Wirral University Teaching Hospital NHS
NHS Foundation Trust

Council of Governors

15th June 2016

Council of Governors
Wednesday 15th June 2016
4.00 p.m.
Boardroom, Education Centre, APH

AGENDA

1.	**Apologies for Absence** Chairman	v
2.	**Declarations of Interest** Chairman	v
3.	**Minutes of Previous Meeting (16th March 2016)** Chairman	d
4.	**Matters Arising** Chairman	v
5.	**Chairman's Business** Chairman	v
6	**Governance**	
6.1	**Quality and Safety Committee Review** Dr Jean Quinn	p
6.2	**CQC Action Plan Progress** Medical Director	P d
6.3	**Financial Accounts 2015/16 and Quality Report Audit Findings** Karen Murray and Stephen NIxon	P d
7	**Performance**	
7.1	**Report from Governor Workshop** Lead Governor	d
7.2	**Trust Performance** Chief Executive	p
7.3	**Audit Committee Report** Chair's Report	p
7.4	**Board of Directors' Meeting Minutes 30th March, 27th April 2016**	d

Chairman

7.5	**Board of Directors Meeting 25th May 2016, update** Chairman		v
8	**Strategy and Development**		
8.1	**Strategy Update** Director of Strategy		p
9	**Standing Items**		
9.1	**Annual Plan Advisory Committee (APAC) Minutes**		d
9.2	**Any Other Business** Chairman		v

Date of Next Meeting
Wednesday 15th September 2016

Closed Session
For Governors only

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COUNCIL OF GOVERNORS UNAPPROVED MINUTES OF MEETING HELD ON 16th MARCH 2016

BOARDROOM EDUCATION CENTRE ARROWE PARK HOSPITAL

Present:

Michael Carr	Chairman
Paula Clare	Staff Governor
Mandy Duncan	Stakeholder Governor
Steve Evans	Public Governor
Paul Harris	Public Governor
Robert Howell	Public Governor
Eileen Hume	Public Governor
Evelyn Hurren	Public Governor
Sue Mitchell	Public Governor
Rosemary Morgan	Staff Governor
Norman Robinson	Staff Governor
Carol Skillen	Staff Governor
Len Smith	Public Governor
Angela Tindall	Public Governor
George Wadham	Public Governor

In attendance:

Cathy Bond	Senior Independent Director
Mike Coupe	Director of Strategy
Andrea Hodgson	Non-Executive Director
Graham Hollick	Non-Executive Director
Gareth Lawrence	Acting Director of Finance
Evan Moore	Medical Director
John Sullivan	Non-Executive Director
Carole Self	Director of Corporate Affairs
Julie Adley-Sweeney	Membership Manager
James Mawrey	Director of Workforce
Chris Oliver	Interim Director of Operations
Stephen Nixon	Grant Thornton
Karen Murray	Grant Thornton

Foundation Trust Members:

John Davies
Barbara Kerr

Apologies:

Fleur Flanagan	Public Governor
Derek Hampson	Public Governor
Fadil Hannan	Stakeholder Governor
Kathy Hodson	Stakeholder Governor
Rohit Warikoo	Public Governor
David Allison	Chief Executive
Mark Blakeman	Director of Infrastructure &Informatics
Gaynor Westray	Director of Nursing and Midwifery
Cathy Maddaford	Non-Executive Director
Jean Quinn	Non-Executive Director

Ref	Minute
CoG 15-16/065	**Apologies for Absence** Apologies were noted as above.
CoG 15-16/066	**Declarations of Interest** There were no interests declared
CoG 15-16/067	**Minutes of the Previous Meeting** The minutes of the previous meeting held on the 9th December 2015 were approved as an accurate record.
CoG 15-16/ 068	**Matters Arising** The Chairman raised the following: **Minute 15 – 16/050 – Matters Arising** The Council was advised that an appointment had been made to the role of Chief Operating Officer and that Mrs Janelle Holmes would take up her new role on 1st April 2016.
CoG 15-16/ 069	**Chairman's Business** The Council was advised that the Trust had taken part in the Patient Experience Network National Awards (PENNA) and had been short listed in five categories and had won two awards. The first was for the Trust's work on the Listening into Action (LiA) initiative and the second was awarded to Mr Mark McKenna, Interim Head of Patient Experience who won the Patient Experience Professional of the Year. The CoG extended its thanks to the teams involved. The Chairman updated the Council on a recent Diabetic Consultant appointment, Dr Srnivas-Shankas. The Chairman advised the Council of the upcoming dates for Junior Doctors industrial action for April and assured the Council that the Trust would endeavour to minimise the impact upon patient care. The Council was provided with a copy of the feedback letter from Monitor which detailed their analysis of the Trust's Q3 submissions. The Council was informed that the Trust had a Financial sustainability risk rating of 2 and a Governance rating of Red. The Council noted the formal feedback letter.
Governance	
CoG 15-	**Care Quality Inspection Programme**

Ref	Minute
16/ 070	The Chairman provided an insight into the newly established internal Care Quality Inspection Programme. This would replace the previous Board Walkabouts with a newly devised structure based upon the mock inspections previously undertaken by the Trust. Training was to be provided prior to the inspections, with the first session being held on 13th April. The Chairman encouraged Governors to join the inspection teams.
CoG 15-16/ 071	**Grant Thornton - Introduction** Mrs Karen Murray and Mr Stephen Nixon provided a presentation on the role of an auditor and how they intended to support the Trust. The Council was advised of the responsibilities and principles required to undertake this in accordance with the code of practice issued by the National Audit Office (NAO) in April 2015. The Council was provided with the timetable of reporting and an overview of the procedure required in preparing the audit report on the content of the Quality Report.
CoG 15-16/ 072	**Quality Accounts – Determination of Local Indicators** The Medical Director presented a report on the Quality Account, including progress during this year and priorities for next year. The Council was informed of the three main priorities in 2015/16, these being: Patient Experience; Clinical Effectiveness and Safety. Each of these priorities having a number of areas and targets within them as follows: Dementia Care: • Training provided to approximately 1800 clinical staff and partners such as nursing homes. • Launch of Dementia Strategy. • 85% of dementia patients have completed a “This is Me” booklet, signed by their carer. Eating and Drinking: • Initiatives established such as, snack packs; ward nutrition boards; flexible visiting and mealtime co-ordination. • Spot audit in January provided good results. Pressure Ulcers: • Although the Trust will not be able to meet its target in Q3, January and February had seen improvement in the number of pressure ulcers at grade 2. • New tissue viability nurse and assistant posts created. • Purchasing of new profile beds • New Pressure Ulcer Prevention Policy currently being drafted. Missed Medications: • Addition of critical medicines to ward stock lists where necessary and appropriate. • Nursing Millennium Ambassadors to support colleagues in using the system correctly Mortality: • Initiatives such as Advancing Quality, seven day specialist review and a new framework for mortality reviews are helping to drive improvement. • HSMR continuing to reduce month-by-month and better than the National average • Mortality for patients admitted at weekends, now not statistically higher than those admitted during the week. Readmissions:

Ref	Minute
	• A redesigned audit tool to improve the quality of data for whether readmissions were unavoidable. • Earlier intervention in the last year of life such as, Community Geriatrics working with nursing homes and emergency healthcare plans and advanced directives. The Medical Director advised the Council of possible new priorities for next year and the continuation of some existing priorities which had not yet been achieved. The Council was advised that the priorities mortality and dementia care would be discontinued and replaced with End of Life Care and the SAFER bundle to improve patient flow. The Council was informed of the two key areas for External Audit, theses being Referral to Treatment (RTT) and A&E 4 hour standard which would be in addition to a local performance indicator chosen by the Council. The Council selected the Malnutrition Universal Screening Tool (MUST) as their local indicator.
CoG 15-16/ 073	**CQC Inspection Report** The Council was provided with the full Care Quality Commission Report of the inspection which took place in September 2015. The Medical Director also presented an overview of the inspection, informing the Council of the overall rating of "Requires improvement". He provided an insight in to the methodology used, to rate the Trust and each of the areas identified. The Council was advised of each of the five categories which the inspection was based upon and then were each service had been rated.
	Performance
CoG 15-16/ 074	**Report from Governor workshop** A report was provided by the Lead Governor regarding the workshop which took place on the 17th February 2016. He reported that this had been delivered in two distinct sections. The first of these was a presentation by Senior Nurse, Debbie Mills who provided an overview of the work undertaken within the Cardiovascular Diagnostic Services. This was followed by a visit to the department and a question and answer session. The second section of the workshop was a joint Board session. The Director of Corporate Affairs provided information on the structure of the NHS as previously requested. Governors were asked to provide feedback regarding their development and induction training, along with their opinions concerning future workshops and pre- CoG meetings. Louise Taylor, CQC Compliance Manager provided a presentation on the internal Care Quality Inspection Programme, which the Trust had undertaken in preparation for the CQC visit in September 2015. The Trust was keen for this style of inspection to become a regular occurrence, replacing the previous Board Walkabouts.

Ref	Minute
CoG 15-16/ 075	**Trust Performance** The Council received a presentation from the Acting Director of Finance on behalf of the Chief Executive. He provided information on the Trust's performance in relation to key targets. In areas where the Trust was failing a target, further narrative and information was provided in terms of action being taken. The Acting Director of Finance informed the Council that with regard to cancer targets they had all been met and remained green. The A&E 4 hour standard and Never Events remained red with A&E reaching 81.70% against a target of 95% and the Trust reported 3 Never Events against a tolerance of zero. The Council was advised of a more detailed analysis of A&E showing activity levels including both self - presenting attendances and ambulance arrivals. The Council was advised that the Trust trajectory for 2015/16 was 29 avoidable toxin positive C.Difficile infections and as at January 2016 it had seen 35. The Trust was awaiting confirmation from NHS England re the trajectory for 2016/17. All key actions which had been identified in the plan submitted to Monitor were now completed, such as: • A robust HPV programme • Daily side room review • Weekly C. diff report to senior management • Post infection review to include presentation to Director of Infection Prevention & Control The result being that the Trust had not reported any avoidable C. diff cases since January. The Council received information regarding RTT high level actions undertaken including: • A Deep-dive review into the RTT process • Weekly activity meetings now include RTT assurance • Refocus from validation to pathway management and activity delivery with additional resource within outpatient clinics The Acting Director of Finance was pleased to report that Patient Satisfaction in Friends and Family In-Patients Test remained green with 993 respondents having taken part in January 2016. The staff survey 2015 had shown significant improvements and the Staff Engagement score was the highest in the last 7 years. The Council was provided with an overview of the Trust's strategic objective to achieve financial, commercial and operational excellence and advised that the Trust's cash position remained above plan. The Council was assured that with regard to the junior doctor strike, the Trust had taken a pragmatic safety based approach to minimise impact.
CoG 15-16/ 076	**Finance Business Performance and Assurance Committee Report** Mr Graham Hollick, Chair of the Finance, Business Performance and Assurance Committee presented a report to the Council on the work of the Committee. He provided an overview of the purpose and structure of the Committee, in providing assurance to

Ref	Minute
	the Board of Directors for the financial and operational performance of the Trust. The Council was advised of a number of aspects undertaken within the work of the Committee, such as: Delivery of the financial plan; ratifying and reviewing policies for effective management of finance and performance; reviewing business cases where appropriate. The Council was provided with further information regarding the Trust's financial performance for 2015/16 and an insight into its current position. This included a forecast deficit of £15m with a CIP program of £13m. The previous three year period had seen the Trust deliver a CIP in excess of £30 m worth of savings.
CoG 15-16/ 077	**Board of Directors' Meeting Minutes 27th January 2016** The Council received the minutes of the above meeting.
CoG 15-16/ 078	**Board of Directors' Meeting 24th February 2016, Update** The Chairman provided a verbal update from the most recent Board of Directors' Meeting this included a report from the quarterly meeting with Monitor, a review of C.diff and CIP for 2015/16, a portion of which was recurrent and had not been achieved for 2016/17.
Strategy & Development	
CoG 15-16/ 079	**Sustainability and Transformation Plan** The Director of Strategy provided a presentation on the delivery of the 5 Year Forward View 2016-2021. He explained the various planning outputs contained in this such as; Strategic Recovery plan / WUTH 2020; Operational Plan 2016/17 and Sustainability Plan 2016/2021. He highlighted a number of challenges to overcome in order to improve health and wellbeing, quality and development of new models of care and improving efficiency to achieve financial balance. The Council was provided with information surrounding Healthy Wirral and the benefits of integrated care. It was advised of the need to redesign care pathways for an aging population with more complex needs and a greater demand for critical care.
Membership and Engagement	

Ref	Minute
CoG 15-16/ 080	**The Public Perception of Arrowe Park Hospital** Mrs Barbara Kerr, a Trust Ambassador and a long standing member of the Membership and Engagement Committee provided the Council with feedback on the activities that she had undertaken. She had attended a number of meetings held by community groups across Wirral, encouraging people to take an interest in the hospital and its services in a positive way. She also provided the Council with examples of the type of questions most frequently asked by the public. Mrs Kerr's work led to a significant number of attendees becoming members of the Trust.
Standing Items	
CoG 15-16/ 081	**Annual Plan Advisory Committee (APAC) Minutes** The Council noted the minutes and the work of the Annual Plan Advisory Committee.
CoG 15-16/ 082	**Any Other Business** The Chairman informed the Council that this would be the final meeting for Mr Gareth Lawrence as Acting Director of Finance and thanked him for his input at Council Meetings. The Chairman thanked the Council and members of the public for their attendance and closed the meeting.
CoG 15-16/ 083	**Date and Time of Next Meeting** Wednesday 15th June 2016 at 4.00pm.

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Chairman

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Date

Council of Governors	
Agenda Item	
Title of Report	CQC – Trust-wide Action Plan update
Date of Meeting	
Author	Joe Roberts, Head of Assurance
Accountable Executive	Dr Evan Moore, Medical Director
BAF References	Strategic Objective 7 - Supported by financial, commercial and operational expertise Key Measure 7a - Fully comply with our registration with the Care Quality Commission
Level of Assurance	Positive
Purpose of the Paper	To note
Data Quality Rating	Bronze
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken	Not applicable

1. Executive Summary

This is an updated version of the CQC Action Plan, to show progress at mid-May 2016.

2. Background

In April 2016 the Senior Management Team approved the action plan, based on the results of the September inspection, to be submitted to the Care Quality Commission. The action plan is designed to address those issues which made us non-compliant with the CQC Regulations in the Health and Social Care Act (also known as the 'Fundamental Standards'). Therefore it does not cover every issue which was mentioned in the report, just those which are of the highest priority. Other issues are covered by divisional action plans.

A routine engagement meeting was held on Thursday 19th May involving representatives of CQC and of our Trust, and the progress of the action plan was one of the main issues for discussion.

3. Key Issues

The action plan has been RAG-rated according to the status completion of the actions. It includes 82 actions in total, of which 31 are not yet due (these are shown as 'grey' in the

attached document). This means that there are 50 actions which should be complete by now. Of these, 42 have been completed and are shown as green.

The remaining actions are shown as amber. These actions are progressing although they were not complete by their original deadlines, which were mainly the beginning of May. It is expected that these actions will be done by the end of May, or June at the latest. Commentary is provided within the action plan for these items. No actions are shown in red in the action plan as there has been progress with all of them.

For completed actions, the attached document also states what evidence we have that we have done the actions, for example copies of revised policies, meeting minutes etc. These documents are held in a portfolio on our shared network drive so that they are ready for inspection by CQC. We are still in the process of obtaining evidence documents for a small number of actions. Some actions relate, for example, to meetings which do not have formal agendas or minutes; in these cases we have had to obtain e-mail confirmation from the department concerned that the issue was discussed.

CQC made clear at the engagement meeting that they expected us to make more rapid progress in respect of End of Life Care – particularly individual care plans, which are being implemented on a pilot basis before going Trust-wide in November. In response to this feedback we will be accelerating this programme and a meeting is scheduled on Monday 23rd May involving senior nurses and Palliative Care Consultants in order to make this happen.

4. Next Steps

The next steps is to ensure that all the remaining actions are implemented and maintained in full. We will need to be ready to provide CQC with documentary evidence that we have done what we said we would do. Where actions have been delayed, these should be completed by late June at the latest.

Some actions involve awareness raising or changes to policy – it is important that this results in changes to practice and improvements in service quality. This will be monitored through audit and the Care Quality Inspection programme.

We also intend to merge this action plan (which includes 'must do' and 'should do' actions) with the more aspirational divisional action plans which are aimed at moving us from 'requires improvement' to a 'good' rating.

5. Conclusion

Although some deadlines have not been met, we are making progress with the action plan and envisage that we should be able to implement all the actions in full.

6. Recommendation

The Council is asked to note progress with the action plan.

