017	
3	BM17-18/072	Include the risk of CQUIN monies being used ahead of formal approval by the CCG being received on the BAF	**DJ**			
Date of Meeting 24.05.17						
4	BM17-18/039	Provide regular reports on the A & E 9 point action plan – specifically those areas that relate to the Trust	**JH**	**Ongoing – last review June 17**	June 17	
5	BM17-18/049	Review the financial risks on the BAF in relation to possible further intervention or special measures	**DJ**		July 17	

6	BM17-18/049	Review the IT risk on the BAF in relation to cyber security	**PC**	Work is 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 Dgitial – dates being agreed. WUTH is leading work on Cyber for Cheshire and Mersey STP	July 17	
Date of Meeting 26.04.17						
7	BM17-18/006	Provide a trajectory to achieve "good" in the next CQC inspection	**SG**		June 17	
8	BM17-18/013	Provide details of what "good" looks like under the Equality and Diversity indicator for inclusive leadership	**GW**	**Scheduled for update in September 17**	June 17	
9	BM17-18/013	Ensure Equality and Diversity is covered throughout the Trust's Mandatory training programme	**GW**		June 17	
Date of Meeting 25.01.17						
10	BM16-17/244	The Board agreed that the reporting of Advancing Quality Indicators needed to be strengthened	**SG**	**The Board to receive an update on the work of the Quality Governance Review as part of a Development workshop in July 17**	March 17	**Being reviewed as part of the Quality Governance Review**
Date of Meeting 25.05.16						
11	BM16-17/033	Include progress on the implementation of the junior doctors contract as part of the Board Development Programme	**SG**	**Agreed to defer this until later in the financial year in light of current position**	July 16	
12	BM16-17/036	Full review of the performance report to be undertaken to avoid this becoming unmanageable	**JH**	**The new Director of Operations and Performance is reviewing this and will provide an update in September 17**	Sept 17	

13	BM16-17/037	Explore the impact of technology when reporting CHPPD in the future	**GW**		April 17	**Update will be provided at March Board**
14	BM16-17/040	Board to continue to receive CQC updates until the next inspection on a quarterly basis	**SG**	This action has now been delegated to the Quality and Safety Committee and will form part of their workplan and updates will be received via the Chairs Report – **Action therefore closed**		
Date of Meeting 30.03.16						
15	BM15-16/297	Present the Medical Engagement Strategy	**SG/JM**	**Included as part of Board Development session in July 17**	May16	