Wirral University Teaching Hospital NHS
NHS Foundation Trust

Board of Directors Meeting

24 September 2014

MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 24 SEPTEMBER 2014 COMMENCING AT 9.00AM IN THE BOARD ROOM EDUCATION CENTRE, ARROWE PARK HOSPITAL

AGENDA

1.	**Apologies for Absence** Chairman	v
2.	**Declarations of Interest** Chairman	v
3.	**Patient's Story** Director of Nursing and Midwifery	v
4.	**Chairman's Business** Chairman	v
5.	**Chief Executive's Report** Chief Executive	d

6. Strategy and Development

6.1	**Response to consultation document issued by Clatterbridge Centre for Oncology NHS Foundation Trust on their proposed relocation of services to central Liverpool** Director of Strategy and Partnerships	d
6.2	**Cerner Progress Update** Director of Informatics	d

7. Performance and Improvement

7.1	**Integrated Performance Report**	
	7.1.1 Integrated Dashboard & Exception Reports Director of Informatics	d
	7.1.2 Finance Report Director of Finance	d
	7.1.3 Emergency Department Staffing Report Medical Director	d
7.2	**Report of the Audit Committee** • **4 September 2014 Committee** Chair of the Audit Committee	d
7.3	**Report of the Quality and Safety Committee** • **10 September 2014 Committee** Chair of the Quality and Safety Committee	d

8. Strategies and Annual Reports

8.1 Risk Management Policy and Strategy d
Medical Director

9. Governance

9.1 External Assessment d
- **Month 5 Monitor Compliance Report**

Director of Finance
- **Quarter 1 2014-15 Feedback - Wirral** d

Chief Executive

9.2 Board of Directors

9.2.1 Minutes of the Previous Meeting d
- **30 July 2014**

9.2.2 Board Action Log d
Associate Director of Governance

10. Standing Items

10.1 Any Other Business v
Chairman

10.2 Items for BAF/Risk Register d
Chairman

10.3 Date and Time of Next Meeting: v
Wednesday at 29 October 2014 at 9am

Board of Directors		
Agenda Item	5	
Title of Report:	Chief Executive's Report – September 2014	
Date of Meeting:	24 September 2014	
Author:	David Allison, Chief Executive	
Accountable Executive :	David Allison, Chief Executive	
Corporate Objective Ref as outlined in the BAF	**2, 4, 5 ,11**	
Level of Assurance		**Board Confirmation**
Full		
Data Quality Rating	**n/a**	
FOI status :	**Document may be disclosed in full**	

1. External Activities

Commissioners

The Trust received an outline from the CCG of expectations in respect of allocations of Winter and RTT Monies; a copy of the letter is appended for information *(appendix i).*

The Capability and Governance Review into NHS Wirral Clinical Commissioning Group CCG has now been received, the Trust has received a copy of the review as a stakeholder. Further information regarding the review is available from the Cheshire, Warrington and Wirral Area Team at NHS England. Relations with the CCG remain very open and constructive.

Urgent Care Recovery Plan

On 17 September 2014 the Wirral Health and Social Care Community approved the 4 Hour A & E Standard recovery plan. Full details of the plan are attached at (a*ppendix ii*). The Plan contains the trajectory for improvement for this site for the months up until March 2015.

Better Care Fund

The Trust has been involved in the refresh of Better Care Fund proposals which have been iterated following initial submission earlier in the year. Whilst the strategic direction of travel in relation to BCF proposals aligns with the Trusts own view that more care should be diverted from the acute sector into primary and community care settings and whilst greater rigour has been applied to the development of proposals for this second iteration, plans remain at a very early stage of development. There also remain risks associated with the projected diversion of activity not being delivered or being off set of increases in demand related to the demographic pressures faced by the local health economy. At present the proposals are not sufficiently well developed enough for the Trust to refresh its own activity assumptions (particularly given current increases in the levels of emergency admissions), but this will be kept under review as proposals develop. The Trust has been crystal clear that whilst it supports the direction of travel and would welcome changes in the nature of urgent care demand, that it will also require support to 'transform' its systems and capacity to manage unscheduled care if the proposals do start to have an impact, particularly in the initial phases. This has been made explicit to the CCG and Local Authority in the Trust's commentary on the BCF, submitted as part of the overall application to NHS England.

Monitor

Our monthly update call took place with Monitor on 2 September 2014 which predominantly focused on the review of the Trust's strategic plan. The Trust provided comprehensive responses to the key strategic development areas; key risks and key assumptions made as requested by Monitor. The call also included current views on the Better Care Fund as outlined above and the relationships with the interim senior team at the CCG which continue to improve. The Trust also updated Monitor on the M4 and M5 financial performance position, outlining the arrangements put in place to improve the Trust's cash position and confirmation that the Trust was confident of achieving a Continuity of Services Rating for Q2 of 2 subject to the continuation of the Income and Expenditure Plan.

The Trust also updated Monitor on the progress being made to achieve the A&E 4 hour standard highlighting the improvements made from Q4 2013/14 to date. The Trust summarised all the action it was taking in a follow up letter and submitted the approved Urgent Care Recovery Plan, signed off by all partners, on 17 September.

CQC

The CQC are undertaking a responsive inspection of Arrowe Park Hospital on 18 and 19 September 2014 focussing in particular on 3 of the Essential Standards. A verbal update of the feedback following the inspection will be provided at the Board of Directors Meeting.

External Review

The Trust outlined the nature of the external support commissioned at its Board Meeting in July 2014. The Trust has just finalized the Financial Governance and Reporting Review with KPMG, the recommendations of which are to be reviewed by the Board together with the actions identified to secure improvements.

The cash management review from KPMG has been finalised and the recommendations are progressing well, with improvements being seen in the Trust's cash position, further detail of which can be seen in the Finance Report.

The work with Atkins/FTI continues in relation to the cost improvement programme. A result of this work has identified the need for further savings to be identified as discussed previously with the Board. The Trust can confirm that in response the Executives have been tasked to deliver a further 10% across each of their non-clinical portfolios. Plans are progressing well, with a further review planned for 22 September 2014 with a view to implementing the actions from the 1 October 2014. The Board is asked to formally endorse this action which will result in a reduction in budgets.

2. Internal Activities

Health & Safety Update

Further to the visit from the HSE on 8 August 2014 to review a needle stick injury to a staff member from a Hepatitis C patient, the report has now been received and is appended for information *(appendix iii)*. The process has been improved to ensure that any future incidents comply with the correct reporting procedures and the Trust Board are asked to note the concluding comments:- "In my experience, the Trust would appear to be a leader for managing and reducing risks from exposure to sharps and therefore injuries. With permission, I will refer other Trusts to look at your management system, implementation and management of sharps."

Infection Prevention & Control

We continue to experience an outbreak of Carbapenemase Producing Enterobacteriaceae (CPE) at Arrowe Park. However, following implementation of outbreak control measures including collaboration with Public Health England, the latest data suggests we now have a level of control on this current outbreak and can expect to see continued improvement in the coming weeks. However, we remain at risk of further index cases coming into our hospitals, and this further reinforces the need for the robust action plan we now have in place to manage the ongoing risk associated with Anti-Microbial Resistance. The current risk has been discussed in detail at the Operational Management Team and the Quality and Safety Committee and the Board is asked to formally receive the risk as part of its escalation process, details of which are under item 10.2.

Freedom to Speak – Letter from Jeremy Hunt MP

At the Board Development Day in August the Board received a copy of the recently received letter from the Secretary of State for Health encouraging all Boards to play their part in ensuring that colleagues from across the organisation had an opportunity to report issues of concern through appropriate reporting lines or anonymous 'Whistleblowing' processes. The Board considered this correspondence and noted that a recently agreed 'Whistleblowing Policy' had been publicised through the Trust both through the Chief Executive's Monthly open forum and through the regular 'Start the Week' e-bulletin.

The review was in keeping with key outputs from the Francis Report, which advised organisations to take the time to review their existing policy to ensure appropriate systems are in place for staff.

The review findings were that the main aims, purpose and principles of the existing Policy should remain unchanged. However, the presentation of the Policy did require improvements with the emphasis on 'keeping it simple' and transparent. The following changes are noted below:-

- The scope is expanded to be as inclusive as possible. The new document specifically includes students; work experience; and holders of honorary, observer and research contracts.
- A process map is included in order to provide a simple overview of how the procedure operates.
- The Policy sets out the requirements for a Policy Administrator. The reason for this is that it will make certain that the Trust is more closely able to report and monitor concerns. The policy also makes clear that issues raised through other routes, e.g. directly with a Director, will need to be channelled through the Raising Concerns Policy and process. The importance of accurate reporting, monitoring and actioning is of course a key learning from the Francis Report.
- Although all issues raised as a Raising Concern issue will be recorded; only those which fall under the definition of the Public Disclosures Act will be investigated using the Raising Concern procedure. The policy includes a maximum timeframe for investigations. For those which do not fall under the Public Disclosure Act then these concerns raised will be filtered and employees re-directed, as appropriate, to other procedures to address issues, e.g. Grievance, Bullying & Harassment.
- The Policy makes reference to external signposting e.g. National Whistle-blowers helpline, GMC, NMC. However, at all times the Policy notes that staff should raise the concerns via this Policy regardless of whether they have chosen to report to an external body.
- The Policy includes any changes which are required in order to meet new legislation e.g. Enterprise & Regulatory Reform Act 2013, Bribery Act. The most recent legislation being the Enterprise & Regulatory Reform Act 2013 which came into force in June, 2013 (elements of the Act being enforceable in October, 2013 and April, 2014).

- Changes have also been made to various contact details, including the reference to external bodies to whom whistleblowing complaints can be made.

The opportunity to respond to the 'Freedom to Speak up' review had also been publicised to colleagues through 'Start the Week'.

Workforce

128 staff received certificates on 5 September for qualifications achieved through the Leadership and Development Centre supported by local Higher Education Colleges. These include: apprenticeships, leadership and management qualifications and other vocational programmes.

The PROUD Awards 2014 will be taking place at the Floral Pavilion in New Brighton, evening of Tuesday 30 September, hosted again by the brilliant and funny Pauline Daniels, sponsored by Typhoo. A very high number of applications have been received and the event will be a positive celebration for our hard working and dedicated workforce.

Supported Internships

Supported Internships are for young people with severe learning difficulties and/or disabilities aged 16 to 24 with a Statement of Special Educational Needs, a Learning Difficulty Assessment, or an Education, Health and Care Plan who want to move into employment and need extra support to do so. The internships is for an academic year and consists of 3-days per week of a work placement and additional learning support in college. The Trust will host nine young people aged 18-23 as the Wirral Pilot from September 2014 to June 2015. Positions will be across the Trust and include the main reception at APH, Assistant CSW roles in Dermatology and Surgical Day Case at CBH, in addition to facilities and a range of administration areas. The expected outcomes include life/work skills, independent travel, increased confidence and self-esteem as well as increasing then knowledge and awareness of our staff in working with colleagues with learning difficulties.

The Trust has recently won the **NW National Apprenticeship Award** (employers over 5000 employees). The Trust was the only NHS winner in the North West and credit should be extended to all our apprentices and the team who support them.

Listening into Action (LiA)

The Trust has been working with Listening into Action as part of the National Pioneer's Programme for the last 2 years. We come to the end of our 2nd Year as a Beacon Trust on 30 September 2014 and our sponsor group have therefore been planning how we sustain this way of working as we go forward independent of Optimise Consultancy. A year 3 implementation plan has been agreed which integrates with staff satisfaction and engagement and in summary includes the following key areas:

- Develop Staff Engagement Strategy and plan that brings together Listening into Action, Staff Satisfaction, Staff Survey and Friends and Family, Leadership and Management, transformation, rewards and recognition, communications and values and behaviours
- Review focus of LiA Sponsor Group, Staff Satisfaction Steering Group

- Complete Wave 4 Teams
- Continue annual CEO led Big Conversations with Year 3 focus on managers and leaders and maintain CEO visibility programme
- Develop network of LiA Champions
- Integrated LiA Core team back into HROD and continue provision of enabling support
- Re-launch plan
- Measure how our staff feel through the Staff Friends and Family Test and National Staff Survey, using the results to determine areas for improvement

The implementation plan will underpin the strategy and will be monitored by the Workforce and Communications Group and LiA Sponsor Group and reported to the Partnership Steering Group. Working independently of Optimise as we go into year 3 in October 2014, the Trust has the agreement of Optimise to continue with the LiA branding and methodology without cost and will continue to be part of the National Pioneer's network.

Staff engagement is essential to improving quality and productivity within a challenging environment and it is important that this agenda continues to sit firmly within our workforce strategic priorities, particularly at a time of significant challenge within the NHS and within this Trust.

HSJ Shortlist

It is pleasing to note that our considerable efforts regarding staff engagement have been recognised by the Health Service Journal, who have shortlisted our Trust for the HSJ Award for Staff Engagement.

David Allison
Chief Executive
September 2014

appendix i

Wirral Clinical Commissioning Group

01.09.2014

Ref: JD/LQ

David Allison
Chief Executive
Wirral University Teaching Hospital

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Dear David

Re: Winter and RTT Monies

I thought it may be helpful if I outlined my expectations in respect to the above allocations particularly given the risks across the health economy to both provider and commissioner. In both instances it is my expectation that the CCG will receive, directly, treasury resources to support the delivery of the 4 hour NHS Constitution A&E Standard and separately a further resource to ensure the 18 week RTT Target.

You will be aware that winter money requires a collaborative approach to delivery of the standard, reductions in the numbers of breaches against the standard and a range of community and primary care initiatives that support whole systems delivery. For planning purpose I understand that Wirral Hospitals notional allocation against the winter money as recommended by the urgent care working group is £1.27m which in summary is described below

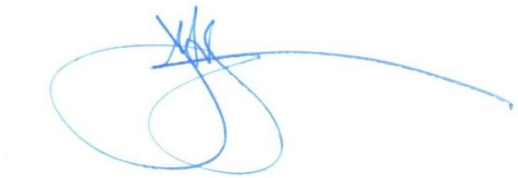
- ED Nurses £114k
- ED Medic £132k
- Acute Physician £132K
- Acute Geriatrician £132k
- Porters £18k
- towards additional bed capacity £742k

In respect of RTT allocations, as the National risk analysis was based upon NHS Provider patient waiting lists we have jointly agreed an activity profile, costing up to £1.3m to support the delivery of 18 weeks and supportive gains into the 16-18 weeks so ensuring the continued delivery of this target over winter and at year end. As this allocation is specific to Wirral Hospital, upon receipt of assurances in respect of additional activity separate to the Wirral CCG contract and associated reduced waiting times the CGG will pass this allocation directly to the Trust.

It is my understanding that the CCG has been invoiced for some of this additional RTT work already and that you are bearing the risks of managing a very difficult period in respect of demand on emergency care. Hence I thought it may be helpful to provide you with the assurances that the CCG will, upon receipt itself, make these resources identified above available.

I know we have both welcomed the announcement of supportive resources and that we will work closely to ensure that we maximise the patient benefit and impact within these allocations.

Kind Regards



Jon Develing
Accountable Officer- Wirral CCG

Wirral Health and Social Care Economy

4-hour standard

Recovery Plan

Performance Dashboard

To be completed weekly for circulation to urgent care recovery plan group

Week commencing:-

Combined Arrowe Park site compliance against 4 hour standard (Target 95%)	
WUTH compliance against 4 hour standard (Target 95%)	
Total number of minor breaches as percentage of overall breaches	
Total number of inappropriate medical redirects	
Total number of patients who avoided admission via GP phone line	
ED Admission Rates	
GP Admission Rates	
Ambulance Turnaround Times	

4 hour Standard Trajectory

Month (2014 / 2015)	Expected Achievement (as a single site)
October	94%
November	96%
December	95%
January	94%
February	96%
March	95%

Admission avoidance

Objective: To prevent unnecessary attendances and admissions to Hospital.

Executive Sponsor: John Lancaster, Director of Operations, Wirral Community Trust (WCT) / Sharon Gilligan, Director of Operations, Wirral University Teaching Hospital (WUTH)

Management Lead: Sarah Quinn, Commissioning Manager, Wirral Clinical Commissioning Group (WCCG) / Chris Oliver, Associate Director of Operations, Medical and Acute Specialties Division, WUTH

Clinical Lead: Dr Hannah McKay, GP, Urgent Care Lead, WCCG / Dr Ranj Mehra, Clinical Head of Division, Medical and Acute Specialties Division, WUTH

Action	Aim	Impact / Outcome	When	Lead
To implement a new medical assessment model. In summary to ensure that all GP & ED admissions are reviewed by an Acute Physician	Reduce admissions from Q1 2013/14 baseline (Health economy agreement to reduce non-elective admissions by 5% in 2015/16)	Reduce medical admissions	Commence 6th October 2014	Rob Cooper, Divisional Manager, Medical and Acute Specialties Division, WUTH Dr Gavin Francis, Consultant in Acute Medicine, WUTH
Redesign the pathway for patients who present with substance misuse issues to avoid admission from ED	To discharge patients from ED to community provision	Reduction in admissions. Initial scoping suggests 25 per month.	Commence 6th October 2014 (Requires Systems Resilience funding)	Rob Cooper, Divisional Manager, Medical and Acute Specialties Division, WUTH Paul McGovern, Commissioning Support Manager, WCCG Ann Taylor, Substance misuse liaison nurse, WUTH
To review the job plan of	Reduce over 74 years	Increased number of	Commenced August 2014,	Dr Ranj Mehra, Clinical

the community Geriatrician to enable the provision of a responsive service that meets patients' needs	avoidable ED admissions	assessments undertaken in the community to avoid hospital attendance Reduction in admissions and readmissions	second phase September 2014	Head of Division, Medical and Acute Specialties Division, WUTH Chris Oliver, Associate Director of Operations, Medical and Acute Specialties Division, WUTH
Review SPA function and admission avoidance pathways (Perfect day action)	To reduce inappropriate GP admissions	Utilisation of local directory of services to redirect patients into other appropriate care settings	October 2014	Sarah Quinn, Commissioning Manager, WCCG Dr Hannah McKay, GP, Urgent Care Lead, WCCG John Lancaster, Director of Operations, WCT
Discontinue direct admission rights for Nurse Practitioners to ensure all nurse admissions have been discussed with a GP	Reduce inappropriate admissions	Reduce inappropriate admissions	September / October	John Lancaster, Director of Operations, WCT
Pathway development: • Continence • Falls • Frequent attenders • IV Antibiotics (Perfect day action)	To reduce attendances to ED	Reduce avoidable admissions by redesigning community focussed pathways	Development in progress for completion by: • Continence – TBC • Falls – April 2015 • Frequent attenders – October 2014 • IV Antibiotics – November 2014	Sheena Hennell, Commissioning Manager, WCCG Paul McGovern, Commissioning Support Manager, WCCG Sarah Quinn, Commissioning Manager, WCCG

				Jacqui Evans, Head of Service, Wirral Department of Adult Social Service (WDASS)
Develop a single front door on the Arrowe Park site (Perfect day action)	To ensure only patients requiring ED skill set attend the ED with other patients streamed to alternative care providers	Redirect patients who could be seen in primary care or community urgent care and reduce ED attendances by agreeing and implementing joint protocols.	Mid October	Chris Oliver, Associate Director of Operations, Medical and Acute Specialties Division, WUTH John Lancaster, Director of Operations, WCT Sarah Boyd Short, Commissioning Support Manager, WCCG
Access to diagnostics and hot reporting of x-rays. (Perfect day action)	Rapid diagnosis to be made for patient to be directed appropriately	Reduction of GP admissions to assessment areas by providing planned access on the day	December	Maureen Wain, Deputy Director of Operations, WUTH Sheena Hennell, Commissioning Manager, WCCG
To review OOH GP admissions (Perfect day action)	Ensure patients requiring admission have had appropriate medical assessment prior to referral for admission	Reduce inappropriate admissions	By end of September	Dr Hannah McKay, GP, Urgent Care Lead, WCCG Dr Kathy Ryan, GP, Lead for GP Out of Hours Service, WCT
To review admissions to AMU from speciality clinics (Perfect day action)	Ensure patients requiring admission have had appropriate medical	Reduce medical admissions	Commence 6th October 2014	Chris Oliver, Associate Director of Operations, Medical and Acute

	assessment prior to referral for admission			Specialties Division, WUTH
Develop a communication strategy similar to 'choose well' (Perfect day action)	Provide patients with the relevant information in order to support streaming of patients to most appropriate provider	Develop a A&E campaign as part of Vision 2018 communications strategy	November 2014	Alina McColville, Project Manager, Service Transformation Team, WCT Sarah Quinn, Commissioning Manager, WCCG
Update the Directory of Service (Perfect day action)	Provide comprehensive document detailing full range of services available for patients in Wirral to support streaming of patients to most appropriate provider	Maximise diversion of patients to community services to avoid admission	Paper version updated by November 2014	Rob Cooper, Divisional Manager, Medical and Acute Specialties Division, WUTH Pauline Bolt, Commissioning Support Manager, WCCG Bev Futia, Divisional Manager, WCT Sarah Alldis, Independence Manager, WDASS

ED Processes

Objective: To eliminate ED delays and ensure optimum patent flow through the ED

Executive Sponsor: Dr Evan Moore, Medical Director, WUTH

Management Lead: Rob Cooper, Divisional Manager, Medical and Acute Specialties Division, WUTH

Clinical Lead: Dr Alan Pennycook, ED Consultant, Clinical Service Lead for Emergency Medicine, WUTH

Action	Aim	Impact / Outcome	When	Lead
Implement ED staffing model	Support earlier decision making/requesting of investigations to improve flow	Matching capacity to meeting pattern of demand to reduce breaches	Staffing model approved and will be fully implemented by November 2014	Rob Cooper, Divisional Manager, Medical and Acute Specialties Division, WUTH Dr Alan Pennycook, ED Consultant, Clinical Service Lead, ED, WUTH
Change EDRU to ED assessment	To increase medical workforce availability within ED	Enable management of ED patients within ED	November 2014	Rob Cooper, Divisional Manager, Medical and Acute Specialties Division, WUTH Dr Alan Pennycook, ED Consultant, Clinical Service Lead, ED, WUTH
Review patient pathways within the ED	To streamline clinical care	Standardise working practices of ED consultants to maximise throughput within 4 hour standard	September 2014	Dr Alan Pennycook, ED Consultant, Clinical Service Lead, ED, WUTH

Inpatient Care

Objective: To improve patient flow within the hospital

Executive Sponsor: Sharon Gilligan, Director of Operations, WUTH

Management Lead: Maureen Wain, Deputy Director of Operations, WUTH

Clinical Lead: Dr Ranj Mehra, Clinical Head of Division, Medical and Acute Specialties Division, WUTH

Action	Aim	Impact /Outcome	When	Lead
Develop the role of the substance misuse nurse and streamline the pathway for patients undergoing detox	Avoid 2 admissions a day	Reduction in length of stay (LOS)	Commence 6th October 2014 (Requires Systems Resilience funding)	Rob Cooper, Divisional Manager, Medical and Acute Specialties Division, WUTH Paul McGovern, Commissioning Support Manager, WCCG Ann Taylor, Substance misuse liaison nurse, WUTH
Ensure ambulance response times within one hour for GP admissions (Perfect day action)	To ensure patient arrive at the acute site for medical assessment earlier in the day	Enable timely diagnostics to be undertaken with the aim of increasing the likelihood of same day discharge	October 2014	Sarah Boyd Short, Commissioning Support Manager, WCCG
Implementation of 3 hour TNT	Reduce bed days	Improved utilisation of bed base in assessment areas by reducing wait for test result from 12 hours to 3 hours	October 2014	Maureen Wain, Deputy Director of Operations, WUTH Dr Ranj Mehra, Clinical Head of Division, Medical and Acute Specialties

				Division, WUTH
Increase the utilisation of the discharge lounge (Perfect day action)	To release bed capacity and improve flow within the hospital	Releasing bed capacity earlier in the day, supporting reduction in bed breaches	September 2014	Maureen Wain, Deputy Director of Operations, WUTH
All wards to undertake daily MDT board rounds	To plan for safe patient discharges and improve flow within the hospital	Releasing bed capacity earlier in the day, supporting reduction in bed breaches. Improved planning of discharges.	Mid October 2014	Jo Goodfellow, Associate Director of Strategy and Partnerships, WUTH

Patient Discharge

Objective: To reduce the average number of occupied bed days by minimising delayed discharges

Executive Sponsor: Val McGee, Associate Director of Operations, Cheshire and Wirral Partnerships NHS Trust (CWP) / Sandra Christie, Director of Quality and Nursing, WCT

Management Lead: Jacqui Evans, Head of Service, WDASS / Karen Milnes, Divisional Manager, WCT

Clinical Lead: Dr Paula Cowan, GP, Urgent Care Lead, WCCG

	Action	Aim	Impact /Outcome	When	Leads
1	Implementation of early supported discharge pathways	Reduce number of occupied bed days.	Improve utilisation of current bed base	November 2014	Maureen Wain, Deputy Director of Operations, WUTH John Lancaster, Director of Operations, WCT
2	Implementation of discharge to assess model and pathways	a) Patient assessments to be undertaken in a more appropriate setting b) Reduce occupied bed days (LOS) c) Improve patient experience.	• Reduction in permanent admissions to residential and nursing care homes • Decrease in the proportion of people discharged direct to residential care • Increase in the proportion of admissions to intermediate care beds • Increase in the number of people who are still at home 91 days after discharge from hospital • Increase in the proportion of people who are offered reablement services following discharge from hospital • Reduction in non-elective re-admission rate. • Reduced occupied bed days and LOS	Pilot October - December	Sarah Alldis, Independence Manager, WDASS

3	Improve complex discharge processes, including planning for discharge on admission	a) Patient assessments to be undertaken in a more appropriate setting and improve patient experience b) Reduce occupied bed days (LOS) c) Improve patient experience. - encourage ability to self-care and manage condition safely. - Increased numbers of customers on a reablement plan - Increased numbers of customers making use of assistive technologies.	• Reduction in permanent admissions to residential and nursing care homes • Decrease in the proportion of people discharged direct to residential care • Increase in the proportion of admissions to intermediate care beds • Increase in the number of people who are still at home 91 days after discharge from hospital • Increase in the proportion of people who are offered reablement services following discharge from hospital • Reduction in non-elective re-admission rate. • Reduced occupied bed days and LOS	Pilot October – March 2015	Jacqui Evans, Head of Service, WDASS
3	Care homes including: - falls pathway - appropriate community bed capacity (including IMC / TC / Respite / Short stay and bariatric beds)	a) Reduce delayed discharges to care homes for Wirral b) Reduce A+E attendances from care homes in Wirral c) Reduce emergency admissions from care homes in Wirral d) Improve quality of care in Wirral.	• Reduction in permanent admissions to residential and nursing care homes • Decrease in the proportion of people discharged direct to residential care • Reduction in attendance at A + E • Increase in the proportion of people who are offered reablement services following discharge from hospital • Increase in the proportion of admissions to intermediate care beds • Increase in the number of people who are still at home 91 days after discharge from hospital • Reduction in emergency admissions and hospital LOS.	September – March 2014	Amanda Kelly, Senior Manager, WDASS Pauline Bolt, Commissioning Support Manager, WCCG

5	Explore options to improve capacity and response times with Cheshire West and Chester (CWAC)	b) Reduce A+E attendances from care homes in Wirral c) Reduce emergency admissions from care homes in Wirral	• Reduction in permanent admissions to residential and nursing care homes • Decrease in the proportion of people discharged direct to residential care • Increase in the proportion of admissions to intermediate care beds • Increase in the number of people who are still at home 91 days after discharge from hospital • Increase in the proportion of people who are offered reablement services following discharge from hospital • Reduction in non-elective re-admission rate. • Reduced occupied bed days and LOS	November 2014	Gill Broomhall, Principle Manager, DASS, CWAC
6	Streamline 'Fast Track' pathway for end of life patients (Perfect day actions)	Improve patient journey and reduce length of stay for patient group	Pathway redesigned, in process of approval by clinical governance group	October 2014	Sheena Hennell, Commissioning Manager, WCCG
7	Improve access and availability of equipment from the CES.	b) Reduce A+E attendances from care homes in Wirral c) Reduce emergency admissions from care homes in Wirral	• Reduction in permanent admissions to residential and nursing care homes • Decrease in the proportion of people discharged direct to residential care • Reduce A+E attendances from care homes in Wirral • Reduce emergency admissions from care homes in Wirral	April 2015	Karen Milnes, Divisional Manager, WCT

Completed Actions

Action	Aim
Commence GP phone line To start Monday & Tuesday	Reduce admission, decrease pressure in ED from redirects and reduced flow.
Zero tolerance inappropriate redirects	Decrease pressure in ED
Increase capacity in assessment areas x3	Additional chaired capacity
Managerial change within ED.	Dedicated divisional manager and matron
Agree start date for economy teleconference	To ensure whole economy aware of NEL pressures and actions which are required to ensure timely patient flow
CCG funded point prevalence audit to be carried by Utilisation Management Team	To review all inpatients in order to identify the number who need to be in hospital
Provide CSW and porter for transfer team (accessible 3pm – 10pm)	Support improved flow out of the department
Ward rounds to be commence 8am on acute assessment areas	Post take ward rounds to support flow within the assessment units
Alter oncall junior doctor rota from 9-9 to 8-8	As above
Medical handover to move from 9am to 8am	
Increase the senior Dr presence in ED	Approval of ED medical staffing business case
Increase ENP cover in ED	Approval of ED medical staffing business case
Using the data from the UMR profile medical workforce to meet times of highest demand	Sustainable workforce to ensure capacity meets demand
Zero tolerance to minors breaches	Sustainable improvement in 4 hour performance achieved
Ensure bed management are utilising admission / discharge data on a daily basis including predictor tool	Predict number of admissions and discharges required per day to identify gap

Field Operations Directorate

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Principal Inspector
Mr K Trow

Mr David Allison
Chief Executive
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CH49 5PE
Date 27/8/2014

Reference 4374575

Attention Mr David Allison Chief Executive

Dear Mr Allison

HEALTH AND SAFETY (SHARP INSTRUMENTS IN HEALTH CARE) REGULATIONS 2013
REPORTING OF INJURIES DISEASES AND DANGEROUS OCCURRENCES REGULATIONS 1995

I refer to my visit with Principal Inspector Mr K Trow on 8th August 2014, to investigate a high risk sharps injury to an employee of the trust reported under RIDDOR.

All employers are required under existing health & safety laws to ensure that the risks of sharps injuries are adequately assessed and appropriate control measures are put in place. The sharps regulations as detailed above build on the existing law and provide specific detail on requirements that must be taken by healthcare employers and their contractors.

RIDDOR INVESTIGATION INTO HIGH RISK SHARP INJURY (C12B1F11040)

The HSE investigation was triggered by the reported incident. The aim of the investigation was to ensure that the trust was meeting its requirement under the regulations outlined above.

The incident was investigated by the trusts health & safety team who identified problems with the existing system. These issues were identified before the HSE inspection, with actions were being implemented to improve the present system for managing sharps injuries.

Investigation

Written procedures are in place, follow national standards, giving directions for managing an injury. When procedures are in place and used for a high-risk injury, the effectiveness is often tested. In this case, too much information clearly caused confusion and some procedures were not completely followed for a high risk incident, or there was a delay in actions required.

1. Donor Blood not tested as priority, the sample was saved. This resulted in the staff member being on medication for an extended unnecessary period .This exposes them to not only potential side effects; it is costly to the trust.
2. Injured employee given post exposure prophylaxis medication in A&E, but not followed up in a timely manner by Occupational health. Employee being on nights complicated the issue, however, the case was not given the priority required.
3. Medication given was for four days and by the time an appointment was given by occupational health, the employee had no medication for two days.

Actions

The trust has already identified the following actions to be taken:

Directions for managing sharps injuries to be simplified with specific actions, this will be supplemented by additional guidance.

Medication given to employees will have instructions to advise that this is only for four days and additional medication will be required. Also action them to contact occupational health if they have not been contacted.

Summary

Communication both written and verbal was the identified problem. I am confident that the trust is reviewing the present procedures and pathways, this should prevent a similar occurrence in the future.

