Board of Directors

Public Board

22nd February 2017

MEETING OF THE BOARD OF DIRECTORS ON WEDNESDAY 22nd FEBRUARY 2017
COMMENCING AT 9.00AM IN THE
BOARD ROOM
EDUCATION CENTRE, ARROWE PARK HOSPITAL

AGENDA

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

5. Quality and Safety

5.1	**Care Quality Commission progress report** Director of Nursing and Midwifery	d
5.2	**Patient's story – learning** Director of Nursing and Midwifery	v
5.3	**Pharmacy Transformation Plan** Director of Pharmacy and Medicines Management	d
5.4	**Patient Safety Alert - Nasogastric Tube Misplacement** Director of Nursing and Midwifery	d

6. Performance and Improvement

6.1 Integrated Performance Report

	6.1.1 Integrated Dashboard and Exception Reports Chief Operating Officer	d
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7. Governance

7.1	**Finance Business Performance and Assurance Committee Report** Chair of Finance Business Performance and Assurance Committee	d

7.2 Board of Directors

	7.2.1 Minutes of the Previous Meeting – 25th January 2017	d
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8. Standing Items

8.1	**Items for BAF/Risk Register** Chairman	v
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8.3	**Any Other Business** Chairman	v
8.4	**Date and Time of Next Meeting** Wednesday 29th March 2017	v

Board of Directors	
Agenda Item	4
Title of Report	Chief Executive's Report
Date of Meeting	22 February 2017
Author	David Allison, Chief Executive
Accountable Executive	David Allison, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	ALL
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To Note
Data Quality Rating	N/A
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	N/A

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

Internal

- **Getting it Right First Time (GIRFT)**

On the 19th January the Trust received a visit from Professor Tim Briggs and the national Getting It Right First Time (GIRFT) team. GIRFT are supporting the national Lord Carter

Model Hospital work identifying opportunities to improve clinical variation and quality as a method of driving financial efficiencies in the NHS.

The team was extremely positive with the work they presented for our Trauma and Orthopedic service saying that the clinical outcomes were the best they had seen in the Mersey and Cheshire region. Through 2017/18 the GIRFT team will be developing their methodologies with all surgical specialties having received £60 million of national funding to do this.

WUTH is looking to link closely with the GIRFT work to see if there are any mutually beneficial opportunities with our Global Digital Exemplar status to improve clinical variation further.

- **Global Digital Exemplar (GDE) Programme Board**

The Trust held the inaugural meeting of the GDE Programme Board on 16th February 2017 with colleagues across the Trust and representation from NHS England and the Countess of Chester who is a fast follower to this work.

At the time of writing the Trust was still awaiting the first tranche of funding for this programme.

The Trust Board will receive quarterly updates on the work of the Programme Board as set out in the funding agreement between the Trust and NHS England.

Regulatory

- **Care Quality Commission (CQC)**

The Trust met with the CQC on 10th February 2017 in order to review the Trust's serious incident reporting and root cause analysis processes and structures as there was recognition from the Regulator and the Trust that this required improvement. The CQC was pleased with the approach being adopted by the Trust.

The Trust also discussed future inspections in light of the recent consultation on changes to the regulatory regime. CQC agreed with the Trust that the inspection needed to cover more than the proposed one single service area plus a review of the Well led domain as the Trust needed to be able to demonstrate improvements across the organisation as a whole. The Trust awaits further details on this in terms of timing. The next meeting with CQC is planned for 10th April 2017.

- **Emergency Preparedness, Resilience, Response EPRR Core Standards Assessment**

Attached is the acknowledgement from NHS England to the Trust's self-assessment on the core standards which showed substantial compliance. The Trust is monitoring the action plan to address the minor gaps through its Governance and Assurance Structure.

External

- **Winter Pressures**

The Trust, as with many, continues to be challenged with timely patient flow, which manifests itself in increased waiting times for patients within the Emergency Department.

The Trust continues to focus on the fundamentals of the SAFER programme and escalation of delayed discharges both within the economy and via NHSE.

An area of continued concern is the fragility of the care home and domiciliary care provision. To mitigate the impact on patient flow and egress within the Emergency Department, the Board will be aware that the Trust has sourced additional Discharge to Assess beds, to ensure inpatient beds are for those patients requiring acute inpatient care. The commissioned discharge to assess beds are now starting to see length of stay increase as patients await discharge back home with domiciliary care.

Strategy

The STP reconfiguration of services exercise continues with particular focus at present on maternity and neonatal services. The Trust is fully engaged in these processes to ensure that the high quality care we provide which supports hundreds of vulnerable babies and their families every year continues into the future.

The work on the development of an Accountable Care Organisation on the Wirral is progressing with partners, supported with external facilitation. To aid this work, West Cheshire have shared the work undertaken which is in line with best practice. Partners are due to respond to the PWC guidance on this by the 1st April 2017.

Wirral Health and Social Care Partners have agreed to hold an "Out of Hospital Care Summit" in order to review and develop sustainable plans for the future as a result of inadequate provision in the community.

Celebrating Success

- **Innovation in the NHS**

It gives me great pleasure to advise you that Dr King Sun Leong, our Consultant Physician for diabetes, has been featured in a BBC article highlighting how our work as a Trust is an example of innovation in the UK.

The Trust has a community diabetes clinic reaching patients who are unable to come into the hospital. Essentially this is looking at different ways of offering our services and taking our hospital out into the community. Dr Leong set up the clinic in November 2015, with the aim of capturing patients at an early stage before type-2 diabetes develops further.

He works alongside a GP and a nurse monitoring patients and their lifestyle. Offering advice and treatment at this stage helps to mitigate future health issues. Early intervention is key here and going out into the community ensures that advice and treatment is given at the earliest opportunity.

It is great to see this working within our community. We must continue to be innovative in our approaches to healthcare and thanks go to Dr Leong and his team for all the work around diabetes. Prevention work at an early stage to stop diabetes taking hold will be of benefit to many people in Wirral.

David Allison
Chief Executive
February 2017

NHS England

Mr Chris Oliver
Accountable Officer for EPRR
Wirral University Teaching
Hospital NHS Foundation Trust
Arrowe Park Hospital
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18th January 2017

Dear Chris

RE: Emergency Preparedness, Resilience and Response (EPRR) Core Standards Assurance

Thank you for submitting your organisation's EPRR Core Standards documentation, your statement of compliance level was submitted as Substantial compliance.

We can confirm all information was submitted within the required timescale, signed by your Board of Directors and had a clear action plan relating to any minor gaps.

Areas of work identified within your action plan will be reviewed in the 2017/2018 Core Standards Returns.

Many thanks for your continued support.

Yours sincerely

A. C. Crawshaw

Andrew Crawshaw
Director of Assurance Delivery

cc: EP Lead

High quality care for all, now and for future generations

Board of Directors	
Agenda Item	5.1
Title of Report	CQC Preparedness Update
Date of Meeting	22.2.17
Author	Joe Roberts, Head of Assurance
Accountable Executive	Dr Susan Gilby, Medical Director Gaynor Westray, Director of Nursing
BAF References	Risk 1 - Fully comply with our registration with the Care Quality Commission
Level of Assurance	Positive
Purpose of the Paper	To note
Data Quality Rating	Bronze
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken	Not applicable

1. Executive Summary

The attached report summarises the outcome of the 'Deep Dive' event held on 30th January, outlines changes to the internal Care Quality Inspection programme, and discusses the Trust's response to the CQC consultation about changes to their inspection process.

2. Background

The 'Deep Dive' events involve a panel consisting of Executive and Non-Executive Directors and representatives of the Quality and Safety Team questioning representatives from the clinical divisions and the corporate services in detail about their progress towards completing their action plans and achieving the CQC Fundamental Standards. Four of these have now taken place.

The CQI programme is our principal assurance process regarding compliance with the CQC standards in wards and clinical departments. The programme has been running in its current form since December 2015 although a similar programme of mock inspections ran for eight months in 2015 prior to the full CQC inspection.

In December 2016 CQC published a consultation on changes to their inspection process. One of the most significant proposed changes is a reduction in the number of full comprehensive inspections, to be replaced by a well-led assessment and an inspection of one or two core

services each year. Depending on the outcome of the consultation exercise, these changes will take effect from April.

3. Key Issues

The Deep Dive highlighted that good progress has been made in all three divisions, and in Emergency Planning and Estates management. In particular, a range of initiatives in the Acute & Medical Division are in place to improve patient flow and go above and beyond the actions in the original action plan. However, medicines management remains a concern in clinical areas, as evidenced by the findings of the CQIs, the matron's spot checks of medicines storage, and Pharmacy's controlled drug audits.

The CQIs work on a peer review basis, and in recent months, the operational pressures on the hospital have made it difficult for clinical staff to be released to take part in the inspection teams. The inspection process has slowed as a result. Approximately half of the wards and clinical departments have been visited over the past year. At the current rate of progress it is unlikely that we would be able to visit all areas by the time of a CQC inspection expected in the summer.

The Trust has responded corporately to the CQC consultation process which closed last week. We were in agreement with the great majority of the proposals but were concerned that the reduction in the number of full comprehensive inspections would make it more difficult for Trusts like ours to improve their rating from 'requires improvement' to 'good'.

4. Next Steps

This paper sets out a new approach to the CQIs, which will involve prioritising areas that have not yet been visited, and a more streamlined re-inspection process for areas that are being revisited.

In the near future we will know whether the new CQC Inspection process will be implemented in full, or if there have been any changes in response to the consultation. Depending on the outcome, we will need to update our CQI questionnaires and the evidence which we collect to show whether we are achieving the standards.

We will continue to follow up progress on the outstanding actions in the CQC Action Plans.

5. Conclusion

Generally we are making strong progress in preparing for re-inspection. The Deep Dive events have been very helpful in developing our understanding of our strengths and weaknesses, and of how those weaknesses are being addressed.

6. Recommendation

The Board are asked to note this report.

CQC Preparedness Update – February 2017

Introduction

This paper summarises the outcome of the Deep Dive event which took place at the end of January; informs readers of changes to the Care Quality Inspection programme which should allow more areas to be visited before CQC arrive for their inspection; and advises of the implications of proposed changes to CQC's regulatory model.

Deep Dive – January 2017

Another 'Deep Dive' event – the fourth - was held on 30th January. The leadership teams of the three clinical divisions were required to give presentations covering any of their actions which were still outstanding in the CQC Action Plans, and what they are doing to improve risk management, medicines management and record-keeping in their areas. They were also asked to give an overall assessment of their inspection readiness. Finally, managers responsible for Estates and Emergency Planning gave presentations about their preparedness for inspection.

The Deep Dive provided positive assurance regarding our preparedness for inspection, and highlighted good practice and innovation in some areas, although medicines management remains of concern (detailed results of medicines storage audits and spot checks were provided to participants).

Acute and Medical Specialties Division

Outstanding issues from the Action Plans: Although some individual actions in the developmental action plan have been delayed, for example the revision to the Emergency Nurse Practitioner rotas, a considerable amount of effort has gone into improving patient flow, which goes above and beyond the original action plan. For example, Matrons have been given protected time to ensure that the SAFER initiative is implemented. A new bed management model is being developed and we are working more closely with partner organisations, e.g. through the Integrated Discharge Team and the 'Emergency Village' concept. Many operational difficulties are caused by short 'surges' of demand in the Emergency Department and we are working to anticipate and manage these better.

Risk Management: Good progress was reported with risk management and governance in the division. Good practice and lessons from incidents are being shared through a safety newsletter and good practice meetings within specialties. The divisional quality and safety team are increasing their visibility in clinical areas through ward safety visits. There has been a notable increase in the frequency of incident reporting in Critical Care, previously a low-reporting area, where the impact of a new Matron is now being felt. Two of the division's wards recently achieved the gold standard in the Trust's Ward Accreditation scheme.

Record Keeping: Many of the areas in the regular record-keeping audit where the division performed worst (signing and dating amendments to notes, adding the medical record number to each page, etc) have now been superseded with the advent of electronic medical noting, as Millennium records this information automatically and can provide an audit trail.

Medicines Management: in common with other divisions, and in line with the position that has previously been reported through Care Quality Inspections and action plan updates, there remains room for improvement. The division will be analysing the results of the quarterly audit in more detail to see where and when non-compliance with standards most commonly occurs. These departments and staff will be supported to improve, with accountability for individuals if necessary.

Surgery, Women's and Children's Division

Outstanding issues from the Action Plans: Progress was being made with the small number of actions remaining in the developmental action plan. We have now signed a contract with a software supplier for a new Maternity App that will be available in several different languages; this had been delayed due to some commercial issues with the originally-selected supplier. The division have also identified staff in Maternity to act as 'governance champions', who will promote incident reporting, investigation and shared learning. With regard to Paediatric Life Support training for staff in Theatres, the division are ensuring that it is delivered to all staff who need it by outsourcing training to the Countess of Chester until we are able to deliver it in-house.

Risk Management: the division have reviewed the clinical governance meeting structures in Women's and Children's to make them work better. A local tracking and escalation process has been developed for out of date actions; where necessary, staff are also being encouraged to set more realistic deadlines in the first place.

Record Keeping: while the introduction of electronic medical noting has eliminated many common issues with record keeping standards, the availability of paper casenotes has been problematic for outpatient clinics in some areas such as Fracture Clinic and Oral and Maxillofacial. The time taken to pull out and prepare notes for clinics has been a factor and is partly attributed to gaps in clerical staffing in certain areas. A weekly service improvement meeting is monitoring progress and notes are now being obtained further in advance of the patients' appointment dates.

Medicines Management: in common with the other divisions, improvement needs to be seen in medicines storage and security, including for controlled drugs. There is now an additional audit programme in place, supported by the lead pharmacist and deputy Associate Director of Nursing. Improving medicines management practice in their areas is included in the appraisal objectives of the Sisters / managers of clinical areas; and medicines management is discussed in the monthly ward review meetings. Some capital expenditure is needed to improve security in Theatres, and a capital bid is being produced.

Clinical Support and Diagnostics Division

Outstanding issues from the Action Plans: The age of some of our radiology equipment was of concern to CQC. The divisional leadership reported that approval had been given to replace our scanner CT1 and the procurement process was due to start. An options appraisal to formulate a long term solution for replacement of the other radiology capital equipment had been undertaken, with the financial appraisal being the final action to be completed. Another principal issue was the lack of clarity about what constitutes an 'urgent referral'; the panel were advised that the urgent referral criteria had since been ratified and shared with commissioners. We were also committed to introduce and monitor standards for reporting times for urgent exams; this action was still in progress.

A review of capacity and demand had highlighted the need for additional Radiologists. One new Consultant had taken up their post in November and the Trust was out to advert for more posts at the time of the Deep Dive. As an interim solution, work is being outsourced until we are up to full strength. A nationwide shortage of radiologists is making recruitment more challenging.

Our laboratories are working towards ISO accreditation. Although this is not part of our CQC Action Plans, CQC will take account of ISO compliance in their inspections, and achieving this would stand us in good stead. The divisional leadership reported that they had consulted with their counterparts at organisations which have already achieved ISO accreditation to identify what resources we would need to allocate to the project.

Risk Management: the division's performance has generally been good, with no overdue Root Cause Analysis investigations, policy reviews or gap analyses for NICE guidance. They will be building on this with a new clinical governance newsletter, to be launched in the first quarter of 2017 and a review of governance arrangements for the Cancer Data Team and the Integrated Discharge Team.

Record Keeping: the Trustwide record keeping audit does not report on clinical support services separately and there have been no concerns specific to this division. However, the division reported that they were commencing audits of Allied Health Professionals' entries in clinical notes, starting with Occupational Therapy, and were also working with IT to get the few remaining paper-based assessments onto the Millennium electronic patient record.

Medicines Management: The outpatient prescribing policy is under review and will include improvements around the safe storage/record keeping procedures for prescription pads.

Emergency Planning

The report of the 2015 inspection made few observations or recommendations about emergency planning, and thus there are no actions in our action plans to address the topic. Nonetheless, having a full-time post dedicated to emergency management since January 2015 has made a notable difference, and our Emergency Planning Lead was able to report about substantial improvements that had been made over the past 18 months.

The panel was advised that during the past year emergency plans have been reviewed and published, and NHS England had given us a 'significant assurance' rating against their core standards in 2016. During the year, we dealt effectively with events including junior doctor's strikes, two power outages, and significant developments to the Millennium system. Training and information has been provided for key personnel, for example: an induction programme for 24/7 Hospital On-call Directors and Managers; a hospital on-call booklet; and a regional pandemic flu seminar which was organised by us and held at Arrowe Park.

The priorities for the next six months are: completing a business impact analysis; developing more detailed business continuity plans; updating departmental major incident action cards; and procuring / delivering CBRN training for the Emergency Department.