Issue	Action	Responsible Person	Due Date	Completed Date	Comments	Status	Evidence
REGULATION 11 - CONSENT							
Mental Capacity Act Training The section of the CQC inspection report relating to the 'Medical Care' core service	Implement plan to improve compliance with Mental Capacity Act training across all clinical staff groups in the division from 27.5% to 90% for Level 2, and from 16.8% to 90% for Level 3 within 12 months, prioritising high risk areas.	Dr Ranjeev Mehra – Divisional Medical Director, Acute and Medical Specialties; Julie Reid – Associate Director of Nursing; Amanda Farrell – Divisional Director of Operations	30.9.16 (50% compliance) 30.4.17 (90% compliance)		*The most recent performance statistics (April) show that this is improving and current compliance is as follows:* *Level 1 – 93.01%* *Level 2 – 49.91%* *Level 3 – 20.69%*	*Grey*	*Statistics provided by Learning and Development from OLM Database*
Bed Rails Assessments In their inspection report, CQC observed that the bed rails assessment did not include the recording of consent to the use of bedrails or best interest decisions for patients who lacked capacity to consent. There is a risk that patients and/or their loved ones might not be fully aware of the need for bed rails and this could cause distress. Bed rails may be used inappropriately so possibly depriving an individual of their liberty or increasing the risk of falls from height.	Amend electronic bed rails assessment to ensure capture consent/best interest decisions consistently	Margaret Davies – Dementia Matron	13.4.16	13.4.16		*Green*	*Screen shots from Millennium system*
	Update Falls Prevention Policy to reflect changes to electronic bed rails assessment	Margaret Davies	30.4.16	13.5.16	*The policy has been updated and has gone live on the intranet.*	*Green*	*Revised policy on intranet*
REGULATION 12 – SAFE CARE & TREATMENT							

Issue	Action	Responsible Person	Due Date	Completed Date	Comments	Status	Evidence
Emergency Department – Call Bells CQC judged that the emergency department did not include arrangements to respond appropriately and in good time to people's changing needs. This is because they found that call bells were either out of reach of patients, or not installed at the bed side of patients in the 'trolleys' area of the emergency department.	Install call bells in every area and check as part of patient rounding 2 hourly each day	Helen Morris – Emergency Department Matron	30.9.15	30.9.15	*These actions have been completed although when the department was recently visited two buzzers had been removed for valid clinical reasons but could not be immediately reconnected.*	*Green*	*Observation by Q&S staff; Emergency Department Matron's Audit results; Copy of Patient Rounding pro forma*
Resuscitation Trolleys – Paediatrics CQC judged that we were not doing all that was reasonably practicable to mitigate the risks to service users. This is because a resuscitation trolley on a paediatric ward was not checked regularly and it contained out of date equipment and there was no defibrillator present.	Immediate communication to all staff regarding mandatory obligation to check resuscitation trollies	Pauline Riding – Children's Services Matron	30.9.15	30.9.15	*This was disseminated through handover and care improvement meetings*	*Green*	*E-mail confirmation provided; these meetings are not minuted*
	Replace the respiratory arrest trolley with emergency grab bags at each nurse base. These will have with clear signage to the defibrillator. These will have a seal in place; the seal will be broken on these monthly and equipment checked within, then they will be resealed.		1.5.16	1.5.16	*The grab bags are now in situ and signage regarding location of the defibrillator in place; support from the Resus Team.*	*Green*	*Observation by Quality and Safety staff*
	Develop a Standard Operating Procedure for the use and checking of the grab bags		1.5.16		*This is currently in draft – advice is being obtained from the Resuscitation Team.*	*Amber*	*Copy of draft guidance*
	Communicate new arrangements as follows: cascade at the ward meeting, the weekly care improvement meeting (it will be message of the week); and handovers (medical & nursing). Also, post information on the staff notice board and at each of the nurse bases.		1.5.16	1.5.16	*Staff awareness has been raised*	*Green*	*No documentary evidence for handover / care improvement meetings as these do not have formal minutes and agendas*
Diagnostic Test Results CQC found that there were lengthy delays in the reporting of urgent diagnostic test	Undertake an analysis of capacity and demand for the service	Dr Nitin Rao – Consultant Radiologist;	31.3.16	31.3.16		*Green*	*Copy of report and supporting data*

Issue	Action	Responsible Person	Due Date	Completed Date	Comments	Status	Evidence
results.	Implement mitigating measures in the meantime, including: contract out scans and plain imaging examinations; use an external agency to report plain films on site; Consultants to undertake extra sessions to meet reporting demand.	Pam Black – Radiology Services Manager	31.3.16	31.3.16		*Green*	*Spreadsheets showing number of additional Consultant sessions by month; number and cost of outsourced scans*
	Undertake review of MR reporting and develop action plan based on the findings; develop work plan for Consultant Radiologists		30.6.16	30.6.16		*Grey*	
	Develop and expand Radiology reporting and activity dashboard, covering, for example: access times; turnaround times for all referrals broken down into inpatients / outpatients / direct access / cancer referrals / urgent examinations; Do Not Attends, cancellations; equipment downtime; sickness; maternity leave; and vacancies.		30.6.16	30.6.16		*Grey*	
	Implement action plan based on capacity and demand review		31.3.17	31.3.17		*Grey*	
Infection Prevention and Control CQC found that care and treatment was not always carried out assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated. This is because not all staff in critical care were washing their hands or using antiseptic hand gel as appropriate when delivering patient care or moving from one patient or their bed space to the next.	Increased visibility of the Infection Prevention and Control Team (IPCT) in Critical Care – a member of the team to visit the unit daily to observe practices and to provide 'on the spot' education sessions	Andrea Ledgerton – Associate Director of Infection Prevention and Control	31.12.15	31.12.15		*Green*	*Verbal confirmation that members of IPCT have visited*
	Introduce monthly infection control walkabouts with the Critical Care Team, including the unit manager, matron, IPC Ambassador, and medical IPC lead		3.2.16	3.2.16		*Green*	*Verbal and e-mail confirmation of walkarounds taking place – *awaiting documentation**

Issue	Action	Responsible Person	Due Date	Completed Date	Comments	Status	Evidence
	Facilitate IPC education sessions for Clinical Support Workers in Critical Care		1.2.16		*Two sessions held in January and February. A third and final session will be held in June.*	*Green*	*Programmes for training days and attendance records*
	Support the Clinical Educators for Critical Care to develop and introduce an induction pack for new starters (nursing and medical) relating to IPC to include hand hygiene		30.4.16	30.4.16	*The IPCT have contributed content to the induction pack. However, the induction pack as a whole is still under development in Critical Care.*	*Amber*	*Draft new starter checklist*
	Support the Clinical Educators for Critical Care to lead the introduction of a programme to ensure all staff have had an annual hand hygiene competency assessment		30.4.16		*This commenced in late April. 30 members of staff have taken part during the last three weeks.*	*Green*	*Attendance records held by Critical Care Department*
	Recruit a Matron solely to manage Critical Care - this will support local ownership and closer supervision of infection control in Critical Care		30.4.16		*This has been slightly delayed – interviews took place two weeks later than planned, on 13.5.16*	*Amber*	*E-mail update from Divisional ADN*
Emergency Transfers from Clatterbridge to APH CQC judged that we did not have arrangements to take appropriate action if there was a clinical or medical emergency. This is because there wasn't a standard process or procedure in place in the event that a patient deteriorated and required transfer from Clatterbridge Hospital to an Acute hospital.	Establish group to review process for transfers, including the staff involved in transferring patients from Clatterbridge and Arrowe Park	Dr Melanie Maxwell – Associate Medical Director	30.9.15	30.9.15		*Green*	*Action notes from meetings and subsequent e-mail correspondence*
	Draft and approve a Standard Operating Procedure for such transfers		14.4.16	14.4.16	*This has been added to the Trust intranet. It covers deteriorating patients, the critically ill, and failed day cases.*	*Green*	*Guideline available on intranet*
	Implement and monitor the SOP		30.5.16		*Work is in progress at present. The number of patients transferred from CBH to APH in an emergency is low, which makes it difficult to identify common issues and trends.*	*Grey*	
	Audit the Standard Operating Procedure		30.11.16			*Grey*	

Issue	Action	Responsible Person	Due Date	Completed Date	Comments	Status	Evidence
REGULATION 13 - SAFEGUARDING							
Safeguarding Training CQC judged that safeguarding children's training was not provided in line with best practice guidance. This is because children's safeguarding training did not meet Royal College of Paediatric & Child Health (RCPCH) guidelines 2014.	Complete gap analysis for existing draft training strategy against Safeguarding children and young people: roles and competencies for Staff (PRCH 2014)	Sue Fogarty – Head of Safeguarding	29.2.16	29.2.16		*Green*	*Copy of gap analysis*
	Hold initial meeting with Learning & Development Department to amend draft training strategy and further develop training needs analysis to scope various methods of delivering training, i.e. blended/face to face/e-learning		29.2.16	29.2.16		*Green*	*Notes from meetings*
	Introduce "PREVENT" module into the current training (additional one hour)		30.4.16	14.4.16	*We use a standard presentation devised by the Home Office for use by the NHS*	*Green*	*Copy of training presentation*
	Complete further gap analysis against the Safeguarding Adults: Roles and competences for health care staff – Intercollegiate Document published by NHS England 2016		31.5.16	31.5.16	*We have reviewed the intercollegiate document and identified that we need to reinforce Level 1 and Level 2 Safeguarding training.*	*Grey*	
	Complete training needs analysis and implement new training strategy to ensure staff attain the competencies relevant to each role and follow subsequent guidance.		31.5.16	31.5.16	*The Safeguarding Team have been meeting regularly with the Learning and Development Team to develop a plan which includes training days and blended learning (a mix of e-learning and face-to-face teaching).*	*Grey*	*Notes from meetings*
	Through training plan, prioritise training in high risk areas such as care of the elderly		1.12.16			*Grey*	

Issue	Action	Responsible Person	Due Date	Completed Date	Comments	Status	Evidence
	Scope with Electronic Staff Record (ESR2) developing e-learning for both Level 1 and Level 2 training, following consultation with the Designated Nurses been on the use of NHS England e-Learning safeguarding level 1 & 2 for use with in WUTH, to ensure requirements met for competencies as specific in both intercollegiate documents		1.12.16			*Grey*	
	Implement E-Learning pathway		1.12.16			*Grey*	
REGULATION 15 – PREMISES & EQUIPMENT							
Ward Security CQC were concerned that access to, and exits from, a ward (M1 Clatterbridge) were not appropriately secure. This is because the security arrangements presented a risk that patients may leave and visitors may enter unnoticed.	Fit an electromechanical lock and link to fire alarm system	Gary Lewis, Associate Director of Estates	22.4.16	19.4.16		*Green*	*E-mail update from Maintenance Manager*
	Sister of the ward concerned to check security as part of her daily checks, and ensure that the door is not left open.	Helen Donaldson, Ward Sister	22.4.16	19.4.16	*This should not be necessary now that a lock is in place*	*Green*	*Action now superseded*
REGULATION 16 - COMPLAINTS							
End of Life Care Complaints CQC judged that we did not operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to end of life care	Introduce a category into the Safeguard system to highlight "end of life" complaints and incidents	Risk Information Team	31.12.15	31.12.15		*Green*	*Screen shot from Safeguard database*
	Review the terms of reference of the Palliative Care & End of Life Team meeting to include standing agenda items relating to: incidents reported within WUTH; incidents reported in Wirral Community NHS Trust relevant to WUTH; and complaints reported within WUTH, for review	Dr Melanie Maxwell – Associate Medical Director	29.2.16	29.2.16		*Green*	*Copy of Terms of Reference - *document awaited**
	Bereavement Office team to meet with Coroner; Coroner to address a meeting of Trust staff for a Q&A session	Marsha Parton-Murphy – Bereavement Office Manager	14.4.16	14.4.16		*Green*	*Copy of 'Start the Week' newsletter including item about the Coroner's visit*

Issue	Action	Responsible Person	Due Date	Completed Date	Comments	Status	Evidence
	All complaints and incidents relating to end of life care to be reviewed by the Clinical Lead for Palliative & End of Life Care (alongside standard complaints procedure and governance processes within the clinical divisions), allowing the generation of key themes to inform future training and service development across the organisation	Dr Catherine Hayle – Clinical Lead for Palliative and End of Life Care	31.5.16		*The Risk Information Team are collating this information. However, there has only been one case relating to end of life care in the first two months of the financial year so there has been little to review so far.*	*Grey*	
Death Certification CQC were concerned that complaints were raised in relation to the timely completion of death certificates but the trust had not taken any action to address this at the time of the inspection.	Review and update Trust policy on Death Certification	Jan Eccleston – Associate Director of Risk	31.10.15	31.10.15		*Green*	*Revised policy on intranet*
	Complete a survey of junior doctors to understand their perspective on why death certificates are not completed in a timely fashion	Dr Melanie Maxwell	31.3.16	31.3.16	*This was completed online using 'Survey Monkey'.*	*Green*	*Report from Survey Monkey showing results*
	Undertake a quality improvement project based on the findings of this survey, including a further amendment to the policy.		30.9.16			*Grey*	
REGULATION 17 – GOOD GOVERNANCE							
Risk Registers CQC were concerned that, although all departments had a risk register, the risks were not always managed and mitigated in a timely way.	Hold Patient Safety Week events to highlight the following areas to staff and visitors: incident Reporting; serious incidents and never events; Duty of Candour; safe clinical handover; record keeping and documentation	Jan Eccleston – Associate Director of Risk	18.3.16	18.3.16		*Green*	*Copy of programme for Patient Safety Week and information materials used*
	Review and propose new draft version of the Risk Management Strategy		31.3.16	1.4.16		*Green*	*Copy of draft strategy*
	Deliver focussed training to the staff in Critical Care, to ensure they fully understand the risk processes.		31.5.16		*One of these sessions has taken place so far with a further two booked in.*	*Grey*	*Diary entries for member of staff delivering the training*
	Approve revised Risk Management Strategy and go live		31.7.16			*Grey*	
	Complete full risk register review to 'cleanse' the register of old, mitigated or inappropriate risks		30.9.16			*Grey*	

Issue	Action	Responsible Person	Due Date	Completed Date	Comments	Status	Evidence
Critical Care Transfer Equipment CQC were concerned that the patient transfer equipment in Critical Care did not meet the current Intensive Care Society standards for the transport of critically ill adults.	Seek clarification from the regional Critical Care network with regard to transfer equipment (we have been advised that by having equipment positioned next to the baulk head is in line with current guidance).	Dr Tom Williams – Consultant Anaesthetist	31.3.16	31.3.16	*We are also in discussion with North West Ambulance Service. We have undertaken the actions which we can do and are dependent on their agreement.*	*Green*	*Minutes of meeting of Critical Care Joint Transfer Group, May 2016*
Records Storage CQC were concerned that records were not always secure, accurate or completed fully. This is because record trolleys were left unlocked on some of the medical wards which they visited.	Complete an information governance risk assessment of case notes storage on the wards and an option appraisal for consideration by the Information Governance Group	Mark Blakeman – Director of Infrastructure and Informatics	30.6.16		*We have identified a suitable type of trolley, costing approximately £400 each. We are establishing how many will be needed and are discussing a proposed Standard Operating Procedure for case note storage with Ward Sisters.*	*Grey*	
	Finalise plans to move to fully electronic case notes (i.e. including medical notes)		31.3.17			*Grey*	
Record-keeping in the Emergency Department CQC reviewed a sample of 23 patient records in the emergency department and found that 19 were not fully completed. For example, pain scores were missing in six records, initial observations were missing in three records and information relating to safeguarding and social circumstances was not recorded in five records.	Complete regular casenote and CAS card audits and report to divisional and specialty governance meetings	Dr Tim Bentham – Clinical Governance Lead, Acute Care	31.3.16	31.3.16		*Green*	*Audit plan showing record keeping audits scheduled for this year* **Copies of audit reports awaited**
Maternity – Completeness of Records CQC judged that the electronic record keeping system in maternity did not ensure records were always complete and contemporaneous in respect of each service user	Local mandatory training to include a session on documentation	Mr Mike Ellard – Consultant Donna Lloyd Jones – Divisional Quality and	30.4.16	30.4.16	*This has been slightly delayed but is included in the programme for the mandatory training day on 27th May.*	*Amber*	*Agenda for the training day is not yet available – will be circulated closer to the date*

Issue	Action	Responsible Person	Due Date	Completed Date	Comments	Status	Evidence
	Supervisors of Midwives are to plan to audit notes monthly with summary of findings to Clinical Governance team	Safety Manager, Women's and Children's Services			*It has been agreed that we will use the trust medical record keeping audit tool – 5 cases will be done at the mandatory training day. These tools are in a scannable format so once completed will be submitted to Trust and the results will be shown in the monthly trust audit report that is presented at Trustwide Clinical Governance Team.*	*Amber*	*Copy of audit tool which is being used*
End of Life Care – Assessing and Monitoring CQC judged that we did not collect and analyse all available information in end of life care to support improvements in clinical and operational practice.	Develop an EoL dashboard to monitor the service	Dr Catherine Hayle – Clinical Lead for End of Life Care Dr Melanie Maxwell – Associate Medical Director Claire Pratt – Deputy Chief Nurse	31.3.16	31.3.16		*Green*	*Examples of dashboard reports*
	Participate in the Care of the Dying Evaluation (CODE) project: Quality Assurance for Care of the Dying, Cheshire & Merseyside Strategic Clinical Network (a questionnaire survey of bereaved caregivers regarding their experiences of care and support provided in the Trust during the last days of their relative's life)		30.11.15	30.11.15		*Green*	*Report summarising the Trust's results in the project*
	Analyse the CODE report and generate an action plan, to be implemented by members of the WUTH Palliative & End of Life Team (PEOLT) during April 2016		1.5.16		*This has been slightly delayed – the team have reviewed the report and are meeting during the week commencing 16.5.16 to draft and agree actions. The actions are being incorporated into the CQC Action Plan for End of Life Care.*	*Amber*	

Issue	Action	Responsible Person	Due Date	Completed Date	Comments	Status	Evidence
	Introduce a bereavement survey to capture ongoing experience		1.5.16		*This has been delayed as we needed to identify a suitable survey to use. We now intend to use the West Hertfordshire questionnaire after this has been formally agreed by PEOLT in June.*	*Amber*	
	Analyse the report of the National Care of the Dying Audit for 2016; develop an action plan and disseminate across the Trust		1.5.16		*Because of the large number of detailed recommendations in the report, this has taken longer than expected but should be complete by the end of May*	*Amber*	
Medical Care – Assessing and Monitoring CQC judged that we did not collect and analyse all available information in medical care to support improvements in clinical and operational practice.	Refresh ward dashboards after consulting with ward staff	Dr Ranjeev Mehra – Divisional Medical Director Amanda Farrell – Divisional Director of Operations Julie Reid – Associate Director of Nursing	31.1.16	31.1.16		*Green*	*Example of revised dashboards (Microsoft Excel workbook)*
	Develop individual governance / quality dashboards for each ward		31.5.16	31.5.16		*Grey*	
	Introduce a structured approach to capturing actions agreed within the Divisional Governance meetings to provide assurance that these are implemented					*Grey*	
Maternity – Staffing CQC were concerned that there were insufficient systems or processes established and operated in maternity to effectively ensure a robust response by staff to the guidance provided and action required to mitigate risks. This was because of ineffective staff rostering, staffing escalation process.	Template roster to be reviewed by E-roster team	Debbie Edwards – Head of Midwifery	31.3.16	31.3.16		*Green*	*E-mail confirmation that team have reviewed reports*
	Template report to be rebuilt in the E-roster system		31.5.16		*The rosters are being rebuilt although there is a risk that this work could be delayed due to staffing pressures in the E-Roster team*	*Grey*	
	Update maternity staffing policy		30.11.15	30.11.15		*Green*	*Copy of policy*

