# AGENDA

- **v** = verbal  
- **d** = document  
- **p** = presentation  
- **©** = consent agenda item

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Lead</th>
<th>Reference</th>
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</thead>
<tbody>
<tr>
<td><strong>1.00</strong></td>
<td>1. Apologies for Absence</td>
<td>Chairman</td>
<td>B18-19/066 (v)</td>
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<tr>
<td></td>
<td>To review and agree actions the apologies for absence</td>
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<td></td>
<td>2. Declarations of Interest</td>
<td>Chairman</td>
<td>B18-19/067 (v)</td>
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<tr>
<td></td>
<td>To receive declarations of interest in agenda items and / or any changes to the register of directors’ declarations of interest pursuant to Section 7 of Standing Orders</td>
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<td></td>
<td>3. Minutes of the Previous Meeting (25 July 2018)</td>
<td>Chairman</td>
<td>B18-19/068 (d)</td>
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<tr>
<td></td>
<td>To approve the minutes of the Board of Directors, review the Board Action Log and discuss any matters arising</td>
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<td>4. Patient, Staff and Volunteer Story</td>
<td>Chief Nurse</td>
<td>B18-19/069 (v)</td>
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<td>To review and agree actions</td>
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<td><strong>1.20</strong></td>
<td>5. Chief Executive’s Report</td>
<td>Chief Executive</td>
<td>B18-19/070 (v/d)</td>
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<td></td>
<td>To review and agree actions</td>
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<td>6. Trust Strategies:</td>
<td>Chief Executive</td>
<td>B18-19/071 (d)</td>
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<td></td>
<td>• Corporate 2018-2020</td>
<td>Chief Nurse</td>
<td>B18-19/072 (d)</td>
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<td></td>
<td>• Quality 2018-2020</td>
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### Board Agenda: 26 September 2018

#### QUALITY & SAFETY

<table>
<thead>
<tr>
<th>Item</th>
<th>Lead</th>
<th>Reference</th>
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<tbody>
<tr>
<td>7. Quality Committee - Assurance Reports (20 August and 17 September 2018)</td>
<td>Committee Chair</td>
<td>B18-19/073 (d)</td>
</tr>
<tr>
<td></td>
<td>Chief Nurse</td>
<td>B18-19/074 (d)</td>
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<td></td>
<td>Medical Director</td>
<td>B18-19/075 (d)</td>
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<td></td>
<td>Medical Director</td>
<td>B18-19/076 (d)</td>
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<tr>
<td>To discuss the reports and gain assurance from the Committee, with particular focus on key risk areas:</td>
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<td>• Safeguarding Adults &amp; Children Annual Report</td>
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<td>• Results to Action – Update Report</td>
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<td>• Medical Cover - Gastroenterology</td>
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<td>To review and agree actions</td>
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#### FINANCE & PERFORMANCE

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<tr>
<th>Item</th>
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<tr>
<td>8. CQC Improvement Plan</td>
<td>Chief Nurse</td>
<td>B18-19/077 (d)</td>
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<tr>
<td>To note progress</td>
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#### GOVERNANCE/WELL LED

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<tr>
<th>Item</th>
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<tbody>
<tr>
<td>10. Leadership &amp; Management Development - Proposal</td>
<td>Director of Workforce &amp; OD</td>
<td>B18-19/081 (d)</td>
</tr>
<tr>
<td>To review and approve actions</td>
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#### CONSENT AGENDA (all items 'to approve')

All these items have been read by Board members and the minutes will reflect recommendations, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting.

<table>
<thead>
<tr>
<th>Item</th>
<th>Lead</th>
<th>Reference</th>
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<tr>
<td>© Organ Donation Annual Report 2017/18 and Operational Plan 2018/19</td>
<td>Medical Director</td>
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<tr>
<td>To note the annual report and approve the plan</td>
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<tr>
<td>© Workforce Race Equality Standard</td>
<td>Director of Workforce &amp; OD</td>
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<tr>
<td>To approve</td>
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## CONCLUDING BUSINESS

<table>
<thead>
<tr>
<th>2.55</th>
<th>11. Any Other Business</th>
<th>Chairman</th>
<th>B18-19/082 (v)</th>
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<tbody>
<tr>
<td></td>
<td>To consider any other matters of business</td>
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<tr>
<th>12.</th>
<th>Items for the Risk Register/ Changes to the Board Assurance Framework (BAF)</th>
<th>Chairman</th>
<th>B18-19/083 (v)</th>
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<tr>
<td></td>
<td>To identify any additional items for the Risk Register or changes to the BAF arising from discussions at this meeting</td>
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<tr>
<th>13.</th>
<th>Chair’s Log – Key Messages from the Board</th>
<th>Chairman</th>
<th>B18-19/084 (v)</th>
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<tr>
<td></td>
<td>To agree the key messages to be cascaded from the Board throughout the organisation</td>
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| 14. | Date and Time of Next Formal Meeting: | | |
|-----|-------------------------------------|------------------------|
|     | Wednesday 31 October 2018 at 10am in the Boardroom, Aintree Lodge |          |

*Close 3.00pm*

*Annual Members' Meeting 5.30pm Lecture Theatre Clinical Sciences Building*
Board of Directors  
25 July 2018  
Boardroom at 10am

MINUTES

Present:

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<thead>
<tr>
<th>Name</th>
<th>Title</th>
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<tbody>
<tr>
<td>Neil Goodwin</td>
<td>NG Chairman</td>
</tr>
<tr>
<td>Dianne Brown</td>
<td>DB Chief Nurse</td>
</tr>
<tr>
<td>Joanne Clage</td>
<td>JC Non-Executive Director</td>
</tr>
<tr>
<td>Tristan Cope</td>
<td>TC Medical Director</td>
</tr>
<tr>
<td>David Fillingham</td>
<td>DF Deputy Chairman/Non-Executive Director</td>
</tr>
<tr>
<td>Tim Johnston</td>
<td>TJ Non-Executive Director</td>
</tr>
<tr>
<td>Kevan Ryan</td>
<td>KR Non-Executive Director</td>
</tr>
<tr>
<td>Angie Smithson</td>
<td>AS Deputy Chief Executive / Integration Director</td>
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<tr>
<td>Mandy Wearne</td>
<td>MW Non-Executive Director</td>
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In attendance:

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<tr>
<th>Name</th>
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<tr>
<td>Paul Brannelly</td>
<td>PB Deputy Director of Finance</td>
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<tr>
<td>Caroline Keating</td>
<td>CK Director Corporate Governance/Board Secretary</td>
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<tr>
<td>Michael Games</td>
<td>MG Corporate Governance Manager</td>
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<tr>
<td>Ruth Hoyte</td>
<td>RH Director of Workforce &amp; OD</td>
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<tr>
<td>Beth Weston</td>
<td>BW Chief Operating Officer</td>
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Guests

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<tr>
<th>Name</th>
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<tr>
<td>Jane Williams</td>
<td>JW Matron, Digestive Diseases, Surgery <em>(Item B18-19/048 only)</em></td>
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<tr>
<td>Helen McGuire</td>
<td>HMG Complaints Manager <em>(Item B18-19/048 only)</em></td>
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</table>

4 public governors and 2 staff governors attended the meeting.

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<thead>
<tr>
<th>Ref</th>
<th>Item</th>
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<tbody>
<tr>
<td></td>
<td><strong>CONSENT AGENDA</strong></td>
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<td></td>
<td><strong>Emergency Preparedness, Resilience &amp; Response – Annual Report</strong></td>
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<td></td>
<td>The Board approved the report</td>
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<td><strong>Annual Equality &amp; Diversity Report 2017/18</strong></td>
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<td>MW commented that she had spoken with RH in regard to the section on the minimum statutory requirements about the requirement for further benchmarking. DB stated that she wanted to validate the numbers quoted in relation to Safeguarding.</td>
<td>The Board approved the report subject to the above matters being addressed.</td>
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<td><strong>Annual Reference Costs 2017/18</strong></td>
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<td></td>
<td>The Board approved the report</td>
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<td><strong>Council of Governors – Key issues Report (14 June 2018)</strong></td>
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<td>The Board noted the report</td>
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**PRELIMINARY BUSINESS**

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<tr>
<th>Ref</th>
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<tbody>
<tr>
<td>B18-19/-045</td>
<td><strong>Apologies</strong></td>
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<tr>
<td></td>
<td>Steve Warburton, Chief Executive</td>
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<td></td>
<td>Ian Jones, Director of Finance &amp; Business Services</td>
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<tr>
<td>B18-19/-046</td>
<td><strong>Declarations of Interest</strong></td>
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<td></td>
<td>David Fillingham, Chief Executive of Advancing Quality Alliance (AQuA)</td>
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<td>Dr Neil Goodwin, Interim Chair Liverpool Health Partners</td>
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<td>B18-19/-047</td>
<td><strong>Minutes of the Previous Meeting (23 May 2018)</strong></td>
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<tr>
<td></td>
<td>The minutes of the previous meeting held on 23 May 2018 were approved</td>
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<td>as a correct record. The Action Log was reviewed and noted.</td>
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<td>B18-19/-048</td>
<td><strong>Patient &amp; Staff and Volunteer Story</strong></td>
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<td></td>
<td>Jane Williams, Matron for Digestive Diseases in Surgery, gave a</td>
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<td>presentation on her role as a senior nurse and the impact it had on</td>
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<td></td>
<td>patient experience. She described how the role needed to provide</td>
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<td>visible professional and clinical nursing leadership to demonstrate</td>
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<td>to the team how to deal with difficult situations/conflict</td>
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<td></td>
<td>as well as other clinical issues. As part of her daily duties she</td>
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<td>visits the wards and talks to patient and visitors in order to</td>
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<td>develop trust and good relationships as well as deal with any issues</td>
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<td></td>
<td>or concerns immediately to try to prevent them from escalating into</td>
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<td>complaints. Being visible means that patients can see that she works</td>
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<td>alongside the team and gain assurance that action would be taken when</td>
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<td>necessary. JW then provided an overview of a recent patient complaint</td>
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<td>and described its high level themes, the approach she adopted, the</td>
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<td>reflective practice she undertook with the team and the actions taken</td>
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<td>to change practices and the environment, and ensuring that feedback</td>
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<td>was given to the patient in a way acceptable to them.</td>
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<td>Helen McGuire, Complaints Manager, commented that a focus on early</td>
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<td>intervention and resolution of patient concerns had reduced the level</td>
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<td>of formal complaints in June and July 2018 and the Patient Advice and</td>
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<td>Complaints Team (PACT) were working with the Divisions to deliver</td>
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<td>effective and sustainable change in practice through sharing positive</td>
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<td>experiences and lessons learned.</td>
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<td>KR and DF made reference to the reflective practice and changes to</td>
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<td>the environment and questioned whether this had been agreed with other</td>
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<td>senior nurses. JW advised that she had addressed the matter at induction and 1:1s but had not had the opportunity to share the presentation with other matrons/Nurses at this juncture. However, she was attending the Patient Experience Executive</td>
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<td>Led Group to promote the practice.</td>
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<td>TJ commented on the Aintree Assessment and Accreditation framework and questioned whether the reflective practice should be included. DB advised that the revised framework included a section relating to all patient views being obtained so that it can be triangulated with the national survey and complaints. She added that in reducing the level of complaints, there would be an opportunity for members of PACT to go to areas and hear concerns/complaints in real time.</td>
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<td></td>
<td>MW suggested that JW make contact with Paul Plant, Associate Medical Director for Quality Improvement, to share her presentation and link it to the work being undertaken on the safety culture.</td>
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<td>The Board noted the story.</td>
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**STRATEGIC CONTEXT**

**B18-19/049**  
**Chief Executive’s Report**  
AS highlighted the following key items:

- **Aintree/Royal** – good progress had been made with NHS Improvement (NHSI) providing its approval to the Trusts’ business case for consultancy spend to support the merger process. The Patient Benefit Case continued to be developed and would be presented to the Boards of both Trusts in September for approval. There had been a positive meeting with NHSI’s compliance team and the Board to Board meeting had also been positive.

- **Major Trauma Centre** – the Team had been the subject of two ITV News specials to raise awareness of the real-life consequences of knife and gun crime and promote the good work of colleagues working in the community to educate youngsters. The Team was commended for the excellent portrayal of the working environment within the Trauma unit.

NG questioned whether there had been any feedback from the NHSI Team on the overall merger process and AS advised regular calls were in place to obtain feedback on the Patient Business Case (PBC) and Competition and Markets Authority (CMA) process.

NG then provided an update on the Liverpool Health Partners (LHP) and University of Liverpool Clinical Review. He advised that the clinical research review had been signed off by the Vice-Chancellor Board and the recommendations agreed for a Task & Finish Group to review the future of clinical research at the University. The report addressed succession planning in research areas and made recommendations about investment in areas that chimed with local issues. LHP had appointed a Chief Executive to start on the development of leadership and management capability and a Director of Research had also been appointed.
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<th>Ref</th>
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<td></td>
<td>appointed to develop cancer strategies.</td>
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<td>JC questioned whether research had been included in the PBC and CMA documentation and AS advised that the working groups were including research in their work, including Head &amp; Neck cancer.</td>
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<td></td>
<td>The Board noted the update</td>
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| B18-19/050 | Board Assurance Framework Q1 2018/19 | CK  
CK presented the report and advised that there had been no material changes in the origin of risk scores but there was increased clinical risk arising from the challenges in Gastroenterology and Results to Action in addition to the financial pressures but mitigations were in place. She added that the report referenced the strategic risk log for the merger as an appendix but this had been omitted in error and would be circulated separately to the Board. CK also advised that new risk management software had been procured from RSM LLP and would be implemented over the next two months starting with the BAF. |
| | | |
| | TC commented that discussion had taken place at the Executive Team meeting on the increased demand, escalation beds and the current and emerging risks within the services. He added that the challenges to resource and recruitment placed increased clinical risk on the Trust but this was being combatted by the investment made at the beginning of the financial year. DF stated that discussion had taken place at the Finance & Performance Committee on the high level risks within the Trust and acknowledged that similar pressures existed in other Trusts. However, in his view, the matter needed to be escalated to the Commissioning Groups and NHS England. NG remarked that the challenge in escalation was to articulate the relationship between clinical pressures, finance and resource so that it was clear that there was a correlation on the Trust’s ability to provide high quality care. |
| | | |
| | KR enquired about the new risk management software and its ability to link strategic and operational risks. CK advised that it would enable the BAF and the Risk Register to be located on one system so there would be an opportunity to drill down into individual risks as well as being more proactive on emerging risks. Training on the system would be provided and the opportunity would be taken to provide staff within the Trust with a deeper understanding of risk. |
| | The Board noted the report. | |
| QUALITY & SAFETY | | |
| B18-19/051 | Quality Committee – Assurance Reports (18 June and 16 July 2018) | |
| | The Board received and noted the assurance reports from the Quality Committee meetings held on 18 June and 16 July 2018. MW, Chair of the Committee, highlighted the following key items: | |
• There had been a clear focus on the development of the Quality Strategy which had been informed by the concerns and risks identified through the CQC inspection, the Quality Risk Profile process and the never events during 2017/18
• The Patient & Family Experience Plan had also been reviewed with a request that clarity be provided on how achievements would be captured and monitored in ‘real time’
• Good progress had been made against the CQC action plan which was currently 82% complete against all actions and there was confidence that all would be delivered within the timescales
• There was concern about the level of pressure ulcers and a deep dive was being undertaken with the outcome to be reported to the Committee in October 2018.

DB advised that at the last meeting with the CQC it was made clear that, under the new regime, there was no requirement for them to visit the Trust but they could inspect within the next 12 months. However, with the merger taking place next year the CQC may undertake a full hospital inspection of the new Trust. She also advised that the Royal Liverpool Hospital was awaiting an inspection from the CQC imminently.

**The Board noted the report.**

**Safeguarding Service – Risk Update**

DB presented the report and advised that the training trajectory had been achieved for June 2018 but would continue to be monitored. As a result of the service level agreement with the Liverpool Women’s Hospital ceasing in September 2018, arrangements were in place to interview for a substantive Associate Director of Safeguarding. DB also advised that she had presented at the Sefton Safeguarding Board on the Trust’s progress and received a positive response on the improvements made.

**The Board noted the report.**

**Medical Revalidation Annual Report**

TC presented the report and advised that, for the second year running, the Trust had exceeded the target set by NHS England of 90% appraisal completion rate, achieving 95%, with the level of completed and agreed non-completed appraisals totalling 99%. There had been three Doctors who had failed to complete an appraisal within 2017/18 and did not provide a mitigating reason that was acceptable to the Responsible Officer. These Doctors were managed through the revised and strengthened non-engagement process and had now completed their appraisals. The revalidation compliance rate therefore remained at 100%. A Statement of Compliance was required to be signed by the Chief Executive and submitted to the Higher Level Responsible Officer by 28 September 2018.
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<th>Ref</th>
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<td>B18-19/054</td>
<td>The Board welcomed the excellent performance in achieving appraisal compliance and approved the annual report for 2017/18.</td>
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<td><strong>Results to Action Update</strong></td>
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<td>TC presented the report and advised that the technical issue experienced in November 2017 had been rectified by March 2018 but this had created a backlog in the number of unacknowledged results and so the risk had been increased to 20 from 15 in April 2018. Since then, there had been good progress made in reducing the backlog with Clinical Leads identified in Medicine and Surgery and action plans devised by the Divisions. Furthermore, a clerical team had been established to acknowledge normal results which would allow clinicians to focus on abnormal results. He advised that the Hospital Management Board (HMB) was to review the risk score at its meeting in August 2017 with a view to potentially reducing it back to 15. However, TC was mindful that there remained risks that were dependent on results being acknowledged consistently and acted upon where necessary.</td>
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<td></td>
<td>The Board noted the report.</td>
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<tr>
<td>B18-19/055</td>
<td><strong>Medical Cover- Gastroenterology</strong></td>
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<td>JC advised that the Finance &amp; Performance Committee had reviewed the report on the mitigations put in place to try to reduce the backlog in new and follow-up patients. She stated that she would discuss the future reporting to the Committee with MW. JC then advised that interviews had been undertaken for the vacant consultant post but no appointment was made due to candidate suitability. The Committee had concluded that a review of the action plan was required and potential service redesign considered to obtain a balance of activity in outpatient and inpatients.</td>
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<td>TC then presented the report and advised that the risk had been elevated due to a combination of outpatient capacity as a result of consultants being diverted into other areas, vacant posts, maternity leave and long-term sickness. Since the risk had been increased, there had been sustained improvement in compliance against DM01 national standards, a replacement locum consultant had been appointed to cover medical outliers in surgery, capacity and demand modelling had been completed and cases of need had been developed for specialist nursing posts.</td>
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<td>TC also advised that consideration was being given to redirecting ward based care to outpatient clinics as this outweighed the inpatient risk but would be kept under constant review. JC stated that it was for the HMB to provide clear recommendations on medical cover and on-call arrangements given the challenges within the service.</td>
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TC/BW
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<td></td>
<td>TJ stated that he welcomed the decision not to appoint to the consultant position, resisting the pressure to do so.</td>
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<td>The Board noted the report.</td>
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**FINANCE & PERFORMANCE**

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<tr>
<th>Ref</th>
<th>Item</th>
<th>Action</th>
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<tbody>
<tr>
<td>B18-19/056</td>
<td>Finance &amp; Performance Committee – Assurance Reports (25 June and 23 July 2018)</td>
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<tr>
<td></td>
<td>The Board received and noted the assurance reports of the Finance &amp; Performance Committee meetings held on 25 June and 23 July 2018. JC, Chair of the Committee, highlighted the following matters:</td>
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<td></td>
<td>• There had been excellent progress made since the implementation of the Ambulatory Heart Failure service particularly the benefits to patients, with good clinical leadership and an opportunity to learn from best practice on service redesign</td>
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<td>• A&amp;E had seen improvement in performance despite the high level of attendances. The Non-Executive Directors would be invited to attend a presentation on the progress on the Out of Hospital work in September 2018</td>
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<td>• Referral to Treatment was not meeting the required standard and a decision had been made to maintain performance at 90% and not aim to achieve the 92% standard</td>
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<td>• There had been significant improvement in Diagnostic performance but CT and MR remained challenged</td>
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<td>• There had been a reduction in the level of nursing spend but the Cost Improvement Plans (CIP) target for the year was unlikely to be met based on current forecasts. However, other schemes could be identified that would close the savings gap</td>
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<td>• There continued to be challenges in the Electronic Patient Records (EPR) programme, some of which was within the gift of the Trusts to address but others related to the system provider. Dedicated time had been set aside at the next Committee meeting to undertake a deep dive.</td>
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<td>NG expressed his concern that the CIP savings target would not be achieved by the Trust. DF remarked that the potential savings in theatre productivity were significant and, if achieved, would make considerable inroads into the savings gap. He advised that the Finance &amp; Performance Committee had asked for a refresh of all identified schemes to be brought back next month.</td>
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<td></td>
<td>The Board noted the report.</td>
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<tr>
<td>B18-19/057</td>
<td>Corporate Performance Report (June 2018)</td>
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<td>The Board received the report and noted that a number of the areas within the report were discussed under other items on the agenda. However, the following</td>
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points were raised:

- Stroke performance had been 66.7% in May and there had been further deterioration in June 2018. A third hyper-acute stroke unit bed had been opened and a fourth bed was being used for thrombolysis which should improve performance going forward
- There had been mixed performance against cancer standards particularly in 62-day classic, 2 week referral and breast symptomatic. Discussion regarding GP referrals was due to take place at the CQPG meeting but that had been cancelled and would be on the agenda for the next meeting.

The Board noted the report.

Non-Elective Flow Programme

BW presented the report and highlighted the following

- There had been improvement month on month during Q1 and this was expected to continue for July 2018
- The Trust had been the highest performer for Type 1 admitted in the region
- A 12 week improvement programme was to be undertaken in a concerted effort to take performance to the next level
- Five FY3 Doctors had been recruited and length of stay was being maintained in the Male and Female Assessment Bays.
- The SAFER programme remained on track
- Whilst there had been an improvement in discharges, they were not at sufficient levels
- A more structured approach had been adopted with the Site Team with the introduction of a Silver Command Policy and bed management electronic system
- The demand and capacity bed rightsizing analysis was to be discussed at the HMB in September 2018
- A review of the system wide capacity had been completed by Newton Europe and all partners were to agree actions in response to the findings. A presentation was to be provided to the Hospital Management Board in September 2018 and the Non-Executive Directors would be invited to attend.

NG enquired about the projected performance for the year end and BW advised that it was expected to achieve 90% by Q4 which was realistic given the pressure on the hospital, and achieve 95% by the end of March 2019. BW advised that NHS Improvement had been supportive and was fully aware of the high level of attendances at the Trust and had been pleased with Aintree’s performance to date.

The Board noted the report.
The report was received by the Board and PB highlighted the following matters:

- The Trust reported a cumulative operating deficit of £7,107m against a planned deficit of £7,006m.
- A&E activity was the highest recorded in June 2018 with increased non-elective activity but a deterioration in elective.
- Agency spend continued to be the main driver of expenditure although there had been a reduction in nursing agency spend of £200k with further improvements expected in July 2018.
- The CIP target was almost in line as a result of some corporate schemes being brought forward. The Trust was reporting its position on a bi-weekly basis to NHSI and would be discussed further at the Finance & Performance Committee meeting in August 2018.
- The Trust would require financial support from NHSI in September 2018 and an application would be required. The Trust received its Sustainability & Transformation Fund for Q4 2017/18 monies and would start to repay the funds received from the Commissioning Group during Q1.
- No feedback had been received to date on the Trust’s capital bids although it was anticipated this would be in the Autumn 2018.

NG enquired about the recent visit from NHSI and their views on the Trust’s financial position. PB advised that NHSI recognised the pressure on the Trust but had requested that a revised forecast be submitted in September 2018. AS commented that there remained concern that if there was no change to the current position, NHSI would need to escalate the matter to NHS England. DF observed that the Trust had a good track record of financial planning and management and that there had been no significant variations against the plan but rather slow and steady improvements made.

The Board noted the report.

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### Board Engagement Programme

CK presented the report and advised that a review had been undertaken of the Board engagement programme following discussion at the recent Deloitte sessions. The review had covered Conversations with the Board, Director Walk Rounds, Ask the Board, Individual Shadowing/Visits and Employee/Volunteer of the Month. The time and availability placed on the Non-Executive Directors (NED) had also been considered as part of the review. CK further advised that there would be ongoing evaluation of the agreed programme undertaken to ensure that the revised processes worked for the Board with opportunities to share learning and provide feedback on the new approach.

NG made reference to the Divisional NED links and the NED-Executive Director...
Ref | Item | Action
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(ED) links and advised that the two were not related and that clarification had been provided in appendix 1 to the report. The Board discussed the report and the following were the main issues arising:

**General**
- The opportunity being given to Governors to comment on the proposals and consider their alignment with NEDs in order to build Governor engagement into the programme
- Differences of opinion had been expressed on the matrix in the report on the boundaries of the role where support and engagement could result in less than helpful practices. A view being that the Board should not be constrained to strategic governance/assurance and that some operational detail was necessary in order to see the bigger picture.

**Conversations with the Board**
- The potential to hold cross Divisional Board conversations rather than each individual Division was seen as desirable. NEDs were to make contact with the Divisions to discuss the approach which may result in slightly different arrangements. Divisions could lead on the conversations with the link NED
- Divisions would be fully informed of the proposed approach and their role in the programme
- The logistics of how feedback from the Big and smaller conversations would need to be determined. Not all NEDs would need to attend the small conversations but an invitation would be offered to all
- Use of the Clever Together methodology to provide analysis without the process being over engineered.

**Director Walk Rounds**
- The patient journey approach had previously been adopted but had not worked well for a variety of reasons
- There was an issue with time/availability of NEDs and so it was important to ensure that the revised approach worked for all concerned
- The valuable feedback from current Walk Rounds should not be lost and needed to be built-in to Board discussions in order to share learning and concerns/issues raised
- Preparation and promotion of Walk Rounds could be improved upon
- NEDs would link with the Divisional Medical Directors and Directors of Operations within each Division and report any concerns back to the relevant Executive Director where appropriate
- Governors could be assigned to the Divisions and continue to do Walk Rounds with the link NED
- Divisions could co-create the process ensuring that the administrative burden was reduced and not over engineered whilst capturing the learning and feedback in order to track actions and ensure there was collated evidence of Board involvement and engagement
### The opportunity for Board feedback/commentary could be built in to the Divisional performance reviews with Board discussion taking place at its Part 2 meeting. How feedback was obtained in relation to the Corporate Services Division was to be discussed between KR and RH.

- Build in a review after three months’ time to evaluate whether the revised process was working.

### Employee/Volunteer of the Month

- There was an opportunity to bring the two together and invite both NEDs/EDs to the event
- Better communications were required so that staff were aware of the reasons why an individual was receiving the award
- The possibility of having both award winners at each Board meeting/session to celebrate their success

### Next steps

CK/RH to review the points arising from the discussion and further develop the proposals.

### The Board noted the report

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<tr>
<td>B18-19/061</td>
<td>Audit Committee Assurance Reports (18 July 2018)</td>
<td>CK/RH</td>
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The Board received and noted the assurance report of the Audit Committee meeting held on 18 July 2018. TJ, Chair of the Committee, highlighted the following matters:

- There had been 33 Information Governance (IG) breaches in Q1 and the main theme was clerical error which might have had an impact on patients. One case had been referred to the Information Commissioner’s Office and the response was awaited. The Committee was to track breaches and an awareness campaign was to be launched to promote the importance of data confidentiality and incident reporting
- Good progress had been made on improving theatre stock controls and a new system had been procured which would be implemented between September and November 2018
- There remained concerns with the deficit in Liverpool Clinical Laboratories (LCL) and it had been requested that the matter be resolved internally by the calendar year end or an external review would be commissioned
- The evidence to support the close off of actions arising from Clinical Audits could not be stored on the Clinical Audit Management System (CAMS) and was being held at local level. RSM was to undertake a sample test audit
- A Lesson Learned Group was to be established to review clinical claims that were not the subject of an investigation and the Committee was to undertake a deep dive of the serious incident reporting process in Q4
- There had been significant progress against GDPR compliance
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<td></td>
<td>• It was being recommended that the current Internal Audit contract be extended to the earlier of the date of the proposed merger or March 2020, subject to costs. The Board noted the report and approved the extension of the current Internal Audit contract as outlined above.</td>
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<tr>
<td>B18-19/062</td>
<td>Charitable Funds Committee Assurance Report (18 July 2018)</td>
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<td>TJ presented the report and highlighted the following matters:</td>
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<td>• The investment portfolio had been reviewed and the potential to generate additional income discussed</td>
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<td>• Grants had been made to support the Genome Study, an Osteoradionecrosis Research Project and an innovative lung fibrosis connective tissue disease research project</td>
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<td>• The accounts for the Charitable Funds would be reviewed for approval at the meeting in October 2018. The Board noted the report.</td>
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<td>CONCLUDING BUSINESS</td>
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<tr>
<td>B18-19/063</td>
<td>Any Other Business</td>
<td>None</td>
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<tr>
<td>B18-19/064</td>
<td>Items for the Risk Register/Changes to the Board Assurance Framework (BAF)</td>
<td>None identified</td>
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<tr>
<td>B18-19/065</td>
<td>Chair's Log - Key Messages from the Board</td>
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<td>The following messages were highlighted:</td>
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<td>• The importance of senior nurse leadership and visibility in providing a consistent message to staff that everything had an impact on patient experience. This included reflection on a patient complaint and how it was dealt with empathetically</td>
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<td>• The progress made in addressing the CQC action plan with 82% of plans achieved to date</td>
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<td>• Appraisal and revalidation of medical staff being achieved for the second year running</td>
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<td>• The incremental improvements to A&amp;E performance and patient flow despite record attendances</td>
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<td>• The revisions being made to the Board Engagement programme and the links to be established between the NEDs and Divisions.</td>
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<td></td>
<td><strong>Date and Time of Next Meeting</strong></td>
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<td>Wednesday 27 September 2018 at 1pm, Boardroom, Aintree Lodge.</td>
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The meeting ended at 12.30pm

Chair’s Signature: ___________________________  Date: ___________________________
## Board Action Log (25 July 2018) – Part I

‘BRAG’ rating to assess progress:

- **Blue**: Action completed & independently/externally validated
- **Green**: Action complete & evidenced
- **Amber**: Action on track but not complete
- **Red**: Action overdue for completion or may not be completed

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<tr>
<th>Lead</th>
<th>Date of Meeting</th>
<th>Minute / Reference</th>
<th>Action</th>
<th>Action Deadline</th>
<th>Action Status</th>
<th>Agenda Item</th>
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<tbody>
<tr>
<td>DB</td>
<td>May 2018</td>
<td>B18-19/028</td>
<td>Nursing &amp; AHP Strategy for Care&lt;br&gt;Quarterly progress reports to Board to include RAG ratings against actions</td>
<td>October 2018</td>
<td>A</td>
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<tr>
<td>CK/RH</td>
<td>July 2018</td>
<td>B18-19/060</td>
<td>Board Engagement Programme&lt;br&gt;Proposals to be further developed</td>
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### Deferred Items

The People and OD Strategy was initially to be reviewed in July 2018; however, the Trust commissioned Clever Together as part of its cultural improvement programme and their report on the cultural assessment of Aintree and the Royal Liverpool Hospitals is due by 24 September 2018. The second phase of work will launch end September/October which will enable co-creation of Aintree as a “great place to work”. It therefore seems appropriate to await the outputs of this workshop to allow the development of a more meaningful People and OD Strategy.
Patient C’s experience of Ambulatory Emergency Care (AEC)

Clare Pritchard – Lead Nurse AMU/AED
Patient and Family Shadowing

Patient and Family Shadowing is a technique of capturing and understanding experiences in real time and using them to redesign and improve the care experience using a clear approach.

Patient and family shadowing allows the opportunity for staff to see the care experience ‘through the patients eyes’ by:

- Shadowing/following a patient and or a family member throughout a selected care experience.
- Observing the patient and or family member interacting with staff and the environment to gain insight on the patients experience.
- Providing information through observation, discussion and analysis to care staff to ‘perfect’ the patient and family experience.
What is Ambulatory Emergency Care?

- Consultant led unit which is open from 8.30am until 11pm, Monday to Friday, seeing more than 70 patients per day

- Accepts patients directly from the Emergency Department who present with simple chest pain, Deep Vein Thrombosis (DVT), Pulmonary Embolism (PE), headache and walking ambulatory patients (no need for stretcher)

- Daily hot clinic 8.30am – 5pm which reviews patients who have been discharged from ED or MAB and FAB the previous day but require follow up, including blood transfusions
What was Patient C’s experience?

Patient C said:

• She was treated with respect and dignity

• The Assistant Nurse Practitioner who cared for her was extremely kind

• Staff listened to her and gave her the opportunity to ask questions

• Offered food and a drink

• However, she had got a taxi because of the cost of the car park – a recent day case admission cost £13 to park for the day
My experience of shadowing

Positive:

- Environment was very calm
- Staff friendly and smart
- Staff introduced themselves and explained what they were doing
- Mrs C became unwell during the ECG, her observations were recorded straight away

Room for improvement:

- Very busy area, waiting area filled very quickly and chair positioning made it feel like everyone was on top of each other
- Patients were having treatment and being offered food but there were no tables for them to eat from, sandwiches and hot drinks were being balanced on chairs
- Patients having bloods taken in front of each other
- No pillow cases on the pillows
- TV right above their head, so Mrs C couldn’t see it but it was extremely loud
- Waiting room is very bare
- Staff chatting, personal conversations within earshot of patients
- Staff snacking in front of patients
How is shadowing beneficial?

• The time and ability to take a step back

• Fresh eyes to observe the environment

• Ability to gather information to bring staff ‘back in the room’ using valuable insights from patients’ experiences

• Didn’t get the valuable improvement insights from the patient directly, but from being part of the journey
What next?

• A conversation was held with the senior leader to make staff aware of the impression they gave when eating and chatting on the unit
• Positive feedback from the patient was fed back to the staff
• Pillow cases and bedside tables have been ordered
• More curtains have been put around the treatment chairs to ensure privacy
• Away time is planned with the staff and Clinical Business Manager to look at the processes and flow of the department to make it more streamlined for patients and staff (date to be confirmed)
Report from Hospital Management Board

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<tr>
<th>Report to</th>
<th>Board of Directors</th>
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<tr>
<td>Date</td>
<td>26 September 2018</td>
</tr>
<tr>
<td>Committee Name</td>
<td>Hospital Management Board</td>
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<tr>
<td>Date of Meeting</td>
<td>8 August 2018</td>
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<tr>
<td>Chair’s Name &amp; Title</td>
<td>Steve Warburton Chief Executive</td>
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<td>Executive Lead</td>
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Summary

1. The Hospital Management Board (HMB) receives reports from the Executive Led Groups on the clinical and operational management of the Trust. It also reviews the delivery of the strategic objectives and mitigation of strategic risk by focussing on clinical quality, performance and delivery.

Key Issues

2. Work was being undertaken on data validation regarding CQC registration and paediatric activity. A report was to be submitted to the HMB meeting in September 2018.

Chief Executive’s Update

3. The following matters were highlighted:
   - **Electronic Patient Records (EPR)** – recent changes by the supplier had resulted in greater progress on identified actions. It was envisaged that the Liverpool system would be rolled out nationally in due course. EPR programme to be re-launched in September 2018 to raise awareness.
   - **General Data Protection Regulations (GDPR)** – work plan progressing satisfactorily. Scope for forthcoming internal audit would provide a useful checklist pre-merger.
   - **Merger update** – ‘Clever Together’ workshop with Transaction Programme Steering Group identified from initial staff survey data analysis of both organisations that ‘cultural profiles’ were near identical. It was likely that the new Royal Liverpool Hospital would be completed in autumn 2019 and the final move taking place in spring 2020.