Estates and Facilities

The 2015 Inspection report made only a small number of very specific recommendations affecting particular wards and departments, and these were actioned quickly.

However, there have been a number of positive developments, which were reported by the Head of Estates. A Site Strategy Group has been formed to identify our future estates requirements and our plan to meet them. A ward refurbishment programme has also been submitted.

A regular estates report is now produced every month for the Operational Performance Team, giving a clearer view of estates performance and issues which need to be tackled; previously there had been a lack of management information about the condition of our estate. We also have sources of external assurance – MIAA completed a review of Estates Management which was graded as 'significant assurance', and we performed well in the estates and premises element of the PLACE assessment (although less well in the catering module).

The panel were informed that there were four priorities in the first quarter of 2017: implementing an action plan in response to an external review of water safety; submitting a capital bid to fund

compartmentation measures for fire safety; filling managerial vacancies within the Estates department; and working through backlog maintenance. The first three actions are expected to be complete by April. Jobs in the maintenance backlog are prioritised according to a risk assessment, and the Trust Board is informed of the priority decisions that have been taken.

Development of the Care Quality Inspection Programme

The Care Quality Inspection programme is based around CQC's five key questions (safe, caring, responsive, effective, and well-led) and evolved from the mock inspections which the Trust organised in advance of the 2015 CQC Inspection. One day each month was allocated for inspections, with a morning and afternoon session. Quality and Safety staff are present on each team but the intention is that the majority of inspectors are front-line clinical staff themselves. In December 2016 the frequency of inspections was increased from monthly to fortnightly.

However, in recent months, participation in the inspection teams by staff has dropped, principally because of the operational pressure on the hospital. The high level of admissions and activity means that often staff cannot be made available to act as inspectors. Even when inspection teams have been available, it has been necessary to cut short some visits because the high level of acuity on those wards meant that taking staff aside to ask them questions would risk compromising patient care.

In total, 30 clinical areas have been inspected over the past twelve months, some of which have been re-visited to check on progress, because there were improvements identified in their original inspections. This leaves 29 areas still to be visited.

Based on discussions with CQC at our regular engagement meetings, it is anticipated that the Trust could be re-inspected in the early summer. Given that we have inspected approximately half of the wards / clinics in the past year, it is unrealistic to expect that we could complete full inspections of the remainder in the next five months.

In the meantime, CQC have been consulting on proposals to change their inspection model (see below). More detail would be added to key lines of enquiry relating to medicines management and information governance, and some KLOE's would move from one domain of the inspection to another. If CQC go ahead with the changes, it will be necessary to amend the CQI questionnaires to reflect the new KLOE's.

Way Forward

Those areas which have not yet been inspected as part of the current programme will be prioritised for inspection. Data from the ward profiles compiled by Corporate Nursing will be used to decide which wards should be visited first – for example those which perform poorly on the Friends and Family Test, experience high levels of complaints, or obtain poor results in Matron's spot checks.

Of areas which have already been inspected but achieved 'requires improvement' (note: no areas have been rated inadequate during the past year), there should be a full re-inspection of any which scored 'requires improvement' or worse for three or more of the five key questions. Others will undergo a smaller, more focused inspection looking specifically at the issues which caused concern last time, the 'well led' domain, and a small sample of other questions from the inspection questionnaire.

Areas rated as 'good' will only be revisited when resources permit, or if concerns later become apparent.

Measures will be taken to increase the number of people taking part. The inspections will be publicised more widely in order to seek volunteers – a new poster has been produced with the dates of the inspections for the first half of 2017. We will make a particular effort to use staff who have a clinical background but who are not currently in a patient-facing role. Also, in the past the CQIs have involved volunteers recruited through the Trust's Voluntary Services Office, several of whom were retired clinicians.

CQC Proposals to revise inspection methodology

In late December 2016, CQC published a consultation – *the Next Phase* – about proposed changes to their inspection model. The consultation document starts by setting out nine principles on which the inspection model is based:

1. *We will always take action to protect and promote the health and well-being of people using services where we find poor care.*
2. *We will hold to account those responsible for the quality and safety of care.*
3. *We will be proportionate, and will take into account how each organisation is structured and its track record to determine when and how to inspect.*
4. *We will align our inspection process, where possible, to minimise complexity for providers that deliver more than one type of service.*
5. *We will be transparent about our approach and about how we make regulatory decisions.*
6. *We will not penalise providers that have taken over poor services because they want to improve them.*
7. *We will deliver a comparable assessment for each type of service, regardless of whether it is inspected on its own or as part of a complex provider.*
8. *We will rate and report in a way that is meaningful to the public, people using services and providers.*
9. *We will bring together inspectors who have specialist knowledge of different sectors to inspect jointly, where this is most appropriate for the provider.*

It is also important to be aware of the context for the proposed changes. CQC have found it difficult to resource their comprehensive inspections, which often involve 50+ senior clinicians and senior managers visiting an organisation for 3-4 days. This is partly because the organisations which employ inspection team members find it difficult to release them from clinical duties to work with CQC.

There are significant organisational changes taking place in much of the NHS, and new models of delivering and managing services are being developed, in line with the Five Year Forward View for the NHS. This represents a challenge for CQC as an increasing number of organisations no longer fit easily into one category.

Finally, it has become more common for organisations (more commonly in the private / independent sector) to challenge the findings of inspection reports or their ratings through the legal process.

The Trust has submitted a response to the consultation, following discussion by the Senior Management Team. From the Trust's perspective, the great majority of the proposed changes are welcome, for example:

- Reducing the number of documents requested prior to an inspection
- Placing greater reliance on the results of other external assessments and accreditations, e.g. JAG, CPA, ISO
- Separating gynaecology from maternity, and diagnostic imaging from outpatients, so that these services receive their own separate ratings

- Adding new Key Lines of Enquiry to cover topics such as information governance, promoting healthy lifestyles, and the role of volunteers
- Strengthening relationship management with provider organisations by building on the current structure of engagement meetings

However, the Trust should be aware that CQC are proposing to greatly reduce the number of full comprehensive inspections. Under the plans, these would usually only be done at newly-registered providers, or organisations which give cause for serious concern. Instead, there would normally be an annual review against the well-led criteria, and an inspection of one or two core services. This would make it more difficult for Trusts like ours, which are rated as 'requires improvement', to upgrade to 'good'. Our response highlighted our concerns about this change.

Joe Roberts
Head of Assurance
10th February 2017

Board Of Directors	
Agenda Item	5.3
Title of Report	Hospital Pharmacy Transformation Programme – Second Submission
Date of Meeting	February 2017
Author	Pippa Roberts, Director of Pharmacy and Medicines Management
Accountable Executive	Susan Gilby, Medical Director David Jago, Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	1,2,3,4,5,6,7,8, All 1,2,3,4,5,6,8,9,12,13,14,15,16,18,19,20
Level of Assurance • **Positive** • **Gap(s)**	Positive Where gaps exist they are addressed in the action plan
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Approval
Reviewed by Executive Committee	Senior Management Team 7th February 2017
Data Quality Rating	Gold – externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	n/a

1. Background

An initial draft plan for the Hospital Pharmacy Transformation Programme was submitted to NHSI, following SMT approval at the end of October 2016. The WUTH draft plan was rated 'green' by NHSI and commended as an exemplar. This plan was prepared under the overarching programme of work undertaken to deliver the recommendations from the Carter report issued 5th February 2016.

General feedback was provided to all Trusts via study days in December 2016 to enable plans to be updated if required, before final plans are signed off by Trust Boards and then submitted to NHSI by March 31st 2017. NHSI lifted the restriction on document length to support the Board's understanding of pharmacy services and to give further explanation of corporate governance arrangement for the plans developed.

NHSI also noted a number of themes across plans nationally including challenges with recruitment and retention of pharmacy staff, the ability to transform services at a time of greater financial control when capital investment is limited and the critical dependencies of information technology and willingness of parties to collaborate to support re-configuration plans.

This plan has been further developed to include the recommendations regarding content and to reflect the latest release of the hospital pharmacy metrics and collaboration developments where applicable. It is expected that the plan will be dynamic and be updated to reflect updated hospital pharmacy metrics as they are published.

This plan was recommended by SMT prior to FBPAC submission.

2. Key Issues/Gaps in Assurance

The plan is attached. Gaps in performance, risk and issues are addressed within the plan.

3. Next Steps

This plan will need final approval from the Trust Board of Directors in advance of its submission to NHSI in March 2017.

4. Conclusion

The Trust presents strong performance against the Carter Model Hospital Metrics for Pharmacy services and the medicines optimisation agenda. Where performance is lower than upper quartile there is a plan in place which will be managed as part of the pharmacy and medicines programme within the Trust's transformation portfolio. Collaboration with partners and the use/integration of information technology is a critical dependency for the delivery of many of the efficiencies required.

5. Recommendations

FBPAC are asked to approve the Hospital Pharmacy Transformation plan.

1.0 Executive Summary

Lord Carter published his final report in February 2016 to the Secretary of State for Health, identifying unwarranted variation across all of the main healthcare resource areas. It contained recommendations for transforming hospital pharmacy services across the following key lines of enquiry; money and resources and safe, effective, caring and responsive care. It published a range of hospital pharmacy metrics. The Trust's performance against these metric provides assurance that WUTH Pharmacy Services deliver value for money and are heavily weighted towards the clinical pharmacy, safety and governance activities described in the Lord Carter vision. This paper describes the key areas of work to further develop services and enhance performance through local action within the Trust and through collaboration with primary and secondary health partners.

2.0 Introduction to Pharmacy Services at Wirral University Teaching Hospital (WUTH)

The NHS and Social Care on Wirral serve a population of 300,000 with medicines prescription and administration being the most common healthcare intervention in the acute care setting. The service faces a range of challenges which impact on service provision and as a result upon the use of medicines in our population:

- shorter lifespan than the England national average in our deprived areas,
- stark heath inequalities,
- an ageing population,
- poor health outcomes exacerbated by high levels of unemployment e.g. alcohol related conditions,
- multiple co-morbidities with associated polypharmacy.

At WUTH the integral nature of medicines optimisation within the healthcare pathway is well recognised with the Director of Pharmacy working as a member of the Trust Board of Directors and providing leadership for trust-wide projects.

We strive to deliver "the right medicine, to the right patient, at the right time" and the pharmacy service supports this vision by:

- taking a holistic approach to the patient as an individual,
- providing extended access to medicines advice and supply 24/7; 365 days a year and
- integrating the medicines optimisation agenda in all aspects of the Trust governance structures and within the multidisciplinary healthcare teams at all levels of the organisation.

The Trust employs 182.4 wte pharmacy staff; pharmacists, pharmacy technicians and dispensers, pharmacy support workers and administrative staff. They provide prescribing, traditional clinical pharmacy, medicines management, safety, aseptics, dispensary and procurement, stores and distribution services for WUTH and for two local hospices. They also provide supply and recall only services for the community trust, primary care clinics and the North West Ambulance Service. In addition, the Aseptic Services Unit provides medicines for external customers. The supply of medicines to external organisations requires the service to hold MHRA licences, for wholesaler dealing and aseptic preparation, and Home Office licences on both sites for the supply of controlled

drugs. The dispensary is also registered with the General Pharmaceutical Council of Great Britain. These licences are subject to stringent and extensive service inspections and provide assurance with respect to service quality for both the Trust and external customers. These achievements have secured external customers, for example the North West Ambulance Service contract in 2016, and will facilitate future growth and collaboration opportunities if deemed appropriate. Value for money benchmarks published within the Carter work indicate that the service offers good value for money (see appendix 1).

The seven day clinical pharmacy service offered at WUTH is well respected and integrated within multidisciplinary teams across the Trust. The service is constantly evolving to support Trust quality measures and multidisciplinary workforce developments. The Trust has funded a range of pharmacy extended roles to solve shortages in medical cover; including pharmacist led outpatient clinics; extended technician support at ward level to support prescription accuracy and information provision for patients; and the majority of ward pharmacists are prescribers or can amend prescriptions under Trust guidance as part of the multidisciplinary team. Currently pharmacists initiate ~10% of all medicines in the trust and make 75% of the amendments needed. This equates to ~10,000 newly prescribed medicines and 18,000 modifications to prescriptions per month. Demand for additional clinical pharmacy services are ever increasing as they are seen as a critical part of the solution to manage patient flow, safety and shortages in other healthcare professional groups.

The pharmacy team are committed to establishing safer systems and processes for managing medicines across the health economy and to this end operate a joint medicines formulary with primary care designed to manage the entry of new medicines across the Wirral health economy. Current data indicates 98% of hospital prescribing complies with the Wirral-wide formulary and of the 2% non-compliance over 80% would be deemed appropriate for the individual patient against agreed criteria. The pharmacy team provide support for and authorise all clinical guidance and pathways involving medicines. New developments are being explored via a programme called “net-formulary” which also includes the use of associated apps for mobile devices to improve hospital and GP access to the relevant guidance.

Pharmacy staff review **all** medicines incidents daily (Monday to Friday) and manage all prescribing and dispensing incidents via the Trust risk management system. They are involved with and quality assure all reviews for serious incidents and they ensure that they contain a robust action plans to address the root cause and contributory factors leading to incidents.

They deliver a large number of specific medicines training programmes for multidisciplinary teams, medical and nursing staff across the Trust. There are strong links with John Moore’s University, with 3 senior pharmacists undertaking joint teaching roles. This team organise extensive work and vacation experience schemes to support the pharmacy recruitment plan.

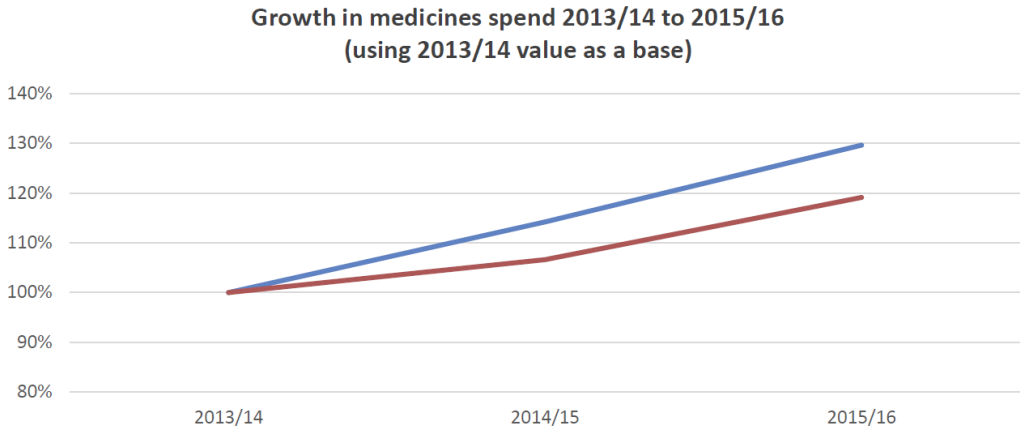
Clinical pharmacy activity in the Trust is supported by medicines procurement and supply services which are constantly evolving and striving to improve key performance indicators monitored by the senior pharmacy management team. The Trust’s medicines expenditure totalled £20m in 2015/16, over £13m of which is paid for by primary care/specialist commissioning as a pass through payment. For payment to be made, drug, patient and indication level data must be provided to commissioners to give assurance that medicines are being used in line with national guidance and good practice. The Trust’s Pharmacy Team were one of the first to provide this level of data assurance nationally. The main pharmacy store (based at Clatterbridge Hospital) issued 717,887

packs of medicines in 2015/16 and provided over 9.5k stock replenishment visits to wards and departments, the majority of which also involve putting stock away in line with our ward standardisation criteria. This releases nursing staff time for patient care and supports Care Quality Commission standards for medicines management. The distribution service has recently introduced an electronic system to track medicine deliveries from the point of issue to delivery to provide a more robust audit trail for the movement of medicines across the Trust.

The Trust operates an automated, technician led dispensary service. Tailored one stop dispensing is utilised to minimise waste, rework and to support efficient flow and the main dispensary at Arrowe Park Hospital is supported by 5 small satellite dispensaries which exist across the hospital (on two sites). There were 357,746 prescription items dispensed through these units in 2015/16. The average turnaround time for discharge medication has been ~30 minutes for the last 3 months. Lean methodology operates throughout the dispensing service. This is supported by prescription prioritisation software and an airtube delivery system from the main dispensary which has eliminated waiting times for medicine deliveries previously taken by portering colleagues on a floor by floor basis.

The Trust has an agreement with primary care that only outpatient medicines required within 48 hours will be dispensed by the hospital pharmacy instead of the national position of 14 days. As a result most medicine requirements are referred to GPs which results in minimal outpatient dispensing occurring via the hospital dispensary.

The pharmacy team have a strong track record in relation to the containment of medicines expenditure. The following graph shows medicines expenditure growth over the last 3 years taken from the national benchmarking survey published in January 2017.



