# Board of Directors
# Public Board

## 29th March 2017

**MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 29th MARCH 2017**
**COMMENCING AT 9.00AM IN THE**
**BOARD ROOM**
**EDUCATION CENTRE, ARROWE PARK HOSPITAL**

# AGENDA

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

## 5. Quality and Safety

| | | |
|---|---|---|
| **5.1** | **Bi-monthly Nurse Staffing Report**<br>Director of Nursing and Midwifery | d |
| **5.2** | **Patient's Story**<br>Director of Nursing and Midwifery | v |
| **5.3** | **Report of the Quality and Safety Committee**<br>Chair of Quality and Safety Committee | d |
| **5.4** | **Quality Account Priorities 2017/18**<br>Medical Director | d |

## 6. Performance and Improvement

**6.1 Integrated Performance Report**

| | | |
|---|---|---|
| | **6.1.1 Integrated Dashboard and Exception Reports**<br>Chief Operating Officer | d |
| | **6.1.2 Month 11 Finance Report**<br>Director of Finance | d |
| | **6.1.3 Transformation Portfolio & Cost Improvement Programme 17-18**<br>Associate Director of Transformation | d |
| | **6.1.4 Budget Approval**<br>Director of Finance | v |

## 7. Governance

| | | |
|---|---|---|
| **7.1** | **Annual review & appraisal of non-financial scheme of reservations & delegations & constitution**<br>Director of Corporate Affairs | d |
| **7.2** | **Annual review & appraisal of standing financial instructions & financial scheme of reservations & delegations**<br>Director of Finance | d |
| **7.3** | **Report of Finance Business Performance and Assurance Committee**<br>Chair of Finance and Business Performance Assurance Committee | d |
| **7.4** | **Report of Audit Committee**<br>Chair of Audit Committee | d |
| **7.5** | **Board of Directors** | |
| | **7.5.1 Minutes of the Previous Meeting – 22nd February 2017** | d |
| | **7.5.2 Board Action Log**<br>Director of Corporate Affairs | d |

## 8. Standing Items

| | | |
|---|---|---|
| **8.1** | **Items for BAF/Risk Register**<br>Chairman | v |
| **8.2** | **Items to be considered by Assurance Committees**<br>Chairman | v |
| **8.3** | **Any Other Business**<br>Chairman | v |
| **8.4** | **Date and Time of Next Meeting**<br>Wednesday 26th April 2017 | v |

| Board of Directors | |
|---|---|
| **Agenda Item** | 4 |
| **Title of Report** | Chief Executive's Report |
| **Date of Meeting** | 29 March 2017 |
| **Author** | David Allison, Chief Executive |
| **Accountable Executive** | David Allison, Chief Executive |
| **BAF References**<br>• **Strategic Objective**<br>• **Key Measure**<br>• **Principal Risk** | ALL |
| **Level of Assurance**<br>• **Positive**<br>• **Gap(s)** | Positive |
| **Purpose of the Paper**<br>• **Discussion**<br>• **Approval**<br>• **To Note** | To Note |
| **Data Quality Rating** | N/A |
| **FOI status** | Document may be disclosed in full |
| **Equality Impact Assessment Undertaken**<br>• **Yes**<br>• **No** | N/A |

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

## Internal

- **New Director of Operations and Performance**

Following a successful recruitment process Anthony Middleton will be joining the Trust as the Director Of Operations & Performance replacing Chris Oliver who is moving to Mid

Cheshire Foundation Trust as their Chief Operating Officer. Anthony has a wealth of operational & performance experience & is currently the Director Performance at Central Manchester Foundation Trust. He will be joining us on 15th May 2017.

- **Global Digital Exemplar Programme**

The Cerner European Collaboration Forum was held in March whereby the Trust and its partners from Wirral CCG gave a presentation on how we are involving our community in Population Health.

As Global Digital Exemplars, this is just one of the many events we are involved in where we are sharing our digital health journey as well as learning from others.

The Director of Informatics and the Medical Director attended the event at the Hilton Metropole in London on Tuesday 21 March 2017 with NHS England NHS Digital and the 15 other GDE sites. The event afforded the Trust the opportunity to hear from a number of places in the United States and Canada about similar models to what is being proposed for the NHS where leading digital hospitals have led the way in chains of hospitals and where other organisations have adopted the best of their systems. It covered their approach and the challenges they faced (including a speaker on the human factors which influences how well systems are used). They were also able to articulate what they felt were the clear benefits of being digital to these organisations and how it provides a platform for developing Accountable Care models.

The Secretary of State for Health Rt Hon Jeremy Hunt addressed the audience and declared his support for this programme and how it would enable transformational improvement in the NHS. When asked directly about the availability of funding he assured the audience that it would be available “soon” but did not identify a specific date.

## Regulatory

- **NHS Improvement**

The Trust met with NHSI on Thursday 23 March 2017 for its regular progress review meeting. The new Delivery and Improvement Director for Cheshire and Mersey, Jill Copeland, chaired the meeting. The meeting afforded the Trust the opportunity to provide updates on operational performance; financial performance; quality and strategic planning.

The meeting was positive in its nature and NHSI colleagues were supportive of the action and approach being adopted by the Trust.

## Strategy

The Trust has been fully engaged with Partners in the Aqua led process which has culminated in an outline business case describing a proposed focus on the elderly (50 plus!) being presented to the Healthy Wirral Partner Group on 23rd March.

A session has been arranged with Deloittes on 3rd April to determine how best to move the Aqua work and Accountable Care (ACO) forward strategically.

This is to be followed by an STP sponsored workshop with PWC on 6th April to ensure a road map is produced that will lead to an ACO by April 2018.

Considerable engagement with the STP and LDSP has focused on the High Quality Hospital Care (HQHC) and Digital agenda work streams and on more detailed work re clinical variation.

Whilst there are some limited opportunities for back office synergies in the Acute Care Alliance, focus has been on advancing clinical discussions.

## Celebrating Success

- **NHS Staff Survey 2016**

The Trust remained committed throughout 2016 to ensuring that the improvement achieved in the 2015 staff survey continued. A staff engagement programme was developed which focussed on a number of key priority areas identified from the 2015 survey, supported by local improvement plans within divisions.

The 2016 National Staff Survey took place between 26th September and 2nd December 2016 and was sent to 1,250 staff via a mixed mode – hard copy and email. During the survey period a high level communications plan was in place to raise awareness with staff of what had been done in response to the 2015 National NHS Staff Survey. Highlights were communicated in the We Said…We Did booklet. The Trust achieved a response rate of 46% which is above average for Acute Trusts.

The results of the 2016 National Staff Survey and management recommendations were presented to the Trust by the Chief Executive from Quality Health on 8th March. The results showed that the Trust has maintained the improvements made in 2015 survey despite the challenges faced over the last 12 months – financial pressures, unprecedented winter pressures, uncertainty regarding the impact of Sustainability and Transformation Plans and negative press publicity.

The Trust's overall staff engagement score of 3.78 was very slightly lower than the national average of 3.81. The overall organisational key findings are noted below:-

| | | 2014 | 2015 | 2016 |
|---|---|---|---|---|
| Q21a | "Care of patients / service users is my organisation's top priority" | 53% | 66% | 71% |
| Q21b | "My organisation acts on concerns raised by patients / service users | 56% | 67% | 70% |
| Q21c | "I would recommend my organisation as a place to work" | 41% | 58% | 62% |
| Q21d | "If a friend or relative needed treatment, I would be happy with the standard of care provided by this | 52% | 66% | 69% |
| KF1 | Staff recommendation of the organisation as a place to work or receive treatment | 3.29 | 3.67 | 3.73 |

It is clear that the focus on the staff engagement programme has continued to make a difference but we recognise that we are on an improvement journey and there is much more to do. The Staff Engagement work programme for 2017 needs to remain fresh and creative in approach and focus to continue making improvements in staff satisfaction and engagement.

A Trust wide plan will now be developed based on the lowest or most deteriorated areas from the 2016 staff survey as the priority areas to drive forward improvements. This will be

supplemented by Divisional specific plans based on their Divisional results and these plans will be monitored and assured through the LiA Staff Engagement Group and the Workforce and Communications Group.

**David Allison**
**Chief Executive**
**March 2017**

| Board of Directors | |
|---|---|
| **Agenda Item** | 5.1 |
| **Title of Report** | Nurse Staffing Report – January / February 2017 |
| **Date of Meeting** | 29 March 2017 |
| **Author** | Clare Pratt, Deputy Director of Nursing<br>Johanna Ashworth-Jones, Senior Analyst<br>Tracey Lewis, Head of Clinical Excellence & Organisational Development |
| **Accountable Executive** | Gaynor Westray, Director of Nursing and Midwifery |
| **BAF References**<br>**Strategic Objective**<br>**Key Measure**<br>**Principal Risk** | 1, 3 |
| **Level of Assurance**<br>**Positive**<br>**Gap(s)** | **Positive**<br>• Introduction of Specialty reporting of staffing fill rates and CHPPD allows for easier comparison of staffing data<br>• 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<br>• Reduction in reported Nursing and Midwifery staffing associated incident during January and February 2017 |
| **Purpose of the Paper**<br>**Discussion**<br>**Approval**<br>**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**<br>**Yes**<br>**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. The report also includes the details of the Trust's monthly submission of Care Hours per Patient Day (CHPPD).

## 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.

The total Trust vacancy rate for the registered nursing and midwifery workforce in February 2017 was reported as 3.63% which is an improved position from 4.45% reported in December 2016 and remains significantly better than the national average of 10%.

When reviewing the vacancy rate for in-patient and Emergency Department Band 5 posts the Trust's electronic staff records (ESR) data identified a vacancy rate of 6.08% for February 2017, this equates to 41.05 WTE Band 5 posts.

**Current Band 5 vacancy position by Division - February 2017**

**Surgery, Women and Children's**

- Vacancy rate is 2.16 % equating to 4.65 WTE Band 5 posts
- Vacancies within this division remains very low

**Medicine and Acute**

- Vacancy rate is 7.92 % equating to 36.4 WTE Band 5 posts
- The Division are currently implementing several incentives to attract and retain registrants. These include additional development posts, enhanced roles for Band 5 nurses and a review of rotational posts within the Division.

Our recruitment strategy has ensured our vacancy rate remains low to ensure a sustainable nursing workforce. Moving forward, additional elements will now be performance managed as indicated below.

- Retention – nurse turnover at WUTH is low at 8.44%, with a stability index of 91.37%, however we need to understand the reason why NMC registrants leave the Trust, in order to identify trends and determine where action may be taken to reduce the turnover rates. Embedding the Trusts exit policy will ensure that practical matters arising from an employee's resignation are dealt with efficiently, and will give individuals an opportunity to provide feedback on their perceptions of the Trust as an employer, and allows the Trust to gather valuable information which may be used constructively to enhance employment practices identify areas of good practice and areas for improvement

- International Recruitment – The Trust has approved the next phase of recruitment with Placement Group to the support recruitment of 50 nurses at a cost of £2,100 per Nurse to be in post by October 2017. A project plan is being discussed that facilitates four overseas recruitment events with nurses starting in cohorts from July 2017. Since January 2016 the NMC require all overseas nurses to undertake an assessment of their knowledge of the English language prior to entry onto the register and require a recent overall score of 7 in the academic version of the International English Language Testing System (IELTS). Candidates must achieve no less than 7 in each of the four areas of reading, writing, listening and speaking. This has reduced the number of overseas nurses ready for registration.

- Nursing Associate Pilot - The Trust, along with our local healthcare partners, is a test site to deliver a training programme for the new Nursing Associate role. This exciting opportunity will enable us to influence development of new roles that will build the future nursing workforce. We have recruited 6 trainee nursing associates who commenced a 2 year work based learning programme January 2017.

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

| | Mar 2016 | April 2016 | May 2016 | June 2016 | July 2016 | Aug 2016 | Sept 2016 | Oct 2016 | Nov 2016 | Dec 2016 | Jan 2017 | Feb 2017 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Establishment | 708 | 708 | 690 | 690 | 691 | 692 | 692 | 692 | 682 | 674 | 674 | 675 |
| Actual Numbers | 661 | 665 | 654 | 653 | 656 | 648 | 649 | 650 | 645 | 634 | 634 | 634 |
| Vacancies | 46 | 43 | 36 | 37 | 35 | 44 | 44 | 42 | 37 | 40 | 40 | 41 |
| Vacancies % | 6.48 | 6.04 | 5.26 | 5.34 | 5.09 | 6.38 | 6.34 | 6.10 | 5.50 | 5.94 | 5.92 | 6.08 |

## 3 Care Hours Per Patient Day (CHPPD)

The Department of Health Efficiency Centre has developed a Model Hospital Portal to allow comparison of hospital data across the range of Carter recommendations. At the beginning of December 2016 new data was launched within the portal based on data collected up until September 2016. The results were shared in the last report however there have been no further updates of data relating to CHPPD since then.

Local monitoring of CHPPD continues. The last six months of overall staffing fill rates and CHPPD are displayed in the tables below.

| Orthopaedics | CHPPD information | Indicators | Sept | Oct | Nov | Dec | Jan | Feb |
|---|---|---|---|---|---|---|---|---|
| Ward 10 **7.6** | Average: **6.8** Range 6-8.8 | CHPPD | 6.5 | 6.9 | 6.6 | 6.6 | 6.5 | 6 |
| | | Fill Rate | 91% | 92% | 93% | 92% | 92% | 91% |
| Ward 11 **9.6** | Average: **8.5** Range 7.6 - 10 | CHPPD | 8.4 | 7.6 | 8.9 | 6.8 | 7.6 | 7.9 |
| | | Fill Rate | 77% | 86% | 103% | 93% | 106% | 103% |
| Ward 12 **12.8** | Average: **9.8** Range 8 - 12.5 | CHPPD | 8.4 | 12.5 | 9.5 | 8.8 | 8.8 | 8 |
| | | Fill Rate | 81% | 65% | 84% | 73% | 87% | 80% |
| M1 **13.4** | Average: **11.4** Range 9 - 14.2 | CHPPD | 9.3 | 10.7 | 11.3 | 12.4 | 9 | 14.2 |
| | | Fill Rate | 73% | 75% | 78% | 70% | 82% | 79% |

| Surgical | CHPPD information | Indicators | Sept | Oct | Nov | Dec | Jan | Feb |
|---|---|---|---|---|---|---|---|---|
| Ward 17 **6** | Average: **6.2** Range 5.7 - 6.5 | CHPPD | 5.9 | 6 | 6.6 | 6.1 | 5.8 | 6.1 |
| | | Fill Rate | 98% | 99% | 114% | 108% | 107% | 110% |
| Ward 18 **5.9** | Average: **5.8** Range 5.7 -6.2 | CHPPD | 5.9 | 5.7 | 5.8 | 6 | 5.7 | 6.2 |
| | | Fill Rate | 101% | 100% | 100% | 95% | 93% | 95% |
| Ward 20 **6** | Average: 5.9 Range 5.6 - 6.7 | CHPPD | 5.8 | 5.8 | 5.8 | 6 | 5.6 | 5.8 |
| | | Fill Rate | 96% | 96% | 98% | 100% | 97% | 105% |
| ESAU **14.5** | Average:**14.7** Range 13 - 17.3 | CHPPD | 15.2 | 13 | 14.6 | 14.9 | 13.3 | 12.6 |
| | | Fill Rate | 98% | 97% | 99% | 95% | 100% | 97% |
| M2 **42.9** | Average: **30.7** Range 12 - 35.4 | CHPPD | 23.7 | 43 | 57.5 | 27 | 23 | 12 |
| | | Fill Rate | 96% | 100% | 89% | 96% | 100% | 100% |
| Dermatology **10.7** | Average: **11.5** Range 8.5 - 16 | CHPPD | 11.5 | 12.4 | 8.5 | 13.2 | 8.5 | 8.6 |
| | | Fill Rate | 100% | 100% | 100% | 100% | 100% | 100% |

| Women's & Children's | CHPPD information | Indicators | Sept | Oct | Nov | Dec | Jan | Feb |
|---|---|---|---|---|---|---|---|---|
| Children's **10.1** | Average: **10.9** Range 8.1 - 14.9 | CHPPD | 11.7 | 10.2 | 9.3 | 12.2 | 9.9 | 12.2 |
| | | Fill Rate | 111% | 112% | 104% | 98% | 95% | 97% |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Maternity **7** | Average: **6.6** Range 5.7 - 6.7 | CHPPD | 6 | 6.7 | 7.6 | 7.6 | 6.6 | 7.6 |
| | | Fill Rate | 94% | 99% | 95% | 102% | 98% | 100% |
| Delivery Suite **36.6** | Average: **36.3** Range 30.8 - 45.5 | CHPPD | 30.8 | 37.3 | 39 | 39 | 37.9 | 41.3 |
| | | Fill Rate | 95% | 95% | 108% | 121% | 108% | 106% |
| Ward 54 **7.8** | Average: **7.5** Range 6.4 - 9.1 | CHPPD | 7.5 | 6.4 | 7.2 | 7.9 | 6.3 | 6.6 |
| | | Fill Rate | 92% | 76% | 78% | 84% | 75% | 71% |
| Neonatal **12.5** | Average: **12.3** Range 10.9- 14.2 | CHPPD | 12.6 | 14.2 | 12.1 | 10.9 | 12.3 | 13.4 |
| | | Fill Rate | 107% | 92% | 99% | 93% | 103% | 90% |