Results to Action

4. Good progress had been made clearing the backlog of historic results. Training was to be cascaded to each CBU which should further reduce the backlog; junior doctors were being advised as part of their induction the importance of acknowledging results and their link to the quality improvement plan. As part of the Safety Culture campaign, all Trust PCs display a reminder to staff to acknowledge and action results. The risk score, currently at 20, would be reviewed at Clinical Effectiveness ELG in September 2018.

Medical Cover – Gastroenterology

5. There had been marginal improvement in outpatient waiting times from the reported position in May and a slight improvement in the incomplete Referral to Treatment pathway month-on-month since April 2018, although it remains below target. Mitigation was in place but this included a heavy reliance on waiting list initiatives to maintain performance despite increasing demand. A locum consultant had been recruited on a short-term basis only. The external review undertaken
by the Cancer Alliance identified high DNA rates and list utilisation as areas for efficiency gains. The Transformation Team was assisting with the review of the booking process and virtual clinics provided support in reducing waiting times; however, a substantial capacity shortfall remains. It was agreed that the risk would remain at 20 and that the Executive Team would discuss further mitigation plans for presentation and sign-off at the meeting in September 2018.

Main A Theatre Electrical and Ventilation Incident
6. Three incidents, two electrical and one ventilation, occurred in the Main A theatres in July, associated with recent improvement works. The decision to complete the project whilst the theatres were in operation was a difficult one, carrying additional risk which had to be weighed against the detrimental effect on patients of having to cancel procedures. Mitigations had been put in place to ensure patient safety and reassure colleagues, whose confidence in the systems had been challenged by the issues.

Corporate Report of the Trust Risk Register
7. The current status of the risk register was presented and discussed, with a view to providing assurance that the key corporate risks were being managed appropriately. The quarterly risk report had been revised to better align with the Board Assurance Framework. On-going work over the coming months would ensure that the escalation and de-escalation of risks was more visible and the roles and responsibilities in relation to risk management were well defined and understood.

Draft Quality Strategy
8. Comments received had been incorporated into the draft “Quality Strategy 2018 – 2020”. HMB agreed that the final version should be submitted to the Quality Committee and then to September’s Board for approval.

Quality Improvement Programme – Progress Report
9. HMB noted the significant progress that had been made with the Quality Improvement Programme. A gateway review for Stages 1 and 2 of the programme had been completed with the successful delivery of Stage 3 dependent upon the clarity of work streams, the establishment of governance structures and wider engagement.

CQC Improvement Plan - Dashboard
10. The action plan was being managed through a fortnightly CQC Delivery Group meeting and at 31 July 2018, 85% of actions were now complete. Work continues apace, with the CQC follow-up visit currently scheduled to take place on 01 October 2018.

Strategy for Care 2018 – 2020 – Project Summary and Delivery Plan
11. The report provided a progress update and a Project Summary and Delivery Monitoring Plan, which had been developed to indicate how the strategy would be delivered over the two-year period. The Quality Committee would receive bi-annual updates on the progress made against delivery of the six key principles.

Complaints Investigation Best Practice
12. Following work completed internally since the Independent Complaints review in June 2017, a presentation had been given to over 100 staff across the Trust involved with handling complaints. This provides guidance on identifying what is a complaint, a more proactive approach to preventing complaints being made and working with complainants to identify desired outcomes.
Aintree Assessment and Accreditation Framework
13. Three AAA assessments had been carried out in Q1 2018-19. Current status was 14 ACE Wards, 7 Green, 8 Amber and 4 Red. The Lead Nurse would continue to monitor the position during Q2 and the Corporate Nursing Team and staff within the Division of Medicine were working together to support wards rated as Amber or Red. The AAA framework had been revised to align with CQC’s fundamental standards and the Associate Medical Director for Quality Improvements was leading on this work which would link with the overarching compliance framework.

Learning from Deaths in the NHS
14. National guidance on Learning from Deaths was launched on 21 March 2017 by NHS England, NHS Improvement and the CQC under the umbrella of the National Quality Board (NQB). A new Structured Judgement (SJR) Tool was being introduced as part of the new Trust mortality review process. This was currently limited to a small number of consultants as part of a phased launch, with full launch expected during August. There had been the long-standing inclusion of deaths of Woodlands Hospice patients being coded as AUH admissions but this data will no longer be included as it had the potential to lead to false mortality figures. Going forward, further work needed to be done to ensure a robust way of identifying and linking Serious Incidents involving a patient death with the mortality review system.

Corporate Performance Report (CPR) and Finance Report (including Executive Led-Group Updates
15. The HMB reviewed the reports with particular focus on the following areas:
   - Bed pressures continue, with all beds planned to be de-escalated remaining open which would impact on finances allocated for winter planning
   - Whilst activity was above that planned overall, income had been slightly below, resulting in the underlying financial deficit position being marginally worse than planned. Coupled with increased agency usage and higher than anticipated spend, a slightly higher than anticipated deficit has resulted
   - Diagnostics demand was outstripping supply, due in part to multiple investigations being carried out rather than requests being joined up. This would be investigated and details brought to the next meeting.

Private Patient Service
16. The report provided the current financial position of the private patient service for the period 2016-2018, and highlighted its underutilisation of operational capacity. It was agreed that the Transformation Team would undertake diagnostic work taking account of whether the operating model could be redeveloped to become profitable. Consideration would be given to opening “Choose and Book” for NHS services as a supplementary means of enhanced patient attraction.

Decisions Made
17. Agreed that the final Quality Strategy be submitted to the Quality Committee.

Recommendation
18. The Board is asked to note the summary report.
Report from Hospital Management Board

Summary

1. The Hospital Management Board (HMB) receives reports from the Executive Led Groups on the clinical and operational management of the Trust. It also reviews the delivery of the strategic objectives and mitigation of strategic risk by focussing on clinical quality, performance and delivery.

Key Issues

Quality Strategy Session

2. The agenda for the HMB was revised so that the first hour of the meeting was dedicated to discussion on the Quality Strategy and other quality issues. The following were discussed:
   - **Draft Quality Strategy 2018-20** – the final version was presented and it was agreed to recommend approval to the Quality Committee and Board of Directors
   - **Quality Strategy Q1 Progress Report** – an update was provided on the portfolio of projects within the delivery plan which highlighted the completed actions to date and the next steps for Q2. It was agreed that there would be monthly scrutiny of risks by exception with a formal report provided quarterly on the updated position with the potential for deep dives to be identified
   - **CQC Improvement Plan** – all the 50 must do actions had been completed with seven should do actions outstanding which were being monitored by the CQC Group. An update was provided on the status of the actions and there was confidence that all would be completed by the end of September deadline. There were two deferred actions relating to dementia and end of life that would be monitored by the Quality Committee post September 2018.
   - **Paediatric Activity** – the report had been commissioned internally following a review of the Equality & Diversity Annual Report which highlighted care of children by the Trust. It had been confirmed that the Trust’s CQC registration provided coverage for services to treat patients of any age. The data had been cleansed and each of the Divisions had provided details of the number of children (aged 16 and under) who had attended certain specialties within the Trust. It was agreed that paediatric data would be provide to the Operations & Performance ELG on a monthly basis and that the HMB would review the position on an annual basis.

Chief Executive’s Update

3. The following matters were highlighted:
   - **Electronic Patient Records (EPR)** – the Programme Board had discussed the current position with the different elements of the project and considered the planned approach moving forward taking account of the timescales for the proposed merger. A re-launch of the programme was scheduled for 19 September 2018 at Aintree Racecourse
Merger update – NHS Improvement had reaffirmed its support for the transaction and the wider internal and external engagement programme would be taking place over the next couple of months.

Bed Rightsizing Outcomes
4. A presentation was provided by representatives from Ernst & Young on their work with an overview provided on the underlying rationale including the context and status to quantify assessment area capacity requirements, understand the inpatient ward bed base requirements and the impact of productivity improvements. Details were also provided of the approach adopted which included evaluation of the assessment areas, inpatient base wards and scenario modelling. An outline of the potential gap to deliver winter demand and elective plan and the mitigations to be put in place to reduce the gap. The next steps included a review of the opportunities to support the delivery of the reduction in length of stay, the potential transformation of models of care to meet patient demand and the internal process improvement to support the reduction in ready for discharge patients.

Out of Hospital Programme
5. A presentation was provided by Newton Europe on their diagnostic work commissioned by Sefton Clinical Commissioning Group. An overview was provided on the focus of the diagnostic undertaken over a 5-week period which was split between discharge decision making and flow/delays. Details were provided on the impact on decision making, placement and home care in particular and the outcomes of the workshops on case reviews and medically fit patients in the two acute hospitals.
6. Some discussion took place on the impact of the risk averse decision that were in the gift of the Trust to influence and it was noted that steering groups were to be established to deliver the actions arising from the outcome of the diagnostic and report through to the A&E Delivery Board

Winter Planning
7. A report was tabled which summarised the requirements to support additional areas over the winter period. It was noted that authorisation was required on the establishment in order to commence recruitment, equipment needed to be purchased as well as additional beds being purchased in time for the opening of the winter ward. It was agreed that the Chief Operating Officer would progress this with the Director of Finance and Chief Nurse.

Medical Cover - Gastroenterology
8. The business case for additional capacity was being finalised following meetings with the team to look at the planned approach to maximise changes to help clear the backlog and reduce the waiting time for first appointments in particular. Further actions had been identified to mitigate the risks and sustainable solutions to improve the current position and these were agreed by the HMB whilst acknowledging that they do not sufficiently match the demand on the service.

BBC ‘Hospital’ Documentary
9. Representatives from the Production Company for the documentary provided an overview of how it would be portrayed with the key theme being the ‘patient story’ but also feature the remarkable work undertaken by the Trusts in Liverpool to illustrate the story of health within the city. It was noted that a number of local Trusts had signed up to being involved in the documentary and that the Communications Team was in discussion with the Production Company with a view to establishing a planning group to support the production as well as ensure that all staff and patients were fully informed in advance of any filming.
Workforce Race Equality Standard (WRES) 2018
10. The HMB was advised that WRES was a requirement for NHS provider organisations and that the Trust was to submit its data annually to NHS England and publish the information on its website. The HMB was requested to provide feedback on the report prior to its submission to the Board of Directors for approval at its meeting in September 2018.

Resourcing Undergraduate Medical Student Supervision
11. It was explained that the Trust was required to provide support educational supervision and clinical teaching of medical students. Funds were allocated within Divisional budgets for this purpose but the changes in requirements meant that there was a financial consequence for the delivery of educational supervision for the Year 3 & 4 undergraduates.

Decisions Made
12. Recommend approval of the Quality Strategy to the Quality Committee and Board of Directors.

Recommendation
13. The Board is asked to note the summary report.
SECTION ONE: BACKGROUND AND CONTEXT

1 Introduction

Aintree University Hospital NHS Foundation Trust’s strategic vision was refreshed in 2016 to:

“be a leading provider of the highest quality health care”

We also reinforced our common purpose of:

“Getting it right for every patient, every time”

At the same time, we agreed our strategic objectives as presented below:

Reshaping our Future

This document sets out the context in which we operate and the strategy we will follow as an organisation to enable us to achieve our vision over the period to 2020. It also informs and sets the framework for delivery of our:

- Strategic Priorities
- Operational Priorities; and,
- Enabling Priorities

These priorities are identified as part of our Annual Business Planning process and form the foundation of our Annual Operational Plan submission to our regulator, NHS Improvement.
2 Where we have come from

Aintree Hospitals NHS Trust was established in April 1992 when Fazakerley Hospital joined with Walton Hospital. The Trust became a University Hospital in 1999 and was authorised as a Foundation Trust in 2006, to become Aintree University Hospitals Foundation Trust. In 2011, the Trust opened the Elective Care Centre, thereby enabling the closure of Walton Hospital.

Since becoming a foundation trust, Aintree has witnessed significant growth and invested £175m+ in capital development to improve facilities on site for its patients and its staff. We have strengthened partnerships with the University of Liverpool, Edge Hill University and the University of Chester and raised our research profile particularly in the context of clinical trials. The training and education of staff combined with our clinical research impact positively on the care we provide for our patients by helping to attract the very best staff.

Today, the Trust provides general acute health care to a population of 330,000 people in North Merseyside and the surrounding area, provides tertiary services to a much wider population of around 1.5 million in Merseyside, Cheshire, South Lancashire and North Wales and also works with a range of partners to provide services in the community. The Trust is a teaching hospital of the Universities of Liverpool, Chester and Edge Hill.

During 2017/18 our staff cared for over 93,000 (2016/17:88,000) patients requiring inpatient or day case treatment, saw 421,000 (2016/17:425,000) patients in the outpatient departments and treated over 168,000 (2016/17: 163,000) patients in the Accident and Emergency Department.

The Trust is one of the largest employers locally with more than 4,900 staff and we are recognised for our support for staff through training (including our award winning apprenticeship programme), engagement programmes and staff development support.

At the end of 2017/18, the Trust had fixed assets of £186million and an annual income in excess of £350 million. Aintree is fully committed to the guiding principles and values of the Care Quality Commission and the NHS Constitution:

<table>
<thead>
<tr>
<th>NHS Constitution</th>
<th>Care Quality Commission</th>
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<tbody>
<tr>
<td>- Working together for patients</td>
<td>- Safe</td>
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<tr>
<td>- Respect and dignity</td>
<td>- Effective</td>
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<tr>
<td>- Commitment to quality of care</td>
<td>- Caring</td>
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<tr>
<td>- Compassion</td>
<td>- Responsive; and</td>
</tr>
<tr>
<td>- Improving lives</td>
<td>- Well-led</td>
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<tr>
<td>- Everyone counts</td>
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</table>
3 The NHS Context

The NHS continues to be under significant pressure to improve quality and provide even greater focus on the holistic needs of patients. In addition, the NHS faces the prospect of sustained financial constraint which can only be addressed if providers of healthcare change radically the way services are delivered.

The NHS Five Year Forward View (October 2014) set out the key opportunities and challenges facing the NHS and the need to take a longer term approach to planning to ensure the NHS remains clinically and financially sustainable.


We all want to know that the NHS will be there for us and our families when we need it the most - to provide urgent and emergency care 24 hours a day, 7 days a week. Staff are working with great skill and dedication to do so, and looking after more patients than ever. But some urgent care services are struggling to cope with rising demand. Up to 3 million A&E visits could have been better dealt with elsewhere. There are difficulties in admitting sicker patients into hospital beds and discharging them promptly back home. To address this, requires collaborative working across the health and social care economy.

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4 The Local Context

The local population served by Aintree includes some of the most socially deprived communities in the country, with significantly lower than the England average life expectancy and high levels of morbidity. The population profile is also ageing rapidly with some neighbourhoods having a projected growth of around 45% expected in the over 75s. These factors combine to create significant demand for hospital-based care.

The Royal College of Surgeons has recommended that the catchment population for an acute general hospital such as Aintree should be between 450,000 and 500,000 people and without this scale, and the efficiency that it offers, any NHS Trust is expected to find maintaining financial sustainability increasingly challenging.

The strategic vision, therefore, set out in the Healthy Liverpool Programme initially and reaffirmed in the One Liverpool Plan (March 2018)3, requires acute providers to work more closely together to transform the delivery of health care services in order to create a Centre of Excellence in the City of Liverpool with a national reputation for research and innovative, clinically-led services that improve the health & wellbeing of our community. The successful achievement of this vision would support Liverpool’s competitive position in the market place for research, education and specialist services with acute providers in Manchester, Sheffield and Leeds.

Aintree, as a provider of acute and specialist hospital services, is collaborating with other hospital providers in multiple ways for future sustainability and to improve services. Liverpool has a unique health care economy with multiple specialist providers. This fragmented configuration of hospitals services means that patient care is also fragmented and variable. This in turn prevents care being provided in a multi-disciplinary joined-up way, resulting in the sub-optimal outcomes and inequalities experienced by the North Mersey population.

When viewed in the national context of improving clinical and financial sustainability for an ever-changing population and in addressing clinical variation, it is clear that the presence of two competing hospitals (Aintree and The Royal Liverpool & Broadgreen University Hospitals NHS Trust) is inhibiting the transformational process that is required at this time. Furthermore, when viewed in the context of excellence in research and development, digital technology and in education and training, the lack of a single university hospital is impairing the ability of Liverpool to fulfil its potential in these areas.

The options for delivering the transformation required have been evaluated with merger seen by both organisations, including their clinicians, as the preferred option. We have already started to collaborate on the development of a single service for adult orthopaedics surgery, intended to reduce variation and improve patient care, also enabling solutions to the fundamental shared challenges around improving outcomes, ensuring that the system has the right workforce capacity, skills and financial sustainability.

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5 Aintree’s Services

The Trust provides high quality elective and emergency care services to meet the day to day needs of its local community. In addition, we also provide high quality specialist services, including:

- Major trauma
- Hyper-acute stroke
- Regional head and neck surgery
- Upper GI cancer
- Hepatobiliary and liver; and
- Specialist endocrine services.

The Trust also works with its partners to provide a range of services in community settings including diabetes, rheumatology, ophthalmology and alcohol services. Other tertiary services provided by the Trust to a much wider population of around 1.5 million in Merseyside, Cheshire, South Lancashire and North Wales include respiratory medicine, rheumatology, maxillofacial and liver surgery. We are proud of our close partnerships with other NHS organisations and Local Authorities.
SECTION TWO: HOW AINTREE ADDRESSES THIS CONTEXT

1 The Trust’s Vision, Common Purpose and Values

The Trust’s vision is:

“To be a leading provider of the highest quality health care”

The Trust’s Board of Directors considers that this statement accurately reflects the ambition of Aintree as a sustainable healthcare provider. Underpinning the vision statement is the Trust’s mission, our common purpose:

“Getting it right for every patient, every time”

This statement expresses the desire of our entire workforce to provide high quality care for all patients and is underpinned by six clear values:

- Deliver safe, compassionate care
- Improve through learning and innovation
- Communicate openly and honestly
- Work as a team
- Use resources wisely, and
- Value each other

The Board of Directors, Council of Governors and Senior Leadership Teams believe that by living the values and working together, Aintree University Hospital will deliver its common purpose and achieve its strategic vision.
SECTION THREE: THE NEXT 5 YEARS

1 Our Strategic Objectives

Liverpool, Sefton and Knowsley have a complex provision of healthcare. The Trust is committed to working in partnership to deliver the best configuration of services for patients. The Board of Directors has set four strategic aims which will ensure that high quality services can be provided sustainably on or from, the Aintree Hospital site.

Our strategic aims are to be:

- the provider of choice
- the employer of choice
- the partner of choice
- clinically and financially sustainable

These aims will be delivered through our strategic objectives, medium-term priorities and a range of supporting workstreams.

Our strategic objectives are aligned to the domains of safe, effective, caring, responsive and well-led (overleaf)

In addition, we have aligned our quality commitments to these strategic objectives. These were created in conjunction with stakeholders to enhance our focus on quality:

- To deliver outstanding care by being a patient-centred organisation that provides high quality, safe and compassionate services.
- To provide the safest and clinically effective health care services to patients and promoting a good quality of life
- To treat patients and families as they wish to be treated
- To deliver sustainable healthcare to meet people’s needs
- To be the leading provider of the highest quality healthcare by attracting and retaining highly skilled, engaged staff and promote an open and fair culture.
## STRATEGIC OBJECTIVES

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</thead>
<tbody>
<tr>
<td>By being a patient-centred organisation that provides high quality, safe and compassionate services</td>
<td>By providing effective treatment to achieve best possible patient outcomes and promote quality of life</td>
<td>By delivering the benefits of education, research and innovation for our patients and staff</td>
<td>By delivering efficient, cost effective services to ensure their long-term sustainability</td>
<td>By working together to support seamless pathways across all sectors</td>
<td>By developing and supporting effective leadership across the organisation to enable our people to achieve our vision</td>
</tr>
</tbody>
</table>

SAFE CARING EFFECTIVE RESPONSIVE WELL-LED
To be the provider of choice

We will do this by demonstrating that our services are safe, clinically effective and provide a positive experience for patients and their families.

The Trust has three distinct service offers which are at the core of our clinical services. These are:

- Specialist Acute Care to meet the needs of the population - these services will be responsive to acute need, be delivered by appropriate staff at the times required, in the most appropriate location

- Specialist Long-Term Conditions Care – focused on the use of technology and work with patients to help them self-manage their condition, providing quick access to expert advice when required. These services will need to be closely integrated with those of partners working in primary, community and social care

- Diagnostic and Support Services – flexible provision of high quality diagnostic and support services which will offer a potential growth opportunity as investigations move closer to the patient, but will also support care of acute and long-term conditions.

The Trust’s Quality Priorities have been developed in partnership with our patients, staff and external partners. We believe that to be the provider of choice, we need to be able to demonstrate to patients and commissioners of services that we provide care that is safe, clinically effective and offers a positive experience for patients and their families.
### Our Quality Objectives

#### Care that is Safe:

**Priorities**
- Reducing Harm and avoiding Never Events
- Compliance with Safeguarding and Mental Capacity Act
- Acting on clinical results
- Improving governance, learning and preventing harm
- Improving the patient journey
- Learning from Harm
- Reducing Avoidable Mortality

#### Care that is Clinically Effective:

**Priorities**
- Deliver reliable effective care – care pathways
- Deliver reliable effective care – advancing quality (AQ) programme

#### Care that provides a positive experience for patients and their families:

**Priorities**
- Drive performance in patient experience
- Act on patient feedback
- Co-create improvements
To be the employer of choice

We will do this by attracting the best people who understand what is expected of them, are capable of doing it and choose to do so.

This will be achieved by developing and engaging our workforce to ensure our staff have the right skills, knowledge, attitude and behaviours to deliver high quality care in the right place, every time.

### People and Organisational Development Goals

**Recruitment and Selection:**

- We will anticipate how many staff we need and recruit them in advance of posts becoming vacant
- We will select people for their attitude as much as their skills
- We will ensure that everyone joining Aintree understands and commits to our common purpose and our values
- We will explore new roles and new ways of working for the future

**Education and Learning:**

- We will support our people to develop the knowledge and skills they need to do their job well
- We will enable our people to make improvements to the way things are done within Aintree and to grow and develop as individuals
- We will enable our people to learn from successes and our failures through continuous improvement

**Leadership and Management:**

- We will manage and lead our people well
- We will strive to become a clinically-led organisation
- We will involve our people in decision-making and listen to what they have to say to develop Aintree as a great place to work

**Recognition and Reward:**

- We will value and recognise our people’s contribution
- We will look after our people’s wellbeing
- We will celebrate all that we have achieved together
To be the partner of choice

Our intention is to be regarded as a preferred partner because we have a high quality offer and a reputation for delivery and integrity.

We will continue to improve the quality and performance of our services to ensure that we meet our terms of authorisation as a Foundation Trust, comply with Care Quality Commission (CQC) standards and meet our contractual obligations with our commissioners.

We will build on our strengths, values and behaviours to create effective partnerships with our patients, commissioners and other providers of care services both within the community environment and across secondary and tertiary care. Working with Clinical Commissioning Groups, we will develop and deliver locally accessible services in parallel with developing an appropriate portfolio of specialist services through collaboration with the Specialist Commissioners and other hospital providers. Our commitment to reducing health inequalities will be at the heart of our partnerships, working together to ensure we do the best we can for our local population. While partnership is a key strategic objective, its implementation is a function of priorities in a number of our plans.

Partnership Goals

Patients – we will help reduce health inequalities in our local population by:

- Promoting health improvement messages at every opportunity
- Working with our patients to improve self-care and management
- Embedding shared decision making and information sharing at every level

Community providers – we will work closely with GPs and other primary, community and social care professionals to:

Develop Integrated Health & Social Care Services; share information; ensure timely access to our expertise; provide locally accessible care; and, help shape care pathways

Specialised Centre – we will contribute to the development of a centre of excellence:

- As the single receiving site for Major Trauma in partnership with The Walton Centre
- As an Integrated Cancer Centre providing Upper GI cancer services within an integrated gastrointestinal service working principally with the Royal Liverpool
- As an Integrated Cancer Centre providing Head and Neck Cancer Services in liaison with Liverpool University and The Clatterbridge Cancer Centre
- As a tertiary acute Stroke Centre in partnership with The Walton Centre to develop surgical interventions
- As the regional provider of specialist services such as respiratory medicine, endocrinology, rheumatology, and hepatobiliary & liver services
- As a teaching hospital of the Universities of Liverpool, Chester and Edge Hill
- As a provider of high resolution diagnostic services
- As the Level 1 Accident & Emergency Service in Merseyside
To be clinically and financially sustainable

Clinical and financial sustainability are inextricably linked and interdependent. In order to secure income through the delivery of high quality services, the Trust must have the right people and resources in place.

Clinical Sustainability

As a provider of healthcare, Aintree has a role that spans health promotion, primary, community, secondary and tertiary care. We have established seven principles as our decision making framework against which all services are measured for inclusion in our portfolio of Clinical Services. Where a service meets these principles, it could be expected that we will continue to deliver the service within current organisational arrangements; if, however, a service cannot guarantee patient safety, clinical quality and performance against standards consistently because of demand or capacity issues, we would consider whether a partner solution should be sought or whether we should have a discussion with the commissioners or provider partners about whether Aintree should continue to provide that service. There may be occasions where services meet most of the seven principles but are on the borderline of making a viable financial contribution because of the nature of the tariff. In such cases we will make investment decisions to secure the sustainability of these services based on their relevance to the Trust’s wider portfolio of services.

Clinical Sustainability

Our seven principles for decision making are:

- Is there a public health benefit arising from the delivery of the service?
- Is it a service the commissioners want to buy?
- Does the service have sufficient volume of activity to be clinically safe?
- If the service requires emergency cover, can this be provided consistently to maximise patient safety seven days a week?
- Is there sufficient capacity to match demand and to ensure all performance and quality standards are met?
- Is the service essential to maintain key linkages/support for other services?
- Is the service financially viable in the context of tariff income?

In applying these principles we will:

- Ensure our service developments are aligned to national and local priorities
- Ensure our services continue to support the highest quality education and research
- Ensure services meet the required standards for delivery as outlined in National Service Specifications, NICE guidance and Cancer Improving Outcomes Guidance
- Ensure emergency and urgent care services are reliable and consistent, seven days a week
- Ensure that the cost of service delivery will not exceed the financial envelope available from the national tariff
Financial Sustainability

In the years ahead, both the NHS and local government face a period of increasing restraint on resources; therefore, we will need to improve the quality of care whilst at the same time finding more cost-effective ways of delivering services.

Financial sustainability will be achieved by securing the income for the services we deliver, ensuring we have good financial stewardship and using our resources efficiently and effectively.

We will maintain clinical and financial sustainability through delivery of our Operational Priorities. This will require ever closer integration with primary, community and social care services to keep people healthy and reduce hospital admissions and to shorten their length of stay in hospital should they need admission. It will also require close partnership working with commissioners and with other providers to ensure the most effective configuration of hospital services as part of the One Liverpool Plan. This strategic objective will be supported by seizing the opportunities provided by new technologies.

Financial Sustainability

- **Securing our income** – we will deliver a balanced portfolio of services across the acute, chronic conditions and diagnostic domains ensuring robust clinical linkages and standards

- **Optimising our borrowing potential to invest upfront in long term facilities**

- **Economy** – we will control our costs through:
  - Procurement savings
  - Changing the way we work
  - Use of Informatics

- **Efficiency** – we will improve productivity by:
  - Reducing the time patients spend in hospital
  - Reducing out-patient cancellations
  - Optimising theatre utilisation

- **Effectiveness** – we will do the right things by:
  - Maximising day case rates and ambulatory care
  - Providing 7-day services
  - Getting it right first time, every time (reducing errors and avoiding readmissions)
SUMMARY

Every element of our Corporate Strategy is focused on improving patient care and will be underpinned by strong leadership and governance, including robust risk management. The Board of Directors, Senior Leadership Team and our staff are committed to delivering this strategy together and in partnership with patients, commissioners and other providers of care in Merseyside and beyond.

Dr Neil Goodwin CBE
Chairman

Steve Warburton
Chief Executive
## Equality Impact Analysis

<table>
<thead>
<tr>
<th>Title</th>
<th>Corporate Strategy 2016-2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategy/Policy/Standard Operating Procedure</td>
<td>Corporate Strategy 2016-2021</td>
</tr>
<tr>
<td>Service change (Inc. organisational change/QEP/ Business case/Project)</td>
<td>Corporate Strategy 2016-2021</td>
</tr>
<tr>
<td>Completed by</td>
<td>Caroline Keating, Director Corporate Governance/Trust Secretary</td>
</tr>
<tr>
<td>Date Completed</td>
<td>20 September 2018</td>
</tr>
</tbody>
</table>

**Description** *(provide a short overview of the principle aims/objectives of what is being proposed/changed/introduced and the impact of this to the organisation)*

The Corporate Strategy is reviewed and approved annually by the Board of Directors. It has been updated to reflect the changes to the quality goals for 2018/20 and any other updates have been incorporated.

**Who will be affected** *(Staff, patients, visitors, wider community including numbers?)*

Staff, patients, visitors and wider community

The Equality Analysis template should be completed in the following circumstances:

- **Considering developing a new policy, strategy, function/service or project (Inc. organisational change/Business case/ QEP Scheme);**
- **Reviewing or changing an existing policy, strategy, function/service or project (Inc. organisational change/Business case/ QEP Scheme):**
  - If no or minor changes are made to any of the above and an EIA has already been completed then a further EIA is not required and the EIA review date should be set at the date for the next policy review;
  - If no or minor changes are made to any of the above and an EIA has NOT previously been completed then a new EIA is required;
  - Where significant changes have been made that do affect the implementation or process then a new EIA is required.

Please note the results of this Equality Analysis will be published on the Trust website in accordance with the Equality Act 2010 duties for public sector organisations.

Section 1 should be completed to analyse whether any aspect of your paper/policy has any impact (positive, negative or neutral) on groups from any of the protected characteristics listed below.
When considering any potential impact you should use available data to inform your analysis such as PALS/Complaints data, Patient or Staff satisfaction surveys, staff numbers and demographics, local consultations or direct engagement activity. You should also consult available published research to support your analysis.

Section 1 – Initial analysis

<table>
<thead>
<tr>
<th>Equality Group</th>
<th>Any potential impact?</th>
<th>Evidence</th>
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<tbody>
<tr>
<td></td>
<td>Positive, negative or neutral</td>
<td>(For any positive or negative impact please provide a short commentary on how you have reached this conclusion)</td>
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</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>Positive</th>
<th>The Corporate Strategy provides a high level overview of the Trust’s vision and strategic objectives from 2016-2021. It is focussed on improving patient care underpinned by strong leadership, governance and risk management. The delivery of the Strategy should have a positive impact on all the Trust’s patients, its staff, commissioners and other providers</th>
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<tbody>
<tr>
<td>Disability</td>
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<td>Gender Reassignment</td>
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<td>Marriage &amp; Civil Partnership</td>
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<td>Pregnancy &amp; Maternity</td>
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<td>Race</td>
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<td>Religion or belief</td>
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<td>Sex</td>
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</table>
If you have identified any **positive** or **neutral** impact then no further action is required, you should submit this document with your paper/policy in accordance with the governance structure.

You should also send a copy of this document to [EqualityImpactAssessment@aintree.nhs.uk](mailto:EqualityImpactAssessment@aintree.nhs.uk)

If you have identified any **negative** impact you should consider whether you can make any changes immediately to minimise any risk. This should be clearly documented on your paper cover sheet/Project Initiation Documents/Business case/policy document detailing what the negative impact is and what changes have been or can be made.

If you have identified any **negative** impact that has a high risk of adversely affecting any groups defined as having a protected characteristic then please continue to section 2.

**Sexual Orientation**

*(Consider any benefits or opportunities to advance equality as well as barriers affecting heterosexual people as well as Lesbian, Gay or Bisexual)*

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[Sexual Orientation table content]

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Uncontrolled copy when printed - Current version held on intranet
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<th>B18-19/072</th>
<th>Date of Meeting: 26 September 2018</th>
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<tr>
<td>Report to</td>
<td>Board of Directors</td>
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<tr>
<td>Report Title</td>
<td>Quality Strategy 2018-2020</td>
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<tr>
<td>Executive Lead</td>
<td>Dianne Brown, Chief Nurse</td>
<td></td>
</tr>
<tr>
<td>Lead Officer</td>
<td>Natalie Palin, Associate Director for Quality and Improvement</td>
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</tr>
<tr>
<td>Action Required</td>
<td>To approve</td>
<td></td>
</tr>
</tbody>
</table>

**Substantial assurance**
- High level of confidence in delivery of existing mechanisms / objectives

**Acceptable assurance**
- General confidence in delivery of existing mechanisms / objectives

**Partial assurance**
- Some confidence in delivery of existing mechanisms / objectives

**No assurance**
- No confidence in delivery

### Key Messages of this Report
- Sets a clear direction for improving quality to realise our strategic vision “to be a leading provider of the highest quality health care.”
- The delivery of the work programme will be monitored through the Executive Led Groups and HMB

### Impact
- Quality
- Finance
- Workforce
- Equality

### Equality Impact Assessment
- Strategy
- Policy
- Service Change

### Strategic Objective(s)
- Deliver outstanding care
- Achieve best patient outcomes
- Deliver sustainable healthcare to meet people’s needs
- Promote research and education
- Provide strong system leadership
- Be a well-governed and clinically-led organisation

### Governance
- Statutory requirement
- Annual Business Plan Priority
- Key Risk
- Service Change
- Other

**Strategy for approval**

### Next Steps
- Establish meeting schedule Quality Improvement programme
- Creation of work programme
- Formal Sign off Project Mandates at HMB
- Quality Strategy up-loaded onto Aintree website
### REPORT HISTORY

<table>
<thead>
<tr>
<th>Committee / Group Name</th>
<th>Agenda Ref</th>
<th>Report Title</th>
<th>Date of submission</th>
<th>Brief summary of key issues raised and actions</th>
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</thead>
<tbody>
<tr>
<td>SIQSG</td>
<td></td>
<td>Draft Quality Strategy 2018-2020</td>
<td>15 June 2018</td>
<td>Report provides the full overview of the safety and Quality Improvement plan</td>
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<tr>
<td>Quality Committee</td>
<td>QC18-19/080</td>
<td>Draft Quality Strategy 2018-2020</td>
<td>20 August 2018</td>
<td>Additional request for amendments</td>
</tr>
<tr>
<td>HMB</td>
<td>HMB18-19/</td>
<td>Draft Quality Strategy 2018-2020</td>
<td>12 Sept 2018</td>
<td>Agreed to recommend approval</td>
</tr>
<tr>
<td>Quality Committee</td>
<td>QC18-19/102</td>
<td>Draft Quality Strategy 2018-2020</td>
<td>17 Sept 2018</td>
<td>Agreed to recommend approval</td>
</tr>
</tbody>
</table>
Executive Summary

1. The current Quality Strategy for 2017-2018 had expired. The refreshed Safety and Quality Improvement Strategy 2018-20 will direct and inform the priorities for the coming year two years. It is intended that a joint Royal Liverpool Broadgreen University Hospital Trust (RLBUHT) and Aintree University Hospital AUH) Quality Strategy will be produced thereafter.

2. The Quality Strategy (2018-20) has been informed through the concerns and risks identified through the Care Quality Commission (CQC) inspection (October 2017), the Quality Risk Profile (QRP) process October 2017, reported Never Events during 2017-18, intelligence data from the last three years, and following consultation with patients, staff and key stakeholders.

3. Since the July and August Quality Committee the suggested improvements have been incorporated into the supplied Quality Strategy.