	2013/14	2014/15	2015/16
PH079:	100%	107%	119%
Group:	100%	114%	130%

The group value was calculated by summing the medicines spend for the entire group (excluding any submissions where figures weren't supplied for all three years) and then deriving the % growth from these derived annual totals.

- Red Line WUTH
- Blue Line National Average for Trusts who are members of benchmarking group

In addition, the delivery of cost improvement initiatives (CIP) has a high profile within the department with all staff having a CIP target within their annual objectives. Over the last 3 years the programme has realised the following savings:

Year	Value (£)
2016/17 (predicted)	842,464
2015/16	765,247
2014/15	1,299,276
2013/14	816,924

New service models have been developed, such as medicines housekeepers who track patients as they move from our Emergency Department to admission areas and onward to specialty wards to ensure medicines move with our patients. This reduces wastage and mitigates the need to supply medicines for patients when they move location across the hospital. This initiative is expected to save circa £150k per annum based on the first 6 months activity.

There is a healthy performance management culture with the pharmacy team with a range of staff engagement initiatives resulting in the service being recognised as amongst the top three departments within the Trust for staff engagement in the 2015 staff survey. A range of initiatives support engagement, including recognition for "save of week" awarded for the most significant prescribing error prevented, employee and idea of month nominated by members of the pharmacy team, and dispensary and clinical quizzes designed to enhance knowledge and motivation amongst team members. Emphasis is placed upon developing staff as individuals and the team as a whole thorough the department's recruitment, retention and education and training plans, alongside the promotion of publications for external recognition at local and national fora.

The service is underpinned by leading edge technology with inpatient electronic prescribing live across the hospital, including recent implementation within adult critical care, theatres, chemotherapy and infusions. The Trust has been awarded global digital exemplar status and will be developing a project plan to deliver this programme of work.

3.0 Carter Metrics and Model Hospital

The iterations of the Model Hospital benchmarks to date and the baseline assessment tool have consistently demonstrated good performance overall (recognising that the data will continue to be refined over time). The metrics indicate that pharmacy services provided at WUTH are good value for money and progressing well towards the clinical vision articulated in the Carter report.

Additional peer groups have been added to the latest issue of metrics. Further discussion is required as to the peer group of choice (Trust Size Clinical Output may be the most appropriate reference point moving forward as this has taken into account the Trust's health related group(HRG) activity) but for the purpose of this submission the "Trust Chosen Peer Group" has been utilised to maintain consistency with the first submission.

In addition, a range of new metrics have been added to the dashboard. Where performance is consistently strong, then the WUTH pharmacy team will continue their highly clinically focused activity and where performance is below upper quartile in any area plans have been made to deliver improvements. This ongoing evaluation and review will continue. Model hospital benchmarking will be used to identify best-in-class performers who will be approached to see what processes can be

adopted. Collaboration, multidisciplinary workforce planning and service redesign will be supported by robust governance arrangements as pharmacy services and medicines optimisation is a key programme of work within the Transformation portfolio at WUTH.

The performance against the key lines of enquiry from the Model Hospital Metrics are described below.

3.1 Money and resources

All of the original indicators in this key line of enquiry demonstrate better than national median or peer median. Three new indicators of performance have been recently issued, including IV paracetamol usage, which is above peer and national averages. Trust data indicates there has been a rise in usage of the intravenous formulation in the medicine and acute division. This is currently under investigation and a plan to reduce will be developed and implemented.

3.2 Safe

Safety indicators within this key line of enquiry demonstrate above national and peer performance for all metrics except e-prescribing for chemotherapy and outpatient prescribing. This position has not changed with the new metric release although in practice chemotherapy prescribing went live in January 2017. E-prescribing will encompass clinical trials in the next 6 months and out-patient prescribing is part of the Digital Exemplar programme of work scheduled in the next two years.

3.3 Effective

A number of additional indicators have been added to this key line of enquiry in the latest publication of metrics. In relation to the effective use of resources to optimise medicines, the following indicate better than national or peer average:

- pharmacist resource deployed in medicines optimisation, safety and governance activities
- the number of pharmacists who are qualified prescribers (note this rises to 57% of eligible pharmacists under the current national guidance)
- the % of medicines reconciled (reviewed and signed off as correct by a pharmacist) within 24 hours
- the number of days stockholding for medicines

Although medication incidents reported as causing harm or death is below the national and peer average, the number of medication incidents reported to NRLS per 100,000 FCEs is below average. A high number of incidents reported is a sign of an open safety culture. This is a stark contrast to the picture in 2013/14 where the Trust was in the upper quartile of reporters nationally. A change to reporting method has in part reduced incident reporting. A plan to improve this indicator is in development.

There are also a number of indicators concerning medicines use in this line of enquiry. The use of biosimilars for etanercept and infliximab has been delayed across Wirral in part due to clinical reticence and also whilst gain share negotiations occurred across the health economy. In October 2016, a subgroup of the Wirral-wide Drug and Therapeutics Panel was established to expedite the safe introduction of etanercept and infliximab biosimilars. The switch of these commenced on 1st February 2017 and has involved a multi-disciplinary team approach to ensure effective patient communication and safe implementation. It is expected that 90% of patients currently prescribed either of these two medicines will receive the biosimilar at their next supply or dose administration.

The models used for this switch programme will be evaluated to inform effective processes for future biosimilar switches. The Trust has been able to offer primary care £75k saving, from the uptake of biosimilars in quarter 4 2016/17, to give an indication of the desire to work more collaboratively in the future.

At present the trust does not currently utilise the national summary care record system which allows hospital staff to identify what medicines a patient was taking before they were admitted. This system is critical to ensure safe prescription entry on admission. Informatics colleagues have previously been keen to adopt the Cerner offer but due to delays in implementation there is now a plan for pharmacists to utilise the national system until the Cerner system is available. The scope of this project is in discussion.

Data quality indicators are above national and in line with peer average. It is expected that the next JAC upgrade will deliver compliance.

Metrics where performance indicators are below average in the published data include:

- The utilisation of dose banded chemotherapy was 20% against a national average of 42% in 2015/16, however for quarter 3 2016/17 WUTH reported a compliance of 84% to NHSE. The Cerner Chemotherapy Electronic Prescribing system, implemented in January 2017, has been configured to routinely dose band all doses. All of the drugs listed within the CQUIN (except clinical trial doses) will be dose banded moving forward.
- Pharmacy deliveries per day (31). This is the total deliveries across both the Arrowe Park and Clatterbridge sites. The metric is intended to measure the number of deliveries into the main delivery point for the hospital which is the Clatterbridge Pharmacy Store. The latest data indicates that the number of deliveries per day into this delivery point is 13 which is below the national and peer average.
- E-commerce metrics for AAH 77% and Alliance 0%. The Trust has implemented a new e-ordering system for all medicines from these companies in the last 6 months and this has resulted in 100% of medicines being ordered electronically from these two companies. The only orders that are placed manually are for supplementary feeds which cannot be ordered electronically at this time. Further work is needed to ensure that all companies are covered and not just the main wholesalers.

3.4 Caring

The trust score from the national inpatient survey for indicates performance above the national and peer average, however plans will be developed to further progress this metric.

3.5 Responsive

The Trust performs above the national and peer average, however plans will be developed to further progress this metric and deliver consistent medicines reconciliation scores 7 days a week.

3.6 People management and culture

Key indicators in this line of enquiry are all above national and peer averages with the exception of sickness absence. The current sickness absence rate was 3.10 in-month (December 2016) and 3.69 rolling over 12 months against a national average of 3.1. Further clarity is being sought on the derivation of this metric. Although the pharmacy team have been compliant with Trust policy in all

sickness absence audits undertaken, it is noteworthy that whilst the 2015/16 staff survey demonstrated above average results from pharmacy respondents in almost all of the indicators (including staff recommending the organisation as a place to work, staff motivation and recognition and the value felt by staff from managers), they also indicated that they felt stressed at work and worked more hours than respondents in other areas of the Trust. This may be contributing to higher sickness absence rates than peers.

4.0 Hospital Pharmacy Transformation Plan Summary

A key component of the delivery of the Carter vision is collaboration designed to release resources and deliver enhanced optimisation of medicines with its resultant efficiencies in medicines budgets and improved outcomes of care. The Transformation Programme at WUTH will operate at 5 levels all designed to maximise productivity and efficiency:

- **Internal;** building on our current strengths to maximise opportunity within our gift
- **Acute Care Alliance;** collaborating with the Countess of Chester (CoCH)
- **Local Delivery Service Plan (LDSP);** collaborating with CoCH, East Cheshire and Mid Cheshire Hospitals to drive efficiencies across the Cheshire and Wirral footprint
- **Sustainability Transformation Plan (STP) footprint:** working with Cheshire and Mersey acute care providers to collaborate where a wider footprint can enhance efficiencies
- **Accountable Care Organisation;** working with our local health partners within the Wirral health economy to develop medicines optimisation strategies across primary and secondary care boundaries

4.1 Local Initiatives - WUTH

A key feature of the Trust's approach to transformation is multidisciplinary workforce planning to support extended medicines optimisation activities and the shortages in other healthcare professional groups predicted in the next 5 years.

Although services will be continuously reviewed to maximise productivity and efficiency gains, key areas where progress is needed against the Carter benchmarks are described below:

Carter theme	Planned Action
Use of Resources	Re-profile as 'core clinical' any pharmacy staff time that is liberated by delivering this HPTP. Furthermore explore opportunities to extend scope and scale of multidisciplinary skill mix that include pharmacy e.g. role of medicines ward assistants
	Review the rationale for increased paracetamol IV usage in the Trust and prepare a plan to reduce usage where appropriate in line with benchmarks
Safe	Prepare a project plan for the global digital exemplar work to extend e-prescribing to the chemotherapy clinical trials, the neonatal unit and labour ward and outpatients. Also some first of type complex prescribing and care pathways involving medicines for inpatients which have previously remained on paper. This will also include a closed loop medicines administration pilot, the delivery of process efficiencies and enhancing reporting arrangements to support real time patient management and audit work

Effective	Continue to review all options for prescribing qualifications on an annual basis to maximise the ability to release staff and increase the numbers of prescribers. Plans exist to include non-medical prescribing in the Liverpool University Postgraduate Clinical diploma course from October 2017 and it is intended that our resident pharmacists will take that option, providing agreed competence gateways are completed to a satisfactory level. Our trajectory describes 80% of eligible staff prescribing by 2020.
	Ascertain weekend medicines reconciliation rates and standardise performance across 7 days.
	Provide electronic access to GP information to support accurate medicines reconciliation (initially via SCR and then via Cerner).
	Utilise the current cost improvement governance to review nationally publicised savings opportunities. Although high cost drugs information is provided at a detailed level as previously described, work is ongoing with finance teams to ensure this is recorded accurately in reference costs. We will continue to develop the system to facilitate fast adoption of best value medicines, specifically biosimilar medicines but also across the medicines portfolio.
	Continue to implement the dose banded chemotherapy strategy as new drugs are included in the national CQUIN.
	Develop and implement a plan to increase medication incident reporting to upper quartile performance.
	Work with suppliers to reduce the number of deliveries whilst monitoring the impact on other supply chain benchmarks. Reduce stock deliveries to the main pharmacy store to national median performance through alternative supply systems.
	Further increase electronic ordering to upper quartile performance metrics across all suppliers.
	Implement JAC upgrade to deliver data quality improvements to upper quartile performance.
Caring	Work with the multidisciplinary team to further enhance the results to the inpatient survey through the provision of verbal information during the inpatient stay and at discharge and written communication regarding medicines.
Responsive	Continually review pharmacy services to support service standardisation 7 days a week.
People Management and Culture; well led	Hold focus groups to understand if additional action could further reduce sickness absence. Prepare and implement the plan to reduce work related stress and excess hours.
	Develop a medicines optimisation dashboard and implement the transformation programme governance structure.

4.2 Collaboration – Acute Sector Providers

Although there is a clear direction of travel towards collaboration at an STP, LDSP and Acute Care Alliance level there are varying levels of maturity within plans at this time and there is a need for clear taxonomy at each level of collaboration. It is expected that detailed plans will evolve and be clarified as relationships mature.

An initial review indicates that, across the STP, LDSP and acute care alliance between WUTH and CoCh, there are opportunities to collaborate as follows:

Service	Acute Care Alliance	LDSP	STP
Procurement, stores and distribution	√		
Aseptic services and production	√	√	√
QC	Already occurs		
Dispensing			
Homecare	√	√	√
Medicines Information	√	√	√

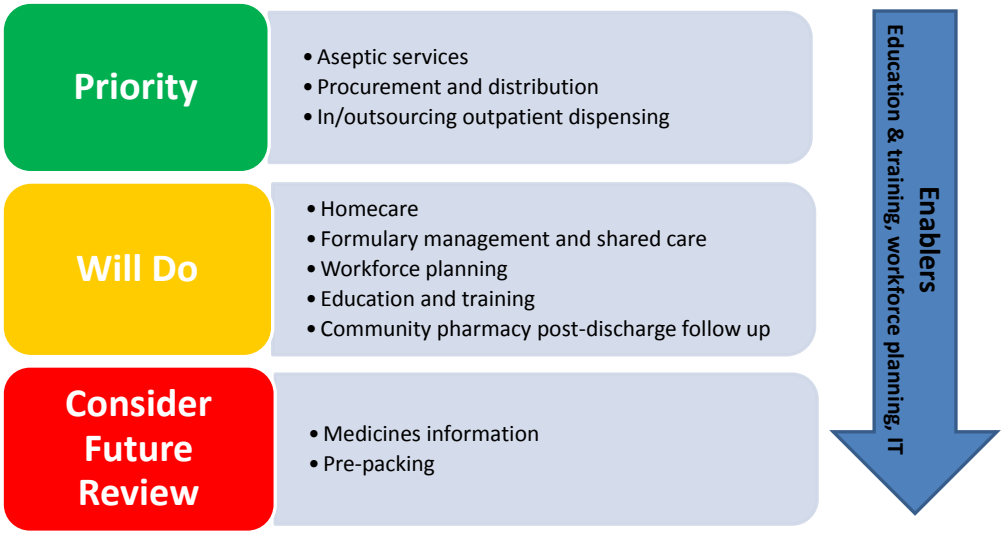
It is clear from discussions that the integration of information technology is essential if opportunities are to be realised. Without this golden thread, it will not be possible to remove much of the duplication within the infrastructure currently based on different hospital sites.

At an LDSP level it is noteworthy that the estate across all four aseptic units is in need of a facilities upgrade. Capital is in short supply. LDSP Pharmacy Leads have committed to the rationalisation of products made to create capacity with immediate effect with the aim of closing one of the four units at the earliest opportunity. There is also broad agreement for a reduction in Aseptic Units across the LDSP footprint from four to two over the next 3-5 years (depending on capital availability). This will reduce overheads but retain resilience within the health economy for periods of downtime.

There is also a recognition that to train the workforce numbers to meet future healthcare needs a collaborative approach is needed towards the education and training of both pre-registration pharmacists and the wider multidisciplinary team. Exact plans will develop as the transformation programme evolves.

The Chief Pharmacists across the LDSP have agreed to prioritise the workstreams, with the opportunity to partake based on relevance to individual organisations.

Diagram 1: LDSP Priorities



4.3 Collaboration - Accountable Care Organisation

The Wirral health and social care economy is moving towards an Accountable Care Organisation underpinned by its desire to undertake population health management using the Cerner solution "HealtheIntent". This solution is intended to transform care for the population of Wirral through a combined health record and data registries, which contain indicators that a patient is receiving all of the interventions they need for a named condition to improve health and wellbeing. This presents an exciting opportunity for clinical pharmacy teams to operate across primary and secondary care boundaries to implement care pathways and optimise medicines in an integrated way with community partners. This work will be integral to the initiative to limit unwarranted clinical variation with its associated efficiencies. HealtheIntent is first of type in the UK and the initial five registries built are adult and childhood diabetes, adult and childhood asthma and chronic obstructive pulmonary disease. Although exact milestones for integration into one organisation are not yet confirmed the direction of travel will provide opportunity for this programme of transformation.

A more recent development is a joint bid with one of the local GP Federations, Primary Care Wirral, for the NHSE funded GP clinical pharmacy pilots. If successful our service would follow the patient across all sectors of health and social service provision. This service model provides seamless care for patients; resilience and delegated employment responsibilities for general practice; and specialist professional support for the pharmacists as part of a well-established and respected team. This will be small scale initially, however for patients, this is a step towards our vision of one team supporting Wirral's population across high risk care interfaces, to gain maximum benefit from medication and minimise avoidable harm.