| Acute Care | CHPPD information | Indicators | Sept | Oct | Nov | Dec | Jan | Feb |
|---|---|---|---|---|---|---|---|---|
| MSSW **8.2** | Average: **7.2** Range 5.9 - 8.8 | CHPPD | 6.3 | 6.4 | 7.2 | 6 | 6.3 | 7 |
| | | Fill Rate | 84% | 83% | 89% | 79% | 84% | 91% |
| AMU **10.6** | Average: 12 Range 10.3 -14.9 | CHPPD | 14.9 | 14.3 | 9.5 | 13.8 | 14.2 | 10.3 |
| | | Fill Rate | 97% | 95% | 91% | 92% | 97% | 102% |
| EDRU **9.6** | Average: **9.5** Range 7.7 -10.7 | CHPPD | 10.3 | 9.1 | 10.6 | 10.5 | 7.7 | 9.6 |
| | | Fill Rate | 106% | 103% | 103% | 99% | 101% | 99% |
| ITU **35.8** | Average: **34** Range 26.8 -41.6 | CHPPD | 36.3 | 35.6 | 29.2 | 26.8 | 29.6 | 33.9 |
| | | Fill Rate | 90% | 88% | 90% | 94% | 89% | 72% |
| HDU **27.6** | Average: **27** Range 21.6 -36.3 | CHPPD | 25.1 | 26.9 | 30.9 | 25.2 | 23.7 | 21.6 |
| | | Fill Rate | 99% | 93% | 98% | 96% | 96% | 95% |

| DME / Rehab | CHPPD information | Indicators | Sept | Oct | Nov | Dec | Jan | Feb |
|---|---|---|---|---|---|---|---|---|
| Ward 21 **6.3** | Average: **5.6** Range 5.1 - 6.4 | CHPPD | 5.8 | 6.1 | 6.5 | 5.8 | 6.3 | 6.3 |
| | | Fill Rate | 92% | 96% | 105% | 95% | 109% | 107% |
| Ward 22 **5.7** | Average: 5.9 Range 5.4 - 6.6 | CHPPD | 5.7 | 5.7 | 5.5 | 5.4 | 5.4 | 5.5 |
| | | Fill Rate | 97% | 99% | 99% | 96% | 96% | 97% |
| Ward 23 **7.3** | Average: **7** Range 6.7 - 7.8 | CHPPD | 7 | 6.8 | 7.8 | 6.9 | 6.7 | 7 |
| | | Fill Rate | 98% | 98% | 97% | 98% | 97% | 98% |
| Ward 27 **7.5** | Average: **6.7** Range 5.7 - 9.4 | CHPPD | 6.7 | 9.4 | 6.3 | 5.6 | 5.7 | 5.7 |
| | | Fill Rate | 97% | 98% | 99% | 97% | 89% | 91% |
| M2 Rehab **5.5** | Average: **5.6** Range 5.2 - 6 | CHPPD | 5.4 | 4.9 | 5.5 | 5.7 | 5.2 | 5.3 |
| | | Fill Rate | 96% | 96% | 98% | 97% | 97% | 96% |
| CRC **6** | Average: **6.1** Range 5.6 - 6.3 | CHPPD | 6 | 6.3 | 6.3 | 6.8 | 6.2 | 6.5 |
| | | Fill Rate | 98% | 106% | 106% | 107% | 107% | 114% |

| Medicine | CHPPD information | Indicators | Sept | Oct | Nov | Dec | Jan | Feb |
|---|---|---|---|---|---|---|---|---|
| Ward 26 **6.6** | Average: **6.1** Range 5.6 - 6.7 | CHPPD | 6.7 | 6.3 | 6 | 5.7 | 5.9 | 6.4 |
| | | Fill Rate | 95% | 96% | 94% | 94% | 94% | 102% |
| Ward 30 **8.1** | Average: **7** Range 6.2 - 7.5 | CHPPD | 7.5 | 7.2 | 7 | 7.4 | 6.2 | 6.3 |
| | | Fill Rate | 91% | 86% | 90% | 88% | 87% | 91% |
| Ward 32 **6.7** | Average: **7.6** Range 6.1 - 10.5 | CHPPD | 7.7 | 6.1 | 5.8 | 6 | 5.6 | 5.8 |
| | | Fill Rate | 103% | 91% | 94% | 91% | 91% | 94% |
| CCU **14.9** | Average: **13.1** Range 12.2 - 16.3 | CHPPD | 16.3 | 14.4 | 12.1 | 13.2 | 12.8 | 12.3 |
| | | Fill Rate | 100% | 93% | 93% | 87% | 86% | 89% |
| Ward 33 Changed to winter November 2016 | Average: **5.9** Range 5.8 - 6 | CHPPD | 5.9 | 6 | 5.9 | 5.9 | 6 | 6.2 |
| | | Fill Rate | 90% | 86% | 92% | 90% | 92% | 95% |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Ward 36 **6** | Average: **5.6** Range 5.2 - 6 | CHPPD | 5.5 | 5.5 | 5.6 | 5.5 | 5.2 | 5.3 |
| | | Fill Rate | 87% | 94% | 94% | 91% | 90% | 92% |
| Ward 37 **7.5** | Average: **7** Range 5.8 - 7.9 | CHPPD | 7.6 | 7.4 | 6.9 | 6.8 | 6.7 | 5.8 |
| | | Fill Rate | 97% | 101% | 96% | 91% | 94% | 100% |
| Ward 38 **5.7** | Average: **5.2** Range 3.2 - 5.9 | CHPPD | 6.4 | 3.2 | 5.6 | 5.7 | 5.7 | 5.3 |
| | | Fill Rate | 106% | 93% | 98% | 91% | 99% | 97% |
| Ward 25 **9.4** | Average: 8.8 Range7.5 - 11.4 | CHPPD | 8.2 | 8 | 11.4 | 9 | 7.5 | 7.1 |
| | | Fill Rate | 100% | 111% | 119% | 124% | 122% | 115% |
| Ward 24 (IPC) | Average : 7 Range 6.8 -7.2 | CHPPD | | | | 7.2 | 6.8 | 7 |
| | | Fill Rate | | | | 100% | 92% | 98% |

As detailed in the last staffing reporting, an Associate Director of Nursing (ADN) report has been introduced to provide an auditable trail. The report provides details from Ward Sisters/Charge Nurses and Matrons on rational for variance from planned staffing, mitigating actions that have been taken and an overall sign off from the ADN to provide assurance that safe staffing was in place. This assurance report also helps monitor trends for both over 100% and under 100% fill rates to help inform divisions regarding staffing establishments. Following on from the introduction of this report there is also an increased level of confidence in the data reported as all variances are reviewed at a greater level.

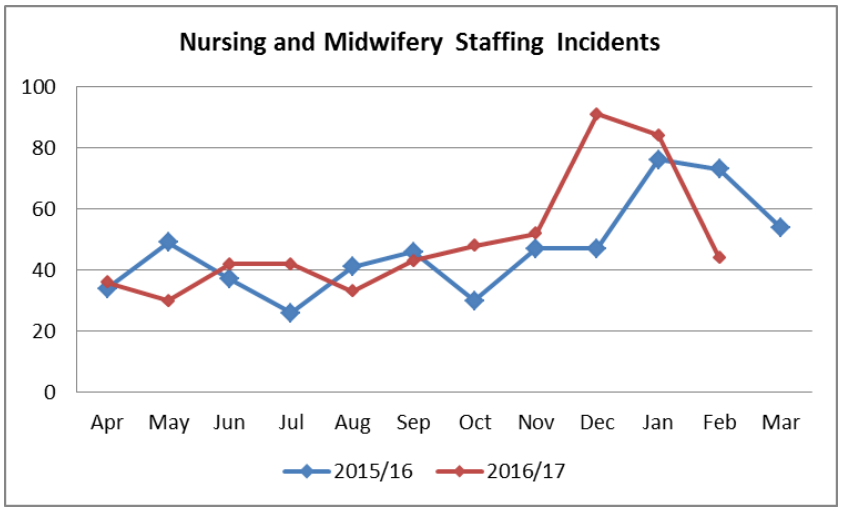
Ward 54 and M1 have been RAG rated as red for their overall staffing fill rate within this reporting period. Ward 54 in January and February 2017 and Ward M1 in January 2017. Staffing levels were deemed safe and assurance provided within the ADN assurance report as outlined below.

Ward 54: Due to reduced elective activity CSW staff were reallocated to support areas of higher patient acuity and occupancy. Appropriate staffing was in place at all times and RN hours were at an acceptable level for ward.

Ward M1: Staffing was reduced to reflect the reduction in activity, staff were reallocated to support other areas where required and staffing was in line with patient acuity as reflected in the high CHPPD.

## 4 Reported Staffing Incidents

Following on from the extraordinary spike of reported Nursing and Midwifery staffing associated incidents in December 2016 we have seen a reduction in reported incidents during January 2017 and February 2017, with a reported total of 44 in February 2017 compared to 73 in February 2016. A monthly summary report highlighting themes and trends is reported to the Senior Nursing and Midwifery Team and during February there were no areas that featured as having a significant frequency in staffing incidents. In addition to the decline in the number of incidents over the past two months there has also been a reduction in the highest recorded Risk Score associated with the reported incidents.




## 5 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 acuity review is due to be completed in Q1 2017 and a meeting has been held with key staff to facilitate this during April 2016 and May 2016. A newly devised SOP for safe staffing reporting will be disseminated during this meeting
- Future reports will feature a breakdown of RN/RM and CSW CHPPD to allow the Board of Directors to have grater oversight of Safe Staffing across the organisation

## 6 Recommendations

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

| Board of Directors | |
|---|---|
| **Agenda Item** | 5.3 |
| **Title of Report** | Report of the Quality & Safety Committee – 08 March 2017 |
| **Date of Meeting** | 29 March 2017 |
| **Author** | Cathy Maddaford, Chair of the Quality and Safety Committee |
| **Accountable Executive** | Gaynor Westray, Director of Nursing and Midwifery<br>Dr Susan Gilby, Medical Director |
| **BAF References**<br>• **Strategic Objective**<br>• **Key Measure**<br>• **Principal Risk** | Risks 1, 2, 3, 4, 12 and 19 |
| **Level of Assurance**<br>• **Positive**<br>• **Gap(s)** | Gaps with mitigating action |
| **Purpose of the Paper**<br>• **Discussion**<br>• **Approval**<br>• **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**<br>• **Yes**<br>• **No** | N/A |

This report provides a summary of the work of the Quality and Safety Committee which met on the 08 March 2017. Key focus areas are those which address the gaps in assurance/control in the Board Assurance Framework.

**Board Assurance Framework (BAF)**

The Committee reviewed the BAF and agreed the following:

- **Risk 1 – Quality and Safety** – to be updated to reflect the recent Never Event in Theatres and the position in Ophthalmology.
- **Risk 12 – C difficile** – risk reduced to reflect the substantial work undertaken to maintain and improve infection prevention and control processes which have resulted in a significant reduction in the number of avoidable cases of C difficile being reported in 2016/17.

- **Risk Appetite Statement** – draft narrative statement reviewed ahead of this being included in an overarching matrix which will be presented to the Board for approval in April 17.
- **No new risks at 15+ reported**
- **Risks within the Trusts control** – the Committee supported the recommendation by Finance Business Performance and Assurance Committee to distinguish which risks, either in full or in part, were within the gift of the Trust to control and those which relied upon health and social care partners.

**Ophthalmology**

The Committee received the updated position within the ophthalmology service following the recent Never Event. The Interim Medical Director outlined the action taken by the Trust to ensure patient safety ahead of the commissioned external review by the Royal College of Ophthalmologists in April 2017.

**Workforce & OD Dashboard and Report**

The Committee received the Workforce and OD Dashboard Report and agreed to highlight the following to the Board:

- Vacancy rates remained low although this was higher in the Division of Medicine and Acute which was receiving particular focus from the Trust
- Sickness absence rates had increased slightly over the winter period although work was ongoing to address this
- Attendance at the recent Apprenticeship Event was reported as strong which would support the Trust in achieving its aim of employing 131 apprentices a year.
- The number of grievances reported in the quarter was deemed to be high prompting the Committee to request further detail to be able to understand if this was an issue in a particular area.

**The Lampard Review**

The Committee received notification that NHSI and NHSE had requested an update on the actions taken in response to Kate Lampard's report into the themes and lessons learnt from the NHS investigations into the matter relating to Jimmy Saville which was published in February 2015. NHS Trusts had 9 recommendations in relation to a variety of Safeguarding issues, 8 of those recommendations the Trust has complied with. The 1 recommendation that the Trust, along with many Trusts, is not compliant with is as follows:

- *All NHS hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years.*

Following further discussion at the Senior Management Team and the Workforce and Communications Groups, it was recommended to the Quality and Safety Committee that the Trust remained consistent in its original response because of the following reasons:

**Statutory Requirements** - NHS England confirm that periodic criminal record checks are not a legal requirement, therefore any decision to require DBS checks and the frequency by which they are carried out should be risk assessed and agreed at a local level.

**A survey undertaken with HR&OD Directors** within the local footprint confirms only one Trust within the region, namely Mersey Care undertake 3 yearly DBS checks. There is no Trust in the LDSP footprint that plans to introduce the requirement for staff to undertake DBS checks on a 3 yearly basis in light of the Kate Lampard report.

**The Trust has in place a Safe Employment Policy** detailing the requirement for all new appointments with the exception of admin and clerical staff as being subject to an Enhanced or Standard check with the Disclosure and Barring Service. There is currently no requirement for staff in any areas of the Trust to undertake a DBS check every 3 years unless subject to a service level agreement.

**Professional body requirements:-**

- Nurses and Midwives are required to undertake a process of revalidation every 3 years in order to maintain their professional registration. This process requires the completion of details regarding Health and Character to include the requirement to declare any criminal offences.
- Medical Staff are also required to demonstrate that they meet the professional standards set by the GMC. This includes the requirement to evidence annual appraisals have taken place in order to revalidate.
- Senior Managers within the Trust are required to comply with the Fit & Proper Persons test. This process requires the completion of details regarding Health and Character to include the requirement to declare any criminal offences.

Since the original decision in 2015 the Trust has agreed to amend its HR policies to ensure that all staff are clear as to the need to self-declare should they have any criminal convictions, and to commit to undertaking annual communications to ensure staff are clear of this requirement. The Committee also requested that the Director of Workforce confirm that all staff have had a CRB/DBS check since its introduction in 2004.

The Committee requested that this be formally noted by the Board.

**NHS Staff Survey**

The Committee received the 2016 NHS Staff Survey Results acknowledging that members had also received a formal briefing on these from the Chief Executive of Quality Health earlier in the day. The Committee recognised that maintaining the position from the previous year was notable given the significant improvements made in that year. The Committee agreed that the areas highlighted for improvement would be supported with an action plan developed by staff over the coming weeks. Full details of the action plan are due to be presented to the Committee in May 2017.

**Health and Safety – Quarter 3 Report**

The Committee received the detailed Quarter 3 Report and agreed to highlight the following areas to the Board:

- The outcome of the Asbestos Report revealed no high risk items although there were three areas of work that needed to be undertaken as soon as possible which were being progressed.
- A rise in staff health and safety incidents compared to Quarter 2 which require further investigation

The Board will receive the Annual Health and Safety Report in May 2017.

**Quality Account – Quarter 3 Report**

The Committee received the Quarter 3 report and agreed to highlight the following areas to the Board:

- **Support with Eating and Drinking** – although good progress was reported via the patient experience questionnaires, the Committee noted that the response rate was low and the results did not triangulate with the Trust's nursing audit in this area.
- **Pressure Ulcers** – although there was a reduction in Grade 2 pressure ulcers, there had been a further avoidable Grade 3 pressure ulcer necessitating further work in this area
- **Missed Critical Medication errors**- the Committee was disappointed with the deterioration in compliance in this area despite the increased work being undertaken. The Committee supported the action being taken to strengthen individual accountability and that all missed medication errors not just critical ones should be captured and improved going forward

- **Reduced Emergency Admissions within 30 days** – a slight improvement was reported compared to the previous year although this was still short of the overall target
- **Patient Flow –** performance was reported below target with increased work being undertaken to embed this methodology across the Trust
- **End of Life Care** – good progress was reported and acknowledged as part of the Committees review of the 6 monthly detailed report in this area although it was recognised that further improvements could still be made.