Key Issues / Proposal

4. The Quality Strategy (2018-2020) is structured around the three key areas that patients, families, staff and stakeholders have continued to tell us are important to them:

- Care that is Safe
- Care that is Clinically Effective
- Care that Provides a Positive Experience to Patient and their Families

And with enabling and supporting action relating to:

- Explicit Safety Culture
- Workforce engagement and leadership

5. The Quality Strategy 2018-20 provides clarity with regards to the key priorities for patients and in support of our common purpose of ‘getting it right for every patient, every time’.

6. The CQC and QRP action plans have been combined into a single overarching ‘Quality and Improvement Plan’ (QIP), as there are several area of duplication across both reports. This will be overseen by the Board of Directors, and led by an identified Executive Lead, supported by a formal governance structure. This delivery plan will guide the achievement of the strategic ambitions detailed within the Quality Improvement Strategy.

7. The QIP is being delivered as Trust wide transformation, using a formal programme management methodology and quality improvement approach, supported by a cohesive staff engagement, cultural and development plan.

8. The amendments to the title and sections of the Quality Strategy have been incorporated into the Quality Strategy 2018-2020 now presented. The project focus for the care pathway work stream has been amended to reflect, the improvements that have already been delivered to date.
Implications / Impact

Quality

9. It is expected that implementation of the Quality Strategy (2018-20) and its associated delivery plan will support the continuation of improvements in quality demonstrated during the lifespan of the strategy.

10. The Board commitment to the creation of a Safety Culture Steering Group is a key enabler of the strategy which is being driven by the Exec Led Explicit Safety Strategic Group.

Workforce

11. The continued application of Quality Improvement Training for Capacity and Capability will allow staff to develop skills and learning in quality improvement, human factors techniques in support of local quality improvement initiatives that have the potential for spread throughout the organisation.

12. The strategy makes clear our continued ambitions to improve overall staff engagement as measured through the National Staff Survey (NSS), through the delivery of a Culture Improvement plan to make Aintree “Best Place to Work”, Culture Assessment and leadership investment.

Conclusion

13. The Quality Strategy (2018-20) provides an overarching plan of action to support improvements in safe, effective and patient centred care. The strategy places, patients, families and staff as central drivers for the achievement of quality in all services across the Trust.

Recommendation

14. The Board of Directors is asked to approve of the Quality Strategy (2018-20).

References and further reading

Quality Strategy (2017-18), Aintree University Hospital NHS Foundation Trust


Author: Natalie Palin, Associate Director for Quality and Improvement

Date: 24 August 18
Quality Strategy 2018-2020

August 2018
## Content

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<td><strong>3. Our values</strong></td>
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<td><strong>4. Our Quality Commitments</strong></td>
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<td><strong>9. Safety Culture</strong></td>
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<td><strong>10. Culture and Leadership</strong></td>
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<td><strong>11. Building Improvement Capacity</strong></td>
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<td><strong>12. Monitoring and Measurement</strong></td>
<td>12</td>
</tr>
</tbody>
</table>
1. Introduction

This Quality Strategy details our commitments to improving the safety and quality of care. Safer and better quality care occurs when patients, families, staff and volunteers work together with the common purpose of ‘Getting it Right for Every Patient Every Time.’ We recognise that it is important to aim for excellence and that Safety and Quality must be the cornerstone of our values, in which safety is our absolute priority.

Over the last four years, we have achieved success in the delivery of our Quality Strategy. However, we recognise that we still have improvements to make in the delivery of safe, quality and consistent care. In the development of this Strategy we asked our staff and stakeholders about their priorities and they told us these were - competent staff, the right treatment at the right time, lessons learned implemented and clear and timely communication with families and carers. In delivering these key priorities we need to ensure that every member of staff in the hospital can fully play their part; by supporting, engaging and empowering them to be able to deliver consistent quality care.

This Quality Strategy has been written in the context of an inspection by the Care Quality Commission (CQC) (2017) and Quality Risk Profile (QRP) which provided the Trust with a risk estimate for each outcome in the essential standards of quality and safety; and we have focussed on these areas within our improvement plan. Immediate actions have also been taken following Never Events in 2017-18 to ensure appropriate learning, risk mitigation and prevention. This Strategy describes how we will incorporate this learning and achieve the aspirations we have for our services during the next two years. Despite the challenges we face, we remain committed to quality and moving closer to realising our strategic vision “to be a leading provider of the highest quality health care.”

Steve Warburton
Chief Executive
Aintree University Hospital NHS Foundation Trust
2. Our Vision

To be a leading provider of the highest quality health care

Our single common definition of Quality encompasses three important elements, but Safety will be our number one priority

- Care that is safe - working with patients and their families to reduce avoidable harm and improve outcomes
- Care that is clinically effective - not just in the eyes of clinicians but in the eyes of patients and their families
- Care that provides a positive experience for patients and their families

We recognise the importance of a whole system approach to achieve our aspirations through patients, staff and wider stakeholders’ engagement. To do this, we must create a culture of continuous improvements, through active engagement with staff and patients.

3. Our Values

- Deliver safe compassionate care
- Value each other
- Communicate openly and honestly
- Work as a team
- Improve through learning and innovation
- Use resources wisely

4. Our Quality Commitments

The commitments below which are aligned to the Trust’s fundamental standards and objectives have been created in conjunction with stakeholders to enhance our focus on quality incorporating the Strategy for Care, Patient and Families Experience Plan and our Workforce priorities.

<table>
<thead>
<tr>
<th>Commitment</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well led</th>
</tr>
</thead>
<tbody>
<tr>
<td>To deliver outstanding care by being a patient-centred organisation that provides high quality, safe and compassionate services.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>To provide the safest and clinically effective health care services to patients and promoting a good quality of life.</td>
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<tr>
<td>To treat patients and families as they wish to be treated</td>
<td></td>
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<tr>
<td>To deliver sustainable healthcare to meet people’s needs.</td>
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<tr>
<td>To be the leading provider of the highest quality healthcare by attracting and retaining highly skilled, engaged staff and promote an open and fair culture.</td>
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</tr>
</tbody>
</table>
5. Our Framework for Improvement

Governance for Quality

The Trust is committed to the delivery of its Quality Strategy and has established systems and processes across the organisation to support the delivery at Trust Board level. The Trust has a Quality Committee which plays a key role in overseeing quality issues and providing assurance to the Board. Quality governance is also the combination of structures and processes at and below Board level which focus on Trust-wide performance including:

- Ensuring that required standards are achieved
- Investigating and taking action on sub-optimal performance
- Planning and driving continuous improvement
- Identifying, sharing and ensuring the delivery of best practice
- Identifying and managing risks to the quality of care

Ensuring required quality standards are achieved
The Trust’s focus for 2018-19 includes the delivery of the Joint CQC and QRP, Quality Improvement Plan and minimum achievement of ‘Good’ rating (CQC) in future inspections. The achievement of the improvement plan will be Executive-led with a strong organisational management commitment through our Clinical Divisions and Corporate Services; safety and quality need to be taken seriously at every level of the organisation and recognised as everyone’s priority. Our initial focus will be on areas of concern or underperformance from a safety and quality perspective. A programme management approach has been established in order to drive improvements across each of the work streams.

The Trust will significantly develop its ward Accreditation Scheme, which will form part of an assurance framework of ‘mock inspections’ to ensure key standards of quality, safety and patient experience are being reliably delivered in practice. We will be taking a system approach to continuous quality improvement recognising the interconnections across the system from the staff working in the system to patients cared for and supported by the system, and by the system itself.
6. Safe Care

To deliver outstanding care by being a patient-centred organisation that provides high quality, safe and compassionate services.

Despite the hard work and good intentions of healthcare professionals, patients are harmed in hospitals every day. It is our duty and responsibility to protect patients and we are committed to providing harm-free care at Aintree. Safety of patients is our number one priority and we strive for a continual reduction of avoidable harm resulting from sub-optimal clinical care.

We will continue to monitor harm through the reporting of all patient safety incidents, but we will also focus on detecting and measuring harm using the Safety Thermometer, thereby enabling us to take remedial action and learn from sub-optimal care.

<table>
<thead>
<tr>
<th>Priorities</th>
<th>Improvement areas</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing Harm</td>
<td>Achievement of 98% of harm free hospital care relating to:-</td>
<td>1-2</td>
</tr>
<tr>
<td></td>
<td>• Hospital Acquired Pressure Ulcers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Catheter Associated Urinary Tract Infections</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Venous Thrombo-embolism</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Reduce Patient Falls with harm by 5%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Infection Control</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• No case of MRSA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 100% compliance with Hand Hygiene</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• C-Difficile Infections &lt;=46</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Deteriorating patient</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Ensure the improvement in monitoring and escalation</td>
<td></td>
</tr>
<tr>
<td>Safeguarding and Mental Capacity Act</td>
<td>• Increase compliance and assurance with Safeguarding policy and procedures</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>• Improve Trust delivery of care to patients with a cognitive impairment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 95% of staff to have appropriate level of safeguarding training for children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Achieve higher compliance with CQC regulation 13</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>• Review and implement Safeguarding Level 3 for Adults and Children training to</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Trust staff</td>
<td></td>
</tr>
<tr>
<td>Acting on clinical results</td>
<td>• Prevent any future backlog to unacknowledged clinical investigation results</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>• Standardise the management of abnormal results and normal results</td>
<td>2</td>
</tr>
<tr>
<td>Governance, learning and preventing harm</td>
<td>• Deliver regulatory compliance with CQC fundamental standards</td>
<td>1-2</td>
</tr>
<tr>
<td></td>
<td>• Increase incident reporting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Enable accurate monitoring of performance against key safety metrics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Improve consistency and timeliness of investigations, sharing learning</td>
<td></td>
</tr>
<tr>
<td>Improvement in patient journey</td>
<td>• Achieve the (4-hour) emergency access standard</td>
<td>1-2</td>
</tr>
<tr>
<td></td>
<td>• Implement an intensively supported programme to roll out SAFER and patient flow</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• bundle</td>
<td></td>
</tr>
<tr>
<td>Learning from Harm</td>
<td>• Achieve zero never events</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>• Achieve 100% compliance with the WHO Checklist</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Mitigate risk of Never Events occurring</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Increase visibility of theatre leadership</td>
<td></td>
</tr>
</tbody>
</table>
Reducing Mortality

Overall mortality at Aintree is measured in three ways across all specialities: two are risk adjusted indices, the Summary Hospital Mortality Index (SHMI) and Hospital Standardised Mortality Ratio (HSMR); the third is crude mortality rate expressed as a percentage of all inpatient discharges.

Our intention is to reduce the incidence of potentially avoidable deaths. We aim to demonstrate improvement in the delivery of evidence based care, measured by compliance with the Advancing Quality Care Bundle (see description in section 7) and showing progress across a range of mortality metrics including crude mortality rate, SHMI and HSMR.

<table>
<thead>
<tr>
<th>Priorities</th>
<th>Improvement areas</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing Avoidable Mortality</td>
<td>• Improve the prevention, early detection and treatment of Acute Kidney Injury (AKI)</td>
<td>1-2</td>
</tr>
<tr>
<td></td>
<td>• Ensure identification and management of pneumonia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Ensure identification and management of sepsis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Achieve early recognition and management of the deteriorating patient</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Deliver end of life care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Commence Structured Judgement Review</td>
<td></td>
</tr>
</tbody>
</table>

7. Clinically Effective

To provide the safest and clinically effective health care services to patients and promoting a good quality of life.

There is good evidence that consistent delivery of high-quality care leads to better outcomes for patients. The Institute of Healthcare Improvement (IHI) has developed the concept of ‘care bundles’ designed to assist healthcare providers in delivering the best possible care for patients with specific conditions. A care bundle is a structured way of improving the process of care and consists of a small, straightforward set of evidence-based practices that, when performed together and reliably have been proven to improve patient outcomes.

The Care Pathways work stream is a significant part of the Quality plan and in most cases will require a system wide approach and re design to support the delivery of sustainable improvements.

<table>
<thead>
<tr>
<th>Priority Areas</th>
<th>Improvement Areas</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliver reliable effective care</td>
<td>Care Pathways</td>
<td>1-2</td>
</tr>
<tr>
<td></td>
<td>• Achieve Cancer 62 day target 85% of the time.</td>
<td></td>
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<tr>
<td></td>
<td>• Deliver Stroke improvements</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Achieve RTT and diagnostics over 6 week waiters</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Improve End of Life Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Improve Dermatology</td>
<td></td>
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<td></td>
<td>• Improve Server Asthma</td>
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<tr>
<td></td>
<td>• Improve Cardiology care</td>
<td></td>
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<tr>
<td></td>
<td>• Improve Gastro care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Reduce last minute cancellations from theatre</td>
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</tbody>
</table>
During the next year we will aim to consolidate and improve on our performance and in particular will look to see where we are able to safely extend our services over seven days a week.

8. Patient and Family Experience

To treat patients and families as they would wish to be treated

We understand that many of our patients often experience life-changing diagnoses and treatments, and it is our ambition to make their experience the best that it can possibly be. In order to do this, we recognise the need for our patients to feel valued and supported and to have access to the support they require from their carers and relatives.

To achieve our aims, we will deliver a programme of actions to ensure that our patients and families describe our Trust as their provider of choice, based on the quality of their experience. The work we focus on will be based on the guiding principle that all care will be viewed through the eyes of patients and their families. We believe listening, talking and responding to our patients and the public should be part of our everyday work, and we want to ensure that the voice of our patients and their families are at the heart of improving our services.

<table>
<thead>
<tr>
<th>Priority Areas</th>
<th>Improvement Areas</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drive performance in Patient Experience</td>
<td>Develop and implement a Patient &amp; Family Experience Plan 2018-2020</td>
<td>1</td>
</tr>
</tbody>
</table>
| Patient feedback | • Introduce Real Time patient satisfaction questionnaires on wards  
• Relaunch Patient Shadowing Programme  
• Put in place informal and early intervention to respond to patient concerns and questions  
• Increase FFT inpatient recommendation to 96%  
• Complete 75% of complaints responses in a timely manner | 1-2  |
| Co-create improvements | • Deliver 4 Always Events  
• Involve patients in Quality Improvement areas | 1-2  |
9. **Safety Culture**

To deliver sustainable healthcare to meet people’s needs.

We recognise that the cornerstone of our approach is the creation of an Explicit Safety Culture. An organisation with a Safety Culture places an importance on safety beliefs, values and attitudes and is characterised as ‘the way we do things around here’. We acknowledge that Human Factors and Safety Culture are directly connected; and by having a holistic view of organisation culture and behaviours, interactions between systems and processes we can improve our culture through:

- **Safe People** – Workforce practices that support a culture of safety, accountability for improvement at all levels.
- **Safe Systems** – Leadership, Cross system working
- **Safe Culture** – Just Culture, Open and frequent communication, High incident reporting and ‘closing the loop.’

We recognise that culture change does not occur overnight; however, the Board has committed to making this a reality. The first phase will focus on increasing awareness, measuring staff safety perceptions and identifying areas of good practice. An Executive Led Steering Group has been established and will be accountable for the implementation of the delivery plan.

<table>
<thead>
<tr>
<th>Priority</th>
<th>Goal</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Culture Training</td>
<td>• Providing training and awareness for all level of staff</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>• Create the framework to underpin the delivery of an Explicit Safety Culture.</td>
<td></td>
</tr>
<tr>
<td>Safety Culture</td>
<td>• Implement the Explicit Safety Culture Plan deliverables</td>
<td>1-2</td>
</tr>
</tbody>
</table>

Outcome measures that we would expect to see will be developed through consultation and the steering group.

10. **Culture and Leadership**

To be the leading provider of the highest quality healthcare by attracting and retaining highly skilled, engaged staff and promote an open and fair culture.

**Culture**

The Trust’s ambition is to drive a cultural improvement plan over the next 2 years to improve staff engagement to ensure the Trust is able to deliver safe quality healthcare. We have made slight improvements in the National Staff Survey (NSS) 2017 in levels of staff engagement and moved out of the bottom quartile for overall staff engagement. However, the Trust remains in the bottom quartile for 8 key findings. We want to make it easy for all staff to play a part in making the Trust ‘a great place to work’ and will apply the **Five Steps to Cultural Improvement (A best practice tool for culture development):**
1. Develop a Shared Vision
2. Develop appropriate leadership
3. Equip staff to undertake quality improvement
4. Establish a culture based on trust from board to floor
5. Ensure staff engagement is a board priority

<table>
<thead>
<tr>
<th>Priority</th>
<th>Goal</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Survey</td>
<td>• Increase ownership of survey results at a local level.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>• Address areas of variation in staff engagement across the organisation.</td>
<td></td>
</tr>
<tr>
<td>Culture improvement plan</td>
<td>• Form a culture and performance baseline to define organisational maturity in terms of staff engagement capability</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>• Generate ideas to enhance delivery of cultural engagement plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Co-create a “Best Place to Work” plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Co-create with the workforce a shared set of values and behaviours</td>
<td></td>
</tr>
<tr>
<td>Measuring impact</td>
<td>• Monitor progress and demonstrate improvement</td>
<td>1-2</td>
</tr>
</tbody>
</table>

**Leadership**

We value and recognise the importance of good leadership. Safe care cannot be provided unless our leaders feel supported, confident, informed and empowered. We offer a range of development programmes for our leaders, ensuring they continue to learn and improve and achieve the best out of the teams they lead. We ensure they have the information they need to do their jobs and understand what patients need.

Our leaders will be supported to work with patients and families to develop and improve services by sharing best practice between services, and using tools that support patient engagement. Our leaders will work together to develop and maintain a culture where high quality care is provided to give our patients the best outcomes.

<table>
<thead>
<tr>
<th>Priority Areas</th>
<th>Goals</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase performance</td>
<td>• Develop a leadership model and competency framework</td>
<td>1-2</td>
</tr>
<tr>
<td></td>
<td>• Revise leadership development model</td>
<td></td>
</tr>
<tr>
<td>Equipped to succeed</td>
<td>• Develop and implement Leadership Training for Clinical Directors</td>
<td>1-2</td>
</tr>
<tr>
<td></td>
<td>• Enable staff to complete the Mary Seacole Programme</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Deliver Core Management Training</td>
<td></td>
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<tr>
<td></td>
<td>• Provide the opportunity for Masters and Degree qualifications</td>
<td></td>
</tr>
</tbody>
</table>
11. Building Improvement Capacity

The Quality Strategy will only be successful if we make continuous Quality Improvement (QI) in the way things are done at Aintree. We will continue to focus on improving capacity and capability throughout our workforce, building on the commitment that the Trust has made since 2016 of training staff through a QI and Human Factors training programme, which to date has trained over 450 staff. We will continue to pursue a tiered approach to capacity and capability at all levels of the organisation. QI training is now incorporated into all Preceptorship Programmes, Core Management and Junior Doctors Training programmes.

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Priority Areas</th>
<th>Year</th>
</tr>
</thead>
</table>
| Awareness and capability                  | • Deliver Quality Improvement Awareness sessions  
• Deliver 6 Practitioner Basic QI Training sessions  
• Include Preceptorship Training, F1 Training | 1-2  |
| Holistic coaching and Quality Improvement support | • Deliver Team base improvement coach (Quest) | 1-2  |
| Building a system for improvement         | • Deliver 2 Expert QI Training cohort session                                 | 1-2  |

12. Monitoring and Measurement

Robust and ambitious targets will be set for each of the Quality areas to identify progress and success in achieving this improvement plan. There will be a portfolio of projects for which key performance indicators will be agreed in consultation with clinical leaders and agreed to ensure delivery of compliance with local and National Performance/ quality indicators. These will be linked to our quality goals. A dashboard will be developed to enable monitoring at the Local Improvement Team level and provide assurance to the Trust Board through the Quality Committee.
The Dashboard will display performance data extracted from the current systems and databases, it will permit the triangulation between metrics to occur and assist in the identification of trends and fluctuation in performance.

The Dashboard format and linkages to data were presented to the Quality Committee in September 2018.
Equality Analysis

An Equality Impact Analysis (EIA) is a systematic way of analysing and reviewing equality information from a range of sources to identify the potential or actual effects of the Trusts functions, policies, strategies, services and projects on people with different protected characteristics by the Equality Act 2010:

This document should be submitted along with the corresponding paper/policy to equalityimpactassessment@aintree.nhs.uk

<table>
<thead>
<tr>
<th>Title</th>
<th>Quality Strategy 2018-2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategy/Policy/Standard Operating Procedure</td>
<td>Policy</td>
</tr>
<tr>
<td>Service change (Inc. organisational change/QEP/ Business case/Project)</td>
<td></td>
</tr>
<tr>
<td>Completed by</td>
<td>Natalie Palin</td>
</tr>
<tr>
<td>Date Completed</td>
<td>18 Sept 2018</td>
</tr>
</tbody>
</table>

Description (provide a short overview of the principle aims/objectives of what is being proposed/changed/introduced and the impact of this to the organisation)

The strategy has been written to outline the trusts aims in regards to quality in the three domains clinical effectiveness, safe, patient and family experience. The strategy outlines the ambitions and the key priority areas for the next two years.

Who will be affected (Staff, patients, visitors, wider community including numbers?)

The strategy effects all staff, patients and visitors to the Trust; as quality and safety culture area embedded as core components of the strategy.

The Equality Analysis template should be completed in the following circumstances:

- Considering developing a new policy, strategy, function/service or project (Inc. organisational change/Business case/ QEP Scheme);
- Reviewing or changing an existing policy, strategy, function/service or project (Inc. organisational change/Business case/ QEP Scheme):
  - If no or minor changes are made to any of the above and an EIA has already been completed then a further EIA is not required and the EIA review date should be set at the date for the next policy review;
  - If no or minor changes are made to any of the above and an EIA has NOT previously been completed then a new EIA is required;
  - Where significant changes have been made that do affect the implementation or process then a new EIA is required.
Please note the results of this Equality Analysis will be published on the Trust website in accordance with the Equality Act 2010 duties for public sector organisations.

Section 1 should be completed to analyse whether any aspect of your paper/policy has any impact (positive, negative or neutral) on groups from any of the protected characteristics listed below.

When considering any potential impact you should use available data to inform your analysis such as PALS/Complaints data, Patient or Staff satisfaction surveys, staff numbers and demographics, local consultations or direct engagement activity. You should also consult available published research to support your analysis.

### Section 1 – Initial analysis

<table>
<thead>
<tr>
<th>Equality Group</th>
<th>Any potential impact? Positive, negative or neutral</th>
<th>Evidence (For any positive or negative impact please provide a short commentary on how you have reached this conclusion)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>Positive/Neutral</td>
<td>The strategy outlines how the Trust is committed to improving quality amongst our workforce, patients and service users.</td>
</tr>
<tr>
<td><strong>(Consider any benefits or opportunities to advance equality as well as barriers across age ranges. This can include safeguarding consent, care of the elderly and child welfare)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Disability</strong></td>
<td>Positive/Neutral</td>
<td>The strategy outlines how the trust is committed to improving quality for our staff workforce, patients and service users.</td>
</tr>
<tr>
<td><strong>(Consider any benefits or opportunities to advance equality as well as impact on attitudinal, physical and social barriers)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Gender Reassignment</strong></td>
<td>Positive/Neutral</td>
<td>The strategy outlines how the trust is committed to improving quality for our staff workforce, patients and service users.</td>
</tr>
<tr>
<td><strong>(Consider any benefits or opportunities to advance equality as well as any barriers impacting on transgender or transsexual people. This can include issues relating to privacy of data)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Marriage &amp; Civil Partnership</strong></td>
<td>Positive/Neutral</td>
<td>The strategy outlines how the trust is committed to improving quality for our staff workforce, patients and service users.</td>
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<tr>
<td><strong>(Consider any benefits or opportunities to advance equality as well as any barriers impacting on same sex couples)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pregnancy &amp; Maternity</strong></td>
<td>Positive/Neutral</td>
<td>The strategy outlines how the trust is committed to improving quality for our staff workforce, patients and service users.</td>
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<tr>
<td><strong>(Consider any benefits or opportunities to advance equality as well as impact on working arrangements, part time or flexible working)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td>Positive/Neutral</td>
<td>The strategy outlines how the trust is committed to improving quality for our staff workforce, patients and service users.</td>
</tr>
<tr>
<td><strong>(Consider any benefits or opportunities to advance equality as well as any barriers impacting on ethnic groups including language)</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
If you have identified any positive or neutral impact then no further action is required, you should submit this document with your paper/policy in accordance with the governance structure.

You should also send a copy of this document to EqualityImpactAssessment@aintree.nhs.uk

If you have identified any negative impact you should consider whether you can make any changes immediately to minimise any risk. This should be clearly documented on your paper cover sheet/Project Initiation Documents/Business case/policy document detailing what the negative impact is and what changes have been or can be made.

If you have identified any negative impact that has a high risk of adversely affecting any groups defined as having a protected characteristic then please continue to section 2.

**Section 2 – Full analysis**

If you have identified that there are potentially detrimental effects on certain protected groups, you need to consult with staff, representative bodies, local interest groups and customers that belong to these groups to analyse the effect of this impact and how it can be negated or minimised. There may also be published information available which will help with your analysis.

<table>
<thead>
<tr>
<th>Religion or belief</th>
<th>Positive/Neutral</th>
<th>The strategy outlines how the trust is committed to improving quality for our staff workforce, patients and service users.</th>
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</thead>
<tbody>
<tr>
<td>(Consider any benefits or opportunities to advance equality as well as any barriers affecting people of different religions, belief or no belief)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Positive/Neutral</th>
<th>The strategy outlines how the trust is committed to improving quality for our staff workforce, patients and service users.</th>
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</thead>
<tbody>
<tr>
<td>(Consider any benefits or opportunities to advance equality as well as any barriers relating to men and women e.g.: same sex accommodation)</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>Positive/Neutral</th>
<th>The strategy outlines how the trust is committed to improving quality for our staff workforce, patients and service users.</th>
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<tbody>
<tr>
<td>(Consider any benefits or opportunities to advance equality as well as barriers affecting heterosexual people as well as Lesbian, Gay or Bisexual)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Is what you are proposing subject to the requirements of the [Code of Practice on Consultation](#)?

Is what you are proposing subject to the requirements of the Trust’s Workforce Change Policy?

Who and how have you engaged to gather evidence to complete your full analysis? (List)

What are the main outcomes of your engagement activity?

What is your overall analysis based on your engagement activity?
Section 3 – Action Plan

You should detail any actions arising from your full analysis in the following table; all actions should be added to the Risk Register for monitoring.

<table>
<thead>
<tr>
<th>Action required</th>
<th>Lead name</th>
<th>Target date for completion</th>
<th>How will you measure outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>

Following completion of the full analysis you should submit this document with your paper/policy in accordance with the governance structure.

You should also send a copy of your paper/policy and EIA to EqualityImpactAssessment@aintree.nhs.uk

Section 4 – Organisation Sign Off

<table>
<thead>
<tr>
<th>Name and Designation</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual who reviewed the Analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chair of Board/Group approving/rejecting proposal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual recording EA on central record</td>
<td></td>
<td></td>
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</tbody>
</table>
Summary

The Quality Committee continues to receive reports and provide assurance to the Board of Directors against its work programme via a summary report submitted to the Board after each meeting. Full minutes and enclosures are made available on request.

Key Issues

HMB Agenda – August 2018 and Corporate Performance Report (CPR) July 2018 – Partial Assurance
The Committee reviewed the HMB Agenda and was advised that the presentation relating to Complaints Investigations would be provided to the Committee in September 2018. The Corporate Performance Report was reviewed and the following was discussed:

- The significant pressures place on Cancer services due to increased demand and level of referrals from GPs. Patient choice also impacted on performance and it was suggested that further information be provided in future reports to highlight this and provide assurance relating to the impact on patient safety.

Gastroenterology Partial Assurance
The report highlighted the actions taken to date and the outcomes in response to the deteriorating position in the service together with details of the next steps to mitigate the risk further and identify more sustainable solutions to improve the position. The Committee requested that some modelling be undertaken on the impact of the actions contained in the next steps and provided in the next report.

Results to Action Partial Assurance
The Committee welcomed the significant progress made in clearing the backlog of unacknowledged results and recorded its appreciation to the DMD for Diagnostics and Clinical Leads on the improved position. The Committee was advised that a further review would be undertaken in September 2018 with a view to de-escalating the risk.

Draft Quality Strategy and Draft Patient & Family Experience Plan Acceptable Assurance
The Committee was advised that both documents had been the subject of consultation across a number of stakeholders and the feedback/comments received had been incorporated where appropriate. A final request for comments was provided following which the final versions of the documents would be presented to the Committee and then the Board for final approval in September 2018.
CQC Improvement Plan Partial Assurance
The report highlighted that there were 3 Must Do and 8 Should Do actions outstanding but there was confidence that these would be completed and evidenced before the end of September 2018. There was one deferred action relating to dementia and cognitive impairment which was being revisited as a result of new guidance published by NHS Improvement. RSM LLP had commenced its audit and the plans for undertaking mock inspections had also commenced.

Serious Incidents – Quarterly Report Partial Assurance
The report provided a two year overview of the key themes arising from reported serious incidents and the Committee was advised that there had been 24 recorded incidents in 2016/17 increasing to 47 in 2017/18 (which included eight never events). The key themes were grade 3/4 pressure ulcers, preventable falls, delayed diagnosis and failure to act on test results. Deep dives had commenced on falls and pressure ulcers with reports on the outcomes to be presented to the Safety & Risk ELG in September 2018.

Never Events – Update Acceptable Assurance
The report summarised the eight never events reported in 2017/18 and detailed the immediate actions taken as well as the next steps. An external review had been undertaken and a detailed report had been provided with meetings with the surgical teams taking place in August 2018 to feedback the findings of the investigation into theatre culture. Actions were ongoing and many have been concluded to date. An overarching improvement plan was to be developed with facilitation from Advancing Quality Alliance (AQuA) during September 2018 which would be presented to the Committee and Board in October 2018.

Carabapenemase Producing Enterobacteriaceae (CPE) Update Acceptable Assurance
The report provided an update on the work and actions undertaken to combat the potential outbreak in CPE cases. Increased screening had been introduced impacting on the levels of identification of patients with CPE and the IPC Team would monitor any new cases identified. Furthermore, the Trust would continue to learn from other Trusts who had identified high numbers of CPE and managed to reduce transmission.

Aintree Assessment & Accreditation (AAA) Acceptable Assurance
In regard to the Q1 2018/19 report, the Committee was advised that enhanced support was being provided to wards 22 and 23 by the Quality Excellence Support Team (QuEST) to help improve performance against the current standards.

The Committee then reviewed the proposed new framework and was advised that it had been reviewed with key stakeholders and updated in line with CQC Key Lines of Enquiry with an expectation of going live in September 2018. The methodology for completing the assessments had also been enhanced to ensure that there was a holistic and comprehensive objective peer review. The Committee approved the revised framework.

Corporate Report of the Trust Risk Register Q1 2018/19 – Partial Assurance
The report highlighted the additions to the risk register and the closed corporate risks as well as providing an overview of the key themes. The report was designed to provide the first step towards risk management becoming better embedded in the organisational decision making process and would form the basis of better discussions at Safety & Risk ELG and HMB. There was some discussion about the omission of risk mitigations in the report that would aid the provision of assurance and the need for the initial risk score and target risk score to be different otherwise there was an implication that the mitigations were ineffective. The Committee was advised that the Trust had procured the 4Risk software from RSM and that the Board Assurance Framework strategic risks had been populated onto the system. Arrangements would be made for training to be provided to appropriate staff during
September/October 2018. Consideration was also to be given to having risk as a standing item on the agenda and what information was to be provided.

**Learning from Deaths Acceptable Assurance**

The report provided an update on the progress made on the implementation of the NQB guidance and structured judgement reviews (SJR). The Committee was advised that the SJR was being introduced as part of the new mortality review process with full launch expected during August 2018. The data recording the total number of deaths, reviews and preventable deaths had been included in the report and there was a requirement for this to be published on the Trust website. However, as the numbers of preventable deaths was low there was a risk of them being patient identifiable and it was suggested that the Communications Team consider this as part of the safety culture programme.

**Clinical Audit Forward Plan 2018/19 Partial Assurance**

The Committee was advised that following challenge on the level of audits taking place in year the Divisions had reviewed their Clinical Audit Plan and declared them as being justifiable and achievable. The Committee questioned whether the Trust was getting the most out of the audits undertaken and whether they could be aligned to the quality improvement programme. It was suggested that a workshop be arranged to consider the clinical audit programme for 2019/2020 for this purpose. However, it was also agreed that the Divisions review the prioritisation of the audits for 2018/19 and reassess whether any could be removed.

**NICE Guidance and Quality Standard Risk Assessments Partial Assurance**

The Committee reviewed the risk assessment for the management of complex fractures and the involvement of plastic surgery and was advised that as the Trust did not have a service on-site it utilised those provided by Whiston when necessary. Discussions were ongoing about the continued use of this facility but it would not fully meet the standard required in the guidance. It was agreed that the risk assessment give consideration to the management of patients who were unable to utilise the service and revert back to the Committee next month with the potential for compliance against the standard to be reviewed earlier than the 18 months suggested.

**Safeguarding Services Update Partial Assurance**

The Committee was advised that there had been a slight deterioration in performance against the training trajectory but this had been expected during the summer months but will continue at pace to reach the compliance target of 80% by the end of September 2018. The service level agreement with the Liverpool Women’s Hospital ceases at the end of August 2018 and plans were in place to recruit to the substantive safeguarding post.

**Decisions Made**

- Approved the revised AAA framework

**Recommendation**

The Board is asked to note the report.
Summary

The Quality Committee continues to receive reports and provide assurance to the Board of Directors against its work programme via a summary report submitted to the Board after each meeting. Full minutes and enclosures are made available on request.

Key Issues

**HMB Agenda –September 2018 and Corporate Performance Report (CPR) August 2018 – Partial Assurance**

The Committee reviewed the HMB Agenda and noted that presentations had been received on Bed Rightsizing and the Out of Hospital programme. In terms of the former, the Executive Team was to discuss the outcomes further following which a report would be submitted to Board in October 2018. The outcome of the diagnostic work and implementation planning undertaken by Newton Europe was to be presented at the next summit meeting on 24 September 2018. The CPR was reviewed and the following was discussed:

- A deep dive had been undertaken on pressure ulcers over the last 18 months and a report would be submitted to the Committee in October 2018
- Cancer performance had been challenged due to a significant increase in referrals which had been raised with the CQPG

**Gastroenterology Partial Assurance**

The report highlighted the short-term actions being taken to address the backlog of follow-up patients. A case of need was being finalised which would set out the medium to long term requirements to improve the service and put sustainable solutions in place and this was to be presented to the HMB in October 2018.

**Draft Quality Strategy 2018-2020 Acceptable Assurance**

The Committee agreed to recommend the approval of the Quality Strategy to the Board at its meeting in September 2018.

**Quality Strategy Q1 Progress Report Acceptable Assurance**

The report provided details of the progress made against the portfolio of projects within the delivery plan which had been monitored whilst the Quality Strategy had been going through its various iterations. The Committee had welcomed that progress had been monitored and requested that levels of confidence in terms of year-end delivery of the objectives be provided for the next quarterly report.
CQC Improvement Plan  Acceptable Assurance
The report highlighted that all the must do actions had been completed but there remained three outstanding should do actions which were being progressed. Two actions had been deferred for monitoring by the Committee post September and this had been agreed with the CQC. The next meeting with NHS Improvement, NHS England and the CQC was scheduled for 1 October 2018 where the Trust would highlight the progress it had made in closing off all the action identified from the inspections with a view to being de-escalated from enhanced monitoring. The Committee had welcomed the progress that had been made and agreed that the assurance level be improved from partial to acceptable.

CQC Insight Report  Acceptable Assurance
The report highlighted that there were 24 indicators showing deterioration from the last published report and had been reviewed by the Safety & Risk ELG but it was noted that the information contained in the report was out of date. Following discussion it was requested that the next report groups those areas that were of track, include trend graphs, provide additional narrative where appropriate and comparisons.