5.0 Risks and Mitigation

The following are key risks to the programme:

- **Engagement:** of other colleagues in collaboration may not be forthcoming. Governance frameworks within the Acute Care Alliance /ACO/ LDSP/STP will be utilised to escalate and manage this risk.
- **Cerner configuration:** may not be made available to meet UK requirements to drive efficiency. The Cerner User Group will be strengthened with senior management support and the Global Digital Exemplar governance framework will be used to highlight and escalate non delivery and bring pressure to bear to enhance configuration when necessary
- **Financial:** the most cost effective model for various supply chain activities may not be affordable from the perspective of a single organisation (e.g. if involving substantial capital costs). Obvious mitigation is to work with (many) other organisations to share these costs.
- **Geographical:** the challenge of delivering consolidated/centralised services across a wide geography. No obvious mitigation exists other than making this a contractual requirement for any new provider.
- **Absence of willing commercial partners:** who can provide necessary services at an acceptable cost (e.g. for over-labelling). Mitigation: support is expected from the Carter team at national level to mitigate this risk.
- **Lack of agreement from commissioners to use incentives via gain share to support change:** this will be mitigated with an agreed pathway for collaboration initially and integrated budgets in the long term as the ACO develops.
- **Management capacity:** there may be insufficient bandwidth within the management teams to provide the level of transformation needed. Appropriate levels of transformation support are yet to be finalised depending in final scope of programme but will be escalated and managed via the programme governance arrangements.

6.0 Issues and Mitigation

- **Recruitment and retention:** remains an issue both nationally and locally and there is a need to increase trainees to keep up with the demand for pharmacy services in all sectors of healthcare. Discussions are being held with Health Education England to develop workforce planning models to meet requirements**.**
- **Technological system interoperability:** underpins our capability to transform services further within the Trust and with our local health partners. The need to rationalise systems between collaborating services will be a key component of the transformation required to release efficiencies, without which much of the duplication of effort currently within neighbouring organisations will continue. Currently the CoCH and WUTH work with JAC as their pharmacy stock control system and it is intended that the Cerner Millennium experience is extended to CoCH. At present other acute providers in the LDSP are on two additional systems. As the model for collaboration develops the IT requirements will be finalised and the scale of this issue will be escalated.

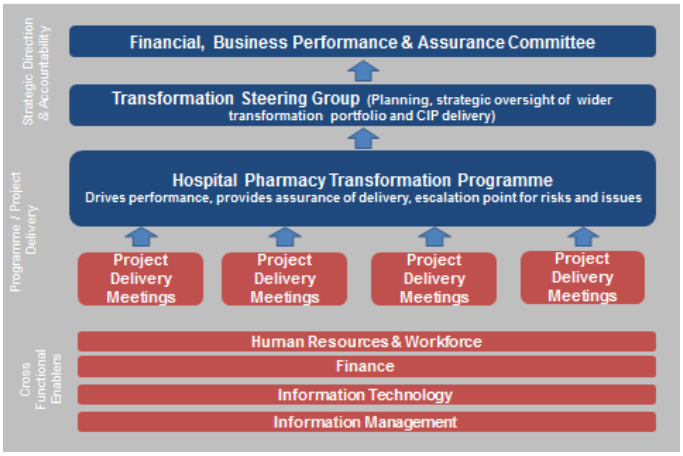
- **Clinical flows**: for East Cheshire are towards Stockport and for Mid Cheshire are towards North Staffordshire Hospitals. If services are to be reconfigured it makes sense for pharmacy alliances to follow established clinical flows. As the scope for the programme is finalised the alignment of East Cheshire and Mid Cheshire will be clarified and the scope for collaboration will be modified accordingly**.**

7.0 Governance Arrangements

The pharmacy senior management team model, governance infrastructure and metrics currently provide assurance on service quality and performance across the department. The wider pharmacy team have experience in tailored service developments and a track record in benefits realisation.

A Hospital Pharmacy and Medicines Optimisation Transformation Programme Board will be established moving forward to oversee the HPTP with the Director of Pharmacy and Medicines Management as the Senior Responsible Officer. Project groups will be established to manage significant pieces of work which support the programme. The HPTP will be supported by the Trust's Service Transformation Team and their associated governance frameworks, including key performance metrics displayed on a medicines optimisation dashboard, risk, issues, actions and decision (RAID) logs and project and programme highlight reports. The programme will report into the Trust's Transformation portfolio.

Diagram 2: Programme Governance Arrangements

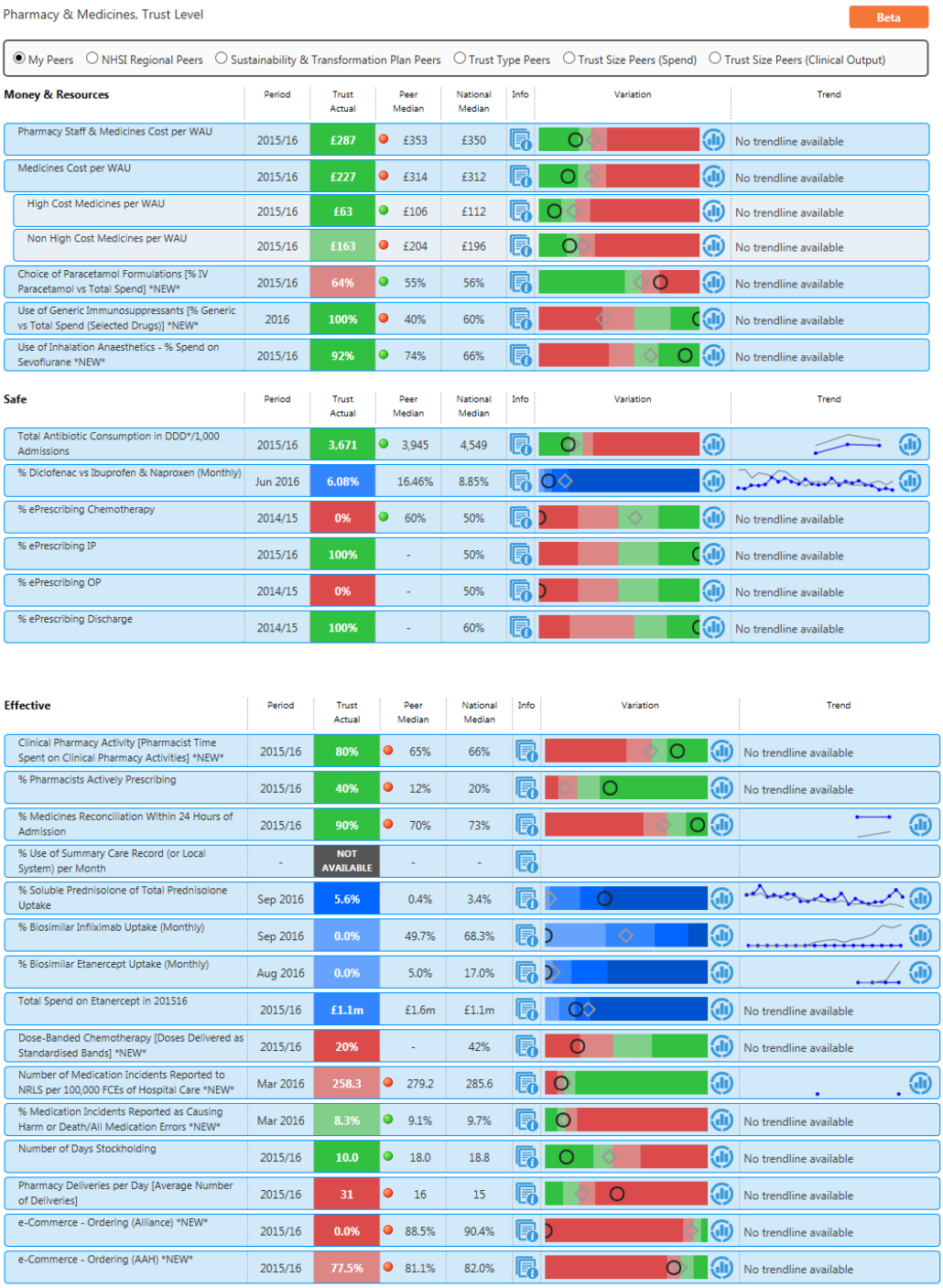


The Director of Pharmacy will also sit on the LDSP group to support and lead elements of the collaboration agenda across the LDSP footprint.

8.0 Conclusion.

Overall the Hospital Pharmacy and Medicines Optimisation metrics alongside Pharmacy performance benchmarks give assurance that patients at this Trust are receiving the Carter vision of clinically focussed safe and effective pharmacy services. They also demonstrate that the clinical service is underpinned by strong Trust medicines supply services which support the wider medicines optimisation and patient flow agenda. This plan presents a framework for the further transformation of pharmacy services within the Trust and for the collaboration with partners. This will be monitored using the metrics presented by the NHSI productivity team. These will be further developed into a Pharmacy and Medicines Optimisation Dashboard. Further work is needed to improve some of the indicators described and these will be performance managed through the governance structures for the HPTP.

Appendix One



Pharmacy & Medicines, Trust Level

Beta

My Peers | NHSI Regional Peers | Sustainability & Transformation Plan Peers | Trust Type Peers | Trust Size Peers (Spend) | Trust Size Peers (Clinical Output)

Money & Resources	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Pharmacy Staff & Medicines Cost per WAU	2015/16	£287	£353	£350			No trendline available
Medicines Cost per WAU	2015/16	£227	£314	£312			No trendline available
High Cost Medicines per WAU	2015/16	£63	£106	£112			No trendline available
Non High Cost Medicines per WAU	2015/16	£163	£204	£196			No trendline available
Choice of Paracetamol Formulations [% IV Paracetamol vs Total Spend] *NEW*	2015/16	64%	55%	56%			No trendline available
Use of Generic Immunosuppressants [% Generic vs Total Spend (Selected Drugs)] *NEW*	2016	100%	40%	60%			No trendline available
Use of Inhalation Anaesthetics - % Spend on Sevoflurane *NEW*	2015/16	92%	74%	66%			No trendline available

Safe	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Total Antibiotic Consumption in DDD*/1,000 Admissions	2015/16	3,671	3,945	4,549			
% Diclofenac vs Ibuprofen & Naproxen (Monthly)	Jun 2016	6.08%	16.46%	8.85%			
% ePrescribing Chemotherapy	2014/15	0%	60%	50%			No trendline available
% ePrescribing IP	2015/16	100%	-	50%			No trendline available
% ePrescribing OP	2014/15	0%	-	50%			No trendline available
% ePrescribing Discharge	2014/15	100%	-	60%			No trendline available

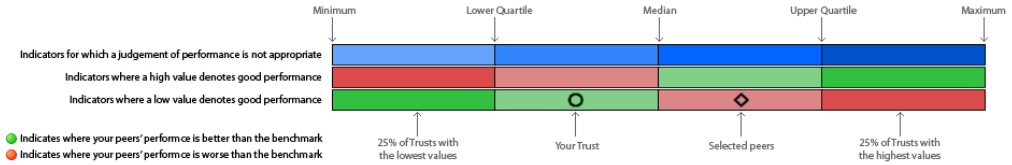
Effective	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Clinical Pharmacy Activity [Pharmacist Time Spent on Clinical Pharmacy Activities] *NEW*	2015/16	80%	65%	66%			No trendline available
% Pharmacists Actively Prescribing	2015/16	40%	12%	20%			No trendline available
% Medicines Reconciliation Within 24 Hours of Admission	2015/16	90%	70%	73%			
% Use of Summary Care Record (or Local System) per Month	-	NOT AVAILABLE	-	-			
% Soluble Prednisolone of Total Prednisolone Uptake	Sep 2016	5.6%	0.4%	3.4%			
% Biosimilar Infliximab Uptake (Monthly)	Sep 2016	0.0%	49.7%	68.3%			
% Biosimilar Etanercept Uptake (Monthly)	Aug 2016	0.0%	5.0%	17.0%			
Total Spend on Etanercept in 201516	2015/16	£1.1m	£1.6m	£1.1m			No trendline available
Dose-Banded Chemotherapy [Doses Delivered as Standardised Bands] *NEW*	2015/16	20%	-	42%			No trendline available
Number of Medication Incidents Reported to NRLS per 100,000 FCEs of Hospital Care *NEW*	Mar 2016	258.3	279.2	285.6			
% Medication Incidents Reported as Causing Harm or Death/All Medication Errors *NEW*	Mar 2016	8.3%	9.1%	9.7%			No trendline available
Number of Days Stockholding	2015/16	10.0	18.0	18.8			No trendline available
Pharmacy Deliveries per Day [Average Number of Deliveries]	2015/16	31	16	15			No trendline available
e-Commerce - Ordering (Alliance) *NEW*	2015/16	0.0%	88.5%	90.4%			No trendline available
e-Commerce - Ordering (AAH) *NEW*	2015/16	77.5%	81.1%	82.0%			No trendline available

Effective	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Data Quality of NHS England Monthly Data Set Submissions From Providers *NEW*	Sep 2016	22	22	20			No trendline available

Caring	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
National Inpatients Survey - Medicines Related Questions	2015/16	75.9%	72.2%	73.1%			

Responsive	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Sunday ON WARD Clinical Pharmacy Hours of Service (MAU/Equivalent)	2015/16	7.5	4.0	7.0			

People, Management & Culture: Well-led	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
% Sickness Absence Rate	2015/16	3.9%	3.0%	3.1%			
% Staff with Appraisals Completed	2015/16	97%	91%	85%			
% Staff with Statutory and Mandatory Training	2015/16	98%	96%	91%			
% Staff Turnover Rate	2015/16	13%	13%	14%			
% Staff Vacancy Rate *NEW*	2015/16	5%	6%	6%			No trendline available



BOARD OF DIRECTORS	
Agenda Item	5.4
Title of Report	Patient Safety Alert - Nasogastric tube misplacement: continuing risk of death and severe harm (NHS/PSA/RE/2016/006)
Date of Meeting	22 February 2017
Author	Jan Eccleston, Associate Director of Risk Management
Accountable Executive	Gaynor Westray, Director of Nursing and Midwifery
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	1. To be the Top NHS Hospital Trust in the North West for Patient, Customer and Staff Satisfaction
Level of Assurance **Positive** **Gap(s)**	Positive Action plan in place
Purpose of the Paper **Discussion** **Approval** **To Note**	Discussion and Approval
Reviewed by Assurance Committee	As required by the alert this paper and the associated self-assessment and action plan was shared with the Clinical Commissioning Group on the 26 January 2017. It is being presented to the Trust Board for information and assurance purposes.
Data Quality Rating	Bronze – qualitative data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken **Yes** **No**	No

1. Executive Summary

In July 2016 NHS Improvement (NHSI) issued a patient safety alert titled: *Nasogastric tube misplacement: continuing risk of death and severe harm (ref: NHS/PSA/RE/2016/006).* The alert highlighted several actions required to achieve compliance and this report forms part of the actions required namely sharing the key findings of the assessment and the main actions that have been taken in the form of a public board paper.

NHSI review of local investigations into these incidents suggests identified areas for improvement in respect of organisational processes for implementing previous alerts. This patient safety alert is directed at Trust Boards and the processes that support clinical governance rather than front line staff.

2. Background

The use of misplaced nasogastric and orogastric tubes was first recognised as a patient safety issue by the National Patient Safety Agency (NPSA) in 2005. Three further alerts were issued by the NPSA and NHS England between 2011 and 2013. Introducing fluids or medication into the respiratory tract or pleura via a misplaced nasogastric or orogastric tube is classified as a Never Event.

Between September 2011 and March 2016, nationally 95 incidents were reported to the National Reporting and Learning System (NRLS) and/or the Strategic Executive Information System (StEIS) where fluids or medication were introduced into the respiratory tract or pleura via a misplaced nasogastric or orogastric tube.

Checking tube placement before use via pH testing of aspirate and, when necessary, x-ray imaging, is essential in preventing harm. Examination of these incident reports by NHSI clinical reviewers shows that misinterpretation of x-rays by medical staff who did not appear to have received the competency-based training required by the 2011 NPSA alert is the most common error type. Other error types involve nursing staff and pH tests, unapproved tube placement checking methods, and communication failures resulting in tubes not being checked.

The Trust has reported one never event relating to a misplaced nasogastric tube in June 2014 (RCA13407). On review and following discussion with the NHS England patient safety/never events team this was downgraded from a never event as it was identified as a displaced nasogastric tube rather than a misplaced one.