**CQC Progress Report**

The Committee received a full progress report and agreed to highlight the following areas to the Board:

- Improvements were reported in corporate areas and Divisional action plans although the concerns highlighted in the Quality Report in relation to missed medication errors were evidenced in the internal Care Quality inspections.
- The Committee supported the increased focus on work being undertaken to strengthen clinical handovers although regular audit in this area was deemed essential to ensure the processes were embedded.
- The next engagement meeting was confirmed as 10th April 2017

**Quality Impact process – Cost Improvement and Transformation Portfolio**

The Committee was pleased with the changes made to the quality impact process to ensure that a full risk assessment was undertaken ahead of progressing with any cost improvement plans with additional evaluation reviews to be undertaken thereafter which would measure the impact both positive and negative.

**Clinical Quality Dashboard**

The Committee supported the recommendation that the dashboard be completely overhauled in line with the findings of the Quality Governance Review which was currently being undertaken.

**Quality Governance Review**

The Committee was observed by Darren Thorne from Facere Melius Ltd as part of the review on Quality Governance which had been commissioned by the Medical Director. This work builds upon the findings from the Monitor Well led Governance Review undertaken in June 2016.

**Major Incident Plan**

The Committee received the full Major Incident Plan and an update on the work undertaken to ensure that the Trust was able to respond appropriately to national and regional incidents in the future. The Committee approved the plan.

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

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

**Cathy Maddaford**
**Chair of Quality and Safety Committee**

| BOARD OF DIRECTORS | |
|---|---|
| **Agenda Item** | 5.4 |
| **Title of Report** | Quality Account Priorities for 2017/18 - Proposal |
| **Date of Meeting** | 29.3.17 |
| **Author** | Joe Roberts, Head of Assurance |
| **Accountable Executive** | Dr Susan Gilby – Medical Director<br>Gaynor Westray – Director of Nursing and Midwifery |
| **BAF Reference** | Risk 2 - Patient Experience: The challenging NHS environment impacts on patient satisfaction impacting on clinical outcomes & public confidence |
| **Level of Assurance** | Full |
| **Purpose of the Paper** | Discussion and approval |
| **Data Quality Rating** | Mixture of gold, silver and bronze data |
| **FOI status** | Document may be disclosed in full |
| **Equality Impact Assessment** | Not required |

## 1. Executive Summary

The purpose of this paper is to propose to the Board the draft priorities for the Quality Account in 2017/18. It is proposed that we should maintain five of the same priorities as in 2016/17 (pressure ulcers, medication – critical missed doses, patient flow, nutrition and hydration, and end of life care), while discontinuing readmissions as a priority topic. It would not be replaced, and over time the intention is to reduce the number of priorities to three or four. This would encourage a more focused approach and improve our chance of achieving the targets which we have set for ourselves.

## 2. Background

The Quality Account is a mandatory document which Trusts have had to produce every year since the Health and Social Care Act 2009 came into force. The contents of the document are stipulated by the regulations made under the Act, and by guidance updated each year by NHS Improvement. In addition to reporting performance against a range of

national indicators, each Trust should identify at least three priority topics from within its own services and report progress against its own targets in the Quality Account. Responsibility for selecting these priorities ultimately rests with the Trust Board although it is expected that they will take into account the views of their organisation's internal and external stakeholders.

During 2016/17 the Trust had six priorities – the table below summarises the targets for each and the progress made at the end of quarter 3 of this financial year.

| Topic and target | Performance at end of Q3 |
|---|---|
| *Nutrition and Hydration*<br>• 85% of patients will report receiving assistance with eating, and 90% with drinking, if they needed it<br>• Patients' nutritional and fluid input will be recorded in their electronic record of care by the end of quarter 4 | • In quarter 3, 93% of patients said that they received help with eating and drinking if they needed it (but the number of patients completing the Learning with Patients Questionnaire was low)<br>• Electronic recording of food intake is high on the priority list for the Wirral Millennium project team but is not in place yet |
| *Pressure Ulcers*<br>• 50% reduction in grade 2 pressure ulcers compared to the previous year<br>• Zero tolerance of avoidable grade 3 or 4 pressure ulcers | • 47% reduction in the number of grade 2 pressure ulcers compared to the same period last year<br>• There have been 3 avoidable grade 3 pressure ulcers during first three quarters of 2016/17 |
| *Medication – Missed Doses*<br>• No more than 3% of critical medication doses to be missed<br>• An appropriate care score of 70 | • 6.4% of critical medications missed (audit in quarter 3)<br>• Appropriate Care Score of 56 in Quarter 3 |
| *End of Life Care*<br>• Relaunch End of Life Care Strategy<br>• More and better training for staff to care for patients at the end of life<br>• Increased staffing for palliative care – new Consultant posts<br>• Implement new Record of Care to plan and record patients' care | • End of Life Care Strategy revised and relaunched (October 2016)<br>• Training needs analysis completed (August 2016)<br>• End of Life Care Facilitators delivering training programme to staff<br>• New Palliative Care Consultant posts recruited (second Consultant commences in post May 2017)<br>• New Record of Care in place, now using version 2<br>• Encouraging results from audit of record of care and Relatives' Bereavement Survey (November 2016) |
| *Patient Flow – SAFER initiative*<br>• We will aim for 25% of all medical discharges from base wards to be before noon<br>• We will aim to improve compliance within specialty care ('right patient right bed') so that no more than 10% of patients are admitted to the 'wrong' bed | • SAFER has been rolled out to all Medical wards<br>• On average, 15% of discharges are taking place before noon<br>• 'Right patient right bed' is proving difficult to measure accurately although current data is not showing a clear trend |
| *Readmissions*<br>• achieve a 1% reduction on overall readmissions compared to 2015/16<br>• No more than 10% readmissions to be potentially avoidable | • Readmissions percentage for year to date is 8.9% (compared to 9.1% last year)<br>• The percentage of these readmissions considered avoidable in our audit fluctuates from month to month but is slightly above the target of 10% |

Traditionally the Trust has maintained the same priority topics until the targets have been achieved in full. Accordingly, in January 2017 the Clinical Governance Group agreed that we should recommend retaining five of the six priorities for 2017/18, while discontinuing readmissions. The rationale for readmissions to no longer be included is that there is no specific programme of work associated with it, although in recent years some other initiatives have contributed to improvement. We originally included readmissions as a 'balancing measure', because there was potentially a risk that measures to accelerate

discharge could result in patients being discharged too early and then readmitted through the Emergency Department soon after. Although the level of unplanned readmissions has fluctuated and we have not always met our Quality Account target, this risk has not been realised.

The Group also decided that we should consult with stakeholders regarding the choice of a new priority topic to replace readmissions. This consultation took place in February and early March 2017. This involved writing to the three statutory consultees for the Quality Account (Wirral Council's Health and Families Performance Panel, the Clinical Commissioning Group, and Health Watch); an online survey for staff, publicised through the midweek e-mail bulletin; and information stands at Arrowe Park and Clatterbridge Hospitals to seek views from patients and visitors. Consultees were asked to choose from a list of nine options. This list was derived from the objectives in the Trust's Quality Improvement Strategy for 2016-19 but excluded topics which were current Quality Account priorities (e.g. end of life care), previous priorities which were discontinued (e.g. dementia care) or which are reported in the QA anyway without being one of the six priorities (e.g. infection prevention and control).

At the time of writing none of the three external stakeholders has expressed any preference for a new topic. The response to the staff and public consultation was disappointing (55 responses in total). There was strong support for retaining five of the six priorities (85%). However, the response to the question about what should be the replacement priority was inconclusive, with no clear majority for any option – see the table below:

| Option | % favoured |
|---|---|
| Reducing outpatient cancellations | 22.4 |
| Implement the seven day working plan | 12.2 |
| Ensure good communication (handover of care) | 12.2 |
| Advancing Quality: implementing new care bundles | 12.2 |
| Review the Risk Management training programme | 10.2 |
| Develop patient reported experience measures | 10.2 |
| Deliver the Sign Up to Safety pledge (sepsis, missed fractures, pressure ulcers) | 8.2 |
| Reduce clinical variation through development of pathways and care bundles | 8.2 |
| Implement guidance from NICE | 4.1 |

### 3. Key Issues

Performance data for quarter 4 is not yet available but it appears that the existing targets are unlikely to be met in full. When targets are not met, it is practice in the Trust to roll forward the priority into the next financial year. In certain cases it has been difficult to measure performance accurately – for example, last year the methodology for the audits of avoidable readmissions and of medication missed doses was changed in order to produce more robust data.

The Trust has always set either five or six priorities in its Quality Account, divided between the categories of patient safety, patient experience and clinical effectiveness. However, there is no requirement to have this number; the regulations state that Trusts should have "at least three". The Head of Assurance has reviewed Quality Accounts from a range of

Acute Trusts – many have fewer priority topics than we do and several have just the minimum of three. The advantage of having fewer priorities is that an organisation can focus more closely on those which it does have, and thus be more likely to achieve them.

**4. Next Steps**

It is proposed to discontinue readmissions as a priority topic for 2017/18, while retaining the other five priorities from 2016/17 and adding no new topics. In future years the number of Quality Account priorities will be further reduced so that the Trust has no more than four in any one year.

At this stage we do not normally set performance targets for each of the priorities – these are set by checking performance data after the year end; reviewing the milestones in the Quality Improvement Strategy; and discussing with senior managers and clinical leaders responsible for the services concerned about what level of improvement is necessary and feasible. These specific targets for 2017/18 will be incorporated into the 'Looking Forward' section of later draft of the 2016/17 Quality Account. The key criteria are that the targets should be demanding but achievable, and there should be clear, reliable metrics which make it obvious whether or not they have been met.

In the meantime, work has commenced on the 2016/17 Annual Quality Account. An initial draft, based on ten months' worth of data, was presented to Clinical Governance Group in March 2017. In early April the draft will be updated with the full year's data, and subsequent drafts will be presented to Quality and Safety Committee, the Audit Committee, and finally the Board of Directors, for discussion and approval. It will also be sent to the local authority, the CCG and Healthwatch for their comments. The report will be signed by the Chairman and Chief Executive following the May Board meeting and published in early June.

**5. Conclusion**

The Trust has fulfilled the requirement to seek opinions from internal and external stakeholders about what its Quality Account priorities should be. Retention of five out of the six priorities reflects the views of those who responded to the consultation. By reducing the number of priorities from six to five, and further reducing the number in future, the Trust will be able to focus more closely on its Quality Account priorities in future.

**6. Recommendation**

The Board is asked to approve the selection of priority topics for 2017/18 as set out in this paper.

| Board of Directors | |
|---|---|
| **Agenda Item** | **6.1.1** |
| **Title of Report** | **Integrated Dashboard and Exception Reports** |
| **Date of Meeting** | **29th March 2017** |
| **Author** | **Chris Oliver, Director of Operations**<br>**John Halliday, Assistant Director of Information** |
| **Accountable Executive** | **Janelle Holmes**<br><br>**Chief Operating Officer** |
| **FOI status** | **Document may be disclosed in full** |
| **BAF References**<br><br>• **Strategic Objective**<br>• **Key Measure**<br>• **Principal Risk** | **All Strategic Objectives (1 through 7)**<br><br>**All Key Measures (1A through 7D)**<br><br>**All Principal Risks** |
| **Level of Assurance**<br><br>• **Positive**<br>• **Gap(s)** | **Partial with gaps** |
| **Purpose of the Paper**<br><br>• **Discussion**<br>• **Approval**<br>• **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**<br><br>• **Yes**<br>• **No** | **No** |

## 1. Executive Summary

This report provides a summary of the Trust's performance against agreed key quality and performance indicators. The Board of Directors is asked to note the performance to the end of February 2017.

## 2. Summary of Performance Issues

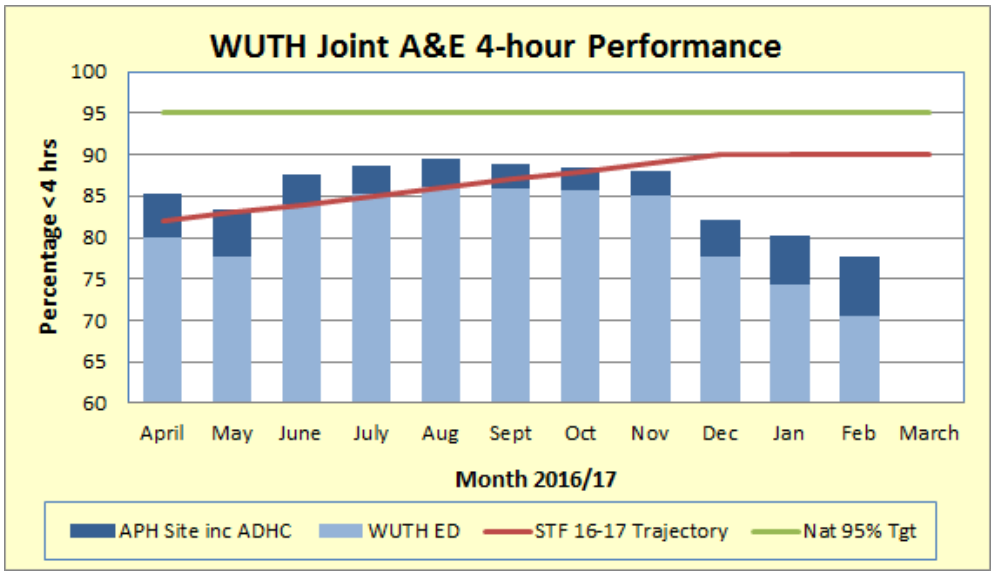
The key issues relating to external validation is achievement of the A&E and RTT targets, with detailed comments against each area below.

## 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 February was 77.64% as measured across a combined ED and All Day Health Centre performance at the Arrowe Park site. ED alone was 70.60%.

The performance in February for the emergency access standard did not achieve the regulatory compliance level of 95% or the Sustainability and Transformation Fun (STF) trajectory of 90.0%, as illustrated below.




Despite improving performance from June onwards with the opening of the ambulatory care unit the impact of both the decommissing of the GP All Day Health Cente by NHSE in November followed by the CQC action in December which saw the suspension of 75% of the Domiciliary Care provision and 4 registered care homes has seriously impacted the organisation agreed recovery trajectory. These capacity changes happened in the 'winter months' at the same times as 2% increase in overall attendances, 6% increase

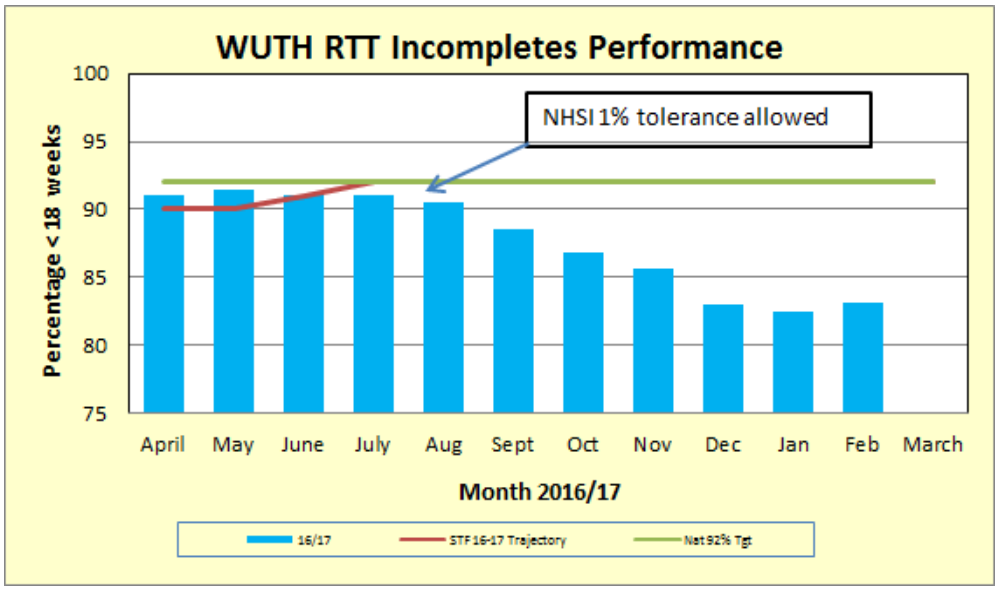
ambulance arrivals peaking in January & February with a 35% increase in those patients with a higher acuity (triaged to resuscitation area in ED). Both the increase in acuity & corresponding decrease in egress resulted in an overall increase of 2 days in the non elective Length of Stay & deterioration in the ED performance metric despite having both planned & unplanned escalation capacity open throughout this period. The number of medically optimised patients throughout this period tracks at around 100 patients per day.

The fragility of the care home and domiciliary care market, is a national concern with a significant impact on Wirral due to the health economy's elderly demographics. The Trust has met with other economy organisations and has agreed to fully scope the community offer but also to include those patients who remain in acute care but are medically optimised. It is envisaged that the bed modelling work with provide a greater understanding of the current capacity and where care could be delivered to obtain both improvements in patient flow but also the cost of the current bed base across all organisations. The Board will be kept updated on this economy wide bed modelling work.