I am particularly impressed that Wirral NHS Trust have been introducing and using safe sharps since 2008, and have almost eliminated non safe sharps except for clinical procedures identified where the risk of a safe sharp would have clinical risk implications.

The management of sharps from risk assessment, clinical risk assessment, procurement and implementation to supply in clinical areas, is one of an efficient, streamlined management system, which has reduced the risk to employees from sharps injuries. In my experience, the trust would appear to be leader for managing and reducing risks from exposure to sharps and therefore injuries. With permission, I will refer other trusts to look at your management system, implementation and management of sharp risks.

I would like to thank all the employees and staff representatives we met with for their co-operation and time, especially Andre Haynes and Peter Bolan for openly providing information requested, facilitating the inspection and for the hospitality shown to us during the inspection.

Please contact me if you would like to discuss any of these issues further.

Yours sincerely

Lucia Holmes
Specialist Inspector FOD Health North
HM Inspector Health & Safety

cc Mr Peter Bohan Head of Organisational Health & Effectiveness
cc Mr Anthony Hassall, Executive Director of Strategy & Organisational Development
cc Staff representatives.

Board of Directors		
Agenda Item	6.1	
Title of Report	Response to consultation document issued by Clatterbridge Centre for Oncology NHS Foundation Trust on their proposed relocation of services to central Liverpool	
Date of Meeting	24 September 2014	
Author	Jo Goodfellow, Associate Director of Strategy and Partnerships Anthony Hassall, Executive Director of Strategy and Partnerships	
Accountable Executive	Anthony Hassall, Executive Director of Strategy and Partnerships	
Corporate Objective Ref as outlined in the BAF	10	
Level of Assurance		**Board Confirmation**
Full		
Data Quality Rating	N/A	
FOI status	Document may be disclosed in full	

Transforming Cancer Care in Merseyside and Cheshire

Response to consultation document issued by Clatterbridge Centre for Oncology NHS Foundation Trust on their proposed relocation of services to central Liverpool by Wirral University Teaching Hospital NHS Foundation Trust-24th September 2014

1. Introduction

On 28th July 2014, the Clatterbridge Cancer Centre NHS Foundation Trust (CCC) announced a public consultation on a new cancer hospital providing expert care for the people of Merseyside and Cheshire. The consultation - 'Transforming Cancer Care' will close on 19th October 2014. Whilst acknowledging that existing cancer services in Merseyside and Cheshire are superb, CCC believes the service cannot stand still. It describes a number of reasons for the need to Transform Cancer care:

- Cancer services will need to expand to meet the predicted increase in demand across Merseyside and Cheshire.
- The Clatterbridge Cancer Centre does not have access to intensive care, medical or surgical specialties on its main site in Wirral. In 2013, 74 patients were transferred by ambulance from the Clatterbridge Cancer Centre because there were no intensive care or medical/surgical specialties on site. In 2008 a review commissioned by Merseyside and Cheshire Cancer Network concluded that the Clatterbridge Cancer Centre needed on-site access to acute medical and surgical specialities to provide the best care to older, sicker patients into the future.
- The Wirral site is not centrally located for the Merseyside and Cheshire population it serves. Around 63% of current patients live closer to central Liverpool than to Wirral.
- To provide the best cancer care the centres experts need to carry out research and clinical trials. At the moment some trials cannot be carried out because they can only take place in centres with intensive care and key specialties on site.

The document proposes therefore to invest £118m to:

1. Expand services provided by Clatterbridge Cancer Centre to meet increasing demand for specialist cancer care
2. Develop a new Clatterbridge Cancer Centre alongside the Royal Liverpool University Hospital and Cancer Research UK's Liverpool Cancer Trials Unit. This would become The Clatterbridge Cancer Centre's main site.
3. Continue to provide outpatient treatment for most cancer at The Clatterbridge Cancer Centre in Wirral and a second radiotherapy unit at Aintree.

Whilst the Consultation does not close until 19 October, this is the last Board opportunity to formally approve a response, prior to that date.

This paper contains the suggested response from the Trust to the formal Consultation questions and proposes how the impact of the proposed changes will be managed between the two organisations, given the significant links between the two Trusts.

2. The impact upon Wirral University Teaching Hospital

The table below indicates the services that will relocate from, and remain at the Clatterbridge site:

What will remain at the Clatterbridge Cancer Centre site?	What will relocate to the new centre in Liverpool?
• Outpatient radiotherapy	• Inpatient beds
• Outpatient chemotherapy	• Teenage and young adult unit
• Outpatient appointments	• Outpatient and diagnostic imaging for patients for whom travel to central Liverpool will be more convenient
• Planning and diagnostic imaging	
• National eye proton therapy	
• Specialist support services	
It is expected that around 90% of Wirral and West Cheshire patient attendances could continue to be at the Wirral site	

The Trust has sought the views of its clinical cancer leads, Divisions and Corporate departments on the proposal to understand the potential impact of the proposed changes in two areas:

1. Patient care and experience
2. The extent of the existing contractual and operational relationship with Clatterbridge Cancer Centre and the potential future impact of the changes on the Trust's financial and operational position going forward, and how we would propose to mitigate any exposure

These responses have enabled the Trust to formulate a response to the formal consultation questionnaire.

i) Impact upon patient care and experience should the proposals be approved

The following comments have been received:

- The proposals represent an enhancement to treatment for people suffering from malignancy and especially those who are acutely ill
- Clear patient pathways will need to be established for patients whose inpatient care will move to the Liverpool site where they have previously received acute care at Arrowe Park Hospital
- The impact of the proposed transfer of inpatient care to the Liverpool site upon the Acute Oncology service should be considered. In particular the impact the change in patient pathway will have upon the working practices of the team.
- Although it identifies the impact that the transfer of inpatient care to the Liverpool site may have for patient's travel arrangements, the proposals should consider that impact upon older or vulnerable relatives/carers visiting their sick family members in Liverpool. They may perceive the journey as complex and daunting and should be given support and information to assist them
- There needs to be evidence that close clinical working relationships will be maintained with WUTH. For example attendance at multidisciplinary team meetings held in Wirral
- There is support for the proposal to maintain outpatient treatment for most cancer at the Wirral site

ii) Position of contractual and operational relationships with CCC and potential future impact should the proposals be approved

The WUTH contracts team have established two main contracts with CCC which cover the provision of clinical and non-clinical services. A range of service level agreements have been

attached to these contracts in 2014-15. Within hotel services there are currently 36 facilities staff supporting the non-clinical contract.

The potential impact of the proposed changes upon existing contracts is being assessed. The Deputy Director of Operations, WUTH is meeting with the Director of Operations and Performance, CCC at the end of October 2014 to establish a more detailed understanding of the proposed changes and their impact upon WUTH services currently contracted to CCC.

This will inform service leads at WUTH who will model the impact upon their service line and workforce. They will identify a mitigation plan to manage any impact upon the service, should they be approved. The Deputy Director of Operations will be the lead for this piece of work, which will then meet and report on a regular basis through the Operational Management Team into the Executive Team. It should be remembered that the move of services to central Liverpool will not take place until 2017-18 at the earliest.

3. Proposed WUTH response to the Transforming Cancer Care consultation document

Consultation question	Proposed response
1. Do you support the Vision?	The Trust fully supports the vision for transforming cancer care as outlined in the Consultation document.
2. Do you believe our proposals will help deliver it and improve the quality of care that people with cancer receive in Merseyside and Cheshire?	Yes. In line with the recommendations of the 2008 review, we understand the need for CC to be collocated both with a major acute hospital but also to be more readily accessible for patients from across Merseyside. We are pleased that a significant proportion of diagnostic and outpatient facilities will continue to be available from the Clatterbridge site, protecting access for Wirral patients.
3. Do you feel any groups would be affected for the better or the worse, by the proposed changes	Acutely ill patients – Although we have worked in collaboration with CCC to ensure the needs of acutely ill patients are met, there is no doubt that the availability of rapid on site access to acute care services and facilities will enhance the patient experience for this group. Where older and vulnerable relatives and carers from Wirral/Cheshire are visiting their sick family members in Liverpool, there may be a perception that the longer journey for inpatient care is more complex and daunting. Additional support and information should be given to support them to enable them to manage this change.
4. If you have visited the CCC's Wirral site what can we learn from it for the new centre?	We are proud to have the CCC Wirral site co located with our Clatterbridge Hospital facilities.

Consultation question	Proposed response
	The Wirral site has a number of advantages including ease of access from the motorway network and ring-fenced parking for users of the service. The rural location is attractive to patients, visitors and staff alike. The design of the new Centre should as far as is possible attempt to mirror some of these advantages.
5. Do you support the Vision?	The Trust fully supports the vision for transforming cancer care as outlined in the Consultation document.
6. Should appointment times be extended? They are currently Monday-Friday 9-5pm	As a 24/7 provider we do see the advantages of extending the availability of appointment times – for routine or urgent consultation beyond the traditional 9 – 5, Monday to Friday core hours. This will need to be balanced with the need to have a more flexible workforce so as to achieve extended opening hours within existing staffing costs.
7. Which is more important to you (the patient), quality of care or distance of travel received to receive it?	Although this is an organisational response, we are clear that both high quality care and accessibility are important factors. However the fact that outpatient and diagnostic interventions will continue to be available on the Clatterbridge site offers some reassurance that the price of losing locally accessible inpatient care will be higher quality inpatient care on the Liverpool site.
8. Do you agree that inpatients that need to stay in hospital overnight would get better, safer care on a site with intensive care/other specialists?	The 2008 report made this case with strong evidence. We agree.
9. Would any of the proposed changes affect you personally in terms of travelling for treatment or to visit someone	See response to question 2.
10. Other comments	• The proposals represent an enhancement to treatment for people suffering from malignancy and especially those who are acutely ill • Clear patient pathways need to be established for patients whose inpatient care will move to the Liverpool site who have been previously received acute care at Arrowe Park Hospital • The impact of the proposed transfer of inpatient care to the Liverpool site upon the Acute Oncology service should be considered. In particular the impact the change in patient pathway will have upon the working practices of the Arrowe Park team.

Consultation question	Proposed response
	• There needs to be assurance that close clinical working relationships will be maintained with WUTH. For example attendance at multidisciplinary team meetings held in Wirral • We recognise and support for the proposal to maintain outpatient treatment for most cancer at the Clatterbridge site. • We look forward to working closely with CCC should the proposals be approved as both organisations plan for the transition from the current to the proposed future configuration of services.

4. Summary

This paper summarises the case made by Clatterbridge Cancer Centre to Transform Cancer care in Merseyside and Cheshire. The proposal recommends the relocation of inpatient beds and the Teenage and Young Adult Unit from the Clatterbridge Cancer Centre site to Liverpool.

Comments received by staff at WUTH on the impact of the proposals on patient care and experience have been used to compile a response to the consultation on behalf of the Trust.

The existing position of contractual and operational relationships has been summarised and ongoing work, led by the Deputy Director of Operations, will identify the impact of the proposed changes upon WUTH and the mitigation plans required to manage any exposure.

The Board are asked to:

- Note the paper
- To approve the Trust's responses to the consultation document

Board of Directors		
Agenda Item	6.2	
Title of Report	Cerner Progress Update	
Date of Meeting	24 September 2014	
Author	Mark Blakeman, Director of Informatics	
Accountable Executive	Mark Blakeman, Director of Informatics	
BAF Reference	7	
Level of Assurance		**Board Confirmation**
Incomplete		
Data Quality Rating	Silver – quantitative data that has not been externally validated	
FOI status	Document includes FOI exempt information	

Summary of actions required

This paper provides the Board of Directors with an update on the Wirral Millennium implementation.

The Board of Directors are asked to:

- Note that a further paper will be provided to the Board in October giving further details of the costs and benefits of the future phases. In particular, this paper will help the Trust to re confirm its commitment to future phases of the programme

- Note that a range of cash releasing benefits have now been identified from the Millennium programme and that these have been developed into PODs in line with the Trusts standard approach for managing cost improvements

- Note that further work is under way to explore the potential for further cash releasing benefits

Cerner Update

Version No: 0.1
Issue Date: August 2014

CONTENTS

1 INTRODUCTION

This document provides an update on the Cerner Programme. In particular it describes the current position and the work underway to compare the costs and benefits of the future phases.

2 BACKGROUND

As the Board will recall, the Trust signed a contract with Cerner for the provision of Wirral Millennium in December 2008 following a formal procurement process which had started in January 2005. The original OJEU advert which started the procurement process was for 'Computer software and computer and related services'. The contract signed was for ten years with the option to extend the agreement for a further two years if needed.

The contract was for the creation of a Bespoke Wirral Cerner Millennium Solution (including hardware and software environments) with the development and implementation of the solution split over three phases. The first five years of the contract was to represent a partnered development of the solution with the final five years reverting to a solution supported by Cerner. The contract included access to the full Cerner catalogue of application licences up until the end of the fifth year of the contract i.e. to December 2013 on a Term licence arrangement, at which point it was envisioned that the full Wirral solution would be implemented and the Trust would then enter a further five year period of steady state running up until the end of the agreement.

In 2010 the Trust signed a separate contract with Cerner for the provision of their Picture Archive Communication System (PACS) to replace the existing GE PACS provided under the National Programme for IT (NPfIT).

Whilst the contract was to have been implemented in three phases as the project has progressed these very large phases have been split down into a series of sub phases. The Trust is currently live with phase 2a and is due to go live with phase 2b in December.

In December 2013, following the successful implementation of phase 2a of the Cerner systems (Labs, Maternity and Inpatients) the Trust Board agreed to a contract reset with Cerner that:

- Dealt with a range of outstanding contractual issues, including extending the Term Licence.
- Clarified the scope of the final phase, phase 3.
- Agreed to outsource the provision of the hardware environment into Cerner's data centre in Slough.

In July 2014 a further contract variation was agreed with Cerner to take account of the changes to the implementation timetable and scope following the Trust's successful bid for £3.5m from the Safer Hospitals Tech Fund. The revised contract creates a new sub phase – 2c which brings forward some of the functionality previously in phase 3 as well as extending the contract marginally to include a number of additional solutions that were previously outside the contract. In the main these new elements are solutions that are first of type for the UK market.

The Trust is currently on course to deliver phase 2b in December 2014. Phase 2b will deliver a range of functionality, including:

- Inpatient Medicines Management – allowing the Trust to retire its PCIS system which currently has support costs of £1.1m p.a.
- Nursing inpatient documentation and task management.
- Junior doctor inpatient documentation and work lists.
- Outpatient noting.

This capability is a key tipping point towards delivering a paper light hospital and the need to use paper medical records in the Trust.

Looking forward, stages 2c and 3 will deliver functionality that will be new to the Trust including electronic records for all critical care areas, full anaesthesia records in theatres and integrated Pharmacy stock control.

Providing a fully digital record will enable the Trust to remove paper based processes from almost all clinical areas. The aim is to have a full digital record for each of the Trust's patients with data captured, stored and made available digitally and will ensure that the Trust meets the requirements of national IM&T strategy and that it has complied with the recommendations of the Francis report. It will also allow the Trust to meet the requirements of the Health and Social Care Information Centre's (HSCIC) proposed National Hospital Data and Datasets information standards.

Although both Cerner and the Trust are still fully committed to the partnership approach to the implementation programme, given the financial pressure that is currently being exerted on the organisation and the larger NHS, the Trust will need to reconfirm its commitment to the scope of the future Cerner phases, particularly phase 3.

3 CURRENT POSITION

Whilst there were delays early in the project, the Wirral Millennium implementation programme has resulted in very successful go lives with good adoption of the use of the system and minimal disruption to patient care, the running of the hospital or to statutory reporting. This is relatively unique in the NHS and highlights the maturity of both the organisation and the Informatics Team.

To date the programme has always been driven by the need to replace its legacy system - PCIS and to provide a platform for future developments which has determined the implementation approach of major phases with large amounts of functionality going live at the same time. This also suits the technical limitations that exist around the safe testing and movement of new functionality from non-production domains into the live, production domain as well as the limited Informatics resources available to work with Cerner.

4 CASH RELEASING BENEFITS

Despite its significant achievements the key weakness to the Trusts approach to IT system implementation has been the management of benefits.

Although a range of benefits were described early in the project as part of the business case, the ongoing measurement of benefits was abandoned relatively early into the implementation in part due to a lack of both capacity and capability.

As part of the revised business case approved by the Board in December 2013, it was proposed that a properly resourced Continuous Improvement Team be put in place.

Whilst due to financial constraints, this part of the business case wasn't approved; the Trust did get a one off sum of £250k to fund a temporary business change and benefits management team as part of its successful Safer Hospitals tech fund bid. The aim of this funding is to support the identification and realisation of benefits from both previous and future phases.

It should be remembered that the Trust is at the forefront of IT utilisation in the UK and that there is very little UK specific evidence or experience to fall back on with regard to benefits management.

Given the relative immaturity of the Trusts benefits management approach and the temporary nature of the current capability, to date the Trust has had to rely on estimates of benefits from Cerner's experience in the USA when making business case decisions. Whilst this experience is invaluable in making strategic decisions, it is much less helpful when trying to understand exactly how the Trust can translate these strategic capabilities into operation efficiencies.

Supported by both the WHES team and FTI a series of Project Outline Documents (PODs) have been identified describing the operation benefits of the system over the next 36 months. The total value of these PODs is in the range of £2.7m to £4.3m pa by 2018/19.

These benefits cover a range of opportunities, including:

- Retirement of old systems, providing direct cost reduction
- Improved administration processes both for outpatients and at ward and department level, speeding up processes for staff and patients as well as reducing expenditure on support staff
- The opportunity to remove paper, particularly the physical patient record from the organisation, reducing the considerable amount the Trust currently spends supporting these processes
- The ability to better manage patient pathways, such as improving the management of sepsis and reducing readmissions
- Improving the efficiency of our clinical audit programmes by real time collection of data
- Nursing task management and documentation, increasing the time our nurses spend with patients
- Improving flow through the hospital with better bed management systems
- The use of modern technologies such as voice recognition to speed up care and reduce our dependency on manual time intensive processes.

5 FURTHER BENEFITS

The Trust has always recognised that the Wirral Millennium Programme is strategic in nature and that the total benefits provided by the system will extend far beyond those that are immediately cash releasable.

Given the finical constraints within the NHS and specifically the need to radically improve the efficiency of the organisation, the identification and management of the maximum range of cash releasing savings is essential to the financial health of the organisation. As part of this the Trust is looking again at the assumptions that have been made with regard to benefits that would deliver non cash releasing quality and efficiency savings to see if they can instead drive cash releasing savings.

6. NEXT STEPS

The Board of Directors in October will be provided with:

- A full update on progress with the implementation of phase 2b.
- An updated capital and revenue plan including changes made associated with the safer hospitals safer wards
- A more detailed view of the benefits programme, including progress with extending the benefits as described above.
- An options appraisal with regard to the future phases of the Wirral Millennium programme.
- An update on the potential to expand the use of the Millennium solution to other partner organisations.

7. CONCLUSION

The Board of Directors are asked to:

- Note that a further paper will be provided to the Board in October giving further details of the costs and benefits of the future phases. In particular, this paper will help the Trust to re confirm its commitment to future phases of the programme.
- Note that a range of cash releasing benefits have now been identified from the Millennium programme and that these have been developed into PODs in line with the Trusts standard approach for managing cost improvements.
- Note that further work is under way to explore the potential for further cash releasing benefits.

Board of Directors		
Agenda Item	7.1.1	
Title of Report	Integrated Performance Report	
Date of Meeting	24 September 2014	
Author	John Halliday, Assistant Director of Information	
Accountable Executive	Mark Blakeman, Director of Informatics	
Corporate Objective Ref as outlined in the BAF	Risks 1 to 9, and 11 to 14	
Level of Assurance		**Board Confirmation**
Full		Board confirmation
Data Quality Rating	Silver – quantitative data that has not been externally validated	
FOI status	Document may be disclosed in full	

1. Executive Summary

This report provides a summary of the Trust's performance against agreed key quality and performance indicators.

The Board of Directors is asked to note the performance to the end of August 2014.

2. Background

The dashboard has been developed based on the principle that the report:

- Should focus the Board's attention on the issues they should be focused on, particularly those issues reserved for the Board;
- Should enable the Board to monitor the delivery of external regulatory requirements as well as the Trust's longer term strategic goals and importantly to gain assurance that the right conditions are in place to continue to do so;
- Should recognise and support the delegation to the Finance Business Performance and Assurance, Audit, and Quality and Safety Committees;
- Sets out clear performance targets and where performance fails to meet the required level has a standardised format for providing further information.

With the new monthly performance reporting cycle to the Board, the metrics and thresholds will be reviewed to ensure they provide assurance against the key targets and milestones in both the new Annual and Strategic Plans. Cognisance will also need to be taken of the reporting requirements, including frequency, to all Board Committees.

3. Key issues

Individual metrics highlighted as Red for August are A&E 4-hour Standard, RTT 18 Weeks, Never Events, Attendance, Expenditure, CIP Performance, Non-core Spend, Advancing Quality and Monitor CoS. Exception reports are included for all these metrics.

Details on all metrics and their associated performance RAG thresholds are included in the report.

4. Next steps

The list of indicators and associated thresholds will continue to be reviewed to ensure the report remains relevant and of value. Additional metrics will be incorporated to reflect any further Annual and/or Strategic Objectives not currently covered by existing indicators.

5. Conclusion

Performance across a range of metrics is provided for information.

6. Recommendations

The Board of Directors is asked to note the performance to the end of August 2014.

WUTH Integrated Performance Dashboard - August 2014

Meeting Our Vision

Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period
Satisfaction Rates					
Patient Satisfaction - F&F Achievement Score Inpatients			JG	95.1%	August 2014
Patient Satisfaction - F&F Net Promoter Inpatients			JG	66	August 2014
Patient Satisfaction - F&F Net Promoter ED			JG	81	August 2014
Patient Satisfaction - F&F Net Promoter Maternity			JG	81	August 2014
Staff Satisfaction (engagement)			AH	3.64	2013
First Choice Locally & Regionally					
Market Share Wirral			AH	81.9%	March to May 2014
Demand Referral Rates			AH	3.5%	Fin Yr-on-Yr to Aug 14
Market Share Non-Wirral			AH	9.0%	March to May 2014

Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period
Organisational Risk Issues					
Key Performance Indicators					
A&E 4 Hour Standard			SG	93.5%	Q2 to August 2014
RTT 18 Weeks Standards			SG	2 tgts not met	August 2014
Cancer Waiting Time Standards			SG	All met	Q2 to August 2014
Strategic Objectives					
Delayed Transfers of Care			SG	3	12-mth ave to July 2014
Readmissions			EM	8.7%	July 2014
Harm Free Care			EM	94.0%	August 2014
HIMMs Level			MB	5	August 2014
NIHR KPIs			EM	tbc	

A Healthy Organisation

Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period
Clinical Outcomes					
Never Events			EM	1	August 2014
Complaints			JG	38.2	12-mth ave to July 2014
Infection Control			JG	0 MRSA; 1 C diff	August 2014
Productivity					
Bed Occupancy			SG	92.1%	August 2014
Theatre Utilisation			SG	65.5%	August 2014
DNA Rate			SG	8.8%	April to August 2014
Workforce					
Attendance			AH	95.2%	12-mth ave to Aug 2014
Qualified Nurse Vacancies			AH	2.5%	August 2014
Mandatory Training			AH	97.9%	August 2014
Appraisal			AH	83.9%	August 2014
Turnover			AH	9.1%	August 2014
Finance					
Contract Performance			AM	3	August 2014
Expenditure Performance			AM	1	August 2014
CIP Performance			AM	1	August 2014
Capital Programme			AM	3	August 2014
Non-Core Spend			AM	8.3%	August 2014

External Validation

Indicator	Previous Rating	Current Rating	Exec Lead	Actual	Period
National Comparators					
Advancing Quality			EM	2 areas below target	May 2014
Mortality: HSMR			EM	79.7 (low ci 75.2)	June 2013 to May 2014
Mortality: SHMI			EM	1.08 (low ci 0.89)	Apr 2012 to March 2013
Regulatory Bodies					
Monitor Risk Rating - Finance CoS			AM	1	August 2014
Monitor Risk Rating - Governance			SG	Not Green or Red	Q2 Aug 2014
CQC			EM	0	August 2014
Local View					
Commissioning - Contract KPIs			SG	1	August 2014
Commissioning - CQUINS			EM	tbc	tbc
Education			AH	Level 2	June 13

integrated Performance Dashboard - Metric Thresholds

Meeting Our Vision

Indicator	Definition	Green	Amber	Red
Satisfaction Rates				
Patient Satisfaction - F&F Achievement Inpatients	Friends & Family Survey - Achievement Score : Inpatients	>=85%	>=71% to < 85%	<71%
Patient Satisfaction - F&F Net Promoter Inpatients	Friends & Family Survey - Net Promoter Score : Inpatients	+86 to +100	+65 to +85	-100 to +64
Patient Satisfaction - F&F Net Promoter ED	Friends & Family Survey - Net Promoter Score : ED	+86 to +100	+65 to +85	-100 to +64
Patient Satisfaction - F&F Net Promoter Maternity	Friends & Family Survey - Net Promoter Score : Maternity	+86 to +100	+65 to +85	-100 to +64
Staff Satisfaction (engagement)	Results from staff satisfaction survey	>=3.69	>=3.59 to <3.69	<3.59
First Choice Locally & Regionally				
Market share : Wirral	WUTH share of Wirral CCG elective hospital inpatient activity	>= 85%	>= 80% to <85%	< 80%
Demand : Referral Rates	Outpatient referrals received from all GP/GDPs - G&A specialties	>= 3% YoY variance	0% to <3% YoY	<0% YoY
Market share : Non-Wirral	WUTH share of West Cheshire GP Referred New OP activity	>=8%	>=6% to <8%	<6%

Organisational Risk Issues

Indicator	Definition	Green	Amber	Red
Key Performance Indicators				
A&E 4-hour Standard	% of patients attending ED & ADHC treated within 4 hours	>=95%	n/a	<95%
RTT '18' Week' Standard	All RTT standards met for the Trust as a whole	All met at Trust level	n/a	Not all met at Trust level
Cancer Waiting Time Standards	All Cancer Waiting Standards met for the Trust per quarter	All met at Trust level	n/a	Not all met at Trust level
Strategic Objectives				
Delayed transfers of care	Average No of patients with a delayed transfer of care at month-end	<= 4	>4 and <6	>= 7
Readmissions	% of patients readmitted non-electively within 30 days of discharge	<= 7.5%	>7.5% and <= 10%	> 10%
Harm Free Care	Compliance with Safety Thermometer definition of Harm Free Care	>= 95%	>= 93% to <95%	<93%
HIMMS Level	Current HIMMs level under Electronic Medical Record Adoption Model	5	n/a	<5
NIHR KPIs	tbc	tbc	tbc	tbc

A Healthy Organisation

Indicator	Definition	Green	Amber	Red
Clinical Outcomes				
Never Events	Number of occurences of "Never Events"	0 per month	n/a	>= 1 per month

Complaints	Number of occurences of formal complaints	<30 per month	30 to 50 per month	> 50 per month
Infection Control	MRSA Bacteremia CDIFF	0 MRSA Bacteraemia, and less than 3 cdiff cases per month	0 MRSA Bacteraemia and 3 or 4 cdiff cases per month	>= 1 MRSA Bacteraemia or > 4 cdiff cases per month
Productivity				
Bed occupancy	Average % of General & Acute Beds occupied at midday	<=85%	>85% to <95%	>=95%
Theatre utilisation	Average % of scheduled operating minutes utilised	>=85%	>=65% to <85%	<65%
DNA Rate	Percentage of booked OP appointments that DNA	<=7.5%	>7.5% to <9.0%	>=9.0%
Workforce				
Attendance	Rolling 12-month staff attendance rate	>= 96%	>=95.3% to <96.0%	< 95.3%
Non Core Pay Spend	% of total spend year to date	<5%	>=5.0% to 6.5%	>=6.6%
Qualified Nurse Vacancies	% vacant posts	<=2.5%	>2.5% to 5%	>5%
Mandatory Training	Rolling 12-month staff mandatory training rate	>= 95%	>= 85% to <95%	< 84.9%
Appraisal	Rolling 12-month staff appraisal rate	>= 85%	>= 80% to <85%	<80%
Turnover	Rolling 12-month staff turnover rate	<10%	>= 10% to <12%	>=12%
Finance				
Contract Performance	Delivering both contracted volumes and values	>=3	2	1
Expenditure performance	Delivering planned levels of expenditure	>=3	2	1
CIP Performance	Delivering a recurrent CIP in-year & deliverable future proposals	>=3	2	1
Capital Programme	A sound investment programme mainatained & resourced appropriately	>=3	2	1

External Validation

Indicator	Definition	Green	Amber	Red
National Comparators				
Advancing Quality	Combined rating	All areas above target	1 area below target	> 1 area below target
Mortality : SHMI	SHMI	Lower CI < 0.90	Lower CI 0.90 to 0.99	Lower CI >= 1.0
Mortality : HSMR	HSMR	Lower CI < 90	Lower CI 90 to 99	Lower CI >= 100
Regulatory Bodies				
Monitor Risk Rating - Finance	Monitor Risk Assessment Framework - Continuity of Service rating	4	3 or 2*	2 or 1
Monitor Risk Rating - Governance	Monitor Risk Assessment Framework - Governance rating	Green	n/a	Red
CQC	Number of concerns raised by CQC following inspections	0	1 to 2	>2
Local View				
Commissioning - Contract KPIs	Number of Quality KPIs in the contract not being achieved	<=2	3 to 4	>=5
Commissioning - CQUINs	Number of CQUINs not being achieved	0	1 to 3	>=4
Education	GMC level	Level 3	Level 2	Level 1

WUTH Performance Dashboard Exception Report August 2014

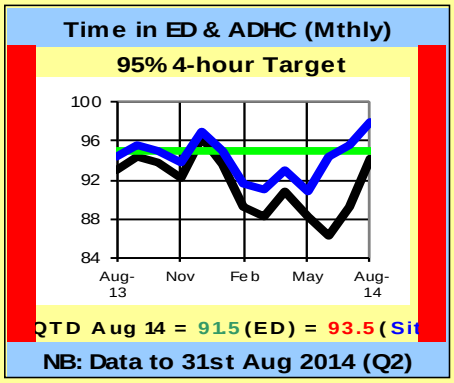
Indicator :
A&E 4-hour Standard

Rating	Target	Actual	Period
Red	>= 95%	93.5%	Q2 2014/15

Issue:

The standard is a minimum of 95% of A&E attendances being admitted, transferred or discharged within 4 hours. Performance for August was 95.5%, including the All Day Health Centre at Arrowe Park site.WUTH's ED alone achieved 94%. This makes the joint Q2 position to the end of August 93.5%.

Historic data:



Proposed Actions:

The background of continued increased demand and consultant vacancies has previously been highlighted. The health economy urgent care recovery plan has been further developed, building upon the initial findings of the Utilisation Management Team and the 'Perfect Day' initiative. This sets out a trajectory for performance against the target and is monitored weekly within the Trust and with the CCG. The recovery plan is also monitored monthly through the Urgent Care Working Group. The economy is also benefiting from Greater Manchester CSU support as we deliver against the recovery plan's milestones.

Assessing Improvement:

The difficulties with this standard are continuing. The continued collaboration of all stakeholders working together, both within the Trust and with external partners, is essential to deliver the necessary improvements.

Impact:

Patients can expect to be treated within 4 hours when attending A&E or WiCs. Waiting longer is a poor patient experience and will reflect on the reputation of the Trust. As a national target, non-achievement has Governance implications with Monitor, and financial consequences under the contract with local Commissioners.