3. Key Issues/Gaps in Assurance

The alert required the following actions:

- Identify a named executive director who will take responsibility for the delivery of the actions required in this alert.
  Update: the Director of Nursing and Midwifery is the identified Executive lead for this alert
- Using the resources supplied with this alert, undertake a centrally coordinated assessment of whether your organisation has robust systems for supporting staff to deliver safety-critical requirements for initial nasogastric and orogastric tube placement checks.
  Update: the self-assessment was completed and documented by the Nutrition Nurse Specialist and one of the Surgical Matrons.
- If the assessment identifies any concerns, use the resources supplied with this alert to develop and implement an action plan to ensure all safety-critical requirements are met.
  Update: the self-assessment identified gaps in relation to competency based training for staff and an action plan has been developed to address the gaps identified
- Share this assessment and agree any related action plan within relevant commissioner assurance meetings
  Update: a report relating to the self-assessment and action plan was shared with the Commissioners at the January 2017 Quality and Clinical Risk meeting
- Share the key findings of this assessment and the main actions that have been taken in the form of a public board paper.
  Update: this paper completes the requirements of the actions on the alert once presented to the public board. The action plan will be monitored through to completion by the operational leads

The areas of non-compliance identified as part of the self-assessment were as follows:

	Self-assessment safety critical area	WUTH Response	Action planned	Timescales
1	Are you confident that all clinical staff (regardless of profession or level of seniority) who confirm nasogastric tube placement by pH or x-ray have been assessed as competent through theoretical and practical learning?	The current training programme does not cover interpretation of x ray positions.	Competency based training programme to be established which will ensure that all clinical staff will be competent in reviewing nasogastric tube position by x ray.	29 February 2017
2	Can frontline staff easily identify staff who have (and who have not) been assessed as competent in the interpretation of x-rays for confirming nasogastric tube placement?	Frontline staff are unable to identify clinicians who are competent in interpretation chest x rays of NG position	Once an established training programme for clinicians is implemented the database will be available for clinical staff to view	21 April 2017
3	Are you confident that locum, agency and newly recruited staff would know not to undertake nasogastric placement checks?	We are not confident that locum, agency or bank staff are competent in NG position checks as we have no record of their training.	All wards and department managers have been emailed to highlight that that locum, agency and newly recruited staff should not undertake nasogastric placement check.	31 October 2016 (completed 17.10.16)
4	Are you confident the current focus on compliance with safety- critical requirements will become 'business as usual' and are you confident clinical audit and quality improvement teams have built this into their plans?	It has been identified that there is a gap in regular auditing of the NGT pathway to ensure that this is business as usual. The last audit was in July 2016 and although the results were positive ongoing assurance regarding compliance is required.	Undertake a quarterly audit against the NGT pathway and develop an action plan as required for areas of non-compliance Report the results of the audit through to the Nutrition Steering Group	First audit by the 21 April 2017 (Q4 data) then quarterly thereafter

The alert identified areas for improvement in respect of organisational processes for implementing previous alerts. This had already been identified as a risk in the Trust by the Associate Director of Risk and that there was a lack of assurance regarding the implementation of new and historic NHSI (previously NPSA) alerts. A new process has been developed in relation to NHSI alerts and all new alerts now have identified leads, action plans, deadlines and quarterly reports are submitted to Clinical Governance Group (CGG) detailing alerts, progress and those completed.

There is a programme in place where older alerts (issued before the new process was established) are being revisited and reviewed and assurance sought on continued compliance. The quarterly report to CGG details progress against these reviews.

4. Next Steps

An action plan has been developed to address the identified gaps following the self-assessment.

The action plan is being implemented and monitored through to completion by the Surgical Matron and Nutrition Nurse Specialist. All actions relating to the alert are to be completed by 21 April 2017. Progress will be monitored and the alert will only be signed off as compliant once approved by the Executive Lead.

5. Conclusion

Overall apart from the areas identified above and in the action plan the Trust is compliant with the areas of concern identified on the self-assessment document.

6. Recommendations

The Trust Board is asked to note the contents of this report and action plan and identify if further assurance is required.

Board of Directors	
Agenda Item	**6.1.1**
Title of Report	**Integrated Performance Dashboard**
Date of Meeting	**22nd February 2017**
Author	**Chris Oliver, Director of Operations** **John Halliday, Assistant Director of Information**
Accountable Executive	**Janelle Holmes** **Chief Operating Officer**
FOI status	**Document may be disclosed in full**
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	**All Strategic Objectives (1 through 7)** **All Key Measures (1A through 7D)** **All Principal Risks**
Level of Assurance • **Positive** • **Gap(s)**	**Partial with gaps**
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	**Discussion**
Data Quality Rating	**Silver – quantitative data that has not been externally validated**
FOI status	**Document may be disclosed in full**
Equality Impact Assessment Undertaken • **Yes** • **No**	**No**

1. Executive Summary

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

2. Summary of Performance Issues

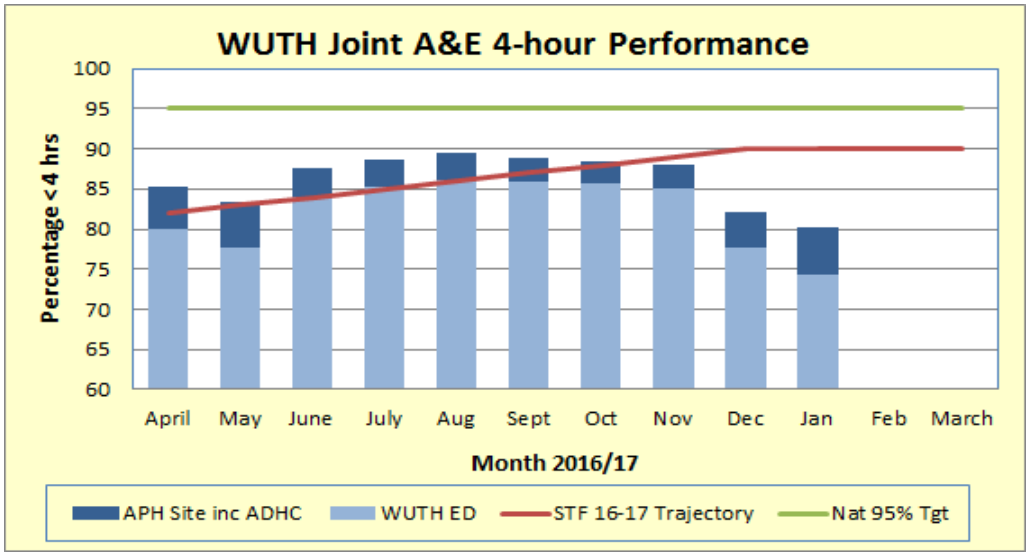
The key issues relating to external validation is achievement of the A&E and RTT targets, with detailed comments against each area below.

3. Detailed Explanation of Performance and Actions

a. A&E 4 Hour Target

Against the A&E standard of a minimum 95% of patients to be admitted, transferred or discharged within four hours, the month of January was 80.31% as measured across a combined ED and All Day Health Centre performance at the Arrowe Park site. ED alone was 74.33%.

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

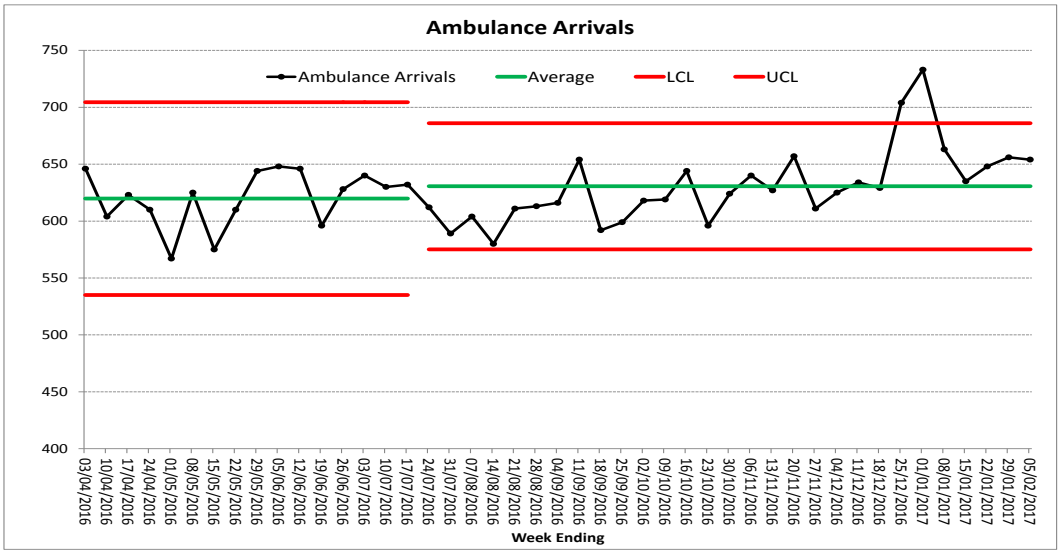


The main reasons for the deterioration in position since December can be split into demand & acuity coupled with egress or discharge issues

Demand/Acuity

The graph below demonstrates the demand placed on the Emergency Department from an increase in ambulance arrivals. The proportion of the ambulance conveyances being received by either the majors or resus areas has increased,

providing some indication of an increase in acuity, which is being reported by clinical teams on the base wards.



Egress /Discharge

In addition the numbers of delayed Transfers of Care has increased suggestive of the ongoing fragility of the care home and domiciliary care market. This was further exacerbated in December when the largest provider of domicillary care on the Wirral voluntarily suspended its provision. This has yet to be reprovided. To mitigate the impact on patient flow the Board will be aware that the Trust has sourced additional Discharge to Assess beds. Unfortunatly however the commissioned discharge to assess beds are now starting to see length of stay increase as patients await discharge back home with domiciliary care. The Trust has escalated its concern to NHSI and NHSE and resolution / mititgation is overseen via the A & E Delivery Board.

The Trust has undertaken a number of actions both internally and across the economy in line with the national escalation operating framework to maintain patient flow across the organisation to minimise ED delays & reduce ambulance turnaround times.

Based on the unplanned changes to health economy capapcity which are outside WUTH control an appeal for the release of the Q4 STF will be lodged.

b. 18 Weeks Referral To Treatment (RTT)

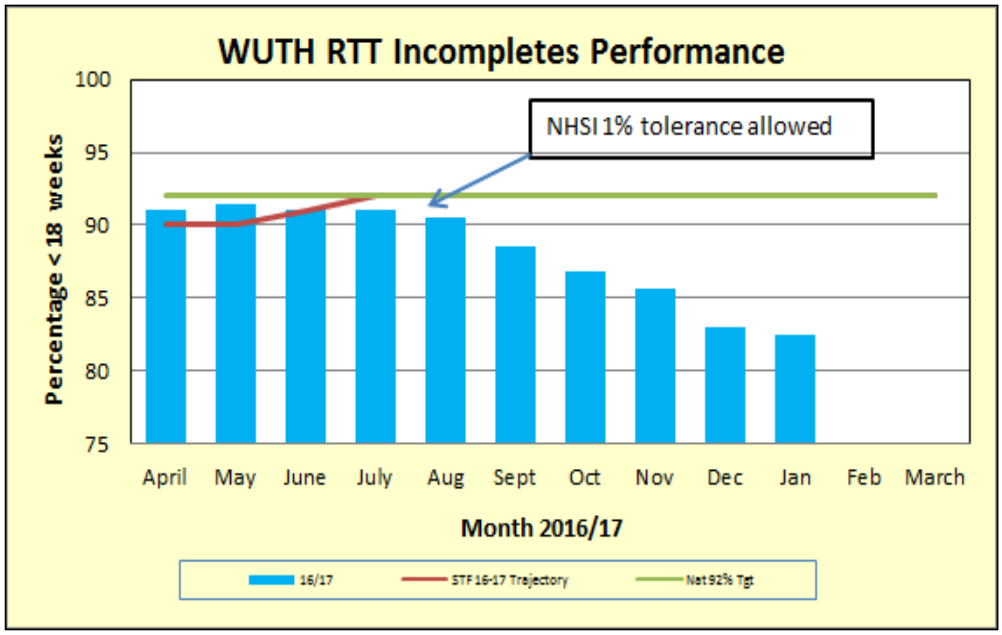
The focus of RTT is now solely on the incomplete standard, with the threshold set at a minimum 92% of patients waiting to be at 18 weeks or less.

As expected the Trust did not achieve the national standard and STF trajectory at the end of January, with the final position being reported at 82.51%.

It is expected that RTT performance will reduce to circa 80% by March 2017 as cleansing of the patient tracking list continues and waiting list initiatives remain

on hold except for those specialities requiring additional capacity to meet cancer standards.

NHS Improvement have been briefed on the action plan and the expected impact on performance and are assured in the actions the Trust is taking to sustainably improve performance. The Intensive Support Team are now working alongside our internal RTT Improvement team to provide additional support and external challenge.



c. Diagnostic Six Weeks Wait

Although a supportive measure for RTT, the standard that patients should wait less than six weeks for a diagnostic test is a key performance metric in its own right. Waiting times against a subset of 15 diagnostic investigations are measured at the end of every month. The threshold standard is that a minimum of 99% of patients waiting should have waited less than 6 weeks. WUTH performance for the end of January was 99.64%.

d. Cancer

For Cancer access targets, the 62-day standard continues to be the most difficult to achieve, and this is reflected in performance levels at a national level. This particular standard also has an explicit line in STF trajectories, with the expectation the 85% standard will be achieved each month. Cancer waiting time performance is only finalised many weeks after month-end due to the time required to confirm diagnosis and share patient pathways between providers. The current performance against the 62-day Cancer standard for the current quarter is detailed in the dashboard. Although challenging the Trust does not foresee non-compliance with cancer waiting time standards.

e. Infection Control

For C Difficile, there have been three cases in the month of January, however only one of these was considered avoidable. The year-to-date position is therefore 12 cases, and below the maximum plan trajectory of 24 cases for this period.

4. Recommendation

The Board of Directors are asked to:

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

WUTH Integrated Performance Dashboard - Report on January for February 2017 BoD

Area	Indicator / BAF	Nov	Dec	Jan	Trend / Future Concern	*Target (for 'Green')*	Latest Period	Exec Lead
Meeting Our Vision	**Satisfaction Rates**							
	Patient - F&F "Recommend" Rate	99%	98%	98%		>=95%	January 2017	GW
	Patient - F&F "Not Recommend" Rate	0%	1%	1%		<=2%	January 2017	GW
	Staff Satisfaction (engagement)	3.97	3.97	3.97		>=3.69	Q2 2016/17	JM
	First Choice Locally & Regionally							
	Market Share Wirral	81.3%	82.6%	83.0%		>= 85%	August to Oct 2016	MC
	Demand Referral Rates	-5.5%	-6.8%	-7.3%		>= 3% YoY variance	Fin Yr-on-Yr to Jan 2017	MC
	Market Share Non-Wirral	8.4%	7.9%	8.0%		>=8%	August to Oct 2016	MC
	Strategic Objectives							
	Harm Free Care	95%	95%	96%		>= 95%	January 2017	GW
	HIMMs Level	5	5	5		5	January 2017	PC
Operational Excellence	**Key Performance Indicators**							
	A&E 4 Hour Standard	87.94%	82.12%	80.31%		>=95%	January 2017	CO
	RTT 18 Weeks Incomplete Position	85.62%	83.00%	82.51%		>=92%	January 2017	CO
	Diagnostics 6 Weeks Standard	99.90%	99.68%	99.64%		>=99%	January 2017	CO
	Cancer Waiting Time Standards	On track	On track	On track		All met at Trust level	Q4 to Jan 17	CO
	Infection Control (MRSA mth, c Diff cumulative)	0 MRSA; 10 C diff	1 MRSA; 11 C diff	0 MRSA; 12 C diff		0 MRSA Bacteraemia in month, and cdiff less than cumulative trajectory	January 2017	GW
	Productivity							
	Delayed Transfers of Care	27	43	43		Metric definition redefined	December 2016	CO
	Delayed Complex Care Packages	65	66	78		<= 45	January 2017	CO
	Bed Occupancy	92.7%	93.7%	91.6%		<=85%	January 2017	CO
	Bed Occupancy Medicine	90.3%	92.7%	95.1%		<=85%	January 2017	CO
	Theatre Utilisation	90.0%	92.5%	83.6%		>=85%	January 2017	CO
	Outpatient DNA Rate	8.1%	8.5%	7.9%		<=6.5%	January 2017	CO
	Outpatient Utilisation	83.2%	82.1%	82.0%		>90%	January 2017	CO
	Length of Stay - Non Elective Medicine	5.1	5.6	5.3		<= 5.0	January 2017	CO
	Length of Stay - Non-elective Trust	4.4	5.0	5.1		<=4.2	January 2017	CO
	Contract Performance (activity)	-3.9%	-4.0%	-4.0%		0% or greater	January 2017	CO
	Finance							
	Contract Performance (finance)	-0.8%	-0.9%	-1.4%		On Plan or Above YTD	January 2017	DJ
	Expenditure Performance	-1.2%	-0.7%	-1.5%		On Plan or Below YTD	January 2017	DJ
	CIP Performance	9.2%	0.0%	0.0%		On Plan or Above	January 2017	DJ
	Capital Programme	64.4%	24.6%	26.5%		On Plan	January 2017	DJ
	Non-Core Spend	9.6%	9.4%	9.3%		<5%	January 2017	DJ
	Cash Position	101%	-30%	-21%		On plan or above YTD	January 2017	DJ
	Cash - liquidity days	-26.7	-28.9	-30.5		> 0 days	January 2017	DJ
A Healthy Organisation	**Clinical Outcomes**							
	Never Events	2	0	0		0 per month	January 2017	SG
	Complaints	31	28	24		<30 per month	January 2017	GW
	Workforce							
	Attendance	95.68%	95.61%	95.59%		>= 96%	January 2017	JM
	Qualified Nurse Vacancies	3.29%	4.45%	4.04%		<=6.5%	January 2017	GW
	Mandatory Training	97.76%	92.70%	92.24%		>= 95%	January 2017	JM
	Appraisal	84.88%	92.17%	83.46%		>= 85%	January 2017	JM
	Turnover	10.45%	10.60%	10.46%		<10%	January 2017	JM
	Agency Spend	8.7%	10.6%	12.5%		On plan	January 2017	GW
	Agency Cap	105	85	88		0	January 2017	JM
External Validation	**National Comparators**							
	Advancing Quality (not achieving)	2	2	2		All areas above target	January 2017	SG
	Mortality: HSMR	86.96	88.92	89.56		Lower CI < 0.90	April to Oct 2016	SG
	Mortality: SHMI	0.983	0.983	0.983		Lower CI < 90	Jan to Dec 2015	SG
	Regulatory Bodies							
	NHSI - Use of Resources (UoR) Rating	3	3	3		1 or 2 (NHSI amended Oct 2016)	January 2017	DJ
	CQC	Amber	Amber	Amber		Overall CQC rating Requires Improvement	January 2017	SG
	Local View							
	Commissioning - Contract KPIs	7	7	6		<=2	January 2017	CO