**b. 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.

As expected the Trust did not achieve the national standard and STF trajectory at the end of February, with the final position being reported at 83.15%. In addition the Trust reported 4 x 52 week breaches. Full Root Cause Analysis has been completed and patient treatment plans are in place..




The Trust continues to make significant progress against the agreed improvement plan currently focussing on capacity & demand modelling & patient level tracking as opposed to over 18 week breach validation. This work is being supported by the elective Intensive Support Team. Data quality reports are being validated so that speciality level recovery plans can be completed by

the Divisional Business Managers. In late February NHSE confirmed additional funding (Circa £200k) would be made available to the Trust to support with validation of patient records. The validation work is being coordinated by the newly formed Patient Tracking Team

### c. 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. WUTH performance for the end of February was 99.80%.

### d. 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 does not foresee non-compliance with cancer waiting time standards.

### e. Infection Control

For C Difficile, there have been three cases in the month of February, however only one of these was considered avoidable. The year-to-date position is therefore 13 cases, and below the maximum plan trajectory of 27 cases for this period.

## 4. Recommendation

The Board of Directors are asked to:

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

**WUTH Integrated Performance Dashboard - Report on February for March 2017 BoD**

| Area | Indicator / BAF | Dec | Jan | Feb | Trend / Future Concern | *Target (for 'Green')* | Latest Period | Exec Lead |
|---|---|---|---|---|---|---|---|---|
| Meeting Our Vision | **Satisfaction Rates** | | | | | | | |
| | Patient - F&F "Recommend" Rate | 98% | 98% | 99% | | *>=95%* | February 2017 | GW |
| | Patient - F&F "Not Recommend" Rate | 1% | 1% | 0% | | *<=2%* | February 2017 | GW |
| | Staff Satisfaction (engagement) | 3.97 | 3.97 | 3.97 | | *>=3.69* | Q2 2016/17 | JM |
| | **First Choice Locally & Regionally** | | | | | | | |
| | Market Share Wirral | 82.6% | 83.0% | 80.6% | | *>= 85%* | Sept to Nov 2016 | MC |
| | Demand Referral Rates | -6.8% | -7.3% | -7.9% | | *>= 3% YoY variance* | Fin Yr-on-Yr to Feb 2017 | MC |
| | Market Share Non-Wirral | 7.9% | 8.0% | 7.0% | | *>=8%* | Sept to Nov 2016 | MC |
| | **Strategic Objectives** | | | | | | | |
| | Harm Free Care | 95% | 96% | 96% | | *>= 95%* | December 2016 | GW |
| | HIMMs Level | 5 | 5 | 5 | | *5* | February 2017 | MB |
| Operational Excellence | **Key Performance Indicators** | | | | | | | |
| | A&E 4 Hour Standard | 82.12% | 80.31% | 77.64% | | *>=95%* | February 2017 | CO |
| | RTT 18 Weeks Incomplete Position | 83.00% | 82.51% | 83.15% | | *>=92%* | February 2017 | CO |
| | Diagnostics 6 Week Standard | 99.68% | 99.64% | 99.80% | | *>=99%* | February 2017 | CO |
| | Cancer Waiting Time Standards | On track | On track | On track | | *All met at Trust level* | Q3 to Dec 2016 | CO |
| | Infection Control (c Diff cumulative) | 1 MRSA; 11 C diff | 1 MRSA; 12 C diff | 1 MRSA; 13 C diff | | *0 MRSA Bacteraemia in month, and cdiff less than cumulative trajectory* | February 2017 | GW |
| | **Productivity** | | | | | | | |
| | Delayed Transfers of Care | 43 | 43 | 39 | | *Metric definition redefined* | February 2017 | CO |
| | Delayed Complex Care Packages | 66 | 78 | 84 | | *<= 45* | February 2017 | CO |
| | Bed Occupancy | 93.7% | 91.6% | 91.1% | | *<=85%* | February 2017 | CO |
| | Bed Occupancy Medicine | 92.7% | 95.1% | 95.3% | | *<=85%* | February 2017 | CO |
| | Theatre Utilisation | 92.5% | 83.6% | 88.2% | | *>=85%* | February 2017 | CO |
| | Outpatient DNA Rate | 8.5% | 7.9% | 7.4% | | *<=6.5%* | February 2017 | CO |
| | Outpatient Utilisation | 81.8% | 82.0% | 82.2% | | *>90%* | February 2017 | CO |
| | Length of Stay - Non Elective Medicine | 5.6 | 5.3 | 4.9 | | *<= 5.0* | February 2017 | CO |
| | Length of Stay - Non-elective Trust | 5.0 | 5.1 | 5.5 | | *<=4.2* | February 2017 | CO |
| | Contract Performance (activity) | -4.0% | -4.0% | -4.2% | | *0% or greater* | February 2017 | CO |
| | **Finance** | | | | | | | |
| | Contract Performance (finance) | -0.9% | -1.4% | -1.6% | | *On Plan or Above YTD* | February 2017 | DJ |
| | Expenditure Performance | -0.7% | -1.5% | -2.2% | | *On Plan or Below YTD* | February 2017 | DJ |
| | CIP Performance | 0.0% | 0.0% | 0.0% | | *On Plan or Above* | February 2017 | DJ |
| | Capital Programme | 24.6% | 26.5% | 22.4% | | *On Plan* | February 2017 | DJ |
| | Non-Core Spend | 9.4% | 9.3% | 9.3% | | *<5%* | February 2017 | DJ |
| | Cash Position | -30.0% | -21.0% | 76.0% | | *On plan or above YTD* | February 2017 | DJ |
| | Cash - liquidity days | -28.9 | -30.5 | -32.9 | | *> 0 days* | February 2017 | DJ |
| A Healthy Organisation | **Clinical Outcomes** | | | | | | | |
| | Never Events | 0 | 0 | 1 | | *0 per month* | February 2017 | SG |
| | Complaints | 28 | 24 | 32 | | *<30 per month* | February 2017 | GW |
| | **Workforce** | | | | | | | |
| | Attendance | 95.61% | 95.59% | 95.61% | | *>= 96%* | February 2017 | JM |
| | Qualified Nurse Vacancies | 4.45% | 4.04% | 3.63% | | *<=6.5%* | February 2017 | GW |
| | Mandatory Training | 92.70% | 92.24% | 91.84% | | *>= 95%* | February 2017 | JM |
| | Appraisal | 92.17% | 83.46% | 83.68% | | *>= 85%* | February 2017 | JM |
| | Turnover | 10.60% | 10.46% | 10.51% | | *<10%* | February 2017 | JM |
| | Agency Spend | 10.6% | 12.5% | 12.6% | | *On plan* | February 2017 | GW |
| | Agency Cap | 85 | 88 | 103 | | *0* | February 2017 | JM |
| External Validation | **National Comparators** | | | | | | | |
| | Advancing Quality (not achieving) | 2 | 2 | 2 | | *All areas above target* | February 2017 | SG |
| | Mortality: HSMR | 88.92 | 89.56 | 92.01 | | *Lower CI < 0.90* | April to Nov 2016 | SG |
| | Mortality: SHMI | 0.983 | 0.983 | 0.983 | | *Lower CI < 90* | Jan to Dec 2015 | SG |
| | **Regulatory Bodies** | | | | | | | |
| | NHSI - Use of Resources (UoR) Rating | 3 | 3 | 3 | | *1 or 2 (NHSI amended Oct 2016)* | February 2017 | DJ |
| | CQC | Amber | Amber | Amber | | *Overall CQC rating Requires Improvement* | February 2017 | SG |
| | **Local View** | | | | | | | |
| | Commissioning - Contract KPIs | 7 | 6 | 7 | | *<=2* | February 2017 | CO |

| | |
|---|---|
| **Quarter** | 4 |
| **Period** | 01/01/2017 - 31/03/2017 |

| | |
|---|---|
| **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 4 - Total**

| | | Breaches | | | Treatments | | | Compliance | |
|---|---|---|---|---|---|---|---|---|---|
| **Division** | **Tumour Group** | **Actual** | **Predicted** | **Total** | **Actual** | **Predicted** | **Total** | **Actual** | **Predicted** |
| Medicine | Haematology | 0 | 0 | 0 | 7 | 1 | 8 | 100.00% | 100.00% |
| | Lung | 1 | 0 | 1 | 8 | 3 | 11 | 87.50% | 90.91% |
| | Other | 1 | 0 | 1 | 2.5 | 0.5 | 3 | 60.00% | 66.67% |
| Med & Surg | Upper GI | 0 | 0 | 0 | 6 | 0 | 6 | 100.00% | 100.00% |
| Surgery | Breast | 0 | 0 | 0 | 24 | 2 | 26 | 100.00% | 100.00% |
| | Colorectal | 3 | 0 | 3 | 12.5 | 1 | 13.5 | 76.00% | 77.78% |
| | Head & Neck | 1 | 0 | 1 | 2.5 | 0.5 | 3 | 60.00% | 66.67% |
| | Skin | 0 | 0 | 0 | 36.5 | 2 | 38.5 | 100.00% | 100.00% |
| | Urology | 12 | 1 | 13 | 42 | 2 | 44 | 71.43% | 70.45% |
| Women's | Gynaecology | 2 | 1 | 3 | 4 | 2 | 6 | 50.00% | 50.00% |
| | **Total** | **20** | **2** | **22** | **145** | **14** | **159** | 86.21% | 86.16% |

**Quarter 4 - January**

| | | Breaches | | | Treatments | | | Compliance | |
|---|---|---|---|---|---|---|---|---|---|
| **Division** | **Tumour Group** | **Actual** | **Predicted** | **Total** | **Actual** | **Predicted** | **Total** | **Actual (Final)** | **Predicted** |
| Medicine | Haematology | 0 | 0 | 0 | 4 | 0 | 4 | 100.00% | - |
| | Lung | 1 | 0 | 1 | 7 | 0 | 7 | 85.71% | - |
| | Other | 1 | 0 | 1 | 2 | 0 | 2 | 50.00% | - |
| Med & Surg | Upper GI | 0 | 0 | 0 | 3 | 0 | 3 | 100.00% | - |
| Surgery | Breast | 0 | 0 | 0 | 14 | 0 | 14 | 100.00% | - |
| | Colorectal | 1 | 0 | 1 | 6.5 | 0 | 6.5 | 84.62% | - |
| | Head & Neck | 1 | 0 | 1 | 2 | 0 | 2 | 50.00% | - |
| | Skin | 0 | 0 | 0 | 17.5 | 1 | 18.5 | 100.00% | - |
| | Urology | 5 | 0 | 5 | 19.5 | 0 | 19.5 | 74.36% | - |
| Women's | Gynaecology | 2 | 0 | 2 | 4 | 0 | 4 | 50.00% | - |
| | **Total** | **11** | **0** | **11** | **79.5** | **0** | **80.5** | 86.16% | - |

**Quarter 4 - February**

| | | Breaches | | | Treatments | | | Compliance | |
|---|---|---|---|---|---|---|---|---|---|
| **Division** | **Tumour Group** | **Actual** | **Predicted** | **Total** | **Actual** | **Predicted** | **Total** | **Actual** | **Predicted** |
| Medicine | Haematology | 0 | 0 | 0 | 3 | 1 | 4 | 100.00% | 100.00% |
| | Lung | 0 | 0 | 0 | 1 | 3 | 4 | 100.00% | 100.00% |
| | Other | 0 | 0 | 0 | 0.5 | 0.5 | 1 | 100.00% | 100.00% |
| Med & Surg | Upper GI | 0 | 0 | 0 | 3 | 0 | 3 | 100.00% | 100.00% |
| Surgery | Breast | 0 | 0 | 0 | 10 | 2 | 12 | 100.00% | 100.00% |
| | Colorectal | 2 | 0 | 2 | 6 | 1 | 7 | 66.67% | 71.43% |
| | Head & Neck | 0 | 0 | 0 | 0.5 | 0.5 | 1 | 100.00% | 100.00% |
| | Skin | 0 | 0 | 0 | 19 | 1 | 20 | 100.00% | 100.00% |
| | Urology | 7 | 1 | 8 | 22.5 | 2 | 24.5 | 68.89% | 67.35% |
| Women's | Gynaecology | 0 | 1 | 1 | 0 | 2 | 2 | N/A | 50.00% |
| | **Total** | **9** | **2** | **11** | **65.5** | **13** | **78.5** | 86.26% | 85.99% |

| Board of Directors | |
|---|---|
| **Agenda Item** | 6.1.2 |
| **Title of Report** | Month 11 Finance and Cost Improvement Programme Report |
| **Date of Meeting** | 29th March 2017 |
| **Author** | Gareth Lawrence, Deputy Director of Finance |
| **Accountable Executive** | David Jago, Executive Director of Finance |
| **BAF References**<br>• **Strategic Objective**<br>• **Key Measure**<br>• **Principal Risk** | <br>8<br>8c,8d |
| **Level of Assurance**<br>• **Positive**<br>• **Gap(s)** | Positive |
| **Purpose of the Paper**<br>• **Discussion**<br>• **Approval**<br>• **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**<br>• **Yes**<br>• **No** | No |

***Overview***

This paper provides an update to the Board of Directors on the financial performance of the Trust at month 11 (28th February) of the 2016/17 financial year.

At the end of February (month 11) the Trust has reported a YTD deficit of £(10.9)m inclusive of £1.5m impairments, therefore the normalised deficit is £(9.4)m which is £7.1m adverse to plan. The adverse variance is being driven by three key elements:

- Non achievement of STF targets - £2.2m
- Non delivery of the Health economy challenge - £3.4m
- Continued Operational pressures as a result of Health Economy challenges.

The Trust is currently forecasting to deliver a forecast deficit of £(10.5m). The deterioration from the plan is a result of the non achievement of the "Health Economy Challenge" of £5m, the subsequent loss of STF of £3m and operational pressures relating to reductions in care within the health economy via the Better Care Fund. The Trust has not included any further external costs within the current financial position, during March the A&E delivery Board have agreed to share the costs across all providers which mitigates some of the risks within the forecast.

The Trust has delivered £10.1m of efficiencies as at the end of February against the target of £9.9m and is forecasting to deliver the 2016/17 target of £11.2m.

The Trust's cash balance at the end of February was £5.7m, which is £2.5m above plan. The cash position has been supported by cash preservation measures, below-plan capital outflows, and an additional drawdown of cash from the working capital facility, offset by adverse EBITDA performance. Forecast year end cash balances are below plan materially driven by the issues noted above, and are supported by approved borrowings in month 12 of £1.5m, in addition to a further £2.2m drawdown agreed with NHSI in lieu of the outstanding Q3 STF receipt, as disclosed to the Board of Directors in month 10. The Trust is forecasting a total cash support requirement of £17.5m for the full year.

The Trust has achieved an overall Use of Resources (UoR) Rating of 3, which is 'below' the recalculated plan rating of 2. The adverse performance is driven by the issues noted above in respect of the £5.0m stretch challenge and loss of STF.