Paediatric Activity - Care of Children  Acceptable Assurance
The report had been commissioned following a review of the data contained within the Equality & Diversity Annual Report provided to the Board in July 2018. The Trust’s registration licence had been reviewed and it had been confirmed that it was covered to provide care for all ages. The data had also been validated and each of the Divisions had undertaken a review of activity including the safeguarding processes in place and it was confirmed that all the appropriate systems and controls were in place.

Safeguarding Annual Report 2017/18  Acceptable Assurance
The report highlighted the Trust’s activities in relation to its statutory duties and identified the priorities for the next 12 months. The report also outlines the changes that were made to the service following the independent reviews and CQC Inspection during 2017 in relation to the team and associated governance arrangements. It was noted that there had been challenges in regard to staff training but this was being monitored and actions taken to improve the position. The Committee stated that it had increased confidence in the way safeguarding was being addressed and would recommend the approval of the Annual Report to the Board of Directors.

Organ Donation Annual Report 2017/18 and Operational Plan 2018/19  Acceptable Assurance
The Committee received a presentation, to supplement the report provided, which provided an overview of the annual data; the best practice undertaken for referrals and the presence of a Specialist Nurse for organ donation conversation; details of organ donations and the number of transplants that had taken place; the improvements made to the service and increased awareness throughout the Trust; the action plan for the 2018/19. The Committee welcomed the progress that had been made and the sensitivity shown to families on this delicate matter. Suggestions were made for increasing awareness further through use of the website as well as education sessions with various teams throughout the Trust.

Decisions Made

- Agreed to recommend approval of
  - Quality Strategy 2018-2020
  - Safeguarding Annual Report 2017/19
  - Organ Donation Annual Report 2017/18 and Operational Plan 2018/19

Recommendation

The Board is asked to note the report.
### Key Messages of this Report (2/3 headlines only)

- Good progress has been made in meeting Safeguarding Objectives for 2017/18
- Robust Governance and Assurance frameworks are in place to monitor future progress and provide assurance
- Comprehensive TNA has been developed and targeted training will continue
- Workstreams for 2018 – 2010 have been identified

### Impact

<table>
<thead>
<tr>
<th>Quality</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance</td>
<td>Compliance</td>
</tr>
<tr>
<td>Workforce</td>
<td>Legal</td>
</tr>
<tr>
<td>Equality</td>
<td></td>
</tr>
</tbody>
</table>

### Equality Impact Assessment - NA

- Strategy
- Policy
- Service Change

### Strategic Objective(s)

- Deliver outstanding care
- Achieve best patient outcomes
- Promote research and education
- Deliver sustainable healthcare to meet people’s needs
- Provide strong system leadership
- Be a well-governed and clinically-led organisation

### Governance

- Statutory requirement
- Annual Business Plan Priority
- Key Risk
- Service Change
- Other

### Next Steps

Agree priorities for 2018/20 and note that this will be monitored via the Hospital Safeguarding Group and reported into Quality Committee and Board of Directors.
## REPORT HISTORY

<table>
<thead>
<tr>
<th>Committee / Group Name</th>
<th>Agenda Ref</th>
<th>Report Title</th>
<th>Date of submission</th>
<th>Brief summary of outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Safeguarding Group</td>
<td>13</td>
<td>Safeguarding Adults &amp; Children Annual Report</td>
<td>05/09/18</td>
<td>Recommend approval to the Board</td>
</tr>
<tr>
<td>Quality Committee</td>
<td>QC18-19/107</td>
<td>Safeguarding Adults &amp; Children Annual Report</td>
<td>17 Sept 2018</td>
<td>Welcomed progress and agreed to recommend approval to the Board</td>
</tr>
</tbody>
</table>
Executive Summary

1. The purpose of this report is to provide an Annual Report of activities undertaken in relation to the Statutory Duties required by the Trust in relation to Safeguarding Adults and Children. It will also provide details of the priorities identified for Safeguarding for the next 12 months.

2. All NHS bodies have a statutory duty to make arrangements to safeguard and promote the welfare of children and adults, with a particular emphasis placed on the provision of greater assurance to the Board of Directors and external partners that those at the greatest risk of abuse, regardless of age, continue to be protected within our services.

3. Following independent reviews and a CQC inspection during 2017, changes were made to the Trust Safeguarding team and governance arrangements.

4. Safeguarding is a fundamental component of all care provided by all the staff within Aintree University Teaching Hospital NHS Foundation Trust (AUH). Safeguarding vulnerable people is a complex process and this year has been challenging in respect of ensuring that we respond effectively and efficiently to the challenges of safeguarding both our patients and staff.

5. The newly developed Hospital Safeguarding Group (HSG) and Safeguarding Operational Group (SOG), provide the Board of Directors, Clinical Commissioning Group (CCG) and External Safeguarding Boards (LSCB/SAB) with assurance that the Trust is able to respond effectively and demonstrate accountability, for all aspects of Safeguarding Adults and Children.

6. Much has been achieved over the past 12 months; this annual report reflects the key safeguarding activities and achievements for Adults and Children for the period 01 September 2017 to 31 August 2018 and provides a synopsis of the objectives for future development in relation to Safeguarding.

7. The report provides the Board of Directors with assurance that the Trust is working towards having the required effective systems and processes in place to safeguard patients who access services in the Trust; and will be able to demonstrate that the Trust is meeting its statutory responsibilities in relation to safeguarding.

8. Over the coming year the Safeguarding Team have identified several priorities, which are outlined in the report, all of which are central to supporting core activities to safeguard within AUH.

Recommendation

9. The Board of Directors is asked to approve the Annual Report.

10. Once approved this annual report will be submitted to the Liverpool, Sefton and Knowsley Safeguarding Children’s Board’s and the Integrated Safeguarding Adult Board and become a composite document with other partner organisations.

Author: Dianne Brown, Chief Nurse / Executive Lead for Safeguarding
Date: 17 September 2018
Safeguarding Adults & Children Annual Report: Board of Directors 26 September 2018

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Safeguarding Training Strategy 2018-2021 (available on request)
Background

In April 2017, two internal audits were completed, looking at both children and adult safeguarding arrangements within the Trust. The audit findings that with regard to Adult Safeguarding arrangements within the Trust, there was no assurance and only partial assurance for Children’s Safeguarding. As such the Trust was found to be open to the risk of not being compliant with its statutory and contractual obligations.

In light of Internal Audit findings a further external independent review was commissioned and a peer review from the safeguarding team of a local provider was completed in 2017. Both reviews concluded that there was little or no assurance of compliance in relation to safeguarding Adults or Children within AUH.

In September 2017, Aintree University Hospital (AUH) Board of Directors approved to support an overarching themed Improvement Plan to address concerns that had been identified in relation to Safeguarding.

To provide the specialist strategic safeguarding support and the specific statutory and contractual posts required, under the Terms of an SLA, Liverpool Women’s Hospital NHS Foundation Trust (LWH) have provided key personnel; an Associate Director of Safeguarding for Children & Adults / Named Nurse and Midwife for Safeguarding Children, Named Nurse for Safeguarding Adults / Lead for MCA & DoLS / LD & Dementia and a Safeguarding Manager / PREVENT Lead. The Team supported the existing structure in respect to specific statutory and contractual posts and developed an accurate, prioritised work plan with achievable objectives to ensure Aintree University Hospital Foundation Trust (AUH) can deliver the objectives required of a Safeguarding Service within a large acute Foundation Trust.

AUH had not fully complied with their statutory responsibility around the Mental Capacity Act (MCA) 2005 and to the Deprivation of Liberty Safeguards (DoLS) 2009. Although some training in respect of DoLS and the Mental Capacity Act (2005) had been provided, it was evident that clinical colleagues were not fully conversant with the Act. Furthermore, the processes required to meet the Act were not appropriately embedded and integrated across the Trust and DoLS applications were not consistently completed and managed within AUH to a standard required of the Local Authority and the Care Quality Commission (CQC).

Whilst there was commitment at Executive and Senior Management level in respect to improving Safeguarding standards within the Trust, a visible operational understanding and delivery of Safeguarding was not always evident and this is required to safeguard vulnerable patients and to ensure assurance to the Regulators with regard to the Trust’s ability to comply with Safeguarding requirements.

In September 2017, the Board of Directors received an overarching themed Improvement Plan to address concerns that had been identified in relation to Safeguarding. It was clear that the Trust wanted to embed a culture of compliance rather than seek a ‘quick fix’. It was agreed that the Trust’s Quality Committee would oversee a 3-year Strategy and Operational Work plan with an inbuilt Trajectory of improvement.

In October 2017, the Trust underwent an inspection by the CQC. The Trust was able to provide the CQC with the following:

- A clear vision for Safeguarding provision within Aintree; a detailed Safeguarding Strategy for the future (2017 – 2020) with clear links to the Nursing Strategy and Trust Core Values
- An accompanying accurate, prioritised operational work plan and inbuilt trajectory to demonstrate progression and compliance; which provides achievable objectives and ongoing assurances
- A robust Training Strategy, to ensure strict monitoring of compliance as per legislative requirements
✓ Restructuring of the Safeguarding Service to ensure compliance with the relevant legislative and contractual requirements and the recruitment of the relevant post’s to support this process.

Although remedial work had already begun and was progressing at pace, specific skills and knowledge had not been embedded across the organisation and as such, the Care Quality Commission issued the Trust with a warning notice in relation to its failure to demonstrate that we had in place an effective process to ensure the timely identification and assessment of those persons who may lack the capacity to consent to their care and treatment. They concluded that the Trust had not provided assurance that there was an effective process for overseeing and monitoring this group of patients.

Further enhanced daily processes were implemented immediately, and have continued to date. These processes have assisted in providing assurance that patients with impairments of mind are identified and managed in accordance with both Trust Policy and Statutory Requirements.

In addition, further key risks were identified in relation to the findings and statutory requirements relating to Safeguarding Adults and Children; and as a matter of priority, action has now begun to ensure that the Trust fully complies with the required safeguarding legislative framework and requirements and is able to evidence this moving forward.

The Trust Strategy and vision for Safeguarding will be led by the Hospital Safeguarding Group (HSG) which is chaired by the Chief Nurse who has executive responsibility for Safeguarding and will include our strategic partners and have oversight and scrutiny from a Non-Executive Director.
Report

Summary of Current Position
Safeguarding Specific Objectives for 2017-2018

Throughout the reporting period outlined in the executive summary for 2017/18, substantial progress has been made against the Safeguarding Work Plan and the overall objectives, which is to:

Ensure that Aintree University Hospital NHS Foundation Trust safeguarding arrangements are statutory compliant with appropriate legislation and national/local guidance in respect of those at risk

In order to provide the assurance required to demonstrate our progress the following has been achieved:

<table>
<thead>
<tr>
<th>Objective</th>
<th>Progress</th>
<th>RAG</th>
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<tbody>
<tr>
<td>Safeguarding Vision, Strategy and Leadership</td>
<td>1. Peer Review of Safeguarding Services commissioned to provide assurances 2. Create a current Safeguarding Position Paper to inform the Trust Board 3. Develop the Safeguarding Annual Report 2016-17 to document the safeguarding service work over the previous 12 months 4. Create a Safeguarding Work Plan to track all work completed to improve the safeguarding service in line with the Corporate Safeguarding Strategy 5. Develop a Corporate Safeguarding Strategy 6. Review Trust Safeguarding Training Strategy to ensure it meets legislation and national guidance</td>
<td></td>
</tr>
<tr>
<td>Improving Quality and Learning and Workforce Development</td>
<td>1. Recruit a Named Nurse for Safeguarding Adults / Lead for MCA/DoLS 2. Recruit an Associate Director for Safeguarding 3. Develop Learning Disabilities basic awareness training 4. Ensure historic safeguarding risks are quality assured and</td>
<td></td>
</tr>
</tbody>
</table>
Safeguarding Adults

The Care Act 2014 sets out a clear legal framework for how local authorities and other statutory agencies should protect adults at risk of abuse or neglect. Local authorities have the statutory duty to:

- Co-ordinate a multi-agency approach that seeks to prevent abuse and neglect and stop it quickly when it happens.
- Make enquiries, or request others to make them, when they think an adult with care and support needs may be at risk of abuse or neglect and they need to find out what action may be needed.
- Establish Safeguarding Adults Boards, including the local authority, NHS and police, which will develop, share and implement a joint safeguarding strategy
- Carry out Safeguarding Adults Reviews when someone with care and support needs dies as a result of neglect or abuse and there is a concern that the local authority or its partners could have done more to protect them.
- Arrange for an independent advocate to represent and support a person who is the subject of a safeguarding enquiry or review, if required.

Significant progress has been made in providing assurance in respect to compliance with the Act following:

- Recruitment into the Safeguarding Team of an experienced adult social worker with a background in Safeguarding Adult enquiries and a senior Nurse/Adult Social worker qualified as a Best Interest Assessor for DoLS.
- Development and introduction of a quality assurance process to reduce the significant number of inappropriate Safeguarding Adult referrals.
- Review and updating, in accordance with local and national guidance of the Safeguarding Adult policy.
- Establishment of internal processes to ensure compliance with all multiagency enquiries and reviews.
Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS)

The Act formalises the process for assessing whether a patient is mentally capable of consenting to a proposed treatment, investigation or plan of care and ensures the individual making the decision for, or on behalf of, a person who lacks capacity is done, or made, in his or her best interests.

In response to the limited assurance identified following on from the assurance reports completed at the beginning on 2017, prior to the commencement of the Service Level Agreement between AUH and LWH, and the recommendations cited in the CQC report significant changes have been made to provide assurance in respect to implementing the Act as part of healthcare delivery.

These include:

- Development and delivery of a robust safeguarding training strategy including MCA & DoLS based on the National Mental Capacity Act Competency Framework (2017). The strategy now delivers training in three separate tiers:
  - Tier 1 - general awareness via e-learning
  - Tier 2 - specific knowledge relevant to implementing the Act within the Acute Healthcare setting delivered face to face to those involved in planning care and or taking consent for treatment or care.
  - Tier 3 – a competency based programme, using scenarios and actors to provide an opportunity for candidates to practice both assessing capacity and make best interest decisions. Competency is then demonstrated by the submission of a portfolio of evidence.
  - Bespoke area specific training for high risk areas and Senior Medical Staff complaint with MCA level 2.
- Implementation of a robust daily reporting system for all wards and departments to identify any patient who may potentially lack capacity for Safeguarding to review and provide relevant advice and support in respect to the Act.
- Full review and update of the MCA & DoLS policies including a comprehensive review of supportive documentation i.e. templates for recording capacity assessments and best interest decisions in accordance with statutory guidance.
- Access to expert guidance and support in respect to implementing the Act
- Development and implementation of a quality assurance check for all DoLS authorisations prior to submission to the relevant Local Authority.
- Development and implementation of an online tool to improve the quality of DoLS authorisations submitted to the Safeguarding Team.
- Weekly reports to Senior Management Teams in respect to Training compliance and MCA activity including issues of note and learning.

Moving Forward Safeguarding Adults training Level 3 must be delivered in accordance with the agreed training trajectory and consideration should be given in respect to the impact of the draft Safeguarding Adults Intercollegiate Competency Framework, due to be published in August 2018, on the current training strategy.

Consideration should also be given in respect to testing the internal safeguarding adult processes, in particular those relating to contributing to Local Authority enquiries, in accordance with the agreed audit cycle.

Learning Disabilities and Dementia

The Equality Act 2010 requires the Trust to ensure patients (and their relatives and carers) who have a cognitive impairment (regardless of age, gender, sexual orientation, ability or ethnicity), receive high quality, compassionate care from diagnosis through to the end of life.

A Strategy to support patients attending AUH with a cognitive impairment has been drafted and focuses on the following priorities:
Aintree University Hospital NHS Foundation Trust

- Ensure a robust training strategy is embedded to meet local requirements.
- Ensure the prompt identification and coding of people with learning disabilities, autism and dementia.
- Ensure there is a senior person identified in the Trust with responsibility for patients with learning disabilities, autism and dementia.
- Ensuring people with learning disabilities and autism, families and carers are involved in the process of planning and decision making where appropriate.
- Embedding knowledge and understanding of learning disability, dementia and the Mental Capacity Act 2005.
- Ensuring reasonable adjustments are made to meet the specific needs of such patients.
- Introduce accessible information ‘easy to read’ and offer support to ensure equal access to health services.
- Strive to create a hospital environment that is comfortable and therapeutic to the needs of those with a cognitive deficit. We aim to have environments that promote orientation, calming, comfortable and familiar.

Due to the limitations of operational resources it was agreed that progress towards providing a strategy and supportive policies and processes to provide assurance in respect to patients attending the Trust with a cognitive impairment including dementia and learning disabilities would commence in September 2018.

**Learning disability mortality review programme (LeDeR)**

Following the Confidential inquiry into premature deaths of people with learning disabilities (CIPOLD, 2013) one of the key recommendations was the establishment of a national learning disability mortality review to understand the circumstances leading to a death and whether such deaths could potentially be avoided in the future through improvements to health and care services.

This is a national review related to deaths of people with a Learning disability, co-ordinated by Bristol University and funded until June 2018. It is mandated by NHS England that we notify the LeDeR Local Area Contact of any death of a person with a learning disability.

The LeDeR Local Area Contact, in turn, nominates two individuals, external to the Trust (who have received specific training) to review the death using the LeDeR methodology.

Currently AUTH have an internal notification process for identifying and reporting in accordance with contractual requirements developed and embedded within the last year.

In order to embedding the required policies and procedures the Trust will identify key staff to participate in LeDeR training and reviews.

**Domestic Abuse**

Domestic abuse is any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.

This can encompass, but is not limited to:

- Psychological, physical, sexual, financial and emotional abuse
- Controlling behaviour - a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour
Coercive behaviour - an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. This definition includes so called ‘honour’ based violence, female genital mutilation (FGM) and forced marriage.

Multi-Agency Risk Assessment Conference (MARAC)

As many victims are afraid of reporting abuse and/or violence to Police, identification of high risk victims of domestic abuse has been made possible by the use of a risk identification tool. These identified victims are discussed at a Multi-Agency Risk Assessment Conference (MARAC), which is a core group, representing both the statutory and voluntary sector.

The aim of a MARAC is to allow for maximum information sharing between relevant agencies within an agreed protocol. It allows for the agencies to identify those most at risk from violence and abuse and thereafter jointly construct a management plan to provide a professional, co-ordinated approach to all reported incidents of domestic abuse.

The Trust is required to provide health information relevant to the cases being discussed for all MARAC meetings and attend the meetings where victims who are referred by the Trust, are discussed.

In 2017/18 the MARAC/AUH internal processes and Domestic Abuse Policy have been reviewed by the Trust Safeguarding Service. The ‘Domestic Abuse (CAADA) National Risk Assessment Tool’, used by other health providers remains AUH’s Risk Assessment Tool for disclosures of Domestic Abuse; and the Trust continues to work in collaboration with our external statutory partners to ensure there is a robust response to women and men identified to us as subject to any form of domestic abuse.

Harmful Practices - (Female Genital Mutilation (FGM) / Forced Marriage (FM) / Honour Based Violence (HBV)

The ‘Protecting Vulnerable People Agenda’ remains a priority for Liverpool. As such, some preparatory work has already been undertaken by the Office of the Police and Crime Commissioner and Police, looking at the Strategic Governance required. This work has been in consultation with statutory partners and voluntary sector and has led to the formation of the Harmful Practices Group. As well as developing an agreed Pan-Merseyside Policy, this group will raise awareness among professionals and practitioners of harmful practice such as Forced Marriage, Honour Based Violence and Female Genital Mutilation. Requirements for future working in relation to Harmful Practices will be directed through the recommendations of the Pan Merseyside Working Group and will be reported through the Hospital Safeguarding Group.

Safeguarding Children

Working Together to Safeguard Children (2015), updated 2018, sets out how organisations and individuals should work together to safeguard and promote the welfare of children and young people in accordance with the Children Act 1989 and the Children Act 2004.

All providers of NHS health services, including Foundation Trusts are required to identify a Named Doctor and Named Nurse for Safeguarding Adults and Children and a Named Midwife (if the organisation provides maternity services). AUH supports the statutory requirements for Safeguarding Children with the role Band 7 Safeguarding Specialist Nurses who has Children’s background and Dr Libby Wilson who is the Named Doctor for Safeguarding Children.

Child Sexual Exploitation (CSE)

Recent high profile cases in the UK (Rochdale, Rotherham, Oxfordshire and Wirral) have highlighted health services significant contribution in the identification and response to cases of
sexual exploitation. As such, NHS England has recognised CSE as a national priority for all health staff and agencies.

Although due to be updated, the Pan Merseyside/Cheshire Child Sexual Exploitation Multi-Agency Strategy (2014 -2017) sets out agency responsibilities in the identification of young people who use our service. To ensure staff are aware of how to recognise young people potentially at risk and know how to refer them as appropriate moving forward, the following has been put in place:

- All AUH will receive CSE Training in their Mandatory Level 1 and 2 Training and Safeguarding Children Level 3
- Staff in high risk areas such as ED will have a ‘checklist’ to help them identify vulnerabilities and behaviours which might be indicative that a young person might be at risk of CSE
- Following the recent Joint Targeted Area Inspection (JTAI) in Liverpool, all CSE referrals are discussed in the Multi Agency Safeguarding Hub (MASH) and then shared with all Trust’s in order to undertake any additional information requests and ‘flag’ on Sigma

Building on the foundation work already completed by the Safeguarding Team, CSE will be a priority in the coming 12 months.

Voice of the Child

The failure to listen to children and ensure their views are taken into account in child protection cases has been highlighted in many Serious Case Review findings. However, actively involving children is difficult to embed in a provider organisation which predominantly delivers healthcare to adults.

We do however, provide care to young adults under 18 years of age, especially in an unplanned and specialist care setting and we will therefore be required to work in conjunction with our external partners to address this risk.

As part of the SEND (0-25) improvement journey our local Commissioners have established a Health Economy SEND Strategic Working Group. The Trust Head of Safeguarding (interim) will be the strategic lead for SEND from within our organisation and the Named Nurse for Safeguarding Children will also attend meetings to progress this work.

Looked After Children (LAC)

A “Looked After Child” (LAC) is a child who is accommodated by the local authority; a child who may be the subject of an Interim Care Order, full Care Order or Emergency Protection Order; or a child who is remanded by a court into local authority accommodation or Youth Detention Accommodation.

In addition where a child is placed for Adoption or the local authority is authorised to place a child for adoption - either through the making of a Placement Order or the giving of Parental Consent to Adoptive Placement - the child remains a LAC until a final order has been granted by the courts. LAC may be placed with parents, foster carers (including relatives and friends), in Children’s Homes, in Secure Accommodation or with prospective adopters.

Healthcare services have a responsibility to keep children safe and as a LAC may access the Trust via unplanned care, staff are asked to notify the Safeguarding Team of this young person’s admission or attendance.
Aintree University Hospital NHS Foundation Trust

Child Protection Information Sharing (CP-IS)

CP-IS connects Local Authority Children’s Social Care systems with those used by NHS unscheduled care settings, such as A&E, Walk-in Centres, and Maternity Units. It ensures that health care professionals are notified when a child or unborn baby with a child protection plan (CPP) or looked after child status (LAC) is treated at an unscheduled care setting. CP-IS is a secure system with clear rules governing the access and only authorised staff involved in the care of a child are able to access the information.

Social care teams are alerted automatically when a child in their care attends an unscheduled care setting every time the system is accessed.

Providing instant access to this information means vulnerable children can be identified wherever they are cared for in England.

Sefton and Knowsley Local Authorities are currently utilising the system within their unscheduled care settings, however Liverpool Local Authority is currently awaiting go live.

Key Principles:
- The CP-IS is for use in an unscheduled setting, i.e. not booked with our services and as such they may have no maternal notes.
- The expectant mother’s details are checked on the system via smartcard access directly to the summary care record via NHS Spine Portal.
- The unborn is linked directly to the mother’s NHS number and therefore only maternity staff with the correct access (RBAC) codes can see maternal records.
- The information we receive from searches shows live and current data.
- The details of the plan will not be visible – normal safeguarding process will be followed if attendance is of a concern.
- The name and the title of staff requesting information (this can be defaulted for whole trust e.g. Safeguarding Team) is recorded and becomes part of an attendance record that is visible to any other consequent departments that access the child records.
- The staff can see a record if mothers are accessing multiple organisations.

The criteria for CP-IS is to access the system for any child who accesses AUH Emergency Department. AUH fully integrated with CP-IS on 26th March 2018 and since that date has noted the following benefits:-

- The risk of missing a child known to a Local Authority (nationwide) is reduced
- With instant access to child protection information, communication with the appropriate social worker can take place quickly leading to a better outcome for the child.

Training

Due to the current developing safeguarding legislative requirements and to provide assurance our staff are trained appropriately, the Safeguarding Training Strategy received a full review in 2017.

The Safeguarding Training Strategy, which includes a specific MCA/DoLS training framework, was presented and approved at WELG and Quality Committee in April 2018 which is available on request.

Trust Compliance

The Trust’s compliance levels for safeguarding training at the end of Q1 2018 are:

<table>
<thead>
<tr>
<th>Session</th>
<th>CCG Compliance Threshold (%)</th>
<th>Compliance as of June 2018 (%)</th>
<th>Compliance RAG rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 1</td>
<td>90%</td>
<td>96.1%</td>
<td>Green</td>
</tr>
</tbody>
</table>
Safeguarding Adults & Children Annual Report: Board of Directors 26 September 2018

### Safeguarding Children Level 2
90% 96.0%

### Safeguarding Children Level 3
90% 96.0%
Staff not received this level of training for 12 months. TNA reviewed in 2018, increased to 256 staff (was 135)

### Safeguarding Children Level 4
90% 100%

### Safeguarding Adults Level 1
90% 96.1%

### Safeguarding Adults Level 2
90% 96.0%

### Safeguarding Adults Level 3
90% 96.0%
Staff not received this level of training for 12 months. TNA reviewed in 2018, increased to 1512 staff (was 135)

### Safeguarding Adults Level 4
90% 100%

### MCA & DoLS Level 2*
90% 54.39%

### Prevent (Basic Awareness)
90% 96.1%

### Prevent (WRAP)**
90% Unknown

*MCA/DoLS Level 2 Training - Staff had not received this level of training previously. A TNA was developed in 2018, and approximately 2000 Trust staff were identified as requiring the training. As of the end of June 2018 the current compliance is 54.39%

**Prevent (WRAP) - TNA reviewed in 2018 to match NHS England Competency Framework and subsequently increased to approximately 2000 staff (was approx. 235). Local records of training from safeguarding Team indicates that approximately 2000 have completed this training in the past 4 years however work is required to amend the Trusts TNA to provide assurance to CCG and Home Office and this will be undertaken in 2018/19.

### MCA/DoLS Level 3 Training

MCA/DoLS Level 3 sessions commenced in June 2018 specifically targeting the 468 staff who have already completed Level 2 training. Wards and Departments are responsible for nominating individuals who fit the criteria i.e. involved in delegated consent, identifying DoLS or establishing patient care plans, to attend training. Monthly compliance reports on training levels will be overseen within the Divisions and monitored via the Hospital Safeguarding Group.

### Risk, Performance, Governance and Assurance

#### Risk Management

Currently the strategic risk for Safeguarding (Risk 3898) was originally scored at 20 (4*5) and is located on the Trusts Board Assurance Framework (BAF). However due to the completed progress in the Safeguarding Service the score has been reduced to a score of 15.

To enable the Trust to monitor and audit the operational actions taken to decrease the risk score robustly it was agreed that all actions would sit within 4 separate service level risks underneath the BAF. These risks which are included monthly as appendices for the Quality Committee to view any progress made are categorised as follows:

1. Safeguarding – Vision, Strategy and Leadership (Risk 3954)
2. Safeguarding – Governance, Accountability and Assurance (Risk 3956)
3. Safeguarding – Improving Quality and Learning (Risk 3957)
4. Safeguarding – Compliance and Effectiveness (Risk 3958)
Performance Clinical Commissioning Group (CCG) Key Performance Indicator (KPI) Reports

At the start of the year the CCG KPI Quarterly submission had been submitted by the Trust (Q1) which the CCG declared awarded limited assurance for. However over the annual period of 2017/18 the compliance against the quarterly KPI requirements consistently improved as demonstrated in the table overleaf.

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<tbody>
<tr>
<td>Training</td>
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<td>Gov P&amp;P</td>
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<td>Multi Agency</td>
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<td>Supervision</td>
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<td>Audit Tool</td>
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<td>Overall</td>
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*Q2 submission not supplied whilst all previous submitted data and documents were assessed for accuracy and once verified were submitted within Q3

Further work is required and documented within the service work-plan to in order to continue to raise the Trusts compliance.

Governance

Policies

Following publication of updated legislation and national guidance, AUH Safeguarding Team ensured all safeguarding policies were compliant and accurate. Within the Trust, standard procedure is to ensure policies are reviewed 3 yearly however, LSCB recommends that Safeguarding policies are reviewed every 12 months due to the regular changes in guidance and law and this has been agreed through the Trust HSG.

During external reviews, the Safeguarding Children’s Policy was found to demonstrate partial assurance and the Safeguarding Adults Policy was rated as giving no assurance. The actions that arose from these audits were completed in 2017/18 and were monitored through the Trusts Audit Committee; as a consequence the two policies were thoroughly reviewed and were accepted and approved by the Hospital Safeguarding Group in May 2018.

Assurance

Hospital Safeguarding Group (HSG)

The newly developed HSG drives the organisation by ensuring safeguarding arrangements within the Trust are regularly reviewed, thus providing assurance to the Trust Board that AUH is meeting its statutory obligations and locally agreed objectives.

The HSG Terms of Reference include representation from the Designated Nurses (CCG), Non-Executive Director (Safeguarding Champion) and is chaired by the Chief Nurse. The Board provides strategic overview and scrutiny across all aspects of Safeguarding.

The Terms of Reference for the HSG outlines the body of work encompassed ensuring the following items are discussed:
Safeguarding Operational Group (SOG)

The Safeguarding Operational Group (SOG) supports the HSG. Its primary purpose being to ensure that safeguarding children and adults is a Trust wide priority through monitoring compliance with training, incident trends, Safeguarding Inspection Reports, Serious Case Review findings and Safeguarding performance and activity. The group, which is newly developed, will provide assurance to the HSG that safeguarding arrangements within the Trust are compliant with appropriate legislation and national/local guidance in respect of Safeguarding Adults and Children.

Statutory Duties

Local Safeguarding Children Board (LSCB) Section 11 Audit

Section 11 of the Children Act (2004) places duties on a range of organisations and individuals to ensure their functions (and any services that they contract out to others) are discharged having regard to the need to safeguard and promote the welfare of children.

The 'NHS Standards for Safeguarding Self-Assessment Monitoring Audit Tool' and the external Safeguarding Boards 'Section 11 Audits', remain integral as a framework to demonstrate to commissioners and external boards that as providers we have the appropriate comprehensive and effective single and multi-agency policies and procedures to safeguard children and vulnerable adults.

AUH has continued to update the system throughout the year ensuring Section 11 compliance and accurate recording. All information submitted to Sefton, has been made available to Liverpool, and Knowsley Safeguarding Boards.

Serious Case Reviews (SCRs)

Working Together to Safeguard Children sets out very specific criteria for conducting SCRs. A SCR is undertaken by a Local Authority Board appointed Independent Author when a child dies, or is significantly harmed and neglect is known and/or suspected to be a factor in the case. The purpose of the review is to establish whether lessons can be learned with regard to how professionals and organisations work together to safeguard and promote the welfare of children and formulate action plan’s to improve intra-agency working.

The Safeguarding Team regularly update the Safeguarding Training to include any findings from local and national SCRs. To further embed the learning the Safeguarding team will deliver a bi-monthly one hour ‘lessons learned’ training session, in conjunction with our Learning and Development Department.

During this reporting period the Safeguarding Team has had involvement in one Serious Case Review for Sefton.
Domestic Homicide Reviews (DHRs)

Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force in April 2011.

The Home Office (2011) defines DHR as a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by –
   (a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or  
   (b) a member of the same household as himself,

All requests for information in relation to potential DHRs have been completed during 2017/18.

Disclosure and Barring Service (DBS)

In October 2012 the Secretary of State for Health requested an independent oversight of the investigations at three NHS hospitals (Leeds General Infirmary, Stoke Mandeville and Broadmoor) and the Department of Health into the associations that the late Sir Jimmy Savile OBE, had with those hospitals and the department, and allegations that Savile committed sexual abuses on the hospitals’ premises.

Subsequently, the independent author was asked to consider the findings of 28 internal investigations by NHS organisations into further allegations of abuse by Savile at various other NHS hospital sites.

In the wake of increasing concern about the nature and enormity of Savile’s activities, the Secretary of State also requested the report identify key themes from the investigations and to look at NHS-wide procedures in light of the investigations’ findings and recommendations.

AUH are compliant with all recommendations apart from recommendation 7:
   • All NHS hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years. The implementation of this recommendation should be supported by NHS Employers.

AUH does have Disclosure and Barring Service (DBS) regulations in place in the Trust. However this is only applicable for all new employees and volunteers, who are screened and checked as part of the employment/volunteer process. Safer recruitment processes are followed to prevent unsuitable people gaining employment in the NHS. A risk assessment tool is used to put in place safeguards so that staff can begin working in the hospital before the final DBS clearance is obtained.

Safeguarding Internal Referral Procedures

The current referral process for safeguarding concerns are built in to SIGMA, however with the implementation of an updated EPR system, AUH have the ability to amend the referral processes for Safeguarding and this is a key priority so the Trust can use robust and efficient procedures which benefit patients and staff alike. Key staff are involved in the redevelopment project to ensure that the new system will be fit for purpose.

Engagement with Partner Agencies

Partnership working and information sharing is known to reduce potential risk/s, which for AUH will enhance the care delivered to our patients, staff and the wider community. As such, the Safeguarding Team continue to work with local partner agencies to enhance a cohesive approach and collaborative working thus strengthening networks to ensure that adults and children are protected.
Aintree University Hospital NHS Foundation Trust

Partner agencies include Multi-Agency Safeguarding Hubs (MASH), Domestic Abuse Coordinators, Police Protection Units (PPU), as well as involvement in the Multi-Agency Risk Assessment Conferences across Sefton, Liverpool and Knowsley (MARAC) in relation to domestic abuse, Multi-Agency Child Sexual Exploitation (MACSE) and Multi-Agency Response to Guns and Gangs (MARGG). The Team also attend a number of the Safeguarding Boards Sub Groups for Health and SCR/DHR panel’s and Practice Learning Events and Critical Incident Review Groups.

Safeguarding Team Structure and Future

To ensure compliance with the safeguarding standards expected of an Acute Trust, a key deliverable for the key personnel from Liverpool Women's NHS Foundation Trust was a full review of Aintree’s existing Safeguarding Service.

It was found that the existing structure did not provide the appropriate skill mix and expertise within the Team to enable them the delivery of a robust service, accessible to frontline staff.

Due to the required commitment at Executive and Senior Management level within Aintree, in respect to improving safeguarding within the Trust, there was substantial investment into the recruitment of key posts.

The Team have now effectively integrated and started to implement the relevant processes to enable the provision an effective, efficient service to patients and staff of LWFT, who require safeguarding from abuse, whether it physical, financial, sexual, racial, emotional / psychological or neglect.

As such, the Team have begun to build on their knowledge and competencies in Safeguarding. Working together centrally in one office will further develop the confidence and expertise in decision making within their chosen field; which will promote and enhance learning and ensure resilience between the roles enabling clinical capacity and relevant core and specialist clinical competence within the service.

The initial foundations to promote a joined-up approach viewing safeguarding as a continuum from the unborn baby until older age, combining both child and adult safeguarding have now been successfully established. Moving forward, maintaining the function and embedding all aspects of safeguarding practice across the Trust is essential for an effective Safeguarding Service.