WUTH Cancer - 62 Day Standard

Quarter	4
Period	1/01/2017 - 31/03/201

Target	62 Day Wait
Indicator	GP Urgent Referral to First Definitive Treatment
Threshold	Min 85%

		Quarter 4 - January 2017							
		Breaches			Treatments			Final Compliance	
Division	**Tumour Group**	**Actual**	**Predicted**	**Total**	**Actual**	**Predicted**	**Total**	**Actual**	**Predicted**
Medicine	Haematology	0	0	0	3	1	4	tbc	**100.00%**
	Lung	1	0	1	2.5	0.5	3	tbc	**66.67%**
	Other	1	0	1	1	0	1	tbc	**0.00%**
Med & Surg	Upper GI	0	0	0	3	0	3	tbc	**100.00%**
Surgery	Breast	2	0	2	14.5	2	16.5	tbc	**87.88%**
	Colorectal	1	0	1	5	4	9	tbc	**88.89%**
	Head & Neck	2	0	2	3	0	3	tbc	**33.33%**
	Skin	1	0	1	17.5	0	17.5	tbc	**94.29%**
	Urology	3	0	3	20.5	0	20.5	tbc	**85.37%**
Women's	Gynaecology	0	0	0	0.5	2	2.5	tbc	**100.00%**
	Total	**11**	**0**	**11**	**70.5**	**9.5**	**80**	tbc	**86.25%**

Board of Directors	
Agenda Item	6.1.2
Title of Report	Month 10 Finance and Cost Improvement Programme Report
Date of Meeting	22nd February 2017
Author	Gareth Lawrence, Deputy Director of Finance
Accountable Executive	David Jago, Executive Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	 8 8c,8d
Level of Assurance • **Positive** • **Gap(s)**	Positive
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To note
Data Quality Rating	Silver – quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

Overview

This paper provides an update to the Board of Directors on the financial performance of the Trust at month 10 (31st January) of the 2016/17 financial year.

At the end of January (month 10) the Trust has reported a YTD deficit of £(8.3)m inclusive of £1.5m impairments, therefore the normalised deficit is £(6.8)m which is £4m adverse to plan. The adverse variance is being driven by three key elements:

- Non achievement of STF targets - £1.3m
- Non delivery of the Health economy challenge - £1.7m
- Continued Operational pressures as a result of Health Economy challenges.

The Trust is currently forecasting to deliver a forecast deficit of £(10.5m). The deterioration from the plan is a result of the non achievement of the "Health Economy Challenge" of £5m, the subsequent loss of STF of £3m and operational pressures relating to reductions in care within the health economy via the Better Care Fund. The Trust submitted the forecast Protocol to NHSI in line with National guidance at Q3 and still awaits official feedback. While the Trust is forecasting a £(10.5)m deficit the increased operational pressure as a result of winter will put at risk the delivery of the forecast. The Trust has not included any further external costs within the current financial position as these have been agreed on the behalf of the A&E delivery Board and will be discussed at the next meeting.

The Trust has delivered £9.4m of efficiencies as at the end of January against the target of £8.6m and is forecasting to deliver the 2016/17 target of £11.2m.

The cash balance at the end of January was £2.6m, which is £0.7m below plan. The YTD cash position has been supported by lower-than-planned capital expenditure, and an additional drawdown of cash from the working capital facility. This has been offset by EBITDA performance and movements in working capital. Cash for the remainder of the financial year is forecast to be under plan, supported by additional borrowings of £2.5m through an extension in the 2016/17 working capital facility, which is in line with previous forecasts shared with the Board.

The Trust has achieved an overall Use of Resources (UoR) Rating of 3, which is 'below' the recalculated plan rating of 2.The adverse performance being explained by the issues noted above in respect of £5.0m stretch challenge and loss of STF The UoR Rating replaced the Financial Sustainability Risk Rating (FSRR) with effect from month 7, as required by the Single Oversight Framework.

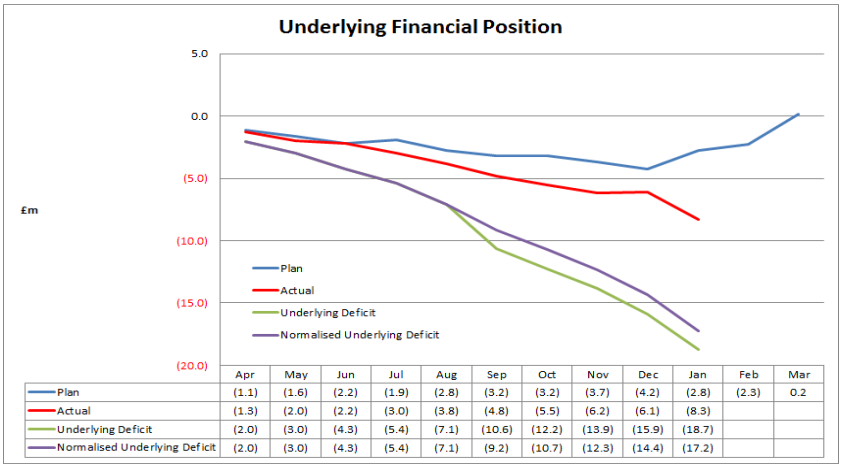
Income and Expenditure Performance

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

Table 1: Summary Financial Statement

	PLAN	MONTH 10			YTD			Forecast		
	Full Year Plan £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
NHS Clinical Income	294.936	24.937	23.418	(1.519)	245.976	242.520	(3.456)	294.936	289.443	(5.493)
Other Income	29.987	2.511	2.525	0.014	24.824	26.545	1.721	29.987	31.597	1.610
Employee Expenses	(213.306)	(16.761)	(18.962)	(2.201)	(180.597)	(186.442)	(5.845)	(213.306)	(223.948)	(10.642)
All Other Operational Expenses	(97.763)	(8.084)	(8.147)	(0.063)	(81.648)	(79.816)	1.834	(97.763)	(95.921)	1.842
EBITDA	**13.854**	**2.603**	**(1.165)**	**(3.768)**	**8.555**	**2.808**	**(5.746)**	**13.854**	**1.171**	**(12.683)**
Post EBITDA Items	(13.673)	(1.165)	(1.026)	0.140	(11.348)	(11.116)	0.232	(13.673)	(13.171)	0.502
Net Surplus/(Deficit)	**0.181**	**1.438**	**(2.191)**	**(3.628)**	**(2.793)**	**(8.308)**	**(5.515)**	**0.181**	**(12.000)**	**(12.181)**
Adjusted Net Surplus/(Deficit)		**1.438**	**(2.191)**	**(3.628)**	**(2.793)**	**(6.780)**	**(3.988)**	**0.181**	**(10.472)**	**(10.653)**
EBITDA %	**4.3%**	**9.5%**	**(4.5%)**	**(14.0%)**	**3.2%**	**1.0%**	**(2.1%)**	**4.3%**	**0.4%**	**(3.9%)**

Table 2: Underlying Financial Performance



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

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

As previously reported to the Board of Directors agreement has been reached with Wirral CCG for an envelope contract value for 2016/17 which covers c80% of the Trusts clinical income. In the absence of the 'envelope' agreement the income position would have deteriorated by £4.6m. As a result of increased Non Elective pressures, associated clinical contracts underperformed in month by £0.3m compared to forecast.

During January all points of delivery underperformed in terms of activity excluding A&E attendances and Outpatient Diagnostics.

Cumulatively all PODs are underperforming in terms of actual activity delivered against the plan, with the exception of Outpatient Diagnostics A&E attendances and Non Elective (NEL). Penalties increased in month in relation to readmissions, NEL marginal rate and outpatients FUP caps. As a result of the financial envelope the penalties do not affect the financial position.

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

Operational expenditure is above plan for the month of January by £(2.3)m.

Pay costs exceeded plan by (£2.2m) in month, and are showing a cumulative overspend of (£5.8m). The issues as previously reported to the Board of Directors driving the current cumulative adverse performance in pay are:

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

- Other pay pressures relate to internal escalation capacity being open since April 2016 and increased costs within A&E to deal with increased levels of acuity and attendances. The Trust is working with external partners via the A&E Board and the System Wide Recovery group. The impact of these escalation costs beds are a further c(£0.2m) in January and (£1.9m) cumulatively with discharge to assess beds in Elder-home costing a further c(£0.1m) to date.

- Non–delivery of cost improvement plans in relation to pay work-streams of c(£1.5m) comprises some of the pay overspend; this has been partially mitigated by vacancies within the Divisions. The CIP slippage impact in January is c(£0.3m) which has been partially mitigated by vacancies of c£0.1m.

- Other operational pressures in medical staffing costs have continued during the month. Within the Emergency Department, the medical staffing position there is a further (£0.1m) impact in January and there remains a pressure of approximately (£0.6m) in the year to date position.

- WLIs still remain low in January but are continually reviewed in light of RTT and cancer targets with spend occurring in a number of specific specialties. The Trust continues to monitor its respective waiting lists to ensure that any areas of patient safety are addressed.

Agency spend is currently within the NHSI ceiling by £0.9m, breaches continue to be reviewed and agreed by the Executive team on a weekly basis with deep dives of all agency spend reviewed within OMT with respective actions plans to potentially reduce further.

Non Pay is marginally higher than plan in month but remains cumulatively £1.8m below plan largely supported by non recurrent measures .

Cost Improvement Programme (CIP)

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

Table 3 – CIP Performance by Workstream and Division

	YTD			In Year			Recurrent		
Workstream	NHSI Plan £m	Actual £m	Variance £m	NHSI Plan £m	Forecast £m	Variance £m	NHSI Plan £m	Forecast £m	Variance £m
Theatres/ Elective Pathway	1.1	1.1	0.0	1.5	1.4	(0.1)	1.5	1.4	(0.1)
Outpatients (Medical & Surgical)	0.6	0.2	(0.4)	0.7	0.2	(0.5)	0.7	0.3	(0.4)
Patient Flow - EL & NEL	0.6	0.0	(0.6)	0.8	0.0	(0.8)	0.8	0.0	(0.8)
Radiology	0.2	0.3	0.1	0.2	0.4	0.2	0.2	0.4	0.2
Pathology	0.3	0.1	(0.2)	0.4	0.1	(0.3)	0.4	0.2	(0.2)
Nurses & Therapies Staffing	0.5	0.5	0.0	0.6	0.7	0.1	0.6	0.3	(0.3)
A&C Review - Clinical/ Non Clinical/ Management	0.9	0.3	(0.6)	1.0	0.4	(0.6)	1.0	0.2	(0.8)
Medical Staffing	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Central HR Initatives	0.6	0.7	0.1	0.7	0.9	0.2	0.7	0.8	0.1
COCH Collaboration	0.1	0.0	(0.1)	0.3	0.0	(0.3)	0.3	0.0	(0.3)
Pharmacy Services & Medicines Management	0.3	0.8	0.5	0.4	0.9	0.5	0.4	0.5	0.1
Procurement & Inventory Management	1.0	0.6	(0.4)	1.3	0.8	(0.5)	1.3	0.5	(0.8)
IT Enabled	0.2	0.2	0.0	0.2	0.2	0.0	0.2	0.1	(0.1)
Special Purpose Vehicles/ Contract optimisation	0.2	0.0	(0.2)	0.5	0.0	(0.5)	0.5	0.0	(0.5)
Estates/ Site Review	0.4	0.1	(0.3)	0.6	0.2	(0.4)	0.6	0.2	(0.4)
Facilities	0.4	0.3	(0.1)	0.4	0.4	0.0	0.4	0.2	(0.2)
Coding	0.8	0.8	0.0	1.0	1.0	0.0	1.0	1.0	0.0
Central Commercial Opportunities & Private Patients	0.2	0.1	(0.1)	0.3	0.2	(0.1)	0.3	0.2	(0.1)
Divisional & Departmental Schemes	0.3	0.5	0.2	0.4	0.6	0.2	0.4	0.6	0.2
Other	(0.1)	2.8	2.9	(0.1)	3.0	3.1	(0.1)	1.4	1.5
TOTAL PRE RISK ADJUSTMENT	**8.6**	**9.4**	**0.8**	**11.2**	**11.4**	**0.2**	**11.2**	**8.3**	**(2.9)**
Adjustment for risk			0.0		(0.2)	(0.2)			0.0
TOTAL	**8.6**	**9.4**	**0.8**	**11.2**	**11.2**	**0.0**	**11.2**	**8.3**	**(2.9)**
Medicine & Acute	2.5	1.2	(1.3)	3.1	1.5	(1.6)	3.1	1.1	(2.0)
Surgery, Women & Children	2.8	2.0	(0.8)	3.6	2.7	(0.9)	3.6	2.1	(1.5)
Clinical Support Services	1.4	0.9	(0.5)	1.7	1.0	(0.7)	1.7	0.9	(0.8)
Corporate	1.4	2.1	0.7	1.8	2.6	0.8	1.8	2.4	0.6
Central	0.5	3.2	2.7	1.0	3.6	2.6	1.0	1.8	0.8
TOTAL PRE RISK ADJUSTMENT	**8.6**	**9.4**	**0.8**	**11.2**	**11.4**	**0.2**	**11.2**	**8.3**	**(2.9)**
Adjustment for risk			0.0		(0.2)	(0.2)			0.0
TOTAL	**8.6**	**9.4**	**0.8**	**11.2**	**11.2**	**0.0**	**11.2**	**8.3**	**(2.9)**

The year to date position as at the end of January is £9.4m which is £0.8m ahead of the target of £8.6m.

The Trust is forecasting to deliver the planned CIP target of £11.2m in year although all this will not be recurrently. Included within the agreed Financial Plan for 2017/18 was the recurrent shortfall of £2.9m.

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

Cash position and Use of Resources (UoR) Rating

The January cash position is £2.6m, which is £0.7m below plan. Cash balances are lower than planned as the YTD position has been supported by technical non cash backed savings. The Trust has currently drawn down £12.8m from the working capital facility and forecasts that a further c£2.5m will be required before year end, which is in line with the paper previously presented to Board.

The Trust continues to submit monthly 13 week cash flows to NHSI in order to access further borrowing when required. Further borrowing will only be required if the Trust does not receive the Q3 STF before the end of March. The Trust is not forecasting to exceed 30 days of operational expenditure in year. Therefore, all cash support should be provided by the working capital facility, with current rates of interest at 3.5%.

Capital expenditure is £1.6m under plan as at the end of January as a result of delayed starts to some capital projects; there are no major concerns on this timing difference.

The overall financial position returns an overall UoR Rating of 3, which is 'below' the planned rating of 2, as detailed overleaf.