Issue	Action	Responsible Person	Due Date	Completed Date	Comments	Status	Evidence
	Review and update maternity escalation policy		30.11.15	30.11.15		*Green*	*Copy of policy*
	Train senior midwives to support them in the implementation of escalation plans		31.5.16	30.3.16	*This has taken the form of one to one meetings with the Head of Midwifery rather than a formal training programme*	*Green*	*Not documented as not a formal training programme, but Head of Midwifery's diary entries available to confirm meetings*
Women's and Children's – Learning from Incidents CQC were concerned that there was insufficient implementation of changes in best practice guidance from lessons learnt from incidents or root cause analysis.	Complete Cultural Review of the maternity service and draft action plan	Mr Mike Ellard – Clinical Service Lead, Obstetrics and Gynaecology Dr Adrian Hughes – Consultant Paediatrician and Governance Lead for Children's Services Donna Lloyd-Jones –Quality and Safety Manager for Women's and Children's Services	1.4.16	1.4.16	*Actions in the plan are due by the end of June at the latest*	*Green*	*Copy of action plan showing current status of actions*
	Review the current Clinical Governance structure in the Women's and Children's division		31.5.16	31.5.16		*Grey*	

Issue	Action	Responsible Person	Due Date	Completed Date	Comments	Status	Evidence
Community Midwives' Equipment CQC were concerned that community midwives did not have easy access to emergency medication and equipment detailed in best practice guidance. The equipment must be checked and items provided within the use by date.	Benchmark current practice against best practice	Debbie Edwards Cathie Kelly – Matron	30.4.16	30.4.16	*We have reviewed the equipment in use and decided that all Midwives will be allocated standardised delivery equipment and medication*	*Green*	
	Develop Standard Operating Procedure for checking and maintenance of equipment – this should ensure community Midwives use only the "Born Before Arrival" (BBA) bags provided and this will include agreed medication (under discussion with pharmacy)		30.4.16		*A programme of assurance checks is being developed but this will not be fully implemented until late June.*	*Amber*	
REGULATION 18 – STAFFING							
Staffing Levels – Trustwide Actions CQC were concerned that there was not a systematic approach to determining the staff and range of skills required. There were not always sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet the needs of the patients. There were shortages of nurses, midwives and medical staff in several areas throughout both hospitals, particularly in the emergency department, maternity, medical care services, children and young people services, surgical services and radiology.	Deliver Year 2 of Workforce & Organisational Development Strategy	James Mawrey – Director of Workforce	31.3.17			*Grey*	
	Make further refinements to the dashboard to include Medical Workforce metrics in addition to Nurse metrics		31.5.16	11.5.16	*The workforce dashboard as reported to various committees, including the Quality and Safety committee, has now been amended to include detailed Medical Workforce metrics including month by month establishment data, consultant vacancy rates and the status of on-going senior medical staff recruitment.*	*Green*	*Recent example of Workforce Dashboard*

Issue	Action	Responsible Person	Due Date	Completed Date	Comments	Status	Evidence
	Continue to monitor Nursing & AHP key metrics on monthly basis to ensure all actions being taken (local, regional, national, return to practice, grow your own, new ways of working e.g. Associate Physician role), and with support from Health Education North West, appoint a recruitment and retention facilitator to focus upon nursing workforce		31.5.16	11.5.16		*Grey*	
	Agree enhanced key performance indicators with NHS Professionals via the Service level agreement meetings		31.5.16		*There has been discussion with NHSP and we have informally agreed a set of indicators; these will be finalised at the next meeting before the end of May.*	*Grey*	
	Develop a Medical Workforce Strategy to complement the Workforce & Operational Development Strategy		31.5.16			*Grey*	
	Deliver the Nurse Revalidation programme (the work programme of the Clinical Excellence Team has been re-prioritised to place more focus on revalidation).		31.5.16	11.5.16	*The programme was delivered and a plan is in place for 2016/17. In April we achieved 100% compliance for those registered and required to revalidate.*	*Green*	*Copy of performance report to Workforce & Communication Group (most recent report not yet available)*
Children's Services CQC were concerned that the systems to determine staffing levels in children's and young people's services were not robust.	Make contact with Children's Network regional leads regarding the acuity tools which they use to determine staffing levels; attend national workshop on staffing for children's inpatient areas	Pauline Riding – Children's Services Matron	31.3.16	31.3.16		*Grey*	
	Commence an acuity audit, using the SCAMPS audit tool		30.4.16	30.4.16	*The audit has commenced and is still underway in mid-May*	*Green*	*Copy of audit questionnaire being used*

Issue	Action	Responsible Person	Due Date	Completed Date	Comments	Status	Evidence
	Develop an action plan based on the results of the SCAMPS audit, when it is complete		31.7.16	31.7.16		*Grey*	
Theatre Recovery CQC found that there was an insufficient number of staff in theatre recovery with training in paediatric life support despite regularly caring for children.	Scope training availability of Paediatric Life Support (PLS) for recovery staff	Lilian Rimmington – Theatres Matron Jan Poynton – Recovery Co-ordinator	1.4.16	1.4.16		*Green*	*Division confirmed that they had identified suitable training*
	Review of recovery nursing establishment versus demand		31.12.16	31.12.16		*Grey*	
	Review recovery practitioner job descriptions					*Grey*	
	Establish an escalation policy for recovery staffing					*Grey*	
	Train all band 6 recovery nurses to ensure at least one PILs trained nurse on each shift					*Grey*	

The Audit Findings for Wirral University Teaching Hospital NHS Foundation Trust

Year ended 31 March 2016

25 May 2016

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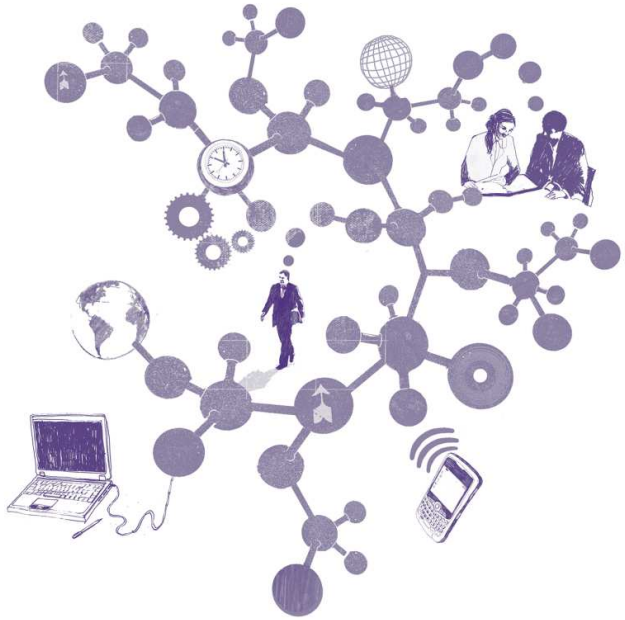

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13th May 2016

Dear Members of the Audit Committee

Audit Findings for Wirral University Teaching Hospital NHS Foundation Trust for the year ending 31 March 2016

This Audit Findings report highlights the significant findings arising from the audit for the benefit of those charged with governance, as required by International Standard on Auditing (UK & Ireland) 260, the National Health Service (NHS) Act 2006 and the National Audit Office Code of Audit Practice. Its contents have been discussed with management.

As auditors we are responsible for performing the audit, in accordance with International Standards on Auditing (UK & Ireland), which is directed towards forming and expressing an opinion on the financial statements that have been prepared by management with the oversight of those charged with governance. The audit of the financial statements does not relieve management or those charged with governance of their responsibilities for the preparation of the financial statements.

The contents of this report relate only to those matters which came to our attention during the conduct of our normal audit procedures which are designed primarily for the purpose of expressing our opinion on the financial statements. Our audit is not designed to test all internal controls or identify all areas of control weakness. However, where, as part of our testing, we identify any control weaknesses, we will report these to you. In consequence, our work cannot be relied upon to disclose defalcations or other irregularities, or to include all possible improvements in internal control that a more extensive special examination might identify. We do not accept any responsibility for any loss occasioned to any third party acting, or refraining from acting on the basis of the content of this report, as this report was not prepared for, nor intended for, any other purpose.

We would like to take this opportunity to record our appreciation for the kind assistance provided by the finance team and other staff during our audit.

Yours sincerely

Karen Murray

Engagement Lead

Contents

Section 1: Executive summary

Purpose of this report

This report highlights the key issues affecting the results of Wirral University Teaching Hospital NHS Foundation Trust ('the Trust') and the preparation of the Trust's financial statements for the year ended 31 March 2016. It is also used to report our audit findings to management and those charged with governance in accordance with the requirements of International Standard on Auditing (UK & Ireland) 260, and the National Health Service Act 2006 ('the Act').

Under legislation the Comptroller and Auditor General (C&AG) has a duty to prepare a code of audit practice prescribing the way in which auditors of public authorities are to required to carry out their audit functions. This Code of Audit Practice ('the Code') is prepared by the National Audit Office (NAO) on behalf of the C&AG. Section 10 of Schedule 6 of the Local Audit and Accountability Act 2014 mandates the application of this Code to Foundation Trust audits from 2015/16 onwards.

Under the Code we are required to report whether, in our opinion, the Trust's financial statements give a true and fair view of the financial position of the Trust and its income and expenditure. We are also required to give an opinion on some elements of the Remuneration report and some elements of the Staff Report. We are required to consider other information published together with the audited financial statements, whether it is consistent with the financial statements, apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit; or otherwise misleading and in line with required guidance.

We are required to carry out sufficient work to satisfy ourselves on whether the Trust has made proper arrangements to secure economy, efficiency and effectiveness in its use of resources ('the value for money (VFM) conclusion'). Auditor Guidance Note 7 (AGN07) clarifies our reporting requirements in the Code and the Act so that if we are not satisfied then we are required to report by exception.

The Act also details the following powers and duties for Foundation Trust auditors, which we are required to report to you if applied:

- a referral to the regulator if we have reason to believe that the Trust or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure. (section 7 of schedule 10 of the Act);
- a public interest report if we identify any matter that comes to our attention in the course of the audit that in our opinion should be considered by the Trust or brought to the public's attention (section 3 of schedule 10 of the Act).

In addition to our responsibilities under the Code we are also required to carry out a limited assurance engagement on the Trust's Quality Report in accordance with the requirements of ISAE 3000 (Revised), Assurance Engagements Other than Audits or Reviews of Historical Financial Information.

Introduction

In the conduct of our audit we have not had to alter or change our audit approach, which we communicated to you in our Audit Plan dated 22 March 2016.

Our audit is substantially complete and we expect to sign our opinion once the Board approve the accounts on 25 May 2016. We are finalising our procedures in the following areas:

- review of the final version of the financial statements, Annual Report and Annual Governance Statement;
- obtaining and reviewing the management letter of representation;

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- updating our post balance sheet events review, to the date of signing the opinion;
- completion of the NAO Whole of Government Accounts review; and
- agreeing the audited accounts to the final version of the FTC forms

We received draft financial statements and accompanying working papers at the commencement of our work, and in accordance with the national deadline

Key audit and financial reporting issues

Financial statements opinion

We have not identified any adjustments affecting the Trust's retained deficit position which was reported at £15.425m. Adjustments arising from the audit were limited to improvements to presentation and disclosure within the notes to the accounts.

The key messages arising from our audit of the Trust's financial statements are:

- management produced a set of good quality financial statements, supported by most of the working papers
- there were no material errors in the draft accounts
- the audit adjustments arising from our work relate to disclosure and classification issues only and do not affected the reported financial position of the Trust.

Further details are set out in section two of this report.

We anticipate providing a unqualified audit opinion in respect of the financial statements (see Appendix B).

Other Financial Statement responsibilities

As well as an opinion on the financial statements, we are required to consider the consistency of other information published with the financial statements.

Based on our review of the Trust's Annual Report, which includes the Annual Governance Statement (AGS), we are satisfied that it meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual and is consistent with the audited financial statements.

Controls

Roles and responsibilities

The Trust's management is responsible for the identification, assessment, management and monitoring of risk, and for developing, operating and monitoring the system of internal control.

Our audit is not designed to test all internal controls or identify all areas of control weakness. However, where, as part of our testing, we identify any control weaknesses, we report these to the Trust.

Findings

Our work has not identified any control weaknesses which we wish to highlight for your attention.

Further details of the audit work performed are provided within section two of this report.

Value for Money

Based on our review, we are satisfied that, in all significant respects, the Trust had proper arrangements in place to secure economy, efficiency and effectiveness in its use of resources.

The Trust delivered a deficit of £15.4m against a planned deficit of £13.5m. This was in line with revised budget and largely due to increased pressures arising from the junior doctors industrial action.

The Trust has agreed a financial plan with NHS Improvement (NHSI), formerly Monitor to achieve a £200k surplus in 2016/17, including receipt of £9.9m Sustainability and Transformation Funding.

Achieving financial sustainability in the longer term is dependent upon future service re-configuration and partnership work. The Trust's position as a key player in the "Healthy Wirral" programme is set to bring this about, although progress so far has been limited due to competing priorities in the region.

The Trust received a "Requires Improvement" CQC inspection rating in March 2016. This reflected mixed performance across the Trust's sites and services. However, the Trust has responded positively to the report and action plans are in place to address the weaknesses.

Further detail of our work on Value for Money are set out in section three of this report.

Other statutory powers and duties

We have not identified any issues that have required us to apply our other statutory powers and duties under the Act. This is set out in section four of this report.

Quality Report

We have completed our limited assurance procedures on the Trust's Quality Report, based on Monitor's 'Detailed guidance for external assurance on quality reports 2015/16'. We have provided a separate report to the Trust's Council of Governors setting out our results and conclusions and planned limited assurance opinion.

The way forward

Matters arising from the financial statements audit and our review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources have been discussed with the Acting Director of Finance.

Acknowledgement

We would like to take this opportunity to record our appreciation for the assistance provided by the finance team and other staff during our audit.

Grant Thornton UK LLP
13 May 2016

Section 2: Audit findings

Materiality

In performing our audit, we apply the concept of materiality, following the requirements of International Standard on Auditing (UK & Ireland) (ISA) 320: Materiality in planning and performing an audit. The standard states that 'misstatements, including omissions, are considered to be material if they, individually or in the aggregate, could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements'.

As we reported in our audit plan, we determined overall materiality to be £4,605,000 (being 1.5% of gross revenue expenditure). We have considered whether this level remained appropriate during the course of the audit and have made no changes to our overall materiality.

We also set an amount below which misstatements would be clearly trivial and would not need to be accumulated or reported to those charged with governance because we would not expect that the accumulated effect of such amounts would have a material impact on the financial statements. We have defined the amount below which misstatements would be clearly trivial to be £250,000. This remains the same as reported in our audit plan.

As we reported in our audit plan, we identified the following items where we decided that a lower level of materiality was appropriate:

Balance/transaction/disclosure	Explanation
Cash and cash equivalents	This balance is sensitive by nature. Cash and Cash Equivalents is also one of the few balances in the statements that can be directly agreed to third party confirmation which we receive directly from the Trust's bank. Additionally, agreeing the cash and cash equivalents balance to the reconciled bank statements is a key source of assurance over the integrity of the Trust's ledger.
Disclosures of senior manager salaries and allowances in the remuneration report	A lower materiality level is appropriate because of the public interest in these disclosures and the statutory requirement for them to be made.
Disclosure of auditor's remuneration	This is a statutory disclosure requirement. It is also a requirement of ethical and auditing standards that the external auditor's fee for undertaking the audit of the accounts, together with the amount charged for the provision of other services, is accurately disclosed.
Related Parties	Users of the statements will have an interest in the Trust's transactions with related parties. Misstatements affecting the value of the transactions disclosed may alter reader's perception of the Trust's relationship with its related parties.

Audit findings against significant risks

"Significant risks often relate to significant non-routine transactions and judgmental matters. Non-routine transactions are transactions that are unusual, either due to size or nature, and that therefore occur infrequently. Judgmental matters may include the development of accounting estimates for which there is significant measurement uncertainty" (ISA (UK&I) 315).

In this section we detail our response to the significant risks of material misstatement which we identified in the Audit Plan. As we noted in our plan, there are two presumed significant risks which are applicable to all audits under auditing standards.

	Risks identified in our audit plan	Work completed	Assurance gained and issues arising
1.	**Income from Patient Care Activities and other operating income include fraudulent transactions** Under ISA (UK&I) 240 there is a presumed risk that revenue may be misstated due to the improper recognition of revenue. For this Trust, we have concluded that the greatest risk of material misstatement relates to the occurrence/ existence of revenue from patient care activities and occurrence of other operating revenue. We have also considered the risk of fraudulent expenditure recognition and rebutted this risk.	As part of our audit work we have: • tested the material revenue streams, including a review of unusual significant transactions • reviewed the documentation relating to year-end settlements and contract variations agreed with commissioners and confirmed these agreements are properly reflected in the accounts • reviewed the output from the Agreement of Balances exercise and discussed any significant variances • tested debtors for subsequent payment	Our audit work has not identified any issues in respect of fraudulent revenue recognition.
2.	**Management override of controls** Under ISA (UK&I) 240 there is a presumed risk that management will over-ride controls. This risk is present in all entities.	As part of our audit work we have: • reviewed the entity level controls • tested a sample of journal entries • reviewed the accounting estimates, judgements and decisions made by management • reviewed unusual significant transactions	Our audit work has not identified any evidence of management over-ride of controls. In particular the findings of our review of journal controls and testing of journal entries has not identified any significant issues. We set out later in this section of the report our work and findings on key accounting estimates and judgements.

Audit findings against significant risks continued

"Significant risks often relate to significant non-routine transactions and judgmental matters. Non-routine transactions are transactions that are unusual, either due to size or nature, and that therefore occur infrequently. Judgmental matters may include the development of accounting estimates for which there is significant measurement uncertainty" (ISA (UK&I) 315).

In this section we detail our response to the significant risks of material misstatement which we identified in the Audit Plan. As we noted in our plan, there are two presumed significant risks which are applicable to all audits under auditing standards.