Key Objective for 2017-18

As outlined in this Annual Report, there has been significant activity and scrutiny within the reporting period. The Trust has moved for a position of being unable to demonstrate that there are robust mechanisms in place to safeguard adults, young people and children from abuse, to one where we now have agreed processes and policies and a robust Governance structure to monitor these are embedded. Currently the Trust is delivering against the agreed Safeguarding Improvement plan and this delivery will continue into 2018/19.

Post CQC Inspection and as approach’s to safeguarding continually evolve in respect to newly recognised forms of harm and abuse, the newly developed structures and process will continue to develop in response. Aside from further embedding of existing developed processes and Operational Work Plan, key areas / objectives for improvement have been identified in the priorities for 2018/19:

- Through continued collaboration between the Local Authority, Police and other services and external partners; further develop and implement improvements in the quality and provision of services for adults, children and young persons to ensure that safeguarding practice and procedures are adhered to and compliant with National and Local standards, primary legislation, Government guidance and strategy
- Provide expert advice and strategic direction to Aintree University Hospital NHS Foundation Trust Chief Executive, Board of Directors, Chief Nurse, Managers and Clinicians as required on Safeguarding in accordance with National and Local policy and in the best
Aintree University Hospital NHS Foundation Trust

interest of the reputation of the Trust; and ensure the provision of assurance relevant to Safeguarding, to the Hospital Board

- Ensure a close working relationship between Aintree University Hospital NHS Foundation Trust and commissioners and external agencies/partners, regarding service delivery relating to safeguarding issues; and including provision of quarterly Key Performance Data (KPIs)
- Building on the developed Safeguarding Team and processes, compliant with legislation, within Aintree University Hospital NHS Foundation Trust; further develop the collaborative vision for Safeguarding across provider organisations

Conclusion

Following the initial external reviews completed 2017, the interim arrangements for the management and provision of a comprehensive Safeguarding Service from Liverpool Women's NHS Foundation Trust has ensured the completion of a ‘deep dive’ into the existing safeguarding processes in place across the organisation.

Based on the findings an agreed work plan that set out the key objectives and trajectory for the delivery of identified priorities and future work streams, was developed and has been delivered.

To date, work completed by the team, outlined above in the ‘Current Position - Safeguarding Specific Objectives for 2017-2018’ has been a full review of the arrangements across the Trust including; data flow internally and externally, patient demographics, the existing safeguarding service structure, safeguarding policies, training requirements and performance.

All NHS bodies have a statutory duty to make arrangements to safeguard and promote the welfare of children and adults, with a particular emphasis placed on the provision of greater assurance that those at the greatest risk of abuse, regardless of age, continue to be protected within our services.

Whilst the foundations have been set and steady progress against the detailed Operational Work Plan has been completed, this progress will need to continue as a matter of priority in the coming 12 months and over the next three years in order for the Board to be assured that the Trust complies with the required safeguarding legislative framework.

Authors: Amanda McDonough
Associate Director of Nursing & Midwifery for Safeguarding

Date: 30/07/2018

Appendix 1

Safeguarding Adults, Children and Young People at Risk – Training Strategy
Report to Board of Directors

Report Title Results to Action – Results acknowledgement

Executive Lead Tristan Cope, Medical Director

Lead Officer Dr Rebecca Hanlon, DMD, Diagnostic & Support Services

Phil Downey, DDO, Diagnostic & Support Services

Action Required To approve

Substantial assurance
High level of confidence in delivery of existing mechanisms / objectives

Acceptable assurance
General confidence in delivery of existing mechanisms / objectives

Partial assurance
Some confidence in delivery of existing mechanisms / objectives

No assurance
No confidence in delivery

Key Messages of this Report

Risk discussed at CEELG 19 September 2018; agreed to reduce the risk rating from 20 to 15 based on:

- IT issue which caused system to run slower than normal between December 2017 and March 2018 now fully resolved after system fix application
- System issue caused rate of acknowledgement to fall to c. 65% at the start of the year. Figure now recovered back up to 93% for August 2018 (i.e. 93% of all results ordered between January 2017 to August 2018 acknowledged).
- Radiology clearing backlog of unacknowledged results and training CBU staff to make results acknowledgment sustainable going forward

Impact

- Quality
- Finance
- Workforce
- Equality

Risk
Compliance
Legal

Equality Impact Assessment - not applicable

- Strategy
- Policy
- Service Change

Strategic Objective(s)

- Deliver outstanding care
- Achieve best patient outcomes
- Promote research and education
- Deliver sustainable healthcare to meet people’s needs
- Provide strong system leadership
- Be a well-governed and clinically-led organisation

Governance

- Statutory requirement
- Annual Business Plan Priority
- Key Risk
- Service Change

- Other

rationale for Board submission required:

Next Steps

7. B18-19/075 - Results to Action – Update Report
## REPORT HISTORY

<table>
<thead>
<tr>
<th>Committee / Group Name</th>
<th>Agenda Ref</th>
<th>Report Title</th>
<th>Date of submission</th>
<th>Brief summary of key issues raised and actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMB</td>
<td>HMB18-19/025</td>
<td>Results to Action – Results Acknowledgement</td>
<td>09 May 2018</td>
<td>Risk rating raised to 20 on the risk register</td>
</tr>
<tr>
<td>HMB</td>
<td>HMB18-19/042</td>
<td>Results to Action – Results Acknowledgement</td>
<td>13 June 2018</td>
<td>Progress noted and next steps agreed</td>
</tr>
<tr>
<td>Quality Committee</td>
<td>QC18-19/050</td>
<td>Results to Action – Results Acknowledgement</td>
<td>18 June 2018</td>
<td>Progress noted and next steps agreed</td>
</tr>
<tr>
<td>HMB</td>
<td>HMB18-19/061</td>
<td>Results to Action – Results Acknowledgement</td>
<td>11 July 2018</td>
<td>Risk score to remain at 20 and next steps agreed</td>
</tr>
<tr>
<td>Quality Committee</td>
<td>QC18-19/070</td>
<td>Results to Action – Results Acknowledgement</td>
<td>16 July 2018</td>
<td>Risk score to remain at 20 and next steps agreed</td>
</tr>
<tr>
<td>Board of Directors</td>
<td>B18-19/054</td>
<td>Results to Action – Results Acknowledgement</td>
<td>25 July 2018</td>
<td>Progress noted. Risk remain at 20</td>
</tr>
<tr>
<td>HMB</td>
<td></td>
<td>Results to Action – Results Acknowledgement</td>
<td>8 August 2018</td>
<td>Progress noted. Risk to be reviewed at CEELG in September.</td>
</tr>
</tbody>
</table>
Results to Action (R2A) – Results Acknowledgement

Executive Summary

1. The electronic acknowledgement of results (R2A) following laboratory and diagnostic procedures went live in June 2013. Since then there has been an on-going issue of a proportion of results not being acknowledged electronically.

2. There have been a small number of SIs where a failure to acknowledge and/or act on results has been part of the root cause.

3. The R2A system was running ineffectively between November 2017 and March 2018 and this has contributed to an increase in backlog and reduction in results acknowledgement. The technical issue has now been resolved.

4. A Task and Finish Group has been convened to oversee improvement, and Divisional Clinical Leads appointed to drive Divisional performance through clinical engagement.

Background

5. In January 2018, the functionality of the R2A on Sigma deteriorated due to an IT issue which has subsequently been fixed. As a result of the system issues the acknowledgment rate fell from around 90% to 65% at that point in time. The figures have subsequently recovered. The risk rating was increased from 15 to 20 as a result of the system issue and dip in performance.

6. The following actions have been completed through the R2A Task & Finish Group:

- There has been ongoing Clinical engagement in Medicine lead by Dr John Hollingsworth. Plans have been submitted from DME, Stroke, Rheumatology, Haematology and Palliative care.

- Results acknowledgement was discussed at the Surgical DAG meeting on 27 July 2018. A new Clinical Lead has been established in Surgery – Mr Chris Loh Consultant ENT Surgeon. He has arranged for ENT and MFU to have a focussed group session of results acknowledgement on an audit afternoon in September. He has also put together a training video on how to acknowledge results which will go live on the intranet shortly. Engagement has also started with Orthopaedics, DDU and Urology.

- The Radiology clerical team has been established and have:
  - completed a total of 37 hours of results acknowledgement to date.
  - cleared the last 2 years of chest x-ray reports for Cardiology and are planning to do the same for Respiratory.
  - cleared 400 historic unacknowledged results for Therapies.
  - arranged to clear the last two years of abdominal x-rays for Urology.
  - met with the Orthopaedics, Urology and ENT and will target these areas next.
  - arranged to train staff in these CBUs to acknowledge their own results going forward.
• Work has started with the Communications Team via Fin McNichol to improve Clinical engagement. 300 stickers have initially been ordered from an external company to be placed on Trust pcs on the wards and in AED. Further stickers and posters can be ordered depending on the impact of the first roll out. The logo below is now on the Trust PCs and Sigma home page.

![Keep your patients safe](image)

• The Junior Doctor’s induction booklet has been updated and put through document control. A presentation was given to the Junior Doctors at their induction on 2 August 2018 and this has also been embedded in the Junior Doctor handbook.

• Plans to train all ward clerks to acknowledge daily ward results are being scoped out, with Richard Miller-Holliday as lead.

• The Trust policy on results acknowledgement has been updated and ratified by CEELG.

7. The overall number of unacknowledged results for the last 12 months has reduced by 7378 between May and July 2018. This is encouraging progress considering this has occurred against a background of increased activity and results ordering in the Trust. The breakdown of the reduction is as follows;

- 4165 in Medicine
- 1886 in Surgery
- 1327 in AED

Total = 7378

8. The percentage of acknowledged results since January 2018 is currently 93% (see table below). The 7% of unacknowledged results are largely historic and work is underway with the clerical team and CBUs to clear these.

9. There is an inevitable lag in results acknowledgement performance from the end of a given month – i.e. results will continue to be reviewed and acknowledged after the end of the month. Performance will therefore always look worse for the immediately preceding month, particularly if analysed at the beginning of the next month. It is possible to make comparisons, but caution must be deployed to compare similar points in time.
### Table 1 – January to December 2017

<table>
<thead>
<tr>
<th>Category</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
<th>Dec-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>% ACKNOWLEDGED</td>
<td>94.39%</td>
<td>93.82%</td>
<td>93.69%</td>
<td>94.12%</td>
<td>93.49%</td>
<td>93.90%</td>
<td>93.65%</td>
<td>93.04%</td>
<td>93.34%</td>
<td>93.28%</td>
<td>92.82%</td>
<td>92.84%</td>
</tr>
<tr>
<td>% UNACKNOWLEDGED</td>
<td>5.61%</td>
<td>6.18%</td>
<td>6.31%</td>
<td>5.88%</td>
<td>6.51%</td>
<td>6.10%</td>
<td>6.35%</td>
<td>6.96%</td>
<td>6.66%</td>
<td>6.72%</td>
<td>7.18%</td>
<td>7.16%</td>
</tr>
</tbody>
</table>

### Table 2 – January to August 2018

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>% ACKNOWLEDGED</td>
<td>93.08%</td>
<td>92.47%</td>
<td>92.39%</td>
<td>91.81%</td>
<td>91.22%</td>
<td>91.09%</td>
<td>90.26%</td>
<td>86.83%</td>
<td>92.56%</td>
</tr>
<tr>
<td>% UNACKNOWLEDGED</td>
<td>6.92%</td>
<td>7.53%</td>
<td>7.61%</td>
<td>8.19%</td>
<td>8.78%</td>
<td>8.91%</td>
<td>9.74%</td>
<td>13.17%</td>
<td>7.44%</td>
</tr>
</tbody>
</table>
Proposal

10. The risk rating was reviewed at Clinical Effectiveness ELG in September 2018 and it was agreed to reduce the risk from 20 back to the original rating of 15. The rationale for the reduction is based on the fix on the system, the work done by the clerical team to clear the backlog and the improved Clinical engagement.

Next steps

11. The Board of Directors is asked to note the progress and approve the reduction in the risk rating from 20 to 15 as recommended by the Clinical Effectiveness ELG.

Author: Dr Rebecca Hanlon, DMD Support Services
Date: 19 September 2018
## Key Messages of this Report

1. Due to a reduction in outpatient capacity the outpatient waiting times in gastroenterology has increased to an unacceptable level and is now classified as a level 20 risk for the Trust.
2. Mitigations have been put in place to minimise risk to patient outcomes and experience however these offer short term solutions.
3. Proposals to improve the position on a more sustainable basis are being developed by Divisions of Surgery and Medicine.

### Impact

- Quality: ☒
- Finance: ☐
- Workforce: ☐
- Equality: ☐
- Risk: ☒
- Compliance: ☐
- Legal: ☐

### Equality Impact Assessment N/A

- Strategy: ☐
- Policy: ☐
- Service Change: ☒

### Strategic Objective(s)

- Deliver outstanding care: ☒
- Achieve best patient outcomes: ☒
- Promote research and education: ☐
- Deliver sustainable healthcare to meet people’s needs: ☒
- Provide strong system leadership: ☐
- Be a well-governed and clinically-led organisation: ☐

### Governance

- Statutory requirement: ☒
- Annual Business Plan Priority: ☐
- Key Risk: ☒
- Service Change: ☐
- Other

### Next Steps

To improve access to services and quality of care for patients and reduce the clinical risk associated with long waiting times.
## REPORT HISTORY

<table>
<thead>
<tr>
<th>Committee / Group Name</th>
<th>Agenda Ref</th>
<th>Report Title</th>
<th>Date of submission</th>
<th>Brief summary of key issues raised and actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Management Board</td>
<td>HMB18-19/050</td>
<td>Medical Cover - Gastroenterology</td>
<td>13 June 2018</td>
<td>Agreed next steps</td>
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<tr>
<td>Finance &amp; Performance Committee</td>
<td>FP18-19/041</td>
<td>Medical Cover - Gastroenterology</td>
<td>25 June 2018</td>
<td>Position noted – continue to report monthly whilst risk is rated at 20</td>
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<tr>
<td>Hospital Management Board</td>
<td>HMB 18-19/062</td>
<td>Medical Cover - Gastroenterology</td>
<td>11 July 2018</td>
<td>Position noted – continue to report monthly whilst risk is rated at 20</td>
</tr>
<tr>
<td>Hospital Management Board</td>
<td>HMB 18-19/081</td>
<td>Medical Cover – Gastroenterology</td>
<td>8 August 2018</td>
<td>Position noted – continue to report monthly whilst risk is rated at 20</td>
</tr>
<tr>
<td>Quality Committee</td>
<td>QC18-19/078</td>
<td>Medical Cover – Gastroenterology</td>
<td>20 August 2018</td>
<td>Modelling on impact of actions to be undertaken</td>
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<tr>
<td>Finance &amp; Performance Committee</td>
<td>FP18-19/067</td>
<td>Medical Cover – Gastroenterology</td>
<td>28 August 2018</td>
<td>Position noted</td>
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<td>HMB</td>
<td>HMB18-19/112</td>
<td>Medical Cover – Gastroenterology</td>
<td>12 Sept 2018</td>
<td>Position noted and actions agreed</td>
</tr>
<tr>
<td>Quality Committee</td>
<td>QC18-19/101</td>
<td>Medical Cover – Gastroenterology</td>
<td>17 Sept 2018</td>
<td>Modelling of current actions to be undertaken and reported back in October 2018</td>
</tr>
</tbody>
</table>
Medical Cover - Gastroenterology

Executive Summary

1. This report provides an update on the demand and capacity issues in gastroenterology.

2. The service has experienced significant operational challenges as a result of increased demand and reduction in outpatient capacity.

3. As a result of the reduction in outpatient capacity, there has been a decline in the number of patients being seen within 18 weeks and an increased number of patients waiting for first and follow up outpatient appointments along with an increased number of patients waiting over 6 weeks for a diagnostic endoscopic procedure.

4. Following discussions at the Safety & Risk Executive Led Groups in May 2018, the risk for the service remains at level 20. This was ratified at the Surgical Divisional Assurance Group in August 2018.

Current Position

5. In July 2018 the incomplete 18 week RTT pathway position for gastroenterology was 75.4% against the 92% national standard. This is a decline in position following three consecutive months where the position had improved (April 74.9%, May 75.6% & June 76.5%).

6. Over the last 13 months the total caseload for Gastroenterology has grown by 453 patients from 1,566 reported in July 2017 to the 2,019 reported in July 2018. The total number of patients waiting over 18 weeks to be seen has increased to 497 in July 2018 compared to 173 in July 2017.

7. The current 1st routine outpatient waiting time for general gastroenterology has deteriorated from 41 weeks in June to 45 weeks in July. The loss of the Locum Consultant during July has contributed to a deteriorated position. There has been a marginal increase in patients waiting over 30 weeks for 1st appointment. There are currently 207 patients waiting over 30 weeks and 37 patients waiting over 40 weeks for 1st appointment compared to 199 patients waiting over 30 weeks and 15 patients waiting over 40 weeks reported in June 2018.
8. The current total first outpatient waiting list for gastroenterology has continued to increase and at July 2018 stands at 2,537 patients.

9. The current total outpatient follow up waiting list for gastroenterology has continued to increase and at July 2018 stands at 9,865 patients.

10. Following 4 consecutive months of improvement the endoscopy DM01 position has declined during July 2018. There were 12 patients for colonoscopy and 10 patients for gastroscopy that waited over 6 weeks. Endoscopy is reporting a position of 2.56% against the maximum 1% national standard.

11. The Surveillance position for patients waiting beyond their planned review date has decreased from 130 in June to 71 in July. This is a welcome improvement for the Trust as these are patients where previous lesions have been seen and removed and are more likely to have recurrence if they are not seen and assessed within a reasonable timeframe. The national timeframe beyond the due date of review as defined by JAG is 7 weeks. The table below summarises the timeframe beyond the planned review date for the 71 delayed patients.
12. Therapeutic endoscopic procedures are monitored each week at the capacity meeting and the current waiting time beyond the expected date of treatment has increased. This has been as a result of increased 2-week wait cancer referrals and the capacity pressures within the service. There are currently 49 patients waiting for Therapeutic procedures going back to January 2018 as demonstrated below.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>7-12 weeks</th>
<th>13-16 weeks</th>
<th>17-25 weeks</th>
<th>26+ Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colonoscopy</td>
<td>36</td>
<td>12</td>
<td>15</td>
<td>1</td>
</tr>
<tr>
<td>Flexi Sigmoidoscopy</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastroscopy</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All other Procedures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>42</strong></td>
<td><strong>13</strong></td>
<td><strong>15</strong></td>
<td><strong>1</strong></td>
</tr>
</tbody>
</table>

13. The gastroenterology department provide a specialist service for the diagnostic and therapeutic management of indeterminate strictures and large stones of the biliary system when standard endoscopic retrograde cholangiopancreatography (ERCP) is unsuccessful or considered inappropriate. The “SpyGlass” procedure is a visualisation and intervention system that is used within the specialist endoscopy theatre. This relatively new procedure has been very successful and Dr Richard Sturgess is now receiving an increased number of referrals requiring timely intervention. Each list requires anaesthetic support. A maximum of 2 cases per list can be scheduled. The current waiting lists are of concern with regard to capacity and demand for this specialised procedure. The waiting times are detailed below:

<table>
<thead>
<tr>
<th>Therapeutic Endoscopy</th>
<th>Due Month</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-18</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Feb-18</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Apr-18</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>May-18</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Jun-18</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Jul-18</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Aug-18</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>49</strong></td>
<td></td>
</tr>
</tbody>
</table>

14. The scheduled additional activity is maintaining the current position but there is insufficient workforce to schedule further additional activity to reduce waiting times. A Case of Need has been drafted and is due to be submitted to the Executive Team for consideration by 2nd October 2018.

15. The Cancer Alliance review of endoscopy services identified opportunities to improve the utilisation of core capacity. AQuA will be supporting the service to progress opportunities to improve the utilisation of baseline capacity from October 2018.
16. Following discussions with the Cancer Alliance in August 2018, it has been acknowledged by the Cancer Alliance that some of the methodology used to capture this data was not entirely reliable. It has been agreed that different methodology will be used in a further audit, reflecting the current list utilisation. This will reflect the complexity of cases requiring multiple slots and the correct scoring of patients listed for procedures. This outcome will inform the improvement work facilitated by AQuA.

17. As a short term solution to reduce delays for patients, Medinet has been approached by the Trust to potentially support the service. Medinet is a leading company that supports the NHS to reduce waiting times. Discussions are taking place to potentially commission this consultant led service to review 1,800 new patients over 150 clinics over the next 4-6 months. A meeting will take place in September 2018 with clinical and operational managers from AUH and the Medinet team to explore this option further. The potential impact of conversion to elective or endoscopy procedures for such a high volume of patients’ needs to be considered.

18. If an additional 1,800 new patients were reviewed by Medinet over the next 5 months, this would significantly reduce waiting times and improve the RTT position. This recovery trajectory is summarised in the chart below. If there is no increase in referrals, the number of patients waiting over 18 weeks would significantly reduce and compliance with the RTT standard of 92% would be achieved by March 2019.

![Gastroenterology-RTT trajectory chart]

**Actions to Date**

19. An improvement plan was developed by the Surgical Division in response to the deteriorating position in gastroenterology and immediate actions were taken to mitigate the risks.

<table>
<thead>
<tr>
<th>Action</th>
<th>Outcome</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthened administrative processes</td>
<td>5% reduction in DNAs since implementation. This has improved utilisation of existing resource.</td>
<td>DDO Surgery</td>
</tr>
<tr>
<td>Implemented virtual Consultant led clinics</td>
<td>Reviewed 150 follow up appointments – 123 (82%) discharged back to GP. On-going capacity to see 60 virtual follow up and 20 new face to face patients per week. This additional activity ceased from the beginning of September due to 2 luminal Consultants being required to complete the wards rounds.</td>
<td>DMD Surgery</td>
</tr>
<tr>
<td>Locum Gastroenterology Consultant commenced 10 August 2018. Committed to work 2 weeks in August and 3 weeks in September</td>
<td>Increased activity of 30 new, 100 follow up appointments and 30 colonoscopies during this period. This will cease mid-September.</td>
<td>DMD Surgery</td>
</tr>
</tbody>
</table>
Aintree University Hospital NHS Foundation Trust

Medical Cover - Gastroenterology: Board of Directors 26 September 2018

<table>
<thead>
<tr>
<th>Action</th>
<th>Outcome</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointed Medical Locum Consultant to review patients on gastroenterology wards</td>
<td>Released 4 Gastroenterology Consultants sessions per week to undertake outpatient activity. This ceased 31st August and the luminal consultants increased back up to 2 on the wards each morning.</td>
<td>DMD Surgery</td>
</tr>
<tr>
<td>Arranged 153 additional paid sessions in endoscopy (April 2018 to July 2018)</td>
<td>688 endoscopic procedures undertaken April to July 2018 delivered via additional paid sessions.</td>
<td>DDO Surgery</td>
</tr>
</tbody>
</table>

**Next Steps**

20. The Division continues to develop the improvement plan in order to mitigate the risks further and identify more sustainable solutions to improve the current position.

<table>
<thead>
<tr>
<th>Action</th>
<th>Outcome</th>
<th>Lead</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review existing utilisation; complete demand and capacity exercise (supported by AQUA)</td>
<td>Assurance on effective and efficient use of existing resource.</td>
<td>DDO/DMD Surgery</td>
<td>September 2018</td>
</tr>
<tr>
<td>Explore possibility of appointing Medinet (consultant led in reach agency service)</td>
<td>Additional capacity in outpatients and endoscopy (a total of 1,800 patients)</td>
<td>DDO/DMD Surgery</td>
<td>September 2018</td>
</tr>
<tr>
<td>Finalise Case of Need for gastroenterology service</td>
<td>Gain clarity on immediate and medium term actions required to support and improve the service (including clinical, quality and financial risks)</td>
<td>DDO/DMD Surgery</td>
<td>September 2018</td>
</tr>
<tr>
<td>Trust MD to meet with Medicine &amp; Surgery DMD to agree General Medicine element of Consultant job plans</td>
<td>If model changes, this will increase the potential to recruit to the Consultant vacancy</td>
<td>Trust Medical Director</td>
<td>September 2018</td>
</tr>
<tr>
<td>Complete Specialist Nurse/ job plan reviews</td>
<td>Potential for additional outpatient sessions to be provided by the CNS.</td>
<td>DDN Surgery</td>
<td>September 2018</td>
</tr>
<tr>
<td>UGI CNS to train to provide endoscopic capacity; HEEN interview for selection is w/c 20th August 2018.</td>
<td>After a 5 month period of training this will result in 24 additional gastroscopy slots per week.</td>
<td>DDN Surgery</td>
<td>September 2018</td>
</tr>
<tr>
<td>Re-write the advert prior to release to refresh the content. Advertise the substantive and locum Consultant posts</td>
<td>Recruit to vacancy.</td>
<td>CD Gastroenterology</td>
<td>October 2018</td>
</tr>
</tbody>
</table>

**Conclusion**

21. Whilst additional capacity has been created to mitigate risks, this is not sufficiently matched to demand.

22. Sustainable solutions are required in order to provide assurance on quality and performance standards within the gastroenterology service. These solutions are being progressed with pace and will report through the Surgical Division’s Assurance Group, HMB and the Quality Committee.

**Recommendations**

23. The Board of Directors is asked to note the current position of the gastroenterology service.

**Author:** Joanne Eccles, Divisional Director of Operations, Surgery & Anaesthesia

**Date:** 4 September 2018
Agenda Item (Ref) B18-19/077  Date of Meeting: 26 September 2018
Report to Board of Directors
Report Title CQC Improvement Plan – update on progress
Executive Lead Dianne Brown, Chief Nurse
Lead Officer Wendy Prestage, CQC Project Lead
Action Required To review and agree actions

<table>
<thead>
<tr>
<th>Substantial assurance</th>
<th>Acceptable assurance</th>
<th>Partial assurance</th>
<th>No assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>High level of confidence in delivery of existing mechanisms / objectives</td>
<td>General confidence in delivery of existing mechanisms/ objectives</td>
<td>Some confidence in delivery of existing mechanisms / objectives</td>
<td>No confidence in delivery</td>
</tr>
</tbody>
</table>

Key Messages of this Report
- The CQC issued their final reports following their inspection of the Trust. An improvement plan in response has been formulated and was shared with the CQC on 29 March 2018.
- Action plan being managed through a fortnightly CQC Delivery Group, chaired by the Chief Nurse.
- The 50 Must Do actions have been completed or completed with evidence to be reviewed. There are 12 open Should Do actions, 7 of these are beyond their original review date.
- Internal Audit is currently undertaking an audit to review the process and evidence of the Must Do actions relating to Medicines Management, Safeguarding, Staffing and DNACPR.

Impact
- Quality ☒
- Finance ☐
- Workforce ☐
- Equality ☐
- Risk ☐
- Compliance ☒
- Legal ☐

Equality Impact Assessment
- Strategy ☐
- Policy ☐
- Service Change ☐

Strategic Objective(s)
- Deliver outstanding care ☒
- Achieve best patient outcomes ☒
- Promote research and education ☐
- Deliver sustainable healthcare to meet people’s needs ☐
- Provide strong system leadership ☒
- Be a well-governed and clinically-led organisation ☒

Governance
- Statutory requirement ☒
- Annual Business Plan Priority ☐
- Key Risk ☐
- Service Change ☐
- Other ☐

rationale for Board submission required:

Next Steps
Deliver the improvement plan with the input of the Divisional teams. Progress against the improvement plan monitored through a fortnightly CQC Delivery Group, chaired by the Chief Nurse.
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<thead>
<tr>
<th>Committee / Group Name</th>
<th>Agenda Ref</th>
<th>Report Title</th>
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<th>Brief summary of key issues raised and actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Committee</td>
<td></td>
<td>CQC Improvement Plan</td>
<td>Monthly</td>
<td>Updated status of actions</td>
</tr>
<tr>
<td>HMB</td>
<td>Quality Session</td>
<td>CQC Improvement Plan</td>
<td>12 Sept 2018</td>
<td>Concerns with outstanding actions not being completed within the timescales. Mock inspections to begin in Nov 2018. Final report to be submitted to HMB in October 2018.</td>
</tr>
<tr>
<td>Quality Committee</td>
<td>QC18-19/104</td>
<td>CQC Improvement Plan</td>
<td>17 Sept 2018</td>
<td>Progress noted</td>
</tr>
</tbody>
</table>
Executive Summary

1. This report provides an update on the 12 recommendations as to action the Trust must take to comply with its legal obligations and a further 56 recommendations as to action the Trust should take. This has resulted in a total of 175 individual actions.

2. Duplicate actions have been closed off so reporting is against a single action. Approximately 93% of actions have been completed or completed with evidence to be reviewed.

Assurance and Governance

- Oversight of the action plan is provided by the allocation of an Executive Lead for each action
- Executive Team review of completed actions and evidence prior to closure
- CQC Delivery Group meet on a fortnightly basis
- Divisional weekly meeting
- Support provided by the Project Lead and Associate Director of Quality Governance

3. All actions are broken down by RAG status in relation to the target completion date:

   - Red – Implementation of the action is beyond the original target date and is therefore overdue or action is not expected to be complete by the target date
   - Amber – Action is expected to be completed in line with the target date
   - Green – Action complete and evidence signed off
   - Evidence received – awaiting review

Must Do Actions

4. The 50 Must Do actions have been completed.

Should Do’s

5. The following charts show the breakdown of Should Do actions and the due dates:
6. Currently, there are 7 Should Do actions that have passed their target date; the following list details the actions.

<table>
<thead>
<tr>
<th>Division</th>
<th>Sub Action Ref</th>
<th>Enhancements and additional actions</th>
<th>RAG Status</th>
<th>Origin Target Date</th>
<th>Revis ed Target Date</th>
<th>Progress Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent &amp; emergency</td>
<td>S9.1</td>
<td>9.1. Evidence of assurance reporting through Medical Division DAG identifying ownership for managing medical devices safely</td>
<td>Red</td>
<td>Jul-18</td>
<td>Jul-18</td>
<td>EBME report to be presented at September DAG’s</td>
</tr>
<tr>
<td>Surgery</td>
<td>S39.2</td>
<td>39.2. Undertake audit of implementation of SOP (Pre-OP)</td>
<td>Red</td>
<td>Jul-18</td>
<td>Jul-18</td>
<td>Awaiting evidence from audit</td>
</tr>
<tr>
<td>Surgery</td>
<td>S39.3</td>
<td>39.3. Present findings to DAG escalate any issues to CEELG</td>
<td>Red</td>
<td>Aug-18</td>
<td>Aug-18</td>
<td>Scheduled for the Senior Leadership Team meeting in September</td>
</tr>
<tr>
<td>Surgery</td>
<td>S43.2</td>
<td>43.2. Monitoring of implementation of NatSSIP and LocSSIP</td>
<td>Red</td>
<td>Apr-18</td>
<td>Apr-18</td>
<td>NatSSIP policy is being drafted; Theatre LocSSIP policy is being rewritten. Audit of Endoscopy has commenced</td>
</tr>
<tr>
<td>EOLC</td>
<td>S51.3</td>
<td>51.3. Clinical Audit management system to be updated with outcomes and action plans from completed audits</td>
<td>Red</td>
<td>Jun-18</td>
<td>–</td>
<td>Registration forms and action plans being updated</td>
</tr>
</tbody>
</table>

7. Of the remaining 6 amber actions 4 are expected to be completed by their due dates.

8. The delivery of the EOL training will be scoped and proposals presented to WELG. The action will be monitored through the EOL Strategic Group.

9. NatSSIP training for key personnel (Surgery) - 66% of staff have been trained; the trajectory for the remaining staff (circa 140) has been requested.
Breakdown of Actions by Executive

10. The table below shows the breakdown of actions by revised target date, approximately 93% of actions have been completed / completed with evidence to be reviewed:

N.B September Red rated actions are beyond the original due date.

Deferred Actions

11. The below table shows the actions/sub actions that have been deferred with the rationale, it is recommended that these actions should be monitored by the Quality Committee post September.

<table>
<thead>
<tr>
<th>CQC Action</th>
<th>Division</th>
<th>Sub Action Ref</th>
<th>Enhancements and additional actions</th>
<th>Original Target Date</th>
<th>Rationale for deferment</th>
</tr>
</thead>
<tbody>
<tr>
<td>S27. The trust should ensure that all areas comply with best practice in relation to care of persons living</td>
<td>Medical care services</td>
<td>S27.1</td>
<td>27.1 Undertake gap analysis on standards of dementia/cognitive impaired patients</td>
<td>Jul-18</td>
<td>The strategy for Cognitive Impairment will be updated to ensure that new guidelines and best practice are incorporated and complied</td>
</tr>
</tbody>
</table>
with dementia and sensory or cognitive impairments (Medical care services)

<table>
<thead>
<tr>
<th>CQC Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>with dementia and sensory or cognitive impairments (Medical care services)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Division</th>
<th>Sub Action Ref</th>
<th>Enhancements and additional actions</th>
<th>Original Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>S27.2</td>
<td>27.2. Undertake training needs analysis</td>
<td>Aug-18</td>
<td>with. The overall action will be deferred to ensure that a comprehensive assessment is undertaken. This will include Guidance published in June 2018 Learning Disability Improvement Standards for NHS Trusts, NICE Guidance, and the NHS North Region Safeguarding Annual Review. This will also ensure that the appropriate engagement and consultation with internal and external colleagues can be undertaken. This will be completed by November 2018 when the review and plan will be presented at the Hospital Safeguarding Board</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Division</th>
<th>Sub Action Ref</th>
<th>Enhancements and additional actions</th>
<th>Original Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>S27.3</td>
<td>27.3. Results of TNA to be fed back to DAG and HSB</td>
<td>Aug-18</td>
<td>The SLA for Woodlands and Walton is complete. Further work is still ongoing in relation to St Josephs and is expected to be completed by the end of September</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Division</th>
<th>Sub Action Ref</th>
<th>Enhancements and additional actions</th>
<th>Original Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>EOLC</td>
<td>S56.1</td>
<td>56.1. Complete SLAs for Walton and St Joseph's Hospice.</td>
<td>Aug-18</td>
</tr>
</tbody>
</table>

NHSI

12. As a result of the Trust’s participation in the NHSI Moving 2 Good programme, the Trust has confirmed the acceptance of the NHSI support offer for three objectives. Representatives from the Trust will be attending the three NHSI workshops in September and October 2018.

Next 4 weeks

- Completion of the open actions
- CQC Delivery Group Meeting 11 September
- RSM audit feedback
- Internal review of evidence scheduled for 26 September
- SIQSG on 1 October

Recommendation

13. The Board of Directors is asked to review the report and agree any actions.

References and further reading

CQC Inspection Reports – Aintree University Hospital NHS Foundation Trust – March 2018
http://www.cqc.org.uk/provider/REM

Author: Wendy Prestage, CQC Project Lead
Date: 4 September 2018

CQC Improvement Plan: Board of Directors 26 September 2018
Board Committee Assurance Report

<table>
<thead>
<tr>
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<th>Board of Directors</th>
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</thead>
<tbody>
<tr>
<td>Date</td>
<td>26 September 2018</td>
</tr>
<tr>
<td>Committee Name</td>
<td>Finance &amp; Performance Committee</td>
</tr>
<tr>
<td>Date of Committee Meeting</td>
<td>28 August 2018</td>
</tr>
<tr>
<td>Chair’s Name &amp; Title</td>
<td>David Fillingham, Non-Executive Director (Acting Chair)</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Ian Jones, Director of Finance &amp; Business Services</td>
</tr>
</tbody>
</table>

Summary

The Finance & Performance Committee continues to receive reports and provide assurance to the Board of Directors against its work programme via a summary report submitted to the Board after each meeting. Full minutes and enclosures are made available on request.