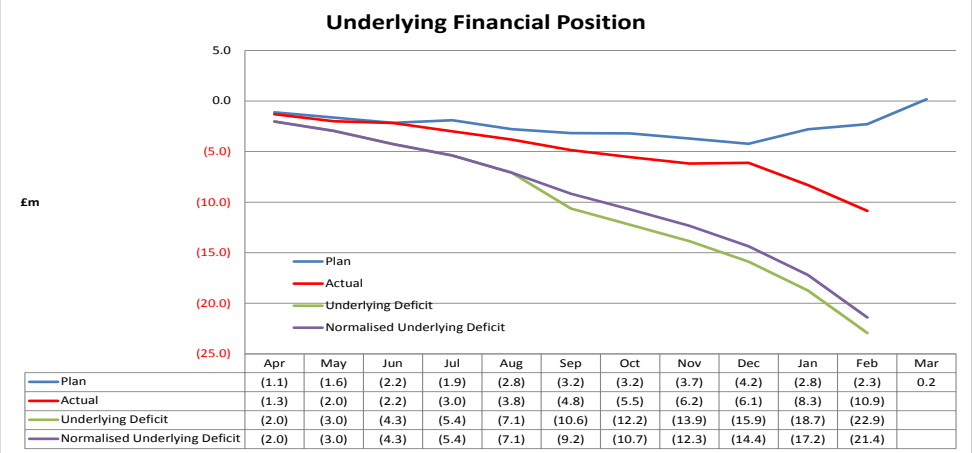
***Income and Expenditure Performance***

In March 2016 the Board of Directors agreed to the control total set by NHSI that enabled access to the STF. Table 1 below details the current performance against the submitted plan and Table 2 shows the underlying financial performance

***Table 1: Summary Financial Statement***

| SUMMARY FINANCIAL STATEMENT | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | PLAN | MONTH 11 | | | YTD | | | Forecast | | |
| | Full Year Plan £m | Plan £m | Actual £m | Variance £m | Plan £m | Actual £m | Variance £m | Plan £m | Actual £m | Variance £m |
| NHS Clinical Income | 294.936 | 23.860 | 22.999 | (0.862) | 269.837 | 265.519 | (4.318) | 294.936 | 289.043 | (5.893) |
| Other Income | 29.987 | 2.566 | 2.561 | (0.004) | 27.390 | 29.107 | 1.716 | 29.987 | 31.511 | 1.524 |
| Employee Expenses | (213.306) | (16.691) | (19.118) | (2.428) | (197.288) | (205.560) | (8.272) | (213.306) | (224.086) | (10.780) |
| All Other Operational Expenses | (97.763) | (8.066) | (8.047) | 0.019 | (89.714) | (87.862) | 1.853 | (97.763) | (95.384) | 2.379 |
| **EBITDA** | **13.854** | **1.670** | **(1.605)** | **(3.275)** | **10.225** | **1.203** | **(9.021)** | **13.854** | **1.084** | **(12.770)** |
| Post EBITDA Items | (13.673) | (1.160) | (0.951) | 0.209 | (12.508) | (12.068) | 0.441 | (13.673) | (13.084) | 0.589 |
| **Net Surplus/(Deficit)** | **0.181** | **0.510** | **(2.556)** | **(3.066)** | **(2.283)** | **(10.865)** | **(8.580)** | **0.181** | **(12.000)** | **(12.181)** |
| **Adjusted Net Surplus/(Deficit)** | | **0.510** | **(2.556)** | **(3.066)** | **(2.283)** | **(9.337)** | **(7.053)** | **0.181** | **(10.472)** | **(10.653)** |
| **EBITDA %** | **4.3%** | **6.3%** | **(6.3%)** | **(12.6%)** | **3.4%** | **0.4%** | **(3.0%)** | **4.3%** | **0.3%** | **(3.9%)** |

***Table 2: Underlying Financial Performance***




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Plan | (1.1) | (1.6) | (2.2) | (1.9) | (2.8) | (3.2) | (3.2) | (3.7) | (4.2) | (2.8) | (2.3) | 0.2 |
| Actual | (1.3) | (2.0) | (2.2) | (3.0) | (3.8) | (4.8) | (5.5) | (6.2) | (6.1) | (8.3) | (10.9) | |
| Underlying Deficit | (2.0) | (3.0) | (4.3) | (5.4) | (7.1) | (10.6) | (12.2) | (13.9) | (15.9) | (18.7) | (22.9) | |
| Normalised Underlying Deficit | (2.0) | (3.0) | (4.3) | (5.4) | (7.1) | (9.2) | (10.7) | (12.3) | (14.4) | (17.2) | (21.4) | |

The Trust underlying position is demonstrated within table 2 above. The normalised underlying deficit reflects the non recurrent savings and income gains that the Trust has delivered/received in year. The non recurrent nature of the savings has been reflected in the agreed financial plan for 2017/18.

As previously reported to the Board of Directors agreement has been reached with Wirral CCG for an envelope contract value for 2016/17 which covers c80% of the Trusts clinical income. In the absence of the 'envelope' agreement the income position would have deteriorated by £5.9m.

During February all points of delivery underperformed in terms of activity excluding A&E attendances.

Cumulatively all PODs are underperforming in terms of actual activity delivered against the plan, with the exception of Outpatient Diagnostics, A&E attendances and Non Elective (NEL). Penalties increased in month in relation to readmissions, NEL marginal rate and

outpatients FUP caps. As a result of the financial envelope the penalties do not affect the financial position.

The financial "envelope" agreed with the CCG is inclusive of all CQUINs payments. Confirmation has been received from Commissioners that quarter 1 and quarter 2 have been achieved. Despite the financial security offered by the envelope it is vital that the Trust continues to implement the agreed CQUIN's to improve patient experience therefore the Trust will continue to shadow monitor all schemes as per previous years.

In February (Month 11) operating expenditure is above plan in month by (£2.4m) with a YTD variance to (£6.4m).

Pay costs exceeded plan by (£2.4m), and are showing a cumulative overspend of (£8.3m). The issues driving the current cumulative adverse performance in pay are:

- A (£1.7m) impact from the health economy challenge which was included in the pay plan for the last quarter of the financial year (£5.0m).

- Other pay pressures relate to internal escalation capacity being open since April 2016 and increased 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 to support the reduction of these escalation areas going forward.

- Non–delivery of cost improvement plans in relation to pay work-streams of c(£1.7m) comprises some of the pay overspend, this has been partially mitigated by vacancies within the Divisions c(£1.1m). The CIP slippage impact in February is c(£0.2m) which has been partially mitigated by vacancies of c£0.1m.

- Other operational pressures in medical staffing costs have continued during the month. Within the Emergency Department, the medical staffing position there is a further (£0.1m) impact in February and there remains a pressure of approximately (£0.7m) in the year to date position.

- WLIs still remain comparatively low in February compared to earlier months but have increased this month. The use of WLIs are continually reviewed in light of RTT and cancer targets with spend occurring in a number of specific specialties. The Trust continues to monitor its respective waiting lists to ensure that any areas of patient concern are addressed.

Focus within the Trust will continue to remain on the use of non-core pay spend across all staff categories and continuing development of recruitment and retention strategies to address staffing gaps together with mitigating the slippage on the delivery of CIP schemes.

Agency spend, during February is lower than plan by some £0.1m, cumulatively this is below the NHSI ceiling rate by £0.9m. This improvement continues to reflect the work the Trust is undertaking on managing agency costs across the organisation and further potential improvement on the agency trajectory is under review.

Non pay costs are marginally lower than the plan in February but remain cumulatively £1.9m lower than plan. The cumulative position reflects one-off reductions in provisions and accruals as well as the non-recurrent benefit of the renegotiation of the Cerner contract c£1.4m which are offsetting operational cost pressures.

### *Cost Improvement Programme (CIP)*

The CIP target for 2016/17 is £11.2m. The table below demonstrates CIP delivery in terms of the year to date, in-year and recurrent position, this is shown by both division and work stream.

### *Table 3 – CIP Performance by Workstream and Division*

| | YTD | | | In Year | | | Recurrent | | |
|---|---|---|---|---|---|---|---|---|---|
| | NHSI Plan | Actual | Variance | NHSI Plan | Forecast | Variance | NHSI Plan | Forecast | Variance |
| **Workstream** | **£m** | **£m** | **£m** | **£m** | **£m** | **£m** | **£m** | **£m** | **£m** |
| Theatres/ Elective Pathway | 1.3 | 1.2 | (0.1) | 1.5 | 1.4 | (0.1) | 1.5 | 1.4 | (0.1) |
| Outpatients (Medical & Surgical) | 0.6 | 0.2 | (0.4) | 0.7 | 0.2 | (0.5) | 0.7 | 0.3 | (0.4) |
| Patient Flow - EL & NEL | 0.7 | 0.0 | (0.7) | 0.8 | 0.0 | (0.8) | 0.8 | 0.0 | (0.8) |
| Radiology | 0.2 | 0.4 | 0.2 | 0.2 | 0.4 | 0.2 | 0.2 | 0.4 | 0.2 |
| Pathology | 0.4 | 0.1 | (0.3) | 0.4 | 0.1 | (0.3) | 0.4 | 0.2 | (0.2) |
| Nurses & Therapies Staffing | 0.5 | 0.6 | 0.1 | 0.6 | 0.7 | 0.1 | 0.6 | 0.3 | (0.3) |
| A&C Review - Clinical/ Non Clinical/ Management | 0.9 | 0.3 | (0.6) | 1.0 | 0.4 | (0.6) | 1.0 | 0.2 | (0.8) |
| Medical Staffing | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Central HR Initatives | 0.6 | 0.8 | 0.2 | 0.7 | 0.9 | 0.2 | 0.7 | 0.8 | 0.1 |
| COCH Collaboration | 0.2 | 0.0 | (0.2) | 0.3 | 0.0 | (0.3) | 0.3 | 0.0 | (0.3) |
| Pharmacy Services & Medicines Management | 0.4 | 0.9 | 0.5 | 0.4 | 0.9 | 0.5 | 0.4 | 0.5 | 0.1 |
| Procurement & Inventory Management | 1.2 | 0.7 | (0.5) | 1.3 | 0.8 | (0.5) | 1.3 | 0.5 | (0.8) |
| IT Enabled | 0.2 | 0.2 | 0.0 | 0.2 | 0.2 | 0.0 | 0.2 | 0.1 | (0.1) |
| Special Purpose Vehicles/ Contract optimisation | 0.3 | 0.0 | (0.3) | 0.5 | 0.0 | (0.5) | 0.5 | 0.0 | (0.5) |
| Estates/ Site Review | 0.5 | 0.2 | (0.3) | 0.6 | 0.2 | (0.4) | 0.6 | 0.2 | (0.4) |
| Facilities | 0.4 | 0.4 | 0.0 | 0.4 | 0.4 | 0.0 | 0.4 | 0.2 | (0.2) |
| Coding | 0.9 | 0.9 | 0.0 | 1.0 | 1.0 | 0.0 | 1.0 | 1.0 | 0.0 |
| Central Commercial Opportunities & Private Patients | 0.2 | 0.1 | (0.1) | 0.3 | 0.1 | (0.2) | 0.3 | 0.2 | (0.1) |
| Divisional & Departmental Schemes | 0.4 | 0.5 | 0.1 | 0.4 | 0.6 | 0.2 | 0.4 | 0.6 | 0.2 |
| Other | 0.0 | 2.6 | 2.6 | (0.1) | 2.9 | 3.0 | (0.1) | 1.4 | 1.5 |
| **TOTAL PRE RISK ADJUSTMENT** | **9.9** | **10.1** | **0.2** | **11.2** | **11.2** | **0.0** | **11.2** | **8.3** | **(2.9)** |
| Adjustment for risk | | | 0.0 | | 0.0 | 0.0 | | | 0.0 |
| **TOTAL** | **9.9** | **10.1** | **0.2** | **11.2** | **11.2** | **0.0** | **11.2** | **8.3** | **(2.9)** |
| Medicine & Acute | 2.8 | 1.4 | (1.4) | 3.1 | 1.5 | (1.6) | 3.1 | 1.1 | (2.0) |
| Surgery, Women & Children | 3.2 | 2.3 | (0.9) | 3.6 | 2.7 | (0.9) | 3.6 | 2.1 | (1.5) |
| Clinical Support Services | 1.5 | 0.9 | (0.6) | 1.7 | 1.0 | (0.7) | 1.7 | 0.9 | (0.8) |
| Corporate | 1.6 | 2.4 | 0.8 | 1.8 | 2.6 | 0.8 | 1.8 | 2.4 | 0.6 |
| Central | 0.8 | 3.1 | 2.3 | 1.0 | 3.4 | 2.4 | 1.0 | 1.8 | 0.8 |
| **TOTAL PRE RISK ADJUSTMENT** | **9.9** | **10.1** | **0.2** | **11.2** | **11.2** | **0.0** | **11.2** | **8.3** | **(2.9)** |
| Adjustment for risk | | | 0.0 | | 0.0 | 0.0 | | | 0.0 |
| **TOTAL** | **9.9** | **10.1** | **0.2** | **11.2** | **11.2** | **0.0** | **11.2** | **8.3** | **(2.9)** |

The year to date position as at the end of February is £10.1m ahead of the target of £9.9m.

The Trust is forecasting to deliver the £11.2m full year target within the plan. While only £8.3m has been delivered recurrently the non-delivery has been factored into the 2017/18 agreed base plan.

It is of note that the above figures are exclusive of the £5m health economy challenge included in the submitted plans approved by the Board of Directors.

### *Cash position, capital expenditure and Use of Resources (UoR) Rating*

The February cash position is £5.7m, which is £2.5m above plan. The cash position has been supported by year-end cash planning measures which have temporarily elevated creditors, below-plan capital outflows, and extension of the working capital facility. These factors have offset the effects of adverse EBITDA performance. The Trust has drawn down £13.8m from the working capital facility to date, and forecasts that a further £3.7m (including £2.2m due to Q3 STF not being received) will be required before year end.

The Trust continues to submit monthly 13 week cash flows to NHSI, in order to access cash support through the working capital facility (borrowings) when required. Additional borrowings have been required as the Trust does not expect to receive the Q3 STF before the end of March. The Trust is not forecasting that these borrowings will exceed 30 days of operational expenditure in year. Therefore, all cash support should be provided by the working capital facility, with current rates of interest at 3.5%.

Capital expenditure is £1.5m under plan as at the end of February as a result of delayed starts to some capital projects. The Trust forecasts the achievement of plan for the full year.

The overall financial position returns an overall UoR Rating of 3, which is 'below' the planned rating of 2, as detailed overleaf. The individual Agency spend rating continues to prevent the UoR Rating from dropping to 4 overall.

***Table 4 – Use of Resources (UoR) Rating***

**Use of Resources (UoR) Rating**

| | Metric | Description | Weighting % | Year to Date Plan | | Year to Date Actual | | Full Year Plan | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | *Metric* | *Rating* | *Metric* | *Rating* | *Metric* | *Rating* |
| Financial sustainability | **Liquidity (days)** | Days of operating costs held in cash-equivalent forms | 20% | -26.6 | 4 | -32.9 | 4 | -24.2 | 4 |
| Financial sustainability | **Capital service capacity (times)** | Revenue available for capital service: the degree to w hich generated income covers financial obligations | 20% | 2.1 | 2 | 0.3 | 4 | 2.4 | 2 |
| Financial efficiency | **I&E m argin (%)** | Underlying performance: I&E deficit / total revenue | 20% | -0.7% | 3 | -3.2% | 4 | 0.1% | 2 |
| Financial controls | **Distance from financial plan (%)** | Show s quality of planning and financial control : YTD deficit against plan | 20% | -0.5% | 2 | -2.5% | 4 | -0.5% | 2 |
| Financial controls | **Agency spend (%)** | Distance of agency spend against cap | 20% | -0.07% | 1 | -12.6% | 1 | -0.1% | 1 |
| | **Overall NHSI UoR Rating** | | | | **2** | | **3** | | **2** |

## Conclusion

The Trust continues to forecast a normalised deficit of (£10.5m) in line with the forecast protocol submitted to NHSI as part of the Q3 submission. As a result of continued non elective pressures there remain risks within the forecast that the Trust continues to seek to mitigate.

The Board is asked to note the non-recurrent support within the position and the additional pressure this will put on the underlying financial position of the Trust going forward into the next financial year.

Cash is currently above plan but has been supported by additional borrowing in line with revised projections. Additional cash support has been agreed as a result of the Q3 STF funding not being received.

The UoR remains a 3 which is lower than the planned 2. The strong performance on the agency metric is currently supporting the Trust from delivering a UoR of 4 which would be the highest level of risk.