Expected date of performance delivery:

Quarter 3 in 2014/15

Executive approval:

Sharon Gilligan, Director of Operations

WUTH Performance Dashboard Exception Report — August 2014

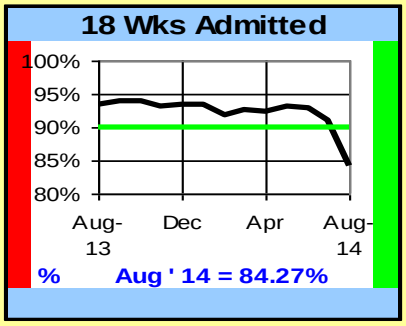
Indicator :
RTT 18 Weeks Standards

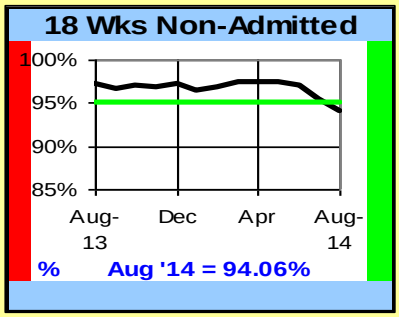
Rating	Target	Actual	Period
Red	All met at Trust level	2 targets not met	August 2014

Issue:

The Trust did not achieve the RTT standards of 90% admitted and 95% non-admitted patients to be treated within 18 weeks for the month of August. WUTH's performance was 84.3% and 94.1% respectively. This failure was anticipated as WUTH, along with many other providers, is currently undertaking additional RTT activity at the request and with funding from NHS England. This is aimed at clearing backlogs of long waiting patients, and so it is acknowledged performance may deteriorate in this period. As a result financial penalties will not be applied for failing specialties for the period of July to September. Monitor have not suspended the standards for this period, but have indicated their view of Trusts failing these standards will take into account this initiative.

Historic data:





Proposed Actions:

Continue to treat the additional RTT patients in line with the agreed NHS England plan through September. Returning to compliance with standards from October 2014 onwards.

Assessing Improvement:

There is weekly reporting to the DH/Monitor on RTT performance, plus weekly progress reports to Wirral CCG on the additional RTT activity. Internal performance management reports are long-established to track progress against all RTT standards at specialty level, and support delivery of the targets.

Impact:

Patients have an expectation, and a right under the NHS Constitution, to be treated within 18 weeks of referral. The standard is a hgh-profile target, underpinned by contractual penalties and Monitor's Risk Assessment Framework. Accessible services for patients are essential to ensure WUTH's ongoing viability.

Expected date of performance delivery:

From October 2014 onwards

Executive approval:

Sharon Gilligan, Director of Operations

WUTH Performance Dashboard Exception Report — August 2014

Indicator :
Never Event : displaced Naso Gastric tube

Rating	Target	Actual	Period
Red	Zero	1	August (reported)

Issue:

Summary of incident:
Following a Medical Emergency Team (MET) call on 16th June 2014 at 20:20, it was found that the patient's Naso Gastric (NG) tube had dislodged and the patient had aspirated feed. The patient was very unwell prior to the event, with multiple comorbidities. The patient passed away on 20th June 2014.

Proposed Actions:

Internal Alert disseminated to the whole organisation regarding the use of adult NGT pathway. RCA commenced. The pathway has been made available to print from the intra net. Annual audit to be implemented to ensure NPSA compliance with Alert 2011/PCA/002. Nutritional Nurse specialist / dieticians /critical care outreach to raise the profile of the pathway use with discussions with the ward managers. Implementation of the pathway onto CERNER ahead of going paperless in November.

Historic data:

Assessing Improvement:

Annual audit via the nursing directorate.
The RCA action plan will be monitored until closure by the CCG.

Impact:

The Trust has a target of no never events per year. The Trust reports each never event to StEIS, CCG, CQC and Monitor. The action plan will be monitored until closure by the CCG.

Expected date of performance delivery:

Expected period when turns 'Green' : April 2015

Executive approval:

Dr Evan Moore, Medical Director

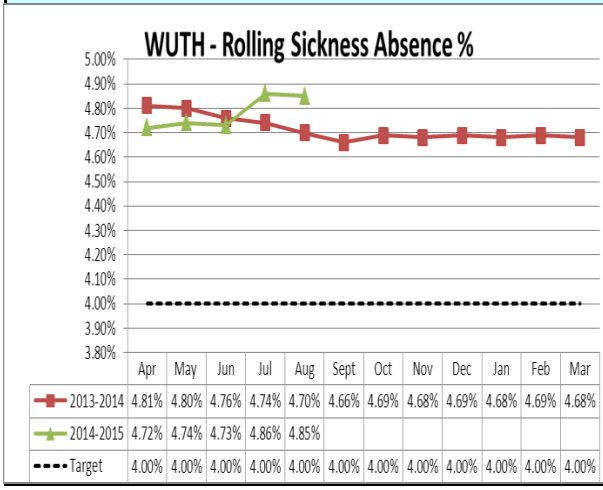
WUTH Performance Dashboard Exception Report — August 2014

Indicator :
Attendance

Rating	Target	Actual	Period
Red	>= 96%	95.15%	Sept 13 - Aug 14

Issue:
Sickness Absence rolling 12 months was 4.85% at August 2014. However the month of August was only 4.26%. This is a significant improvement over previous months figures and represents the lowest August in three years. Currently the rolling 12 months figure has only dropped marginally however continued low monthly perfomances will reduce this further.

Historic data:



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2013-2014	4.81%	4.80%	4.76%	4.74%	4.70%	4.66%	4.69%	4.68%	4.69%	4.68%	4.69%	4.68%
2014-2015	4.72%	4.74%	4.73%	4.86%	4.85%							
Target	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%

Proposed Actions:
Rewrite of policy, Validate data, Review staff on long term sick, Audit policy compliance & corrective action, Special Measures for hotspots, Health and Wellbeing Strategy, Sickness absence training, Detailed monthly reporting and associated drill down, Monthly workforce meetings (HR Managers and line managers), Individual action plans for poor attenders, Self-care scheme, Comprehensive Occupational Health Service.

Assessing Improvement:
Improvements will be monitored via monthly reporting by HR&OD to all appropriate groups including Operational Management Team, Quality and Safety and Workforce and Communications groups.

Impact:
Continued high sickness absence will impact the Trust's ability to deliver quality services and achieve objectives. High sickness absence will lead to high non core spend compromising financial position and increasing CIP pressure. Temporary staffing often cannot provide the continuity of care nor local area knowledge possessed by permenent employees this can lead to quality issues.

Expected date of performance delivery:
Q1 of 2015/16

Executive approval:
Anthony Hassall, Director of Strategy and Partnerships.

WUTH Performance Dashboard Exception Report August 2014

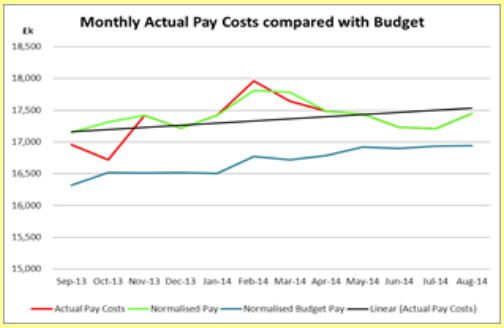
Indicator :
Expenditure Performance

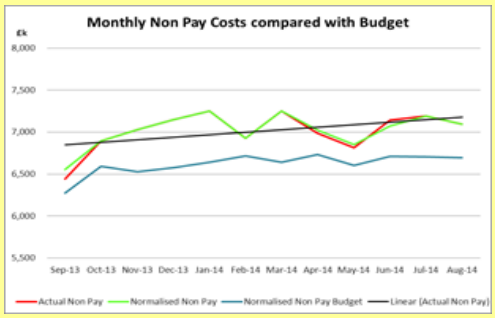
Rating	Target	Actual	Period
Red	3	1	August 14

Issue:

The underlying operational expenditure is £0.9m overspent in month against plan,which is an improvement compared to the first quarter but is a £0.2m deterioration compared to last month. The net actual I&E deficit is £1.3m, £0.1m adverse to plan. The cumulative deficit is now at £4.8m therefore there is a requirement for the financial performance to not only remain on plan for the remaining months of the year but also to recover the £0.6 adverse cumulative deficit to plan.
The overspending themes are CIP slippage of £0.3m, costs of £0.2m due to the additional RTT patients, £0.1m for the unplanned use of beds, additional emergency care costs of £0.1m and costs associated with delivering planned activity at premium rates of £0.3m offset by other pay vacancies of £0.3m and a net £0.2m on non pay.
A more modest level of reserves has been applied again this month to support the position of £0.3m.

Historic data:





Proposed Actions:

Divisional performance reviews both with the Director of Finance and the Executive team are continuing to monitor financial performance. A clear message has been provided within the organisation, emphasising the necessity for the financial position to be improved, both in terms of delivery of activity and control of costs. The following actions are to be applied across the organisation:
-There is a cessation of all non-essential expenditure;
- Where possible necessary expenditure should be delayed;
- Increases in pay costs to be curtailed wherever possible; and
• The generation and delivery of further ideas, in conjunction with FTI Consulting, in closing the financial gap.
The Trust is continuing work with FTI Consulting, who are providing assistance in improving the financial performance and in embedding deeper transformational change.

Assessing Improvement:

The divisional reviews will continue to assess performance on a monthly basis and any corrective turnaround plans will be implemented as necessary. Transformational reviews including the Corporate review together with the generation/delivery of further ideas in conjunction with FTI are to improve /recover the financial position.

Impact:

Overspending against the expenditure financial plans will put at risk the financial sustainability of the Trust for 2014/15 and beyond and have a significant impact on liquidity.
Implementation of the deeper transformational programmes together with all divisional cost management schemes will need to fully realise benefits in a timely manner.

Expected date of performance delivery:

On-going

Executive approval:

Alistair Mulvey, Director of Finance

WUTH Performance Dashboard Exception Report — August 2014

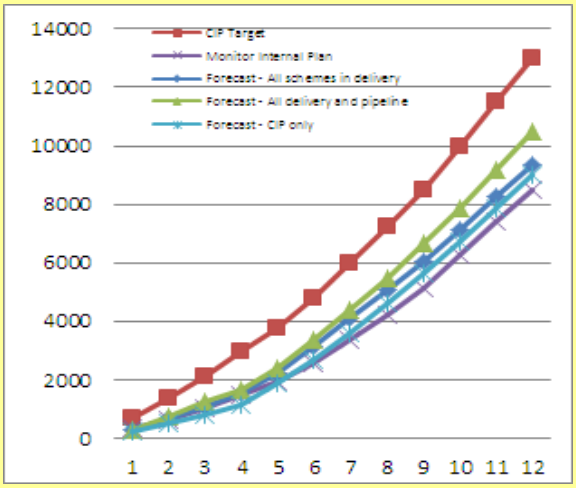
Indicator :
CIP Performance

Rating	Target	Actual	Period
Red	3	1	August 14

Issue:

There is a £4m gap between CIP target and forecast of schemes in delivery and pipeline and the pace of change remains a major risk. It is essential that the areas identified as priority are treated as such by the organisation and that TSG continues to initiate and sustain the momentum throughout the Trust.

Historic data:



Proposed Actions:

The Transformation Steering team continue to meet on a weekly basis and work continues with the support of the external FTI team to develop additional schemes in both the identified priority and existing areas. The initial feedback in August indicated a range of between £1m-2.5m recurrent effect with the in year impact as yet unidentified, although at this stage a number of schemes had not yet been quantified. A further up-date is due next week together with the early indications for 2015/16.

Assessing Improvement:

The Transformation Steering Group will continue to monitor progress of the 2014/15 delivery and further development of the plans on a regular basis both with the sub theme leaders, with the Divisions and with the Executive team.

Impact:

Failure to achieve the CIP target will put at risk the financial sustainability of the Trust for 2014/15 and beyond.

Expected date of performance delivery:

On-going

Executive approval:

Alistair Mulvey, Director of Finance

WUTH Performance Dashboard Exception Report Aug-14

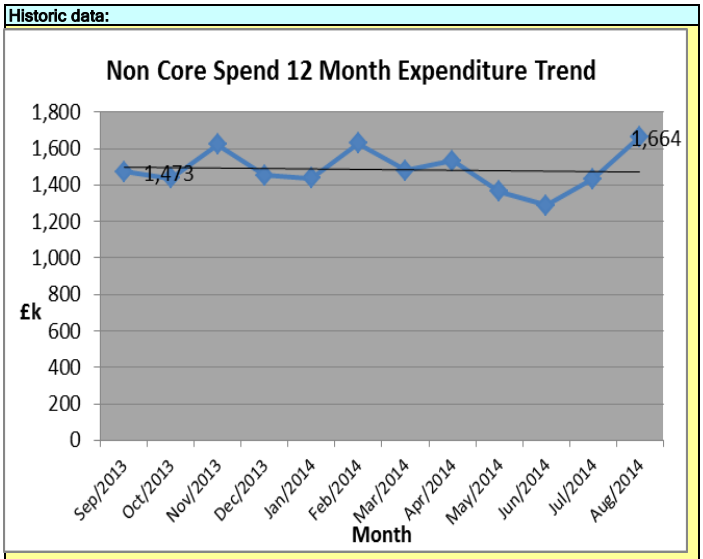
Indicator :
Non Core Pay Spend

Rating	Target	Actual	Period
Red	<5%	8.3%	August 2014

Issue:

In August 2014 £1.7m has been spent on non core pay categories. This represents 8.3% of the total pay expenditure in August. For July and August there is an increase in non core spend compared with June which was the lowest monthly spend in the last 12 months however there has been an impact on non core spend for the accelerated additional referral to treatment patients (RTT) of £259k this month. From a divisional perspective both the clinical divisions show relatively high spend with the Medicine and Acute division at a 12.5% level, Surgery/ Women & Childrens at 10.4% and the Clinical Support division is at 7.1%. All three Divisions are rated as red against the target of 5%. The operational issues requiring non core pay categoeies to be utilised are medical vacancy cover, sickness, staffing for the additional beds and the cohort ward for CPE/VRE and the extra lists/activity to support the accelerated RTT patients which is offset by additional NHS clinical income.

Historic data:



Proposed Actions:

The Workforce Strategy is focused on primarily using core pay spend however from a financial perspective the use of bank has a limited financial impact and allows staffing flexibility.
Continuation of tight control of Non-Core spend will continue in 2014/15 particularly around the impact of premium rates.
Targeted actions are in place to reduce sickness absence and for vacancy control to be managed effectively in the current financial climate. WLI rates (change from procedure rates to sessional rates) have been implemented for 2014/15.

Assessing Improvement:

Associate Director of HR&OD chairs monthly meetings with Senior managers, Finance managers and HR managers to review progress on reduction of non-core spend and further actions.

Impact:

Continued high premium non-core spend will potentially compromise the Trust's financial position. Temporary staffing often cannot provide the continuity of care nor local area knowledge possessed by permenent employees. High levels of temporary staffing can also lead to quality issues.

Expected date of performance delivery:

Ongoing

Executive approval:

Alistair Mulvey, Director of Finance

WUTH Performance Dashboard Exception Report June 2014

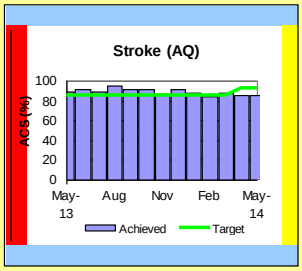
Indicator :
Advancing Quality

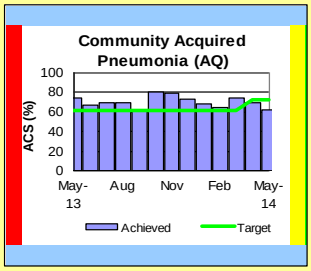
Rating	Target	Actual	Period
Red	All achieving	2 areas under target	May 2014

Issue:

The measures are composite scores, refllecting individual care to patients; the measure is a cumulative score and so lags behind improvement. Acute MI, Community Acquired Pneumonia (CAP) and Stroke services all achieved the required target scores for the year 2013-14. However as stretch targets the thresholds have been raised for 2014-15, and for May CAP and Stroke were below the required scores.

Historic data:





Proposed Actions:

AQ AMI and Heart Failure are now a standard agenda item at the cardiology business meeting, with AQ Clinical Leads proactively feeding back to colleagues. For Stroke the issue is with getting the patients onto the appropriate unit within the prescribed timescales. Pneumonia continues to have poor performance against the smoking cessation measure and an action plan is now on the risk register to address the issue. Additional training is being given in brief intervention to the wards and all the matrons are aware of the need to complete this and are working in their areas to improve. Antibiotic choice and administration times are also below expected to improve off the back of the Trust-wide sepsis campaign. An educational programme is also currently underway to raise awareness, changes are being made to Cerner to prompt CURB scoring and appropriate choice through electronic decision support; the new intake of doctors have received information at induction and we have reprinted and distributed the quick reference guide. However, due to reporting delays it is unlikely the impact of the actions will be seen before Christmas.

Assessing Improvement:

Monthly reports are provided for the Clinical Governance Group. A Missing Measures meeting is held fortnightly to identify changes in performance.

Impact:

Patients are not receiving evidence-based interventions as described by Advancing Quality. These measures are not CQUINs for 2014-15

Expected date of performance delivery:

Improvement ongoing through 2014-15

Executive approval:

Evan Moore, Medical Director

WUTH Performance Dashboard Exception Report — August 2014

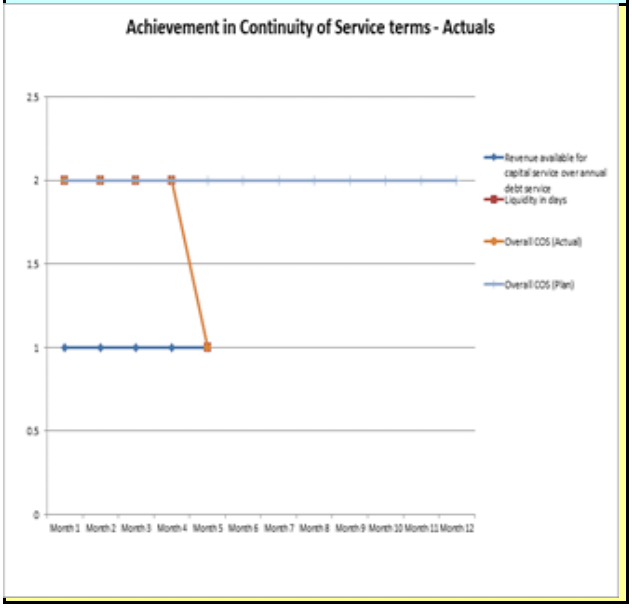
Indicator :
Continuity of Service (CoS)

Rating	Target	Actual	Period
Red	2	1	August 14

Issue:

The COS achieved in August is a 1 against a plan of 2, and while there has been an improvement to the income & expenditure position in recent, the overall CoS rating continues to be behind the planned level as a consequence of the adverse cumulative income & expenditure performance and as Springview has not yet been sold as planned. Monitor is aware of the impact of these issues on the Trusts ratios for month .

Historic data:



Proposed Actions:

Sustained improvement in the income & expenditure position is required in order to deliver the planned CoS rating. The draw down of the loan in month 6 will support the liquidity position as will the sale of Springview in October.

Assessing Improvement:

The loan has been finalised and the first tranche drawn down in September 2014. This will support the Trusts liquidity in the absence of the sale of springview until October. Improvements to expenditure and CIP positions are addressed in other exception reports

Impact:

Failure to improve the underlying financial performance of the Trust will lead to a gradual erosion of the underlying liquidity of the Trust which my result in future COS ratings also falling to a 1 and impact the Trust's ability to repay the loan.

Expected date of performance delivery:

September 2014

Executive approval:

Alistair Mulvey, Director of Finance

Board of Directors		
Agenda Item	7.1.2	
Title of Report	Finance Report	
Date of Meeting	24 September 2014	
Author	Jim Davies, Deputy Director of Finance	
Accountable Executive	Alistair Mulvey, Director of Finance	
Corporate Objective Ref as outlined in the BAF	13	
Level of Assurance		**Board Confirmation**
Full		
Data Quality Rating	Silver – quantitative data that has not been externally validated	
FOI status	Document may be disclosed in full	

1. Executive Summary

Income and Expenditure Position

The *planned* income and expenditure position for Month 5 showed an in month deficit of £1,148k, the plan being based on the expectation that the income profile for August would be amongst the lowest of the year due to a combination of annual leave and the expectation that patients may choose not to have their elective care provided in the summer period. It was also planned that expenditure levels against reduced income levels would remain broadly constant and therefore generate an in month deficit. Against the plan, an *actual* deficit of £1,288k was delivered, resulting in an adverse variance of £140k in month.

The cumulative position for the first 5 months shows a deficit of £4,779k against the planned deficit of £4,207k; representing an adverse variance against plan of £572k. In order for the Trust to operate within its full year plan, a cumulative deficit of £4.2m, the current level of deficit will need to be recovered in the remaining seven months of the financial year. The key risks to this position including:

- Continuation of current expenditure patterns;
- Increases in the scale of savings required in the later part of the financial year;
- Affordability challenges across the local health economy if income over performance persists.

In mitigating these pressures and risks the Trust is continuing its close and constructive engagement on transformational turnaround activities with FTI/Atkins and a clear message, through the Chief Executive Forum, has been provided within the organisation that given the financial position it is required that:

- There is a cessation of all non-essential expenditure;
- Where possible expenditure should be delayed;
- Increases in pay costs to be curtailed wherever possible; and
- The generation and delivery of further ideas, in conjunction with FTI, in closing the financial gap must continue through the current year and into the new financial year.

The achievement of the objectives being balanced with maintaining access targets and delivering the highest quality of care in the safest environment.

Cost Improvement Programme (CIP)

The Trust began the year with an annual CIP target of £13.0m delivery of which was a necessary requirement to deliver the overall financial plan. These savings requirements were removed from the budget position at the start of the year.

At the time of submitting the annual plan identified savings schemes were valued at £8.5m, these schemes were removed from budget in line with the profiled delivery. The unidentified balance of savings of £4.5m was removed from budgets on an equal basis throughout the financial year (£375k per month).

As at month 5 the total CIP target was £3.8m against which £2.4m has been achieved, the shortfall of £1.4m representing the cumulative impact of the schemes which are yet to be identified and therefore manifest as an overspending within the I & E position.

As noted above actions continue throughout the organisation to identify further cost reduction opportunities however these pressures represent a significant risk in the achievement of the Trusts overall financial position.

Cash Position & Continuity of Service Ratios (COS)

Despite the weaker than planned I & E performance the Trusts cash position is £7.8m better than plan, the drivers of this improvement being:

- Implementation, through the finance function, of a series of cash management actions, specifically including:
    - Earlier receipts of payments due, notably through negotiations with Commissioners
    - Stringent management of supplier payment terms
- Capital spend below plan

  It should also be noted that these positive movements more than compensate, on a cash only basis, for the delay in the sale of Springview, which is anticipated to complete in October 2014. This sale will further improve the Trusts current cash position although it should be noted that elements of the improvement are timing improvements and may therefore reverse later in the year.

  The combination of the current I & E performance and deterioration in the liquidity position due to the delay in the sale of Springview has resulted in a Continuity of Service rating of 1 in Month 5 against a plan of 2. Mitigating actions have been taken into September and it is forecast, dependent upon I & E performance, that the CoS rating will return to a planned level of 2 for September and the quarter.

  The financial position is summarised as follows:

SUMMARY FINANCIAL STATEMENT MONTH 5 2014/15 (AUGUST)						
	In Month (£000)			Year to Date (£000)		
	Plan	Actual	Variance	Plan	Actual	Variance
Operating Revenue	24,187	24,657	469	123,004	124,233	1,229
Employee Expenses	(16,944)	(17,449)	(505)	(84,489)	(86,821)	(2,332)
All Other Operational Expenses	(6,696)	(7,092)	(397)	(33,443)	(35,227)	(1,783)
Reserves	(549)	(286)	263	(3,660)	(1,398)	2,262
EBITDA	(1)	(171)	(169)	1,412	788	(624)
Post EBITDA Items	(1,146)	(1,117)	29	(5,618)	(5,567)	51
Net Surplus/(Deficit)	(1,148)	(1,288)	(140)	(4,207)	(4,779)	(572)
EBITDA %	(0.0%)	(0.7%)	(0.7%)	1.1%	0.6%	(0.5%)
Capex Accruals Basis	1,497	353	(1,144)	7,233	4,814	(2,419)
Net Cashflow	3,097	3,534	437	(3,302)	4,676	7,978
Cash and Equity (Taxpayer's Equity)	(251)	(1,288)	(1,037)	149,330	147,260	(2,070)
COS Liquidity Days	1.61	(0.91)	(2.52)	(12.18)	(14.86)	(2.68)
CIP as % Op Expense	3.4%	2.9%	(0.5%)	3.1%	1.9%	(1.2%)
Net Current Assets (Less Liabilities)	1,316	(1,002)	(2,318)	(5,442)	(5,625)	(183)
Borrowing (Loans & Finance Leases)	27	27	0	(6,080)	(6,080)	0

2. Key Issues and Analysis

The Trust has a deficit of £4.8m at Month 5 against a plan of £4.2m; this position is not sustainable going forward. The Trust is working with FTI Consulting, who are providing assistance in improving the financial performance and in embedding deeper transformational change.

For the Trust to achieve its plan for the year it will be necessary for there to be no further deterioration in the position for the remaining months of the year; and furthermore that the adverse variance reported in the first 5 months is recovered.

Divisional Analysis
The divisional analysis of the financial position is provided below:

Divisional Analysis of Income & Expenditure Position to Month 5 (August)

Detail	Acute & Medical £000	Surgery £000	Women & Childrens £000	Diagnostics £000	Corporate £000	Central £000	Total £000
Income							
Planned Income	47,281	39,208	17,303	7,587	8,691	2,935	123,004
Actual Income	48,795	38,330	16,850	8,243	8,645	3,370	124,233
Variance	**1,514**	**(878)**	**(453)**	**656**	**(46)**	**435**	**1,229**
Expenditure							
Planned Expenditure	33,429	29,571	12,158	14,791	27,984	3,660	121,593
Actual Expenditure	35,563	30,701	12,176	15,405	28,203	1,397	123,445
Variance	**(2,134)**	**(1,130)**	**(18)**	**(614)**	**(219)**	**2,263**	**(1,852)**
Variance (EBITDA)	**(620)**	**(2,008)**	**(471)**	**42**	**(265)**	**2,697**	**(624)**
Post EBITDA							
Planned Post EBITDA	0	0	0	0	0	5,618	5,618
Actual Post EBITDA	0	0	0	0	0	5,567	5,567
Variance	**0**	**0**	**0**	**0**	**0**	**51**	**51**
Total Variance to Plan	**(620)**	**(2,008)**	**(471)**	**42**	**(265)**	**2,749**	**(572)**

The above highlights that clinical divisions, with the exception of Diagnostics are reporting adverse variances to plan with these adverse variances being off set through central budgets.

At an aggregate level income continues to overachieve within Medicine and Diagnostics with under achievement within Surgical Care and Women and Children's Services.

All divisions are showing overspending positions; this includes the impact of non achievement of CIP. These costs being off set through the application of centrally held reserves.

Whilst all clinical divisions are reporting adverse positions year to date it should be noted that within Medicine, despite a cumulative deficit, there have been two successive months of surplus whilst within surgical care month on month deterioration has continued with a marked deterioration in month 5.

Overview of Aggregate Pay Position

The most significant area of expenditure for the Trust; and the most significant areas of expenditure growth in August, relates to pay. The total pay spend for August was £17.4m compared to £17.2m in the two preceding months, and a budget of £16.9m. The following figure provides further detail of the monthly and cumulative position in the year to date, and also splits expenditure between permanent (core) spend and other (non-core) spend types.

Analysis of Pay Spend

Detail	April £000	May £000	June £000	July £000	August £000	YTD £000
Budget	**16,789**	**16,922**	**16,901**	**16,933**	**16,944**	**84,489**
Pay Costs						
Permanent	15,950	16,081	15,944	15,776	15,785	79,536
Bank Staff	299	326	297	355	347	1,625
Agency Staff	318	357	311	379	537	1,902
Overtime	318	208	209	162	174	1,071
Locum	418	336	301	374	435	1,865
WLI (In Year)	180	138	170	164	171	822
Total	**17,484**	**17,444**	**17,234**	**17,210**	**17,449**	**86,821**
Variance	**(695)**	**(522)**	**(332)**	**(277)**	**(505)**	**(2,332)**
Pay Reserves	495	205	70	122	50	942
Variance (after reserves)	**(200)**	**(317)**	**(262)**	**(155)**	**(455)**	**(1,389)**

As reflected above improvements in the overall level of expenditure were seen through June and July however this improvement has not continued into August.

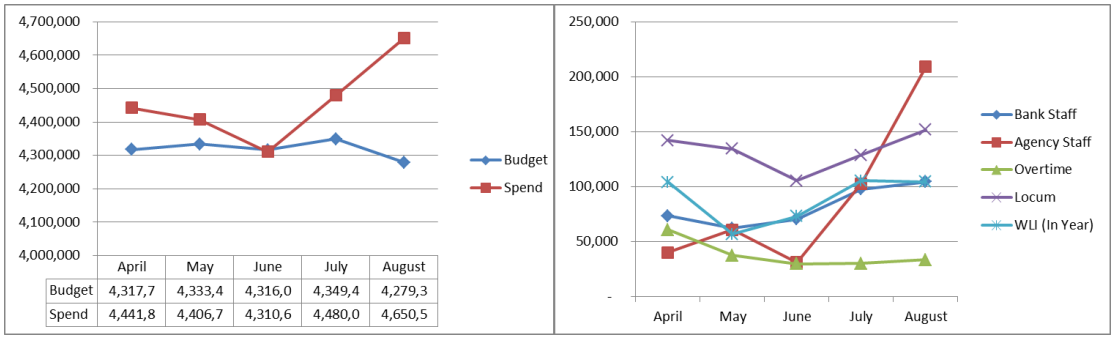
It can be seen that whilst marginal reductions in the costs associated with substantive staff have been realised there have been increases in the costs associated with the use of temporary or flexible labour. The use of flexible labour is in some instances planned and attracts additional income although in many instances are reactive and driven by service need at a point in time.

Divisional Pay Analysis
The following figures indicate for each Division;

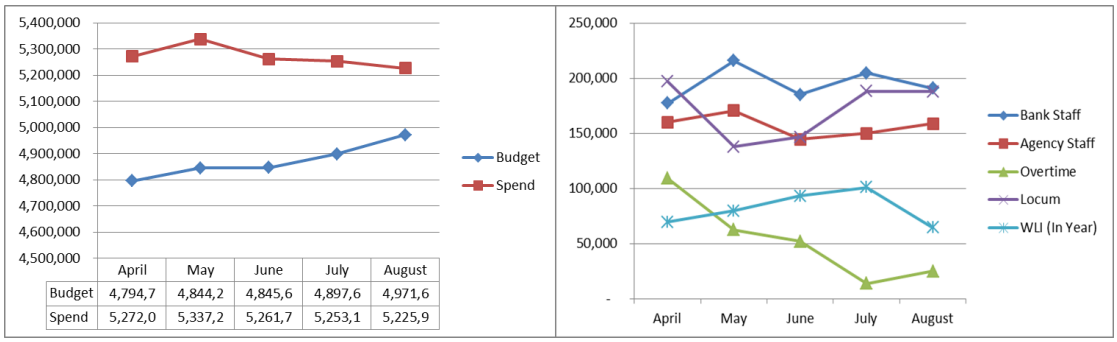
1. The trend for the first 5 months on both budget and expenditure; and
2. The split of spend by expenditure type e.g. permanent staff, bank, agency etc.

The senior management teams within the Divisions have provided further explanation and context to the respective positions, and this is included in further detail below.