Key Issues

Corporate Performance Report (CPR) (Month 4) - Partial Assurance

The following key areas were discussed:

- **Referral to Treatment (RTT) – Incomplete Waiting List** – a report was tabled in light of the Letter received from NHS Improvement (NHSI) which provided details of the growth in the level of referrals seen by the Trust across all specialties from the Commissioning Groups. It also highlighted the trajectory scenarios for RTT performance on the assumption that there would be no further growth in referrals but it was requested that information be provided on the impact on the trajectory if current levels of referrals remain in place. The report also highlighted the potential solutions to reducing the waiting lists in each of the specialties and the positive impact this would have on the RTT position. The Committee was concerned about data quality/completion and wanted to ensure that the Trust and the Commissioning Groups/NHSI were discussing the same data set; acknowledged the growth in demand and the plans in place to mitigate the risks but there were costs associated with that; the level of GP referrals needed to reduce in order that the Trust could address the waiting list backlog; the need for a whole system review on how to meet demand more effectively

- **Gastroenterology** – a significant level of waiting list initiatives were being used to improve the service and reduce the backlog but this was not sustainable given the financial pressures it place on the Trust and the waiting list continued to grow. The Trust had commissioned Medinet to assist in supporting the address of the backlog.

- **Ophthalmology** – a deep dive had been undertaken on the reported incidents of moderate harm for patients with macular degeneration which revealed that no patients had suffered harm. However, the service had introduced measures to increase capacity to monitor this cohort of patients. The Committee agreed that this matter be monitored by the Quality Committee going forward

- **Cancer Performance** – the Trust had complied with three of the eight standards for July. Again, there had been a significant increase in the level of GP referrals which was being discussed with the CCGs. Furthermore, patient choice was also impacting on performance and the Committee requested details of patient choice numbers versus delays imposed by the Trust

- **Respiratory** – there had been pressure on the service due to consultant vacancies, long-term sickness and increased demand in asthma and the sleep service in particular. Arrangements were being made to review job plans and pathways with a view to redesigning to reduce the waiting list backlog. A further update was requested for October 2018
Aintree University Hospital NHS Foundation Trust

- **AED 4 hour** – there had been an overall improvement in performance trajectory despite a slight deterioration recently. There continued to be high attendances during July which had impacted on performance.

**Finance Report (Month 4) – Acceptable Assurance**
The Trust was slightly behind its planned deficit due to increased attendances and bed pressures with a significant number of escalation beds remaining open to cope with demand. The increased activity in elective care was creating capacity issues and impacting on RTT performance. Medical agency staffing continued to be high but there was a steady downturn in nursing agency spend. The Committee also reviewed the Trust’s current loan borrowings including the principal and interest payments associated with them. The Committee agreed to recommend the approval to the Board of the interim revenue loan from the department of Health. The Committee noted the report on the findings of NHSI following a visit from its agency intelligence team, the recommendations of which the trust was in the process of implementing.

**Electronic Patient Record (EPR) – Update Partial Assurance**
A report and presentation was provided which outlined the key issues affecting the programme and the effective action that could be taken to mitigate the issues. The Committee had a general discussion with the Programme Director about the challenges experienced by the Trusts with the Provider on the design and build of the various modules; the impact the non-signing of the contract by the Royal Liverpool Hospital, principally due to NHSI, on the relationship with the Provider on delivery of the systems to timescales; the impact of the delay on implementing other interim IT solutions that benefit patient care. The Committee believed that there needed to be a concerted effort by the Boards of all three Trusts to resolve the issues to avoid any further delays in the implementation of the system. The Committee requested that a strategic review of the current position be undertaken by the Trust Board at its private meeting in September 2018.

**Transformation Programme Update Partial Assurance**
A presentation was provided which highlighted the work being done by the Transformation team with the Directorates to get more of a grip on the expected financial savings within each of the executive portfolios and the confidence level that the savings would be achieved. Examples were provided of the innovations being developed particularly in respect of the use of digital technology which would further reduce the overall shortfall. The Committee welcomed the progress that had been made but acknowledged that the schemes needed to be delivered and that engagement was key to the success of that delivery.

**Decisions Made**

- Recommend approval of the Interim Revenue Loan from the Department of Health

**Recommendation**
The Board is asked to note the report.
Summary

The Finance & Performance Committee continues to receive reports and provide assurance to the Board of Directors against its work programme via a summary report submitted to the Board after each meeting. Full minutes and enclosures are made available on request.

Key Issues

Corporate Performance Report (CPR) (Month 5) - Partial Assurance
The following key areas were discussed:

- **AED Performance** – whilst performance remained below the standard there had been sustained improvement month on month against the trajectory despite the Trust seeing the highest number of attendances during the summer months. There had also been improvements against the clinical indicators and ambulance handover times.

- **Stroke** – there had been significant improvement with performance during Q2 compared to Q1 but there remained an issue with bed availability which was being reviewed by the Stroke Focus Group. There was also an ongoing risk in relation to stroke patients transferred from Southport & Ormskirk hospital which was being monitored.

- **Gastroenterology** – the risk relating to outpatient waiting times remains a concern and a focussed action plan to mitigate the risks was being implemented with a case of need being developed to address the medium/long term solutions which would be presented to the Hospital Management Board before submission to the Board Committees.

- **Referral to Treatment (RTT)** – there had been a slight deterioration in performance for July and August 2018 but this is against a backdrop of increasing referrals. The Trust's plans to reduce the waiting lists, in line with national expectations, had been submitted to NHSE in August 2018.

- **Cancer Performance** – the 62-day performance deteriorated a factor in this being the significant increase in the number of 2-week referrals. Recent analysis highlighted that the level of case load had increased by over 30% on last year but the numbers of diagnosed cancer cases remained static. The Committee requested that some analysis be undertaken on referral patterns and reported back next month.

- **Diagnostics** – there had been an improvement in performance for diagnostic waits during August 2018 but there remained concerns over the level of demand particularly for CT and MR imaging. Additional capacity was being sourced to reduce waits and mitigate risks with monitoring being undertaken by the Operations & Performance ELG.

Partial Assurance
Aintree University Hospital NHS Foundation Trust

The Committee had a general discussion on how it gains assurance that the action plans included within the exception reports have impacted on performance. It was agreed that a review of exception reports would form part of future meetings in line with the timescales outlined in each respective action plan.

Management of Employee Attendance Partial Assurance
Further analysis had been undertaken and the report highlighted that there was inconsistency in the way in which sickness absence and other leave was being recorded across the Trust. Analysis had shown that short-term absence rates were lower than longer term. Return to work interviews remains a concern with documentation not routinely included in sickness management meetings. A deep dive was to be undertaken with the outcome to be reported in November 2018.

Finance Report (Month 5) Acceptable Assurance
The Trust was slightly behind its planned deficit, driven principally by the additional escalation beds that have remained open to meet the surge in demand, as well as a shortfall in funding against the national pay award. Agency spend remains high, albeit with a reducing trend over the year. It is expected that this downward trend will reverse as we move through winter. Excluding the escalation beds, which have a direct impact on use of agency (nursing, medical and AHPs), it has been estimated that agency spend would have been in the region of £2m less over the period. So far the Trust had not drawn down on financial support from the loan from the Department of Health but this was expected to be required late October / early November 2018. The decision from NHSI on the capital bids was not expected until Nov/Dec 2018, but the Trust had been successful in a supplementary capital bid to increase winter capacity.

Transformation Programme Update Partial Assurance
Progress continues to be made against the savings target but there remains a degree of risk in the delivery of schemes within Executive and senior manager portfolios. There also remains a risk in the delivery of the theatres/elective pathways projects which continue to be monitored by the Transformation Team. The self-check-in kiosks had been successfully launched within Radiology outpatients with approximately 85% of patients utilising the technology in the first week and the inter-hospital transport initiative had indicated a 20% reduction in taxi usage.

Decisions Made
N/A

Recommendation
The Board is asked to note the report.
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<th>Agenda Item (Ref)</th>
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<tr>
<td>Report to</td>
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</tr>
<tr>
<td>Report Title</td>
<td>Corporate Performance Report, Month 5 2018-19</td>
<td></td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Ian Jones, Director of Finance &amp; Business Services, Beth Weston, COO</td>
<td></td>
</tr>
<tr>
<td>Lead Officer</td>
<td>Paul Brannelly, Deputy Director of Finance</td>
<td></td>
</tr>
<tr>
<td>Action Required</td>
<td>To review &amp; agree any actions arising</td>
<td></td>
</tr>
</tbody>
</table>

### Key Messages of this Report

- 3 SIs in month, 6 grade 2 pressure ulcers, moderate and more severe harms remain above last years run-rate.
- No never events, however compliance with WHO checklist dipped significantly in-month.
- 2 cases of C-Diff in August. Run-rate for the first 5 months close to national target.
- Friends and family ‘scores’ remain mixed. Inpatient satisfaction remains below local and national benchmarking.
- Mortality; SHMI now below 100, HSMR remains below 100 and crude mortality lower than last year.
- Diagnostics & Stroke standards missed, but improved.
- 4 of the 8 cancer standards missed including Cancer 62-day which shows a declining trend.
- RTT target missed, declining trend and waiting lists numbers up
- AED 88.9%, below the standard but an improving trajectory
- Bed pressures continue, RFDs remain high, ALoS higher than expected levels, AED attendances and urgent care admissions up
- Underlying financial position marginally worse than plan, agency usage and spend remains high albeit showing an improving trend. Elective pressures growing/anticipated to improve FTT/Waiting lists. Cash loan requirement expected from October/November.

### Impact (Is there an impact arising from the report on the following?)

- Quality
- Finance
- Workforce
- Equality

- Risk
- Compliance
- Legal

### Equality Impact Assessment (if there is an impact on E&D, an Equality Impact Assessment must accompany the report)

- Strategy
- Policy
- Service Change
### Strategic Objective(s)

- Deliver outstanding care
- Achieve best patient outcomes
- Promote research and education
- Deliver sustainable healthcare to meet people’s needs
- Provide strong system leadership
- Be a well-governed and clinically-led organisation

### Governance (is the report a……?)

- Statutory requirement
- Annual Business Plan Priority
- Key Risk
- Service Change

**Other**

rationale for Board submission required:

### Next Steps (actions following agreement by Board/Committee of recommendation/s)

### REPORT HISTORY

<table>
<thead>
<tr>
<th>Committee / Group Name</th>
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<td></td>
</tr>
<tr>
<td>Board of Directors</td>
<td></td>
<td>Corporate Performance Report</td>
<td>Monthly</td>
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AED                                                   27
Diagnostics                                           28
Radiology                                             29
Stroke                                                30
RTT                                                   31
Cancer                                                32

Further reading (available on request):                Exec Lead:
Nurse staffing Return                                 33 and 34
**Board Assurance metrics**
**August 2018**

**BAF ref: SR1**

### SI's
- **Level 1 - Moderate harm**
  - 3 SI in August 2018, cumulative 17
  - Delay and treatment of patient with ischaemic bowel. Incorrect Warfarin management leading to extensive Arterial Thrombosis and Sub-optimal fixation of a leg fracture.
  - No never events in the current year

### Harms
- **Level 1 - Moderate harm**
  - Total incidents: 3181 (2752 last year)
  - Total Harms: 1050 (1047 last year)
- **Level 2 - Severe harm or death to patient.**
  - Level 1 harms: 61 reported (49 last year)
  - Level 2 harms: 11 reported (10 last year)

### Inpatients Falls with Harm
- 97 falls in August.
  - No harm - 71
  - Low harm - 24
  - Moderate harm - 2
  - Severe harm - 0
  - Death - 0
- 193 falls caused harm to date, compared to 172 last year

### Pressure Ulcers
- Number of hospital acquired pressures ulcers
  - There were 6 grade 2 pressure ulcers in August, against an in month target of <6.
  - There were 0 grade 3/4 pressure ulcers in month, 6 to date for year (7 in total for 2017/18).
  - Exception Report on page 26

### Trends
- **SI's**
  - Reduction in number of SIs
- **Harms**
  - Improvement on previous years incidents with level 1 harm or above
- **Falls**
  - 5% Improvement on falls with harm compared to last year
- **Pressure Ulcers**
  - No more than 70 grade 2 pressure ulcers
**Quality Committee**

### Never Events

- **Description:** Never events are serious largely preventable patient safety incidents
- **Current position/comments:** 0 Never Events in August 2018. 0 Never Events for year to date

### WHO Checklist

- **Description:** Compliance with the WHO Checklist audits has decreased from 96.5% to 56.7% and remains below the previous 100% compliance. NATSSIP training is ongoing in the division with WHO safer champions introduced from May 2018 on every theatre list.

### Safety Thermometer

- **Description:** Tool to survey a snapshot of harm free patient care. Includes pressure ulcers, falls, catheters, UTIs and VTE.
- **Current position/comments:** August 98.63%, marginally above the national median performance of 97.93%.

### Readmissions

- **Description:** Number of emergency readmissions within 28 days of discharge
- **Current position/comments:** DFI observed readmission rate: 10.45%. DFI expected readmission rate: 9.63%
Number of cases of hospital acquired MRSA bacteraemia (methicillin-resistant staphylococcus aureus)

0 x cases of MRSA were reported in August. 2 x avoidable cases reported this year.

Zero avoidable cases for the year

Number of cases of hospital acquired MSSA bacteraemia

1 case of MSSA was reported in month. Cumulatively this takes the total to 5 cases against target of 22.8.

17% improvement on the 23 cases reported cumulatively to Nov 2016/17

Number of cases of C-Diff

There have been 2 cases of C-Diff in month when compared to the monthly trajectory of 3.8 cases. Year-to-date the Trust has had 18 cases. Three cases have been listed for appeal.

External requirement of no more than 46 cases.

Internal stretch target of a 50% improvement

Number of beds closed due to infection

A total of 0 bed days have been lost to the Trust due to infection in current financial reporting year.

<0.5%
There were three patient safety alerts issued in August that required action. During the month two alerts were closed within timescale. Cumulatively 8 alerts remain open within timescale and 3 open outside of timescale.

### Bed Occupancy

Bed occupancy % measured at midnight. August occupancy levels were 92.3% which is lower than July’s performance. Occupancy levels remain high despite the trust having 140 additional beds open above baseline capacity (+105 since Nov/Dec). Without these extra beds, bed occupancy would be 100%.

### Safe Staffing

Actual staffing compared to planned for registered nurses, midwives and care staff. This month six wards reported a daytime fill rate of less than 80% for Registered Nurses (RNs), Ward 19 (76.4%), Ward 24 (75.7%), Ward 15 (78.4%), ACCU (78.1%), ABN (72.7%) and Ward 25 (57.9%). Ward 25 has reduced to 18 beds throughout the whole month of August and on occasions reduced to 11 beds. See further reading pages 33 and 34.

### Safe Staffing CHPD

Care hours per day split between registered nurses and care staff. Performance: In month 22,467 care hours delivered which is down from 23,105 in July. Nurse/Midwives averaged 3.8 (3.9 July) and Care staff 3.2 (3.1 July).

### Patient Safety Alerts

Response to patient safety alerts issued by NHS. There were three patient safety alerts issued in August that required action. During the month two alerts were closed within timescale. Cumulatively 8 alerts remain open within timescale and 3 open outside of timescale.
Performance 77.13% (69.54%) increase in performance from the previous month of 7.59%. Performance, Estates and Facilities 80.70%; DSS 80.28%; Corporate 77.98%; Medicine 77.24%; Surgery 73.57% and Ops Management 73.40%.

Reporting methods have recently changed for Training compliance. Compliance is now being monitored by competency.
Would patients recommend service to friends & family.
Introduced in 2013 for Inpatients
August: 93.0% of patients would recommend Aintree, a slight decrease on July’s performance. Graph indicates a declining trend in performance. July performance of 93.1% was below both the NHSE average of 95.76% and local benchmarking for Merseyside Trusts of 95.42%.

Would patients recommend service to friends & family.
Introduced in 2013 for AED
August: 90.29% of patients would recommend AED, an decrease on July’s performance. July performance of 91.26% was above than NHSE average of 86.65% but slightly above local benchmarking for Merseyside Trusts of 84.69% for the same month.

Would patients recommend service to friends & family.
Introduced in 2013 for Outpatients
August: 95.34% of patients would recommend outpatient services, a slight decrease on last month’s performance. July performance of 95.48% was above the NHSE average of 93.94% and local benchmarking or Merseyside Trusts of 93.79%.

No. of compliments received by the Trust
This month 928 compliments from all sources (incl. social media) were received.
**Board Assurance metrics**

**August 2018**

<table>
<thead>
<tr>
<th>Description</th>
<th>Current position/comments</th>
<th>Trend</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Complaints &amp; Concerns</strong></td>
<td>The Trust received 12 new complaints in August 2018 which are being dealt with by the Patient Advice and Complaints Team. There was 1 re-opened complaint in the month.</td>
<td></td>
<td>5% improvement on last year</td>
</tr>
<tr>
<td><strong>Complaint Response Rate</strong></td>
<td>July: 13 new complaints received, 10 responded to within 25 working days (77%); 3 over 25 days (23%) and 0 still open. August: 0 new investigation opened by PHSO (13 ongoing).</td>
<td></td>
<td>75% of complaints received responded to within 25 days No complaints responded to after 60 days</td>
</tr>
<tr>
<td><strong>Complaint Response Clearance Distribution</strong></td>
<td>New complaints since August 17: 50% cleared within 38 days; 75% within 56 days; and 90% within 82 days.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mixed Sex Accommodation</strong></td>
<td>Number of unjustified breaches to the mixed sex accommodation standard.</td>
<td>Zero cases in August.</td>
<td>Zero cases of unjustified breaches per month</td>
</tr>
</tbody>
</table>

**Are we caring?**

**BAF ref: SR1**
**Board Assurance metrics**

**August 2018**

**BAF ref: SR1**

<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Number of patients screened for Venous Thromboembolism</strong></td>
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<tr>
<td><strong>VTE Screening</strong></td>
<td></td>
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<tr>
<td><strong>Dementia FAIR</strong></td>
<td>Total number of patients admitted as emergency &gt;75yrs old screened for Dementia</td>
<td></td>
<td>&gt;=95%</td>
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<tr>
<td><strong>MUST</strong></td>
<td>% of patients at risk of Malnutrition screened with appropriate tool</td>
<td></td>
<td>&gt;=85%</td>
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<tr>
<td><strong>Are we caring?</strong></td>
<td>VTE screening performance in August was 92.3% against the 90% target. Work is ongoing to improve performance, data quality and completion of proformas in a timely fashion</td>
<td></td>
<td>&gt;=95%</td>
</tr>
</tbody>
</table>
### SHMI Performance

- **Description:** Risk adjusted mortality ratio based on number of expected deaths. National published figure from HSCIC.
- **Current position/comments:** SHMI for the period Jan 17-Dec 17 (latest available from Dfi) 98.82 which is better than previous SHMI value and within tolerance levels.
- **Target:**
  - **Target:** Blue
  - **Above expected - Red**
  - **Below expected - Green**

### HSMR Performance

- **Description:** Ratio is the number of observed deaths divided by predicted deaths. HSMR looks at diagnoses which most commonly result in death.
- **Current position/comments:** HSMR has increased slightly to 98.61. Position remains better than expected.
- **Target:**
  - **Target:** Blue
  - **As expected - Red**

### Mortality Crude Rate

- **Description:** Number of deaths as a proportion of admissions. August crude mortality: 1.78%, (2017/18 av. 2.44%). Mortality is considered and discussed as part of mortality report to Quality and Safety Committee.
- **Target:**
  - **Target:**
  - **Previous year average**
  - **Crude**

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#### Lead Committee

- **Are we effective?**
  - **Description:**
  - **Target:**
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### Board Assurance metrics

**August 2018**

**BAF ref: SR2/SR3**

#### Lead Committee

<table>
<thead>
<tr>
<th>Description</th>
<th>Current position/comments</th>
<th>Trend</th>
<th>Target</th>
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</thead>
<tbody>
<tr>
<td><strong>Improving Staff Health and Wellbeing</strong></td>
<td>National CQUIN</td>
<td>Year round plan of implementation of the Health and Wellbeing CQUINS for 2017/18 has been developed. Delivery against the plan was above target. Uptake of flu vaccinations by frontline healthcare workers was 87.5% against a target of 70%</td>
<td></td>
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</tbody>
</table>

#### Quality Committee

<table>
<thead>
<tr>
<th>Description</th>
<th>Current position/comments</th>
<th>Trend</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reducing the Impact of Serious Infections (2a-c)</strong></td>
<td>National CQUIN</td>
<td>Q1: Eligible patient data: - 99.5% screened for sepsis; - 56.7% got antibiotics &lt;1 hr of diagnosis; - 55.9% had an antibiotic review &lt;72 hrs. Improvement actions: Sepsis training modules established, new sepsis screening tool, guidance and clerking pro-forma developed, approved and launched. Sepsis boxes being used on wards.</td>
<td></td>
</tr>
<tr>
<td><strong>Reducing the Impact of Serious Infections (2d)</strong></td>
<td>National CQUIN</td>
<td>Q4: - Antibiotic prescribing +7.17%; - Carbapenem prescribing -8%; - Piperacillin/tazobactam -42% due to a national shortage of the drug. Trust is in discussion with Commissioners regarding a local contract variation for this element of the CQUIN. Guidance is being sought from NHSE. (Latest available data)</td>
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</table>

#### ALoS

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</thead>
<tbody>
<tr>
<td><strong>Average length of stay observed compared to expected length of stay reported by Dr Foster intelligence</strong></td>
<td>DFI expected LoS: 6.23; DFI observed LoS: 7.27 days (Oct. 2017 most recent Dfi data) The Trust LoS continues to be consistently above expected rates.</td>
<td></td>
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</tr>
</tbody>
</table>
### AED 4-Hour Standard

- **Maximum wait time of 4 hours in A&E from arrival to admission, transfer or discharge.** Target of 95%.

- **July performance 88.98%.**

- In month there were 849 breaches and zero 12 hour trolley wait.

- Exception Report is included at page 27

### AED Median Wait to See a Clinician

- **Key performance indicator.**

- All patients expected to see a decision making clinician within 60 minutes.

- In August patients saw a senior decision making clinician within 70 mins against a planned threshold of 60 minutes.

### Breaches

- **Ambulance handover time**
  - average time
  - Number of ambulance waits >30 mins < 60mins
  - Number of ambulance waits >60mins

- **August performance 11.57 mins.**

- 89, 30-60 min handovers delays; 28, >60 mins delays. Aintree performance was 4th out of 10 in the Cheshire & Merseyside area and 8th out of 30 in the North West.

### Handover time

- **Ambulance handover time**
  - **Count of cuts**
  - Ambulance waits >60 mins
  - Ambulance waits >30 mins < 60mins

- **Ambulance notified to handover (15 mins)**

- Reduced breaches over 30 mins and 60 mins - 50% improvement

### AED Breach Analysis

- **AED breaches analysed between admitted, non-admitted and patients requiring admission to other hospitals (e.g. mental health) / its social service provision / GP or A&UH clinics.**

- The increase in non-admitted breaches correlates closely to reported AED Performance.

- There is no obvious correlation between breaches and the number of attendances. The mix of majors/minors is relatively stable over the period.
### AED - patients in department > 12 hrs

**Description:** Time spent in AED department from arrival.

- 125 patients spent a total of 12 hours or more in AED during August, a decrease on the 253 patients reported in the previous month.
- This was also a decrease on number of patients within department for >12hrs in comparison to August 2017 (239).

**Trend:** Improvement on last year.

### Diagnostics

**Description:** Diagnostic tests to be carried out within 6 weeks of request being received. This is measured on the National DM01 return.

- August performance: 2.69% an improvement on the 3.90% reported in July.
- Pressure still noted in MRI, CT, Non-obstetric Ultrasound, Colonoscopy and Gastroscopy.

**Exception Reports are included at page 28 and 29**

### Stroke

**Description:** All Stroke patients who spend at least 80% of their time in hospital on a stroke unit.

- Reporting updated in line with SINAP guidance.
- August performance: 74.47%.
- Work continues to address pressures within Stroke performance, including review of ongoing bed requirements.

**Exception Report on Page 30**
## Board Assurance metrics
### August 2018

<table>
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<tr>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Finance &amp; Performance</strong></td>
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<tr>
<td><strong>RTT</strong></td>
<td>Percentage of incomplete pathways for English patients within 18 weeks. The threshold is 92%.</td>
<td>Overall August performance: 89.3%</td>
</tr>
<tr>
<td></td>
<td>Specialty level target not met by: General Surgery, Urology, Trauma &amp; Ortho, Ophthalmology, MFU, Cardiothoracic Surgery, Gastroenterology and Thoracic Medicine.</td>
<td>&gt;92%</td>
</tr>
<tr>
<td></td>
<td>Exception report on page 31</td>
<td></td>
</tr>
<tr>
<td><strong>RTT 52 wks</strong></td>
<td>Shape of the RTT wait previous quarter vs 1st April</td>
<td>No patients are waiting over 52 weeks. The trend shows a slight deterioration in the profile between 0 and 20 weeks, consistent with the downward trend in RTT incomplete pathway performance.</td>
</tr>
<tr>
<td><strong>RTT 40wks to 52 wk waits</strong></td>
<td>Number of patients waiting between 40 and 52 weeks and current TCI status</td>
<td>72 patients currently waiting between 40-52 wks, compared to 36 patients on the 1st April. Gastroenterology accounts for the vast majority of the increase. Of the 72 patients, 36 have since had their RTT clock stopped, 24 have an OP appointment and 13 been offered TCI dates within the 52 weeks.</td>
</tr>
</tbody>
</table>
First treatment for cancer within 62 days of urgent referral through GP 2 week referral route. 85% threshold.

August performance: 70.8% (unvalidated)
This is below 85% target

Exception Report on Page 32

Patients referred from GP with suspected cancer should have their first appointment within 14 calendar days.

August performance: 92.7% (unvalidated)
This below the national standard of 93%

Exception Report on page 32

Patients receiving first definitive treatment within 1 month of cancer diagnosis.

August performance: 98.3% (unvalidated)
This is above the national standard of 96%

A maximum 62-day wait from referral from an NHS cancer screening service to the first definitive treatment.

August performance: 100% (unvalidated)
This is above the national standard of 90%.
### Board Assurance metrics

**August 2018**

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<tbody>
<tr>
<td><strong>Cancer 31-day Drugs</strong></td>
<td>a maximum 31-day wait for subsequent treatment where the treatment is an anti-cancer drug regimen.</td>
<td></td>
<td>&gt;98%</td>
</tr>
<tr>
<td><strong>Cancer 31-day Surgery</strong></td>
<td>a maximum 31-day wait for subsequent treatment where the treatment is surgery.</td>
<td></td>
<td>&gt;94%</td>
</tr>
<tr>
<td><strong>Cancer Breast Symptomatic</strong></td>
<td>Maximum 2-wk wait to for investigation of breast symptoms, even if cancer is not initially suspected.</td>
<td></td>
<td>&gt;93%</td>
</tr>
<tr>
<td><strong>Cancer Consultant Upgrades</strong></td>
<td>Maximum 62-day wait for the first definitive treatment following a consultant’s decision to upgrade cancers.</td>
<td></td>
<td>&gt;85%</td>
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</table>

**August performance:**
- **Cancer 31-day Drugs**: 100% (unvalidated)
- **Cancer 31-day Surgery**: 92.3% (unvalidated)
- **Cancer Breast Symptomatic**: 90.1% (unvalidated)
- **Cancer Consultant Upgrades**: 85.7% (unvalidated)

**Exception Report on Page 32**
Number of operations cancelled for non-clinical reasons.

Standard achieved in month with 0.54%.

22 operations were cancelled

All patients were readmitted and had their operation within 28 days.

Cancelled patients readmitted within 28 days

<0.8%

Outpatients Cancelled

Number of outpatient appointments cancelled for non-clinical reasons.

In August 7.0% of outpatient appointments were cancelled meaning the Trust's internal standard of <5% was missed in month.

<5%

Outpatient DNA First Attendance

Number of patients not attending their outpatient appointment as a proportion of total attendances

OPFA DNA rate was 11.00%.

This continues to be monitored via the Outpatient Improvement Group.

<10%

Outpatient DNA Follow-up Attendance

Number of patients not attending their outpatient appointment as a proportion of total attendances

OPFU DNA rates were 10.61% against a target level of 10.0%.

This continues to be monitored via the Outpatient Improvement Group.

<10%
 Requirement to run 95% of sessions planned and utilise 90% of the in-session time.

The Trust is part of a system discharge project to aim to ensure minimal delays to discharge and to improve patient experience.

% of beds lost due to patients delayed in hospital meeting the criteria for DTOC

DTOCs increased in month to 5.00%, with 1235 bed days lost. (last year 3.81% and 859 bed days lost).

The Trust is part of a system discharge project to aim to ensure minimal delays to discharge and to improve patient experience.

Average number of patients each month in acute beds that are medically optimised and are ready for discharge

In August the Trust had on average 129 medically optimised patients in beds. This is above the target level of less than 50 patients.

*Note the reporting of the Ready for Discharge numbers here has been amended to reflect both non acute (Aintree 2 Home and Ward 34) as well as acute patient delays.

Overall Utilisation has decreased from 66% to 60% against a target of 85.5%.

Sessions held versus those timetabled decreased from 87.2% to 78.4% and remains below the 97% target.

Number procedures undertaken as a daycase instead of an inpatient compared against expected levels as per DFI

DFI observed day case rate: 85.19%; DFI expected day case rate: 85.55%.

Performance was marginally below expected levels in September (latest available DFI data).
Board Assurance metrics
August 2018

**Description**

- **Improving Services (mental health needs) Presenting to A&E**
  - National CQUIN
  - Project Group established and Q3 actions on track. Cohort of patients with medically unexplained symptoms identified and care plans have been developed. The identified cohort has reduced the cumulative number of attendances to A&E by 45% in August from baseline.

- **Advice & Guidance**
  - National CQUIN
  - An internal project group has been established with relevant clinical and managerial leads and the Trust is providing advice and guidance services for the following specialties: T&O, ENT and ophthalmology. Currently 51% of GP referrals are supported by A&G services. (No available data for April and May 2018)

**Trend**

- **Reduction**
  - Actual vs Plan

**Target**

- Sustainably reduce by 20% the number of attendances to A&E for a selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions. Qtrly milestones to be achieved.

- A & G Services Operational or 35% of GP Referrals by start of Q4. Qtrly milestones to be achieved.
Capital spend against planned programme

Following feedback from NHSI, the planned capital programme initially approved at £18.3m (£3.1m internally generated with a further £15.2m loan) has been revised to a total of £8.0m.

Spend to date is £0.419m against a budget of £0.628m. Spend to date is predominantly against backlog maintenance areas, the car park barriers scheme and the design elements of the Tower Block Cladding scheme.

Reported surplus / (deficit)

I&E performance against the control total

Reported operating surplus in month continues to be above plan. Reported surplus £2.565m, against a planned surplus of £2.399m. Cumulatively at the end of August the Trust is £397k above its cumulative planned surplus. (£166k in month.)

Cash

Cash balances totalled £9.0m against a plan of £1.7m. The positive variance of £7.3m was predominantly related to the receipt of 2017-18 STF Q4 and bonus cash in addition to £5.6m CCG cash in advance of contract income. Consequently, anticipated first drawdown of interim revenue loan has moved to November 2018.

Use of Resources

NHSLs (independent regulator) measure of financial risk

Capital Service Cover: a rating of 4
Liquidty: a rating of 4
I&E %: a rating of 4
I&E % variance from Control Total: a rating of 1
Agency: a rating of 4

Overall, the risk rating is a ‘3’, in line with the plan.
The trust delivered £473k non-recurrent savings in month against a target of £562k. The £473k included £283k of slippage from a review of the Balance Sheet, the balance are savings on drugs, non-recurrent staffing vacancies, and procurement. Cumulatively at 31st August the Trust is £143k behind on its savings plan.

Income is above planned levels in M5 due to increased income from contracts outside of Acting as One.

Operational Expenditure is above plan in month, £122k relating to the pay award funding shortfall. In addition, pay pressures in urgent care/escalation beds continue. High use of agency medics & nursing continues although nurse agency is marginally lower than last month. These pressures are offset by underspends in other areas, additional income, slippage on reserves/ release of non-recurrent slippage from the balance sheet.
Activity is above plan in month by 666 attendances and above plan cumulatively by 982 attendances in Month 5.

Activity was above plan in Month 5 by 309 attendances (347 above Daycases, -37 below Inpatients, cumulatively 779 above Daycases, -618 below Inpatients)

Activity was above plan in Month 5 by 1844 attendances and is above plan cumulatively by 3159 attendances in Month 5.

Activity is above plan in month by 1844 attendances and is above plan cumulatively by 3159 attendances in Month 5.

Activity was above plan in Month 5 by 309 attendances (347 above Daycases, -37 below Inpatients, cumulatively 779 above Daycases, -618 below Inpatients)

Activity undertaken in an outpatient setting

Activity is above plan in month by 666 attendances and above plan cumulatively by 982 attendances in Month 5.

Activity undertaken in an outpatient setting

Daycase and elective inpatient activity

AED and Urgent care admissions are above plan in Month 5 (506 and 643 respectively, cumulatively 2255 and 2566)
**Board Assurance metrics**

**August 2018**

**Finance & Performance**

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**Establishment**

Variation between funded establishment and actuals in post (all staff groups)

(Finance figures)

Est 5034 Actuals 4636; Variance 398

Vacancy Rate: 8.58%

Turnover: 10.73%

Total Live vacancies: 344

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**RN Nursing**

Variation between RN funded establishment and actuals in post

(ESR Pipeline Data - Includes Escalation Area’s)

All registered Nursing Vacancies band 5 to band 7 and Pre Reg - 109.62 FTE inclusive of 8.00 FTE Pre Registration Nurse’s.

Live Registered Nursing Vacancies 78.86 FTE a further 15.00 FTE at offer stage. 10.00 FTE RN’s (inc NQNs) due to start in next 3 months and 46.00 FTE in the next 3 months.