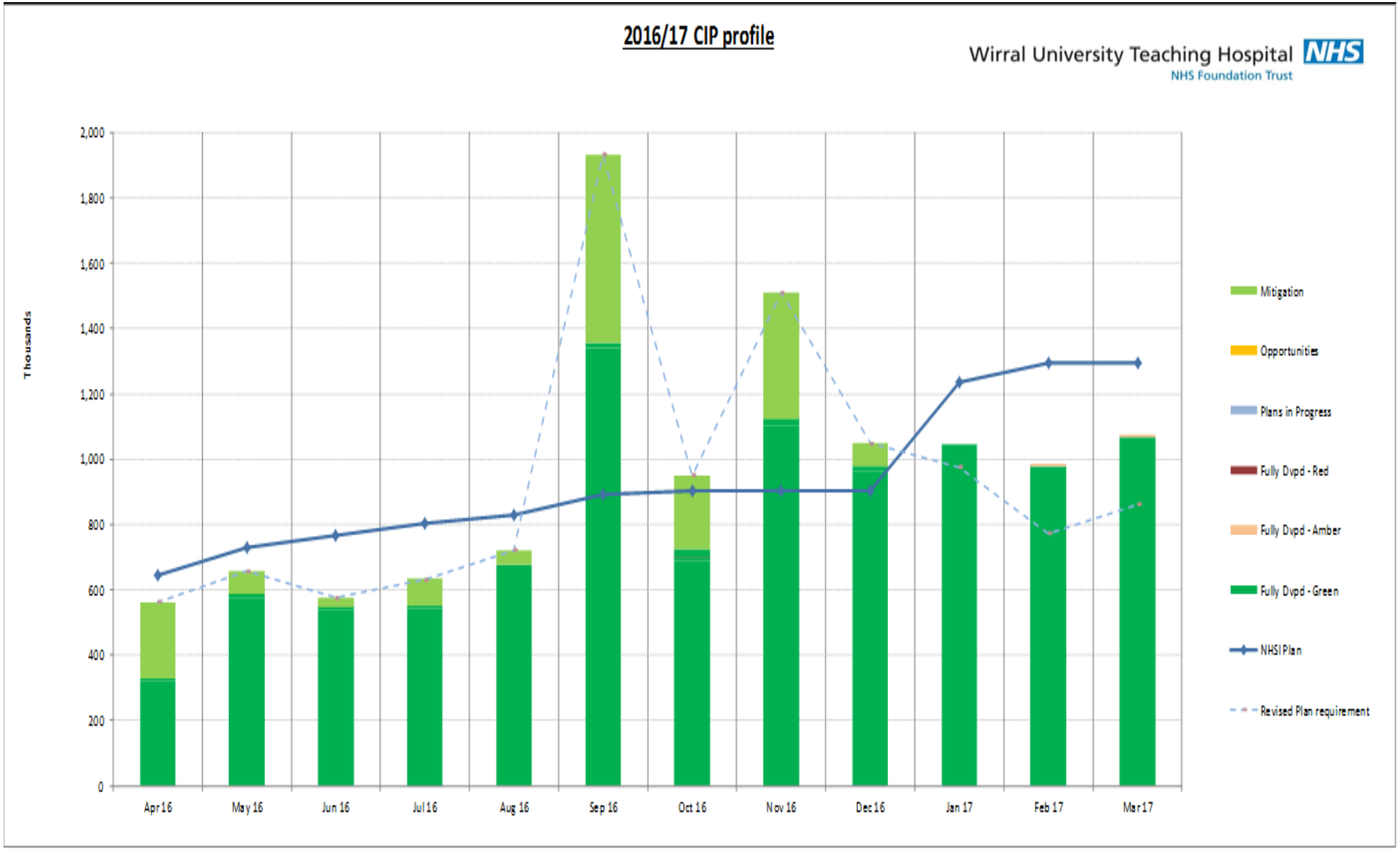
## Recommendations

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

**David Jago**
Director of Finance
March 2017

## Appendix 1: CIP Monthly Profile

**The following chart highlights the CIP trajectory by Monitor Status and Risk Rating for the year, as at M10.**



| BOARD OF DIRECTORS | |
|---|---|
| **Agenda Item** | 6.1.3 |
| **Title of Report** | Transformation Portfolio & Cost Improvement Programme 17-18 (Presentation) |
| **Date of Meeting** | 29th March 2017 |
| **Author** | Natalia Armes – Associate Director of Transformation |
| **Accountable Executive** | Janelle Holmes – Chief Operating Officer |
| **BAF References**<br>**Strategic Objective**<br>**Key Measure**<br>**Principal Risk** | Enabled by: financial, commercial and operational excellence 6&8 |
| **Level of Assurance**<br>**Positive**<br>**Gap(s)** | |
| **Purpose of the Paper**<br>**Discussion/ To Note** | The purpose of the presentation is to provide the Board with an overview of the Transformation Agenda and an update in relation to the Cost Improvement Programme progress.<br><br>The presentation will cover:<br>• An overview to the approach taken<br>• Latest planning position in terms of Cost Improvement<br>• Overview of Transformation Agenda and priorities<br>• Example of one of the Transformation Programmes |
| **Reviewed by Assurance Committee** | Finance Business and Assurance Committee |
| **Data Quality Rating** | Bronze – qualitative data |
| **FOI status** | Document may be disclosed in full |
| **Equality Impact Assessment Undertaken**<br>**Yes**<br>**No** | N/A |

| Board of Directors | |
|---|---|
| **Agenda Item** | 7.1 |
| **Title of Report** | Annual Review of Non-Financial Scheme of Reservation and Delegation and Constitution |
| **Date of Meeting** | 29 March 2017 |
| **Author** | Carole Self, Director of Corporate Affairs |
| **Accountable Executive** | Carole Self, Director of Corporate Affairs |
| **BAF References**<br>• **Strategic Objective**<br>• **Key Measure**<br>• **Principal Risk** | 8. Strategic Objective – Enabled by: financial, commercial and operational excellence. |
| **Level of Assurance**<br>• **Positive**<br>• **Gap(s)** | Positive |
| **Purpose of the Paper**<br>• **Discussion**<br>• **Approval**<br>• **To Note** | Approval |
| **Data Quality Rating** | Silver – quantitative data that has not been externally validated |
| **FOI status** | Document may be disclosed in full |
| **Equality Impact Assessment Undertaken**<br>• **Yes**<br>• **No** | Not applicable |

## 1. Executive Summary

The purpose of this paper is to present to the Board an update of the Trust's Scheme of Reservation and Delegation and Constitution. The Audit Committee reviewed both documents at its meeting on 03 March 17 and agreed to recommend these to the Board and in terms of the Constitution to the Council of Governors for approval.

In line with the requirements of the Constitution the Council of Governors approved the amendments at its meeting on 15 March 2017.

## 2. Key changes

- **Scheme of Reservation and Delegation (SoRD)**

The SoRD has been updated to be consistent with the scheme of delegation financial aspects

and now reflects the latest terms of reference of each of the Committees.

The full document has been circulated to members separately. Minor changes have been highlighted in red for ease of review, and have been amended for consistency purposes.

- **Constitution**

The Trust has taken the opportunity to review the Constitution as part of the review of the Corporate Governance Manual. The changes made are minor in nature and relate to elements of consistency in the main relating to the standards of business conduct policy and the fit and proper persons test.

For clarity there are no amendments that impact on the role of the Governor which would require approval by members at the Annual Members meeting. Again members have received a copy of the amended constitution under separate cover.

## 3. Recommendations

The Board is asked to approve the revised Constitution and the revised Scheme of Reservation and Delegation. Following approval the Constitution will be forward to NHS Improvement as required and published on the Trust's website.

| Board of Directors | |
|---|---|
| **Agenda Item** | 7.2 |
| **Title of Report** | Annual Review of Standing Financial Instructions and Financial Scheme of Delegation |
| **Date of Meeting** | 29 March 2017 |
| **Author** | Deborah Harman<br>Assistant Director of Finance – Financial Services |
| **Accountable Executive** | David Jago<br>Director of Finance |
| **BAF References**<br>• **Strategic Objective**<br>• **Key Measure**<br>• **Principal Risk** | 8. Strategic Objective – Enabled by: financial, commercial and operational excellence. |
| **Level of Assurance**<br>• **Positive**<br>• **Gap(s)** | Positive |
| **Purpose of the Paper**<br>• **Discussion**<br>• **Approval**<br>• **To Note** | Approval |
| **Data Quality Rating** | Silver – quantitative data that has not been externally validated |
| **FOI status** | Document may be disclosed in full |
| **Equality Impact Assessment Undertaken**<br>• **Yes**<br>• **No** | Not applicable |

## 1. Executive summary

The purpose of this paper is to present to the Board of Directors an update of the Trust's Standing Financial Instructions (SFIs), and its associated appendices including the financial Scheme of Delegation, for approval.

## 2. Background and changes

As part of the annual review process, the documents have been generally refreshed, including consistency improvements to ensure alignment across the documents. The SFIs now include

new content covering business cases and the Trust's Charity, and more references to the Trust's updated Standards of Business Conduct policy.

The Audit Committee reviewed the SFIs and its associated appendices at its meeting on 3 March, and agreed to recommend the documents to the Board for approval. The full document has been circulated to members separately.

## 3. Recommendations

The Board is asked to approve the new SFIs with associated appendices, for immediate distribution and inclusion on the Trust's intranet.

**Deborah Harman**
**Assistant Director of Finance – Financial Services**

March 2017

| Board of Directors | |
|---|---|
| **Agenda Item** | 7.3 |
| **Title of Report** | Report of the Finance, Business Performance and Assurance Committee – 24 March 2017 |
| **Date of Meeting** | 29 March 2017 |
| **Author** | Andrea Hodgson, Chair of the Finance, Business Performance and Assurance Committee |
| **Accountable Executive** | David Jago, Director of Finance |
| **BAF References**<br>• **Strategic Objective**<br>• **Key Measure**<br>• **Principal Risk** | 4, 7, 8<br>4a, 7a, 7b, 7d, 8a, 8c, 8d,<br>5, 6, 7, 8, 9, 16, 17, 20 |
| **Level of Assurance**<br>• **Positive**<br>• **Gap(s)** | Gaps with mitigating action |
| **Purpose of the Paper**<br>• **Discussion**<br>• **Approval**<br>• **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**<br>• **Yes**<br>• **No** | Not applicable |

This report provides a summary of the work of the Finance, Business Performance and Assurance Committee, which met on the 24 March 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, which were the revised content of:

- Risk 1 (Quality and Safety) to reflect that a further Never Events in both Ophthalmology and Maternity that had been identified during the reporting period
- Risk 4 (4 Hour A&E Standard) included reference to the national indicator of access of 80% as recommended by the Board of Directors in February 2017. The Committee received

confirmation that should the Trust fall below 80% compliance against the standard, reviews would be conducted as normal practice in the instance of 12-hour trolley breaches to determine any potential level of harm to patients.

And the revised risk score of:

- Risk 12 (C.diff) for which the risk score had been reduced to reflect the positive work undertaken to improve infection prevention control processes which had resulted in a significant reduction in the number of avoidable cases of C.diff.

The Committee reviewed the aggregate risk profile, which distinguished between BAF risks for which it was within the gift of the Trust to positively effect and those risks, which were dependant on the external influence. The Committee agreed that aspects of the Section 111 risk were within the control and influence of the Trust, and the risk narrative would be updated accordingly. Discussion also concluded that whilst the likelihood assessment of the 11 risks in the upper quadrant were felt to be appropriate, the catastrophic assessment required review. The Committee also requested that the BAF be developed to include enhanced commentary which would provide a forward look in respect of projected improved outcome and timeline for performance changes anticipated in order to prioritise the use of resources appropriately, particularly where there were complex interdependencies.

The Committee reviewed the proposed draft Risk Appetite Statement noting that the objective was to manage risks to within the Trust's risk appetite, and that as a result it was not necessarily possible to 'avoid taking any risks'. In addition it was noted that CQC rating was a key '*indicator'* to optimising quality and financial stability. It was agreed the suggested changes would be incorporated by the Director of Corporate Affairs and recommended to the Board.

**M11 Financial Position**

The Committee reviewed the year to date position, which reported a cumulative normalised deficit of £9.4m against a planned deficit of £2.3m. The main drivers behind this variance are the non achievement of STF (£2.1m), Health economy challenge (£3.4m) and the continued operational pressures as a result of pressures within the wider Health Economy.

The Trust continues to forecast a £10.5m deficit for the full year. The negative variance continued to be materially accounted for by the non-delivery of the £5m health economy challenge and c£3m continued operational pressures as a result of reductions to health and social care across the wider health economy. The Committee noted that the potential addition £500k risk to the full year outturn position had been materially mitigated through an agreement to apportion costs across partners within the local health economy to mitigate the current domiciliary care position had been reached.

The Committee was advised that the Trust cash position remained below forecast as a result of delayed receipt of the Q3 Sustainability and Transformation Fund (STF) funding which was due to be received on 24th March 2017 (received 24/03/2017). The drivers of the additional cash requirement are the non achievement of the STF in Q4 (£2.5m), delayed payment of the Q3 STF (£2.2m), EBITDA performance below plan and non cash backed savings.

The Committee noted that whilst the cash position was supported by below plan capital expenditure, a drawdown of a further £2.2m from the Trust working capital facility had been required in period due to the delay in receipt of Q3 STF monies. It was confirmed that on receipt of the Q3 STF funding, the £2.2m would be required to be returned immediately. The Committee requested that future reports clearly define within the current and projected cash position and an update on the proposed use of loan monies in order to support Board approval of cash drawdown requirements.

The Use of Resources (UoR) rating was reported at level 3, which is below the planned score of 2. The Committee explored the potential impact to the Trust should the UoR rating deteriorate to 4. It was confirmed that in such circumstances the Trust would continue to work with NHS Improvement (NHSI), in line with the Single Oversight Framework, to further develop plans to improve sustainability.

The Committee noted that the Trust remained on track to deliver the full £11.2m Cost Improvement Programme target for 2017/18 in line with the Trust plan.

The risks and appropriate mitigations were outlined and debated by the Committee in relation to income, expenditure, CIP and cash. The Committee discussed escalation to Board the potential risk to the year-end forecast cash position, full year-end outturn and potential impact should the Trust UoR rating deteriorate.

**Better Care Fund Options Appraisal**

The Committee received a verbal update on the provisional Better Care Fund (BCF) plan for 2017/18 that had been presented at the most recent Health and Wellbeing Board and for comment from those within the local health economy. Whilst the indicative update was that a further 50% of funding was likely to be made available, the Trust was still awaiting confirmation how this additional funding would be allocated between Adult Services and Health. It was confirmed that the Trust had contacted both the Local Authority and Wirral Clinical Commissioning Group (WCCG) to express an interest in assisting in the development of the BCF allocation plan for 2017/18 to ensure funding is optimised to improve patient flow and experience across the wider health economy.

**Going Concern Statement**

The Committee reviewed the draft Going Concern Statement and process that would be undertaken at the year-end. The Committee requested that key aspects including the Commissioner Contract, the funding position and cash requirements as well as the definition of 'foreseeable' future were clearly articulated in order for the Board to be to fully evaluate the going concern requirements. In addition the committee requested that the next iteration provide a narrative, which clearly outlines the risks to financial performance identified throughout 2017/18 and the mitigating actions taken to address them. This would underpin, and assist the Board of Directors in agreeing, the Going Concern Statement.

**Performance Report for Period ending 28 February 2017**

The Committee noted that the Trust continued to report a deterioration post-December 2016 in the 4 Hour A&E Standard as a consequence of closure of the on-site all day health center, an increase in demand and acuity and delayed transfers of care due to a lack of available domiciliary care in the community. It was confirmed that the Trust's Service Transformation Team would oversee a collaborative project with those in the local health economy to improve bed modelling. The Committee noted that NHSI had voiced support of the mitigating actions to be employed to address the issues identified at the most recent Progress Review Meeting and the Committee was pleased to note the positive feedback from WCCG following a recent visit to the Trust's Emergency Department.

The Committee confirmed the Trust's expected deterioration in Referral to Treatment Target (RTT) performance, which had occurred as a consequence of the Patient Tracking List (PTL) cleanse. The Committee noted that an improvement trajectory would be agreed following completion of the current capacity and demand work being undertaken by each specialty. The Committee was disappointed to note that 4 patients had been identified as exceeding a 52 week wait during the cleanse and sought to understand their respective treatment position. The incidents had been reported to the necessary external bodies and a harm review process was to be established to determine the level of harm to such patients as a consequence of extensive treatment delays. The committee received confirmation that work was underway as part of the cleanse activity to determine if there was any risk of further >52 week wait cases. The Committee supported escalation of current findings and reporting status to the Board for consideration pending completion of the full cleanse activity.

The Committee noted that zero avoidable cases of C Difficile (C.diff) had been identified during February 2017, which resulted in a year-to-date performance of 12 cases for 2016/17. This remained well below the cumulative plan threshold of 29 for 2016/17. The Committee noted that the Trust C.diff threshold for 2017/18 would remain at 29.

The Committee was pleased to note the ongoing compliance with all cancer targets.

**RTT Progress Report**

The Committee noted that the Elective Care Intensive Support Team had now reviewed the Trust action plan and would support the Trust in realising improved RTT performance. Construction of the required information reports to support RTT management was near to completion and the information would be utilised to support backlog and data quality review. Whilst initial projections suggested the Trust's RTT position would deteriorate to circa 80% prior to improving, a credible improvement trajectory plan was dependent on completion of the demand/capacity analysis, which is underway across the wider health economy.

The Committee noted that following completion of a review of patients identified as appropriate for removal from waiting lists, a recovery trajectory would be calculated.

**Non-Core Spend Report**

The Committee received an update on non- core spend which included 2 key considerations:

(1) Narrative position in respect of the 2016/17 agency spend threshold of £8.1m; and
(2) A revision to the treatment of individuals employed through personal service companies from 1/4/2017 who are to be treated as 'employees' for NI and PAYE purposes and for the Trust to account appropriately for all HMRC obligations

The Trust reported a cumulative non-core spend of £7m for the year to date which remained below the 2016/17 threshold of £8.1m. The Committee was however disappointed with the presentation and the content of the report and requested that future reports include breach exception reporting, outlining the cause and justification for breaches and provide a timescale for when substantive resolutions would be reached. The Committee further requested that the Non-Core Agency Spend Report be constructed as an assurance report to enable the Trust's attestation regarding Agency compliance to be suitably evidenced.

The Committee received an update on the changes to the IR35 legislation regarding employment of non-core staff through Personal Service Companies (PSCs), which would come into effect on 1st April 2017. The Committee could not assess the impact to the Trust on the information put before the Committee as a result of the changes and noted that work would be required to be undertaken by the HR Team to identify the Trust's exposure and action plan to mitigate the risk. The Committee requested that a report be presented at the April 2017 meeting to outline non-core staff appointment procedures and Trust non-core spend control requirements to be flagged with the Audit Committee for incorporation in the annual audit plan and the Board

The Committee also reviewed the proposed changes to Workforce Supply guidance and noted that work would be undertaken to determine the impact to the Trust and, in collaboration with those within the wider health economy, begin to reduce the employment of NHS substantive staff via an agency over a period whilst still securing patient safety.