	Risks identified in our audit plan	Work completed	Assurance gained and issues arising
3.	**Valuation of property, plant and equipment** The Trust re-values its land and buildings on a rolling 5 yearly basis to ensure that carrying value is not materially different from fair value. The last full revaluation by the external valuer was at 31 March 2014. The reported valuation at 31 Mach 2016 represents a significant estimate by management in the financial statements.	As part of our audit work we have: • enquired of management the processes and assumptions applied in calculating the estimate • reviewed the competence, expertise and objectivity of the Trust's external valuer to ensure we could rely on management's expert • reviewed the instructions and scope of the work of the Trust's valuer for year end revaluation • reviewed and challenged the information used by the valuer to ensure it is robust and consistent with our understanding • agreed the revaluations made during the year to ensure they are input correctly into the Trust's asset register • agreed the year end reconciliation between the fixed asset register and general ledger • agreed a sample of assets by physical verification and to title deeds	Our audit work has not identified any issues in respect of valuation of property, plant and equipment. The desk top revaluation at 31 March 2016 resulted in a net impairment of £2.2m which was charged £0.3m to expenditure and £2.5m credited to the available revaluation reserve. Our review of the competency of the external valuer and the Trust's method for obtaining and processing appropriate Modern Equivalent Asset (MEA) updated indices is considered reliable. The fixed asset register was reconciled to the general ledger in total at 31 March 2016.

Audit findings against other risks

In this section we detail our response to the other risks of material misstatement which we identified in the Audit Plan.

	Risks identified in our audit plan	Work completed	Assurance gained and issues arising
1.	**Income from Patient Care Activities** Accounting for contract arrangements with commissioning bodies not consistent with terms: Occurrence & valuation (Contractual adjustments with commissioning bodies not adequate: valuation)	As part of our work we have: • documented our understanding of management's controls over revenue recognition • reviewed and tested the revenue recognition policies • tested the material revenue streams, including a review of unusual significant transactions • reviewed the documentation relating to year-end settlements and contract variations agreed with commissioners and confirmed these agreements are properly reflected in the accounts • reviewed the output from the Agreement of Balances exercise and discussed any significant variances • tested debtors for subsequent payment	Our audit work has not identified any issues in respect of revenue from patient care activities.
2.	**Other operating income** Recorded revenues not valid: Occurrence and existence	As part of our audit work we have: • agreed a sample of debtors balances at year end to subsequent receipts • agreed material income streams, including for education and training, to invoices and contracts	Our audit work has not identified any issues in respect of other operating revenues
3.	**Employee remuneration** Employee remuneration and benefit obligations and expenses understated Remuneration expenses not correct	As part of our audit work we have: • documented the processes and controls in place for recording employee remuneration (payroll costs) • walked through the controls established by management to ensure the Trust pays its staff the right amount based on hours worked and their contract of employment • sample tested salaries and wages payments to Trust staff • reviewed the Trust's reconciliation between the General Ledger and the Payroll system • completed a trend analysis and a predictive analytical review comparing actual payroll to expectation and seeking explanations for any variances • reviewed employee remuneration disclosures including senior officers remuneration and pensions to ensure they are in compliance with the Annual Reporting Manual	Our audit work has not identified any issues in respect of employee remuneration

Audit findings against other risks

In this section we detail our response to the other risks of material misstatement which we identified in the Audit Plan.

	Risks identified in our audit plan	Work completed	Assurance gained and issues arising
4.	**Operating expenses** Creditors understated or not recorded in the correct period Operating expenses understated or not recorded in the correct period	As part of our audit work we have: • documented the processes and controls around operating expenses and walked through them to confirm they work in line with our knowledge • sample tested operating expenses to ensure they have been accurately accounted for and are in the correct period • agreed clinical negligence expenditure to invoices from NHSLA (£11.3m) • tested the completeness of the purchase ledger interfaces with the ledger • documented the processes in place for month and year end accruals • tested a sample of creditor balances including accruals • reviewed post year end payments to identify unrecorded liabilities • tested a sample of goods received but not yet invoiced to identify any items which have not been accrued correctly. • performed cut-off testing to confirm payments made in March 2016 and April 2016 have been accounted for in the correct financial year • Considered the completeness of reported accruals and provisions by review of Trust committee minutes and reports and events subsequent to the year end	Our audit work has not identified any issues in respect of operating expenses

Accounting policies, estimates & judgements

In this section we report on our consideration of accounting policies, in particular revenue recognition policies, and key estimates and judgements made and included with the Trust's financial statements.

Accounting area	Summary of policy	Comments	Assessment
Revenue recognition	Income in respect of services provided is recognised when and to the extent that performance occurs, and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.	The Trust's revenue recognition policies are consistent with standard accounting policies and with guidance issued by Monitor. Monitor's Annual Reporting Manual requires the Trust's revenue recognition to be congruent with the principles of IAS 18. Policies are adequately disclosed within the accounts and we have not been made aware of any new material revenue streams which would require additional policies to be put in place. The Trust exercises judgement in arriving at the income for part complete spells. Income for part complete spells have been agreed to the third party confirmation during the audit using the intra-NHS agreement of balances exercise.	
Judgements and estimates	Key estimates and judgements include: – Useful life of PPE – Revaluations – Impairments – Provisions – Accruals – Partially completed spells	For each of these estimates and judgements we have considered the: • appropriateness of the policy under the relevant accounting framework • extent of judgement involved • adequacy of disclosure of accounting policy We are satisfied that the Trust's use of estimates and judgements is reliable and properly disclosed.	

Assessment
● Marginal accounting policy which could potentially attract attention from regulators
● Accounting policy appropriate but scope for improved disclosure
● Accounting policy appropriate and disclosures sufficient

Accounting policies, Estimates & Judgements continued

Accounting area	Summary of policy	Comments	Assessment
Going concern	The Directors have a reasonable expectation that the services provided by the Trust will continue for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the financial statements.	We have reviewed the Directors' assessment of going concern and are satisfied with the assessment that the going concern basis is appropriate for the 2015/16 financial statements. Due to the 2015/16 deficit position, and challenging financial position going forwards, we requested the accounts and Annual Report contained more disclosure supporting the Director's assessment. This has been included. The Trust requires a working capital (cash) loan of £8m during quarter one on 2015/16. The Directors have assurance that this will be received.	
Land and Buildings Valuation	All land and buildings are revalued by professional valuers every 5 years. A three yearly interim valuation is also carried out. Valuations are carried out by Cushman and Wakefield, who is external to the Trust, and in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. In between these valuations the Trust considers whether assets are subject to significant volatility and, where this is the case, undertakes an annual valuation.	A full desktop revaluation has been undertaken during 2015/16 and applied at 31 March 2016. This resulted in an impairment of £2.5 million credited to the revaluation reserve and £0.312 million charged to operating expenditure. We have discussed the basis for the revaluation with management, including MEA basis. We have also obtained representations from the valuer in order to rely upon them as experts and held a conference call with the valuer to fully understand their valuation. We are satisfied that the Trust's accounting policy and accounting treatment of the land and buildings valuation complies with the requirements of the Annual Reporting Manual.	
Financial reporting	In January 2016 a letter was sent from the Department of Health to all NHS Trusts and Foundation Trusts advising them to consider 'removing prudence' from key balance sheet areas.	We have had regard to this requirement when undertaking our procedures. We are satisfied the Trust has taken an appropriate approach that ensures the financial statements reflect appropriate levels of prudence. Specifically, we are satisfied that accruals and provisions are sufficient and robust, and that critical judgements (such as the choice of the alternate site, modern equivalent asset basis for the revaluation of property, plant and equipment) have been appropriately considered and disclosed.	

Assessment

- Marginal accounting policy which could potentially attract attention from regulators
- Accounting policy appropriate but scope for improved disclosure
- Accounting policy appropriate and disclosures sufficient

Other communication requirements

We set out below details of other matters which we, as auditors, are required by auditing standards and the Code to communicate to those charged with governance.

	Issue	Commentary
1.	**Matters in relation to fraud**	• We have not been made aware of any incidents in the period. • No issues have been identified during the course of our audit procedures.
2.	**Matters in relation to related parties**	• We are not aware of any related party transactions which have not been disclosed.
3.	**Matters in relation to laws and regulations**	• You have not made us aware of any significant incidences of non-compliance with relevant laws and regulations. • We have not identified any incidences from our audit work.
4.	**Written representations**	• A standard letter of representation has been requested from the Trust.
5.	**Confirmation requests from third parties**	• We obtained direct confirmations from NHSI for bank balances and loans. • We requested from management permission to send confirmation requests to other third party bankers. This permission was granted and the requests were sent. We are awaiting responses from a number of bankers. We anticipate will be available prior to the signing of the Annual Accounts. We will undertake alternative procedures if these are not received as expected.
6.	**Disclosures**	• Our review found no material omissions in the financial statements.
7.	**Auditable elements of Remuneration and Staff Report**	• We are required to give an opinion on whether the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements directed by the Secretary of State with the consent of the Treasury. • We have audited the elements of the Remuneration report, as required by the Code and found no issues. • We propose to issue an unqualified opinion.

Other communication requirements continued

	Issue	Commentary
8.	**Matters on which we report by exception**	We are required to report on a number of matters by exception in a number of areas: We have not identified any issues we would be required to report by exception in the following areas • if the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual or is misleading or inconsistent with the information of which we are aware from our audit • the information in the annual report is materially inconsistent with the information in the audited financial statements or apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit, or otherwise misleading. • we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider that the Annual Report is fair, balanced and understandable • the annual report does not appropriately disclose matters that were communicated to the Audit Committee which we consider should have been disclosed.
9.	**Review of accounts consolidation schedules and specified procedures on behalf of the DH group auditor**	• We are required to give a separate audit opinion on the Trust's accounts consolidation schedules and to carry out specified procedures (on behalf of the NAO) on these statements under the group audit instructions. In the group audit instructions the Trust was selected as a non-sampled component. • As a result of management reviewing the intra-NHS balances mismatch report, a reclassification amendment was agreed on the summarisation schedules to resolve a mismatch. This had a corresponding classification impact to note 2.2 (Income from Patient Care) and note 29 (Related Parties) to the accounts. The remaining mismatches are listed at Appendix A for reporting to the NAO. These amendments and imbalances do not impact on the outturn in the draft accounts.

Internal controls

The purpose of an audit is to express an opinion on the financial statements.

Our audit included consideration of internal controls relevant to the preparation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of internal control. We have no deficiencies to report.

If we had performed more extensive procedures on internal control, we might have identified more deficiencies to be reported.

During the course of our audit, we noted the Trust does not have signed leases in place to support its use of the accommodation at St Catherine's Hospital and Victoria Community Hospital. From our discussion with management, we accept this does not expose the Trust to a significant financial risk because there is a history of rental payments to confirm the values agreed. However, management accepts the absence of a formal signed lease could give rise to an operational risk if the lessor wished to the end the agreement.

Misclassifications and disclosure changes

The table below provides details of misclassification and disclosure changes identified during the audit which have been made in the final set of financial statements.

	Adjustment type	Value £'000	Account balance	Impact on the financial statements
1	Disclosure	N/A	Going Concern	Management have agreed to expand the disclosure in respect of the going concern assertion in the accounts and Annual Report. The disclosure now provides more detailed explanation of the Director's assessment and reflects the paper considered by the Trust Board.

NAO Whole of Government Accounts (WGA)

Our work on the WGA submission is substantially complete.

We are required to report to the NAO all mis-matches with a value of £250k or above in the Trust's agreement of balances with other NHS bodies. A list is of mis-matches above £250k is provided at Appendix A for your information.

Section 3: Value for Money

Background

We are required by Schedule 10 to the National Health Service Act 2006 ('the Act') and the NAO Code of Audit Practice ('the Code) to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. This is known as the Value for Money (VFM) conclusion.

The Act and the Code only require us to report by exception where we are not satisfied that Foundation Trusts have proper arrangements in place to secure value for money. However, we are required to carry out sufficient work to satisfy ourselves that proper arrangements are in place at the Trust.

In carrying out this work, we are required to follow the NAO's Auditor Guidance Note 3 (AGN 03) issued in November 2015. AGN 03 identifies one single criterion for auditors to evaluate:

> *In all significant respects, the audited body had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people.*

AGN03 provides examples of proper arrangements against three sub-criteria but specifically states that these are not separate criteria for assessment purposes and auditors are not required to reach a distinct judgement against each of these.

Risk assessment

We identified risks in respect of specific areas of proper arrangements using the guidance contained in AGN03 and updated the Audit Committee on 8th April 2016 of progress. We carried out an initial risk assessment in March 2016 and identified the following significant risks for follow up:

- the 2015/16 Financial deficit position may escalate without effective controls and the additional license conditions imposed by Monitor may not be met
- governance arrangements may not be robust in the new Vanguard structure which could de-stabilise the project
- service delivery may be compromised if the FT does not respond promptly and effectively to CQC recommendations

We have continued our review of relevant documents up to the date of giving our report, and have not identified any further significant risks where we need to perform further work.

We carried out further work only in respect of the significant risks we identified from our initial and on-going risk assessment. Where our consideration of the significant risks determined that arrangements were not operating effectively, we have used the examples of proper arrangements from AGN 03 to explain the gaps in proper arrangements that we have reported in our VFM conclusion.

Significant qualitative aspects

AGN 03 requires us to disclose our views on significant qualitative aspects of the Trust's arrangements for delivering economy, efficiency and effectiveness.

We have focused our work on the significant risks that we identified in the Trust's arrangements. In arriving at our conclusion, our main considerations were:

- despite a challenging financial year, the Trust has contained its expenditure and delivered planned cost savings such that the deficit exceeded the planned deficit by a relatively small margin
- the Trust has a financial plan and agreed control total in place for 2016/17
- the Trust has responded well to the planned reconfiguration of services across the Wirral and the wider footprint. It has responded flexibly as the situation changed and has engaged well with partners
- although the outcome of the CQC inspection in March 2016 was disappointing, the Trust has responded positively to the findings. Action plans are in place to deliver the improvements required We have set out more detail on the risks we identified, the results of the work we performed and the conclusions we drew from this work later in this section.

Overall conclusion

Based on the work we performed to address the significant risks, we concluded that:

- the Trust had proper arrangements in all significant respects to ensure it delivered value for money in its use of resources. We only report by exception in our auditors' report where we give a qualified conclusion. The text of our report, which confirms this under the 'matters on which we report by exception' section, can be found at Appendix B.

Key findings

We set out below our key findings against the significant risks we identified through our initial risk assessment and further risks identified through our on-going review of documents.

Significant risk	Work to address	Findings and conclusions
Financial Outturn 2015/16 Financial deficit position may escalate without effective controls and the additional license conditions imposed by Monitor may not be met. The Trust reported a deficit of £15.4m at 31 March 2016. This was £1.9m worse than plan largely due to lost income and pressures caused by the junior doctors strike. The Trust delivered £13.4m CIP savings in 2015/16 of which £11.5m was recurrent. The recurrent CIP plan agreed with Monitor was £16.4m	We reviewed the Trust's budget and outturn position, together with explanations for variances. We have reviewed the additional licence conditions imposed by Monitor and the Trust's arrangements for tracking and reporting progress.	We found the Trust had set a realistic budget for 2015/16, including achievable cost improvement plan savings. Financial performance was closely monitored and reported throughout the year to the Finance, Business and Assurance Committee and the Board. The licence conditions imposed by Monitor are closely monitored by management and reported to Audit Committee. Looking ahead, the Trust has agreed a financial plan for 2016/17 with NHSI which includes a £0.2m surplus control total. This plan provides for £9.9m Sustainability and Transformation Funding. The Trust has also agreed the 2016/17 commissioning contract with Wirral CCG securing £229 million of income. This provides a firm basis for exploring new pathways of care. **We concluded the Trust managed to contain its financial position throughout 2015/16 as closely as possible. It remained within the additional licence conditions imposed by Monitor.**
Vanguard Governance Arrangements Governance arrangements may not be robust in the new Vanguard structure which could de-stabilise the success of the project.	We reviewed the Trust's arrangements for working with other Vanguard parties as supported by the Memorandum of Understanding, including how it communicates progress to the Board.	We found that progress in establishing the "Healthy Wirral" structure is still developing. Efforts are being made to ensure a clear link through to the Sustainability and Transformation Plan that will drive greater service integration across a wider footprint. There is an overarching Memorandum of Understanding signed by all partners to the Vanguard arrangement setting out the structure. There is appropriate reporting of progress through the Trust. The Trust is exploring options for closer integration with Countess of Chester Hospital and the creation of a local delivery system as part of the Cheshire and Mersey Sustainability and Transformation Plan. **We are satisfied the Trust is putting in place an appropriate governance framework to support the on-going work exploring the best options to ensure sustainable patient care. However, this is at an early stage of development reflecting the changing plans around future models of care. The Trust is using its position to provide leadership in the debate on the future of health and social care provision for the region.**

Significant risk	Work to address	Findings and conclusions
CQC Report There is a risk that service delivery may be compromised if the Trust does not respond promptly and effectively to CQC inspection report of March 2016.	We reviewed how the Trust is implementing and monitoring delivery of the action plan agreed to address the findings of the CQC inspection.	The Trust was assessed as "requiring improvement" when the CQC report was published in March 2016. This report reflected a mix of judgements across the Trust's services and sites. The Trust is rightly proud that CQC assessed the Trust as good in providing caring and effective services. It can also reflect positively on the improvements it has made in response to previous CQC findings, for example, the actions taken by the Trust to address CQC's previous concerns about safe nurse staffing levels. Although the overall outcome of the inspection is disappointing, the Trust has again responded in a positive and open way. An action plan has agreed with CQC and implementation is underway. Progress is reported to the Quality and Safety Committee and also to the Board. This ensures service managers are held to account for delivery of the action plan. **We concluded the Trust has engaged appropriately in responding to the CQC report. An improvement plan has been put in place and there are sound arrangements to monitor its delivery.**

Significant difficulties in undertaking our work

We did not identify any significant difficulties in undertaking our work on your arrangements which we wish to draw to your attention.

Significant matters discussed with management

There were no matters where no other evidence was available or matters of such significance to our conclusion or that we required written representation from management or those charged with governance.

Any other matters

There were no other matters from our work which were significant to our consideration of your arrangements to secure value for money in your use of resources.

Section 4: Other statutory powers and duties

Other statutory powers and duties

We set out below details of other matters which we, as auditors, are required by the Act and the Code to communicate to those charged with governance.