---

**RN Temp Staffing**

Demand and Supply

RN Demand up by 1.23% when compared to Aug 18 (down from 3389 to 3431)

RN Supply up 6.34% when compared to Aug 18 (down from 2260 to 2408)

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**HCA Temp Staffing**

Demand and Supply

HCA Demand down by 8.72% when compared to June 18 (down from 5399 to 4911)

HCA Supply down by 16.50% when compared to June 18 (down from 4803 to 4096)

---

**Description**

**Current position/comments**

**Trend**

**Target**

---

**Finance & Performance**

---

**HCA Temporary Staffing**

Demand and Supply

HCA Demand down by 8.72% when compared to June 18 (down from 5399 to 4911)

HCA Supply down by 16.50% when compared to June 18 (down from 4803 to 4096)

---

**Finance & Performance**

---

**Description**

**Current position/comments**

**Trend**

**Target**

---

**Finance & Performance**

---

**Description**

**Current position/comments**

**Trend**

**Target**

---

**Finance & Performance**

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**Description**

**Current position/comments**

**Trend**

**Target**

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**Finance & Performance**

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**Description**

**Current position/comments**

**Trend**

**Target**

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**Finance & Performance**

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**Description**

**Current position/comments**

**Trend**

**Target**

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**Finance & Performance**

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**Description**

**Current position/comments**

**Trend**

**Target**

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**Finance & Performance**

---

**Description**

**Current position/comments**

**Trend**

**Target**

---
Total Core & Non-Core Pay Spend

Combined spend on "Non Core" i.e. above substantive/contracted hours

Total Pay Spend: £19,966,280 (2017/18, £17,760,417)
Core Pay Spend Total: £17,294,648 (2017/18, £15,945,708)
Non Core Spend Total: £2,604,600 (2017/18, £2,348,507)
Bank: £1,061,305 (2017/18, £787,919)
Agency: £1,047,643 (2017/18, £1,319,941)
WLI: £95,154 (2017/18, £44,487)
OT: £118,073 (2017/18, £194,195)

Non-Core i.e. above substantive/contracted hours = Plan or better

Description
Current position/comments
Trend
Target

Finance & Performance

Agency Spend

Amount spent on Agency shifts in total for all staff groups

Performance: £1,047,643 (2017/18, £1,319,941)
Medical: £445,561 (Aug 17 - £329,094)
Nursing: £422,902 (Aug 17 - £737,852)
AHP/P&T: £103,665 (Aug 17 - £88,277)
Support Staff & Maintenance: £32,131 (Aug 17 - £68,739)
Admin: £37,820 (Aug 17 - £59,522)
Senior Managers: £5,564 (Aug 17 - £36,425)

Target < 5% of total agency shifts filled (Overides / Total Agency Shifts = %)

Finance & Performance

Agency Shifts Over Cap

Shifts approved over NHSI capped rates

All Staff Performance 870/2048 = 42.48%
Medical: 573/573 = 100%
Nursing/AHP/Prof & Tech: 306/1208=.25.33%
Longest Agency Appt: 18 months
Highest Cost Agency: £129

Finance & Performance

Attendance Rates

% delivery against target compliance

Graph shows the rolling average attendance rate, which remains below the target of 96%.
Performance: 95.66% (4.34% Attendance)
Long term absence (greater than 28 days) accounts for 68.87% of absences.
Attendance rates (ABS):
Medicine 94.88%; Surgery 95.24%; DSS 96.22%; Corporate 97.33%; E&F 94.27%; Ops Mgmt 99.87%
### Performance
- 78.11% - The figure is now calculated using competencies as opposed to heads.
- Estates and Facilities 83.14%, Ops Mngt 67.75%, Corporate 81.33%, Medicine 77.68%, Surgery 74.07%.

### Training and appraisal compliance
- Scrutinised via the Divisional Workforce and Education groups.

### Trend

<table>
<thead>
<tr>
<th>Month</th>
<th>60%</th>
<th>65%</th>
<th>70%</th>
<th>75%</th>
<th>80%</th>
<th>85%</th>
<th>90%</th>
<th>95%</th>
<th>100%</th>
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</table>

### Target
- >85%
To achieve our improvement target this year we must have no more than 70 Category 2 Pressure Ulcers in 2018-19 (5.8/month). We have also set an aspirational threshold of zero Category 3-4 pressure ulcers with lapses in care during 2018-19. In August 2018, we had a total of 6 Category 2 hospital acquired pressure ulcers. This gives a total of 35 Category 2 pressure ulcers during April to July 2018-19. This means we are currently over our trajectory by a total of 10 against a target of 35 at end Q2. There has been a total of 0 Category 3/4 hospital acquired pressure ulcer verified in August. This equates to a total of 6 Category 3/4 verified in 2018/19 against the aspirational threshold of zero with lapses in care.

Each Grade 3 and 4 ulcer is investigated and the root cause and any lapses in care will then determined with lessons learned shared.

### Proposed actions:

<table>
<thead>
<tr>
<th>Action</th>
<th>Owner</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Root cause analysis is underway to be presented at Pressure Ulcer Prevention Group and roll-out of lessons learned</td>
<td>Monica Moore and Jan Dainty</td>
<td>31-Mar-19</td>
</tr>
<tr>
<td>Collaborative working with Cheshire and Merseyside Pressure Ulcer Action Group to develop a consistent approach to pressure ulcer reduction.</td>
<td>Monica Moore TVN</td>
<td>31.03.2019</td>
</tr>
<tr>
<td>An At risk foot event took place on the 10th April 2018 to highlight best practice for offloading with further pressure ulcer prevention events planned in Q1-Q4</td>
<td>Monica Moore TVN</td>
<td>31.03.2019</td>
</tr>
<tr>
<td>Targeted training to areas with high incidence of hospital acquired pressure ulcers is ongoing. Quality Improvement clinics will be undertaken in the divisions.</td>
<td>Monica Moore TVN</td>
<td>31.03.2019</td>
</tr>
<tr>
<td>Safety walkrounds will be completed and triangulation work in progress. Workstreams form part of the overarching Pressure Ulcer Improvement plan 2018-19</td>
<td>Jan Dainty Lead Nurse</td>
<td>31.03.2019</td>
</tr>
<tr>
<td>Quality Improvement Ward Safety Clinics are ongoing with a focus on Pressure Ulcer Prevention and Falls Prevention. This work remains in progress for Q1-Q4 2018-19</td>
<td>Jan Dainty Lead Nurse</td>
<td>31.03.2019</td>
</tr>
<tr>
<td>As part of the NHSI 'National Stop the Pressure' Pressure Ulcer collaborative the ‘React to Risk’ in the Sskin Bundle work is being rolled out during Q2</td>
<td>Jan Dainty, Lead Nurse</td>
<td>Oct-18</td>
</tr>
<tr>
<td>The Corporate team is supporting best care in the Emergency Department (ED) testing the Sskin Bundle approach to care and a Comfort Round Tool specifically for the needs of ED patients</td>
<td>Jan Dainty, Lead Nurse</td>
<td>Oct-18</td>
</tr>
</tbody>
</table>

### Forecast for improvement:

<table>
<thead>
<tr>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
</table>

An aspirational target of zero hospital acquired Category 3 or 4 pressure ulcers with lapses in care during 2018-19 with no more than 5 Category 2 Pressure ulcers/month.
### Proposed actions:

<table>
<thead>
<tr>
<th>Action</th>
<th>Owner</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement a phased flow improvement plan that involves all improvement work in the department and is monitored through the senior team for the CBU and reported into the Executive Lead NEF Group.</td>
<td>PA</td>
<td>Oct-18</td>
</tr>
<tr>
<td>Following review of PCS, implement a more effective staffing model which will potentially incorporate the GP’s already working in the department and review and update the referral criteria to increase the throughput into the service. Following a recent deep dive review the use of ACC at weekends will be revisited to determine whether there is a demand at weekends (previous audit did not evidence requirement).</td>
<td>RW</td>
<td>Oct-18</td>
</tr>
<tr>
<td>Complete Electronic Flow (NEF) dashboard to enable reliable data to be used to drive decision making. Dashboard has been developed for ED, ACC and assessment areas; development for site team KPI’s in progress to support flow from the department once decision is made to admit.</td>
<td>VJ</td>
<td>Oct-18</td>
</tr>
<tr>
<td>A four day Rapid Process Improvement Workshop is scheduled for 25th to the 28th September to focus on the pathway from registration to discharge from ED and Trial. This has two broad aims - one is to improve the resilience of the pathway by removing waste and increasing throughput and the other is to explore ways in which we can better address surge. The actions from the workshop will be implemented within 4-6 weeks after the event. The CBU will then aim to undertake a Rapid Improvement Event every 3-6 months thereafter. The department has instigated a deep dive desk top session looking at times when the department was particularly busy in the last 12 months.</td>
<td>RH</td>
<td>Sep-18</td>
</tr>
</tbody>
</table>

### Accident and Emergency Department August 2018

The department achieved its performance for the 4 hour standard at 88.98% (T1 and T3) representing an increase from July 18. This increase is the highest in the last 12 months. Ambulance handover performance saw a decrease in the number of delays in excess of 30 minutes to 89 (-41) there was also a decrease in the number of delays in excess of 60 minutes to 28 (-26). The average time from notification to handover saw the best it has been for the last 12 months at 9.09 minutes 44 secs. The median time to see 1st clinician has decreased to 63 minutes (-21) in August against the 45 minute clinical quality indicator. The % of patients seen from registration within 15 minutes has increased to 83.83% (↑-3.63%) from July 74.20%. The clinical quality indicators for the number of patients who leave the department before being seen has decreased to 3.72% from 5.17% in July (+-1.45%). Patients re-attending in August has also decreased to 9.15% against July 14.82% (+-5.67%).
EXCEPTION REPORT
Indicator: DMO1 6 Week Standard

Issue: DMO1 - 2.7% against <1% Standard
During August 14 of the 827 patients on the active waiting list for an endoscopic test waited over 6 weeks for their appointment. Endoscopy has continued to experience pressures with capacity due to a continued increase in colorectal cancer referrals. All patients were allocated a date for their procedure within 6 weeks for the August end of month position however due to a number of 2ww referrals requiring prioritisation within 8 days the patients were moved to dates in early September breaching the DMO1 standard by a couple of days but not causing any clinical concern.

Proposed actions:

<table>
<thead>
<tr>
<th>Action</th>
<th>Owner</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional WLI activity continues to cover the Consultant vacancy.</td>
<td>Jeni Carden-Jones</td>
<td>Oct-18</td>
</tr>
<tr>
<td>Weekly capacity meetings continue with operational and clinical teams to maximise the utilisation of capacity.</td>
<td>Jeni Carden-Jones</td>
<td>Oct-18</td>
</tr>
<tr>
<td>Additional bank administration support are doing telephone reminders 7 days in advance. This approach has seen a reduction in DNA’s to below the national average</td>
<td>Carl Hancox</td>
<td>Oct-18</td>
</tr>
<tr>
<td>A full case of need is being prepared to present to the executive team at September’s Board.</td>
<td>Jeni Carden-Jones</td>
<td>Oct-18</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
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<tbody>
<tr>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
</tr>
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</table>

Additional data (historic):

<table>
<thead>
<tr>
<th>DMO1 August 18 - 2.7%</th>
<th>06 &lt; 07 Weeks</th>
<th>07 &lt; 08 Weeks</th>
<th>08 &lt; 09 Weeks</th>
<th>09 &lt; 10 Weeks</th>
<th>10 &lt; 11 Weeks</th>
<th>11 &lt; 12 Weeks</th>
<th>12 &lt; 13 Weeks</th>
<th>13 plus Weeks</th>
<th>Total WL</th>
<th>Over 6 Weeks</th>
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<tr>
<td>Colonoscopy</td>
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<td>0</td>
<td>308</td>
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<td>Flexible sigmoidoscopy</td>
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<td>0</td>
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<td>Gastroscopy</td>
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<td>1</td>
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<td>Total</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>827</td>
<td>14</td>
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Lead: Joanne Eccles - DDO Surgery
Executive Lead: Beth Weston - COO
Radiology continues to experience a sustained increase in demand for Imaging (CT Cardiac, MR Cardiac, MR MSK and Ultrasound MSK). Demand is in excess of funded capacity. Additional Inpatient activity has a consequence, reducing Outpatient capacity for CT and MR. The following additional sessions have been agreed via Resource panel for September:

- 35 CT sessions
- 35 MR sessions
- 56 Ultrasound sessions (including joint injections - 4 sessions)

The demand for Cardiac Imaging is impacting on performance against this standard. Wait for general CT, MR and Ultrasound is 6 weeks or less. Patients waiting longer than this time are for Cardiac CT and MR, in addition to MSK ultrasound.

### Proposed actions:

- Weekly capacity meetings with operational and clinical teams to monitor performance and maximise capacity.
- Additional MSK sessions agreed through resource panel.
- Cardiac Imaging recovery plan to be developed in order to reduce the wait for these tests.
- MSK Radiologist recruited and commenced at Trust 1st May 2018. Induction period extended, so not yet undertaking US injection sessions. This was expected to continue in October 2018.
- Mobile MR Van on site 1 week in 8, August dates were increased to 15 days. Continue to recruit to CSI. Continue to engage Locum Radiographers.
- Forecast for improvement:
  - Q1
  - Q2
  - Q3
  - Q4

### 2nd July 2018

<table>
<thead>
<tr>
<th>Diagnostic type</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13+</th>
<th>Total</th>
<th>6 wks &amp; Over</th>
<th>% 6 wks &amp; Over</th>
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<td></td>
<td></td>
<td>1277</td>
<td>23</td>
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<td>7</td>
<td>11</td>
<td>4</td>
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<td>935</td>
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### 6th Aug 2018

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<th>9</th>
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<th>13+</th>
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### 3rd Sept 2018

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<th>9</th>
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<th>13+</th>
<th>Total</th>
<th>6 wks &amp; Over</th>
<th>% 6 wks &amp; Over</th>
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</table>
**EXCEPTION REPORT**
Indicator: Stroke 90% Stay August 2018

### Issue:
Performance against the 90% stay standard was 74.46% for August 2018. 47 patients with a diagnosis of stroke were discharged from the Trust during the month. 35 patients spent 90% of their stay on the Stroke Unit, the standard was not achieved for 12 patients. All breaches of the standard are reviewed and reasons for underperformance identified:
- 7 patients required admission to the Stroke Unit but no beds were available
- 1 patient arrived during the night when there was no Stroke Nurse on duty
- 2 patients were atypical presentations and diagnosed after MRI
- 1 patient was transferred to a medical bed for palliative care
- 1 patient was a late referral to the Stroke team. MRI confirmed diagnosis

### Proposed actions:
<table>
<thead>
<tr>
<th>Action</th>
<th>Owner</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement agreed workforce plan to include a review of Stroke Nurse Clinician capacity, ANP, therapy and Band 6 posts. Open 4th HASU bed</td>
<td>M Roberts/A McAvoy</td>
<td>Q2</td>
</tr>
<tr>
<td>Provide Full-Time dedicated Discharge Planner for the Stroke Unit supported by a Discharge Planning Assistant to improve flow out of the unit</td>
<td>M Roberts/Michelle Callan</td>
<td>Q2</td>
</tr>
<tr>
<td>Improve time to senior review in the Emergency Department 8pm to 9am to ensure timely transfer of patients from ED to the Stroke Unit</td>
<td>L Roberts/C Cullen</td>
<td>Q2</td>
</tr>
<tr>
<td>Implement training programme across ED and AMU to improve referral process to the stroke team</td>
<td>C Cullen/M Roberts</td>
<td>Q2</td>
</tr>
<tr>
<td>Embed daily operational meetings to review stroke performance, outliers and discharges to include stepdown beds on A2H and Ward 34</td>
<td>M Roberts/L Roberts</td>
<td>Q2</td>
</tr>
<tr>
<td>Improve SSNAP score for Speech and Language and MDT working</td>
<td>A McAvoy</td>
<td>Q2</td>
</tr>
</tbody>
</table>

### Forecast for improvement:

<table>
<thead>
<tr>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>A</td>
<td>G</td>
<td>B</td>
</tr>
</tbody>
</table>

### Additional data (historic)

**Stroke Performance % - (90% stay on a stroke ward)**

- **Achieved standard**
- **Breaches of standard**
- **Performance %**

**Lead:** Neil Holland - DD - Specialist Medicine

**Executive Lead:** Beth Weston - COO
EXCEPTION REPORT
Indicator: RTT Incomplete Pathway Performance

**Issue:**
Performance against the national standard of 92% of pathways to start treatment within 18 weeks from referral was below target in August at 89.3%. Incomplete pathway totals 18,935 which is an increase of 232 against July’s position.

The significant non-elective pressure experienced at the Trust over the winter period impacted on RTT performance from which the Trust has not yet fully recovered. The increase in non elective demand continues to be compounded by an increase in the number of elective lists being cancelled to accommodate increased urgent trauma cases.

The Trust has also experienced an increased GP demand of 2.5% above agreed plans with commissioners, compounded by patients attending AED subsequently being added to the elective waitinglist which is adding to the increased demand on followup capacity. Cancellations and Did Not Attend (DNA) rates continue to be scrutinised and actions taken to reduce these. The Trust is maximising its capacity with patients being booked into all available clinic capacity as well as additional waiting list sessions although this is adding to the overall waiting times.

**Proposed actions:**

<table>
<thead>
<tr>
<th>Action</th>
<th>Owner</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve theatre utilisation at specialty level.</td>
<td>BDO Surgery</td>
<td>Q2</td>
</tr>
<tr>
<td>Regularly review all long waiting patients within the clinical business units to address capacity issues and undertake WLI’s where available in conjunction with weekly performance meetings with Planning and performance / Business Intelligence leads.</td>
<td>CBMs</td>
<td>Aug-18</td>
</tr>
<tr>
<td>Recruitment of additional EGSU consultants in progress.</td>
<td>Jeni-Carden-Jones</td>
<td>Sep-18</td>
</tr>
<tr>
<td>Continue to support the reduction in Endoscopy waits by supporting WLI scope lists using dropped sessions in the week and additional sessions at weekends.</td>
<td>Jeni-Carden-Jones</td>
<td>Jul-18</td>
</tr>
<tr>
<td>Continued weekly monitoring of diagnostics waiting times to ensure delivery of the 6 week standard as a milestone measure for RTT performance. This to include horizon scanning and capacity / demand planning with Head of Planning and performance.</td>
<td>Carol Baker</td>
<td>Q2</td>
</tr>
<tr>
<td>Continue to meet with ACBMs on a weekly basis to focus on data quality, capacity &amp; demand and pathway validation.</td>
<td>Ian Stewart</td>
<td>Q2</td>
</tr>
<tr>
<td>Continue to support the CBU’s with their RTT validation processes and Standard Operating procedures with a special focus on inter Provider Transfers and data recording / Entry.</td>
<td>Ian Stewart</td>
<td>Q2</td>
</tr>
</tbody>
</table>

**Forecast for improvement:**

<table>
<thead>
<tr>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
</table>

**Lead:** Ian Stewart - Planning and performance

**Executive Lead:** Beth Weston - COO
### Exception Report

**Indicator:** Cancer Performance Exception Report

#### Issue:
The Trust is required to achieve a range of performance targets for Cancer diagnosis and treatments. Performance for each target is validated and finalised around five weeks after the end of the month. Therefore August’s performance is finalised at the beginning of October 2018. The figures in this exception report are therefore likely to change. Currently the Trust is predicted to fail the following targets for August 2018:

- 14 day to first appointment
- Symptomatic Breast (where Cancer is not initially suspected)
- 62 day from referral to treatment
- 31 days subsequent surgical treatment

In August there were significant pressures from increased demand in high volume specialties, specifically in Colorectal, Urology and Head and Neck. The number of patients on a 62-day pathway is 1107 compared to 790 this time last year (30% increase in patients on pathway). There are still a number of patients who choose to delay their pathways because of holiday and work commitments. There are also capacity issues for surgery in other organisations to which the Trust refers patients (e.g. urology at RLBUH). Annual leave in July and August also resulted in reduced capacity in the Tumour groups.

Increased demand has also impacted on Diagnostic services because all patients referred as suspected cancer have to receive the appropriate diagnostic to either confirm or exclude a cancer diagnosis.

#### Proposed actions:

<table>
<thead>
<tr>
<th>Action</th>
<th>Owner</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly Senior Operations Team briefings taking place with focus on measures to reduce delays including those due to patient diagnosis from CCUs or diagnostics. Targeted work lists are now produced to provide focus and remove barriers to the patient journey.</td>
<td>Lead Cancer Services management team/ DDOs and ODHs</td>
<td>Q2</td>
</tr>
<tr>
<td>Meeting dates are now confirmed with the Cancer Alliance to review specific pathways and to highlight reasons for late referrals from other Trusts for areas such as Head and Neck.</td>
<td>Lead Cancer Nurse/Cancer Services team</td>
<td>Q2</td>
</tr>
<tr>
<td>Review of Capacity and Demand undertaken with information shared with Senior Operations Team. Information has been provided to particularly focus on 14 day target and the number of patients who are being booked between 7 and 14 days. This will reduce patient initiated delays at the start of the pathway in line with NICE guidance.</td>
<td>Cancer Management Team/Divisional Director DSS</td>
<td>Q2</td>
</tr>
<tr>
<td>Increased collaborative working with CCG Colleagues CCGs to ensure that delays in patient pathways because of patient choice or delayed results are minimised.</td>
<td>Cancer services management team</td>
<td>Q2</td>
</tr>
</tbody>
</table>

#### Cancer Performance Standards August 2018

<table>
<thead>
<tr>
<th>Indicator</th>
<th>July 2018</th>
<th>August 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment - %</td>
<td>89.0%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Percentage of patients referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment - %</td>
<td>87.9%</td>
<td>90.1%</td>
</tr>
<tr>
<td>Percentage of patients waiting no more than one month (31 days) from decision to treat to first definitive treatment for all cancers - %</td>
<td>129/142</td>
<td>118/130</td>
</tr>
<tr>
<td>Percentage of patients waiting no more than 31 days from referral from an urgent GP referral to first definitive treatment for cancer</td>
<td>96.7%</td>
<td>96.7%</td>
</tr>
<tr>
<td>Percentage of patients waiting no more than 31 days for subsequent treatment where that treatment is surgery - %</td>
<td>100%</td>
<td>93.9%</td>
</tr>
<tr>
<td>Percentage of patients waiting no more than 31 days of subsequent surgical treatment</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Percentage of patients waiting no more than 62 days from referral from an urgent GP referral to first definitive treatment for cancer - %</td>
<td>93.9%</td>
<td>96.0%</td>
</tr>
<tr>
<td>Percentage of patients waiting no more than 62 days from referral from an urgent GP referral to first definitive treatment for cancer - %</td>
<td>77.4%</td>
<td>81.8%</td>
</tr>
<tr>
<td>Percentage of patients waiting no more than 2 months (62 days) from first outpatient appointment</td>
<td>1107/1187</td>
<td>87.9%</td>
</tr>
<tr>
<td>Percentage of patients waiting no more than 3 months (90 days) from decision to treat to first definitive treatment for all cancers - %</td>
<td>88.4%</td>
<td>100%</td>
</tr>
<tr>
<td>Percentage of patients waiting no more than 3 months of subsequent surgical treatment</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Percentage of patients waiting no more than 6 months of subsequent surgical treatment</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Percentage of patients waiting no more than 6 months from referral from an urgent GP referral to first definitive treatment for cancer - %</td>
<td>92.3%</td>
<td>98.3%</td>
</tr>
<tr>
<td>Percentage of patients waiting no more than 6 months of subsequent treatment where that treatment is a cancer drug regimen - %</td>
<td>98.3%</td>
<td>100%</td>
</tr>
<tr>
<td>Percentage of patients waiting no more than 6 months of subsequent treatment where that treatment is a course of radiotherapy</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Percentage of patients waiting no more than 6 months of subsequent treatment where that treatment is an anti-cancer drug regimen - %</td>
<td>92.7%</td>
<td>100%</td>
</tr>
<tr>
<td>Percentage of patients waiting no more than 6 months of subsequent treatment where that treatment is a course of radiotherapy</td>
<td>92.7%</td>
<td>100%</td>
</tr>
<tr>
<td>Percentage of patients waiting no more than 6 months of subsequent treatment where that treatment is a course of radiotherapy</td>
<td>128/141</td>
<td>102/104</td>
</tr>
<tr>
<td>Percentage of patients waiting no more than 6 months of subsequent treatment where that treatment is an anti-cancer drug regimen - %</td>
<td>92.7%</td>
<td>100%</td>
</tr>
</tbody>
</table>

#### Proposed actions:

<table>
<thead>
<tr>
<th>Action</th>
<th>Owner</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer services management team/ DDOs and ODHs</td>
<td>Q2</td>
<td></td>
</tr>
<tr>
<td>Lead Cancer Nurse/Cancer Services team</td>
<td>Q2</td>
<td></td>
</tr>
<tr>
<td>Cancer Management Team/Divisional Director DSS</td>
<td>Q2</td>
<td></td>
</tr>
<tr>
<td>Cancer services management team</td>
<td>Q2</td>
<td></td>
</tr>
</tbody>
</table>

#### Executive Lead:

Phil Downey DDO, Diagnostic and Support Services

Beth Weston COO
EXCEPTION REPORT
Indicator: Staff fill rates - page 1 of 2 Month 05

Overview:
This month six wards reported a daytime fill rate of less than 80% for Registered Nurses (RNs): Ward 19 (76.4%), Ward 24 (75.7%), Ward 15 (78.4%), ACCU (78.1%), A2H (72.7%) and Ward 25 (27.9%). Ward 25 has reduced to 18 beds throughout the whole month of August, and has on occasion reduced to 11 beds. The CHPPD for ward 25 has remained at 6.2 hours which is a more accurate indicator of safe staffing levels. Ward 15 establishment contains Band 4 Domestic Assistants who are qualified in performing dialysis, but are reported as unqualified numbers.

All of the above wards showed that CHPPD remained above 5.7: Ward 19 (17.4), Ward 24 (6.4) Ward 15 (5.7), ACCU (10.7), A2H (8.2).

Safe nurse staffing was also supported by the Ward Managers working clinically to deliver patient care.

It should be noted that the nursing fill rate data measures the percentage of RNs on duty against the planned establishment for the ward, which does not include the additional nurses required to support any additional escalation beds.

In addition, the data reflects the overarching percentage of actual RNs on duty (against planned), and it does not identify the percentage of those RNs who are employed by the Trust and those who are from a Nursing Agency.

The NHSE template also identifies those wards with a variance in the planned and actual number of Health Care Assistants (HCAs) on duty, specifically in relation to those wards with >150% fill rates. A Trust wide review is currently underway around the Enhanced Observation Policy and processes, at the request of the Chief Nurse.

An overview of the outlier wards for each of the Divisions is provided below, in conjunction with a rationale and/or any mitigating actions that are in place.

Additional info (Divisions)

- In total, four wards within the Division reported HCA fill rates of >150% on nights in August 2018, with only one area reporting high fill rates for both day and night shifts. The rationale for the high use of HCAs is, as previously indicated, the continued increase in patient dependency levels and the use of ‘specials’ and 1:1 care to support safe care for cognitively impaired patients. In addition, HCAs have been utilised on occasion to support unfilled RN shifts on those wards with RN vacancies. Additional HCAs were also required to support the ‘flexing up’ of inpatient beds to meet increased demand (for example, on the Frailty Assessment Unit (FAU) and Ward 8).

- Four wards reported a HCA fill rate of >200% on nights during August 2018: Ward 8 (212.9%), Ward 24 (216.1%), Ward 20 (212.6%) and the Frailty Assessment Unit (254.8%). This relates to the escalation capacity and patients requiring Level 3-4 enhanced observations.

- Ward 8 continues to have an additional eight beds open. There were also an additional 51 beds opened across the winter pressure wards during August 2018. FAU increased its bed base by an additional 6 beds on an ‘ad hoc’ basis during the month, resulting in HCA fill rates of >100% on some shifts.

- Supervisory Ward Managers regularly support direct patient care to ensure that the staffing risks are shared across the Division. Further mitigating actions include the block booking of agency nurses and twice daily Matron meetings. All ward areas are risk assessed on a daily basis and staff are moved to support areas with a high number of vacancies to ensure continuity of care for patients. There is also a rolling recruitment programme in place for a number of wards within the Division.

- During August 2018, there were three moderate and above harm incidents confirmed on inpatient wards in the Division of Medicine:

  i) Patient on haemodialysis and their needle became dislodged resulting in heavy bleeding; patient became unresponsive and required a MET call (Moderate)

  ii) Patient had an unobserved fall resulting in a fractured neck of femur (Moderate)

  iii) Patient had an unobserved fall resulting in a fractured neck of femur (Moderate)

A concise root cause analysis investigation is ongoing into each incident at present and will determine if sub-optimal staffing was a contributory factor. The incident investigations and accompanying action plans will be approved at Weekly Meeting of Harm.
Three Wards within the Division reported HCA fill rates of >150% during August 2018, with two wards reporting this percentage for both day and night shifts. The increased use of HCAs is related to high patient dependency levels and the use of ‘specials’ to support safe care, and demonstrates the number of highly dependent patients requiring 1:1 care. Additional HCAs were also required to support the ‘flexing up’ of inpatient beds.

To support an increase in orthopaedic trauma, there has been an increase in beds throughout August; the nine additional escalation beds on Ward 17 have now been permanently funded.

During August 2018, there were three moderate and above harm incidents confirmed on inpatient wards in the Division of Surgery:

(i) Patient was given a gentamicin overdose resulting in acute kidney injury (Moderate)
(ii) Patient had with a new diagnosis of Crohn’s disease was lost to follow-up for 2 years (Moderate)
(iii) Patient admitted with provisional diagnosis of Crohn’s disease leading to small bowel obstruction. CT delayed with eventual diagnosis of perforation leading to surgery (Moderate)

A concise root cause analysis investigation is ongoing into each incident at present and will determine if sub-optimal staffing was a contributory factor. The incident investigations and accompanying action plans will be approved at Weekly Meeting of Harm.

A process is in place within each Division to identify any shortfalls in nurse staffing on a daily basis, and this is also discussed and addressed during Matrons Safety Huddle. Any plans and decisions are overseen and approved by the Divisional Directors of Nursing/AHP, and any shortfall in nurse staffing out of hours is escalated and addressed by the Clinical Manager on Site.

A review of nurse staffing establishments has been completed and demonstrates an ongoing increase in patient acuity and dependency studies. This information is used to advise the Board of Directors on proposed changes to nursing establishments to support a sustainable and reliable staffing model which will meet the needs of our patients and reduces our reliance on additional temporary staff. The biannual Safe Nurse Staffing report has been given approval and is currently being implemented.
<table>
<thead>
<tr>
<th>Agenda Item (Ref)</th>
<th>B18-19/080</th>
<th>Date of Meeting: 26 September 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report to</td>
<td>Board of Directors</td>
<td></td>
</tr>
<tr>
<td>Report Title</td>
<td>Finance Report, M5 2018-19</td>
<td></td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Ian Jones, Director of Finance &amp; Business Services</td>
<td></td>
</tr>
<tr>
<td>Lead Officer</td>
<td>Paul Brannelly, Deputy Director of Finance</td>
<td></td>
</tr>
<tr>
<td>Action Required</td>
<td>To review &amp; agree actions</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Substantial assurance</th>
<th>Acceptable assurance</th>
<th>Partial assurance</th>
<th>No assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>High level of confidence in delivery of existing mechanisms / objectives</td>
<td>General confidence in delivery of existing mechanisms / objectives</td>
<td>Some confidence in delivery of existing mechanisms / objectives</td>
<td></td>
</tr>
</tbody>
</table>

**Key Messages of this Report (2/3 headlines only)**

- The Trust has a slightly higher deficit than its planned deficit position for the month.
- Activity is above plan overall, but elective activity behind plan in month. Outpatient, AED attendances and urgent care admissions remain up.
- Expenditure pressures have continued in both Medical and Nurse staffing.
- CIP is behind plan and progress is being made on the identification of new schemes.
- Cash remains positive, with revenue support expected from November

**Impact (is there an impact arising from the report on the following?)**

- Quality
- Finance
- Workforce
- Equality
- Risk
- Compliance
- Legal

**Equality Impact Assessment (if there is an impact on E&D, an Equality Impact Assessment must accompany the report)**

- Strategy
- Policy
- Service Change

**Strategic Objective(s)**

- Deliver outstanding care
- Achieve best patient outcomes
- Promote research and education
- Deliver sustainable healthcare to meet people’s needs
- Provide strong system leadership
- Be a well-governed and clinically-led organisation

**Governance (is the report a……?)**

- Statutory requirement
- Annual Business Plan Priority
- Key Risk
- Service Change
- Other

**Next Steps (actions following agreement by Board/Committee of recommendation/s)**
## REPORT HISTORY

<table>
<thead>
<tr>
<th>Committee / Group Name</th>
<th>Agenda Ref</th>
<th>Report Title</th>
<th>Date of submission</th>
<th>Brief summary of key issues raised and actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance &amp; Performance Committee</td>
<td></td>
<td>Finance Report</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td>Board of Directors</td>
<td></td>
<td>Finance Report</td>
<td>Monthly</td>
<td></td>
</tr>
</tbody>
</table>
Finance & Performance Committee – Update

Finance Report, M5 2018-19

Key Messages of this Report

- Financially the Trust is £0.397m worse than the planned Deficit of £11.698m, of which £0.153m relates to the shortfall in the pay award.

Background

1. This paper presents the activity and financial performance data for August 2018 (Month 5) against NHSI’s contracts and internal standards.

Key Issues

2. Main issues for August 2018:
   - The Trust reported a cumulative operating deficit of £12.055m against a planned deficit of £11.698m.
   - Planned care performed above plan, with elective activity below plan in month by 37 spells (Medicine +10, Surgery -42, -5 Clinical Support). Outpatient workload was up by 2,510 attendances in month, AED attendances were up in month, NE admissions were above the contract plan by +643 spells.

Figure 1: Activity Performance

<table>
<thead>
<tr>
<th>Type of Activity Summary</th>
<th>Activity - Plan</th>
<th>Activity - Actual</th>
<th>Activity - Variance</th>
<th>Cumulative Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
<td>2018/19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accident and Emergency</td>
<td>13,603</td>
<td>14,109</td>
<td>506</td>
<td>3.7%</td>
</tr>
<tr>
<td>Day case</td>
<td>3,118</td>
<td>3,465</td>
<td>347</td>
<td>11.1%</td>
</tr>
<tr>
<td>Elective Admission</td>
<td>657</td>
<td>620</td>
<td>(37)</td>
<td>-5.7%</td>
</tr>
<tr>
<td>Emergency Admission</td>
<td>4,071</td>
<td>4,714</td>
<td>643</td>
<td>15.8%</td>
</tr>
<tr>
<td>Outpatient First Attendance</td>
<td>8,063</td>
<td>8,320</td>
<td>257</td>
<td>3.2%</td>
</tr>
<tr>
<td>Outpatient Follow Up</td>
<td>17,568</td>
<td>18,986</td>
<td>1,418</td>
<td>8.1%</td>
</tr>
<tr>
<td>Outpatient Procedures</td>
<td>4,497</td>
<td>5,294</td>
<td>797</td>
<td>17.7%</td>
</tr>
<tr>
<td>ARMD</td>
<td>405</td>
<td>443</td>
<td>38</td>
<td>9.4%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>51,982</td>
<td>55,951</td>
<td>3,969</td>
<td>9.13%</td>
</tr>
</tbody>
</table>
• Medical Divisions position was above plan in month by £0.197m, cumulatively below plan by -£0.530m to date a variance of -4.52%.

• Surgery’s position was behind plan in month by -£0.166m and -£2.862m to date a variance of -21.27%.

• Clinical Support Services performed close to plan and Corporate functions performed better than budget.

• Spend on agency against the Trust plan and the agency cap is higher than planned by £2.472m, but is showing a declining trend as nurse vacancies reduce and the control measures put in place take hold. The Trust continues to experience record levels of demand through AED, with the subsequent impact on admissions leading to the continuation of c52 escalation beds open above the revised bed base for 18/19. This pressure is a significant factor in the level of agency spend being incurred.

• The non-recurrent nature of this additional capacity is fueling agency spend, with an estimated impact of c£2.7m to-date (primarily medics/nursing). Excluding this estimated cost, agency spend would have been close to our planned run-rate for the period.

• Based on the current level of agency spend, the Trust has a rating of 4 against its ‘Use of Resources Rating’, where performance against the agency cap is a key measure.

Figure 2: Agency Spend Vs Cap

<table>
<thead>
<tr>
<th>Period</th>
<th>Q1</th>
<th>Q2 (to date)</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency Plan</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>Actual Agency</td>
<td>(£2.662)</td>
<td>(£1.514)</td>
<td></td>
<td></td>
<td>(£4.176)</td>
</tr>
<tr>
<td>Agency Ceilings</td>
<td>(£4.854)</td>
<td>(£2.294)</td>
<td></td>
<td></td>
<td>(£6.148)</td>
</tr>
<tr>
<td>Spend above Plan</td>
<td>(£1.692)</td>
<td>(£0.790)</td>
<td>0.000</td>
<td>0.000</td>
<td>(£2.472)</td>
</tr>
</tbody>
</table>

• Productivity and efficiency delivery was below target in month and largely achieved through the consolidation of annual non-recurrent corporate service savings.

• Financial Sustainability Risk Rating, (FSRR) of 3.

• Cash balances remain positive during August. The trust has forecast that cash balances will be sufficient until November 2018 after which time revenue support is forecast will be required.