Surgery

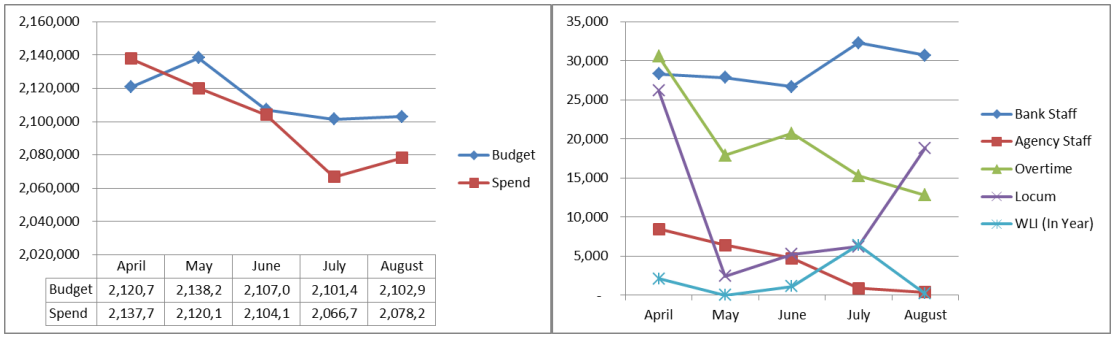


Medicine & Acute



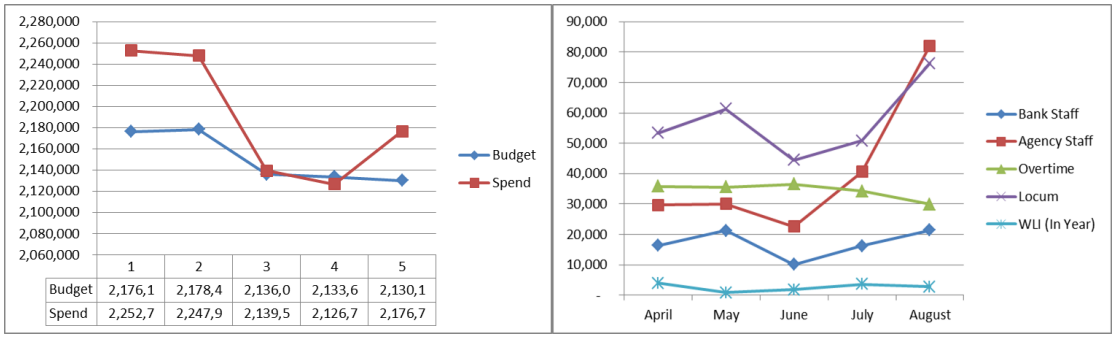
	April	May	June	July	August
Budget	4,794,7	4,844,2	4,845,6	4,897,6	4,971,6
Spend	5,272,0	5,337,2	5,261,7	5,253,1	5,225,9

Women's & Children's



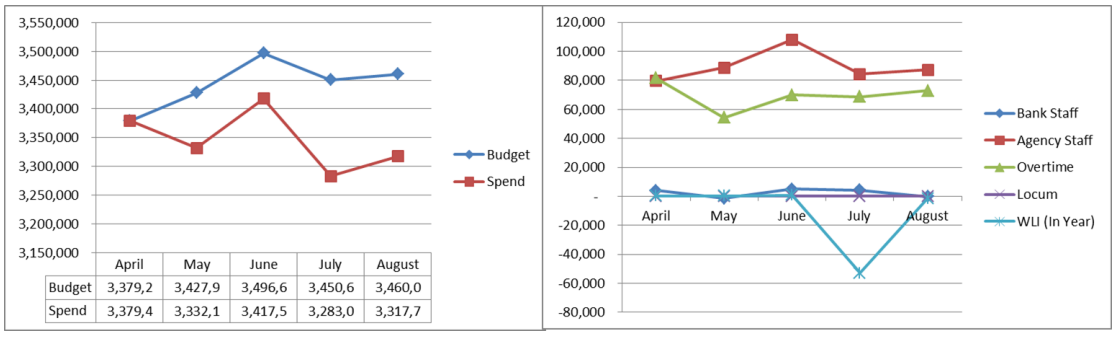
	April	May	June	July	August
Budget	2,120,7	2,138,2	2,107,0	2,101,4	2,102,9
Spend	2,137,7	2,120,1	2,104,1	2,066,7	2,078,2

Diagnostics



	1	2	3	4	5
Budget	2,176,1	2,178,4	2,136,0	2,133,6	2,130,1
Spend	2,252,7	2,247,9	2,139,5	2,126,7	2,176,7

Corporate



	April	May	June	July	August
Budget	3,379,2	3,427,9	3,496,6	3,450,6	3,460,0
Spend	3,379,4	3,332,1	3,417,5	3,283,0	3,317,7

The divisional financial performance is reviewed formally by the Director of Finance with the Assistant Director of Operations and the Principle Financial Accountant for the division on a monthly basis and through the broader monthly performance meetings held between the divisional teams and the executive team.

Key Divisional Issues

Acute and Medical Care – The division reported an £80k surplus in month 5, the second successive month within which a surplus was reported albeit the cumulative position continues to reflect a deficit against plan of £620k year to date.

Income within the division is over achieving by c£1.5m, the main drivers of this include additional volumes of activity within planned care work streams both out-patients and in-patient care (£43k and £655k respectively relating to 378 out-patient and 1,248 in-patients) and increased volumes of patients from a non elective care perspective. Non elective activity has increased by 799 patients equating to £1,124k. The Division has generated this additional non elective activity within a reduced bed base of 40 funded beds. However, Emergency Department attendances are up against plan by 583, but due to penalties imposed relating to the 4-hour breaches, the net income position for ED is down against plan by £366k.

The costs of service delivery have exceeded the planned budget by £2.1m. The most significant element of pressure relates to staff costs, c£1.5m with the balance being slippage against CIP plans and over spending against clinical supplies.

From a pay perspective, the cumulative deficit relates to:

- ED staffing, £0.5m - the Board of Directors have supported a revised staffing model; this will see the current level of overspending reduce to c£20k per month rather than the previous £100k per month. The excess costs which will persist relate to the use of temporary/locum staff whilst substantive staff are appointed, plans are in place to expedite the recruitment process.
- Gastro currently has overspending of c£350k as locum staff are required to fulfill vacant posts. It should be noted that the current over recovery of income within gastro is £360k and therefore off sets these costs. Recruitment processes are underway to fill posts substantively.
- Nursing costs – nursing budgets are currently £650k overspending of this:
    - £175k relates to staffing of additional beds opened through the preceding 5 months as patient demand and infection control and prevention measures have impacted on the core bed stock
    - £242k relates to staff sickness cover. Sickness levels were at 5.6% at their height in 14/15 and through a programme of work have been reduced to 4.19% in August, and
    - £231k relates to the provision of additional staff for Specialing of patients as a function of their acuity needs. A revised process of agreement for the use of additional staff has been implemented and seen favourable financial results in the last two months although is likely to remain a pressure moving forwards.

Pressures through non pay subjective lines include variable costs associated with clinical supplies of c£300k which are driven by over activity and therefore covered by income secured. To ensure controls and best practice processes for ordering goods is in place the divisional teams are working closely with procurement colleagues.

The division continues to work closely with the PMO and FTI to maximize delivery of CIP. Whilst the division is confident that it will achieve its target on a recurrent basis in year the division is facing a c£500k year to date pressure. All efforts continue to be focused on bridging the in year gap. A detailed forecast outrun based on current performance levels and run rates is being prepared and will be reported at month 6.

Surgical Care – The divisions overall financial position deteriorated in month 5 by £535k generating a cumulative year to date deficit of £2.0m. Within the overall deficit position expenditure variances are £1.1m year to date a deterioration in month of £459k and income under performance is currently £0.9m of which £76k was in month.

The key cumulative drivers of the overall expenditure variance include:

- £147k to support additional bed capacity, of which 81k relates to the provision of the Trust CPE cohort ward;
- £178k relates to Non-PbR excluded devices and high cost drugs, which are pass through costs and attract additional income;
- £303k relates to Park Suite underperformance, against which there is strategic agreement to identify a different PP provision, this will be supplemented with in year price changes where available. Agreement was reached at the beginning of the year that whilst this service sat within the Surgical division any associated pressure would be centrally managed;
- £276k of CIP underperformance and
- £202k WLI expenditure

The above costs, which reflect the cumulative position, were also incurred on a proportionate basis in month 5. Specifically in month 5 additional costs, covered by income, were incurred in the delivery of additional RTT activity, the direct costs of these attributable to Surgical Care were c£240k.

From an income perspective the division has cumulative under performance of £868k of which £76k was in month 5.

Whilst there are variations in income across several points of delivery and specialities the key feature within the division both cumulatively and in month relates to orthopaedic activity. Year to date orthopaedics is £728k behind plan. The division has also seen year to date under performance against non elective sources of income by £138k and out-patient income of £384k, half of which relates to penalties imposed by the CCG in relation to the follow-up cap. Favourable variances, most notably against RTT income and income streams associated with Wales go some way to mitigate these gross income pressures.

The division continues to scrutinise the detail of the orthopaedic position from both a retrospective and prospective perspective increasingly focusing on a daily and weekly basis on the volume of operations booked to ensure slots are filled and resource utilisation maximised and available capacity used for alternative services where appropriate.

The PBR orthopaedic plan was set this year based on available capacity to treat patients. Within the year there has been a significant casemix shift which means that higher volume, lower casemix cases are no longer being received into the Trust thus affecting the ability to deliver the plan.

To help mitigate the impact of this the Division approached Betsi Cadwaladr LHB to undertake cases to help with Welsh waiting time targets for both orthopaedics and ophthalmology to backfill the loss of English activity. These activities are now developing although there were some initial operational anomalies to over come. Good working between the respective organisational teams have resolved these issues and it is hoped that this will support a longer term strategic alliance for future service delivery and it is forecast that the financial benefits of this service provision will flow into future periods and within September the Division has secured another 116 orthopaedic cases to be undertaken from Betsi.

In addition to in-patient and day case pressures outpatient income remains challenging for the division. New outpatient activity decreased in August and Directorate teams are currently working on recovery plans for their individual areas to recoup lost activity. Specific pressures are being experienced in both ENT and Breast Care services and these are being interrogated in detail.

Whilst the overall divisional position remains significantly challenging the focus has been and continues to be on:

- Minimising costs where possible with engagement and support with the PMO and more recently FTI who are specifically supporting changes within theatre use and utilisation;
- Exploring, with success, new markets for the provision of services, specifically within north Wales
- Delivering additional RTT volumes where possible to underpin loss of core income and
- Ensuring prospective systems are in place for the booking of patients to allow the divisional management teams can support the maximisation of use of clinics and available in-patient resources.

A detailed forecast outrun based on current performance levels and run rates is being prepared and will be reported at month 6.

Women and Children's Services – The divisions overall financial position deteriorated in month 5 by £66k contributing to an adverse cumulative variance of £469k.

Whilst there are variations to budgets and pressures within the division across expenditure areas these largely break even with underspending in certain areas off setting underachievement of CIP of c£250k. The main driver of the divisions position relates to under recovery of income with PBR income deteriorating by £58k in month taking the year to date position to £226k behind plan mainly due to delayed commencement of North Wales gynaecology contract (622 cases in year) this drives a shortfall in Gynaecology overall of £255k behind plan YTD..

In addition PBR well baby income is £134k behind plan due to changes in case- mix coding.

The rates of deterioration in non PbR income which had been c£80k per month to month 4 slowed in month 5 with an in month shortfall of £9k contributing to the cumulative deficit of £243k this is largely relates to care provided through the neonatal unit, despite poor cumulative performance neonatal activity has improved in the past 2 months and achieved plan for the first time this year in month 5.

A detailed forecast outrun based on current performance levels and run rates is being prepared and will be reported at month 6.

Diagnostics - The Division reported an in month overspend of £10k with a cumulative underspend of £42k. Whilst at an aggregate level the division continues to deliver its financial objectives there are variations across income and expenditure components.

From an income perspective Non PbR income continues to outperform the plan being c£400k head of plan. This is driven by direct access income across a range of disciplines. Specifically radiology has experienced a 24% increase in activity resulting in a £337k income over achievement with high demand continuing in areas such as Ultrasound. Additionally Pathology income is up £84k (3.5%) although activity has dropped below budgeted levels over the last 2 months.

Whilst these income gains generate a contribution there is an affordability risk across the economy if these levels of diagnostic demand continue.

The division is reporting a favourable pay variance as it holds vacancies as it progresses its staffing restructure proposals in consultation with staff side colleagues. These savings partially off setting additional costs associated with the delivery of excess direct access activities.

Non pay budgets are c£200k over spending year to date, the bulk of these costs being variable costs associated with direct access volumes however the division is experiencing costs pressures in the provision of blood products, c£75k year to date and the drivers and users of blood products which the division supply's to the broader organisation are being interrogated in more detail.

The division remains c£400k behind its year to date CIP target and whilst this is off set through income on a non recurrent basis continues to be the greatest single risk to maintaining a robust divisional financial position. The division is working closely with FTI in exploring further opportunities which include not only tactical but also strategic opportunities across many of the divisions disciplines.

A detailed forecast outrun based on current performance levels and run rates is being prepared and will be reported at month 6.

3. Next Steps

The Trust continues to work closely with FTI Consulting, who are providing assistance in improving the financial performance and in embedding deeper transformational change. The financial performance of the divisions are being closely monitored through the monthly performance review process. A clear message has been provided within the organisation, emphasisng the necessity for the financial position to be improved, both in terms of delivery of activity and control of costs.

A detailed review and reforecasting of the full year position and performance based upon divisional forecasts and input from FTI is being undertaken to provide further detail and clarity to afford the organisation to opportunity to increasingly manage its overall operational delivery and financial plan on a prospective basis.

4. Conclusion

The in month position shows a deficit of £1,288k, against a plan of £1,148k, resulting in an adverse variance of £140k. The year to date position shows a deficit of £4,779k, which is £572k worse than planned. In order for the Trust to operate within its plan it will be necessary that the position does not deteriorate any further in the remaining months of the year; and furthermore that the Trust recovers the adverse performance for the first 5 months of the year. A clear message has been provided within the organisation as to the importance of delivering against activity plans, and in controlling and minimising costs.

5. Recommendations

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

Alistair Mulvey
Director of Finance
September 2014

Board of Directors		
Agenda Item	7.1.3	
Title of Report	Emergency Department Staffing Report	
Date of Meeting	24 September 2014	
Author	Mr Chris Oliver, Associate Director of Operations	
Accountable Executive	Dr Evan Moore, Medical Director Mrs Sharon Gilligan, Director of Operations	
Corporate Objective Ref as outlined in the BAF	2, 4, 11, 12,	
Level of Assurance		**Board Confirmation**
Concerned		
Data Quality Rating	Silver – quantitative data that has not been externally validated	
FOI status	Document may be disclosed in full	

1. Introduction and Background

This paper outlines the Medical & Acute Specialties Divisional proposal to amend and invest in medical staffing, advanced nurse practitioners and emergency nurse practitioners within the Emergency Department.

The paper details the increases in patient acuity, age and demand over the last 4 years and outline that whilst additional costs have been incurred and continue to be incurred this is not reflected within the budgetary position with the costs having been accomodated as an overspend.

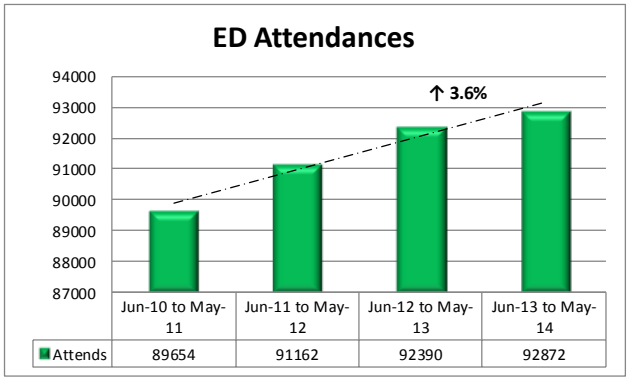
The paper proposes to 'normalise' these increases in expenditure through a revised and more bespoke staffing model, and including a diversion in current medical staff overspend into additional nurse practitioners, offering opportunities to both improve the patient experience and ability to deliver the four hour emergency standard. Whilst reducing the overall total costs and formalising the budget position to ensure costs are managed within this resource going forwards.

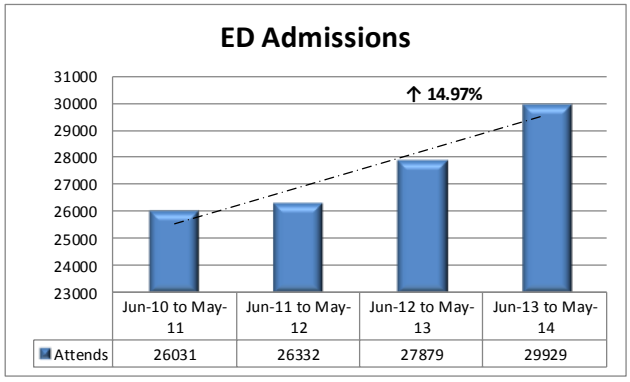
The planned spend in 2014/15 in the department under the current model is £4.768m. The revised structure (with an increase of 14.86wte) will attract a full year cost of £4.777m. Therefore whilst a budgetary adjustment is required actual spend associated with an improved normalized position with in built flexibility will only increase anticipated spend by £9k.

2. Data

Since June 2010 the department has seen a 3.6% rise in attendances to the Emergency Department (ED). Although this rise is small in comparision to a national picture, it does represent an increase of 3,218 patients over the four year period. It should also be noted that whereas elsewhere in the country the local ED may be the only provision available to patients, over this time period the Wirral has seen the opening of 3 Walk in Centres (WIC) and 7 Minor Injury Units (MIU) which have had a positive impact in diverting patients with minor presentations away from the ED, the offset is the ED is treating patients who require more complex healthcare interventions.

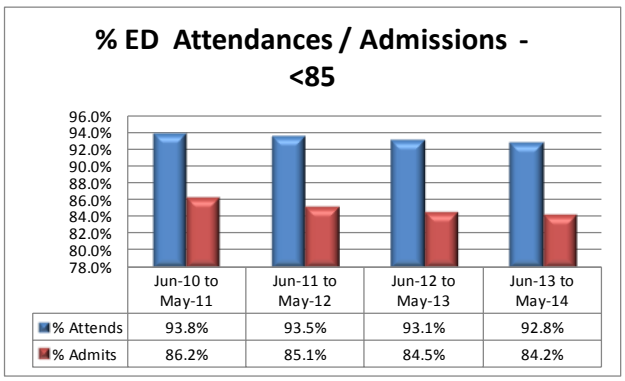
The graphs below compare ED attendances and admissions to the ED over the same time period.

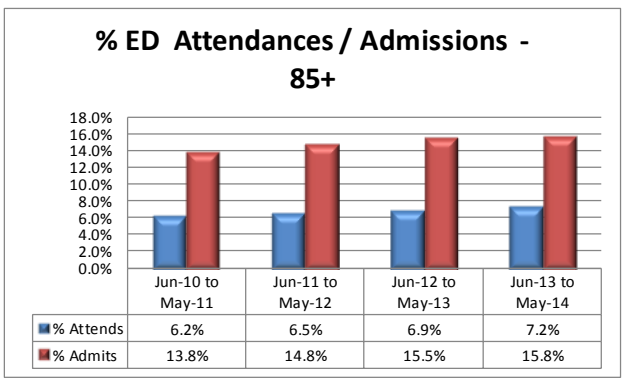




The increase of 3,898 admissions since 2010 equates to a 14.97% increase over the last 4 years. Benchmarked admission data shows that Wirral's ED does admit a higher proportion of patients than other EDs of a similar size. Explanations for this are related to the demographics of the local population, especially in the age group over 85 years and the frailty of these patients and the lack of suitable alternatives to admission available in the community.

The change in Wirral's demographics and how these impact on healthcare can be illustrated in the following graphs:



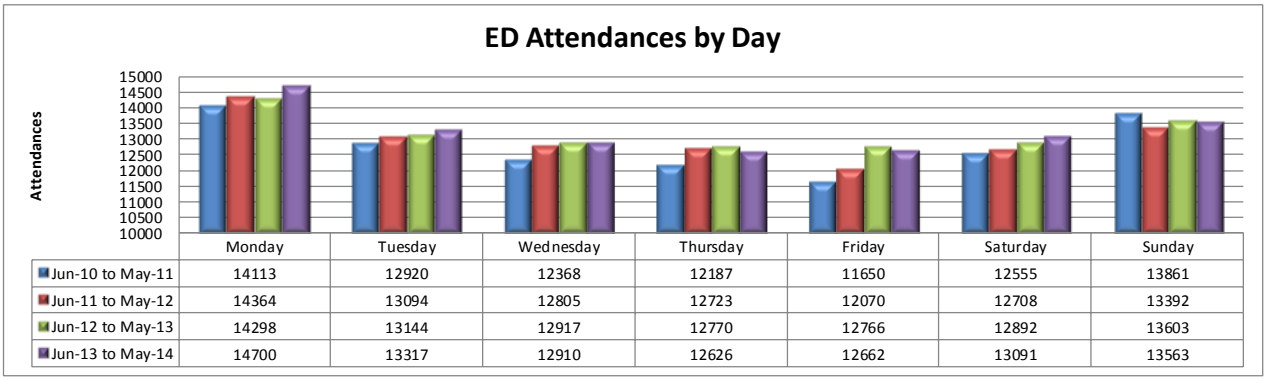


Both ED attendances and ED admissions for those patients aged over 85 years has increased.

Patients presenting at the ED are frailer, sicker and tend to have more complex healthcare needs. One impact of increasing primary care provision is that patients will be maintained in the community for longer, only presenting to hospital when in the crisis stage of health decline, this has been evidenced with increased presentations to resus and an increase in MET (Mews Emergency Team) calls for those patients admitted.

The data illustrated in table above shows a growth in both attendances and admissions for those patients aged over 85 years, whilst evidencing the 'feel' within the ED, does raise concern regarding Wirral's ability to reduce presentations at the acute site and gives an even greater reliance on the Vision 2018 workstreams.

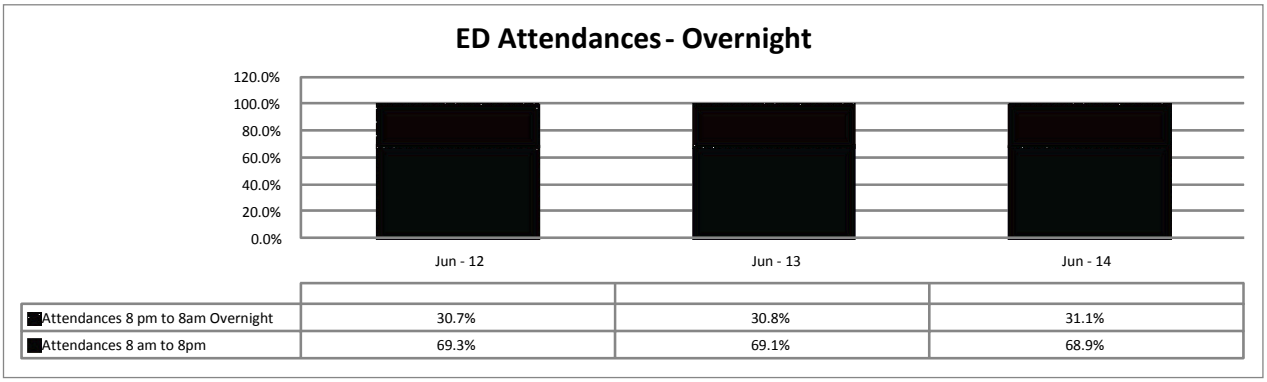
The medical model proposed has been modelled on activity by day and hour to ensure that the workforce provision is used efficiently and is able to manage the changes in presentations.



	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Jun-10 to May-11	14113	12920	12368	12187	11650	12555	13861
Jun-11 to May-12	14364	13094	12805	12723	12070	12708	13392
Jun-12 to May-13	14298	13144	12917	12770	12766	12892	13603
Jun-13 to May-14	14700	13317	12910	12626	12662	13091	13563

The table above illustrates the changes in daily presentations; however it is also key to reviewing changes in presentation during the overnight period. Historically this is a period when medical staffing reduces significantly.

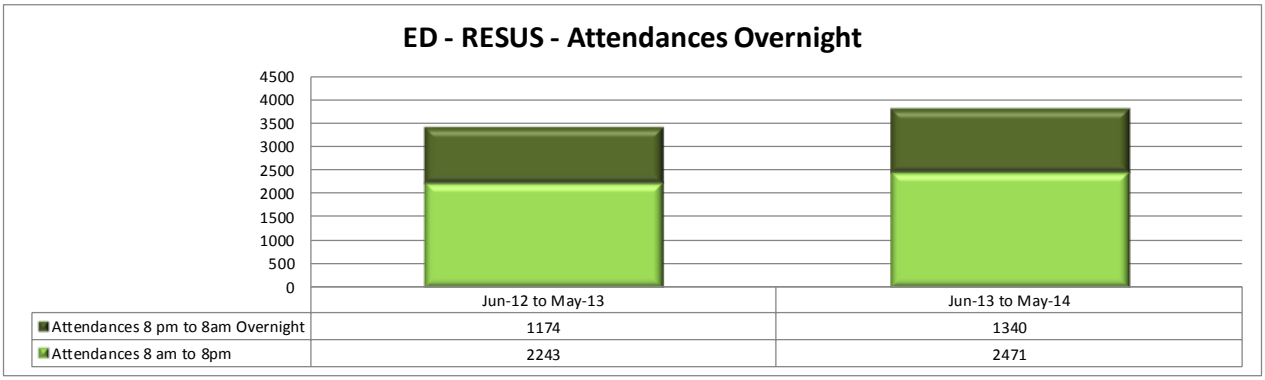
The graph below illustrates a small increase in overnight presentations to the ED.



Attendances 8 pm to 8am Overnight	30.7%	30.8%	31.1%
Attendances 8 am to 8pm	69.3%	69.1%	68.9%

Daytime (8am – 8pm) presentations have increased over the last 3 years by 1.16%, whereas at a time when medical numbers reduce the department has seen overnight (8pm – 8am) presentations increase by 3.50%, with a 1.44% (413 patients) increase in the last year.

Medical and nursing leads within the department have voiced concern not only with the increase in overnight attendances but also the acuity of these presentations.



	Jun-12 to May-13	Jun-13 to May-14
Attendances 8 pm to 8am Overnight	1174	1340
Attendances 8 am to 8pm	2243	2471

Within the last 12 months there have been an additional 166 patients transferred to resus overnight. Although not large in number, this increase places a considerable strain on the department in terms of patient flow and ensuring junior doctors are able to discuss cases with the one SpR on duty overnight.

The increase seen during the daytime for resus capacity has increased by 10% (228 patients) during the last year whereas overnight demand has increased by 14% (166 patients).

3. External Influences

As part of the economy's Vision 2018 work programme the health economy is expecting to see a reduction in ED attendances, as well as admissions; with the consequence of a reducing inpatient bed base. However, there is little evidence of any attendance / non elective admission avoidance schemes which have had a material impact on the hospital to date – although the Better Care Fund proposals continue to be developed and iterated. It is against this background that the current medical model has been reviewed to provide a redesigned workforce plan that will future proof the department, but offer flexibility should these aspirations begin to have an impact through revising the need for the number of locum shifts built into the new model.

Over the last two years, the department has had two major reviews. The first review was undertaken by ECIST (Emergency Care Intensive Support Team) with the second review undertaken by the GMCSU (Greater Manchester Commissioning Support Unit). As well as focusing on the ED both reviews also made recommendations regarding patient flow across the hospital. The reviews have now assisted the economy in producing Wirral's first cross organisation (health and social care) urgent care recovery plan. One of the main improvement recommendations is the introduction of the SIFT (Senior Intervention at First Treatment) model of care into the ED. Introducing SIFT enables patients upon arrival at the ED to be assessed by a senior doctor who will commence a treatment plan, order diagnostics and if a patient requires additional community based care this can be arranged in a timely manner. The proposed workforce model will enable the sustainable delivery of SIFT to match patient demand.

4. Financial Position

As noted earlier within the paper, the ED budget has been overspent against the medical staffing element of the budget for over 4 years. During this time the only investment has been for inflationary increases.

The table below illustrates the yearly increases in overspend; with last year (2013/14) overspend totalling £1.3m on ED medical staff. In part this overspend has been to cover gaps in the Consultant rota whilst a large proportion has been to employ medical staff at premium costs to ensure patient safety and enhance patient flow.

Since 2011, actual expenditure has increased by £1.3m (43%) against a budget increase of £115k (4%). However, individual budget lines have seen invesment and disinvestment over these years. This is most noteable between the consultant and staff grade / SpR budget lines, as illustrated within the table below.

Consultants				Staff Grade/SpR				F2s				All Medical Staff			
Year	Budget	Actual	Variance	Year	Budget	Actual	Variance	Year	Budget	Actual	Variance	Year	Budget	Actual	Variance
	(£)	(£)	(£)		(£)	(£)	(£)		(£)	(£)	(£)		(£)	(£)	(£)
2011	957,194	1,171,467	(214,273)	2011	1,046,089	798,502	247,587	2011	1,005,193	1,143,253	(138,060)	2011	3,008,476	3,113,221	(104,745)
2012	1,246,336	1,312,431	(66,095)	2012	848,608	847,555	1,053	2012	970,822	1,334,983	(364,161)	2012	3,065,766	3,494,968	(429,202)
2013	1,264,139	1,518,297	(254,158)	2013	847,826	1,018,559	(170,733)	2013	965,537	1,304,108	(338,571)	2013	3,077,502	3,840,964	(763,462)
2014	1,230,933	1,773,853	(542,920)	2014	858,084	1,186,291	(328,207)	2014	1,034,013	1,488,293	(454,280)	2014	3,123,030	4,448,438	(1,325,408)

5. Redesign Of Workforce & Additional Investment

Changes to demand and acuity of demand show that the current workforce model within the Emergency Department is primed for redesign to ensure a more responsive intervention on the patients' journey within the ED.

The proposed redesigned workforce and rota will provide a sustainable medical workforce model, which has been benchmarked against Trusts of similar size. It should be noted that there will continue to be a requirement to employ Trust locum or agency medical staff to complete the proposed workforce model, due to the reduced number of medical trainees and the high national vacancy level of emergency medicine positions. The proposed model makes allowance for this need to use workforce resource flexibly.

The emergency department has had a high success rate of recruiting nurses and this has been taken into consideration in the proposals to increase the numbers of qualified ANP and ENPs which will minimise the time delay to full delivery of the workforce model.

The department currently has 2 wte consultant posts advertised, the initial response has been very encouraging with two excellent candidates having applied.

In summary the redesigned model requires the following workforce:

	Current Budget		New Requirement		Additional Requirement	
	wte	£	wte	£	wte	£
Consultant	10.62	1,245,046	10.00	1,172,360	(0.62)	(72,686)
Cons CSL	0.10	7,524	0.10	7,524	0.00	0
Cons Prem (Flexible workforce)			0.50	125,549	0.50	125,549
Staff Grade	4.00	307,320	4.00	307,320	0.00	0
SPR	8.00	556,800	8.00	556,800	0.00	0
SpR Locum (Flexible workforce)			2.33	327,300	2.33	327,300
SHO/CF	18.00	1,112,535	24.00	1,382,400	6.00	269,865
SHO/CF Locum (Flexible workforce)			2.13	199,430	2.13	199,430
Medical sub total	**40.72**	**3,229,225**	**51.05**	**4,078,683**	**10.33**	**849,458**
ANP	2.48	149,213	4.55	265,001	2.07	115,789
ENP	5.12	290,197	7.58	434,057	2.46	143,860
ANP/ENP sub total	**7.60**	**439,410**	**12.13**	**699,058**	**4.53**	**259,649**
Total Requested via this Business Case	**48.32**	**3,668,635**	**63.18**	**4,777,741**	**14.86**	**1,109,107**

The overspend on ED medical staff in 2013/14 was £1.3m.

The current forecast overspend for ED medical staff in 2014/15 is £1.1m. As illustrated above the redesigned medical staffing element requires investment of £849k. However, to fully benefit from nurse led services as recommended by the GMCSU a further £260k is required to expand and develop the advanced nurse led services.

The department is confident that it will be able to fill the Consultant establishment with substantive posts during 2014/15, removing the need for agency or locum staff to fulfill the basic ten person rota. However, agency rates have been built into the Consultant requirements for the weekend 12 noon until 9pm shift, which is currently not in the ten person job plans. From a Deanery perspective it is unlikely that Wirral will obtain additional SpR or F2 posts and therefore agency and locum rates have been factored into this establishment, noting the flexible workforce element in the table above.

The above model provides increased senior cover during the overnight period for both medical, ANP and ENP capacity. The model will then enable the ENPs to effectively manage the 'minors' workstream with minimal F2 input, whilst the increased presence of ANP and senior medical staff (non Consultant) will enable one senior to be present in resus (if required) whist another senior is able to ensure that patients in 'majors' continue to have senior review and discharge/admission plans produced, as well as providing additional support to junior medical staff.