	Issue	Commentary
1.	**Referral to the regulator**	• We have not identified any issues which we need to report to the regulator.
2.	**Public interest report**	• We have not identified any matters that would require a public interest report to be issued.

Section 5: Fees, non-audit services and independence

We confirm below our final fees charged for the audit and confirm there were no fees for the provision of non audit services

Fees

	£
Trust audit	38,400
Charitable fund audit	2,600
Total audit fees (excluding VAT)	**41,000**

Fees for other services

Service	Fees £
Audit related services	
Assurance on your quality report	6,000

Independence and ethics

We confirm that there are no significant facts or matters that impact on our independence as auditors that we are required or wish to draw to your attention. We have complied with the Auditing Practices Board's Ethical Standards and therefore we confirm that we are independent and are able to express an objective opinion on the financial statements.

We confirm that we have implemented policies and procedures to meet the requirements of the Auditing Practices Board's Ethical Standards.

Section 6: Communication of audit matters

Communication to those charged with governance

International Standards on Auditing ISA (UK&I) 260, as well as other ISAs, prescribe matters which we are required to communicate with those charged with governance, and which we set out in the table opposite.

The Audit Plan outlined our audit strategy and plan to deliver the audit, while this Audit Findings report presents the key issues and other matters arising from the audit, together with an explanation as to how these have been resolved.

Respective responsibilities

The Audit Findings Report has been prepared in the context of the document on the Roles and Responsibilities of the National Audit Office (NAO) and local auditors issued by the NAO (https://www.nao.org.uk/code-audit-practice/wp-content/uploads/sites/29/2015/03/Role-of-NAO-and-local-auditors.pdf)

Our annual work programme is set in accordance with the Code of Audit Practice ('the Code') issued by the NAO (https://www.nao.org.uk/code-audit-practice/about-code/). Our work considers the Trust's key risks when reaching our conclusions under the Code.

It is the responsibility of the Trust to ensure that proper arrangements are in place for the conduct of its business, and that public money is safeguarded and properly accounted for. We have considered how the Trust is fulfilling these responsibilities.

Our communication plan	Audit Plan	Audit Findings
Respective responsibilities of auditor and management/those charged with governance	✓	
Overview of the planned scope and timing of the audit. Form, timing and expected general content of communications	✓	
Views about the qualitative aspects of the entity's accounting and financial reporting practices, significant matters and issues arising during the audit and written representations that have been sought		✓
Confirmation of independence and objectivity	✓	✓
A statement that we have complied with relevant ethical requirements regarding independence, relationships and other matters which might be thought to bear on independence. Details of non-audit work performed by Grant Thornton UK LLP and network firms, together with fees charged Details of safeguards applied to threats to independence	✓	✓
Material weaknesses in internal control identified during the audit		✓
Identification or suspicion of fraud involving management and/or others which results in material misstatement of the financial statements		✓
Compliance with laws and regulations		✓
Expected unmodified auditor's report		✓
Uncorrected misstatements		✓
Significant matters arising in connection with related parties		✓
Significant matters in relation to going concern		✓

Appendices

Appendix A: Schedule of WGA mismatches over £250k

Name of Organisation	Balance	Trust	Third Party	Difference
NHS England	Expenditure	696k	nil	(696k)
Countess of Chester Hospital NHS FT	Expenditure	5,484k	6,130k	646k
East Cheshire NHST	Expenditure	nil	380k	380k
Wirral Community NHST	Expenditure	703k	1,513k	810k
NHS Wirral CCG	Income	225,261k	226,200k	(939k)
Cheshire & Merseyside Local Office	Income	4,761k	5,248k	(487k)
Health Education England	Income	9,572k	9,831k	(259k)
Cheshire & Merseyside Local office	Payable	629k	Nil	629k
Wirral Community NHS Trust	Payable	103k	471k	(368k)
Clatterbridge CCC	Payable	105k	1,011k	906k
NHS Wirral CCG	Payable	1,065k	2,365k	1,300k
NHS Wirral CCG	Receivable	1,798k	2,166k	368k
NHS England	Receivable	50k	427k	377k

Appendix B: Audit opinion

Independent auditor's report to the Council of Governors of Wirral University Teaching Hospital NHS Foundation Trust

Our opinion on the financial statements is unmodified

In our opinion the financial statements of Wirral University Teaching Hospital NHS Foundation Trust (the 'Trust'):

- give a true and fair view of the state of the financial position of the Trust's affairs as at 31 March 2016 and of the Trust's expenditure and income for the year then ended; and
- have been prepared properly in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the 2015/16 FReM as contained in the NHS Foundation Trust Annual Reporting Manual and the Directions under paragraph 25(2) of Schedule 7 of the National Health Service Act 2006.

Who we are reporting to

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with paragraph 24(3) of Schedule 7 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors as a body, for our audit work, for this report, or for the opinions we have formed.

What we have audited

We have audited the financial statements of Wirral University Teaching Hospital NHS Foundation Trust for the year ended 31 March 2016 which comprise the Trust statement of comprehensive income, the Trust statement of financial position, the Trust statement of changes in taxpayers' equity, the Trust statement of cash flows and the related notes.

The financial reporting framework that has been applied in their preparation is applicable law and IFRSs as adopted by the European Union, and as interpreted and adapted by the 2015/16 Government Financial Reporting Manual (the 2015/16 FReM) as contained in the NHS Foundation Trust Annual Reporting Manual (ARM) and the Directions under paragraph 25(2) of Schedule 7 of the National Health Service Act 2006 issued by Monitor, the Independent Regulator of NHS Foundation Trusts.

Overview of our audit approach

- Overall materiality: £4,605,000, which represents 1.5% of the Trust's prior year gross revenue expenditure;
- Key audit risks were identified as:
  - Occurrence and valuation of income from patient care activities and existence of the associated receivable balances
  - Occurrence of other operating income and existence of the associated receivable balances
  - Valuation of property, plant and equipment
  - Completeness of operating expenditure on goods and services

Our assessment of risk

In arriving at our opinions set out in this report, we highlight the following risks that, in our judgement, had the greatest effect on our audit:

Audit risk	How we responded to the risk
Occurrence and valuation of income from patient care activities and existence of the associated receivable balances Over 90% of the Trust's income is from contracts with NHS commissioners of healthcare services. The Trust invoices its commissioners throughout the year for services provided, and at the year-end estimates and accrues for activity not yet invoiced. Invoices for the final quarter of the year are not finalised and agreed until after the year end and after the deadline for the production of the financial statements. This can involve further negotiation of contractual adjustments with commissioners. There is therefore a risk that income from patient activities from commissioners recognised in the financial statements may be misstated. We identified the occurrence of income from patient care activities and existence of the associated receivable balances as a significant risk requiring special audit consideration. We also identified valuation of income from patient care activities as a risk requiring particular audit attention.	Our audit work included, but was not restricted to: • evaluating the Trust's accounting policy for recognising income from patient care activities for appropriateness and consistency with the prior year; • gaining an understanding of the Trust's system for accounting for income from patient care activities and evaluating the design of the associated controls; • using a summary of expenditure with the Trust accounted for by other NHS bodies provided by the Department of Health to identify any significant differences in income and receivable balances with contracting bodies; • testing, on a sample basis, amounts recognised as income from patient care activities in the financial statements to signed contracts and invoices; • testing, on a sample basis, contract variations and non-contractual income adjustments made to year-end balances to supporting documentation; and • testing, on a sample basis, receivable balances at the year end to subsequent receipt of payment. The Trust's accounting policy for income from patient care activities, including its recognition, is shown in note 1.4 to the financial statements and related disclosures are included in note 2. The Trust's accounting policy for the associated receivables is shown in note 1.13 to the financial statements and related disclosures are included in note 16.
Occurrence of other operating income and existence of the associated receivable balances 9% of the Trust's income is derived from services which are not directly related to core patient activity such as training and income from other bodies. Income is recognised when the service has been performed and at the year-end income is accrued for services that have been performed but for which an invoice has not been issued. We therefore identified occurrence of other operating income, and existence of the associate receivables as a significant risk requiring special audit consideration.	Our audit work included, but was not restricted to: • evaluating the Trust's accounting policy for recognising other operating income for appropriateness and consistency with the prior year; • gaining an understanding of the Trust's system for accounting for other operating income and evaluating the design of the associated controls; • testing, on a sample basis, other operating income recognised in the financial statements to signed contracts and invoices; • testing, on a sample basis, other income transactions to supporting documentations; and • testing, on a sample basis, receivable balances at the year end to subsequent receipt of payment. The Trust's accounting policy for other operating income, and its recognition, is shown in note 1.4 to the financial statements and related disclosures are included in note 3. The Trust's accounting policy for the associated receivables is shown in note

Audit risk	How we responded to the risk
	1.13 to the financial statements and related disclosures are included in note 16.
Valuation of property, plant and equipment The valuation of property, plant and equipment requires significant judgement and represents 81% of the total asset value on the Trust's statement of financial position. The Trust's last full external valuation was as at 31 March 2014 and the policy is for an interim valuation every 3 years and full revaluation every 5 years, with significant estimation uncertainty in the intervening years. We therefore identified the valuation of property, plant and equipment as a significant risk requiring special audit consideration.	Our audit work included, but was not restricted to: • obtaining management's assessment of the valuation of property, plant and equipment and understanding the valuation process including the design of key controls and significant assumptions used; • reviewing the competence, objectivity and expertise of management's valuer; • reviewing the instructions issued to the valuer and the scope of their work; • challenging and obtaining corroborative evidence of the assumptions made by management in relation to: o the valuation of property, plant and equipment, in particular the modern equivalent asset basis; o the useful lives of property, plant and equipment; and o the amount of depreciation charged in the year. The Trust's accounting policy for property, plant and equipment is shown in note 1.8 to the financial statements and related disclosures are included in note 11.
Completeness of operating expenditure on goods and services Expenditure on goods and services represent 31% of the Trust's total expenditure. Management uses judgement to estimate accruals of expenditure for amounts that have not been invoiced at the year end. We therefore identified completeness of expenditure on goods and services as a risk requiring particular audit attention.	Our audit work included, but was not restricted to: • gaining an understanding of the systems used to recognise expenditure on goods and services and year-end accruals, and evaluating the design of the associated controls; • review of the year-end reconciliation of the subsidiary interface and general ledger control account, to ensure that all transactions from the subsidiary system are reflected in the financial statements; • testing, on a sample basis, post year-end payments one month after year-end to confirm the completeness of year-end creditors and accruals; and • considering the completeness of reported accruals and provisions by review of Trust committee minutes and reports and events subsequent to the year end. The Trust's accounting policy for expenditure on goods and services is shown in note 1.5 to the financial statements and related disclosures are included in note 4.

Our application of materiality and an overview of the scope of our audit

Materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

We determined materiality for the audit of the Trust's financial statements as a whole to be £4,605,000, which is 1.5% of the Trust's prior year gross revenue expenditure. This benchmark is considered the most appropriate because we consider users of the Trust's financial statements to be most interested in how it has expended its revenue and other funding.

We use a different level of materiality, performance materiality, to drive the extent of our testing and this was set at 60% of financial statement materiality for the audit of the Trust's financial statements.

We also determine a lower level of specific materiality for certain areas such as cash, disclosure of senior manager salaries and allowances in the Remuneration Report and related party transactions.

We determined the threshold at which we would communicate misstatements to the Audit Committee to be £250,000. In addition we have communicated misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

Overview of the scope of our audit

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Chief Executive Officer as Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

We conducted our audit in accordance with ISAs (UK and Ireland) having regard to the Financial Reporting Council's Practice Note 10 'Audit of Financial Statements of Public Bodies in the UK (Revised)'. Our responsibilities under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code) and those standards are further described in the 'Responsibilities for the financial statements and the audit' section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

We are independent of the Trust in accordance with the Auditing Practices Board's Ethical Standards for Auditors, and we have fulfilled our other ethical responsibilities in accordance with those Ethical Standards.

Our audit approach was based on a thorough understanding of the Trust's business and is risk based, and in particular included an interim visit to evaluate the Trust's internal control environment including its IT systems and controls over key financial systems.

Overview of the scope of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria issued by the Comptroller and Auditor General in November 2015, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to

achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined these criteria as those necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016 and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Other reporting required by regulations

Our opinion on other matters required by the Code is unmodified

In our opinion:

- the part of the Remuneration Report and Staff Report subject to audit have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2015/16 FReM as contained in the NHS Foundation Trust Annual Reporting Manual; and
- the other information published together with the audited financial statements in the annual report is consistent with the Trust's audited financial statements.

Matters on which we are required to report by exception

Under the ISAs (UK and Ireland), we are required to report to you if, in our opinion, information in the annual report is:

- materially inconsistent with the information in the audited financial statements; or
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit; or
- otherwise misleading.

In particular, we are required to report to you if:

- we have identified any inconsistencies between our knowledge acquired during the audit and the Directors' statement that they consider the annual report is fair, balanced and understandable; or
- the annual report does not appropriately disclose those matters that were communicated to the Audit Committee which we consider should have been disclosed.

Under the Code of Audit Practice we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust ARM or is misleading or inconsistent with the information of which we are aware from our audit; or
- we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in respect of the above matters.

Responsibilities for the financial statements and the audit

What the Chief Executive, as Accounting Officer, is responsible for:
As explained more fully in the Chief Executive's Responsibilities Statement, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Direction issued by Monitor and for being satisfied that they give a true and fair view. The Accounting Officer is also responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.

What we are responsible for:
Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Code of Audit Practice and ISAs (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

We are also required under Section 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Certificate

We certify that we have completed the audit of the financial statements of Wirral University Teaching Hospital NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Karen Murray
Director
for and on behalf of Grant Thornton UK LLP
Manchester

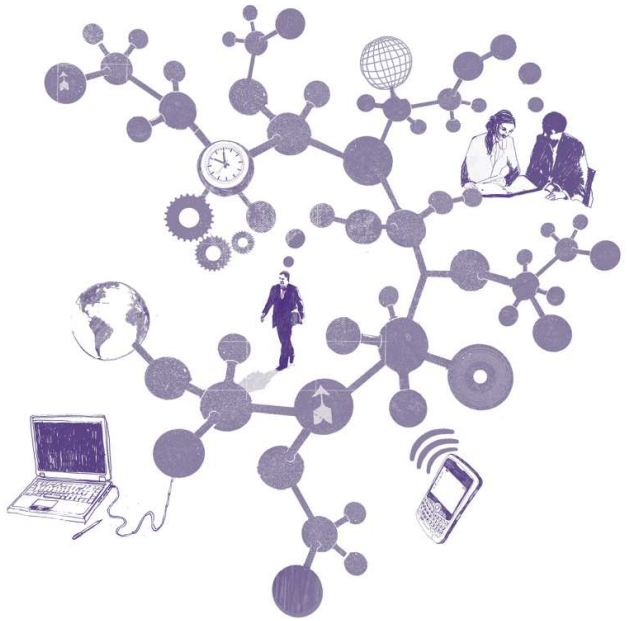
May 2016

Report to Governors on the Quality Report 2015/16

Wirral University Teaching Hospital NHS Foundation Trust

Year ended 31 March 2016

25 May 2016



Karen Murray
Engagement Lead
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Stephen Nixon
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The contents of this report relate only to the matters which have come to our attention, which we believe need to be reported to you as part of our audit process. It is not a comprehensive record of all the relevant matters, which may be subject to change, and in particular we cannot be held responsible to you for reporting all of the risks which may affect the Council or any weaknesses in your internal controls. This report has been prepared solely for your benefit and should not be quoted in whole or in part without our prior written consent. We do not accept any responsibility for any loss occasioned to any third party acting, or refraining from acting on the basis of the content of this report, as this report was not prepared for, nor intended for, any other purpose.

Contents

Executive summary

The Quality Report

The Quality Report is a mandatory part of a foundation trust's Annual Report. Its specific aim is to encourage and improve the foundation trust's public accountability for the quality of the care it provides. It allows leaders, clinicians, governors and staff to show their commitment to continuous, evidence-based quality improvement, and to explain progress to the public.

Purpose of this report

This report to governors summarises the results of our independent assurance engagement on your Quality Report. It is issued in conjunction with our signed limited assurance report, which is published within the Quality Report section of the Trust's Annual Report for the year ended 31 March 2016.

In addition, this report provides the findings of our work on the indicator you selected for us to perform substantive testing on, to provide assurance to support your governance responsibilities.

In performing this work, we followed Monitor's Detailed guidance for external assurance on quality reports 2015/16' ('Guidance').

The output from our work is a limited assurance opinion on whether anything has come to our attention which leads us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS FT annual reporting manual (ARM) and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in Monitor's Guidance;
- the indicators in the Quality Report subject to limited assurance are not reasonably stated in all material respects in accordance with the ARM and supporting guidance and the six dimensions of data quality set out in the Guidance.

Conclusion

Our work on your Quality Report is substantially complete although we are finalising our procedures in respect of:

- checking the final version of the Quality Report to ensure it reflects changes discussed with management
- obtaining a letter of representation from management

On completion of our audit we are proposing to issue a qualified conclusion on your Quality Report.

The text of our proposed limited assurance report is at Appendix B.

Basis for qualified conclusion

Our audit opinion is qualified because the underlying data quality for both the referral to treatment incomplete pathways and A&E indicators subject to audit contain data errors and do not comply with the guidance issued.

Executive summary

Key messages

- We confirmed the Quality Report had been prepared in all material respects in line with the requirements of the ARM and supporting guidance.
- We confirmed the Quality Report was not materially inconsistent with the sources specified in Monitor's Guidance
- Our testing of the mandated indicator for referral to treatment incomplete pathways included in the Quality Report is qualified. We identified six data accuracy errors from the 25 cases we tested. These related to clock starts, clock starts and other reporting matters.
- Our testing of the mandated indicator for A&E waits is qualified. Our testing of 40 cases identified three where the A&E discharge time could not be agreed to the patient records
- Our testing of the local indicator selected by governors, percentage of admitted patients who had risk assessment for malnutrition (MUST) found no evidence that the reported indicator was not reasonably stated in all material respects in accordance with relevant calculation

We have made recommendations for improvement which we have discussed and agreed with management. These can be found at Appendix A.