**Information Governance Toolkit**

The Committee was pleased to note the Significant Assurance assigned following the Mersey Internal Audit Agency (MIAA) review of the Trust's compliance with Information Governance Toolkit and sought confirmation that the outstanding unsubstantiated areas including corporate records audit and ICT networks operate securely were being actioned. As such the Information Governance Toolkit would be submitted at the end of March 2017.

**IT Service Continuity Update**

The Committee was advised of the progress made to address the recommendations made by MIAA following a review of IT Service Continuity. It was confirmed that a follow-up audit would be undertaken by MIAA ahead of year-end to review the previously assigned Limited Assurance and the outcome of the review would be included within the Trust's Annual Governance Statement.

The Committee received the report however noted its disappointment that some of the outstanding review observations dated from December 2015. The Committee received reassurance from the Director of Informatics that the actions were underway and due for completion by the end of April. The Committee was advised that the action reference replacement of air-conditioning was incorrect, and subject to review of the 2017/18 capital investment plan. An update would be brought to the Committee in due course.

**Water System Review**

The Committee was advised of the progress made to address the recommendations made by MIAA following a review of the Trust Water Safety practices. It was confirmed that a follow-up audit would be undertaken by MIAA ahead of year-end to review the previously assigned Limited Assurance and the outcome of the review would be reflected within the Trust's Annual Governance Statement.

**NHS Improvement – Monthly Return**

The Committee noted the content of the NHSI Month 11 financial commentary, which detailed the financial position at the end of February 2017 and cumulatively against the 2016/17 plan.

**Global Digital Excellence Programme Board**

The Committee received and approved the Global Digital Excellence Programme Board Terms of Reference subject to substantial revision of the members list to include those with primary accountability and key attendees only - to be identified through application of a RACI (Responsibility, Accountability, Communication and Information) approach.

The Committee noted that a business case would be drafted to seek support to develop enhanced Cerner functionality in order to meet the advanced requirements of the Trust. It was confirmed that review of the initial Cerner Business Case would be undertaken to ensure that the objectives and benefits were still appropriate, supported by clinical engagement and aligned with the Trust's strategy.

**Medicine and Acute**

The committee received an overview of the Division Income and Expenditure performance as well as a review of the key issues and 2017/18 CIP schemes. The key points explored within the presentation were:

- Financial performance off plan driven by escalation areas and non achievement of income plan
- Increased pressures within drugs and consumables where being investigated.
- Division would link in to HR regarding on going Junior Doctor gaps and pursue potential alternatives.

The Committee was pleased to hear how the demand and capacity planning was being conducted across the hospital however requested that the recruitment strategy and development plans were considered in conjunction with the Non-Core Agency Spend mitigation strategy.

**Assurance Reporting**

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

- Finance, Strategy and Planning Group
- Global Digital Excellence Programme Board
- Information, Information Governance and Coding Group
  The Committee noted the report of a data protection breach during the reporting period and requested that further information be provided at the April 2017 meeting.

The Committee noted that revised Terms of Reference for the Finance, Strategy and Planning Group and Information, Information Governance and Coding group working committees remained outstanding.

**Andrea Hodgson**
**Chair of Finance, Business Performance and Assurance Committee**

| Board of Directors | |
|---|---|
| **Agenda Item** | 7.4 |
| **Title of Report** | Chair of Audit Committee Report |
| **Date of Meeting** | 29 March 2017 |
| **Author** | Cathy Bond, Chair of the Audit Committee |
| **Accountable Executive** | David Allison, Chief Executive |
| **BAF References**<br>• **Strategic Objective**<br>• **Key Measure**<br>• **Principal Risk** | All |
| **Level of Assurance**<br>• **Positive**<br>• **Gap(s)** | Positive |
| **Purpose of the Paper**<br>• **Discussion**<br>• **Approval**<br>• **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**<br>• **Yes**<br>• **No** | Not applicable |

The Audit Committee met on 3rd March 2017 and reports upon the following items to the Board of Directors:

**Annual Governance Statement**

The Committee received an outline of the suggested content of the Annual Governance Statement (AGS) for 2016/17 and agreed that the statement be framed around the key themes of the Single Oversight Framework. The AGS would balance in-year controls and key risks and challenges with future risks and positive improvements which have realised enhanced rigour as well as detailing the actions taken to address areas of limited assurance as identified by Mersey Internal Audit Agency.

The Committee requested that the following items be included in the AGS:
- Control mechanisms which enable safe staffing levels
- Recognition of reliance on information systems and potential threats to cybersecurity, including implemented controls
- The positive work undertaken to improve Risk Management processes
- The positive work conducted as part of the Information Governance Toolkit

The Committee was advised that a draft AGS was to be presented to the April 2017 meeting for comment and a final AGS would be presented at the May 2017 meeting for approval.

**Board Assurance Framework**

The Committee received the updated Board Assurance Framework (BAF) and noted the input of the Finance, Business Performance and Assurance Committee and Quality and Safety Committee in respect of review of risk content and score.

The Committee was provided with a detailed outline of the Trust process following Never Events and received confirmation that future Root Cause Analysis (RCA) following such instances would be broadened to consider wider systemic issues and inform Trustwide practices, particularly with regards to outpatient procedures. The Committee noted that lessons learned following Never Events would be disseminated Trustwide and requested that any issues identified during a RCA be included in the AGS for 2016/17.

The Committee reviewed the draft Risk Appetite Statement which thematically outlined acceptable levels of risk. It was requested that the statement be redrafted to mirror the MIAA risk categories and be simplified through the utilisation of a matrix ahead of its meeting of April 2017.

**Financial Assurance Report**

The Committee was appraised of the Trust plan to implement revised guidance with regards to financial management of overseas patients whereby relevant staff would be trained to ensure adherence to national guidance wherever possible although the Trust risk exposure was limited as a consequence of the small patient cohort. The Committee noted that the guidance maintained that overseas patients would continue to receive non-elective or urgent procedures at no cost.

**NHS Improvement Licence – Compliance Review**

The Committee received the Provider Licence Quarterly Checklist which had been updated to reflect the actions being taken to address the breach in licence conditions outlined by NHS Improvement (NHSI) in August 2015.

The Committee noted the following key matters:

- G4(2) – Assignment of significant assurance from MIAA on the Fit and Proper Persons Test
- G6 – Potential risk of further regulatory action following trigger of a governance concern in respect of Referral to Treatment Target (RTT) performance. The Committee noted the full support of NHS Improvement (NHSI) in respect of the Trust RTT action plan
- IC1 – The potential impact to the Trust should the latest recommendation from the Neonatal Network in respect of revised locality of Neonatal services be endorsed which may lead to public consultation
- CoS31 – Reflected the Trust's current borrowing position
- FT1 – Now recorded the Trust's review of its Constitution.

The Committee noted that the Finance, Business Performance and Assurance Committee would receive an update regarding the potential impact of the recent Wirral Clinical Commissioning Group consultation which proposed further changes to commissioning for Procedures of Low Clinical Value.

**Legal Update**

The Committee noted the revised guidance pertaining to Conflicts of Interest in the NHS which would come into force on 1st June 2017 and following receipt of the Model Policy, expected in March 2017, the Trust Standards for Business Conduct Policy was to be updated to incorporate the revised guidance. The Committee was advised of an ongoing audit being undertaken by Mersey Internal Audit Agency to review local practices in respect of declarations, the outcome of which would be utilised to inform best practice.

The Committee was advised of the positive changes proposed as part of the CQC regulatory regime consultation however it was disappointed to note the potential future lack of comprehensive inspection which would prevent the Trust from improving its rating. The Committee was advised however that the Trust had secured a future full CQC inspection at its CQC Engagement Meeting of 10th February 2017. Feedback regarding the proposed limitations around comprehensive inspection had been provided via the consultation.

The Committee noted the proposed the consultation regarding the NHSI/CQC Well Led domain and UoR assessment and agreed reluctance to commission a further review, following completion of the recent Well-Led Review in August 2016. The Committee was advised that feedback had been provided in respect of the potential negative impact of the proposed utilisation of the UoR as an assessment tool due to it being indicative of organisational, rather than system performance.

**Annual Review of Non-Financial Scheme of Reservation and Delegation and Constitution**

The Committee received the updated Non-Financial Scheme of Reservation and Delegation (SoRD) which had been revised to:

- Ensure consistency with the financial SoRD
- Accurately outline employee delegated authority
- Reflect the revised Terms of Reference for the sub-Committees of the Board of Directors.

The Committee recommended the Board of Directors approve the Non-Financial SoRD subject to the following amendments:

- Revision of the audit section to read 'review of the annual opinion letter received from the external auditors' rather than 'review of the annual management letter received from the external auditors'
- Inclusion of the responsibility of the Medical Director in respect of all non-financial IT systems.

The Committee received the Trust Constitution which had been revised to reflect the renewed content of the Standards for Business Conduct policy and recommended its approval to the Board of Directors and Council of Governors.

The Committee was advised that the Remuneration Committee Terms of Reference would be reviewed ahead of its next meeting to reflect the revised guidance in respect of Very Senior Manager pay.

**Annual Review of Standing Financial Instructions and Financial Scheme of Reservation and Delegation**

The Committee recommended that the Board of Directors approve the Standing Financial Instructions and Financial SORD which had been revised to ensure alignment with the Trust matrix, which had been approved by the Committee in April 2016, and ensure consistency with the Non-Financial SORD and Constitution.

The Committee was advised that the Financial SoRD would be made available via the staff intranet, presented to the Operations Risk Management Team, promoted by the Principal Financial Advisers and declarations of receipt sought from budget holders.

**Access Targets – Data Quality Review**

The Committee noted that the Trust was expected to receive an unqualified opinion in respect of the 4 Hour A&E Standard for 2016/17 but anticipated receipt of a qualified opinion with regards to RTT for 2016/17 due to data quality issues.

The Committee was disappointed to note the anticipated receipt of a qualitied opinion in respect of RTT for 2016/17. The Committee was appraised of the complexity of the RTT action plan which would not be fully realized until quarter 4 of 2017/18. The Committee endorsed the Trust approach to tackling RTT data quality issues and noted that the RTT action plan had been subject to review by the Intensive Support Team who had recommended no further actions.

**Internal Audit**

The Committee reviewed the outcome/ratings of the audits undertaken during the reporting period as follows:

- Nurse Staffing Levels – Limited Assurance
- Estates Maintenance – Significant Assurance
- Cost Improvement Programme Governance Arrangements – Significant Assurance
- Fit and Proper Person – Significant Assurance
- Quality Spot Checks Phase 2 – Significant Assurance
- Information Governance Toolkit – Significant Assurance
- Cyber Security Baseline Technical Controls – Assurance level not applicable

The Committee was disappointed to note the receipt of Limited Assurance in respect of Nurse Staffing Levels and invited key colleagues to provide clarification regarding the basis for the assignment of Limited Assurance and the actions to be taken to address the recommendations.

The Committee noted that confirmation of completion of 'high' risks identified during audits assigned Limited Assurance would be sought ahead of financial year end to facilitate a review of assurance levels and inform the content of the AGS.

The Committee was pleased receive the Independent Review of Internal Audit Standards which confirmed MIAA conformity with the requirements of the Public Section Internal Audit Standards.

**Anti-Fraud**

The Committee was advised of the outcomes of the MIAA Fraud Investigations Benchmarking Report for 2015/16, which had been circulated ahead of the meeting for information. It was confirmed that the Trust had remained within the pack in respect of performance against comparable organisations within the Mersey Internal Audit client base.

The Committee received and approved the Anti-Fraud Work-Plan which had been designed to reflect the needs of the Trust and mirrored the content and level of resource as required in previous years.

**External Audit**

The Committee approved the External Audit Plan and Fees as confirmed during the meeting.

The Committee noted the importance of reflecting on the financial challenge within the wider health economy when considering the Trust as a going concern. The Committee noted that a review of the Going Concern statement would be undertaken by the Finance, Business Performance and Assurance Committee to ensure its resilience ahead of its inclusion within the Annual Report.

**Cathy Bond**
**Audit Committee Chair**

**BOARD OF DIRECTORS**

**UNAPPROVED MINUTES OF PUBLIC MEETING**

**22 FEBRUARY 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 |
| Gaynor Westray | Director of Nursing and Midwifery |

**In attendance**

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

**Apologies**

*denotes attendance for part of the meeting

| Reference | Minute | Action |
|---|---|---|
| **BM 16-17/266** | **Apologies for Absence**<br>Noted as above | |
| **BM 16-17/267** | **Declarations of Interest**<br>None | |
| **BM16-17/268** | **Chairman's Business**<br><br>The Chairman updated the Board on 4 recent consultant appointments, 3 in anesthesia and one in radiology as follows:<br><br>**Anesthesia** – Dr Huddlestone<br>Dr Karthikeyan<br>Dr Chevannes<br><br>The Chairman advised members that the Board meeting in May had had to be changed to be able to comply with national submission timescales. The Board meeting in May therefore would now take place on the 24th and not the 31st as originally planned. | |
| **BM16-17/269** | **Chief Executive's Report**<br><br>The Chief Executive highlighted the following items from the report: | |

| Reference | Minute | Action |
|---|---|---|
| | **Getting it right first time GIRFT** – the Chief Executive advised that this work had been undertaken in Trauma and Orthopaedics with very positive outcomes, so much so that the Trust was hoping to host the GIRFT team in the future. This work also linked closely with the work being undertaken to improve clinical variation using Cerner as part of the Trust's Global Digital Exemplar status. Although the Board was pleased with this work, it sought clarification as to the financial contribution from Trauma and Orthopaedics and how this would be resolved. The Director of Finance advised that the service benchmarked well with peers and that it was the impact of the type of work being undertaken by the Trust that was impacting on the contribution. The Chief Operating Officer advised that this would be improved once the MSK Programme work was implemented.<br><br>**Global Digital Exemplar (GDE) Programme Board** – the Board was updated on the inaugural meeting of the Programme Board which reported good representation. The Chief Executive advised that the first tranche of the GDE funding amounting to £3.8M had still not been received. NHS England had confirmed that this was a result of the Treasury process and not due to a lack of commitment from the Department of Health. The Board sought to clarify that the Trust was not committing to resource expenditure ahead of formal receipt of these monies. The Director of Finance confirmed that this was not the case and that the Trust would have to re-profile how the funding would be accepted to ensure it could comply with financial year end timescales. The Board was advised that the Trust was expecting the decision imminently.<br><br>**Care Quality Commission (CQC)** – the Chief Executive outlined the changes in the CQC relationship team as a result of promotional changes and re-structure on their part. The Board was pleased to note that a key member of that team would remain in place as the lead which would provide the consistency the Trust needed. The Board was advised that as the Trust would require a more detailed inspection this year, this would not be unannounced there would be a short period of notice in order to facilitate this.<br><br>**Emergency Preparedness, Resilience, Response EPRR Core Standards Assessment** – the Board noted this substantial compliance and the plans to address the minor gaps highlighted.<br><br>**Winter Pressures** – the Board was updated on the fragility of the care home and domiciliary care provider market and the latest action taken by the CQC which had resulted in 4 care homes on the Wirral not now able to take on new patients. The Chief Executive confirmed that this further exacerbated concerns with out of hospital care. The Board sought to establish the extent of the lack of funding in social services on the Wirral and what impact therefore the increase in council tax contributions was likely to make. The Chief Executive advised that raising council tax would equate to £3.9M next year however £3.2M of this would be used to improve tariffs for existing providers, which although modest would help with sustainability. He confirmed that this would not improve capacity more than around 10 beds noting that this was against the decrease last year of at least 44 beds. The Board debated how it might mitigate some of the impact being experienced as a result of CQC action and therefore improve care in out of hospital | |

| Reference | Minute | Action |
|---|---|---|
| | provision.<br><br>The Board sought to understand what action was being taken as a result of the comments from NHSE on the Better Care Funding BCF funding allocation and evaluation this year. The Chief Executive confirmed that there was now more visibility at the A & E Delivery Board and the Trust had prepared a letter outlining its concerns with the BCF ahead of the approval process for 2017/18. The Board agreed that the absence of evidence based models rendered the process not fit for purpose.<br><br>**Strategy** – the Board was advised that the key focus at present in the Sustainability and Transformation Plan STP was in Womens and Childrens and in particular neonatal services.<br><br>The Chief Executive raised concerns that LDSP colleagues could not now make the meeting on the 27th March 2017 which was required to finalise the response to the PWC Accountable Care Organisation guidance ahead of the 1st April 2017 timeline.<br><br>**Innovation in the NHS** – the Chief Executive was pleased to highlight that Dr King Sun Leong, Consultant Physician for diabetes had been featured in a BBC article for the innovative work on diabetes. The Board debated the future funding for this work and that of respiratory as this was only available up until the end of March 2017. The Chief Executive advised that health economy colleagues had agreed to fund this going forward on a fair shares basis. | |
| **BM16-17/270** | **Care Quality Commission Progress Report**<br><br>The Director of Nursing and Midwifery presented the latest CQC progress report and reported on the key highlights as follows:<br><br>"**Deep Dives"** - The "deep dive" events which focus on compliance against the fundamental standards as well as seeking to establish progress against key areas identified for improvement, these being medicines management; clinical handover; risk management and record keeping.<br><br>**CQIs** - The Board was advised of the changes made to the internal Care Quality inspections to ensure that information was triangulated from ward accreditations, clinical audits and patient experience. The proposals included prioritisation of areas that had not yet been inspected with a more streamlined approach being deployed for those areas that require a re-visit.<br><br>**Consultation** – the Board was updated on the latest consultation proposals by CQC in relation to the future inspection regime and how the Trust had responded to these.<br><br>**CQC engagement meeting** – the Director of Nursing and Midwifery updated the Board on the outcomes of the recent meeting on the 10th February which predominantly focused on the Trust's processes for serious incident and root cause analysis reporting as it was acknowledged that this required improvement. The meeting also touched upon the arrangements for the next inspection in light of the recent consultation on the future regulatory regime | |