Table 4 – Use of Resources (UoR) Rating

	Metric	Description	Weighting %	Year to Date Plan		Year to Date Actual		Full Year Plan	
				Metric	*Rating*	*Metric*	*Rating*	*Metric*	*Rating*
Financial sustainability	**Liquidity (days)**	Days of operating costs held in cash-equivalent forms	20%	-27.4	4	-30.6	4	-24.2	4
	Capital service capacity (times)	Revenue available for capital service: the degree to which generated income covers financial obligations	20%	1.9	2	0.7	4	2.4	2
Financial efficiency	**I&E margin (%)**	Underlying performance: I&E deficit / total revenue	20%	-1.0%	3	-2.5%	4	0.1%	2
Financial controls	**Distance from financial plan (%)**	Shows quality of planning and financial control : YTD deficit against plan	20%	-0.5%	2	-1.5%	3	-0.5%	2
	Agency spend (%)	Distance of agency spend against cap	20%	-0.07%	1	-12.5%	1	-0.1%	1
	Overall NHSI UoR Rating				**2**		**3**		**2**

Conclusion

The Trust as previously reported has delivered the financial plan for Q3 and as a result will receive the respective allocation of the STF. The Trust has revised the forecast outturn with NHSI in line with the national protocol and is now reporting through submitted templates a deficit of £(10.5)m after technical adjustments.

The Board is asked to note the non-recurrent support within the position and the additional pressure this will put on the underlying financial position of the Trust entering into Q4 and 2017/18 planning.

Cash is currently off plan and further extensions to the working capital facility will be required in Q4 in line with previous plans discussed at the Board.

Despite the Trust's strong performance against the Agency spend metric, the overall UoR Rating has 'decreased' to 3, with this score being worse than the planned rating of 2. This deterioration is driven by the month 10 position and factors noted re "stretch"challenge and consequent loss of STF in January.

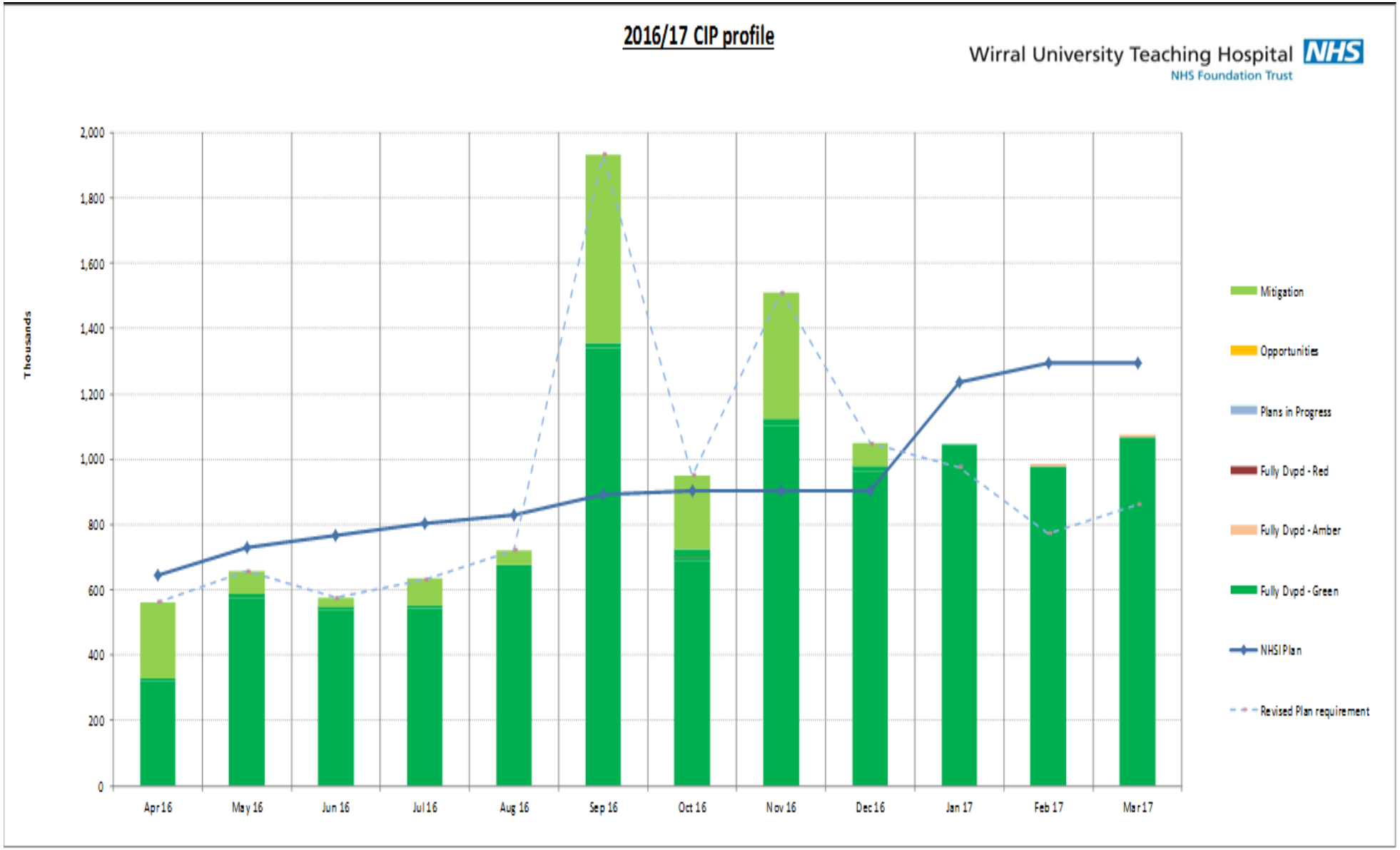
Recommendations

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

David Jago
Director of Finance
February 2017

Appendix 1: CIP Monthly Profile

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



Board of Directors	
Agenda Item	7.1
Title of Report	Report of the Finance, Business Performance and Assurance Committee – 17 February 2017
Date of Meeting	22 February 2017
Author	Andrea Hodgson, Chair of the Finance, Business Performance and Assurance Committee
Accountable Executive	David Jago, Director of Finance
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	4, 7, 8 4a, 7a, 7b, 7d, 8a, 8c, 8d, 5, 6, 7, 8, 9, 16, 17, 20
Level of Assurance • **Positive** • **Gap(s)**	Gaps with mitigating action
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Discussion
Reviewed by Assurance Committee	Not applicable
Data Quality Rating	Not applicable
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	Not applicable

This report provides a summary of the work of the Finance, Business Performance and Assurance Committee which met on the 17 February 2017. Key focus areas are those which address the gaps in assurance/control in the Board Assurance Framework.

Board Assurance Framework

The Committee was pleased to note the continued development of the Board Assurance Framework (BAF) and the progress of the Divisional training programme.

The Committee noted the key changes to the BAF during the reporting period which included support of an increase of the risk 9 (4 Hour A & E Standard) risk score to 20. The risk score had been increased to reflect the below trajectory performance for December 2016 and January 2017

due to winter pressures and delayed transfers of care as a consequence of the CQC decision to suspend Premier, the largest domiciliary care provider on the Wirral, from accepting new patients for a period of 6 months due to quality issues. The Board is asked to formally review the risk score of 20 for A & E performance as part of its duties under the risk management strategy. The committee discussed the aggregate risk profile presented and sought to understand what further mitigating action could be undertaken to reduce the collective risk exposure within the Trust.

M10 Financial Position

The Committee reviewed the year to date position which reported a cumulative normalised deficit of of £6.8m against a planned deficit of £2.8m. The Trust continues to forecast a £10.5m deficit for the full year. The negative variance is materially accounted for by the non-delivery of the £5m health economy challenge, equating to a £1.7m in month allocation, and continued operational pressures as a result of reductions to health and social care across the wider health economy. The Committee noted that the Trust did not anticipate receipt of the Q4 STF funding linked to the full year anticipated outturn and forecast performance for Q4. The Committee noted the risk of further £500k deterioration to the full year outturn position should the current operational pressure and the current health economy domiciliary care position persist.

The Committee was advised that the Trust cash position remained below forecast as a result of delayed receipt of the Q3 STF funding. NHS Improvement (NHSI) had been alerted to the issue and the Committee was advised to the potential utilisation of the Trust working capital facility to sustain the Trust cash position. The Committee noted that whilst the cash position was supported by below plan capital expenditure, a draw down of a further £2.5m of loan facilities prior to the year-end would be required should the STF monies not be received.

The Use of Resources (UoR) rating was reported at level 3, which is below the planned score of 2. The Committee explored the potential risks to the UoR rating and going concern requirements. A full exploration of the going concern assessment would be reviewed at the next meeting.

The Committee challenged the continued pay spend driven by the continued escalation areas over and above planned levels. The Committee was also advised of the ongoing discussions to resolve the funding challenge for the escalation beds established in January 2017. The Committee supported the negotiation approach to achieve an equitable solution with the Healthy Wirral Partners Board across local health economy and resolve the outstanding funding challenge.

The risks and appropriate mitigations were outlined and debated by the Committee in relation to income, expenditure, CIP and cash. The Committee discussed escalation to Board on the risks around the deteriorated forecast cash position, year-end outturn and potential costs associated with the increased community bed provision.

Transformation and Cost Improvement Programme at M10

The Committee received the Cost Improvement Programme (CIP) performance at M10 which confirmed an overall positive achievement of £9.4m cumulative savings, against a forecast of £8.6m. The year to date performance and planned CIP trajectory contributes to an end of year forecast of £11.2m. The team were applauded for the progress and projected full year outturn remains in line with the Trust plan. However, the Committee noted that this included c£3m of non-recurrent savings which placed greater pressure on 2017/18.

The Committee noted progress in respect of development of the CIP for 2017/18 which included £1.7m of fully formed projects and the considerable progress that it expected ahead of financial year end to solidify a further £5m of further initiatives.

The Committee reviewed and approved the Transformation Steering Group Terms of Reference subject to the following amendments:

- Clarification of the group's role in respect of prioritization calls, monitoring of progress and key deliverables as well as benefit realisation; and
- Inclusion of the role of the extended members to ensure effective ownership and accountability within the reporting framework.

The Committee was pleased to note that future meeting agendas would include an item pertaining to an in-depth review of individual CIP projects.

Strategic Overview of Transformation Portfolio 2017/18

The Committee was pleased to receive an overview of the transformation agenda for 2017/18 which included an outline of the robust processes employed to develop both transformation and cash release schemes and monitor delivery.

The Committee noted the importance of increased clinical colleague involvement in both the development and management of transformation initiatives.

Agency Cap Compliance Report

The Committee was pleased to note that the Trust remained on course to achieve its agency spend reduction target for the financial year end and the key contributory impact it made to the UoR rating. The Committee commended the controls and management framework that were clearly evident. However the Committee requested greater visibility of the unplanned escalation costs and associated agency spend so that the true reductions in reducing agency spend could be more directly correlated with the underlying performance. The team were encouraged to continue to challenge and control agency spend noting the cost pressures and 2017/18 trajectory and encouraged to continue to explore collaboration with colleagues to minimize agency spend.

Performance Report for Period Ending 31 January 2017

The Committee noted that the Trust had reported a continued deterioration post-December 2016 in the 4 Hour A&E Standard as a consequence of an increase in demand and acuity further exacerbated by delayed transfers of care due to a lack of available domiciliary care in the community. The Committee noted the importance of working collaboratively across the local health economy following suspension of further community domiciliary and intermediate service providers, so that a resolution to the current lack of services may be sought. It was confirmed that the Trust held a strong position to make an STF appeal with regards to the 4 Hour A&E Standard due to the above outlined external factors which had negatively impacted on performance.

The Committee confirmed the Trust's expected deterioration in Referral to Treatment Target (RTT) performance, which had occurred as a consequence of the Patient Tracking List (PTL) cleanse. However it noted that RTT had begun to stabilise now as expected.

The Committee noted an increase in the year-to-date number of avoidable cases of C Difficile (C.diff) to 12 cases up until the end of January 2017. This remains well below the cumulative plan trajectory for 2016/17. The Committee noted that the risk score of BAF risk 12, which pertained to C.diff, would be subject to revision to reflect the positive year to date performance.

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

RTT Progress Report

The continued degradation in RTT consequently triggers a governance concern. The Committee noted that although NHSI had been and continue to be appraised of the external factors contributing to the position, the Trust would remain at risk of potential further regulatory action.

The Committee was advised of the RTT Improvement Programme including dependency on clinical input and process efficiencies that are required to be implemented to deliver improved RTT compliance following completion of the PTL cleanse.

Improving Data Quality and Clinical Coding

The Committee received confirmation of the work to be undertaken to develop enhanced data quality frameworks to support improved data quality analysis, timely availability of accurate information, real time data capture and robust coding processes.

The Committee stated the importance of successful implementation of the proposed data quality frameworks to ensure that the agreement of key strategic decisions would be based on accurate and reliable information. The approach would be refined to ensure that it adequately considered the efficiency and accuracy of data gathering processes, effectiveness of controls and data quality implications underpinning decision risk.

Wirral Millennium Programme Report

The Committee was advised of the success of the Wirral Millennium Phase 3 Implementation which had come to fruition following installation of the Chemotherapy Module at the end of January 2017.

The Committee noted the incorporation of Wirral Millennium legacy projects into the Global Digital Exemplar (GDE) Programme or Transformation Portfolio for further development. The Committee was advised that the first GDE Programme Board had been conducted on 16th February 2017 and was well attended.

Hospital Pharmacy Transformation Plan

The Committee was pleased to note that the Trust's initial Hospital Pharmacy Transformation Plan had been commended as an exemplar in late 2016. The Committee received a further plan which would seek to enhance the viability of clinical patient facing pharmacy services in order to reduce costs further in line with the recommendations of the Lord Carter Review.

The Committee noted the Trust's improved compliance against the additional Carter metrics since their publication in January 2017 and the positive performance of the Pharmacy Department which had led to an integration of pharmacy services across the Trust.

The Committee requested that work was undertaken to define Trust success in respect of minimization of prescribing errors. The outcome report is also to be presented to the Quality and Safety Committee.

The Committee recommended the Hospital Pharmacy Transformation Plan for approval by the Board.

NHS Improvement – Monthly Return

The Committee noted the content of the NHSI Month 10 financial commentary which detailed the financial position at the end of January 2017 and cumulatively against the 2016/17 plan.

Assurance Reporting

The Committee received Chair's reports from the following Working Executive Committees and welcomed the review of TOR currently underway:

- Finance, Strategy and Planning Group
- Informatics and Electronic Medical Devices Group
- Information, Information Governance and Coding Group

Andrea Hodgson
Chair of Finance, Business Performance and Assurance Committee

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF PUBLIC MEETING

25 JANUARY 2017

**BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL**

Present

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

In attendance

Carole Self	Director of Corporate Affairs
James Mawrey	Director of Workforce*
Jayne Kearley	Member of the Public
Mark Lipton	Deputy Medical Director

Apologies

*denotes attendance for part of the meeting

Reference	Minute	Action
BM 16-17/237	**Apologies for Absence** Noted as above	
BM 16-17/238	**Declarations of Interest** None	
BM 16-17/239	**Patient's Story** The Director of Nursing and Midwifery outlined the proposal to replace the traditional patient's story with learning from serious incidents in the future which the Board supported. The Director of Nursing and Midwifery briefed the Board, with the permission of Mr and Mrs Knight, on the shared learning into the aftercare provided to the family following their baby daughter Pip's diagnosis with a rare genetic disorder which sadly led to the couple having to make the heartbreaking decision to terminate the pregnancy at 22 weeks. Through their personal experience they found there was a need for a bigger and more privately located room within the Women and Children's Hospital for parents who may receive difficult news during a pregnancy. It has been named 'The Applepip Suite' after their baby daughter Pip and remains as a lasting legacy.	
BM 16-	**Chairman's Business**	

Reference	Minute	Action
17/240	The Chairman welcomed Dr Susan Gilby, the new Medical Director of the Trust to her first meeting of the Board of Directors.	
BM 16-17/241	**Chief Executive's Report** The Chief Executive focussed on the following areas from his report: **Director of Operations** – the Board was updated on the plans to recruit to Mr Oliver's replacement with his departure expected in the next 6 months. **Care Quality Commission** – the Chief Executive outlined the plans being progressed to prepare the Trust not only for its next inspection but to ensure the ongoing improvement in quality and safety within the organisation **Winter Pressures** – The Board noted the "flash" interim report received ahead of the meeting and the ongoing pressures in A & E together with the actions being taken to mitigating these risks. The Board was advised that the Trust had benefitted from £66K of a total of £300K NHS England monies to assist with the demand. **Celebrating success** – the Chief Executive was pleased to announce that the Trust had been shortlisted in five categories in the HSJ awards.	
BM16-17/242	**Report of the Quality and Safety Committee** The Chair of the Quality and Safety Committee presented the revised terms of reference for the Committee for approval by the Board on the understanding that a further review would be undertaken in March 2017 to take account of the views of the newly appointed Medical Director. The Board approved the terms of reference on this basis. The Board was updated on the review of the Board Assurance Framework and the plans to review the risk descriptors for risk 1 and risk 4, CQC rating and 7 day working respectively to reflect the key elements of quality, safety and clinical outcomes. The Board was also advised that the Committee had supported the "Using the Board Assurance Framework Guidance" and agreed that the overall risk profile would be used in future meetings. The reduction in risk score in relation to CQC preparedness was supported by the Committee as was the inclusion of the risks associated with the suspension of the full HPV programme, the inability to discharge patients in a timely manner and the potential outcomes of the ophthalmology reviews. Although the overall workforce and organisational development scores remained positive, the Board was advised of the Committee's request for a further report into the actions being taken to address the medicine and acute nurse vacancy rates which had been exacerbated by opening the winter escalation wards. The next steps in terms of preparation for the care quality inspection were outlined and it was reported that Ward M1 was the first ward to be awarded an "outstanding" rating during an internal inspection. The Board was pleased to note the above national average performance for organ donation during 2015/16 and gave their thanks to volunteer Paul Dixon for his continued commitment in encouraging the public to join the organ donation register, and thanked Dr Quinn for her continuing involvement.	