Acknowledgements

We would like to thank the Trust staff for their co-operation in completing this review.

Compliance with regulations

We checked that the Quality Report had been prepared in line with the requirements set out in Monitor's *Annual Reporting Manual*.

Requirement	Work performed	Conclusion
Compliance with regulations	We reviewed the content of the Quality Report against the requirements of Monitor's published guidance which are specified in Annex 2 to Chapter 7 of the NHS Foundation Trust *Annual Reporting Manual* 2015/16 and the additional detailed guidance for Quality Reports 2015/16.	Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016, the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust *Annual Reporting Manual*. However, we noted a small number of exceptions which management agreed to address in the final version of the report: • *Inclusion of a section on how the Trust responds to the Duty of Candour* • *Updating of various minor disclosure matters*

Consistency of information

We checked that the Quality Report is consistent in all material respects with the sources specified in Monitor's *Detailed Guidance for External Assurance on Quality Reports 2015/16*.

Requirement	Work performed	Conclusion
Consistency with other sources of information	We reviewed the content of the Quality Report for consistency with specified documentation, set out in the auditor's guidance provided by Monitor. This includes the board minutes for the year, feedback from commissioners, and survey results from staff and patients.	Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016, the Quality Report is not consistent in all material respects with the sources specified in the *Detailed Guidance for External Assurance on Quality Reports*.
Other checks	We also checked the Quality Report to ensure that the Trust's process for identifying and engaging stakeholders in the preparation of the Quality Report has resulted in appropriate consultation with patients, governors, commissioners, regulators and any other key stakeholders.	Overall, we concluded that the process has resulted in appropriate consultation.

Data quality of reported performance indicators

We undertook substantive testing on certain indicators in the Quality Report.

Selecting performance indicators for review

The Trust is required to obtain assurance from its auditors over three indicators.

Monitor requires that we select two indicators in a prescribed order of preference from the list of four mandated indicators that are relevant to this Trust.

These two indicators are subject to a limited assurance opinion: we have to report on whether there is evidence to suggest that they have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust *Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports*.

In line with the auditor guidance, we have reviewed the following indicators:

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; selected from the subset of mandated indicators because this indicator was mandated by Monitor as first in a prescribed order of preference;
- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge. The testing of this indicator was mandated by Monitor as second in a prescribed order of preference.

In 2015/16, NHS foundation trusts also need to obtain assurance through substantive sample testing over one additional local indicator included in the quality report, as selected by the governors of the trust. Although the foundation trust's external auditors are required to undertake the work, this is not subject to a formal limited assurance opinion in 2015/16.

In line with the auditor guidance, we have reviewed the following local indicator:

- % of admitted patients who had risk assessment for malnutrition (MUST). This indicator was chosen by Governors during their Council meeting on 16 March 2016 due to the importance of nutrition for patient wellbeing.

Data quality of reported performance indicators (continued)
Indicators subject to limited assurance opinion

Indicator & Definition	Indicator outcome	Work performed	Conclusion
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period. This indicator reports the proportion of patients on incomplete pathways for consultant led referral to treatment waiting times. Trust target is to achieve a minimum of 92%.	***Q1 93.0%*** ***Q2 92.1%*** ***Q3 91.7%*** ***Q4 90.3%***	We reviewed the process used to collect data for the indicator. We checked that the indicator presented in the Quality Report reconciled to the underlying data. We then tested a sample of 25 items in order to ascertain the accuracy, completeness, timeliness, validity, relevance and reliability of the data, and whether the calculation is in accordance with the definition. The sample included breaches and non breaches. Our testing identified six data accuracy errors from the 25 cases we tested. Of these errors 2 related to incorrect clock start dates and two related to incorrect clock stop times. The remaining two were other reporting errors. The errors ranged from 16 to 109 days.	Based on the results of our procedures we are unable to confirm that the indicator has been reasonably stated in all material respects for the year ended 31 March 2016. Following the initial audit testing the Trust has acted promptly to carry out an internal review of the data quality for this indicator and has actions in place to improve the indicator reporting. The indicator is qualified on the Accuracy criteria.

Data quality of reported performance indicators (continued)
Indicators subject to limited assurance opinion

Indicator & Definition	Indicator outcome	Work performed	Conclusion
Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge. This indicator reports the proportion of patients assessed in A&E within 4 hours from arrival to either admission, transfer or discharge.	***WUTH patients:*** ***83.3%*** ***Target 95%***	We reviewed the process used to collect data for the indicator. We checked that the indicator presented in the Quality Report reconciled to the underlying data. Our review of the data collection process identified that A&E performance includes patients attending both Arrowe Park A&E (Wirral FT patients) and the walk in centre provided by Wirral Community NHS Trust (WCT). Guidance states that patients from other providers can only be included in the Trust's A&E performance if the Trust is clinically responsible for the service, and operates and manages the service. The WCT patients are captured from the adjacent A&E drop in centre operated by WCT itself. In accordance with guidance these patients should be excluded or separately identified from the Wirral FT A&E performance. To comply with the guidance and avoid audit qualification due to the relevance of the A&E data, management decided report A&E performance for the Wirral FT and WCT patients separately. Our opinion covers the Wirral FT patient A&E waiting time data only. We selected an initial sample of 25 patients for detailed testing to ascertain the accuracy, completeness, timeliness, validity, relevance and reliability of the data, and whether the calculation is in accordance with the definition. The sample included breaches and non breaches, patients who had been re-classified from breaches and patients reported within a few minutes of four hours. Our testing of Wirral FT patients identified three cases where the A&E discharge time could not be supported by underlying records. One patient's A&E card could not be located to validate the timings and the other two patient's records held contradictory timings from that input on the A&E system. We therefore extended the sample by a further 15 cases at management's request. We found no further errors in these cases.	Based on the results of our procedures we are unable to confirm that the indicator at 31 March 2016 has been reasonably stated. The indicator is qualified on the Accuracy criteria due to the A&E waiting times not being validated to patient records for three cases out of 40.

Data quality of reported performance indicators (continued)
Local indicator not subject to limited assurance opinion

Indicator & Definition	Indicator outcome	Work performed	Conclusion
Percentage of admitted patients who had risk assessment for malnutrition (MUST)* *Malnutrition Universal Screening Tool As described in the Quality Report, the method of collecting and reporting malnutrition data has changed during 2015/16. The assessment of whether a patient receives malnutrition screening within 7 days of admission is reported from Quarter 4 only.	***2015/16 Quarter 4*** ***84.9%*** ***Target 85%***	We reviewed the process used to collect data for the indicator. We checked that the indicator presented in the Quality Report reconciled to the underlying data. We then tested a sample of 25 items in order to ascertain the accuracy, completeness, timeliness, validity, relevance and reliability of the data, and whether the calculation is in accordance with the definition. Patients were selected from both the breach and non-breach populations. We also selected cases which had been moved from breach to non-breach. The Trust extracted the quarter 4 data from Cerner Millenium Patient system and this was tested against patient notes.	Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016, the indicator has not been reasonably stated in all material respects. However, because of a change in the way this data has been collected over time, it is not appropriate for the Trust to report performance for 2013/4, 2014/15 and 2015/16 alongside each other in the Quality Report. We have recommended that the Trust maintains a log of MUST breach cases which have been reviewed and amended to non-breach. The 93% reported MUST compliance in the Quality Report needs updating to report the Q4 performance (87%).

Fees

Fees for the audit of the Quality Report

Service	Fees £
For the audit of the Quality Report 2015/16	£6,000

Appendix

Appendix A - Action plan

	Assessment	Issue and risk	Recommendations	Management Response	Responsible Officer and implementation date
1.	●	The Referral to Treatment (RTT) incomplete pathways indicator has a qualified audit opinion due to six errors noted with the clock times. There is a risk the Trust does not have adequate procedures in place to ensure that clock times are accurately recorded.	Revisit the instructions given to staff involved in the recording of clock start and end times at the Trust to ensure that the DH guidance followed.		
2.	●	The A&E 4 hour wait indicator is qualified because for three patients the data on the A&E system did not match the patient records. There is a risk that the Trust does not have adequate procedures in place to ensure that A&E waiting times guidance is properly followed.	Strengthen the arrangements to validate A&E data capture to ensure the A&E 4 hour wait indicator is accurately reported.		
3.	●	The collection and reporting methodology for MUST screening has changed during 2015/16 and it is therefore not appropriate to compare 2015/16 performance to previous years.	Amend the reporting of previous years malnutrition screening to make it clearer that processes have changed.		
4.	●	The Trust reviews patients who are MUST non compliant and where appropriate transfers them to compliant. No record of cases reviewed is maintained.	Maintain an audit trail of MUST patient reviews showing the outcome.		

Assessment
- ● Significant deficiency – risk of significant misstatement
- ● Deficiency – risk of inconsequential misstatement

Appendix B – Form of limited assurance report

Independent Practitioner's Limited Assurance Report to the Council of Governors of Wirral University Teaching Hospital NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Wirral University Teaching Hospital NHS Foundation Trust to perform an independent limited assurance engagement in respec of Wirral University Teaching Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2016 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in Annex 2 to Chapter 7 of the 'NHS Foundation Trust Annual Reporting Manual 2015/16' (the 'Criteria').

Scope and subject matter
The indicators for the year ended 31 March 2016 subject to the limited assurance engagement consist of those national priority indicators as mandated by Monitor:

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathway at the end of the reporting period
- percentage of patients with a total time in A&E of four hours or less from arrival t admission, transfer or discharge (Wirral University Teaching Hospital patients only)

We refer to these national priority indicators collectively as the 'Indicators'.

Respective responsibilities of the Council of Governors and Practitioner
The Council of Governors are responsible for the content and the preparation of the Quality Report covering the relevant indicators and in accordance with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual 2015/16' issued by Monitor and 'Detailed guidance for external assurance on quality reports 2015/16.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the Criteria
- the Quality Report is not consistent in all material respects with the sources specifie in Monitor's 'Detailed guidance for external assurance on quality reports 2015/16; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS Foundation Trust Annual Reporting Manual 2015/16' and supporting guidance and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports 2015/16'.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual 2015/16, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period 1 April 2015 to 25 May 2016;
- Papers relating to quality reported to the Board over the period 1 April 2015 to 25 May 2016;
- Feedback from Commissioners dated May 2016;
- Feedback from Governors dated May 2016;
- Feedback from local Healthwatch organisation dated May 2016;
- Feedback from Overview and Scrutiny Committee dated 16 May 2016;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2014/15;
- The national patient survey dated 2014;
- The national maternity survey dated 2015;
- The national staff survey dated 2015;
- Care Quality Commission Intelligent Monitoring Report dated May 2015; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated March 2016.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

The firm applies International Standard on Quality Control 1 and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

We have complied with the independence and other ethical requirements of the Code of Ethics for Professional Accountants issued by the International Ethics Standards Board for Accountants, which is founded on the fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Wirral University Teaching Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting Wirral University Teaching Hospital NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2016, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body, and Wirral University Teaching Hospital NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed
We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management
- analytical procedures
- limited testing, on a selective basis, of the data used to calculate the indicators back to supporting documentation
- comparing the content requirements of the 'NHS Foundation Trust Annual Reporting Manual 2015/16' to the categories reported in the Quality Report; and
- reading the documents.

The procedures performed in a limited assurance engagement vary in nature and timing from, and are less in extent than for, a reasonable assurance engagement and consequently, the level of assurance obtained in a limited assurance engagement is substantially lower than the assurance that would have been obtained had a reasonable assurance engagement been performed.

Appendix B – Form of limited assurance report

Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual 2015/16'.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Wirral University Teaching Hospital NHS Foundation Trust.

Our audit work on the financial statements of Wirral University Teaching Hospital NHS Foundation Trust. is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as Wirral University Teaching Hospital NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to Wirral University Teaching Hospital NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to Wirral University Teaching Hospital NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Wirral University Teaching Hospital NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Wirral University Teaching Hospital NHS Foundation Trust and Wirral University Teaching Hospital NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Basis for qualified conclusion
The indicator percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period did not meet the six dimensions of data quality in the following respect:

- Accuracy – Our testing identified errors in data accuracy in six of the 25 cases we tested. These errors included data input for both clock starts and clock stops, aswell as completeness of reporting. The errors ranged from 16 to 109 days.

The indicator for the percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge did not meet the six dimensions of data quality in the following respects:

- Accuracy – Our testing of 25 cases identified three where the A&E discharge time could not be agreed to the patient records.

Qualified conclusion
Based on the results of our procedures, with the exception of the matters reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the Quality Report is not prepared in all material respects in line with the Criteria;
- the Quality Account is not consistent in all material respects with the sources specified in Monitor's 'Detailed guidance for external assurance on quality reports 2015/16"; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS Foundation Trust Annual Reporting Manual 2015/16' and supporting guidance and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports 2015/16'.

Grant Thornton UK LLP
Chartered Accountants
Manchester

25th May 2016

Appendix C – Form of management representation letter

Dear Sirs

Wirral University Teaching Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2016

This representation letter is provided in connection with the limited assurance engagement i respect of Wirral University Teaching Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2016 for the purpose of reporting on the Quality Report and certai performance indicators contained therein in accordance with the 'Detailed guidance for external assurance on quality reports 2015/16' published by Monitor.

We have fulfilled our responsibilities, as set out in the terms of the limited assurance engagement letter dated 29 April 2016 for the content and preparation of the Quality Repor in accordance with the requirements of the Health Act 2009 in the terms set out in the NHS Quality Accounts) Regulations 2010 and subsequent amendments and the requirements set out in the 'NHS Foundation Trust Annual Reporting Manual 2015/16' issued by Monitor.

We confirm to the best of our knowledge and belief having made such enquiries as we considered necessary for the purpose of appropriately informing ourselves:

i We have complied with the relevant requirements as set out in the Statement of Directors' Responsibilities for the Quality Report.

ii We acknowledge our responsibility for the design, implementation, maintenance and monitoring of internal controls over the collection and reporting of the measures of performance included in the Quality Report and certain performance indicators.

iii We have provided you with:

   a. access to all of the Trust's Quality Report performance records and all othe records and related information, including the minutes of all directors and governors' meetings and ensured that there is no relevant performance information of which you are unaware;
   b. additional information that you have requested from us for the purpose of this limited assurance engagement; and
   c. unrestricted access to persons within the Trust from whom you determined it necessary to obtain evidence.

iv We have communicated to you all deficiencies in internal controls relevant to the Quality Report and certain performance indicators contained therein that are not clearly trivial and inconsequential of which we are aware.

v We have disclosed to you all our knowledge of any actual, suspected or alleged intentional non-compliance with the Regulations or misstatement of information contained within the Quality Report and that indicators contained within the Quality Report are free from such misstatement.

vi We have not adjusted the misstatements identified from your work brought to our attention by you, attached to this letter, as they are immaterial, individually and in aggregate to the Quality Report and certain performance indicators contained therein.

vii The disclosures within the Quality Report fairly reflect our understanding of the Trust's performance over the period covered and have been prepared in accordance with the 'NHS Foundation Trust Annual Reporting Manual 2015/16' issued by Monitor and supporting guidance.

viii [Any other matter considered appropriate].

Approval

The approval of this letter of representation was minuted by the Trust's Board at its meeting on 25 May 2016.

Yours faithfully

Name……

Position……..

Date……..

grant-thornton.co.uk

GOVERNORS' WORKSHOP Thursday 21st April 2016

6 governors present

Chairman's business

The Chairman gave an update on several matters which included finance (it was disappointing that Vanguard funding would not continue next year), A & E trajectory, and C.Diff (no cases for 3 months).

Laboratory Medicine

The Directorate Manager of Laboratory Medicine, Andrew Bamber, gave a clear and enthusiastic presentation on the services provided. The main departments are Blood Sciences, Microbiology and Cellular Pathology. Microbiology is a shared service with the Countess of Chester Hospital, situated in a modern building in Bromborough. The importance of the service can be gauged from the following statistics: 239 staff; 3.2 million tests per year; over 300 orderable tests; 24/7 working (exc. Cellular path).

We visited the Blood Sciences department where we were shown the journey that a blood specimen takes from being received into the laboratory, given a unique identification bar code and then travelling automatically to the appropriate testing machine(s) and, where necessary , being assessed by a technician, before the results are collated and reported back to the prescriber. We were impressed by the robotic technology which is capable of dealing with large numbers of haematology and biochemistry tests every day. We were even more impressed with the enthusiasm of the members of staff who showed us round and explained how it all works! I think they were disappointed that we could not stay longer. After the visit, Andrew answered govenors' questions and was thanked for spending his valuable time with us.

Well Led Review – Governor Focus Group

Kate Jury from Deloitte LLP, which is carrying out a governance review for the Trust, led a discussion on a wide range of governance matters.