In addition to the forecast expenditure overspend of £1.1m in 2014/15 the Trust is also incurring fines from the CCG for patient breaches of the four hour access standard, for quarter one the penalties have totalled £239k. The number of patients who waited longer than four hours within the ED during quarter 1 was 2,716 or 11.45% of all quarter one ED attendances at a Trust level only, not including the Walk in Centre activity. The total number of breaches which occoured as a result of an ED medical delay within quarter 1 were 1,046 patients or 39% of all quarter one breaches. It is expected that the revised model will eliminate breaches attributed to ED delays.

The department has just undertaken a second nursing BEST (Baseline Emergency Staffing Tool) acuity review following the first review which was undertaken in 2012. It is envisaged that the latest review may require additional funding to nursing establishments based on the changes illustrated within the data above and the outcome of the BEST review. The BEST acuity data is currently being reviewed with the assistance of the Royal College of Nursing and as such it is not envisaged that a submission for additional funding will be made in 2014/15, but may need to be addressed in 2015/16. The potential increase is noted within this paper to ensure the Board of Directors is aware of the potential need for investment in ED nursing above the ANP and ENP levels included within this paper, but which will be considered as part of the annual and operational planning process in 2015/16.

6. Outcomes

The workforce model described above would, in line with benchmarked data, match most Emergency Departments of Wirral's size. It is envisaged that through a fully substantive Consultant rota, consistent senior leadership will improve with the sustainable delivery of SIFT, as recommended by ECIST (Emergency Care Intensive Support Team). The increase to the junior doctor and ENP numbers will see waiting times reduce which should have the impact of enhanced clinical care, improved patient experience, better patient flow and sustainable achievement of the 4-hour access target. This investment in substantive staff would allow the robust and continual running of 'see and treat' and SIFT (Senior Intervention First Treatment), which would support a sustained improvement in performance. All the above will also be delivered within a balanced budget unless recruitment is prolonged or sickness increases.

The proposed staffing model is also supported by the redesign and resulting layout of the department. On completion of phase 1 the original minors area was redeveloped into the hub; this coupled with the redesign of the resuscitation area to provide four further cubicles will improve patient flow throughout the department. The layout of the hub area will then allow for greater emphasis on nurse-led services and potential collaboration with the Community Trust as the Trust develops the concept of a 'single front door' for all urgent care services on the Arrowe Park site.

Outcomes to be measured are:

- Ensure Wirral continues to be placed within the top five Trusts nationally for FFT
- The main themes of the complaints within the ED are:
  - Waiting time to be seen
  - Communication

  The expansion of the workforce will have a positive impact on these complaint themes, with waiting times reduced, increase in medical staff able to discuss concerns with patients / relatives.

- The investment will allow for the sustainable delivery of SIFT, which will ensure that patients medical treatment plans are commenced on arrival to the ED
- Although the investment in workforce will reduce waiting times for patients within ED, it will not resolve all of the economy wide issues which hinder compliance with the 4-hour access standard. However, breaches of the four hour access standard due to ED delays will be removed.
- The investment within medical staffing will see the department deliver a balanced budget against the medical element.

7. Conclusion

The current medical workforce within the Emergency Department is not fit for purpose. The proposed model provides a workforce that matches benchmarked Trusts is aligned with the recommendations from GMCSU review and is supported by the Clinical Service Lead for Emergency Medicine and will deliver the above outcomes.

8. Recommendation

The Board of Directors is asked to formally support the revised model and associated investment required, notwithstanding that this investment is currently being incurred as part of departmental overspend to budget, following the fuller discussion undertaken at the Directors Development Day in August 2014.

Board of Directors		
Agenda Item	7.2	
Title of Report	Report of the Audit Committee – 4 September 2014	
Date of Meeting	24 September 2014	
Author	Cathy Bond, Chair of Audit Committee	
Accountable Executive	Alistair Mulvey, Director of Finance	
Corporate Objective Ref as outlined in the BAF	All	
Level of Assurance		**Board Confirmation**
Full		
Data Quality Rating	N/A	
FOI status	Document may be disclosed in full	

Context

The membership of the Audit Committee changed as a result of the Governance Review approved by the Board in July. To ensure that the Committee was able to function effectively, a pre-planned induction session was undertaken with new members and the Associate Director of Governance with a further induction session planned for the Audit Committee in December 2014 to take account the changes made by the HFMA this year.

Internal Audit

Limited Assurance received on the Decontamination Report. Assurance sought that the risks associated with the limited assurance rating had been mitigated and that these were progressing in a timely manner. A further update is to be provided at the Audit meeting in December 2014.
The Committee requested a summary of recommendations and management actions for the current year to provide assurance that all actions were being progressed appropriately.

External Audit – Technical Update

Key highlights included a review of the quality accounts process; the "off payroll" payments process; the consultation on the annual reporting cycle for 2014/15 and compliance with Group Reporting requirements

Anti-Fraud Update

A review of the current investigations and referrals to date was undertaken. The Committee challenged when the HR policies and processes were adequate to enable the right action to be taken in relation to fraud. A review of the Anti-fraud policy requested in relation to anonymous allegations and alignment with the whistleblowing policy sought.

Board Assurance Framework

The Committee requested that the sub-committees and the Executives undertake some further work to improve the development. This included a review of the potential assurances; positive assurance and definition of risks to move then from generic in nature to more specific. The Sub-committees are also asked to consider how they would prioritise the risks within the framework for consideration at the next Audit Committee.

The Committee agreed that future reviews of the BAF would include an assessment of how the Board sub-committees gain their assurance as part of their own review process. The outcomes of this work will inform the Audit Committee's annual review of effectiveness.

The Committee noted the inclusion of the risks associated with legislative compliance which was an action arising from the Board.

A further development session for the Audit Committee on the Board Assurance Framework is to be undertaken with MIAA in October 2014.

Monitor Licence – Compliance Review

The Committee noted the report and requested that further detail be included to reflect the issues identified with agreement to the Urgent Care Recovery Plan and adherence to trajectories.

Review of Audit Committee Workplan

The Committee revised the workplan for 2014/15 in line with the HFMA recommendations

Quarterly Financial Assurance/Losses and Special Payments/Waivers and Use of the Seal

The Committee was assured with the progress made on debtor balances over £5,000 and over 6 months old which specifically included progress on agreements reached with Clatterbridge Cancer Centre and Wirral Community Trust.

The Committee noted the two instances on the use of the seal since May 2014.

Cathy Bond
Audit Committee Chair

Board of Directors		
Agenda Item	7.3	
Title of Report	Report of the Quality and Safety Committee	
Date of Meeting	24 September 2014	
Author	Dr Evan Moore, Medical Director Dr Jean Quinn, Non Executive Director/Chair of Quality and Safety Committee	
Accountable Executive	Dr Evan Moore, Medical Director	
Corporate Objective Ref as outlined in the BAF	1, 2, 3, 4, 5, 6, 8, 10, 12, 14, 15	
Level of Assurance		**Board Confirmation**
Full		
Data Quality Rating	Silver – quantitative data that has not been externally validated	
FOI status	Document may be disclosed in full	

Report of the Quality and Safety Committee

10 September 2014

The meeting was quorate and began on time.

3 Chair's Business

Chair explained actions going on across Wirral to identify and prevent Child Sexual Exploitation and comply with national standards. The Chair also updated on End of Life Care work and the Trust's plans to sign up to Safety First initiative.

4.1 Patient Story

The Head of Patient Experience relayed a patient's reflection upon her hospital experience, which gave a patient and clinical emphasis to the meeting. This story relayed a two day stay with a number of waits and delays, particularly on the Surgical Assessment Unit. The Committee is aware of the issues with this service and cross referenced this to the Emergency Surgeon Business Case approved by the Finance Committee of the Board of Directors.

4.2 Annual Concerns and Complaints Report 2013/14

The Head of Patient Experience presented the Annual Concerns and Complaint report. The improvement in response times and the reduction in new complaints and PALS concerns were welcomed. The Committee asked that its thanks to all staff be noted. The Chair asked about our communication training and whether we needed to repeat this.

Assured

4.3 CLIPPE Report Quarter 1 Summary

The Committee reviewed the synopsis of the Quarter 1 CLIPPE and the changes to the Action Log as a result. Of particular concern was the use of Ward 1 as an inpatient area. The Associate Director of Nursing for Surgery described the actions underway to address this, which will be reported back through the Clinical Governance Group. The Chair asked for further information at the next meeting around the use of additional beds on Ward 26.

Assured

5.1 Workforce Dashboard

The Director of Strategy and Partnerships presented the Workforce Dashboard, focusing on attendance management especially special measures. Of particular note was the increase in percentage of overall shift fill rate combined with a decrease in the use of agency staff and the number of additional shifts requested. The Director of Strategy and Partnerships explained the impact of work currently underway to address the Trust's financial stability had affected staff morale which is reflected in the poor score in the Staff Friends and Family Test.

Assured

5.2 Mandatory Training Frequency Change

The Director of Strategy and Partnerships presented a detailed piece of work which reported the types and frequency of mandatory training required. This produces the correct focus and frees up front line staff time.

Assured

5.3 Staff Friends and Family Test – Quarter 1 Results

The Director of Strategy and Partnerships presented the results of the Staff Friends and Family Test. These had previously been discussed as part of the Quarter 1 Workforce Dashboard. The actions to address poor scores were detailed and discussed.

Assured

6.1 Clinical Quality Dashboard

The Committee noted the ongoing improvement in both HSMR and SHMI. The Associate Medical Director explained the work ongoing in relation to weekend mortality which is progressing through the Clinical Governance Group. The Committee noted the improvements in AQ performance especially heart failure. The Committee also noted the issues with the pharmacy robot.

The Committee noted the increase in STEIS reporting and cross referenced this to 6.1 which described the increase in STEIS categories. The ongoing decrease in falls was noted; however, the increase in falls with harm was noted. The Associate Director of Nursing described the work ongoing to address this. The improvements with Grade 2 pressure ulcers, VTE readmission and medication prescribed to patients recorded as allergic were also noted.

The Committee noted the excellent Friends and Family performance. The Head of Patient Experience explained the planned move from net performance score by NHS England. The improvement with patient assistance with eating and drinking was welcomed.

The Associate Medical Director described a recent and very disappointing Never Event. The Committee noted a very unfortunate neonatal death and resolved to ask the Division at their November attendance regarding this and preparation and resourcing of the Welsh Neonatal work.

Assured

6.2 Quality Impact of Cost Improvement Programme Report

The Medical Director presented the Quality Impact of Costs Improvement Report and identified a number of metrics which it felt would need to be monitored in its next report; pressure ulcers (grade 3 and 4), cancelled operations and cancelled out patient appointments.

Partial Assurance

7.1 Accountable Officer Controlled Drugs Report

The Director of Pharmacy and Medicines Management presented the Annual Accountable Officer Controlled Drugs Report; no concerns around control of controlled drugs had arisen in year.

Assured

7.2 Infection Prevention Strategy

The Project Director for Infection Control described the Trust's strategic approach to create the plans to deal with the increasing problem of multi-drug resistant organisms. This work is being undertaken by the Infection Prevention Steering Group which will provide assurance to the Quality and Safety Committee through the Clinical Governance Group.

Assured

7.3 Infection Prevention and Control

The Associate Director of Nursing for Infection, Prevention and Control presented an update to the Committee in relation to our current infection, prevention and control status. Performance around MRSA and C difficile is acceptable; however, a lot of ongoing work is required to achieve this, whilst CPE and VRE levels remain very concerning. Detail around the work ongoing to address these multi-drug resistant organisms was provided and discussed by members of the Committee, particularly in relation to preventative measures and maintenance of the ward environment.

Assured

7.4 Francis Report: Hard Truths Commitment: Publishing of Staffing Data: July 2014

The Associate Director of Nursing for Surgery presented the Nurse Staffing report for July 2014 which assured the Committee that safe staffing levels had been monitored across the Trust for the month. The process used to achieve this was discussed as was the possible implications of the flexibility needed to achieve these numeric ratios.

Assured

7.5 Annual Claims Report

The Medical Director presented the Annual Claims report and briefly the actions underway to address this. The Committee was disappointed to note the increase in number and costs of claims in the past year.

Partial Assurance

7.7 Compliance with CQC Registration

The Associate Medical Director described the work up to date regarding case note entry compliance with CQC standards which have improved over the past twelve months. However, within this areas of good and less good performance were noted.

Assured

7.8 Health and Safety Quarter 1 Report

The Director of Strategy and Partnerships presented the Quarter 1 Health and Safety report this detailed report provided assurance to the Committee that all issues had been identified and the progress made with addressing them. The recent external inspection by HSE which provided additional assurance was also referenced. The Committee asked the Director of Strategy and Partnerships to pass its appreciation to Peter Bohan for this work.

Assured

7.9 Quality Governance Framework

The Associate Director of Governance presented a review and update of the Quality Governance Framework and was keen that elements not yet completed were carried out (4A, 4B and 4C).

Partial Assurance

9.2 Items for the Risk Register

There were no items for the Risk Register.

9.3 Recommendations to the Board

Other than the assurances within the report no additional recommendations were made to the Board of Directors. However, the Committee Chair noted that significant bed pressure had been a theme throughout the meeting.

Board of Directors		
Agenda Item	8.1	
Title of Report	Risk Management Strategy and Policy	
Date of Meeting	24 September 2014	
Author	Maryellen Dean, Associate Director of Risk	
Accountable Executive	Evan Moore, Medical Director	
BAF Reference	All	
Level of Assurance		**Board Confirmation**
Full		
Data Quality Rating	Silver – quantitative data that has not been externally validated	
FOI status	Document may be disclosed in full	

1. Introduction

In line with the Trust's scheme of delegation, the approval of the Risk Management Policy and Strategy is reserved for the Board.

The attached Strategy and Policy highlights the changes made as part of this year's review. The changes reflect the current processes for managing risks and incidents in the Trust. It also reflects the new types of risks that have been assigned to the risk register in order for risks to be managed by the appropriate level of management.

It should be noted that the process for managing risk will continue to be reviewed in the coming year to reflect the issues raised in the Annual Risk Report and the new governance structure.

2. Assurance Process

The Clinical Governance Group has reviewed the changes to the Strategy and Policy and has recommended approval by the Board.

In line with recent changes to the Governance Process, the recommendation for the future review is as follows:

- The Clinical Governance Group review the policy on an annual basis and make recommendations for improvement

- The Quality and Safety Committee determine the level of assurance provided by the Strategy and Policy

- The Board approve the Strategy and Policy

3. Recommendations

The Clinical Governance Group and the Executive recommend the Risk Management Strategy and Policy for approval by the Board of Directors.

Policy Reference: 041

RISK MANAGEMENT STRATEGY and POLICY

Version: 4.6

Name and Designation of Policy Author(s)	Dr Evan Moore, Medical Director
Ratified By	Board of Directors
Date Ratified	TBC
Date Published	TBC
Review Date	27th March 2016
Target Audience	All staff.
Links to Other Strategies, Policies, Procedures, etc	Risk Management Strategy Maternity Services Trust Policy 023 – Concerns and Complaints Handling Trust Policy 041a – Incident Reporting and Management Policy & Procedure Trust Policy 041d – Learning From Experience Policy Trust Policy 108 – Claims Handling Policy & Procedure Trust Policy 118 – Health and Safety Policy Trust Policy 174 – Raising Concerns Policy

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1 Introduction

Wirral University Teaching Hospital NHS Foundation Trust (the Trust) recognises that healthcare provision and the activities associated with caring for patients, employing staff, providing premises and managing finances are all, by their very nature, activities that involve a degree of risk. These risks are present on a day to day basis throughout the Trust.

The continued delivery of high quality healthcare requires the identification, management and minimisation of events or activities which could result in unnecessary risks to patients, staff and the public. The management of risk is therefore a key organisational responsibility and is the responsibility of all staff employed by the Trust.

The Trust acknowledges its legal duty to safeguard patients, staff and the public. There are also sound moral, financial and good practice reasons for identifying and managing risks. Failure to manage risk effectively can lead to harm, loss or damage in terms of both personal injury but also in terms of loss or damage to the Trust's reputation; financial loss; potential for complaints and litigation.

The Trust is committed to ensuring the safety of patients, staff and the public through the integrated management of all aspects of governance and risk. Good governance, i.e. the way that the organisation is directed, controlled and held to account, is at the heart of controlling risk in any organisation. The Trust has adopted an integrated approach to the overall management of risk irrespective of whether risks are clinical, organisational or financial and risk management is embedded within the Trust's overall performance management framework and links with business planning and investment.

As the accountable officers, the Board of Directors have overall responsibility for corporate governance including quality and safety and risk management within the Trust and they have legal and statutory obligations, which demand that the management of risk is addressed in a strategic and organised fashion to ensure that risks are eliminated or reduced to an acceptable level. In view of the statutory duties placed on the Trust and the Accountable Officers of the Trust, the pace of change in the NHS and the growing assurance agenda, it is important that staff are empowered to manage risk at a local level wherever possible and that clear arrangements are in place to escalate risk issues when it is appropriate to do so. This will ensure that risk is managed at an appropriate level in the Trust and ensure that unreasonable delays are avoided.

The increasing numbers of recommendations from the National Patient Safety Agency (NPSA) and National Institute of Health and Clinical Excellence (NICE), developments in information governance, Care Quality Commission (CQC) Regulations are all factors which require the Board of Directors to consider and regularly review the organisational arrangements for integrated governance and risk management.

This strategy is an "umbrella" document covering all aspects of risk management within the Trust. The Trust already has a number of related specialist strategies, policies and procedures related to risk management which should be read in conjunction with this strategy where applicable, particularly the Trust's Risk Management Strategy for Maternity Services

2 Purpose

Risk management is about focusing upon experiences and learning, in order to improve clinical outcomes, achieve Trust objectives, improve the working environment, assess and where possible, anticipate risk and also eliminate or reduce risk or harm. The purpose of this document is to define the strategic direction and policy for risk management in the Trust. It describes the framework and the method that the Trust will use to identify, manage and reduce the risks (actual or potential) which exist within the Trust and its environment and provides clear direction on which to base all future risk management initiatives.

3 Scope

This document sets out the strategy for the continued development of risk management throughout the Trust and the policy to implement it. The document applies to all staff working in or on behalf of the Trust in other environments. It also applies to non Trust staff working in or representing the Trust in any way and contractors employed by others who work on Trust premises. It is imperative that managers and clinicians ensure that the message "risk management is everybody's responsibility" is well understood and acted upon in the Trust.

4 Risk Management Policy Statement

The Trust has adopted the following risk management policy statement and it is upon this which the Risk Management Strategy and Policy is based:

"Wirral University Teaching Hospital NHS Foundation Trust is committed to the control of risks in a strategic and organised fashion, to ensure that risks can be eliminated or reduced to an acceptable level thereby improving the experience and safety of patients, visitors, staff and the public. This commitment is commensurate with the Trust's vision and values. Managing business risk is fundamental to achieving this aim."

5 Aims of the Strategy and Policy

Risk management aims to achieve the optimum level of quality care and treatment of patients and provision of services that are safe and free from unnecessary risks by making maximum use of available resources and reducing wasteful expenditure. The Board of Directors will continuously strive to ensure that there are effective governance and risk management arrangements in place and that these are monitored on an ongoing basis. The Trust's key strategic risk management aims are:

- To adopt an integrated approach to the management of risk and to integrate risk into the overall arrangements for clinical and corporate governance;
- To support the achievement of the Trust's strategic objectives as described in the Trust business plan;
- To comply with national standards e.g. Care Quality Commission (CQC) regulations/standards, Information Governance standards;
- To have clearly defined roles and responsibilities for the management of risk;

- To provide high quality services to patients and to continuously strive to improve patient safety;
- To ensure the safety of its employees;
- To ensure that risks are continuously identified, assessed and minimised;
- To use risk assessments to inform overall business planning/ investment processes in the Trust;
- To encourage open and honest reporting of risk and incidents through the use of the Trust reporting systems;
- To establish clear and effective communication that enables information sharing
- To foster an open culture which supports organisation wide learning.

6 Risk Management Process

The management of risk at the Trust is not dependent on the level of the organisation at which the risk is identified. The principles of risk identification, assessment, action planning and treatment apply at a local and corporate level and risks that cannot be managed at a local level are escalated to the next level of management in order that risks can be mitigated or escalated. Risks scoring 10 or above will be escalated to the RMG by the Division via the Risk Management Team in order that mitigation can be monitored corporately but action still needs to occur where the risk is identified.

Corporate support for mitigation will be given as appropriate. Risk issues which score 15 or above using the Trust risk matrix will be escalated to EDT. Only EDT can determine that a risk is acceptable and agree that the risk cannot be reduced or mitigated any further. Refer to Appendix 3 flow chart concerning the process for staff to follow.

Risk is identified proactively, at a local or corporate level, in response to a potential or known problem that has not resulted in an incident, or reactively once an incident has occurred. The Trust uses a generic risk assessment form and scoring system to support consistent risk assessment. This form is to be used whenever there is no specific risk assessment form.
http://www.whnt.nhs.uk/staff/divisions/corporateservices/qualityandsafety/rm/risk_reporting.html

The process is described below.

6.1 Proactive Risk Identification

Proactive risk assessment enables the Trust to identify actual or potential hazards or threats that may or may not have resulted in actual incidents and ensure adequate control measures are in place to eliminate or reduce the risk of harm occurring. From this information, the Trust can assess whether or not there are sufficient precautions in place or if more needs to be done to mitigate the risk in order to prevent a particular harm or threat materialising. Proactive risk assessment also fulfils the Trust's statutory obligations in terms of Health and Safety risk assessments.

Under the management of Health and Safety at Work Regulations 1992, employers are required to make a "suitable and sufficient" assessment of the risks to the health and safety of employees whilst at work as well as the risks to non employees as a consequence of work activities.

Ongoing proactive risk assessment will minimise the likelihood of both patient safety and non-clinical incidents occurring and supports safety improvements across the organisation.

The Trust uses several processes to allow this to be undertaken:

6.1.1 Range of Internal Inspections

There are a number of internal inspection processes carried out by specialists such as Infection Control or Fire Safety Officer and where risks are pro-actively identified. There is a requirement for all services to carry out a quarterly Health and Safety Inspection and ensure improvements are made if indicated.

6.1.2 Health and Safety Workplace Inspection and Risk Assessments

The Trust-wide Health and Safety Workplace Inspection tool is based on a nationally recognised model which has been developed and adapted in the Trust. All services are required to complete this on a quarterly basis.

Significant risks identified from the assessment will be entered onto the Trust Risk Register with associated action plans to reduce or mitigate the risk. All risks identified must be scored using the Trust risk scoring matrix. This can be found on the intranet in the Quality and Safety section
http://www.whnt.nhs.uk/staff/divisions/corporateservices/qualityandsafety/hsd/Quarterly_Workplace_Inspection_Proforma_.html

6.1.3 Nursing and Midwifery Audit

There is monthly Patient Quality Assurance monitoring and Bi Annual Ward Quality Assurance Monitoring undertaken in patient areas. The audits are a proactive way of measuring compliance with High Impact Actions for Nursing and Midwifery and Essence of Care. Action plans are developed and presented by the manager at the Care Standards Executive Group. Actions not completed are added to the Risk Register and will be escalated in line with the Trust escalation process.

6.1.4 Self Assessment of Risk

Upon identification of an individual risk at any time a staff member can complete a generic risk assessment pro forma or one of the specific non-clinical assessment pro forma which are available on the Trust's intranet site. The risk will be reported to and discussed with a line manager and scored using the Trust risk scoring matrix. Action plans will be developed and the risk will populate the Trust's Risk Register and be escalated in line with the Trust risk escalation process. If immediate action is required this should be undertaken as quickly as possible to minimise the risk. If a staff member has concerns regarding the practice of another employee of the Trust, they should raise their concerns using the Trust Raising Concerns (Whistle blowing) Policy.

6.1.5 Evaluation of National Reports

As key reports are published appointed members of staff will be directed to review the content to evaluate the relevance of the report and standards that will be required of the Trust. This includes deficits in compliance with a range of standards such as Maternity or any of the National Inquiry reports such as those into Peri-Operative Care or Maternal and Child Deaths. It also includes Independent

Inquiries where risks are identified that apply to services within this Trust including those that relate to Safeguarding Children and Vulnerable Adults, clinical services and health and safety.

6.1.6 Central Alert System (CAS)

Review and response to CAS which is an electronic system developed by the Department of Health, the National Patient Safety Agency (NPSA), NHS Estates and the Medicines and Healthcare products Regulatory Agency (MHRA) that includes medicines, healthcare products, medical device, National Patient Safety Agency alerts and NHS Estate warning notices. Where alerts are issued and the Trust is not compliant a risk will be registered and an action plan implemented.

6.2 Reactive Risk Identification

6.2.1 Incident Reporting / Near Miss Reporting

Incident and near miss reporting by staff is an efficient and effective system for identifying risk. Rapid action in resolving how and why an incident may have occurred can facilitate the organisation in learning how to avoid repeat occurrences of similar incidents. The Trust operates within a just and fair blame culture, to ensure that staff feel safe in being open to report events. Incidents and near misses are scored using the Trust's risk matrix and escalated as per the colour dictated from the risk rating, i.e. those colour coded 'orange' or 'red' will undergo an SBAR or RCA investigation where appropriate.

6.2.2 Complaint Reporting

Complaint reporting is a very effective way through which an organisation can learn to manage its services and risks. Complaints are responded to by the Divisions / Corporate Departments and the Trust has a systematic approach which attempts a frontline instant response where possible, followed up and escalated through the line management structure in the Division if necessary. Formal complaint responses are co-ordinated by the Trust's Complaints Manager in accordance with the Trust's Concerns and Formal Complaints Handling Policy and Procedure. Complaints are scored using the Trust's risk scoring matrix and those scoring 10 or above or colour coded 'orange' or 'red' will populate the Trust's Risk Register and RCA Register and be escalated in line with the Trust's escalation process. Informal concerns also provide useful information to support the Trust to enhance the patient experience. Concerns are assigned a risk score by the Patient Advice and Liaison Service (PALS) and concerns and formal complaints will populate the Risk Register if they are colour coded 'orange' and 'red'.

6.2.3 Claims

The review of claims is also an effective way through which the organisation can learn to prevent the reoccurrence of incidents, manage its risks and improve the quality of care delivered. The Trust response to claims is managed on behalf of the Trust by the Legal Services Manager in accordance with the Trust's Claims Handling Policy and Procedure. Divisions are involved in reviews to support the management of risk locally. All claims are scored using the Trust's risk scoring matrix and those colour coded orange or red will populate the Trust's Risk Register and RCA Register and be escalated in line with the Trust's escalation process.

6.2.4 External Assessments and Reviews

Risks highlighted during service reviews and the audit work that is undertaken by the Trust's auditors are sources of risk identification. Risks identified are scored using the Trust's risk matrix and will populate the Trust's Risk Register and be escalated in line with the Trust's escalation process.

6.3 Risk Scoring (Grading)

All risks are scored using the Trust risk matrix (Appendix 4). All risks independent of their origin are scored in line with Trust risk scoring method using the Trust's risk scoring matrix which is available on the Trust intranet under Quality and Safety.
http://www.whnt.nhs.uk/staff/divisions/corporateservices/qualityandsafety/rm/risk_management_documentation.html

Risk scores have two main components; consequence and likelihood. Multiplying these together will give a risk score between 1 and 25. Each box in the risk scoring matrix is allocated a colour which will affect the level of investigation needed following an incident, complaint or claim. Risks that score between 0 to 10 are reviewed within their operational area, whilst risks that score 10 or above are escalated to RMG and those which 15 or above are reviewed by EDT.

Advice with respect to risk scoring can be sought from Ward Managers, Matrons, Lead Nurses, Clinical Governance Leads, Departmental Leads, Divisional Quality and Safety Specialists, Associate Directors of Operations, Heads of Corporate Departments, the Quality and Safety Team, the Health and Safety Team or the Hospital Coordinators.

6.4 Risk Management, Monitoring and Escalation

Risk mitigation and review is an on going process to ensure that all identified risks are eliminated or controlled to their lowest level to achieve this, the Trust will seek to utilise a range of expertise from within its workforce. The Trust will also seek external advice from identified bodies e.g. Care Quality Commission, Health & Safety Executive, NHS Litigation Authority.

The successful implementation of any risk management strategy requires that each individual person across the Trust feels able to contribute, specifically through communication, consultation, monitoring, audit and review of any risk management issue. All these areas ensure that risk management is recognised at the core of the culture of the organisation and thus the strategy becomes a live and current document. All other risks identified from any source, once received by the Risk Management team, will be entered into the Trust Risk Register (independent of the score). A copy of the risk register entry is emailed to the lead to confirm that it is on the risk register, allowing for a check of the content.

All risks entered into the Risk Register, irrespective of origin, will have an identified lead with responsibility for the area where the risk has been identified. Actions plans must be developed by the identified lead who must engage the relevant stakeholders in the Division or Corporate Department. If the risk affects the organisation as a whole then a staff member with corporate responsibility for that specific area will be designated as the risk lead and must prepare an action plan with associated stakeholders within four weeks of recognition of the risk. All actions must have due

dates and the overall lead for an action plan must make sure that anyone who is assigned a task is aware of the action and the date by which is must be delivered.

6.5 Immediate Escalation of and Local Monitoring of Incidents, Complaints and Claims including Serious Incidents

All incidents, complaints and claims are scored using the Trust risk scoring matrix and the resultant score will be assigned a colour in the matrix. Trends will be identified in the quarterly CLIPPE (Complaint, Litigation, Incidents, PALS and Patient Experience) report, quarterly RCA Trend Analysis report and 6 monthly claim report produced by the Quality and Safety Team and Legal Services Team.
http://www.whnt.nhs.uk/staff/divisions/corporateservices/qualityandsafety/rm/reports/incidents.html

6.5.1 Incidents

SIs (i.e. 'orange' or 'red' incidents) need to be escalated immediately so that any remedial action can be taken as necessary. The Risk Management Team is informed by telephone immediately in line with the Incident Reporting and Management Policy and Procedure. The Risk Management Team have an answer machine on extension 2611 which will record messages out of hours.
http://www.whnt.nhs.uk/staff/divisions/corporateservices/qualityandsafety/rm/risk_reporting.html

6.5.2 Complaints

All complaints, irrespective of score, are escalated to the Nominated Complaints Lead in the Division who will monitor actions plans. All complaints are ultimately signed off by the Chief Executive Officer.

6.5.3 Claims

Claims are escalated to the relevant Assistant Director of Operations and Clinician involved. The relevant Lead Nurse monitors actions plans.

6.5.4 Divisional Management Teams (DMT)

All Divisional / Department risks will be monitored for mitigation progress at the DMT. These include clinical, financial and reputational risks e.g. serious incidents, predicted overspend, potential to miss national targets.
The Risk Management team produce a Risk Summary Report for the Divisional Management Team each month which highlights risk issues to support the Division to manage and monitor their risks. This contains Divisional information regarding:

- Policies out of date
- Risks out of date
- Risks due to expire in the next month
- New risks identified in previous month
- Incident data
- Complaints Information including response times and outstanding action plans
- PALS information including outstanding concern responses
- Claims information
- RCA Register Information including outstanding action plans
- Full divisional risk register

6.5.5 Trust Wide Clinical Governance Team (TWCGT)

This team has representation from across the Trust and has responsibility for central monitoring and further escalation of these risks if necessary.

The committee will receive reports detailing the following information:

- Serious Incident reviews which have remained with a serious risk rating
- Outstanding RCA and SBAR investigations
- RCA's with Trustwide shared learning
- Central Alert System update
- Out of date risks
- Out of date policies
- Reports on safety and clinical effectiveness

6.5.6Divisional Performance Reviews

Risks which are not re-scored in a timely manner, or are not being mitigated to an acceptable level of risk, will be highlighted at the Divisional Quarterly Performance Reviews. The Risk Management Department produce a Risk Exception Summary Report for the Divisional Performance Review each quarter which highlights risk issues by exception for update at the Performance Review. This contains Divisional information regarding:

- Policies out of date
- Risks out of date
- Risks which have remained at the same score for 12 months
- Outstanding complaints action plans
- Outstanding claims information
- Outstanding actions from root cause analysis

6.5.6 EDT

If a Division considers that a risk cannot be mitigated further then they must refer it to EDT for acceptance. Furthermore all risks with a risk rating of 15 or greater will be submitted to EDT.