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| | by CQC. The Director of Nursing and Midwifery confirmed that CQC planned to undertake an announced inspection on the Trust later in the year in view of the changes put in place.<br><br>The Board was updated on the changes to the clinical handover and internal transfer policy and the plans to include an electronic handover before the end of March this year.<br><br>The Board debated the continuing concerns with medicines safety including storage; prescribing and administration. The Director of Pharmacy and Medicines Management confirmed that all incidents were being reviewed to ensure appropriate mitigating action was put in place. The Medical Director questioned whether the issue was a cultural one rather than associated with the process and work therefore would be required that enforces responsibility and accountability and lessons learned. She advised that the Trust needed to hold people to account and be clear about the consequences in order to enact the change required.<br><br>The Board was pleased that the estates issues were being managed more proactively, although this was recognized as an ongoing issue. | |
| **BM 16-17/271** | **Patient's Story - learning**<br><br>The Director of Nursing and Midwifery outlined the key learning from the experience of an 83 year old lady who was brought into hospital by ambulance in August 2016 with back pain following a previous fall. The lady was brought into hospital as she was unable to cope at home, she was admitted as there was no appropriate care at home andher discharge was delayed by a week because there was no capacity to take her home. Whilst in hospital, this lady suffered an unwitnessed fall which resulted in a fracture which was not immediately diagnosed resulting in a delayed transfer to the orthopaedic ward. Finally her operation was delayed due to limited capacity. This lady's post-operative care was good however subsequently she developed pneumonia and died.<br><br>The Board was advised that the independent root cause analysis revealed a series of areas for improvement and the Trust had since undertaken the following:<br><br>• Clinical handover processes improved including the policy and the plans to move to an electronic system<br>• Line in standing blood pressure to be recorded electronically in the future<br>• The staffing cover on the medically optimized patient wards reviewed<br><br>The Board questioned the original decision to admit this lady in the absence of alternative out of hospital care. The Chief Operating Officer advised that admission was the easiest option however doing the right thing for the patient needs to be the easiest thing. She advised that in future patients should be stepped up to intermediate care rather than admitted and then stepped down into this setting. | |

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| **BM 16-17/272** | **Pharmacy Transformation Plan**<br><br>The Director of Pharmacy and Medicines Management presented the Pharmacy Transformation Plan acknowledging that this had been formally reviewed and recommended for approval by the Finance Business Performance and Assurance Committee.<br><br>The Board was advised that the plan highlighted the Trust's performance against key metrics and that it provided assurance that its Pharmacy services delivered value for money and were heavily weighted towards clinical pharmacy, safety and governance activities described in the Lord Carter vision.<br><br>Areas where performance was less strong had now been improved. This included E-ordering which was now at 100% and E-prescribing which now included chemotherapy which went live in January 2017.<br><br>The Board was pleased to note the work being undertaken in collaboration with partners and of particular note was the NHSE bid for GP clinical pharmacists.<br><br>The Board thanked the Director of Pharmacy and Medicines Management for the very positive report and the work undertaken. | |
| **BM 16-17/273** | **Patient Safety Alert – Nasogastric Tube Misplacement**<br><br>The Director of Nursing and Midwifery presented the patient safety alert which had been raised by NHSI as a result of a review of local investigations into nasogastric tube incidents which identified areas for improvement in organisational processes. She advised that the patient safety alert was aimed at Trust Boards and the processes that support clinical governance rather than front line staff.<br><br>The Board was advised that the Trust's own self-assessment together with the associated action plan had been shared with the Clinical Commissioning Group as required. The Director of Nursing and Midwifery confirmed that there were 4 main actions to ensure appropriate care, as outlined in the report, all of which were either completed or due to be completed by April 2017.<br><br>The Board acknowledged the report and sought to establish how the Trust received assurance on the outcomes of patient safety alert audits. The Board agreed that the Quality and Safety Committee would review the patient safety alert audits and the learning on an annual basis as part of its work programme. | **CS** |
| **BM 16-17/274** | **Integrated Performance Report**<br><br>• **Integrated Dashboard and Exception Reports**<br><br>The Chief Operating Officer presented the integrated dashboard and highlighted the following areas: | |

| Reference | Minute | Action |
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| | **A & E 4 Hour Standard** – it was reported that performance against the A & E 4 hour standard had continued to deteriorate since December 2016 as a result of the demand placed on the Emergency Department from an increase in ambulance arrivals. The proportion of the ambulance conveyances being received in either the majors or resus areas was also reported as increasing which indicated an increase in acuity which was impacting on the clinical teams on the base wards and the overall patient length of stay.<br><br>The continuing fragility of the care home and domiciliary care market was reported as having an increasing impact on the Trust's ability to discharge patients, which had already been raised with regulators and partners at the A & E Delivery Board. The Board was advised that the Trust continued to take action both internally and across the health and social care economy in line with the national escalation operating framework with a view to maintaining patient flow, minimising delays in ED and reducing ambulance turnaround times.<br><br>The Board sought to establish whether the overall number of attendances had increased of late. The Chief Operating Officer confirmed that for January and February this had normalised however ambulance attendances had increased which appears to have coincided with a decrease at the Countess of Chester which was currently being investigated. The Board also sought to establish whether the overall number of patients treated within a 4 hour period had decreased or increased. The Chief Operating Officer advised that it was not the overall numbers that was the issue more than it was the variability and surge in attendances which was proving difficult to manage.<br><br>The Board sought clarity as to where the accountability for the provision of domiciliary care rested and was advised that this was with the Local Authority. It further queried why the Local Authority was not using the funding not now being used to pay the main domiciliary care provider because of the suspension by the CQC to pay for alternative provision. The Chief Executive advised that the Council response was that they were already doing this.<br><br>The Board was pleased to note that an appeal for STF funding had been submitted in view of the increasing demand and limited out of hospital care bed provision.<br><br>**Referral to Treatment Times RTT –** the Board was updated on the ongoing work to cleanse the patient tracking lists PTLs with performance now reported as levelling out as expected. The Chief Operating Officer advised that there was still more work to do with the information team to ensure that the Trust had the right management of information.<br><br>The Board was pleased that the Intensive Support Team had reviewed the action plan, data quality and supporting information with a view to providing additional support and external challenge.<br><br>**Diagnostic six week wait** – the Board was advised that performance in this area was good at 99.64% as at the end of January 2017.<br><br>**Cancer** – it was reported that compliance with Cancer standards remains good and on track and no issues were anticipated. | |

| Reference | Minute | Action |
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| | **Infection Control** – the Board was advised that there had been 12 avoidable cases of C difficile reported up to January 17 and one case reported in February taking the total year to date to 13 against an annual permitted maximum of 29.<br><br>The Board sought and received assurance that the recent increase in HSMR performance was not a trend. The Medical Director confirmed that there was a backlog in the reporting of this data and that these figures had now reduced as expected.<br><br>The Board debated the reported bed occupancy levels and the impact the escalation beds had on this.<br><br>• **M10 Finance and Cost Improvement Programme Report**<br><br>The Director of Finance presented the M10 finance and cost improvement report and highlighted the following areas:<br><br>The year to date deficit at Month 10 was reported at £8.3M inclusive of £1.5M impairments, the normalised deficit was £6.8M which was a £4M adverse variance to plan. The key elements that had driven the adverse variance were reported as:<br><br>• Non achievement of STF targets equating to £1.3M<br>• Non delivery of the Health Economy Challenge equating to £1.7M<br>• Continued operational pressures as a result of health economy challenges<br><br>The Board was advised that the Trust was still forecasting to deliver a year end deficit of £10.5M although the increased escalation costs continued to be a risk to this. The Board was reminded that the deterioration from plan was as a result of non-achievement of the "Health Economy Challenge" of £5M, the subsequent loss of STF of £3M and operational pressures relating to reduction in care within the health and social care economy via the Better Care Fund.<br><br>The cash balance at Month 10 was reported at £2.6M which was £0.7M below plan. The Board was advised that cash for the remainder of the financial year was forecast to be under plan, supported by additional borrowings of £2.5M through an extension in the 2016/17 working capital facility, which is in line with previous forecasts discussed at the Board.<br><br>Performance against the cost improvement plan was reported as strong with £9.4M delivery of efficiencies at Month 10 against the plan of £8.6M. The Director of Finance confirmed that the achievement of the year end plan of £11.2M was well on track.<br><br>The Use of Resources rating was reported as a 3 against a plan of 2 with compliance with agency spend contributing to what would have been a rating of 4. | |

| Reference | Minute | Action |
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| | Income from Betsi Cadwaladar and West Cheshire was reported below contract which was currently being reviewed.<br><br>The Director of Finance reported an underlying deficit of £22M for 2017/18 which included £2.9M carry forward from the cost improvement programme and assumes no STF funding.<br><br>The Board was pleased with the strong performance on the cost improvement programme and agreed that a fuller discussion on the preparation and plans for 2017/18 would be undertaken at the next meeting.<br><br>The Board sought to establish where the liability rests for the costs of the escalation beds should agreement to costs across partners not be secured. The Director of Finance confirmed that the beds were commissioned by the Local Authority so in theory the risk lies with them however he would prefer that the A & E Delivery Board members stand by their commitment to support these costs on an fair shares basis. The Board considered that it might be helpful to calculate the impact of winter costs should this continue into 2017/18 in order that appropriate mitigation could be put in place.<br><br>The Board sought and received clarity as to the cash drawdowns to date which were £8.2M, £3.6M and £3.5M with a further drawdown agreed by NHSI should the STF cash funding not be received on time. The Board recorded their concerns at having to incur costs because of system failures. | **JH** |
| **BM16-17/275** | **Finance Business Performance and Assurance Committee Report**<br><br>The Chair of Finance Business Performance and Assurance Committee highlighted the following areas to the Board:<br><br>• The impact of agency spend achievement on the Use of Resources score<br>• The forecast achievement of CIP plans although concerns remained as to the number of non-recurrent plans<br>• The review of the BAF and the impact of non-achievement of STF funding on the overall financial position<br>• The plans to cleanse the RTT waiting lists and return to compliance<br>• Data quality<br><br>The Board expressed potential concerns with data quality and coding and the impact not only on future contract arrangements but also at an STP level if activity was underreported. The Director of Finance confirmed that a review of coding in trauma and orthopaedics undertaken by MIAA provided significant assurance and although more work was required to educate in this area, the Trust had improved its position. | |
| **BM16-17/276** | **Board of Directors**<br><br>The Minutes of the Board of Directors held on the 25th January 2017 were confirmed as an accurate record.<br><br>The action log was received as presented. | |
| **BM16-** | **Items for the BAF/Risk Register** | |

| Reference | Minute | Action |
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| **17/277** | The Board agreed to include the following the BAF:<br>• Reference to the need to implement a further harm review should the Trust fall below the 80% A & E access standard | **CS** |
| **BM 16-17/278** | **Items to be considered by the Assurance Committees**<br>**Quality and Safety Committee** – to include a review of patient safety alert audits and the learning as part of its annual work programme | |
| **BM16-17/279** | **Any Other Business**<br>The public member sought to establish whether the increase in business rates proposed by the Government which impact on the Trust. The Director of Finance confirmed that it would to the value of £100K in 2017/18 although a rates review was being undertaken to establish mitigating action. | |
| **BM 16-17/280** | **Date and Time of Next Meeting**<br>Wednesday 29th March 2017 at 9.00am in the Boardroom, Education Centre, Arrowe Park Hospital. | |

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**Chairman**

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**Date**

# ACTION LOG
# Board of Directors
# Updated – March 2017

| No. | Minute Ref | Action | By Whom | Progress | BoD Review | Note |
|---|---|---|---|---|---|---|
| **Date of Meeting 22.02.17** | | | | | | |
| 1 | BM16-17/273 | Quality and Safety Committee to review patient safety alert audits as part of its work programme | **CS** | | May 17 | |
| 2 | BM16-17/274 | The Board to receive an update on the preparation and plans for 2017/18 in relation to cost improvement and transformation plans | **JH** | **Included on the agenda for March 17** | March 17 | |
| 3 | BM16-17/277 | Include a reference to the need to implement a further harm review should the Trust fall below the 80% A & E access standard | **CS** | **Completed** | | |
| **Date of Meeting 25.01.17** | | | | | | |
| 4 | BM16-17/243 | The Board agreed to address the delay in receiving the draft Nurse Staffing report with MIAA | **DJ/CB** | **Completed – discussed at the Audit Committee in March 17** | March 17 | |
| 5 | BM16-17/243 | The Board agreed to request MIAA to undertake a re-audit of the nursing staffing audit ahead of the financial year | **DJ/GW** | **Completed** | March 17 | |
| 6 | BM16-17/243 | The Board requested clarity on the total staffing numbers in the Nursing update report as this appears to have reduced over the last 12 months | **GW** | **The Board was advised that this was in relation to the closure of Park Suite and the escalation ward - completed** | February 17 | |

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| 7 | BM16-17/243 | The Board sought clarification on the variation in CHPPD on specific wards which appeared to be out of the range expected | **GW** | **reported at March Board** | February 17 | **Due to be reported at March Board** |
| 8 | BM16-17/244 | The Board agreed that the reporting of Advancing Quality Indicators needed to be strengthened | **SG** | | March 17 | **Being reviewed as part of the Quality Governance Review** |
| **Date of Meeting 30.11.16** | | | | | | |
| 9 | BM16-17/211 | **QSC** - Review consultant pinch point data<br>**Audit** – review new agency spend limits as part of the review of the scheme of delegation | **JM**<br><br>**DJ** | **Completed**<br><br>**Completed** | January 2017<br><br>February 2017 | |
| **Date of Meeting 27.07.16** | | | | | | |
| 10 | BM16-17/102 | The Board recommended that the Trust review its compliance against the boiler exhaust omissions. | DJ | **DJ in ongoing discussion with Head of Estates.**<br><br>**Now Completed.** | | |
| **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 | CS | **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 | **This work will be undertaken as part of the action plan from the well led Governance review. Timescales agreed as end of March 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 | EM | **Ongoing** | February 17 | |
| **Date of Meeting 30.03.16** | | | | | | |

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| 15 | BM15-16/297 | Present the Medical Engagement Strategy | EM/JM | **This work is underway and will be progressed further now the new Medical Director is in post** | May16 | |
| 16 | BM15-16/299 | Update on the number of discharges before noon as a result of the SAFER roll out | CO | **Ongoing** | April 16 | **Review of SAFER during March & April, supported by Transformation Team. To report May 2017** |
| 17 | BM15-16/300 | Circulate to members the impact of the nursing investment from a financial perspective in order to complete the evaluation process. | GW | **Completed** | April 16 | |
| **Date of Meeting 27.01.16** | | | | | | |
| 18 | BM15-16/244 | Further work recommended on the performance report to ensure that the anticipated impact of planned action was captured, together with the risks, which would aid with future evaluation and analysis | MB | **The Board agreed in February to close this action and progress under reference BM 16/17/036 – Action closed** | March 2017 | |
| **Date of Meeting 28.10.15** | | | | | | |
| 19 | BM 15-16/163 | Surgical Activity -The Board asked for consideration to be given to reporting routinely how and where beds were being protected as well as where these had been absorbed hence impacting on performance. | MB/SG | **The Board agreed in February to close this action and progress under reference BM 16/17/036 – Action closed** | November 2015 | |
| 20 | BM 15-16/163 | RTT - The Board requested that further consideration be given to implementing an "early warning system" thus using the technology the Trust has. | MB/SG | **The Board agreed in February to close this action and progress under reference BM 16/17/036 – Action closed** | November 2015 | |
| **Date of Meeting 30.09.15** | | | | | | |

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| 21 | BM 15-16/132 | The Board requested that the actions being taken to address areas of under performance in the performance report ranked in terms of desired impact, where possible, to aid with review. | PC | **The Board agreed in February to close this action and progress under reference BM 16/17/036 – Action closed** | October 2015 | |