RAH 25/05/16

BOARD OF DIRECTORS

MINUTES OF MEETING

30 MARCH 2016

**BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL**

Present

Michael Carr	Chairman
David Allison	Chief Executive
Cathy Bond	Non-Executive Director
Andrea Hodgson	Non-Executive Director
Graham Hollick	Non-Executive Director
Gareth Lawrence	Acting 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

Apologies

Evan Moore	Medical Director

In attendance

Carole Self	Director of Corporate Affairs
Mark Blakeman	Director of Infrastructure & Informatics
Mark Taylor	Recovery Adviser
Mark Lipton	Deputy Medical Director
Chris Oliver	Interim Director of Operations
Janelle Holmes	Chief Operating Officer from 01.04.16
Maureen Wain	Divisional Director, Surgery Womens & Children*
Adrian Hughes	Clinical Director, Surgery Womens & Children*
Lynn Bedstead	Deputy Director of OD*
Cathy McKeown	Head of Staff Engagement and OD*
Mike Coupe	Director of Strategy*

*denotes attendance for part of the meeting

Reference	Minute	Action
BM15-16/293	**Apologies for Absence** Noted as above	
BM15-16/294	**Declarations of Interest** None	
BM15-16/295	**Patient Story** The Director of Nursing and Midwifery provided the Board with feedback from a family whose father had recently passed away. The feedback highlighted the importance of how the small things can make a big difference, in particular in relation to communication. It was reported that the end of life care experience would have been much improved if the consultant had been open and honest with the family and told them that their father was dying; if the attitude of staff had been empathetic and understanding and if the patient's needs had come before that of staff	

Reference	Minute	Action
	members complaints of internal issues.	
BM15-16/296	**Chairman's Business** The Chairman informed the Board of 4 recent consultant appointments as follows: Haematology – Dr Elizabeth Jones Orthodontics – Dr Seshu (jointly with Alderhey) Emergency Medicine – Dr Nadia Roberts Emergency Medicine – Dr Arasaratnam The Board was advised that the Council of Governors approved the extension to the tenure of Non-Executives Graham Hollick and Cathy Maddaford for a further 3 years from the end of June 2016.	
BM15-16/297	**Chief Executive's Report** **CCG –** the Chief Executive provided the Board with an update on the discussions with the CCG in respect of the closure of the contract for 15/16 as well as the contract for 16/17. He confirmed that both parties had advised regulators that they were optimistic to settle both matters shortly. **Cerner European Collaboration Forum –** positive feedback from this recent event was conveyed as many other NHS organisations were now looking to Cerner to progress with the work on population health management. Particular thanks were extended to the Infection Prevention and Control team who represented the Trust at the event and whose work had been recognised in the organisation. Thanks were also extended to the new Director of Nursing and Midwifery whose impact over the last few weeks had made a significant difference. **Well led Governance Review –** the Board was advised that Deloitte was the successful bidder and would commence work with the Trust in April 2016 **Staff Engagement Update** – an overview of the ongoing work was provided with further detail to be provided later in the meeting. The Board sought to understand how the Trust would maintain and improve on the work to date. The Chief Executive advised that the Medical Engagement Strategy had now been drafted and would be available for review at the next Board meeting; training and development for middle managers was a key focus area for the coming year as was the health and wellbeing agenda with ideas being progressed with local companies. **Celebrating Success** – the Board noted the significant achievements outlined in the report The Board requested an update on the junior doctors industrial action. The Chief Executive advised that the Trust had no alternative but to implement the new contract as this was being recommended by a range of regulators and Education bodies. He did confirm however that the Trust was committed to working with our Junior Doctors to ensure that they were respected and valued as future leaders. The Board was updated on the forthcoming industrial action and the planning being undertaken, which to	**EM/JM**

Reference	Minute	Action
	date had been successful. The Interim Director of Operations outlined the emerging plans for the 26th and 27th April 2016 as Junior Doctors were withdrawing emergency cover on this occasion he agreed he would circulate a further note to the Board outlining the preparations.	**CO**
BM15-16/298	**Vanguard Programme Update** The Chief Executive presented the Programme Update and confirmed that the comments made by the Board in the previous month had been communicated to the Programme Management Office (PMO). He updated the Board on the 3 key areas of the project and progress to date as follows: • PMO established, demand and capacity modelling expertise secured and work being undertaken in this area • Procured the healthy intent platform from Cerner – development of the roadmap and deliverables being progressed • Contracting mechanisms – the alliance contract has had limited progress to date despite the deadline being October 16 The Chief Executive advised the Board that the funding for 16/17 for Vanguard was still awaited and the view nationally of the project which was positive due to the prioritisation process and criteria having been agreed. The Director of Strategy updated the Board on the need to develop key metrics by which to measure success; the gaps in the governance programme becoming evident between the Partners Board and the supporting groups with consideration now being given to a Portfolio Board and the need to progress alliance contracting across a wider portfolio than unscheduled care. The Board sought to understand whether the "What matters to Wirral" consultation would be expanded upon. The Director of Strategy advised not at present. An update on the demand and capacity modelling work was provided and the work with clinical experts. The Board concluded that the report from Healthy Wirral was not clear in terms whether this was an update on Vanguard or the development of the health economy; it was a day diary of a project manager rather than a range of outcomes to be evaluated and the modelling work, albeit welcome, would only be useful if it enabled the health economy to recognise and understand the likely demand in the next 5 – 10 years.	
BM15-16/299	**Integrated Performance Report** The Director of Infrastructure and Informatics presented the Integrated performance dashboard and Executive Directors expanded on areas of focus as follows: **7.1.1 Integrated Dashboard and Exception Reports**	

Reference	Minute	Action
	C difficile – the Director of Nursing and Midwifery advised the Board that the Trust still had 35 reported cases of C difficile for the year with 9 toxin positive cases all being reported as unavoidable confirming that there had been no lapse in care. The Action plan was confirmed as progressing uninterrupted and the C difficile cohort unit being utilised. The Board was advised that the target for 16/17 had now been communicated, this being 29 avoidable cases, the same as the current year. **A & E 4 hour standard –** the interim Director of Operations confirmed that performance was currently at 80.85% for February which was a slight deterioration from January due to the level of demand. The Board noted with regret that the Trust had experienced 6 twelve hour breaches from the decision to admit the patients, all of which had occurred on one night. The Board was advised that the Trust had engaged with ECIP to develop the action plan and the main theme being reported was the need to strengthen escalation processes out of hours. Despite the success of the single front door pilot which was now deflecting 20% of patients from the emergency department, the Trust still had a 1000 more attendances in February compared to the same time the previous year and ambulance attendances remain high with 123 attendances reported on one of the days over the bank holiday. Details of the further pilot between the CCG and NWAS to deflect patients to Victoria Central was provided together with the work being undertaken to allow patients with minor medical conditions to be diverted to Victoria Central once it had been kitemarked, with a timescale of End of May being worked towards. The Board agreed that an update on the discharges before noon for the SAFER roll out wards would be useful for the next meeting and was reassured that the appointment of a programme lead for the economy wide patient flow workstream from funding from ECIP was positive step. The Board sought an update on the closure of the winter ward and Charlotte House from the end of the month which was of concern in view of the continued level of demand. The interim Director of Operations advised that the CCG and Local Authority were in discussions with a view to extending the facility at Charlotte House until June/July 16. As the Trust was thought to be an outlier for the number of ambulance conveyances the Board sought to understand what alternatives were being used elsewhere. The Interim Director of Operations advised that the Trust was looking into the Green Car Scheme being used by GPs in Liverpool; the alternatives to treatment scheme which is being looked at by NWAS which aims to keep patients at home and raising awareness of out of hours provisions which is not being accessed by Wirral patients. The Board was updated on the plans to hold an Ambulance Summit to progress this work. **Advancing Quality Indicators** – the interim Director of Operations advised that the Trust was progressing with a targeted improvement plan for each areas to raise the level of focus. **Referral to Treatment Times (RTT)** – the interim Director of Operations reported that there had been a slight improvement in performance in February despite the industrial action. Key performance by speciality was highlighted. The impact of the forthcoming further industrial action was	**CO**

Reference	Minute	Action
	outlined whilst the action planned for the 6th and 7th April was thought to be minimal, further analysis was being undertaken to establish the impact from the 26th and 27th April action. The Director of Corporate Affairs advised the Board that failure in April would result in a formal governance concern being raised by Monitor as this would equate to 3 quarters of non-compliance. The Board sought to establish the actual impact of the previous junior doctors strike on RTT as minimal elective cancellations had been reported. The interim Director of Operations confirmed that the cancellations were in outpatient appointments which overall had impacted on RTT times due to the small margin between actual performance and the target. **Activity Performance** – although a slight improvement in performance compared to January, overall performance was below plan. The additional outpatient activity in Trauma and Orthopaedics was outlined with an additional 700 patients being seen although the drop in conversion rate from 40% to 25% was a concern which the Trust was currently investigating. **7.1.2 Month 11 Finance Report** The Acting Director of Finance reported the year to date deficit as £14.1M this being a £1.4M adverse variance to the original plan. The in-month deficit was reported at £1.3M which was marginally better than plan. Over performance in clinical income was reported although there were increased costs associated with this performance as work had been diverted elsewhere. Cash was reported at £8.7M, some £5M better than plan. The position was attributed to the cash preservation work carried out by the Trust and the early CCG receipts. FSRR was reported at 2 in line with the plan. Non-core spend was reported at £1.8M in month and the nursing agency costs were reported at 2.7% of the substantive nursing wage bill and therefore below the 3% threshold. The Acting Director of Finance advised the Board that the agency cap was being replaced in April with a ceiling of £8.1M which would mean that the Trust would have to find a reduction in circa 5% compared with the current performance this was reported as below the 35/40% reduction to be made by comparator organisations. Non-recurrent CIP performance was reported on plan although recurrently this was a concern with delivery expected at circa £11.5M against a plan of £16.4M. The Board debated the risks associated with health economy affordability which had led to the CCG imposing penalties and fines at a late stage, this included the opposing views of NHSE and Monitor towards the levying of these during 2015/16. The Board agreed to debate the financial position further, following the discussion to be held in the private part of the agenda on the draft operational plan submission.	

Reference	Minute	Action
BM15-16/300	**Nurse Staffing Data Update** The Director of Nursing and Midwifery presented the Nurse Staffing Data update which provided the Board with details of the actual hours of Registered Nurses/Midwives and Clinical Support Worker's for both day shifts and night shifts versus planned staffing levels for January and February 2016. She reported that the average fill rate was 98% although it was acknowledged that there was some pressure associated with the planned escalation wards being open. The vacancy rates in inpatients and ED were reported at 5.9% compared to 10% nationally and although the international recruitment programme had been a success; this was being halted for 2 months to allow the new staff to integrate. Corporate and Divisional recruitment was confirmed as ongoing although competing recruitment into Vanguard was a concern. The fill rates from NHSP were reported as improving against agreed targets. The Board sought to establish why the fill rates from NHSP varied from the Trust fill rates. This was attributed in part to the use of agency workers but also wards were requesting too many shifts which was being reviewed. The Board reviewed the investment in safer nursing staffing levels made by the Trust over the period 2013/14 – 2015/16 with the following areas highlighted: • 66% reduction in the number of new colonised cases of CPE through the investment in a purpose built isolation unit • Zero reported avoidable Grade 4 pressure ulcers through compliance audits; education; review and assessment • Significant reduction in the numbers of falls through the use of technology as well as cohorting patients who are at risk of falls to provide increased supervisions. AQUA reported in January 2016 that the Trust had one of the lowest falls prevalence rates in the region. • Increase in MEWS compliance from 52% in Q3 2014/15 to 82% in Q3 2015/16 through the provision of improved staffing levels and the use of technology • Improved National Inpatient survey results 2015 by 5% or more as a result of improved staff morale and staff engagement The Board sought and received assurance that all wards were staffed to the appropriate acuity levels and it was agreed that the number of staff on either preceptorship or mentorship programmes would be included in future reports. The Board discussed how to address the perception that nurses were still understaffed. The Director of Nursing and Midwifery confirmed that nurses	**GW**

Reference	Minute	Action
	were busy but that was the nature of their role and she had asked the matrons to talk to patients and staff to reassure them that staffing levels were appropriate. The Board extended their thanks to the Director of Nursing and Midwifery and her teams for the significant progress made. The Director of Nursing and Midwifery agreed to circulate an assessment of the return on the investment in nursing to Board members to complete the evaluation process.	**GW**
BM15-16/301	**Community Paediatrics Progress Report** The Board welcomed Mr Hughes and Mrs Wain to the meeting. Mrs Wain provided the Board with an overview of the work undertaken since the update to the Quality and Safety Committee early in the month. This included the reduction in the patient waiting list; the commissioner review undertaken; the operational review undertaken by the Trust and the assurance that all statutory and urgent referrals were being seen appropriately. The Board was advised that the action plan in response to the operational review was being developed with the clinical team the following day. Mrs Wain advised however that some of the recommendations might prove to be controversial particularly the move away from BATCH guidance, which many organisations had successfully undertaken. An overview of the income versus cost of provision was provided which in the absence of an alternative provider, placed additional financial and operational pressure on the Trust. The Board sought to establish what level of additional resource would be required to deliver the current service provision. Mrs Wain confirmed that if the Trust was to maintain the service in line with BATCH guidance the Trust would need an additional 3.5 wte consultants which was totally unaffordable. The Board was advised that the Trust was experiencing difficulties with securing commitment from the CCG to meet to discuss the next steps in the commissioner review and had therefore sought the assistance of Monitor in progressing this. The trajectory for compliance to RTT time targets was outlined as February 2017 however this was reliant on a reduction in the number of referrals; the nursing resource available for resources which was achievable and the changes to the consultant template which would prove controversial. The Board sought to understand why the team had not instigated the operational review earlier if the issues outlined were reported to be longstanding. Mrs Wain outlined a number of reasons in the main attributed to the change in divisional and management changes. Mr Hughes also outlined disagreements within the clinical team as to what should be the appropriate service provision; some of these are being led by the Medical Director to secure a resolution. Mr Hughes advised the	

Reference	Minute	Action
	Board that the service needed a place to discharge patients to as currently patients are on the list until they reach adulthood. The Commissioner review recommended a reinvestment in parenting service which had been impacted upon by the health and social care education training funding constraints. The Chief Executive reported to the Board that the timescale for improvement of February 2017 was not accepted by Monitor and would need to be brought forward. In order to progress further he requested that the Board be advised as soon as possible what success would look like in the context of the discussion today.	**CO/ MW/ AH**
BM15-16/302	**Care Quality Commission Inspection Report 2016** The Deputy Medical Director presented the overview report which confirmed that the overall rating achieved by the Trust was "requires Improvement" which was in line with the Trust's own self-assessment. In light of the previous discussions on this matter and the briefings provided to the Board, at the draft stage of the Report; following the Quality Summit held on the 14th March 2016 and the Trust's response that it would focus now on the action plan being developed to address the requirement notices. The Board concluded that following sign off by the Senior Management Team on 12th April 2016, the action plan would be circulated to Board members ahead of the 14th April 2016 submission to CQC. The Chief Executive provided the Board with an overview of the other areas of focus, which although not subject to a requirement notice were of a concern to the Trust and CQC. The Board determined that progress was being made in the Emergency Department; Maternity Services and in relation to End of Life however it agreed with the view of the Chief Executive that greater clarity was still required as to the issues in critical care and the action plan to address this. The Board recommended that the resource implications associated with delivering the action plan be outlined in order that this work could be prioritised.	**EM/CS** **EM**
BM15-16/303	**NHS 2015 National Staff Survey Results** The Board welcomed Ms McKeown and Ms Benstead to the meeting. Ms Benstead introduced the agenda item by outlining to the Board how the Director of Workforce had galvanised the team to take action following the 2014 NHS staff survey. Ms McKeown reported through a presentation the work undertaken during 2015 in response to the 2014 NHS staff survey; the significant improvements in the 2015 survey which were reported by Quality Health as the most they had ever seen in one year; the league table by Division and the prioritised action plan following the 2015 survey results.	

Reference	Minute	Action
	The Board sought and received assurance that the action plan would address the areas of concern highlighted in the "learning from mistakes league" as presented later in the Board agenda. The Board discussed how the Trust would share best practice and learn from others; whether the low response rates from acute and medicine were a good representation from that staff cohort which it was confirmed was the case and sought to understand the correlation if any between the poor results in surgery and the good outcome in the CQC report. The Board extended its thanks to the Senior Team, Mr McKeown and Ms Benstead and to all those staff across the Trust who had been involved in this work.	
BM15-16/304	**Publication of "Learning from Mistakes League"** The Deputy Medical Director presented the overview paper following the publication by NHS Improvement of the "learning by mistakes" league. Members were reminded that this had been circulated on the day of publication. The Board sought to understand how the learning from this publication would be progressed. The Deputy Medical Director confirmed that this would be included in the NHS Staff Survey Action Plan as discussed earlier in the meeting.	
BM15-16/305	**Chair of Audit Committee Report** Mrs Bond presented the Chair of Audit Committee Report and highlighted the recommendations in relation to the draft accounting policies 2015-16 and the approach to 3 areas of critical accounting judgement as follows: • The Trust's Charity is not consolidated into Trust "group" accounts as its balances are not material in the context of the Trust's turnover • The Trust has one single reporting segment, that is, "the provision of acute care" no other reporting segments are recognised by management or in the accounts • The Trust is judged to be a going concern Mrs Bond provided the Board with an overview of the discussion with the External Auditors in relation to the going concern judgement and their recommendation which was to separate out the entity from the service when reporting and describe how the Trust was managing its cash flow in order that services would continue. Further debate on the going concern judgement would be undertaken at the Audit Committee and Finance Business Performance and Assurance Committee. The Board approved the recommendations in relation to the Accounting Policies. The Board was advised of the national changes to the Value for Money/Use of Resources assessment and confirmed that the Trust was working with the Auditor to ensure the Trust responded to the changes appropriately.	

Reference	Minute	Action
BM15-16/306	**Report of the Quality and Safety Committee** Dr Quinn presented the report from the Quality and Safety Committee and highlighted the changes made to the Board Assurance Framework and the further plans to review the risks in relation to partnership arrangements and commissioner affordability in light of the emerging risks being discussed. The good work being undertaken in HR was highlighted through the Workforce dashboard and the plans to review the prioritisation of the Cerner programme at the meeting in May 2016. The "deep dive" undertaken into the Advancing Quality work associated with fractured neck of femur was reported positively with some of the criteria already now being met. The work being undertaken on End of Life Care was reported upon with the End of Life Care Plan on a Page being circulated to members. Further progression of this agenda was being explored with partners. Dr Quinn advised the Board of the recommendations from the Committee in relation to the priorities for the Quality Account for 2016/17 which were to remove dementia and reducing mortality in view of the progress made over the last 3 years and replace this with End of Life Care and the SAFER roll out and progress against key indicators. The Board approved the recommendation. An update on the web-holding file action plan was provided which was although there was more work to do progress was now being made. The Community paediatrics update was noted in view of the discussion held at Board under the separate agenda item.	
BM15-16/307	**Report of the Finance Business Performance and Assurance Committee** Mr Hollick presented the report of the Finance Business Performance and Assurance Committee which included the financial position at M11 and operational performance in key areas. Mr Hollick updated the Board on the discussions held in the Committee on the NHSP contract and the recommendation to extend this contract for a further 4 years. As previously circulated members were reminded that the Trust had entered into a one year contract with NHSP on 2nd November 2015 with the option to extend this for an additional four years. Based on the first 3 months of the one year contract all savings were on target to be achieved, or expected to be achieved in full over the life of the contract. Mr Hollick confirmed that if the contract was not to be extended then the Trust would have to pay a one off repayment of a previously agreed discount of £74K to NHSP. The full cost of the contract was confirmed as £1,047M. Mr Hollick confirmed that the Committee agreed to recommend the extension of the contract to the Board following their review and the inclusion of enhanced	

Reference	Minute	Action
	performance indicators. The recommendation was made on the basis that NHSP accept the terms and conditions of the Crown Commercial Framework. The Board agreed to approve the contract extension subject to the terms of the recommendation and the inclusion of a break clause. The Board was advised that although the budget underpinned the financial plan and discussions had been undertaken on this at various meetings, the Committee and the Board would want to formally review and approve the budget in the future.	
BM15-16/308	**Monitor Q3 2015/16 Feedback Letter** The Board received and noted the contents of the report	
BM15-16/309	**Board of Directors** The Minutes of the Board of Directors Meetings held on 24 February 2016 were confirmed as an accurate record. **Board Action Log** The Board action log was updated as recorded	
BM15-16/310	**Items for BAF/Risk Register** The Board agreed to include the commissioner affordability risk.	**CS**
BM15-16/311	**Any Other Business** The Board gave their thanks to Mr Taylor who was due to leave the Trust on 31st March 2016.	
BM15-16/312	**Date and Time of Next Meeting** Wednesday 27 April 2016 at 9.00 a.m. in the Boardroom, Education Centre, Arrowe Park Hospital.	