6.5.7 Board of Directors

EDT/RMG will escalate risks to the Board of Directors as appropriate and they will be notified of all risks which score 20 or above at the next meeting of the Board. The Board of Directors reviews all strategic risks to the organisations objectives via the Board Assurance Framework. The Board of Directors are also made aware of any serious incidents as they occur via the Quality & Safety Committee Chairs report.

6.6 Training

The Trust will ensure that training is provided in order that the objectives of this document are met. A range of courses related to risk management are available which are relevant to the requirements of Board members (including Executive and Non-Executive Directors), senior managers, new line managers, clinicians and other staff with responsibility for risk management within the Trust. Furthermore a mandatory training session is now in place to ensure that all staff receive regular risk training.

An annual risk management training session is delivered to members of the Trust Board and the Operational Management Team. This usually takes place in June or July. The training is intended as an update and the content covers current issues in risk management. Attendance is recorded on the OLM training database. If any members are unable to attend the training session, the Quality and Safety department

will contact their secretaries to arrange for them to receive the same training, delivered on a one-to-one basis by a manager from the Quality and Safety Department within three months of the original group training session.

The Risk Management Team can provide updates on request for individual wards/departments/directorates. Several specialist courses are also open to staff, details of which can be found in the HR/OD Training Portfolio (available on the Intranet http://www.whnt.nhs.uk/staff/st/) e.g.:

- Root cause analysis – (one-day course)
- Risk assessment course – (half-day course)
- Being Open and Incident Decision Tree – (two hour session)
- Health and safety courses – (various short courses)
- Introduction to line management – (two hour session within a 2 day course)
- Health and safety update for managers – (one-day course)
- Risk management training for Board members and senior managers.

6.7 High scoring risks

Risks which have a risk rating of 15 or greater require additional escalation after being submitted to the risk register. A monthly report is submitted to EDT outlining all ongoing risks with a risk rating of 15 or greater in order that the team can ensure that effective monitoring and mitigation is in place for these risks. Furthermore the lead for a 15 plus risk must be approved by the EDT and must be of associate director level.

6.8 Closure of risks

In order for a risk to be closed, it must first be submitted to the Divisional Management Team for approval that all actions have been completed and have resulted in full mitigation of the issues raised with therefore no risk remaining.

7 Definitions

7.1 Risk

Risk is defined by the government in Organisation with a Memory as 'the likelihood, high or low, that somebody or something will be harmed by a hazard, multiplied by the severity of the potential harm'.

7.2 Potential types of Risk

Risk type: Corporate Executive risks
Risk definition: High level corporate risks, these risks must have an Executive as the risk lead
The risk location will be the 'working area' of the risk, and this is to ensure that the risk is reviewed and updated within the given department.

Risk type: Corporate Trustwide risks
Risk definition: Risks which affect every division in the Trust
The risk handler will be the clinical division in which the risk lead belongs to ensure that the risk is reviewed and updated within the given department.

Risk type: Corporate Department risks

Risk definition: Risks which affect a department in the corporate division
The risk location will be the corporate department to ensure that the risk is reviewed and updated within the given department.

Risk type: Divisional risks which affect more than one division
Risk definition: Risks which affect more than one division but not all divisions
The risk location will be the clinical division, and the handler will be the other area affected to ensure that the risk is reviewed and updated within both affected departments.

Risk type: Divisional risks
Risk definition: Risks which affect one clinical division
The risk location will be the clinical division to ensure that the risk is reviewed and updated within the given department.

7.3 Risk Management

Described as a five stage process, namely:

a) The identification of all risks which have potentially adverse affects on the safety of patients, staff and the public and the Trust's business.
b) The assessment, evaluation, elimination and reduction of the risks identified.
c) The creation of a system for the protection of assets and income combined with a cost effective service.
d) The creation of a management environment in which pro-active and positive action is taken to eliminate or reduce risks and ineffective or inappropriate working practices.
e) The creation of an environment in which staff are encouraged and supported to report errors, near misses and incidents so that learning and improvement is the outcome.

7.4 Clinical Governance

Defined by the Government in "A First Class Service: Quality in the New NHS" as "a framework through which NHS organisations are accountable for continuously improving the quality of their services and safe-guarding high standards of care by creating an environment in which excellence in clinical care will flourish".

7.5 Incident

An incident is defined as any event or circumstance which leads to, or could potentially lead to, unintended or unexpected harm, loss, or damage to either patients, staff or the public, incur financial loss or injure the reputation of the Trust.

7.6 Serious Incidents

Serious Incidents (SIs) are incidents which are scored using the Trust risk scoring matrix and are colour coded ‘orange’ or ‘red’ (Appendix 4). These are considered to be significant or high risks i.e. those which pose serious threat to patients, carers, and members of the public, staff or the reputation or finances of the Trust. There is also a list of serious incident categories (see page 5 Incident Reporting and Management Policy) to guide staff.

7.7 Root Cause Analysis (RCA)

RCA is defined as the process by which the underlying cause(s) of patient safety and non clinical incidents are established. The nature and extent of an RCA will be subject to the nature and level of incident. An action plan will be established to address for all root causes identified.

7.8 Situation Background Assessment Recommendation (SBAR)

SBAR is a process used for incidents reported initially as serious to determine if the serious risk rating is accurate. The SBAR will identify the background to the incident and what further action or investigation is required.

7.9 Consequence

Impact caused by an incident, complaint, claim or risk.

7.10 Likelihood

The chance of an incident complaint, claim or risk recurring.

7.11 Harm

An injury (physical or psychological), disease, suffering, disability or death. Unexpected harm is considered to have occurred when it is not related to the natural course of the patient's illness or underlying condition (NPSA 2001).

7.12 Risk

The probability or likelihood that harm, damage or loss may occur, coupled with the consequence of that harm.

7.13 Risk Assessment

A tool used for identifying hazards which arise out of work activities or the existing work environment, identifying who may be harmed and how and then evaluating the extent of the risks those hazards pose, taking into account whatever precautions or mitigation are already in place.

7.14 Acceptable Risk

The Trust recognises that eliminating all risk is not possible and that systems of control must not be so rigid that they stifle innovation, creativity, and the imaginative use of resources. In this context, the Board of Directors defines 'acceptable' as follows:

An acceptable risk is one which has been accepted after proper evaluation and is one where effective and appropriate controls have been implemented. The acceptance of a risk should represent an informed decision to accept the likelihood of that risk recurring. It must be:

- Identified and entered on the Risk Register;
- Quantified (Consequences and Likelihood);
- Reviewed and have been deemed acceptable by the Executive Directors Team;

- Controlled and kept under review at least annually via re-submission to the Executive Directors Team

7.15 Risk Register

The Trust Risk Register is a database, managed by the Quality and Safety Department, of all of the risks which are recorded in the Trust.
It includes:

- the source of a risk (insert codes);
- description of the risk;
- current risk score and residual risk score;
- risk action plan to mitigate the risk;
- date of review.

The Risk Register identifies which staff member is leading on the mitigation of the risk and progress against the plans. The entire and current Risk Register is uploaded onto the intranet at the beginning of every month.

7.16 Root Cause Analysis (RCA) Register

The Trust RCA Register is a tool which is used to monitor the investigations and action plans for all incidents which undergo an RCA in the Trust. RCAs are required for all serious incidents which are confirmed to have an initial serious risk rating by initial review or SBAR, and whereby such an investigation is deemed appropriate i.e. incidents, complaints or claims which have been scored using the Trust risk scoring matrix and is colour coded 'orange' or 'red' and whereby another route of investigation is not more appropriate i.e. HR investigation would negate the need for an RCA.
Where the Near Miss potential score is colour coded as "orange" or "red" then an SBAR or RCA investigation is required.
Other incidents and near misses can be reviewed if a manager considers it would be helpful and these will also be tracked for action plan completion using the RCA Register. The RCA Register can also be found on the Trust intranet.

8 Duties / Responsibilities – Individuals

8.1 Chief Executive

The Chief Executive (CEO) has overall responsibility for having an effective governance system, including risk management, in place in the Trust and for meeting all statutory requirements and adhering to guidance issued by the Department of Health in respect of governance and risk management. To fulfil this responsibility the CEO will:

- Ensure that full support and commitment is provided and maintained in risk management activities;
- Ensure an appropriate Board Assurance Framework is in place;
- Ensure that the Annual Governance Statement adequately reflects the risk management issues within the organisation.

8.2 Medical Director

The Medical Director is the responsible Executive for:

- Quality and safety including clinical governance and risk management which includes patient safety;

8.3 Director of Nursing and Midwifery

The Director of Nursing and Midwifery is responsible for:

- Patient experience;
- Complaints and concerns via PALS;
- Safeguarding;
- Provision of professional leadership for nursing and midwifery including the Infection Control Nursing Team and Tissue Viability Team.

8.4 Director of Finance

The Director of Finance is responsible for:

- Systems of financial control;
- Implementing the Trust's financial policies and ensuring that they are maintained;
- Providing financial advice to the Trust and its Board of Directors;
- Standards of business conduct and Counter fraud;
- Preparing and maintaining Trust accounts.

8.5 Director of Operations

The director of Operations is responsible for:

- Business continuity;
- Day to day operational performance;
- Performance management of the Associate Directors of Operations and the divisional structure.

8.6 Director of Strategy and Partnerships

The director of Strategy and Partnerships is responsible for:

- Reputational strategy management and risk mitigation through the communications and public relations functions;
- Assessment of our strategic market risk.
- Occupational health service;
- Mandatory training provision and compliance monitoring;
- Human resource and organisational development policies;
- Ensuring that the Trust's Health & Safety management systems and processes are developed and maintained.

8.7 Associate Director of Governance -

The Associate Director of Governance is providing support and facilitation of the Board of Directors, Council of Governors, Audit committee and Assurance committees in discharging their duties and responsibilities as outlined; and ensuring that the Trust's corporate governance arrangements meet best practice and are reviewed periodically for effectiveness.

8.8 Director of Estates and Facilities

The Director of Estates and Facilities is responsible for the mitigation of all aspects of environmental risk. This includes:

- Fire safety and fire safety training;

- Water integrity (Legionellae);
- Control of asbestos, plant, machinery & equipment;
- Food safety;
- Construction, Design and Management (CDM);
- Security;
- Clinical and non clinical waste.

8.9 Director of Informatics

The Director of Information is responsible for the mitigation of risks relating to:

- Information technology;
- Data protection;
- Information governance;
- Data storage and security.

8.10 Associate Director of Risk Management

The Associate Director of Risk Management is responsible for the development and maintenance of the organisation wide risk management systems and processes.

The Associate Director of Risk has lead responsibility for maintaining and developing the Trust's database relating to the Risk Register, incident reporting (including serious incidents), complaints, concerns, claims management. Associate Director of risk is responsible for ensuring that Risks, Incidents and Claims are managed effectively throughout the trust.

8.11 Triumvirate for Clinical Divisions/Heads of Corporate Departments

Accountability for the Clinical Divisions lies with the Clinical Head of Division, the Associate Director of Operations and the Lead Nurse and is known as the Triumvirate. Each Triumvirate/ Head of Corporate Department is accountable for the management of risk within their Division/Corporate Department. They will ensure that the risks in their risk registers are regularly reviewed. They are responsible for implementing and monitoring any identified risk management control measures needed within their designated area(s) ensuring that they are appropriate and adequate. Risks will be monitored corporately if they score 10 or above or if they originate from incidents, complaints and claims which are colour coded ‘orange’ or ‘red’ using the Trust risk scoring matrix. Action must be undertaken by management in the Department/Division or area where the risk has been identified.

8.12 Divisional Quality and Safety Specialists

The Divisional Quality and Safety Specialists work with the four clinical Divisions; Medical Specialities and Acute Care, Surgery, Diagnostics and Clinical Support and Women and Children’s Divisions. They co-ordinate the risk management and governance agenda in the Divisions and provide real time information to support risk mitigation. They are responsible for the day to day direction of the risk agenda in the Divisions working with their Divisional Clinical Governance Teams and structures.

8.13 Other Managers in the Trust

All managers have a delegated responsibility for the management of risk in their Departments, Wards, and any other areas. Risk management is integral to their day

to day management responsibilities and managers are authorised to mitigate risks identified at a local level wherever possible.
If risks cannot be mitigated locally, issues should be escalated in the management lines of accountability and action undertaken by management in the Department, Division or area where the risk has been identified as far as possible.

8.14 All Staff

All members of staff, irrespective of profession, grade or discipline, including locums and those with honorary contracts are responsible for:

- Compliance with Trust strategies, policies, procedures and guidelines;
- Working within their own level of competence;
- Identifying risks and reporting of all incidents and near misses;
- Escalation of risk, incidents and near misses as required;
- Attending risk management training as required for the post;
- Using any safety equipment, personal protective equipment and adopting safe working practices;
- Co-operating with management, representatives of enforcement agencies and auditors in respect of Health & Safety issues, investigation of incidents, complaints and claims.

9 Duties / Responsibilities – Committees

The Trust Governance Committee Structure is detailed in Appendix 1 and the Performance Management Structure is detailed in Appendix 2. It may be necessary for the structure to change periodically. Updates will be added to this document without the need for re-approval of the strategy.

Terms of reference will be reviewed annually. Changes in the terms of reference to Trust Committees /Groups will be approved by the Board / relevant committee to which they report.

All committees / groups within the structure have 'Risks Identified' as a standing agenda item and have a responsibility for escalating risk issues discussed at the committee via the chair, or the divisional lead, in line with the Trust escalation process. However, the following Committees/ Groups have specific functions pertaining to risk management (as described in the Risk Reporting Process described in Appendix 3):

9.1 The Board of Directors

The Board of Directors at the Trust is a unitary Board and as such each member of the Board is ultimately equally responsible for the organisation's system of integrated governance and internal control – clinical, financial and organisational. The Board of Directors is required to produce statements of assurance which declare that it is doing its 'reasonable best' to ensure that the Trust meets is objectives and protects patients, staff, the public and other stakeholders against risks of all kinds.

The Board of Directors review and are aware of the risk register in the following ways:

- The Trust-wide Risk Register is available on the intranet at all times for review in full by any staff member including Board members.

- Where a risk scores 20 or above using the Trust risk scoring matrix, the risk will be escalated to the Board following discussion at the first available Executive Directors Team meeting.
- The Board of Directors also receives information relating to serious incidents via the Quality dashboard.
- The Board of Directors defines the structure of the Board Assurance Framework (BAF) such that it meets its assurance requirements and drives the Board's agenda. The BAF is the means by which the Board holds itself to account and identifies the principal risks that would prevent achievement of the Trust's strategic goals and/or regulatory compliance. The BAF defines the control systems in place to mitigate these risks and confirms the assurances that the Board wishes to receive throughout the year to evidence the effective operation of controls and mitigation of principal risks. The Board utilises the BAF as a working document and reviews the BAF structure and content at least annually.
- Members of the Board receive the minutes of the Audit Committee, Quality and Safety Committee and the Finance, Performance and Business Development Committee for information. The Board of Directors also receives a Report on Key Assurances and Risks from the Chairs of the Audit Committee, Quality and Safety Committee and Finance, Performance and Business Development Committee.

9.2 Audit Committee

Directors and senior management are responsible for implementing the Trust policies and procedures and a key source of assurance to the Board of Directors is the Audit Committee. This is the Board Committee with overarching responsibility for the scrutiny of the risk management systems and processes and the maintenance of an effective system of internal control on behalf of the Board. The Audit Committee reviews the effectiveness of the risk management system through regular receipt of a dashboard and via the programme of internal audit review.

The Audit Committee oversees arrangements in place relating to Counter Fraud and Corruption which are compliant with Department of Health requirements and are also subject to external audit. Its roles and responsibilities are described in the terms of reference.

The audit committee receives a risk process dashboard which provides a high-level summary of risk management throughout the Trust. The dashboard submits ongoing data showing where the Trust is or is not meeting key targets from the Risk Management Strategy; for example the number of risks opened and closed each month, the number of risks accepted each month, the number of out of date risks each month and the detail of any new risks with a risk rating of 15 or greater. The dashboard is submitted to RMG and the audit committee quarterly meeting.

9.3 Quality and Safety Committee

The Quality and Safety Committee is responsible to the Board of Directors for assuring the quality of patient care and service delivery in respect of clinical effectiveness, safety, patient and staff experience. The Committee has specific objectives on monitoring high level risk, clinical effectiveness and safety, patient and staff

experience, staff engagement and governance through a range of reports. The Committee has a role to support the integration of clinical, organisational and financial risk management and promotion of a holistic approach to management of risk.

The Chair of Quality and Safety Committee attends Audit Committee. Its roles and responsibilities are described in the terms of reference.

The committee receives notification of all new 15 plus risks added to the risk register, and all new never events reported. The committee also receive a graph outlining the level of harm from serious incidents over a 12 month period.

9.4 Finance, Performance and Business Development Committee

The Finance, Performance and Business Development Committee is an assurance committee of the Board of Directors.

The Committee receives direct reports from E Programme Group, Information Governance Group, Transformation Programme Group, Finance Management Group, Capital management Group and the Business Development Group. The Committee has specific objectives on monitoring high level risk from these area and additional areas as appropriate.

9.5 Risk Management Group (RMG)

The primary purpose of this Group is to oversee the execution of this Strategy and associated key delivery plans. It is responsible for providing assurance to the Committees' of the Board of Directors. The group initially met bi-monthly, but from July 2014 the group will meet quarterly as the group decided at the May 2014 meeting that adequate assurance of risk management processes had been received and therefore bi-monthly review was no longer needed. The group is made up the executive chairs of each of the trust groups within the Governance Structure.

The Risk Register is reviewed by this group in a number of ways at each meeting of the RMG.

- Risks identified by Divisions and Corporate Departments which are scored 10 or above using the Trust risk scoring matrix. Group members provide a quality assurance role with respect to risk scores and mediate on risk scores where there is disagreement about consequence or likelihood. Progress to mitigate these risks is then monitored by RMG;
- Risks which are not reviewed in a timely manner (expired risks irrespective of score);
- Review the root cause analyses by exception in the Trust's RCA Register to hold relevant divisions or departments to account for delays in completing actions
- All risks relating to CQC outcomes
- Risk process dashboard
- Summary reports from each Divisional Management Team meeting in order to escalate any concerns or problem areas

The Trust RCA Register captures information pertaining to RCA reviews which have taken place in all areas of the Trust; the register ensures that all actions as a result of RCA's are monitored until completion, this work is undertaken through the Divisional Clinical Governance Team meetings. A quarterly RCA trend report is produced and submitted to quality and safety committee and Risk Management Group to outline trends and lessons learnt from serious incidents.
RMG escalates risk which is not mitigated in line with the Trust escalation process. It also approves risk management systems and processes. Its roles and responsibilities are described in the terms of reference.
This group was established in April 2013 and replaces the performance management role of the Corporate Risk Management Committee with respect to risk.

9.6 Executive Director Team (EDT)

The EDT is responsible for accepting risks which cannot be mitigated any further. If the EDT considers further mitigation to be appropriate the risk will be returned to the appropriate team for further management.
The EDT will also receive at its weekly meeting new risks 15 and above to ensure rapid dissemination of and action to mitigate these high risks, and also ongoing risks scoring 15 or above.

9.7 Operations Management Team (OMT)

The OMT is responsible for the management of operations within the Trust. Members of this Team are senior members of Trust staff with key management responsibilities. These responsibilities include risk management.
OMT will:

- Performance manage actions and/or risks identified by EDT or RMG as required;
- Discuss risk issues as they arise at the next meeting if scored 15 – 25;

This Committee carried out the functions of the former Hospital Management Board from December 2012 to the new governance structure took effect in April 2013.

9.8 Health and Safety Partnership Team (HSPT)

The Health and Safety Partnership Team is central to risk management of non-clinical risks within the organisation. This "committee" reviews risks, agrees mitigation plans and escalates risk in line with the Trust's escalation policy and procedure. Its roles and responsibilities are described in the terms of reference.

HSPT will:

- Discuss and agree mitigation plans escalated from their subcommittees;
- Discuss risk issues directly as they arise if urgent;
- Escalate risk issues which cannot be resolved to Workforce and Communication group in line with the Trust escalation process;
- Escalate risk issues which score 10 or above using the Trust risk matrix to RMG.

9.9 Divisional Management Teams (DMTs) (formerly Divisional Management Boards)

These team meetings are responsible for reviewing all local risks pertaining to their area, ensuring robust action plans are in place and monitoring action plans to ensure that they are completed on time. They will escalate risks which are outside of their control or which have financial implications which cannot be managed internally. To support management action a Risk Summary Report is produced each month which highlights key issues for management action in relation to policies, risk, incidents, complaints and claims. These Management Teams are responsible for reviewing risks pertaining to their area, ensuring robust action plans are in place and monitoring those action plans to ensure that they are completed on time. DMTs will also:

- Discuss, agree and monitor mitigation plans for all risks belonging to their Division;
- Ensure that risks are reviewed in a timely manner;
- Ensure that risks are fully mitigated prior to closure
- Escalate risk with mitigation plans which score 10 or above using the Trust risk matrix to the RMG;
- Escalate risk with mitigation plans which score 15 or above using the Trust risk matrix to EDT.
- Review incidents, complaints and claims which occur in the Division.

To access the DMT meetings http://www.whnt.nhs.uk/staff/committees_meetings/dmb/

9.10 Divisional Quarterly Reviews

These meetings are held quarterly and a range of business issues will be discussed including pertinent risk management issues. A Risk Exception Summary Report is discussed which highlights risk issues that have not been mitigated in the Division. The Divisional Quarterly Reviews review how risk is managed locally.

10 References

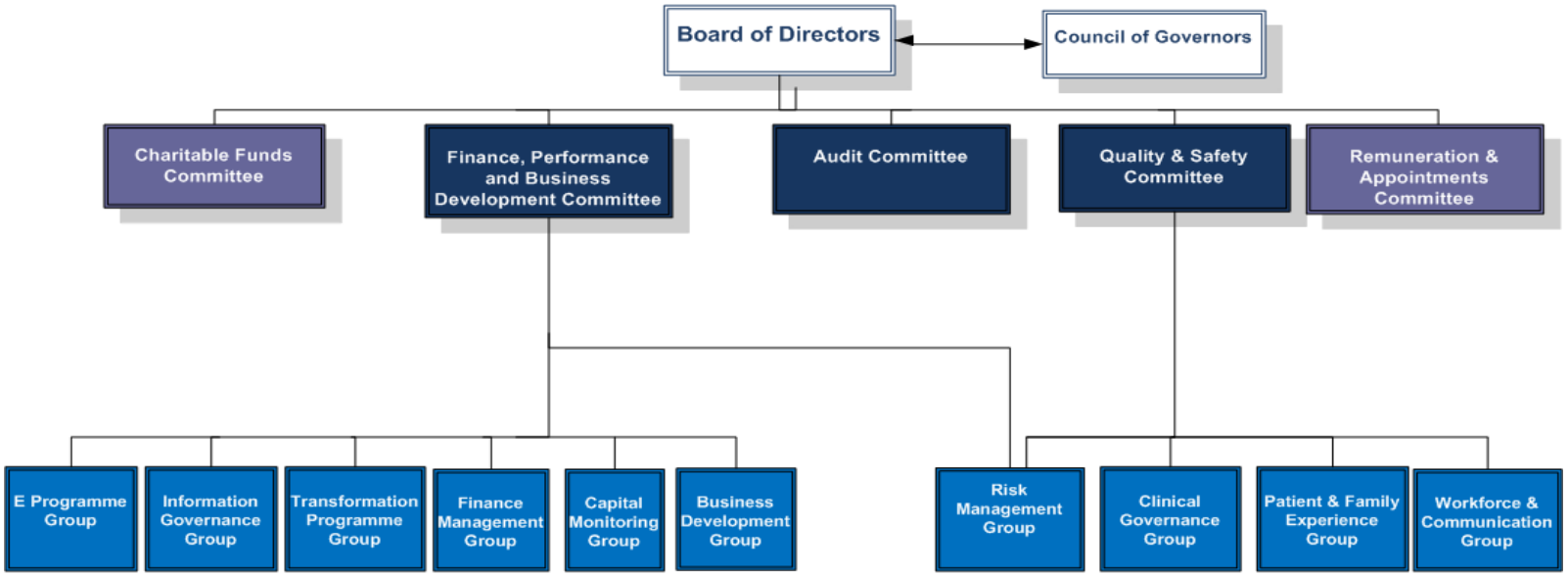
1. Department of Health (2006), *Integrated Governance Handbook*
2. Department of Health (2003), *Building the Assurance Framework: A Practical Guide for NHS Boards*, Gatelog Reference 1054
3. Health and Safety Executive website (2000) *Revitalising Health and Safety*
4. Department of Health (2000), *An Organisation with a Memory*
5. Department of Health (2001), *Building a Safer NHS for Patients*
6. National Patient Safety Agency (2003), *Seven Steps to Patient Safety: A guide for NHS staff*
7. National Patient Safety Agency (2006), *Safety First*
8. NHS Litigation Authority (2012), *Clinical Negligence Scheme for Trusts: Acute Service Standards*

9. NHS Connecting for Health (2011) Information Governance Toolkit,

10. Security of State directions to health bodies on measures to tackle violence and general security management (Statutory instrument 3039/2002)

11. Audit Commission (2009) *Taking it on Trust: a review of how boards of NHS trusts and foundation trusts get their assurance*

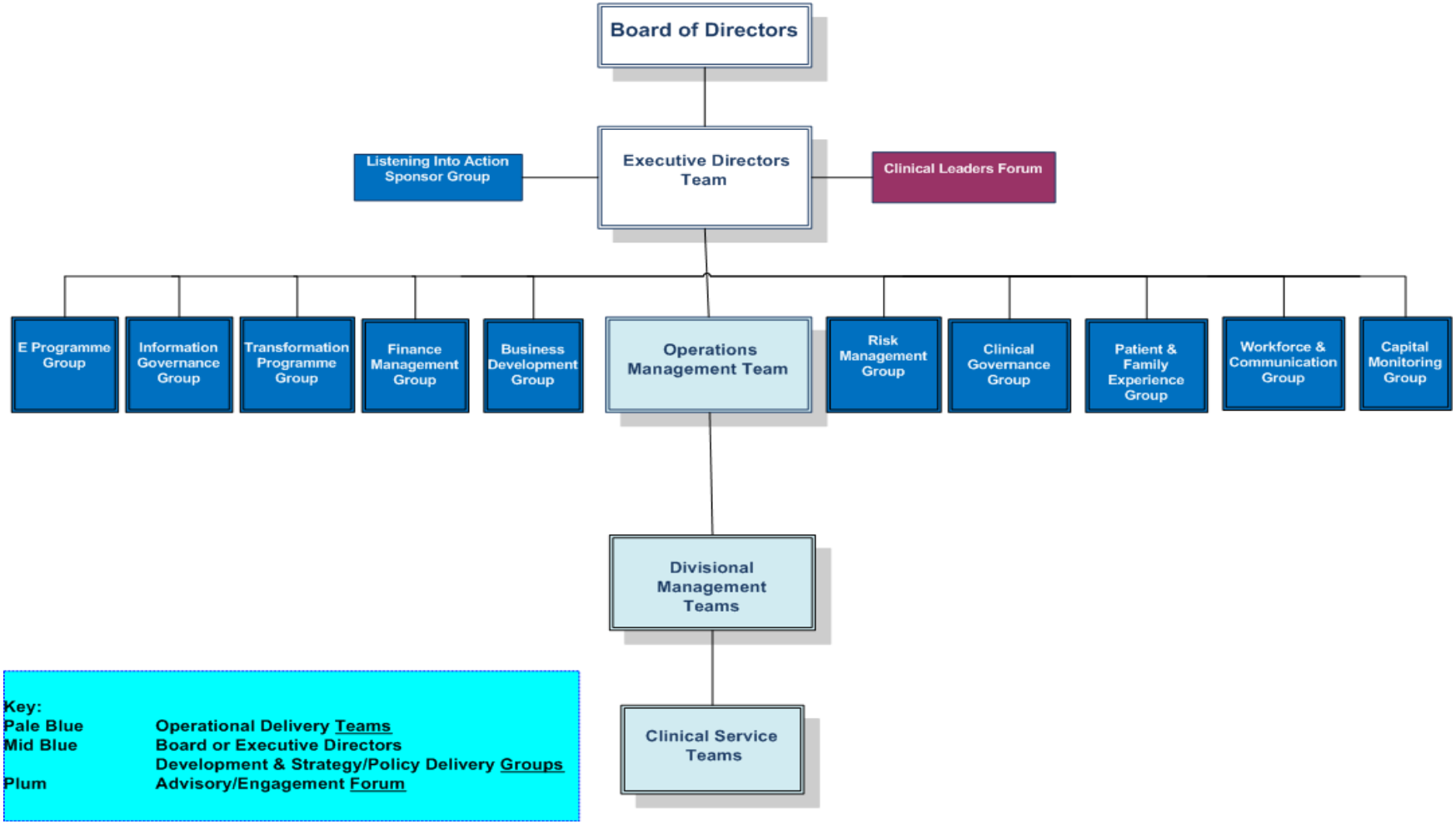
Appendix 1 Governance and Assurance Structure



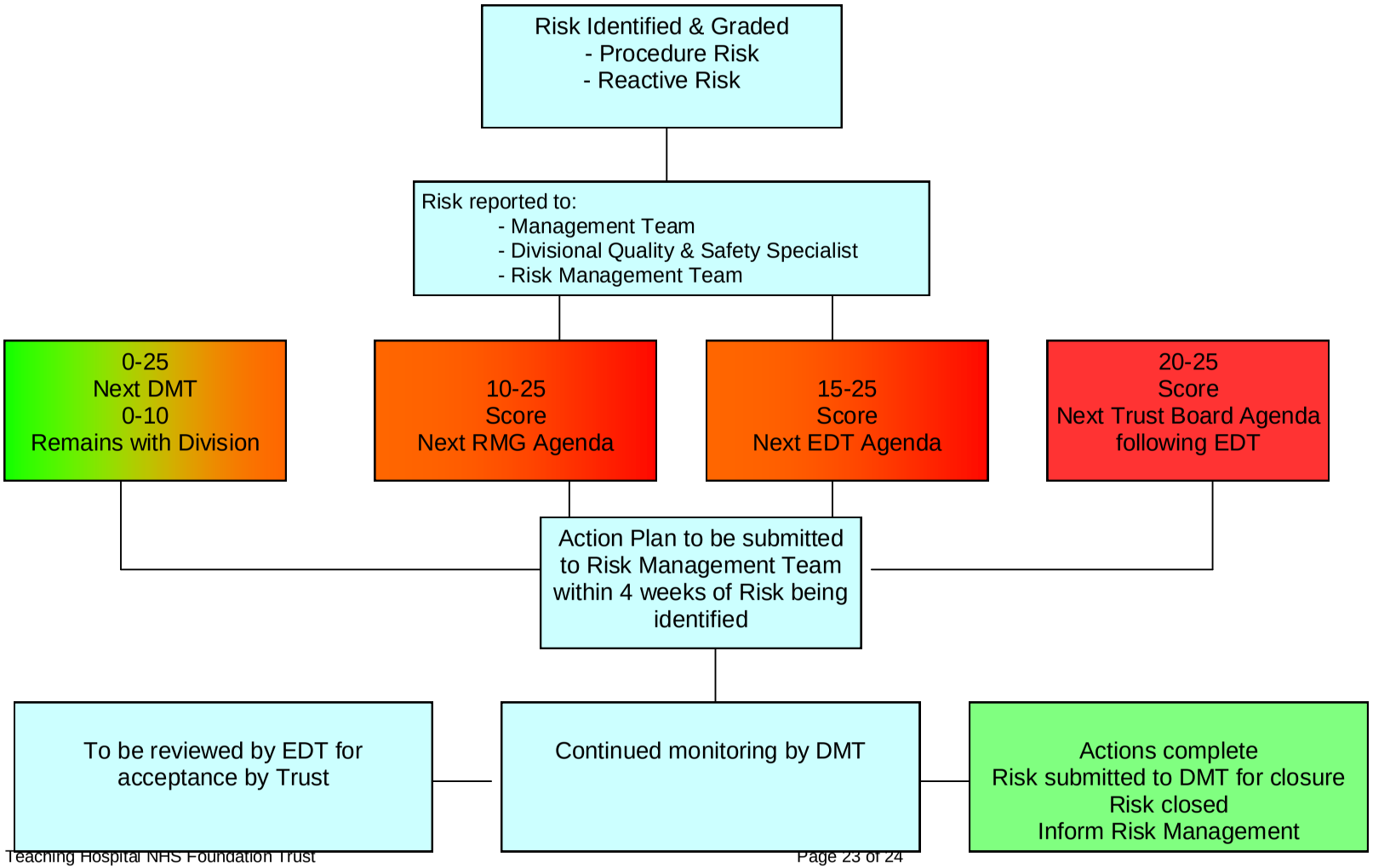
Key:

Dark Blue	**Board Assurance Committees**
Purple	**Defined Board Committees**
Mid Blue	**Board or Executive Directors Assurance Development & Strategy/Policy Delivery Groups**

Appendix 2 Performance Management Structure



Appendix 3 Risk Reporting Process



Appendix 4 Risk Scoring Matrix

The Risk Scoring Method should be applied to all incidents, complaints, claims and risks identified through proactive risk assessments.