Reference	Minute	Action
	The Medical Director updated the Board on the actions being progressed to ensure patient safety in the ophthalmology department following the recent Never Events. She outlined the mandatory checks and processes being followed with plans to undertake spot checks and audits. The Board was advised that the interim external review was felt not to be suitably independent nor did it address the terms of reference fully. The Royal College external review would be undertaken in February/March and would therefore encompass all aspects outlined by the Trust.	
BM16-17/243	**Hard Truths Commitment: Publishing of Staffing Data: 6 monthly update report** The Director of Nursing and Midwifery presented the Staffing Data: 6 monthly update report and focussed on the following recommendations from the "Hard Truths" guidance: **Recommendation 2** – safe staffing - the Board was advised of the progress made and in particular the change in the daily staffing meetings which now looked at Divisional crossover to ensure that the Trust as a whole maintained safe staffing levels. **Recommendation 3** – Using evidence based tools to establish safe staffing – the Board was advised of the range of evidence based tools used across the Trust in line with guidance and best practice and provided with assurance that staffing levels were as expected based on patient acuity. **Recommendation 4–** the Board reviewed the 2 incidents of whistleblowing regarding safe staffing, both of which had been investigated and assurance given regarding safe staffing levels. The Director of Nursing and Midwifery advised that the number of Safe Guardian contacts had been increased in order to promote internal reporting and improve visibility on the wards. The Board was advised that this had been positively received by staff. **Recommendation 8** – displaying ward staffing data – in addition to the information displayed outside each ward it was reported that work had commenced to include this information for non-ward areas examples being theatres and outpatients. **Recommendation 9** – securing future workforce requirements – the Board was advised of the good workforce stability index this being 91.37% and the opportunities afforded to the Trust as a result of the Nurse Associate pilot. The Director of Nursing and Midwifery outlined the key findings and action taken as a result of the MIAA Limited Assurance Report, although the delay in receiving the draft report caused concern which, as agreed, would be addressed with the Auditors directly. The Board sought and received assurance that the data that the nursing report is based on is accurate in view of this report. The Board agreed that the Trust should request MIAA to undertake a re-audit of nurse staffing ahead of the financial year end. The Board was updated on the latest developments under the Recruitment strategy which included proposals to recruit in the Phillipines; speciality recruitment as opposed to whole scale Trustwide recruitment campaigns and a review of the leavers process to understand why staff may be leaving. The work being undertaken with NHS Professionals to recruit a cohort of 15-20 care support workers on a care support development programme was	**CB/DJ** **DJ/GW**

Reference	Minute	Action
	outlined, as was the nurse associate pilot which was designed to develop new roles for the future nursing workforce. The Director of Nursing and Midwifery updated the Board on the Band 5 vacancy rates which overall were low at 4.45% however she raised concerns with vacancy levels in Medicine and Acute who currently had 34 vacancies and therefore required daily management to ensure safe staffing levels. The Board sought to understand the impact on future recruitment based on the access to training changes and was informed of the plans being explored by the Trust into an Apprenticeship programme. The Board requested clarification on the total staffing numbers as the table in the report indicated that these had reduced over the past 12 months. The Director of Nursing and Midwifery agreed to provide this clarification. The Board was updated on the Care Hours Per Patient Day (CHPPD) analysis and findings which showed that the Trust benchmarked well for Nursing and Midwifery Staffing and Registered Nurse Staffing although it was recognised that further work was required to improve this for Care Support Workers. The Board sought further clarification on the variation in CHPPD on specific wards which appeared to be out of the range expected. The Ward areas that were rated as Red in the report for CHPPD/fill rates were outlined as Ward 12, 54 and M1. The Board was advised that in all instances the appropriate staffing levels were in place for the acuity of the patient cohort. The Board debated the impact of the staffing requirements on the escalation ward areas and how this was impacting on staff morale and was advised that staffing was in place and block booked which was receiving positive feedback from staff. The Board sought to understand the perception of staff in times of demand as to staffing levels versus actual safe staffing levels as defined by the Royal College of Nursing. The Board also sought and received assurance that these safe staffing levels were never based on financial constraints.	**GW** **GW**
BM 16-17/244	**Integrated Performance Report** • **Integrated Dashboard and Exception Reports** The Chief Operating Officer presented the integrated dashboard and exception reports which focused on the following areas: **Achievement of the A & E Standard** – it was reported that performance across the site for December was 82.12% compared to the sustainability and transformational fund (STF) trajectory of 90%. The Board was advised that the STF funding for Q3 was achieved in respect of A & E as a result of over performance earlier in the year. Achievement of the Emergency Department alone was reported at 77.73% with January expected to be similar. The Board was advised that this performance was mid-range nationally and receiving both national and regional focus through the A & E Delivery Boards. **Referral to Treatment Times** - it was reported, as expected, that the Trust did not achieve the target of 92%, with the final position being 82.84% at the end of December 2016. The Board was reminded of the planned	

Reference	Minute	Action
	deterioration of this target up until March 17 as the cleansing of the PTLs was undertaken, with the expectation that this would be an upward recovery trajectory thereafter. The Board raised concerns with the Trust's ability to manage the backlog and the activity plans for 2017/18. The Chief Operating Officer advised that the Activity and Income plan for 2017/18 excluded the backlog and aired on the side of caution. She confirmed that the Divisions essentially had 2 streams of work, one to focus on clearing the backlog and the one to achieve the in year activity plan, all of which was factored into the demand and capacity review. The Director of Finance advised the Board that as previously advised there were no penalties built into the financial plan in relation to RTT and A & E performance however the spike in A & E demand would enable the Trust to challenge these. The Board sought clarity on the reasons for the drop in market share in non-Wirral activity. The Chief Operating Officer advised that this was due to waiting times particularly in Ophthalmology which she believed was recoverable. The Chief Executive reaffirmed this as a key priority for the Trust. The Board sought to understand whether under-performance on these key targets was as a result of the achievement of the agency cap. The Chief Operating Officer advised that this was not the case as it was volume related and not staffing related citing the use of the full capacity escalation protocol being used 5 times recently. **Cancer** – the Board was advised that performance was on track with no issues anticipated that would impact on achievement of these targets **Advancing Quality** – two areas of under-performance were reported these being community acquired pneumonia and acute kidney injury, for which actions were being progressed. The Board raised concerns that this area of reporting appeared to lack clarity and therefore needed strengthening. The Medical Director agreed and gave assurance that this would be addressed. **Infection Control** – it was reported that there had been 11 avoidable incidents of C difficile year to date against a trajectory of 29 and last year's performance of 33. The Board was updated on the mitigation plans in place as a result of the temporary suspension of the full HPV programme because the hospital was fully occupied. This included HPV of individual side rooms and wards areas wherever possible. The Board was advised that there were no wards currently closed as a result of Norovirus. • **M9 Finance and Cost Improvement Programme Report** The Director of Finance presented the M9 finance and cost improvement report and highlighted the following areas: At the end of December the Trust reported a YTD deficit of £6.1M inclusive of the £1.5M impairments, therefore the normalised deficit was £4.6M and whilst this was just short of the plan, the Trust delivered the operational control total in order to access STF funding. The adverse variance to plan	**SG**

Reference	Minute	Action
	was attributed to a failure to deliver the agreed RTT trajectory. The Board was reminded of the action that had to be taken to achieve the Q3 control total, a consequence of which now left the Trust with no headroom or any element of accruals that could be used in Q4. In month performance was reported as £400K below plan in respect of clinical income, with the in-year benefit of the financial envelope being £4.3M at M9. The Board was advised of the above plan expenditure on pay and the reasons for this which were attributable to the use of escalation beds. The cash plan was reported at £1.1M below plan with the YTD cash position supported by lower than planned capital expenditure and an additional draw down of cash from the working capital facility. The Board was advised of the need to draw down a further £3.6M of this facility in Q4. The performance against the cost improvement plan was reported as strong with achievement forecast at £11.2M although it was recognised that this did contain non-recurrent elements which would need to be included in the plan for 2017/18. Capital was reported at £1.5M below plan although the Director of Finance assured the Board that the Trust would deliver the plan before the year end. He advised the Board of the significant concerns from the Centre on capital plans which had led to him having to provide assurance in this area. The Use of Resources rating was reported at 3 in line with the plan. The Board sought clarity on the risk of this deteriorating to a 4 and received assurance that this was dependent on performance against agency spend which should continue as expected. The Board was advised that the Trust was still forecasting to deliver a forecast deficit of £10.5M, represented by the non-achievement of the "Health Economy Challenge" of £5M, the YTD and subsequent loss of STF funding of £3M and the operational pressures relating to the reductions in care within the health economy via the Better Care Fund. The Board expressed their thanks in terms of the achievement of the Q3 control total , but sought assurance on the impact of the YTD forecast given that there were no further reserves to draw upon. The Director of Finance advised that the forecast remained at £10.5M although there were risks to delivery expected in January, February and March as a result of the need to fund additional step down beds which the A & E Delivery Board partners would need to address and which had been flagged to the regulator.	
BM16-17/245	**Report of the Finance, Business Performance and Assurance Committee** The Chair of the Finance Business Performance and Assurance Committee presented a summary of the work of the Committee noting that the timing of the meeting had resulted in some of the reporting now being out of date. The Board was advised that the total of cost improvement identified schemes for 2017/18 was in fact £9M and not £11M as outlined in the report, although	

Reference	Minute	Action
	this was showing good progress. There was recognition from Committee members and the Board for the need henceforth to be transformational in order for the target to be achieved**.**	
BM16-17/246	**Report of the Audit Committee** The Chair of the Audit Committee updated the Board on the work undertaken at its meeting on 9th December 2016. This included the risk management processes and systems put in place to manage incidents and risks ahead of procuring a new software system. The Board was advised of the 2 Limited Assurance Reports in relation to IT Service Continuity and Water Safety which received extensive review by the Committee. The Board was advised of the plans to re-audit both areas before the end of the financial year to ensure that significant assurance could be provided. The Board sought to establish whether it needed to undertake a wider review and was advised that this was not necessary as the Committee, Executive leads and MIAA had plans to address these.	
BM16-17/247	**Report of the Charitable Funds Committee** The Chair of the Charitable Funds Committee confirmed that the Annual Report and Accounts for 2015/16 had been received and approved by the Committee ahead of publication on the Trust website. The Board was pleased to note the report from the Independent Examiner which confirmed that there were no matters that had come to their attention during their examination of concern. The Terms of reference were presented for approval by the Board and accepted subject to the inclusion of the Medical Director of on the Membership. The Board was updated on the plans to communicate and consult on the proposal for the Charity Re-Launch as previously advised.	**CS**
BM16-17/248	**NHSI Month 9 Compliance Return** The Board noted the M9 compliance return.	
BM16-17/249	**Board of Directors** The Minutes of the Board of Directors held on the 30 November 2016 were confirmed as an accurate record. The Chairman highlighted the amendment to the public record under minute reference BM16-17/204 following clarification of the position with regards to the Procedure for Handling Concerns about Conduct. **Action Log** The Board accepted the action log as presented although agreed that a full review was required of out of date actions.	

Reference	Minute	Action
BM16-17/250	**Items for the BAF/Risk Register** The Board agreed to reference the reliance on agency spend on the Use of Resource Rating in the risk register.	**DJ**
BM 16-17/251	**Items to be considered by the Assurance Committees** The Board agreed the following: **Finance Business Performance and Assurance Committee** – to review the position with regards to RTT recovery **Quality and Safety** - to have a continued focus on Advancing Quality performance	
BM16-17/252	**Any Other Business** None	
BM 16-17/253	**Date and Time of Next Meeting** Wednesday 22nd February 2017 at 9.00am in the Boardroom, Education Centre, Arrowe Park Hospital.	

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Chairman

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Date

ACTION LOG
Board of Directors
Updated – February 2017

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 25.01.17						
1	BM16-17/243	The Board agreed to address the delay in receiving the draft Nurse Staffing report with MIAA	**DJ/CB**		March 17	
2	BM16-17/243	The Board agreed to request MIAA to undertake a re-audit of the nursing staffing audit ahead of the financial year	**DJ/GW**		March 17	
3	BM16-17/243	The Board requested clarity on the total staffing numbers in the Nursing update report as this appears to have reduced over the last 12 months	**GW**		February 17	
4	BM16-17/243	The Board sought clarification on the variation in CHPPD on specific wards which appeared to be out of the range expected	**GW**		February 17	
5	BM16-17/244	The Board agreed that the reporting of Advancing Quality Indicators needed to be strengthened	**SG**		March 17	
6	BM16-17/247	Include the Medical Director in the terms of reference for the Charitable Funds Committee	**CS**	**Completed**		

7	BM16-17/248	The Board agreed to reference the reliance on agency spend on the Use of Resource Rating in the risk register.	**DJ**		March 17	
Date of Meeting 30.11.16						
8	BM16-17/203	The Trust to determine its own CHPPD levels for each ward in the absence of benchmarking data	**CP/GW**	**Completed**	January 2017	
9	BM16-17/211	**QSC** - Review consultant pinch point data **Audit** – review new agency spend limits as part of the review of the scheme of delegation	**JM** **DJ**		January 2017 February 2017	
Date of Meeting 27.07.16						
10	BM16-17/102	The Board recommended that the Trust review its compliance against the boiler exhaust omissions.	DJ	**DJ in ongoing discussion with Head of Estates.**		
11	BM16-17/	Items to be considered by assurance committees: • FBPAC – an update on how the Divisions are progressing with the demand and capacity work • Consider the learning from this and how this might inform the finance report going forward	JH/DJ	**Included on the Board agenda for February 2017 - completed**	Sept 16	
Date of Meeting 25.05.16						
12	BM16-17/033	Include progress on the implementation of the junior doctors contract as part of the Board Development Programme	CS	**Agreed to defer this until later in the financial year in light of current position**	July 16	

13	BM16-17/036	Full review of the performance report to be undertaken to avoid this becoming unmanageable	JH	**This work will be undertaken as part of the action plan from the well led Governance review. Timescales agreed as end of March 17**		
14	BM16-17/037	Explore the impact of technology when reporting CHPPD in the future	GW		**April 17**	
15	BM16-17/040	Board to continue to receive CQC updates until the next inspection on a quarterly basis	EM	**Ongoing**	February 17	
Date of Meeting 30.03.16						
16	BM15-16/297	Present the Medical Engagement Strategy	EM/JM	**This work is underway and will be progressed further now the new Medical Director is in post**	May16	
17	BM15-16/299	Update on the number of discharges before noon as a result of the SAFER roll out	CO		April 16	
18	BM15-16/300	Circulate to members the impact of the nursing investment from a financial perspective in order to complete the evaluation process.	GW		April 16	
Date of Meeting 27.01.16						
19	BM15-16/243	Provide a weekly progress report on A & E in light of current performance	CO	**Board of Directors to continue to receive updates as part of monthly Board of Directors Performance Report - completed**		
20	BM15-16/244	Further work recommended on the performance report to ensure that the anticipated impact of planned action was captured, together with the risks, which would aid with future evaluation and analysis	MB	**This work will be undertaken as part of the action plan from the well led Governance review – timescales agreed end of March 17**	March 2017	
Date of Meeting 28.10.15						

21	BM 15-16/163	Surgical Activity -The Board asked for consideration to be given to reporting routinely how and where beds were being protected as well as where these had been absorbed hence impacting on performance.	MB/SG	**This work will be undertaken as part of the action plan from the well led Governance review**	November 2015	
22	BM 15-16/163	RTT - The Board requested that further consideration be given to implementing an "early warning system" thus using the technology the Trust has.	MB/SG	**This work will be undertaken as part of the action plan from the well led Governance review**	November 2015	
Date of Meeting 30.09.15						
23	BM 15-16/132	The Board requested that the actions being taken to address areas of under performance in the performance report ranked in terms of desired impact, where possible, to aid with review.	PC	**This work will be undertaken as part of the action plan from the well led Governance review – March 17**	October 2015	