……..……
Chairman

……..
Date

BOARD OF DIRECTORS

MINUTES OF MEETING

27 APRIL 2016

**BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL**

Present

Michael Carr	Chairman
David Allison	Chief Executive
Cathy Bond	Non-Executive Director
Andrea Hodgson	Non-Executive Director
Janelle Holmes	Chief Operating Officer
Graham Hollick	Non-Executive Director
Gareth Lawrence	Acting Director of Finance
Evan Moore	Medical Director
Jean Quinn	Non-Executive Director
John Sullivan	Non-Executive Director
Gaynor Westray	Director of Nursing and Midwifery

Apologies

Cathy Maddaford	Non-Executive Director

In attendance

Carole Self	Director of Corporate Affairs
Chris Oliver	Interim Director of Operations
Mike Coupe	Director of Strategy*

Public attendance

Amanda Farrell	Divisional Director – Medical and Acute Division
Kate Jury	Deloitte
Jane Kearley	Member of the public
Len Smith	Public Governor

*denotes attendance for part of the meeting

Reference	Minute	Action
BM16-17/001	**Apologies for Absence** Noted as above	
BM16-17/002	**Declarations of Interest** None	
BM16-17/003	**Patient Story** The Director of Nursing and Midwifery provided the Board with the feedback from the parents of a 15 year who attended the Childrens Emergency Department with a laceration to the forehead. The feedback was positive and thanks were extended to the staff for being caring and understanding.	

Reference	Minute	Action
BM16-17/004	**Chairman's Business** The Chairman updated the Board on the successful visit by the Mayor Mr Rowland on the 20th April 2016. The visit focused on caring for patients with dementia and the feedback from the Mayor was very positive in terms of how caring staff were and the positive environment. Thanks were extended to the Director of Nursing and Midwifery and the staff for organising this visit. The Medical Director was congratulated on his recent appointment to the Chief Medical Director/Deputy Chief Executive of Betsi Cadwaldar although clearly this would be a loss for the Trust. The Medical Director provided an update on the junior doctors strike, the preparations for the withdrawal of emergency care and how this was being managed. No adverse incidents had been reported and the hospital was described as calm.	
BM16-17/005	**Chief Executive's Report** The Chief Executive provided an update on the following: **CCG** – he confirmed that the contract negotiations had been completed. The Board congratulated the Chief Executive and Acting Director of Finance in concluding these successfully. **National Information Board** – the Board was pleased to note that the Trust had been ranked 4th by the HSJ in the recent digital maturity index as this recognised the good work over many years. The Chief Executive advised the Board that he had invited Matthew Swindells formerly of Cerner and now NHSE to address North West Chief Executives at a meeting on the 10th June to look challenges and opportunities in the Cheshire and Merseyside STP. **Staff Guardians** – the Chief Executive confirmed that 90 of the 92 concerns raised had been concluded; 70% of all concerns were raised and concluded in the same month. The Board confirmed that the Quality and Safety Committee was due to review the themes raised at its meeting in May and therefore a summary should be provided thereafter for the Board. **Celebrating success** – the Board extended its congratulations to the Emergency Department for being awarded the PROUD team of the Quarter and to the Occupational Health Team having achieved the SEQOHS accreditation.	**CS/JM**
BM16-17/006	**Vanguard Programme Update** The Director of Strategy presented the Vanguard Programme Update which included the notification from NHS England that there would not be any Vanguard funding in this financial year. The Board was advised that this was the picture nationally with most Vanguards schemes similarly being affected. The Board was advised that Wirral Partners had suggested that Vanguard be subsumed into Healthy Wirral although the Programme Management	

Reference	Minute	Action
	Board would have to be trimmed down and the projects re-visited to ensure the focus was through collaborating organisations and concentrating on Healthy Intent; Elderly services; unscheduled care; progressing towards an Accountable Care System and health and social care urgent care contracting. The Board recorded its disappointment however it welcomed the opportunity to focus on integration and the opportunity for a different way of working across organisations.	
BM16-17/007	**Annual Operational Plan** • **Review of performance against 2015/16 objectives** The Board noted the report and the progress made during the year; specifically in the improved staff satisfaction results and the progress in information technology which had been recognised in the Digital Maturity Index. The Board recognised that the challenges reported in operational and financial performance was in the context of the broader NHS which was itself under significant pressures. The Board accepted the report subject to the inclusion of performance in both attendance and appraisal rates, both of which were of note. • **2016/17 Annual Plan** The Chairman reminded the Board that it had seen the plan a number of times and to concentrate therefore on the decisions taken more recently. The two key changes were confirmed as the demand, capacity and access standards and the financial position. The Acting Director of Finance advised that the plan now included the contract activity for 16/17 set against 15/16 activity levels. The contract assumed that A & E attendances would remain unchanged whilst non-elective admissions would reduce this was based on the health economy commitment to progress with initiatives such as the pilot to divert patients to Victoria Central for Minor medical emergencies and the medium term plan for this service to be kite-marked accordingly. The Chief Executive confirmed that the activity levels were consistent with the local delivery STP and allowed all parties therefore to focus on a single version of activity to ensure the right behaviours are deployed. The Board was concerned that the Trust had experienced significant difficulties with the achievement of the A & E standard as a result of activity levels and sought to understand therefore how this could be improved in 16/17 and in turn how the Board would monitor improvement. The Chief Executive acknowledged the concerns particularly in light of recent events following the reduction in the Better Care Funding and Vanguard Funding which have led to the CCG decommissioning a number of discharge schemes and the Local Authority looking to reduce the number of care home beds available. The Chief Operating Officer confirmed that the work of the Task and Finish Group would focus on tracking performance and variances which would be reported into the contracting meetings. If activity did continue to rise then the contract	**MC**

Reference	Minute	Action
	monitoring meetings would review this as part of the review of thresholds in the contract. The Board sought to understand what assurance the Trust had that activity levels would not increase further. The Chief Executive confirmed that the negotiations had been based on capacity vs demand; the need to achieve 18 week compliance and the need to remain in a financial envelope affordable to the CCG. The contract allows for an element of risk to be mitigated if there should be any material change in referrals or demand. The Board discussed how the Trust would engage with the CCG and GP partners to enact the change in behaviour required to deliver the health economy strategy and agreed that the next few weeks would be used to articulate how partners measure "value" and use this to inform 2017/18 contractual arrangements. The Board reviewed the changes made to the income, expenditure and cost improvement section of the annual plan following the conclusion of the contractual negotiations resulting in a financial envelope as previously discussed. The Board was reminded of the sensitivity analysis in the document as previously discussed. The Board was pleased with the progress made; extended its thanks to everyone involved in the process and agreed to ratify the report.	
BM16-17/008	**Integrated Performance Report** **7.1.1 Integrated Dashboard and Exception Reports** The Chief Operating Officer presented the performance report focussing on the following areas: **A & E 4 hour standard** – this was reported for March as 80.22%. April to date performance was reported as improving at 84.72% which was on track with the performance improvement trajectory. The Board was updated on the establishment of the task and finish group which was designed to focus on the internal actions to improve performance and patient flow. **18 weeks** – performance for March was reported at 90.46%. The focus of work was on determining capacity and demand and reviewing the job planning templates. The Board sought to establish the actual impact of the junior doctors industrial action on the achievement of this target. The Acting Director of Finance confirmed that more than 20% of capacity was lost in April; 8% due to inpatient activity and 14% in outpatient activity. He did clarify however that the performance on activity ahead of the plan was below expected levels, however because there was no tolerance in the system, this led to the Trust slightly underachieving overall. The Board was conscious of the need not to lose sight of some of the more fundamental underlying difficulties frustrating compliance by focussing too much on the current junior doctors dispute. The Board sought and	

Reference	Minute	Action
	received confirmation that the Trust was taking all the necessary action to try and achieve performance in April however this would not be known for a couple of weeks. **C difficile** – the Board noted the continued progress in this area and the success of the action plan. The Board debated how it would review and assess performance going forward in view of the provider licence requirement to achieve NHS constitutional standards versus achieving compliance against the submission of improvement trajectories for A & E and 18 weeks. The Chief Operating Officer confirmed that this work was being undertaken. The Board sought to understand whether the underperformance in the AQ targets was related to recording or was a potential risk to patients. The Medical Director confirmed that AKI and community acquired pneumonia was associated with recording; sepsis however related to issues with IV fluids and the interaction with the blood gas machine. Work was progressing in all 3 areas to improve performance. The Board agreed that the amended style of reporting was helpful although it would be useful to progress even further to include early warning indicators. The Board noted the performance against the cancer standards which although showed achievement on an aggregate level still had areas where further work was being progressed. **7.1.2 Month 12 Finance Report** The Acting Director of Finance reported the M12 performance which brought to an end a very challenging year for the Trust and the NHS as a whole. The M12 deficit was reported as £15.4M although this was still subject to Audit. The year-end cash position was reported at £3.5M which was £1.9M higher than plan. The Financial Sustainability Risk Rating FSRR was reported at 2 in line with the plan. The Acting Director of Finance outlined the concessions and agreements made to conclude the year-end negotiations and inform the 2016/17 contract which had avoided the need for arbitration and had maintained good relationships. The Board congratulated the Executive on the delivery achievement in line with expectations and the conclusion of negotiations with the CCG. The Board further sought to understand how the risk was finally shared. The importance of the year-end deal was that both parties managed delivery in line with expectations which was a good signal as the Wirral progresses towards an Accountable Care System. The Board queried the significant change in post EBITBA items and why this had impacted on performance for M12. The Acting Director of Finance confirmed that this was the result of a desk top exercise which was	

Reference	Minute	Action
	reported to the Finance Committee in January and concluded in March 16. The desktop review could have resulted in a risk or an opportunity, the conclusion was this enabled a reduction in depreciation charges which led to the final position. The Board extended its thanks to the Acting Director of Finance and the Finance team and formally accepted the report.	
BM16-17/009	**Chair of the Audit Committee Report** Mrs Bond reported on the work of the Audit Committee which included the decision to include changes to legislation that impact on the Audit Committee's work in its workplan. This was the result of the External Audit questionnaire. The Board was pleased to note that the work on the incident web-holding file that had resulted in a significant reduction in the backlog which was now 118 from the previous position of over 1000. The oldest incident was now within compliance levels although the Board agreed that this work needed to continue. The Board noted the work undertaken at Audit Committee in relation to the standing financial instructions and the scheme of delegation which had resulted in the development of a new authorisation matrix, as presented. The Board was advised of the plans to disseminate this work and ensure that all managers with delegated financial responsibility undertook training before authorisation would be permissible. The Board sought clarity on the terminology of "authority" in the matrix which was provided by the Acting Director of Finance. The Chief Executive confirmed that the changes had been fully reviewed and supported by the senior management team. The Board approved the authorisation matrix.	
BM16-17/010	**Report of the Finance Business Performance and Assurance Committee** Mr Hollick presented the report on the work of the Finance Business Performance and Assurance Committee. This included the changes approved by the Committee to the terms of reference for its supporting groups and the recommendation to the Board to the revised terms of reference for the Committee which were subsequently approved by the Board. Mr Hollick outlined the work of the Committee on the review of the Cost Improvement Programme and the review of the "going concern" statement which the Board subsequently approved. The Director of Corporate Affairs advised the Board that the Committee had recommended that the risk associated with commissioner affordability be removed from the Board Assurance Framework and replaced with the risk of managing demand and referral levels in the future. The change	

Reference	Minute	Action
	was a result of the agreement of a financial envelope for 16/17. She also advised that the Committee had recommended that the replacement of the risk in relation to competition in the market be replaced with the risk associated with the development of the Accountable Care System/Organisation. The Board approved both recommendations.	
BM16-17/011	**Review of Register of Interests** The Board accepted the register of interests as presented subject to the following minor amendments: • Mrs Hodgson confirmed that she was no longer the interim CFO for the Universities Superannuation Scheme Ltd • Mr Allison confirmed that NWLA stood for the North West Leadership Academy The Board was pleased that the register of interests now also included the full senior management team and accepted the register accordingly.	**CS**
BM16-17/012	**Equality and Diversity Annual Report** The Director of Nursing and Midwifery presented the Equality and Diversity Annual Report highlighting the positive performance in terms of access to services through clear processes and pathways. There was good recognition of the Trust responding to a variety of different needs. The Board reviewed the outcomes of the Equality Delivery System 2 self-assessment and sought to understand what the Board could do to improve the "undeveloped" rating for inclusive leadership. The Director of Nursing and Midwifery confirmed that this was more to do with how the Trust provided evidence of engagement on the equality and diversity agenda outside of the organisation. The Board noted its disappointment with the lack of sight on the self-assessment or the scheme ahead of publication. The Board agreed that the Workforce and Communication Group would receive an update on the Workforce and OD aspects related to this report, specifically including a review of the current position and what further steps needed to be taken in 2016/17 related to this critical matter. The Board agreed to receive assurance that all the necessary steps had been taken via the Chair of the Quality and Safety Committee Report in July 2016.	**GW/JM**
BM16-17/013	**Monitor Financial Commentary – M12** The Board approved the text and the governance declarations as presented.	
BM16-17/014	**Board of Directors** The Minutes of the Board of Directors Meetings held on 27 March 2016 were confirmed as an accurate record.	

Reference	Minute	Action
	Board Action Log The Board action log was updated as recorded	
BM16-17/015	**Items for BAF/Risk Register** The Board agreed to record the risk in relation to achievement of the control total; the implementation of the junior doctors contract and the early risks identified as a result in the forthcoming change of Medical Director.	
BM16-17/016	**Item to be considered by Assurance Committees** The Board agreed to the following: Quality and Safety Committee to focus on the performance of community paediatrics; the themes from raising concerns and the review of cancer target achievement by speciality Finance Business Performance and Assurance Committee to focus on demand, capacity and achievement of access targets; the achievement of financial targets and the review of thresholds. The Board agreed that A & E monitoring and review would be undertaken at the Board.	**CS** **CS**
BM16-17/017	**Any Other Business** The Medical Director advised the Board of a Never Event that occurred in March 16 but was only evident 6 weeks later. The event was in relation to the extraction of incorrect teeth to create space. The orthodontist noted that the incorrect teeth were extracted at his review appointment and had now planned his treatment accordingly with the space that had been created. There was no harm to the patient; the family were advised of the incident as were the regulators. The Root Cause Analysis is underway. The Board was reminded of the forthcoming development session on risk appetite which had been rearranged to the 19th May 2016.	
BM16-17/018	**Date and Time of Next Meeting** Wednesday 25 May 2016 at 9.00 a.m. in the Boardroom, Education Centre, Arrowe Park Hospital.	

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Chairman

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Date

ANNUAL PLAN ADVISORY COMMITTEE

MINUTES OF
MEETING HELD ON
12th APRIL 2016
EXECUTIVE MEETING ROOM
TRUST HQ

Minute
Apologies for Absence Norman Robinson
Minutes of the Previous Meeting The minutes of the previous meeting were agreed
Matters Arising There were no matters arising
Operational Plan - Final Submission The Committee received the above document and were informed that the Board would be implementing the longer version as a working document subject to contract negotiations. The Committee discussed the complexity of contract negotiation re: activity and cost, as the Commissioners would be guided by NHS England and NHS Improvement would have expectations of the Trust for financial balance.
Local Delivery System Plan – Healthy Wirral The Group was provided with an April checkpoint submission for Local Delivery System Plan (LDSP) which concentrates on five specific areas that collectively seek to capture the leadership, decision making and supporting resources put in place for progression of Sustainability and Transformation Plans (STP) along with major areas of focus and big decisions needed to make a system to drive transformation. This would enable schemes to be identified which would reduce demand or replicate some services at a lower cost.

Minute
The schemes would then be graded into levels of confidence, taking in to account evidence, ideas and possibilities. This will then become a basis for discussions at regional development days and provide an opportunity for footprints to test out hypotheses and an exchange of lessons learned. It will also enable National bodies to understand how STP areas are working together.
Any Other Business There was no other business
Date and Time of Next Meeting 10th May 2016 @ 3pm - Executive meeting Room, Trust HQ

ANNUAL PLAN ADVISORY COMMITTEE

UNAPPROVED MINUTES OF MEETING HELD ON 10th MAY 2016 EXECUTIVE MEETING ROOM TRUST HQ

Minute
Apologies for Absence Robert Howell
Minutes of the Previous Meeting The minutes of the previous meeting were agreed
Matters Arising There were no matters arising
Local Delivery System Plan – Healthy Wirral The group received details of the enabling strategies required to provide Better Health, Better Care and Better Value. These included: patient insight and engagement; clinical insight and engagement; Wirral Care Record; Digital Map; IT; workforce and Program Management Office. Key areas for consideration were the impact on health inequalities, improvement of outcomes and the whole system financial position. The Director of Strategy informed the group of the methodology used in the key planning and subsets of the LDSP, including the projection from 2011-16 and the trajectory to 2021. He further explained how schemes would be evaluated and given a RAG rating.
Any Other Business There was no other business

Minute
Date and Time of Next Meeting 14th June 2016 @ 3pm - Executive meeting Room, Trust HQ