1. **Consequence:** Use **Table 1** to determine the Consequence Score(s) **C**. In the case of incidents, complaints and claims, this is the **actual** consequence (i.e. what actually happened). In the case of proactive risk assessments, it is the potential consequence (i.e. what could potentially happen). All events, actual or future, may have one consequence or several consequences (e.g. affecting patient care, financial impact, adverse publicity, etc). **The score used to calculate the overall consequence is the row from which the highest numerical score is achieved.**
2. **Likelihood:** Use **Table 2** to determine the Likelihood Score **L**. This is the chance that the consequence described above will occur (or recur) to that identified group.
3. **Risk Score:** See **Table 3**. Multiply the Consequence Score **C** with the Likelihood Score **L** to obtain the Risk Rating, which should be a score between 1 and 25.
4. **Near Miss:** Please tick the Near Miss box if applicable. All 'near miss' incidents are to be scored twice; Once for what actually happened and then for what would have happened had intervention not taken place.
5. Orange and Red incidents must be reported to Risk Management on ext. 2611 immediately
6. Root Cause Analysis (RCA) **must** be undertaken for all red/orange incidents and claims. Inform your Line Manager if you feel that an incident, complaint or claim is likely to attract media attention. RCAs **must** be completed within **25 working days (5 working days for MRSA bacteraemia cases)**.

Table 1 – Consequence

Actual Severity = Incidents / Complaints / Claims Potential Severity = Risk Assessments/Near Miss

	1	2	3	4	5
Descriptor	**No Harm / insignificant**	**Very low harm / minor**	**Low harm**	**Moderate**	**Severe/Death**
Clinical impact on the safety of patients (physical/ psychological harm)	No harm: Impact prevented- any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care. Minimal injury requiring no/minimal intervention or treatment No time off work	Impact not prevented any patient safety incident that ran to completion but no harm occurred to people receiving NHS funded care. Minor injury or illness, requiring minor intervention, will probably resolve within one month Staff injury requiring time off work or light duties for 6 days or less Hospital acquired **colonisation** affecting one or more patients, member of staff or the public	Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS funded care. Staff injury requiring time off work or light duties for 7 – 35 days Hospital acquired **infection** affecting one or more patients, members of staff/the public or where a bay closure occurs	Any patient safety incident that resulted in moderate increase in treatment and which caused significant but not permanent harm to one or more persons receiving NHS funded care Moderate increase in treatment is defined as return to surgery, an unplanned readmission, prolonged episode of care, extra time in hospital or as and outpatient , cancelling of treatment or transfer to another area such as ITU as a result of the incident Moderate/ major injuries/Dangerous Occurrences reportable under RIDDOR Requiring time off work or light duties for >36 days with eventual recovery Unexpected admission to critical care area with eventual recovery MRSA Bacteraemia with eventual recovery	Severe: any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS funded care. Death: any patient safety incident that directly resulted in the death of one or more persons receiving NHS funded care. Unexpected death or significant permanent disability where outcome is directly attributable to a safety incident All Never Events* (See list below) Part 1 of death certificate stating hospital acquired infection Hospital acquired **infection** affecting > 1 ward

	1	2	3	4	5
Descriptor	**No Harm / insignificant**	**Very low harm / minor**	**Low harm**	**Moderate**	**Severe/Death**
				Hospital acquired **infection** affecting > 1 bay	
Health & Safety / Non clinical impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment No time off work	Minor injury or illness, requiring minor intervention, will resolve in 6 days or less Staff injury requiring time off work or light duties for 6 days or less	Injury or illness, requiring intervention, is expected to resolve within one month Staff injury requiring time off work or light duties for 7-35 days	Major injuries / dangerous occurrences reportable under RIDDOR Staff injury requiring time off work or light duties for >36 days with eventual recovery	An accident at work resulting in a fatality Significant permanent disability where outcome is directly attributable to a health and safety incident
Objectives / Projects	Insignificant project slippage Barely noticeable reduction in scope or quality	Minor project slippage Minor reduction in scope or quality	Serious overrun on project Reduction in scope or quality	Project in danger of not being delivered Failure to meet secondary objectives	Unable to deliver project Failure to meet primary objectives
Service / Business Interruption Environmental Impact	Loss / Interruption of service Up to 1 hour Minimal or no impact on the environment including contamination, not directly coming into contact with patients, staff or members of the public	Loss / Interruption of service 1 to 4 hours Minor impact on the environment	Loss / Interruption of service 4 to 8 hours Moderate impact on the environment	Loss / Interruption of service 8 hours to 2 days Major impact on the environment including ward closure	Loss / Interruption of service More than 2 days Catastrophic impact on the environment including multiple ward or hospital closure
Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training on an ongoing basis
Finance including claims	No obvious / small loss < £5k	£6k - £99k	£100k to £250k	£251k to £999k	Over £1m

	1	2	3	4	5
Descriptor	**No Harm / insignificant**	**Very low harm / minor**	**Low harm**	**Moderate**	**Severe/Death**
Statutory duty/ inspections	No or minimal impact or breach of guidance/statutory guidance	Breach of statutory legislation reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices low performance rating. Critical report	Multiple breaches in statutory duty Prosecution Complete system change required Zero performance rating. Severely critical report
Adverse Publicity / Reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Element of public expectation not being met	Local media coverage – long term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the house). Total loss of public confidence
Quality/ Complaints	Unsatisfactory patient experience not directly related to patient care Locally resolved concern	Overall treatment or service suboptimal Justified formal complaint peripheral to patient care	Treatment or service has significantly reduced effectiveness Justified formal complaint involving lack of appropriate clinical care, short term effects	Non-compliance with national standards with significant risk to patients if unresolved Justified multiple formal complaints. Serious mismanagement of care, long term effects	Totally unacceptable level or quality of treatment/service Ombudsman Inquiry Legal Claim
Information Governance	Less than 5 people affected or risk assessed as low e.g. files were encrypted	Serious potential breach & risk assessed high e.g. unencrypted clinical records lost. Up to 20 people affected.	Serious breach of confidentiality e.g. up to 100 people affected.	Serious breach with either particular sensitivity e.g. sexual health details, or up to 1000 people affected.	Serious breach with potential for ID theft or over 1000

Consequence	**Likelihood**				
	1	**2**	**3**	**4**	**5**
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

Consultation, Communication and Implementation

Consultation Required	Authorised By	Date Authorised	Comments
Equality Analysis	Pam Lees	13th December 2011	Full Equality Analysis not required
Policy Group	John Vanderwerff	12th October 2011	Checked for workforce / development, medicines, finance, NHSLA standards or wider corporate implications.
Other Stakeholders / Groups Consulted as Part of Development	Specifically Hospital Management Board members, Risk Lead for Maternity, Clinical Governance Lead for Maternity, Health and Safety Team, Chair of the Audit Committee		
Trust Staff Consultation via Intranet	14th December 2011 – 30th December 2011		

Date notice posted in the Trust Monthly Brief (TMB)	April 2013	**Date notice posted on the intranet**	April 2013

Describe the Implementation Plan for the Policy / Procedure / Strategy (Considerations include; launch event, awareness sessions, communication / training via DMTs and other management structures, etc)	**By Whom will this be Delivered?**
▪ Inform Division/Corporate Quality and Safety Management teams via TMB ▪ Incorporate into Quality and Safety based training ▪ Build on the risk tools, systems and processes used and further embed in the organisation ▪ Promote a culture of openness in terms of reporting and learning from incidents for both staff and patients ▪ Ensure that the lessons learnt from incidents, complaints and claims are shared and disseminated across the Trust to foster Trust-wide learning ▪ Use the Trust intranet to publicise and improve access to risk management information including risk management tools	All Trust staff groups named in the document.

Version History

Date	Ver	Author Name and Designation	Summary of Main Changes
Dec 2011	01	Pam Lees, Head of Quality and Safety	Integration of Proactive Risk Assessment Procedure and Risk Identification, Management and Escalation Policy into the Risk Management Strategy and Policy. Reflects approved changes in committee structure. Adjusted risk grading matrix to reflect NPSA matrix and order of matrix adjusted to reflect that consequence is considered prior to likelihood.
May 2012	02	Pam Lees, Head of Quality and Safety	Further detail/clarification on role of committees, insertion of links, revised Trust Wide Governance Structure to reflect reporting changes.
June 2012	03	Pam Lees, Head of Quality and Safety	Updated to provide clarity in section 9.1.7
February 2013	04	Evan Moore, Medical Director	Revised Governance structure and reporting mechanisms incorporated. Changes checked for NHSLA compliance Circulated to EDT members for comments
March 2013	4.1	Sarah Mattocks, Risk Manager	Addition of “Chemotherapy Prescribing” to the Risk Scoring Matrix.
May 2013	4.2	Melanie Maxwell, Associate Medical Director	Clarification of reporting. Update structures
September 2013	4.3	Joe Roberts, Head of Assurance	Additional information regarding Board risk training in section 9.6 to provide clarification for NHSLA Standard 3.6, and corresponding KPI; change in information reported to Risk Management Group
November 2013	4.4	Sarah Mattocks, Risk Manager	Information governance descriptor added to risk scoring matrix
March	4.5	Sarah Mattocks, Risk Manager	Updated risk scoring matrix added to policy

2014			
June 2014	4.6	Maryellen Dean; Associate Director of Risk Management	Review of the strategy to reflect current processes

Monitoring Compliance with the Policy

Describe Key Performance Indicators (KPIs)	Target %	How will the KPI be Monitored?	Which Committee will Monitor this KPI?	Frequency of Review	Lead
In date risk management strategy in place with risk management structures described	Approved	Risk Management Annual Report	RMG	Annual	Risk Manager
Risk Register reviewed at RMG *Risk (score 10 or above, out of date) and incidents (scored and colour coded 'orange' and 'red', overdue actions) are monitored corporately.*	On agenda	RMG agenda and minutes Annual Review of RMG against Terms of Reference Risk Management Annual Report	RMG	Monthly (min 10 per year) Annual	Risk Manager
Review of the Board Assurance Framework by the Board of Directors	Quarterly	Board minutes Satisfactory Internal Audit Opinion Risk Management Annual Report	Board of Directors (BOD) RMG	Annual	Associate Director of Governance
Risks (to be accepted,) are escalated to EDT	On EDT agenda	EDT agenda and minutes Risk Management Annual Report	EDT RMG	As they occur Annual	Risk Manager
Risk (graded at 20) reported to the Board of Directors	100%	Serious Incident Briefing Risk Management Annual Report	BOD	Monthly (min 10 per year)	Risk Manager
All members of the Trust Board the annual Board risk training update, or are followed up and receive the training on a one to one basis if they cannot attend	100%	Risk Management Annual Report	RMG	Annual	Risk Manager

Performance Management of the Policy

Who is Responsible for Co-ordinating Action Plans if KPIs are Not Met?	Which Committee Will Monitor These Action Plans?	Frequency of Review (To be agreed by Committee)
Associate Director of Risk	RMG	12monthly

Board of Directors		
Agenda Item	9.1	
Title of Report	Month 5 Monitor Compliance Report	
Date of Meeting	24 September 2014	
Author	Emma Pridgeon, Assistant Director of Finance – Corporate Financial Services	
Accountable Executive	Alistair Mulvey , Director of Finance	
Corporate Objective Ref as outlined in the BAF	13	
Level of Assurance		**Board Confirmation**
Full		
Data Quality Rating	Silver – quantitative data that has not been externally validated	
FOI status	Document may be disclosed in full	

Executive Summary

The Trust is on monthly monitoring for finance due to its financial position. It is therefore required to submit a template showing the financial position each month and a (brief) commentary on the year to date and in month position. It is not required to submit any financial or governance certifications, these are still required quarterly.

The Committee is asked to note the commentary that has been sent to Monitor for Month 5.

The Trust is now required to submit its commentary to Monitor on Working day 10, therefore it has been agreed to circulate the report to the members of the Finance Business Performance and Assurance Committee (FBP&AC) for information on submission.

Month 5 2014/15 Financial Commentary for Monitor

The following commentary covers the key reasons for the variations against plan as at month 5.

The cumulative financial position of the Trust to Month 5 shows a cumulative deficit of £4.8m against the planned loss of £4.2m, therefore a variance of £0.6m and an in month adverse variance of £0.1m.

NHS Clinical Revenue
Overall there is a gain of £0.9m against plan.

Key variances for the year to date are as follows:

Point of Delivery	Cumulative variance to plan £m	Commentary
Day case	0.6	On a cumulative basis there has been an over-performance in Gastroenterology (£0.3m) and Cardiology (£0.2m), Clinical Haematology (£0.1m), Vascular (£0.3m) and Oral Surgery (£0.1m), partly offset by underperformances in Ophthalmology (£0.2m), Gynaecology (£0.1m) and Trauma & Orthopedics (£0.2m). In month there was a minor variance and small movements across several specialties.
Elective	(0.2)	On a cumulative basis the majority of the variance is caused by an underperformance in Surgical specialties of £0.8m, partly offset by an overperformance in Medicine of £0.1m and due to the treatment of patients on the accelerated RTT pathway of £0.4m. In month the £0.2m favourable variance was largely caused by the accelerated pathway income, partly offset by an underperformance in Trauma and Orthopaedics due to volume and case mix.
Non elective	1.3	Overperformance in Medicine & Acute continues across specialties of £0.9m and also in Women & Children's by £0.2m. Surgery is under recovering by £0.1m. There is a £0.2m reduction for activity over and above the non elective block which is offset by the readmission cap and other income risk adjustments. In month the £0.2m gain reflects the fact that Medicine continues to improve by £0.2m and Women & Children's improved by £0.1m reflecting a more complex case mix. This was partly offset by a £0.1m underperformance in Trauma & Orthopaedics.
Outpatients	(0.4)	Outpatient procedures are cumulatively breakeven, within this there are a number of low value under and over performances. Outpatient Attendances (both first and follow up) are continuing to underperform across most specialties with a total value of £0.5m. The key areas of concern are ENT, Vascular, Gynecology, Paediatrics and Trauma & Orthopaedics. Included in this total is a reduction of £0.3m for the outpatient follow up cap, which represents approximately 3,120 attendances which the Trust is not paid for, discussions continue with the CCG on patient pathway changes to abate these penalties. The balance of the variance is due to RTT income of over £0.1m. The in month variance was due to a £0.3m fall for Outpatient attendances, mainly in ENT and Gynaecology, offset by accelerated RTT income.

A&E	0.1	This area continues to over perform due to increased activity, but is offset by a penalty for activity that has breached the 4 hour wait threshold. It also includes Urgent Care funding from Wirral CCG. The Trust has verbally agreed with the CCG that recognising that it is a 'whole economy issue' the A&E penalties are to be reinvested in the Trust.
Other – tariff	(0.1)	The year to date underperformance is mainly due to Unbundled Diagnostic Imaging of £0.1m. The small adverse in month variance of £0.1m was largely due to a deterioration on Maternity Pathways and transition.
Other non tariff	(0.4)	On a cumulative basis there are over performances in Direct Access Radiology (£0.3m) and Pathology (£0.1m), Critical Care (£0.2m) and Device Exclusions (£0.2m), offset by under recoveries for Critical Care NNU (£0.2m), HRG exclusions (£0.2m) and AMD (£0.2m). There is also an under recovery of High Cost Drugs and other pass through costs which is offset by lower spend (£0.3m). The balance comprises a number of smaller variances. CQUIN is reported as breakeven. In month the small variance is generated by a number of small over recoveries, in particular Adult Critical Care and Direct Access Radiology, offset by underperformances in AMD and HRG exclusions.
Total	**0.9**	

Included in the above figures is a £0.7m increase in income due to income generation schemes (with a net value of £0.6m) across a range of points of delivery. This is £0.1m behind planned levels.

Other Income and Operating Expenditure
These net costs are cumulatively above plan by £1.5m at month 5, an increase of £0.5m in month.

The key elements are:

Reason for variance	Cumulative variance to plan £m	Commentary
CIP delivery	(1.3)	At the outset of the year, it was recognized that not all the recurring and cash CIP schemes would be implemented and delivered from the start of the year, as noted in more detail below. The consequence of this is that cash slippage for the year against the CIP and cost avoidance plan for divisional expenditure and income (net of costs of delivery) is £1.3m, across most cost categories. In month there has been a £0.2m increase in this adverse variance.
Reserve release	2.3	As at month 5 the Trust has released £2.3m of reserves. In month only £0.3m of reserves were released which was considerably lower than earlier in the year.
Emergency care	(0.6)	This variance has increased by less than £0.1m in month in line with trend.
Unplanned beds / capacity	(0.4)	This variance has increased by just under £0.1m in month due to infection control issues driving the need to open isolation/additional wards.

Premium costs	(1.0)	Planned and unplanned activity at premium prices. This has increased by £0.3m in month which is above trend due to higher agency costs to cover leave and vacancies and RTT delivery, largely in Surgery.
Additional activity	(0.4)	There has been over spend of £0.4m which has been directly offset by an increase in NHS clinical income, most notably the income for the RTT (18 to 16 weeks) scheme. This has increased by £0.3m in month.
Non PBR offset	0.2	There has been an underspend of over £0.2m on items offset by a reduction in non PbR income (e.g. High Cost Drugs, Bloods and Device exclusions). There has been only a small change in month to this variance.
Other	(0.3)	There has been a year to date overspend of £0.3m on "other" expenditure/loss of income such as specialling, sickness and maternity cover, loss of private patient income etc., offset by vacancies. There has been a favourable movement of £0.1m this month, largely due to high levels of vacancies.
Total	**(1.5)**	

EBITDA
The impact of the fall in NHS Clinical Income and the overspend at divisional level creates a total adverse variance at EBITDA level of £0.6m year to date.

Achievement of 2014/15 Cost Improvement Programme
The Trust has an annual CIP target of £13.0m this was extracted from the budget at the start of the year. Identified CIP plans (c£8.5m) were extracted according to the profile of the schemes identified (including cost avoidance), with the balance extracted in a flat profile (12 ths). At the time of the plan the balance was £4.5m so under £0.4m was unidentified each month. The full requirement to month 5 identified a savings requirement of £3.8m.

As at month 5 schemes have delivered £2.4m (net of costs of delivery). Of this £0.6m is within Income Generation Schemes and £1.8m within CIP schemes (of which £0.5m is cost avoidance). Therefore there is shortfall of £1.4m against the year to date target of £3.8m.

Post EBITDA Items
There is a minor favourable variance to the post EBITDA budget at month 5 of £0.1m due to the underspend on the capital programme against plan generating an overall adverse bottom line variance of £0.5m at month 5.

Continuity of Service (COS) Rating
The Trust has achieved a COS rating of 1 against a planned rating of 2. The Capital Servicing Capacity metric is below plan due to the fall in the EBITDA position. The Liquidity ratio is a 1 rather than the planned 2 due mostly to the slippage on the sale of Springview which is now expected in October 2014 at a value of £0.8m higher than that initially planned. The Trust has agreed a loan of £7.5m against its capital programme with the ITFF and will draw down the first tranche in September. The Trust has discussed the drivers of the CoS of 1 in August and shared the plans for a return to CoS of 2 in September with Monitor.

Statement of Position (Balance Sheet)
The actual Total Assets Employed and Total Taxpayers Equity equal £147.3m.

The main variations against plan are as follows:

- Trade receivables across NHS and non NHS are slightly below budget. Overperformance amounts due are more than offset by several small debtors which were settled early or were lower than planned.

- There is a £2.4m debtor for the planned sale of Springview which has not yet taken place.

- Trade creditors and accruals are significantly higher than planned due to the timing and agreement of charges received, creditors for contract underperformance (due to assumptions on the payment of the contract profile) and the internal cash management changes.

- Deferred income is higher than planned largely due to the payment of the "maternity prepayment" monies.

- Capital spend (on accruals basis) for month 5 was £4.8m against a plan of £7.2m. This variance is due to the decision to lease equipment that was due for purchase at £0.6m and slippage on the Cerner and IT projects of £1.8m, of which £1.3m is offset by delays on PDC drawdown.

  The Trust has submitted a reforecast of its capital spend at quarter 1. The forecast to month 5 was £5.4m, therefore there is a £0.6m variance. This is due largely to a £0.2m timing difference on Cerner equipment spend and a delay on the A&E modifications project.

- There is a variance of £1.3m for the PDC not drawn down against the Cerner spend above. This is part of a £3.5m allocation in 2014/15 which is still due to be spent this year and was built into the Trust's reforecast.

- The cash balance at the end of month 5 was £14.7m, being £7.8m above the planned £6.9m. As noted above, this is due to the significant increase in creditors and accruals, slippage on capital payments and the maternity deferred income. Within these variances are also those improvements derived from the internal cash management work undertaken which impact the month end cash position. These increases have been partly been offset by the delays in the receipt from the sale of Springview.

Alistair Mulvey
Director of Finance
September 2014

August Reporting - Income Statement

Wirral University Teaching Hospital NHS Foundation Trust

	FY 14/15 FT Plan August 2014 Year to Date £m	FY 14/15 Actual August 2014 Year to Date £m	FY 14/15 Variance August 2014 Year to Date £m
Operating			
NHS Clinical Revenue			
Elective revenue, long stay:			
Tariff revenue	£10.071	£9.836	£(0.235)
Elective revenue, short stay:			
Tariff revenue	£0.000	£0.000	£0.000
Non-Elective revenue:			
Tariff revenue	£31.202	£32.514	£1.312
Planned same day (day case):			
Tariff revenue	£11.422	£12.005	£0.583
Outpatients:			
Tariff revenue	£14.759	£14.413	£(0.346)
Non-Tariff revenue	£0.000	£0.000	£0.000
A&E:			
Tariff revenue	£4.190	£4.279	£0.089
Other NHS Activity:			
Direct access & Op, all services (Tariff revenue)	£1.187	£1.076	£(0.111)
Maternity Pathway (Tariff revenue)	£2.577	£2.481	£(0.096)
CQUIN revenue (Non-Tariff revenue)	£2.148	£2.148	£0.000
Diagnostic tests & Imaging revenue (Non-Tariff revenue)	£1.823	£2.175	£0.352
Critical care - Adult, Neonate, Paediatric (Non-Tariff revenue)	£5.008	£5.197	£0.189
High cost drugs revenue from commissioners (Non-Tariff revenue)	£3.681	£3.385	£(0.296)
Other drugs revenue (all types all bands including Chemotherapy) (Non-Tariff revenue)	£1.018	£1.125	£0.107
Other (Non-Tariff revenue)	£22.094	£21.445	£(0.649)
Total	**£111.180**	**£112.079**	**£0.899**
Non Mandatory / non protected revenue			
Private Patient revenue	£0.656	£0.370	£(0.286)
Other Non Mandatory / non protected clinical revenue	£0.610	£0.430	£(0.180)
Total	**£1.266**	**£0.800**	**£(0.466)**
Other operating income			
Research and Development income	£0.136	£0.259	£0.123
Education and Training income	£3.847	£3.894	£0.047
Donations & Grants received of PPE & intangible assets	£0.000	£0.000	£0.000
Donations & Grants received of cash to buy PPE & intangible assets	£0.000	£0.000	£0.000
Parking Income	£0.497	£0.551	£0.054
Catering Income	£0.814	£0.831	£0.017
Revenue from non-patient services to other bodies	£3.179	£3.572	£0.393
Misc. Other Operating Income	£2.226	£2.379	£0.153
Total	**£10.699**	**£11.486**	**£0.787**
Total Operating Income	**£123.145**	**£124.365**	**£1.220**
Operating Expenses			
Employee Benefits Expenses	£(86.557)	£(84.181)	£2.376
Employee Benefits Expenses - agency and contract staff	£0.000	£(3.766)	£(3.766)
Drug Costs	£(8.764)	£(8.224)	£0.540
Clinical Supplies and Services	£(12.578)	£(13.054)	£(0.476)
Non Clinical Supplies and Services	£(2.116)	£(2.415)	£(0.299)
Consultancy expense	£0.000	£(0.065)	£(0.065)
Movement of Impairment of receivables	£0.000	£0.073	£0.073
Misc other Operating expenses	£(11.719)	£(11.945)	£(0.226)
Total operating expenses	**£(121.734)**	**£(123.577)**	**£(1.843)**
EBITDA	**£1.411**	**£0.788**	**£(0.623)**
Non operating income and expense			
Interest income	£0.123	£0.098	£(0.025)
Interest expense on Non commercial borrowings	£(0.098)	£(0.096)	£0.002
Interest expense on finance leases	£(0.030)	£(0.031)	£(0.001)
Depreciation and amortisation - owned assets	£(3.427)	£(3.363)	£0.064
Depreciation and amortisation - donated assets	£(0.096)	£(0.081)	£0.015
Depreciation and amortisation - finance leases	£(0.120)	£(0.121)	£(0.001)
Other Finance Costs - Unwinding Discount	£(0.022)	£(0.022)	£0.000
PDC dividend expense	£(1.949)	£(1.950)	£(0.001)
Loss on asset disposal	£0.000	£0.000	£0.000
Impairment (Losses) / Reversals net - purchased / constructed assets	£0.000	£0.000	£0.000
Impairment (Losses) / Reversals net - donated / granted assets	£0.000	£0.000	£0.000
Net Surplus / (Deficit)	**£(4.208)**	**£(4.778)**	**£(0.570)**
Comprehensive income and expense			
Revaluation gains /(losses) of donated / granted assets straight to reval reserve	£0.000	£0.000	£0.000
Revaluation gains / (losses) of purchased / constructed assets straight to reval reserve	£0.000	£0.000	£0.000
(Impairments) / reversals of purchased / constructed assets straight to reval reserve	£0.000	£0.000	£0.000
(Impairments) / reversals of donated / granted assets straight to reval reserve	£0.000	£0.000	£0.000
Fair Value gains / (losses) straight to reserves	£0.000	£0.000	£0.000
Other recognised gains and losses	£0.000	£0.000	£0.000
Total comprehensive income and expense	**£(4.208)**	**£(4.778)**	**£(0.570)**

August Reporting - Balance Sheet

Wirral University Teaching Hospital NHS Foundation Trust

	FY 14/15 FT Plan August 2014 £m	Actual August 2014 £m	Variance August 2014 £m
Non current assets			
Intangible Assets - Donated or granted	£0.000	£0.000	£0.000
Intangible Assets - Purchased or created	£12.193	£11.873	£(0.320)
Property, Plant and Equipmen - Donated or granted	£2.276	£2.300	£0.024
Property, Plant and Equipment - Purchased or constructe	£158.478	£156.642	£(1.836)
NHS Trade Receivables, Non-Current	£0.000	£0.000	£0.000
Other non current receivables	£2.134	£2.149	£0.015
Impairment of Receivables for Bad & doubtful debts	£(0.405)	£(0.233)	£0.172
Total non current assets	**£174.676**	**£172.731**	**£(1.945)**
Current Assets			
Inventories	£4.446	£4.184	£(0.262)
NHS Trade Receivables	£9.128	£7.366	£(1.762)
Non-NHS Trade Receivables	£1.012	£2.399	£1.387
Other Receivables	£1.406	£0.825	£(0.581)
Assets Held for Sale	£0.000	£2.435	£2.435
PDC Receivables	£0.000	£0.000	£0.000
Impairment of Receivables for Bad & doubtful debts	£(0.067)	£(0.458)	£(0.391)
Accrued Income	£1.440	£1.333	£(0.107)
Prepayments	£3.195	£2.682	£(0.513)
Cash and cash equivalents	£6.850	£14.710	£7.860
Total Current Assets	**£27.410**	**£35.476**	**£8.066**
Current liabilities			
Current loans	£(0.265)	£(0.266)	£(0.001)
Deferred income	£(2.358)	£(3.712)	£(1.354)
Provisions, current	£(0.745)	£(0.754)	£(0.009)
Trade Creditors	£(8.860)	£(15.729)	£(6.869)
Taxation payable	£(3.917)	£(3.726)	£0.191
Other Creditors	£(3.128)	£(2.755)	£0.373
Capital Creditors	£(1.947)	£(0.727)	£1.220
Accruals	£(8.344)	£(10.023)	£(1.679)
Payments on account	£(0.900)	£(0.900)	£0.000
Finance leases, current	£(0.341)	£(0.340)	£0.001
Interest payable on non commercial loans	£(0.098)	£(0.104)	£(0.006)
PDC creditor	£(1.949)	£(2.065)	£(0.116)
Total Current Liabilities	**£(32.852)**	**£(41.101)**	**£(8.249)**
Net Current Assets / (Liabilities)	**£(5.442)**	**£(5.625)**	**£(0.183)**
Liabilities, non current			
Loans, non current, non commercial	£(5.174)	£(5.174)	£0.000
Deferred income, non current	£(11.840)	£(11.840)	£0.000
Provisions for Liabilities and Charges	£(2.590)	£(2.532)	£0.058
Finance leases, non current	£(0.300)	£(0.300)	£0.000
	£(19.904)	**£(19.846)**	**£0.058**
Total Assets Employed	**£149.330**	**£147.260**	**£(2.070)**
Taxpayers equity			
Public Dividend Capital	£72.385	£71.100	£(1.285)
Retained earnings	£30.119	£29.106	£(1.013)
Revaluation reserve	£46.826	£47.054	£0.228
Total Taxpayers Equity	**£149.330**	**£147.260**	**£(2.070)**

August Reporting - Cashflow

Wirral University Teaching Hospital NHS Foundation Trust

	FY 14/15 FT Plan Year to Date August 2014 £m	FY 14/15 Actual Year to Date August 2014 £m	FY 14/15 Variance Year to Date August 2014 £m
Surplus/(deficit) after tax	**£(4.208)**	**£(4.778)**	**£(0.570)**
Finance income/charges	£0.005	£0.051	£0.046
Donations & Grants received of PPE & intangible assets (not cash)	£0.000	£0.000	£0.000
Other operating non-cash movements	£0.000	£0.000	£0.000
Depreciation and amortisation, total	£3.643	£3.565	£(0.078)
Impairment losses/(reversals)	£0.000	£0.000	£0.000
Gain/(loss) on disposal of property plant and equipment	£0.000	£0.000	£0.000
PDC dividend expense	£1.949	£1.950	£0.001
Other increases/(decreases) to reconcile to profit/(loss) from operations	£0.000	£0.000	£0.000
Non-cash flows in operating surplus/(deficit), Total	**£5.597**	**£5.566**	**£(0.031)**
Movement in Working Capital			
Inventories	£0.000	£(0.048)	£(0.048)
NHS Trade receivables	£(0.485)	£2.168	£2.653
Non NHS Trade receivables	£(0.030)	£(1.177)	£(1.147)
Other receivables	£(0.094)	£1.043	£1.137
Assets held for sale	£0.000	£(2.435)	£(2.435)
Accrued income	£(0.257)	£(0.070)	£0.187
Prepayments	£(1.615)	£(0.831)	£0.784
Deferred income	£(0.210)	£0.974	£1.184
Provisions for Liabilities and Charges	£0.030	£(0.037)	£(0.067)
Tax payable	£(0.001)	£(0.150)	£(0.149)
Trade Payables	£(0.694)	£3.539	£4.233
Other Payables	£(0.014)	£(0.005)	£0.009
Payment on Account	£0.000	£0.000	£0.000
Accruals	£(0.293)	£1.879	£2.172
	£(3.663)	**£4.850**	**£8.513**
Net cash inflow / (outflow) from operating activities	**£(2.274)**	**£5.638**	**£7.912**
Investing activities			
Property - new land, buildings or dwellings	£(1.350)	£(0.779)	£0.571
Property - maintenance expenditure	£(0.250)	£(0.562)	£(0.312)
Plant and equipment - Information Technology	£(1.616)	£(0.046)	£1.570
Plant and equipment - Other	£(0.664)	£(0.260)	£0.404
Expenditure on capitalised development	£0.000	£0.000	£0.000
Purchase of intangible assets	£(3.353)	£(3.181)	£0.172
Increase/(decrease) in Capital Creditors	£0.347	£(0.636)	£(0.983)
	£(6.886)	**£(5.464)**	**£1.422**
Net cash inflow / (outflow) before financing	**£(9.160)**	**£0.174**	**£9.333**
Financing activities			
Public Dividend Capital received	£3.500	£2.215	£(1.285)
Public Dividend Capital paid	£0.000	£0.000	£0.000
Interest (Paid) on non commercial loans	£0.000	£0.000	£0.000
Interest element of finance lease rental payments	£(0.030)	£(0.031)	£(0.001)
Capital element of finance lease rental payments	£(0.135)	£(0.135)	£0.000
Interest (Paid) / Received on cash and cash equivalents	£0.123	£0.096	£(0.027)
Drawdown of non commercial loans	£0.000	£0.000	£0.000
Repayment of non commercial loans	£0.000	£0.000	£0.000
Non current receivables	£2.400	£2.357	£(0.043)
Other Non current receivables	£0.000	£0.000	£0.000
Other cash flows from financing activities	£0.000	£0.000	£0.000
Net increase / (decrease) in cash and cash equivalents	**£(3.302)**	**£4.676**	**£7.977**
Opening cash and cash equivalents	£10.152	£10.034	£(0.118)
Net cash (outflow) / inflow	£(3.302)	£4.676	£7.977
Closing cash and cash equivalents	**£6.851**	**£14.710**	**£7.859**

WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST

Key Ratios / Risk Rating 2014/15

Based on August 2014 Reported Performance

			Risk Rating			
Financial Criteria	**Weight %age**	**Metric to be scored**	**1**	**2**	**3**	**4**
Liquidity Ratio (Days)	50%	Liquidity Ratio (Days)	<-14	-14	-7	0
Capital Servicing Capacity (Times)	50%	Capital Servicing Capacity (Times)	<1.25 x	1.25	1.75	2.50

Wirral Hospital Position

Financial Criteria	**Weight %age**	**Metric to be scored**	**2014/15 ratings - Actual**		**2014/15 ratings - Plan**	
Liquidity Ratio (Days)	50%	Liquidity Ratio (Days)	-14.86	**1**	-12.18	**2**
Capital Servicing Capacity (Times)	50%	Capital Servicing Capacity (Times)	0.40	**1**	0.69	**1**
		Weighted average risk rating		**1.00**		**1.50**
		Overall Risk Rating		**1**		**2**

Board of Directors		
Agenda Item	9.1	
Title of Report	Quarter 1 2014-15 Feedback - Wirral	
Date of Meeting	24 September 2014	
Author	David Allison, Chief Executive	
Accountable Executive	David Allison, Chief Executive	
Corporate Objective Ref as outlined in the BAF	13, 14	
Level of Assurance		**Board Confirmation**
Full		
Data Quality Rating	Gold – externally validate	
FOI status	Document may be disclosed in full	

Executive Summary

Attached is Monitor's analysis of the Trust's Quarter 1 submissions for both Continuity of Services and Governance**.**

17 September 2014

Mr David Allison
Chief Executive
Wirral University Teaching Hospital NHS Foundation Trust
Arrowe Park Hospital
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Upton
Wirral
CH49 5PE

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Dear Mr Allison

Q1 2014/15 monitoring of NHS foundation trusts

Our analysis of your Q1 submissions is now complete. Based on this work, the trust's current ratings are:

- Continuity of services risk rating - 2
- Governance risk rating - Green

These ratings will be published on Monitor's website later in September.

The trust has been assigned a Green governance rating but failed to meet the A&E 4 hour wait target in Q1. This is the third quarter in seven that has been breached.

Monitor uses the above targets (amongst others) as indicators to assess the quality of governance at foundation trusts. A failure by a foundation trust to achieve the targets applicable to it could indicate that the trust is providing health care services in breach of its licence. Accordingly, in such circumstances, Monitor could consider whether to take any regulatory action under the 2012 Act, taking into account as appropriate its published guidance on the licence and enforcement action including its Enforcement Guidance[1] and the Risk Assessment Framework[2].

We expect the trust to address the issues leading to the target failure and achieve sustainable compliance with the target promptly.

We also have the following concerns from our review of the trust's Q1 submissions:

- The trust's liquidity position is below plan at Q1. The trust has reported to Monitor that this is set to decline further, with the Trust forecasting a CoS RR of 1 in Month 5 with improvement in Month 6 following receipt of a loan from the ITFF in September 2014.

[1] www.monitor-nhsft.gov.uk/node/2622
[2] www.monitor.gov.uk/raf

We expect the trust to address the causes of financial decline promptly, and return to plan as soon as possible.

Monitor has decided not to open an investigation to assess whether the trust could be in breach of its licence at this stage for either A&E or financial performance.

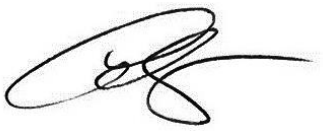
We will monitor A&E performance against a monthly trajectory for recovery that is yet to be determined, and will consider what, if any, further regulatory action may be appropriate if this is not delivered. We will consider the financial position of the Trust on an ongoing basis as part of monthly monitoring arrangements, and monitor the cash position against the revised cash flow forecast provided by the Trust on 1 September 2014.

A report on the FT sector aggregate performance from Q1 2014/15 will shortly be available on our website (in the News, events and publications section) which I hope you will find of interest.

For your information, we will shortly be issuing a press release setting out a summary of the key findings across the FT sector from the Q1 monitoring cycle.

If you have any queries relating to the above, please contact me by telephone on 02037470479 or by email (Carla.Moody@Monitor.gov.uk).

Yours sincerely



Carla Moody
Senior Regional Manager

cc: Mr Michael Carr, Chairman
Mr Alistair Mulvey, Director of Finance

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF MEETING

30th JULY 2014

BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL

Present:	
Michael Carr	Chairman
David Allison	Chief Executive
Cathy Bond	Non-Executive Director
Andrea Hodgson	Non-Executive Director
Anthony Hassall	Director of Strategic & Organisational Development
Cathy Maddaford	Non-Executive Director
Evan Moore	Medical Director
Alistair Mulvey	Director of Finance
Jean Quinn	Non-Executive Director
Graham Hollick	Non-Executive Director
Apologies:	
Sharon Gilligan	Director of Operations
In attendance:	
Carole Self	Associate Director of Governance (minutes)
Mark Blakeman	Director of Infrastructure & Informatics
Terry Whalley	Project Director
Governors:	John Karan, Public Governor
Members of Staff:	Julie Tunney Alex Constantinou
Members of the Public:	None

Reference	Minute	Action
BM 14-15/059	**Apologies for Absence** Apologies were noted as above.	
BM 14-15/060	**Declarations of Interest** Mrs Quinn declared an interest in that her daughter was a member of the Urgent Care Board	
BM 14-15/061	**Patient's Story** The Director of Nursing and Midwifery provided the Board with an overview of 3 letters from patients complimenting the Trust on the level of care they received. The Board was also advised that a significant amount of work had been undertaken on complaints handling, the results of which would be presented in a report to the Board in the next couple of months.	**JG**

Reference	Minute	Action
BM 14-15/062	**Chairman's Business** The Chairman welcomed Ms Hodgson and Mr Whalley to their first Board of Directors Meeting. The Board was advised of a new consultant appointment in Palliative Care this being Dr Kathryn Hale. The Chairman advised of the interview process that was due to take place that afternoon with the Medical Director in respect of cardiologist appointments. The Board was advised of the recent correspondence from the Cabinet Office to all Trusts providing details of the forthcoming Mutual and Health Pathfinder Programme available to 10 Trusts. The Chairman confirmed that having considered the benefits for the Trust and the work required to be undertaken, the conclusion was that the Trust would not bid for the programme at this time although the benefits of the approach were felt to be worthy of consideration in the future. The Board concurred with this view.	
BM 14-15/063	**Chief Executive's Report** The Chief Executive provided an overview of the key highlights in the Chief Executive Report. An update on the external support commissioned through KPMG and Atkins/FTI was provided, with good progress against the themes of cash management and transitional turnaround being reported. The Chief Executive updated the Board on the two joint posts in cardiology currently being recruited in collaboration with the Liverpool Heart and Chest Hospital together with notification of further meetings planned to progress the relationship in tertiary heart and cardiology services in the future. The Board was updated on the recent meeting between the Trust and the Countess of Chester to progress collaboration in a number of specialities for the benefit of the wider population. The Chief Executive confirmed that an Executive to Executive meeting was planned for September in which some of the discussions would be accelerated further, and supported with a "light touch" structure. A joint internal statement was due to be shared between both organisations in order to communicate what the common agenda was and how this would be delivered. The Chief Executive confirmed that more strategic discussions with the Community Trust were required in order that the delivery model for the future could be progressed. The Board was assured that the Community Trust was represented on a number of actions in the Urgent Care Recovery Plan although it was noted that there were some concerns about delay in actioning these.	

Reference	Minute	Action
	An update on the monthly call with Monitor was provided as detailed in the report together with notification of the Trust's invitation for the new Monitor team to visit the hospital site. The Board was updated on the recent outbreak of Carbapenemase Producing Enterobacteriaceae (CPE) and the actions being undertaken by the Trust to identify patients who were positive for CPE and those who had a high risk of exposure through screening in order to ensure they were isolated. The Board were informed of Mr Whalley's involvement in this work programme. The Board were keen to understand to what extent the Trust was an outlier on CPE and whether the screening programme deployed by the Trust had led to a higher number of cases being identified. The Director of Nursing and Midwifery confirmed that the Trust and Central Manchester Hospitals were outliers although following the introduction of national testing, many Trusts were now identifying incidences and were asking for our help, so much so, that a conference to share learning and best practice had been organised for September 2014. The Board were advised that Public Health England supported the approach adopted by the Trust. The Chief Executive outlined the NHS England initiative for reducing referral to treatment targets (RTT) for the whole NHS in order to assist with some of the winter pressures. The Board were advised that although the Trust had been compliant with the RTT for the last couple of years, by participating in the initiative it was likely to lead to a failure in the target for the next quarter which the local commissioners and the regulator Monitor recognised. The Board debated the impact of the RTT initiative and the forthcoming work from Wales on bed capacity and how this would be managed safely. Assurance was given in that additional income would allow the Trust to open more beds. The Board agreed that there should be a clear message to staff to understand the impact of increased bed capacity against a Vision of reducing beds. Mrs Bond asked whether an algorithm could be produced which took into account changes in contractual income and mapped this through to the impact on activity and productivity.	**AM/SG**
BM 14-15/064	**Urgent Care Recovery Plan** The Chief Executive drew the Board's attention to some of the demand challenges described in the covering report which also featured in the Trust's recent letter to the Secretary of State. The Board was appraised of the impact on the 4 hour standard of patients attending with greater levels of acuity and the need therefore to change behaviour on a system wide basis to ensure that only those patients that need to attend A & E do attend. The outcomes of the "Perfect Day" exercise which was designed to consider best practice in a single day, were communicated with particular reference being made to the GP phone line which had managed to redirect 30% of referrals on the day in question.	

Reference	Minute	Action
	The Board were advised that alternatives to admission on a whole system wide basis were required as well as the Trust ensuring that its internal systems were operating at an optimum level. The Chief Executive updated the Board on the work the Trust had been undertaking with Greater Manchester Commissioning Support Unit GMCSU and in particular the point prevalence study, the outputs of which were due to be communicated to the Trust the following day. The Trust was assured from the work with the GMCSU that all the learning undertaken had been incorporated into the overall Urgent Care Recovery Plan. The Chief Executive updated the Board with the current A & E performance, this being 91.2% against a target set for July of 94% in order to achieve an overall trajectory by the end of quarter 2 of 95%. The reasons for non-compliance were debated, one of which was the outbreak of CPE which impacted on the Trust's performance for a full week. The Board were advised of the conversations that the Clinical Commissioning Group were undertaking with Monitor in relation to organisational resilience planning as a health system which focused on incremental long term sustainability which in essence would mean aiming to achieve the A & E standard from the next calendar year. The Chief Executive confirmed that he had expressed his concerns over the timescales for achievement, not only because of the need for the Trust to meet the standard before then but also because this was traditionally the most challenging quarter of the year. The Board was advised that there was a very high risk of non-compliance with the Quarter 2 A & E standard because of the performance to date in July. The Chief Executive confirmed that the Trust was doing all that it could to achieve this with the support of Atkins/FTI focussing on patient flow, length of stay, early decision making, effective discharge and the workforce model in the Emergency Department. The Chief Executive further advised that the Urgent Care Board had agreed the 7 schemes in the Urgency Care Recovery Plan and thus the CCG had in principle agreed to support the funding of the resources from 21st July 2014 in order to deliver these. The Trust had since been advised that the funding was linked to the organisational resilience plan for the health system and as such was concerned about the availability and timeliness of the previously agreed monthly sums. The Chief Executive confirmed that discussions were ongoing with the CCG in order to resolve this. The Board debated the risks around the funding and the links to longer term sustainability and sought assurance that not only the Trust but the health system could deliver the change outlined in the Urgent Care Recovery Plan. The Chief Executive raised concerns around the lack of progress of the Vision 2018 process however he confirmed that the CCG had agreed to review progress against each of the schemes on a monthly basis to determine whether any of the initiatives could be "switched off" as a result of change in referral patterns.	

Reference	Minute	Action
	The Board sought assurance that the additional capacity being put into place in relation to the work required as part of the Urgent Care Recovery Plan, the RTT work and the forthcoming Welsh work could be undertaken safely and with a high degree of quality. The Director of Nursing and Midwifery provided reassurance that additional audits and risk management processes had been put in place to ensure that patients were safe. The impact of the opening of additional beds at short notice was being risk assessed constantly; the situation was being managed although it was noted that this was not easy. She confirmed that an update paper would be provided to the next Quality and Safety Committee with a view to providing assurance against all the areas of concern highlighted. The Board debated the lack of sustainability of the funding beyond 3 months and the impact this would have on the Trust and its ability to do the very best for its patients as well as maintain and improve its financial situation. The Board were also made aware that the additional funding was predicated on being able to provide a satisfactory organisational resilience plan for the whole health economy. The Board debated the increase in demand and whether this alone was a factor in terms of non-compliance. The Chief Executive confirmed that the increase in demand, the change in acuity levels of patients presenting coupled with the financial pressures resulting in a reduction in beds overall and the increased funding required to put the appropriate levels of nurse staffing in place had rendered the Trust unable to open beds in a way that it used to. The Board asked for further assurance and clarity on the key issues and actions being taken should this not be forthcoming from the Utilisation Management event being led by the CCG and the Central Manchester Commissioning Support Unit. The Board agreed to debate this further at the next Development Session. The Board considered the impact of the potential non-compliance with the A & E standard for Quarter 2 on its Provider Licence. The Associate Director of Governance provided an update on the process as outlined in the Risk Assessment Framework and the possible action which could be taken by Monitor. The Board were assured that Monitor had been fully briefed on the current situation.	**SG**
BM 14-15/065	**Integrated Performance Report** **Integrated Dashboard and Exception Reports** The Director of Informatics presented the integrated performance report confirming that the key performance indicators were now shown against each strategic objective. He also confirmed that as a result of the decision at the last Board meeting, the key performance indicators in relation to Cancer standards were now included. The key risks highlighted included the achievement of the A & E standard and the financial position of the Trust which would be discussed in greater detail as part of the Director of Finance report.	

Reference	Minute	Action
	The Director of Informatics confirmed that although the infection control indicator was showing as green, achievement of the standard was still difficult and the standard did not include CPE which the Trust was currently managing. The Board were asked to reflect upon whether CPE should be included in the report in the future recognising that there was currently no standard in this area.	
BM 14-15/066	**Finance Report** The Director of Finance presented the Finance Report which provided an overview of the Trust's high level financial performance to the end of quarter 1. The Board were advised that after three months of the financial year, the Trust was reporting a cumulative deficit of £3.4M against a planned deficit of £3.1M giving an adverse variance year to date of £0.3M. The Director of Finance confirmed that performance for month 3 delivered a marginal surplus against plan of £0.2M which was a marked albeit relative improvement on the previous two months financial performance. The Board were advised that whilst the Trust's income and expenditure performance was marginally off plan, its cash position was materially above plan with cash balances of £11.3M against a plan of £5.6M. The Trust's cash position was largely attributed to early settlement of debtors, delays in the payment of creditors, the slippage in the capital programme together with improvements in the overall cash management systems implemented in the past two months. The Director of Finance confirmed that the current financial performance was delivering a Continuity of Service (CoS) rating of 2 as planned. The Board were advised that in order to maintain the financial position the Trust had had to apply £1.7M of reserves which was not sustainable. Improvements in income targets of £481K year to date were confirmed with over performance of £681K in month three negating the under performance in the preceding two months. The Director of Finance advised of a reduction in pay costs by £200K in relation to April and May, this was attributed to reduced capacity and a reduction in the use of flexible labour. He also confirmed that the additional income associated with the RTT initiative, the Welsh work and the Urgent Care Recovery Plan would cover the expenditure required. The Board discussed the cost improvement plan and noted that although the gap overall was narrowing, the pace was not currently fast enough to impact on the current year. The current plans whilst short of the target in year would deliver the excess of £13M on a full year basis. The Director of Finance confirmed that the Trust had engaged the services of Atkins/FTI in helping to deliver greater levels of in year savings as well as develop a deeper transformational plan for the short, medium and longer term.	

Reference	Minute	Action
	The Director of Finance concluded his report by confirming that the Trust on aggregate was largely on plan; was delivering the planned CoS rating despite there being quite a few pressures as outlined. Mr Hollick was asked for his view as Chair of the Finance, Business Performance and Assurance Committee and whether this overview concurred with the view of this Committee. Mr Hollick confirmed that this did, further adding that concern had been raised at the Committee that there was too much focus on cost avoidance and reliance on additional income as opposed to genuine cost reduction. Concerns were also raised about the slippage in the capital programme and the impact on operations.	
BM 14-15/067	**Urgent Care Costs** The Director of Finance presented the report confirming that this was being presented in response to an action requested by the Board. The Board was advised that the report was a retrospective look at costs for 2013/14. The report focused on the nature of the costs, which specialities these relate to and the learning from this work. The Board were assured that despite the apparent reference to cessation of the HPV programme in the report that this was in actual fact continuing recognising the importance in the Trust. The Director of Finance confirmed that the review had helped both finance, operations and nursing to assess the risk and modelling of the additional work as a result of RTT, Urgent Care and the Welsh Work which would prove invaluable in the future.	
BM 14-15/068	**Report of the Quality and Safety Committee** **14th May 2014; 11th June 2014; 9th July 2014** Mrs Quinn provided an overview of the work of the Quality and Safety Committee over the last 3 months which included a review of patient stories both positive and negative. The Board was advised that the current issues being raised by patients were in relation to communication and attitudes, delays in transfers of care and the use of flexible labour. Of particular note was the work being undertaken to improve staff attendance levels in those areas experiencing the most difficulty; the results of the staff survey which showed an improvement in response rates, some improvements in scores as well as areas which need greater focus and the Friends and Family test results for the Emergency Department which were amongst the best in the country. The Director of Strategic and Organisational Development outlined the actions being put in place to provide the right level of empathy and scrutiny in managing attendance levels in order that these improve. The cost improvement programme/impact on quality dashboard was felt to be a particularly useful tool which provided assurance that the financial constraints were not impacting on the overall key quality indicators as prescribed by CQC and Monitor.	

Reference	Minute	Action
	Risks associated with limited capital needed to be recognised and monitored. The Board reviewed the items highlighted for the risk register and asked that the Associate Director of Governance seek guidance and provide a response to each of these. The Board thanked Mrs Quinn for the report.	**CS**
BM 14-15/069	**Report of the Finance, Performance and Business Development Committee** **27th June 2014; 25th July 2014** Mr Hollick provided an overview of the work of the Finance, Business Performance and Assurance Committee over the last 2 months which included a review of the Terms of Reference as detailed in the Governance Review paper. Mr Hollick confirmed that the Committee had accepted these as a transitional set of terms of reference whilst the changes were being evaluated. The Board was advised that a full review of the proposed sale of Springview; the options for borrowing and the private patient initiative had been undertaken, with recommendations to progress in all three cases. Due to the commercial in confidence nature of these discussions, the Board had agreed to review the recommendations in the private session of the Board. Mr Hollick confirmed that the Board statements in the Monitor Compliance Report Quarter 1 were reviewed and recommended by the Committee although further consideration of the statement in relation to the A & E standard would be worthy of discussion later in the meeting following the earlier debate. Mr Hollick reiterated his earlier concerns relating to the progress of the CIP programme; the slippage in the capital programme and performance against the A & E standard which was being escalated as a specific risk to the Board. The Medical Director provided the Board with clarity on the business case for emergency surgeons which was reviewed by the Committee. He confirmed that this was for 4 surgeons and associated support at a total cost of £500K and was part of the Trust's overall strategy.	
BM 14-15/070	**Nursing and Midwifery Strategy – Progress Update** The Director of Nursing and Midwifery provided the Board with a progress update against the actions highlighted in the "plan on a page". The Board were advised that only 6 actions had not as yet started and were assured that these were not immediately essentially but continue to be a part of the strategy going forward. The Board was advised that regular updates on progress were being provided to the Quality and Safety Committee.	

Reference	Minute	Action
	The Board was advised that the fundamental standards of nursing care were being audited through the Nursing and Midwifery audit processes and this had highlighted further work to be undertaken in the areas of nail and mouth care. The Board was provided with a copy of the Nursing and Midwifery Strategy 2013-18. The Board recorded it's thanks to the Director of Nursing and Midwifery for the work undertaken	
BM 14-15/071	**Monitor Q1 Board Statements** The Associate Director of Governance presented the Monitor Compliance Report Quarter 1 reiterating that the Finance Business Performance and Assurance Committee had previously reviewed this in detail and recommended this for approval by the Board. The Board were reminded of earlier conversations relating to A & E standards and anticipated non-compliance in Quarter 2 and asked to consider in detail this particular statement. The Board broadly agreed the statement with some minor alteration to take into account the level of risk of non-compliance and the reliance on the health economy as a whole. Delegated authority to make the necessary change was given to the Chief Executive. The Board therefore approved the following recommendations: i) it does not confirm for finance, that the Board anticipates the Trust will continue to maintain a Continuity of Service Rating of over 3 over the next 12 months; ii) it does not confirm for governance that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework, and a commitment to comply with all known targets going forwards; **iii)** it otherwise confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per Compliance Framework page 16 Diagram 8 and page 58 and the Risk Assessment Framework page 21, Diagram 6) which have not already been reported **iv)** it anticipates that the Trust's capital expenditure for the remainder of the financial year will not materially differ from the attached reforecast plan	**DA**
BM 14-15/072	**External Assessment** **Q4 Letter from Monitor 2013/14** The Board of Directors noted the letter	
BM 14-15/073	**Health and Safety Update and future reporting** The Director of Strategic and Organisational Development presented the update on Health and Safety advising the Board that this was to provide assurance against the key areas of compliance building on the work	

Reference	Minute	Action
	previously reported to the Board in April 2014. The Board was advised of the changes made to the governance arrangements for Health and Safety with the Executive Lead now Chairing the Health and Safety Group. The Board was advised that employee incidents were reducing and wanted assurance that this was as a result of the training and awareness the Trust had undertaken and not under reporting. The Director of Strategic and Organisational Developments updated the Board on the imminent Health and Safety Executive Visit on 8th August 2014 which included the arrangements and the principle reason for this. The Board asked for a full update on the visit as soon as possible after the 8th August 2014. The Board were provided with an overview of the actions undertaken against the action plan including an explanation of where dates had been reviewed as a result of further action to be undertaken. The further work required to mitigate the risks associated with legionella and asbestos were outlined. The Board were advised that the £84K capital investment required to mitigate some of the risk associated with working at height had been approved with the remainder of the work being risk assessed and actions put in place to mitigate the risk accordingly. The Board agreed to receive a further update on progress at the Board of Directors in November on the proviso that regular updates would be given at the Quality and Safety Committee. The Board were pleased with the progress being made with the exception of asbestos where they felt that this was a little slow. An explanation was provided as to the reason which included further site surveys highlighted the presence of asbestos. The Board supported the suggestion that the Trust's Internal Auditors might be asked to undertake a governance review of Health and Safety over the coming year.	**AH** **AH** **AH**
BM 14-15/074	**Governance Review** The Associate Director of Governance presented a summary of the work undertaken as part of the Governance Review. The report drew together the internal and external recommendations over the past 18 months and followed full debate and engagement at the previous Board Development Session. The Board approved the agenda cycles for the Board, Quality and Safety Committee and the Finance Business Performance and Assurance Committee. The Board approved the terms of reference for the Quality and Safety and Finance Business Performance and Assurance Committees along with the revised Board Assurance Framework.	

Reference	Minute	Action
	The Board thanked the Associate Director of Governance for the Report and agreed for a formal evaluation to be undertaken in January 2015.	
BM 14-15/075	**Report of the Remuneration and Appointments Committee** The Board of Directors noted the report	
BM 14-15/076	**Board of Directors** **Minutes of the meeting dated 25th June 2014** The minutes of the meeting held on the 25th June 2014 were agreed as a correct record of the meeting**.** **Board Action Log** The Board reviewed the action log and agreed that the following actions had now been completed: Minute Ref: BM 14-15/042 – Revised Board Assurance Framework approved 30th July 2014 Minute Ref BM 14-15/016 – Report on Urgent Care Costs received 30th July 2014 Minute Ref BM 14-15/024 – Report on Health and Safety received 30th July 2014 with a further update being received in November 2014 Minute Ref: BM 14-45/097 – Working Capital facility approved at the private session of the Board 30th July 2014 for reasons of commercial in confidence	
BM 14-15/077	**Any Other Business** None	
BM 14-15/078	**Items for BAF/Risk Register** The corporate risk associated with Health and Safety and other wider corporate risks to be discussed between the Chair of the Audit Committee and the Associate Director of Governance.	**CS/CB**
BM 14-15/079	**Date and Time of Next Meeting** Wednesday 24th September 2014 at 9.00 a.m. in the Boardroom, Education Centre, Arrowe Park Hospital.	

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Chairman

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Date

ACTION LOG

Board of Directors

Updated – 24 September 2014

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 30.07.14						
July-14	BM 14-15/061	Update on complaints handling	JG		Nov 14	
July - 14	BM 14-15/063	Algorithm to be produced that took into account changes in contractual income and mapped through to the impact on activity and productivity	AM/SG		Nov 14	
July - 14	BM 14015/064	Further clarity to be provided at a Board Development Sessions on the key issues in relation to Urgent Care as a result of the utilisation management event.	SG	Included in the Board Development Session 24.9.14	Sept 14	

July - 14	BM 14-15/068	Items highlighted for the risk register from Q & S to be considered further and a response provided for each	CS	The identification of ownership of premises and activity will be based on the service level agreement in place with the partner organisation. This will determine the level of liability based on each individual case. If the incident occurred that was a direct result of our activity i.e. we misdiagnosed or used faulty equipment that was taken to the site, we may be deemed responsible under section 3 of the Health & Safety at Work Act for those not in our employment affected by our work activity. If the incident occurred as a result of poorly maintained premises or equipment provided by the host employer they would be held responsible. As part of our duty we would be responsible for highlighting any shortfall in the premises we were working in to the host. HR to liaise with Director of Nursing and Midwifery to advise on the operation of the safe employment policy with respect to these staff from this hospital working safely in the community.	Sept 14	

July - 14	BM 14-15/071	Make the necessary amendments to Monitor Q1 Board statement in relation to A & E Standards	DA	**Completed**	n/a	
July - 14	BM 14-15/073	Provide the Board with an update following the HSE visit on 08.08.14	AH	**Completed**	Nov 14	
July - 14	BM 14-15/073	Provide a progress update on compliance with Health and Safety Legislation	AH		Nov 14	
July - 14	BM 14-15/073	Explore the possibility of the internal auditors undertaking a governance review on health and safety	AH		Nov 14	
July - 14	BM 14-15/078	Consider how corporate risks such as health and safety legislation can be linked to the BAF in the future	CS/CB	**Completed** Corporate risk around legislation developed	Sept 14	
Date of Meeting 25.06.14						
Jun- 14	BM 14-15/054	Cancer targets to be included in the integrated dashboard	MB	**Completed**	July14	
Date of Meeting: 28.05.14						
May 14-	BM 14-15/039	Undertake a review of headroom percentages for nurse staffing once NICE guidelines were published.	JG		October 14	
Date of Meeting: 30.04.14						
Apr 14-4	BM 14-15/016	Additional information to non-core spend data to be developed	MB / AM	To be completed in September 2014 CEO has agreed with DoF that analysis of non-core spend will now be included within the core finance report rather than reporting through the HR route. Analysis now included in the BoD Finance report	July 14	

APR 14-5	BM 14-15/017	Provide proposed financial reporting areas, and related data, for the Board to focus on for 2014/15	MB / AM	To be completed in September 2014 CEO, DoF and John Halliday met with CB to discuss areas of additional information to add insight to BoD discussions. Additionally DoF has met with GH to reframe report-ing through to FPaBAC and subsequently BoD with aim being revisions to October cycle of meetings	July 14	

Board of Directors		
Agenda Item	10.2	
Title of Report	Risk Register	
Date of Meeting	24 September 2014	
Author	Jill Galvani , Director of Nursing and Midwifery	
Accountable Executive	David Allison, Chief Executive	
Corporate Objective Ref as outlined in the BAF	11	
Level of Assurance		**Board Confirmation**
Some concerns		
Data Quality Rating	N/A	
FOI status	Document may be disclosed in full	

1. Introduction

This risk is being escalated to the Board in line with the Risk Management Strategy and Policy.

The Board is asked to note the work being undertaken in this area to reduce the risk which has been discussed at length at the Quality and Safety Committee most recently on the 10th September 2014 and at the Operational Management Team on the 12th September 2014.

An update is also provided in the Chief Executive's Report and the Board of Directors will note the regular weekly updates they have been sent to keep them informed of progress.

2. Recommendations

The Board is asked to consider whether they are assured that this risk is being actively managed to reduce it

Risk Register Report - Risk 2611

Report Produced: 21 August 2014 at 11:26:27 hrs.

R/R Ref No	Division / Directorate / Corporate Department / Source	Description of Risk	Issue	Action Plan Summary	Action Progress	Last Review Date	Target Date / Next Review Date	Lead	Risk Level (Initial)	Risk Level (Current/ Residual)
2611	Corporate Departments Trust Wide External Review	There is a risk that: A multi or pan-resistant highly virulent bacterial infection breaks out within Arrowe Park or Clatterbridge and that this outbreak becomes widespread and/or uncontrolled, in terms of different organisms and/or the number of patients, beds or wards affected. If this occurs this may result in a negative impact in patient safety and/or operations within the hospitals, which could range from additional length of stay, to increased mortality through to possible postponement of elective treatments or even closure for non-elective treatment in the worst case scenario.	There is a gap between current infection prevention capability and the level recommended by Public Health England	1. Mobilise a program of work with exec leadership and engagement 2. Prepare a comprehensive set of actions, comprising short, medium and longer term initiatives that will reduce the likelihood and/or impact 3. Review the risk profile at least monthly to assure progress and/or escalate impediments	1. Completed Jul 2014 2. Completed Aug 2014 3. Ongoing - monthly throughout 2014 by Terry Whalley	21/08/14 Also on Corporate Executive Register	01/10/14	Jill Galvani	**25** Severity: 5 Likelihood: 5	**25** Severity: 5 Likelihood: 5