• The trust has an annual planned deficit of £29.1m. It is essential that in achieving the annual plan targets that all budget holders must manage and control spend within their annual budgets. During August a number of areas have spent considerably in excess of their budgetary plans and urgent work is now required to understand the reasons for this and to ensure that measure are put in place to manage this over the coming months.
3. Director of Finance & Business Services Commentary

The Trust has reported an operating deficit of £12.055m, against a planned deficit of £11.658m for the month.

The Acting as One (AaO) contractual arrangements remain in place and fixes the income values paid by the trusts main commissioners, (with the exception of pass through payments e.g. High cost drugs which will continue to be recompensed at cost). Under a pure PbR contract income would have been £2.3M above plan, albeit this would have been offset by potential contract sanctions of c£1.7M.

Overall activity was above plan, with the upward trend in AED attendances and medical urgent care admissions continuing. Elective activity was close to plan, with daycases offsetting the reduction in elective inpatients. Outpatients are ahead of plan, with a slight shortfall in first attendances offset by significant increases in follow-ups and outpatient procedures.

For planned care (day cases and inpatients) the cumulative positive position of +161 spells is positive, however at a more granular level the over performances in cardiology (+691) and haematology (+243) masks a general under delivery in other areas, particularly within surgery. T&O are some -357 below plan, ENT -101, Ophthalmology -175, MFU -101 and General Surgery -105. This shortfall in elective throughput is a factor in the RTT performance and theatre productivity remains sub-optimal.

Movement in operational pay lines shows an increase in the overspend of £0.547m in month. The principle areas continue to be nursing, over plan in month £0.147 cumulatively £0.809m, and medical staffing costs (agency Pods\WLIs) showing -£0.232m over plan in month no cumulatively -£0.995m. A significant proportion of this is directly associated with the additional capacity and associated agency spend.
3. Director of Finance & Business Services Commentary (cont’d)

- Movement in operational pay lines shows an increase in the overspend of £0.547m in month. The principle areas continue to be nursing, over plan in month -£0.147 cumulatively -£0.809m, and medical staffing costs (agency Pods\WLIs) showing -£0.232m over plan in month no cumulatively -£0.995m. This is in part offset by pay underspends across corporate service and clinical support services.

- Productivity and efficiency delivered in August totalled £0.472m against a target of £0.561m. The contributions in-month were delivered primarily from the consolidation of medicines management gain share arrangements with CCGs\procurement benefits across all areas £0.158m, clinical support services £0.031m and non recurrent slippage from reserves\balance sheet £0.283m.

FORECAST

- Operational pressures continue to drive spend above plan as additional capacity is put in place, both within AED and the wider bed base. This will continue through the remainder of the year, with a further step increase in capacity anticipated for winter. These associated costs will outstrip the £1.8m set aside in the operating plan to cover winter 18/19.

- Elective demand is up, RTT performance has fallen and the size of the waiting list has grown. The Trust has had to pull together an action plan to mitigate the growth in the waiting list. The detail of this is currently being worked up, but will form an added pressure going forward. AUHFT has requested financial support from local CCGs towards these costs and a response is awaited.

- Other access targets around cancer (significant increase in 2-wk referrals) and diagnostics are also under pressure as a result of the increase in demand.

- Pay award funding is some £0.4m short of the actual cost and the trust is currently working through scenarios of possible costs for the medical pay award.

- QEP delivery is £2.2m to-date, with a further £3.5m anticipated over the last 7 months of the year. At this stage it is not anticipated that the £1.3m gap will be covered through additional projects in 18/19.

- These pressure are in-part being mitigated through reserve slippage and an anticipated £1.7m release from balance sheet provisions, these continue to be under constant review.

- Based on current projections and full delivery of the QEP programme in the latter half of the year, the financial outturn is not expected to be materially away from plan.
4. Key Variances

Figure 5 – Key Variance Analysis

<table>
<thead>
<tr>
<th>Subjective</th>
<th>Position @ MS</th>
<th>Budget</th>
<th>Variance</th>
<th>Explanation</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective and Day Care Admissions</td>
<td>20.775</td>
<td>- 12.35</td>
<td>Activity across Elective and Day Care areas are significantly below plan cumulatively.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Staffing</td>
<td>-27.651</td>
<td>- 0.35</td>
<td>The level of overspend in month, £232K was lower than the average of 2017/18, £290K. The key areas ytd are Medicine Pressures Ward, £258K, Acute Medicine, £443k, Elderly Medicine, £200K, Emergency Medicine, £31UK.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse Staffing</td>
<td>33.023</td>
<td>- 0.88</td>
<td>Overspend on nursing £29K in month, previously an average of £139K p.m. 2017-18.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Over spend on agency amounts to £364K, lower than the average of 2017-18 (£532K), overspend on bank is £0.464K (average 2017-18 £535K p.m). Continued use of additional hours and specialising.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Contracted vacancies £719K, Medicine 46 WTE vacancies, Surgery 72 WTE vacancies.</td>
<td></td>
<td></td>
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<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-4.237</td>
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</table>
5. QEP Overview

M5 Savings Position

- The Trust has achieved a M5 CIP saving of £473k against a target of £561k, resulting in a YTD cumulative shortfall position of - (£142k).
- The Trust CIP portfolio value at M5 has increased to £5.7m, from £5.3m at M4.
- Of the project plan, £2.19M has been delivered, with a further £3.54M RAG rated green.
- Efforts are being made to strengthen assurance on amber and red rated schemes, move forward on implementation of the £3.54M of green rated projects, whilst also working to identify new schemes to address the £0.24M shortfall.
- The Trust has been asked to report progress on CIP on a fortnightly basis as part of NHSI risk stratification on delivery of the financial plan. To month 5 this has been relatively light touch as overall the Trust is roughly at plan. Progress and the issues impacting on the Trust financial position and/or delivery of QEP are also picked up through monthly Oversight and Scrutiny Meetings with NHSI.

<table>
<thead>
<tr>
<th>Month</th>
<th>Unidentified</th>
<th>Cumulative Forecast (PMO - Red)</th>
<th>Cumulative Forecast (PMO - Amber)</th>
<th>Cumulative Forecast (PMO - Green)</th>
<th>YTD</th>
<th>Cumulative Actual</th>
<th>Cumulative Target (Finance)</th>
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<td>267,031</td>
<td>494,678</td>
<td>526,464</td>
<td>594,699</td>
<td>577,310</td>
<td>653,315</td>
<td>2,188,600</td>
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<tr>
<td>2</td>
<td>18,900</td>
<td>37,800</td>
<td>54,000</td>
<td>81,000</td>
<td>108,000</td>
<td>108,000</td>
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<td>1,800</td>
<td>115,808</td>
<td>127,991</td>
<td>140,174</td>
<td>152,357</td>
<td>152,357</td>
<td>2,188,600</td>
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<td>1,212,000</td>
<td>1,232,611</td>
<td>1,756,893</td>
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<td>9</td>
<td>2,188,600</td>
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<td>2,188,600</td>
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<tr>
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<td>2,188,600</td>
<td>2,188,600</td>
<td>2,188,600</td>
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<td>2,188,600</td>
<td>2,188,600</td>
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<td>2,188,600</td>
</tr>
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</table>

<table>
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<tr>
<th>Month</th>
<th>Value (£m)</th>
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<td>6</td>
<td>653,315</td>
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<td>8</td>
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<tr>
<td>9</td>
<td>2,188,600</td>
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<td>10</td>
<td>2,188,600</td>
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<tr>
<td>11</td>
<td>2,188,600</td>
</tr>
<tr>
<td>12</td>
<td>2,188,600</td>
</tr>
</tbody>
</table>
6. Medicine Divisional Position

Figure 6 - Year to date variance against plan

<table>
<thead>
<tr>
<th></th>
<th>Medicine Plan</th>
<th>Variance against Plan</th>
<th>M4</th>
<th>M3</th>
<th>M2</th>
<th>M1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M5  £000</td>
<td>M5  £000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Income activity</td>
<td>57,023(46,056)</td>
<td>1,757(1,887)</td>
<td>1,074</td>
<td>1,000</td>
<td>428</td>
<td>(80)</td>
</tr>
<tr>
<td>Expenditure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contract penalties</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Operational variance</td>
<td>10,967(131)</td>
<td>(459)</td>
<td>(203)</td>
<td>(439)</td>
<td>(395)</td>
<td></td>
</tr>
<tr>
<td>Income CIP</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Expenditure CIP</td>
<td>768 (400)</td>
<td>(269)</td>
<td>(155)</td>
<td>(106)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Contribution</td>
<td>11,736(530)</td>
<td>(727)</td>
<td>(358)</td>
<td>(545)</td>
<td>(395)</td>
<td></td>
</tr>
</tbody>
</table>

Current Position

Medicine is behind its planned contribution of £11.736m by -£0.530m, -4.52%, as at month 5.

The divisional income position overperformed in month, up by £0.683m with emergency Care admissions above plan +654 spells however only +£0.315m above plan as a consequence of the presenting case mix of patients being admitted. Elective care activity is up by +285 spells primarily from heart failure activity in Cardiology. Outpatient areas are up by +232 attendances in month.

Expenditure budgets overspent by -£0.355m in month. Pay overruns cover all of the position, Nurse staffing costs over plan -£0.059m in month, -£0.467m to date and medical staffing costs are over plan by -£0.313m in month, -£1.439m to date.

Productivity and efficiency delivered in month amounted to £0.054m, medicines management gain share arrangement with commissioners and procurement. The division are -£0.400m behind plan.
6. Medicine Divisional Position (cont’d)

Activity

Figures 7 through 9 show the divisional activity throughput against plan for the period.

Elective activity was above plan in month +285 spells associated with the Heart Failure pathways changes.

Non-elective admissions overperformed in month up by 654 spells.

Outpatient activity as shown in figure 9 shows an overperformance against plan of 232 attendances with first attendance down by -92, follow-up up +101 and procedures up by +223.
7. Surgical Divisional Position

Figure 10 – Year to date variance against plan

<table>
<thead>
<tr>
<th></th>
<th>Surgery Plan</th>
<th>Variance against Plan</th>
<th>M4</th>
<th>M3</th>
<th>M2</th>
<th>M1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M5</td>
<td>M5</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Income activity</td>
<td>58,075</td>
<td>(2,095)</td>
<td>(2,005)</td>
<td>(906)</td>
<td>(396)</td>
<td>(318)</td>
</tr>
<tr>
<td>Expenditure</td>
<td>(45,470)</td>
<td>(282)</td>
<td>(305)</td>
<td>(505)</td>
<td>(361)</td>
<td>(221)</td>
</tr>
<tr>
<td>Contract penalties</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Operational variance</td>
<td>12,605</td>
<td>(2,376)</td>
<td>(2,310)</td>
<td>(1,412)</td>
<td>(757)</td>
<td>(539)</td>
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<tr>
<td>Income CIP</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Expenditure CIP</td>
<td>846</td>
<td>(485)</td>
<td>(385)</td>
<td>(252)</td>
<td>(152)</td>
<td>0</td>
</tr>
<tr>
<td>Contribution</td>
<td>13,451</td>
<td>(2,862)</td>
<td>(2,695)</td>
<td>(1,663)</td>
<td>(909)</td>
<td>(539)</td>
</tr>
</tbody>
</table>

Current Position

Surgery is £2.862m behind its planned contribution of £13.451m -21.27%.

Planned admitted care activity was above plan by 23 spells in August. Outpatient areas are above plan in month by +2,015 attendances. Non-Elective was below plan in month by 13 spells.

Expenditure budgets were above plan by £0.023m in month. The use of premium rates continues to feature with a further £0.093m in August, to date £0.562m after five months (£0.487m 17/18) higher than planned spend by £0.075m. Whilst it is understood premium rates would be needed in 2018/19 to meet plan (before implementation of improved productivity measures) as they had been required in previous years, this does not triangulate with actual activity delivery. Theatre capacity is back up to full compliment, yet premium rate sessions continue to be relatively at the same levels.

Key Pay overruns continue and relate to nurse staffing £0.064m, £0.455m to date and Medical Staffing below plan in month by £0.017m, £0.045m to date.

A QEP contribution of £0.104m was achieved in month primarily from the medicines management gain share and procurement savings the division are £0.485m behind plan.
Activity
Figures 11 through 13 show the divisional activity throughput against plan for the period.

Elective activity performance is up in month showing an overperformance of 23 spells (day cases +65, inpatients -42), Orthopaedics -58 spells, -357 to date, ENT -18 spells, -101 to date, Ophthalmology -37 spells, -175 to date; Gastroenterology +87, -80 to date.

Non-elective admissions are down in month by 13 spells.

Outpatient activity as shown in figure 13 shows the division are above plan, +2,015 attendances in month recording overperformance for first attendances +353, follow ups +1040, procedures +584 and ARMD +38.
8. Clinical Support Services Position

**Figure 14 – Year to date variance against plan**

<table>
<thead>
<tr>
<th></th>
<th>Clinical Support Services</th>
<th>Variance against Plan</th>
<th>M4</th>
<th>M3</th>
<th>M2</th>
<th>M1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M5</td>
<td>£000</td>
<td>M5</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Income activity</td>
<td>7,225</td>
<td>42</td>
<td>42</td>
<td>106</td>
<td>55</td>
<td>19</td>
</tr>
<tr>
<td>Expenditure</td>
<td>(17,203)</td>
<td>234</td>
<td>185</td>
<td>74</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td>Contract penalties</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td><strong>Operational variance</strong></td>
<td>(9,979)</td>
<td>275</td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Expenditure CIP</td>
<td>331</td>
<td>(181)</td>
<td>(132)</td>
<td>(86)</td>
<td>(49)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Contribution</strong></td>
<td>(9,648)</td>
<td>95</td>
<td>95</td>
<td>94</td>
<td>41</td>
<td>54</td>
</tr>
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</table>

**Current Position and Forecast**

For August the Division is reporting a positive position and is on plan for the month. Income and activity plans were on plan, with expenditure under plan during the month £0.048m.

**Productivity and Efficiency Delivery**

The division delivered a QEP contribution of £0.033m in month, the division are £0.181m behind plan.

9. LcL

RLBUH continue to report a significant deficit on LCL trading activities. The make up of this deficit is unclear and work continues to identify the drivers that have generated this overspend. AUH, at this stage, does not accept shared liability for the reported position other than the an overspend of £0.420m associated with prior year unachieved CIP, which is retained in AUH budgets and a share of legitimate costs that can be tracked to proven increases in activity/demand.
10. Corporate Services Position

Figure 15 – Year to date variance against plan

<table>
<thead>
<tr>
<th></th>
<th>Budget £000</th>
<th>Ops Variance £000</th>
<th>Drugs Variance £001</th>
<th>CIP Shortfall £000</th>
<th>Total Variance £000</th>
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<td>65</td>
<td>0</td>
<td>35</td>
<td>100</td>
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<td>HR</td>
<td>2,726</td>
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</table>

Current Position
Overall corporate services are underspent by £0.730m this has assisted in supporting the overall position in August.

Productivity and Efficiency Delivery
Corporate service areas have withdrawn productivity and efficiency savings of £0.642m to date.
### 11. Reserves

#### Figure 16 – Contingency and Reserve Balances

<table>
<thead>
<tr>
<th></th>
<th>Total Reserve (£000s)</th>
<th>Release to CIP (£000s)</th>
<th>Drawings (£000s)</th>
<th>Balance (£000s)</th>
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<tr>
<td>General reserves</td>
<td>13,204</td>
<td></td>
<td>(5,190)</td>
<td>8,014</td>
</tr>
<tr>
<td>Inflationary reserves</td>
<td>8,066</td>
<td></td>
<td>(5,459)</td>
<td>2,607</td>
</tr>
<tr>
<td>Income related reserves</td>
<td>9,768</td>
<td></td>
<td>(3,501)</td>
<td>6,267</td>
</tr>
<tr>
<td>Developments and pressures</td>
<td>10,816</td>
<td></td>
<td>(4,562)</td>
<td>6,254</td>
</tr>
<tr>
<td>Slippage/Balance sheet Release</td>
<td>(315)</td>
<td></td>
<td>(704)</td>
<td>(1,019)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>41,854</strong></td>
<td><strong>(315)</strong></td>
<td><strong>(19,417)</strong></td>
<td><strong>22,123</strong></td>
</tr>
</tbody>
</table>

- General, inflationary and development reserves are held centrally and allocated to Divisions/Departments when the costs are incurred.
- At the end of August, £19.7m (47%) of reserves has been drawn into budget.
- The Trust sets its budgets based on the recurrent costs of service delivery and therefore anticipates that an element of slippage will occur during the year. This can be used non-recurrently to support emerging pressures not anticipated, or used to support the CIP programme on a non-recurrent basis. An assessment of annual slippage has released £1m to date.
### Commentary

- In summary, fixed assets totalled £184.8m. This is £0.5m lower than the previous month due to depreciation (£0.7m) offset by capital additions of £0.2m.

- Working capital (current assets less current liabilities) was weakened further during August and out turned at minus £26.9m, against a July position of minus £24.8m. Driving this was a deterioration to our underlying cash balance as we start to see the draining impact of financial performance on our cash reserve.

- Trade and other receivables reduced in month by £0.7m. Reduction due to minor historic contract settlements.

- Trade and other payables reduced in month by £0.7m. This reduction is linked to the high supplier payments scheduled for the month of August.

- Other liabilities (Deferred Income) remains above our standard levels by £5m. This is due to receiving contract income in advance of service delivery. The opposite entry is reflected by having a favourable cash balance.

- The reduction of c£2.5m within the equity section of the balance sheet illustrates the reported loss incurred by the Trust during the month.
Figure 18 – Rolling 12 mth cash flow forecast

- Actual Cash
- NHSI Plan
- Cash Forecast
13. Cash (con’t)

Commentary

- Cash balances totalled £9.0m against a planned cash resource of £1.7m.
- The improvement against plan predominantly relates to cash received in July from CCGs relating to contract income paid in advance to cover the non-receipt of 2017-18 STF cash (also paid in July). This cash will be repaid over the Autumn months.
- The 2018/19 Operational Annual Plan, as revised and resubmitted in June 2018, includes the following values that have a significant impact on cash resources:
  - Capital Spend of £8.0m (for which a loan of £3.2m will be required – an application for this loan is in the process of being completed). Should the loan not be successful, capital spend must be contained within internally generated resources (£4.8m – see below).
  - I&E Deficit of £29.1m (not within an agreed control total).
  - Revenue Distressed Cash Funding - £24.2m with the first drawdown now deferred from September to November 2018 (see below).
- The Internally Generated resource of £4.8m that will support the capital programme consists of £3.1m generated during 2018-19 plus £1.7m of the STF Bonus payment received in 2017-18. Using this STF Income to support the 2018-19 capital programme has been agreed as an appropriate use of the cash with NHSI and included in the revised plan submitted on 20 June 2018.
- The first stage of the revenue cash support loan application has been submitted with a first draw down (originally planned for September 2018 in line with the annual plan) now planned for November 2018. This deferment in drawdown is due to the £5.0m cash received from CCGs as a temporary advance payment of contract income. This £5m is planned to be recovered by CCGs over the Autumn months. Should any of the assumptions made in the plan significantly alter then the draw down dates could change.
- In order to support the revenue cash loan, a paper approving the loan application, and devolving authority to apply to the Director of Finance & Business Services, was discussed at the July and August Board of Directors meetings.
- The Trust are continuing to progress all avenues to ensure that all cash due is receipted as soon as possible and that all debts are pursued to ensure cash is received as timely as can be agreed. This includes revisiting cash agreements with local CCGs and routine cash payments covering monthly service contracts with local NHS Trusts.
- As part of the revenue loan conditions, ongoing cash balances will need to be maintained at levels in excess of £1.8m, this roughly equates to 2 days of operating expenditure.
### 14. Use of Resources Risk Rating

**Figure 19 – FSRR**

<table>
<thead>
<tr>
<th>Use of Resources Risk Rating</th>
<th>Plan YTD ending 31-August-18</th>
<th>Actual YTD ending 31-August-18</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Capital Service Cover</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital service metric</td>
<td>(2.814)</td>
<td>(2.995)</td>
</tr>
<tr>
<td>Capital service rating</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>Liquidity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liquidity metric</td>
<td>(31.010)</td>
<td>(29.766)</td>
</tr>
<tr>
<td>Liquidity rating</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>I&amp;E Margin</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I&amp;E Margin metric</td>
<td>(8.40%)</td>
<td>(8.40%)</td>
</tr>
<tr>
<td>I&amp;E Margin rating</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>I&amp;E Variance from Plan</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I&amp;E Variance from Plan metric</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>I&amp;E Variance from Plan rating</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Agency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agency metric</td>
<td>29.16%</td>
<td>102.81%</td>
</tr>
<tr>
<td>Agency rating</td>
<td>3</td>
<td>4</td>
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<tr>
<td><strong>Use Of Resources Rating</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall rating unrounded</td>
<td>3.40</td>
<td></td>
</tr>
<tr>
<td>If unrounded score ends in 0.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rounded score</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Use Of Resources Rating before overrides</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>4 Rating Trigger for Use Of Resources Rating</td>
<td>TRIGGER</td>
<td>TRIGGER</td>
</tr>
<tr>
<td>Use Of Resources Rating after 4 rating override</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Control total override - Control total accepted</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Control total override - Planned or Forecast deficit</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Control total override - Maximum score</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Is the provider in Financial Special Measures?</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Use Of Resources Rating after overrides</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

**Commentary – FSRR Metric**

- **Capital Service Cover**: A rating of 4 is in line with the annual plan. It is anticipated that this ratio will remain 4 to the end of the financial year.
- **Liquidity**: A rating of 4 (lowest score) is in line with the annual annual plan. It is anticipated that this rating will remain 4 to the end of the financial year.
- **I&E Margin**: A rating of 4 is in the annual plan. It is anticipated that this rating will remain 4 to the end of the financial year.
- **I&E Variance from Plan**: This rating is the best and is a result of maintaining the I&E plan.
- **Agency**: The planned agency spend is higher than plan rating (3) and higher than the ceiling.
- **In summary**, whilst the Agency Metric is lower than plan, the combined Overall Use of Resources Risk Rating is a ‘3’ which is in line with the annual plan submission.
15. Capital

Figure 20 – Capital

<table>
<thead>
<tr>
<th>Tranche 1: Internally Generated Resource</th>
<th>Annual Plan</th>
<th>YTD Plan</th>
<th>Current Commitment</th>
<th>YTD Spend</th>
<th>YTD Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Equipment</td>
<td>300</td>
<td>0</td>
<td>21</td>
<td>22</td>
<td>-2</td>
</tr>
<tr>
<td>IT</td>
<td>419</td>
<td>139</td>
<td>57</td>
<td>24</td>
<td>115</td>
</tr>
<tr>
<td>Building, Engineering &amp; Environment, Health &amp; Safety</td>
<td>800</td>
<td>334</td>
<td>219</td>
<td>169</td>
<td>165</td>
</tr>
<tr>
<td>Bed Lift (former Mat Block)</td>
<td>465</td>
<td>5</td>
<td>3</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Car Park Equipment Install and Civils</td>
<td>520</td>
<td>100</td>
<td>89</td>
<td>87</td>
<td>13</td>
</tr>
<tr>
<td>Ward 1 &amp; 2</td>
<td>350</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Orthopaedic Transformation</td>
<td>243</td>
<td>0</td>
<td>7</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internally Generated Resource:</td>
<td>3,097</td>
<td>578</td>
<td>396</td>
<td>309</td>
<td>209</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Tranche 2: Capital Loan</th>
<th>Annual Plan</th>
<th>YTD Plan</th>
<th>Current Commitment</th>
<th>YTD Spend</th>
<th>YTD Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tower Block Cladding</td>
<td>3,000</td>
<td>0</td>
<td>119</td>
<td>106</td>
<td>-106</td>
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<tr>
<td>Bed Lift Replacement</td>
<td>200</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total of Loan Dependant Schemes:</td>
<td>3,200</td>
<td>0</td>
<td>119</td>
<td>106</td>
<td>-106</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Financed By:</th>
<th>Annual Plan</th>
<th>YTD Plan</th>
<th>Current Commitment</th>
<th>YTD Spend</th>
<th>YTD Variance</th>
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</thead>
<tbody>
<tr>
<td>Depreciation</td>
<td>5,753</td>
<td>2,465</td>
<td>2,465</td>
<td>0</td>
<td>0</td>
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<tr>
<td>DOH Loan Repayment</td>
<td>-2,658</td>
<td>-722</td>
<td>-722</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>DOH Loan Drawdown</td>
<td>3,200</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PDC Drawdown</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(Gain)/loss in Working Capital</td>
<td>1,700</td>
<td>-1,100</td>
<td>-1,100</td>
<td>209</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total:</td>
<td>7,997</td>
<td>628</td>
<td>517</td>
<td>419</td>
<td>209</td>
</tr>
</tbody>
</table>

Capital Programme Impact on Cash Balances

To date our cash balances are benefiting from a slow start to the capital programme (as planned). Depreciation charged to I&E of £2.5m has so far been utilised on making capital loan repayments of £0.7m and capital investment of £0.4m, resulting in a short term benefit to cash of £1.3m. This benefit will evaporate as the capital programme gathers momentum.

Commentary

Capital spend at month 5 totalled £419k against a plan of £628k.

During the initial part of the fiscal year the capital programme will remain within its 2018-19 internally generated resource of £3.1m plus £1.7m of the 2017-18 STF cash bonus, a total of £4.8m spend against internally generated resources.

The second phase of the programme will be released on the successful application of a capital loan submitted to the Department of Health (£3.2m).

Commentary on the material schemes is provided below:

- **General Capital Improvements** – To date we have spent £169k addressing various defects across the estate. These improvements include works such as new corridor flooring, enhanced fire safety within the Tower and Maternity blocks, as well as the fitting of new windows.

- **Car Park Equipment Installation** – Following on from last year’s purchase of the new car park equipment (£485k), attention now turns to the installation phase. This programme of works is estimated to cost in the region of £520k with a completion date of December 2018. This brings the total project to c£1m across the two financial years.

- **Tower Block Cladding** – Whilst funding isn’t secured, the unavoidable design costs had to extend into 2018-19 as we worked towards GMP. The project will now pause until appropriate funding is obtained, enabling the construction phase to commence.
Recommendation

16. The Finance & Performance Committee are asked to note the information contained within this report.

References and further reading

17. Transformation Programme Update (on agenda).
18. Cash Assurance Group (appendix 1)

<table>
<thead>
<tr>
<th>Author</th>
<th>Paul Brannelly, Deputy Director of Finance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owner</td>
<td>Ian Jones, Director of Finance &amp; Business Services</td>
</tr>
<tr>
<td>Date</td>
<td>21/09/2018</td>
</tr>
</tbody>
</table>
**Agenda Item (Ref):** CAG 7.02  
**Date of Meeting:** 21\(^{st}\) September 2018

**Report to:** Cash Assurance Group

**Report Title:** Cash Dashboard – including previous and projected 12 months

**Executive Lead:** Ian Jones, Director of Finance & Business Services;  
**Lead Officer:** Dawn Gerrard, Head of Corporate Finance

**Action Required:** To review position, projection & agree any actions.

<table>
<thead>
<tr>
<th>Substantial assurance</th>
<th>Acceptable assurance</th>
<th>Partial assurance</th>
<th>No assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>High level of confidence in delivery of existing mechanisms / objectives</td>
<td>General confidence in delivery of existing mechanisms / objectives</td>
<td>Some confidence in delivery of existing mechanisms / objectives</td>
<td></td>
</tr>
</tbody>
</table>

**Key Messages of this Report**
- August cash position out turned at £9.0m
- Forecast outturn cash projection for September is £5.5m (inclusive of CCG monies of £5m) NHSI plan = £1.9m
- Revenue Support loan is forecast for November 2018
- The 2018-19 final annual plans show a DoH Revenue Support Loan in the region of £24.2m

**Impact (is there an impact arising from the report on the following?)**
- Quality
- Finance  ❌
- Workforce
- Equality
- Risk
- Compliance  ❌
- Legal

**Equality Impact Assessment (if there is an impact on E&D, an Equality Impact Assessment must accompany the report)**
- Strategy
- Policy
- Service Change

**Strategic Objective(s)**
- Deliver outstanding care
- Achieve best patient outcomes
- Promote research and education
- Deliver sustainable healthcare to meet people’s needs
- Provide strong system leadership
- Be a well-governed and clinically-led organisation

**Governance (is the report a……?)**
- Statutory requirement
- Annual Business Plan Priority
- Key Risk
- Service Change
- Other  
  **rationale for Board submission required:** Cash Management Process

---

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Next Steps *(actions following agreement by Board/Committee of recommendation/s)*

<table>
<thead>
<tr>
<th>Committee / Group Name</th>
<th>Agenda Ref</th>
<th>Report Title</th>
<th>Date of submission</th>
<th>Brief summary of key issues raised and actions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

REPORT HISTORY
Executive Summary

3. 2018/19 cash projections (as shown in the cash dashboard below) indicate that without Revenue Cash Support from NHSI, cash will drop below zero in November 2018 which required us to apply for an Interim revenue cash loan in September 2018. Initial contact was made with NHSI in July 2018, informing them of the requirement to draw cash down in September to support the position. However having received the CCG advance of £5m, revised forecasts demonstrate the drawdown can be postponed until November 2018.

4. Liverpool and South Sefton CCGs have provided the Trust with a short term advance on contract income to help mitigate the cash pressures, mainly due to uncertainty around the receipt of the 2017-18 STF monies. However, soon after receiving cash from the CCGs the STF income was also receipted. This is the prime reason for our cash balances at the end of August proving so positive.

5. Discussions have taken place around the repayment of the advance from the CCGs. It is agreed that payments will be made via a phased return spread across quarter 3.

6. Once revenue support is received from the DoH, cash balances are not allowed to drop below £1.754m as instructed by NHSI. Therefore, the level of revenue support (as illustrated in Figure 1 / para 14) will be the balancing factor.

Short-term Cash Projection (< 3 Months)

7. Cash flow forecasts, using a combination of prior period trends and live financial projections, indicate we should be able to maintain cash stability as we progress through September. However, it must be noted, should agreement to settle any outstanding risk issues result in cash payments, this will have an adverse impact on the forecast cash position.

8. Cash balances will be reviewed daily as we progress through the next 3 months to ensure cash balances remain positive. In the cash forecast included below, November is the first month in which we will require revenue support from the DoH to the value of £5.0m.

9. Working capital balances will be used in order to maintain cash stability. Forecast balances show that by delaying the final week payment run of the month will be suffice in maintaining a positive cash balance. It is also considered to be the correct tactic in term of external credibility if we have to adopt such an approach, as it is not expected to attract a great deal of scrutiny by suppliers due to the delay being 7 days (maximum) at its worst case.
Medium / Long Term Cash Projection (> 3 Months)

10. Using the data from within the final 2018-19 annual plan, submitted to NHSI on 20th June, the forward 12 month projection highlights the following:

- The Trust will require a Revenue Support loan in the region of £24.2m in order to maintain cash stability through 2018-19.
- The point at which this loan will be required is currently forecast to start in November and continue throughout the financial year.

11. The following regular actions will be taken to ensure the safeguarding of the cash position to support continued operations.

- Daily cash flow reviews/projections.
- Periodic working capital balance reviews.
- Monthly sub group meetings.
- Working capital balance management.

12. As can be seen within the remaining 7 month cash forecast, cash balances from November are subject to monthly revenue support cash drawdowns.

Scenario Testing – Historical Creditor/Provision Settlements

13. Scenario 1 – Prior year non-routine creditors requiring settlement

Currently the forecasts are set on trend patterns reviewed over a 24 month period and applied to our 2018-19 I&E non-pay expenditure plan. Consequently, any ad-hoc requests for prior year non-routine creditor settlements would cause a stress upon the cash balance. For example if Vascular or other risk monies were to be called upon this would have a direct adverse impact on our cash balance. Again this could be managed through working capital, however this loss of cash wouldn’t be a result of timings and would inevitably accelerate the need to draw down Revenue Support earlier than anticipated.

14. Scenario 2 – % Increase within I&E loss

If the forecast I&E position was to deteriorate by 10% by year end this would increase the cash pressure by £2.9m. In order to mitigate this and safeguard the integrity of the cash position in line with NHSI requirements and the current forecast cash position, we would look to delay the final week’s creditor payment from March into April 2019.

15. Ultimately the Trust finds itself in a position of having very little room to manoeuvre outside of our “routine business” cash cycle. Any minor stress placed upon our cash resource could only be managed through withholding supplier payments and at best this should only been seen as a short term solution.
2018-19 High Level Cash Reconciliation

16. The illustration below outlines the annual cash cycle by focusing attention directly to the drivers within the 2018-19 plans, both I&E and Capital Investment. It also indicated how prior years unsettled cash transactions impact our annual closing cash position.

<table>
<thead>
<tr>
<th>Quick Reconciliation:</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening Balance</td>
<td>11.1</td>
</tr>
<tr>
<td>Net 2017-18 Balance Sheet Movements</td>
<td>-2.9</td>
</tr>
<tr>
<td>2017-18 STF</td>
<td>6.5</td>
</tr>
<tr>
<td>2017-18 Capital Creditors</td>
<td>-6.4</td>
</tr>
<tr>
<td>I&amp;E position 2018-19 (less depreciation)</td>
<td>-23.3</td>
</tr>
<tr>
<td>Loan Repayments</td>
<td>-2.6</td>
</tr>
<tr>
<td>Capital Investment</td>
<td>-4.8</td>
</tr>
<tr>
<td>Revenue Support Loan</td>
<td>24.2</td>
</tr>
<tr>
<td>Closing Balance</td>
<td>1.8</td>
</tr>
</tbody>
</table>

Conclusions and Next Steps

17. Cash will continue to be monitored closely and actively managed in line with revised operating procedures. These revised procedures include an enhanced meeting structure and working capital balance regime that will enable a robust approach to cash management.

18. Discussions have taken place and will continue to establish the exact NHSI cash drawdown criteria. The criteria currently known will be discussed within the appropriate cash forums, with set timeframes and a pragmatic approach agreed to ensure reliable information is available in readiness to support any loan drawdown applications.
### Cash Flow Projections >12 Months

#### PROJECTED MONTHLY CASH FLOW

**Aintree University Hospital NHS Foundation Trust**

**September 21, 2018**

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Cash On Hand</strong></td>
<td>£8,972</td>
<td>£5,509</td>
<td>£2,727</td>
<td>£2,504</td>
<td>£1,754</td>
<td>£1,754</td>
<td>£1,754</td>
<td>£1,754</td>
<td>£1,754</td>
<td>£1,754</td>
<td>£1,754</td>
<td>£1,754</td>
</tr>
<tr>
<td><strong>2. Cash Receipts</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>(a) Contract Income</td>
<td>£26,192</td>
<td>£26,007</td>
<td>£25,875</td>
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Cash Position Excluding DoH Revenue Support

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## Previous 12 months Cash Flow

### 1. Cash On Hand

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<td>O / B</td>
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### 2. Cash Receipts

- **Contract Income**
  - £26,436
  - £25,318
  - £26,085
  - £25,926
  - £25,280
  - £25,787
  - £25,875
  - £31,374
  - £21,245
  - £25,931
  - £27,363
  - £26,246

- **Other Income**
  - £4,066
  - £6,078
  - £3,459
  - £3,497
  - £4,762
  - £4,145
  - £6,438
  - £3,857
  - £3,527
  - £3,914
  - £3,701
  - £5,430

- **Interest Receivable**
  - £3
  - £2
  - £3
  - £7
  - £6
  - £7
  - £7
  - £9
  - £7
  - £6
  - £5
  - £8

- **DoH Capital Funding**
  - £660
  - £378
  - £6,066
  - £107

- **DoH Revenue Support**
  - £1,083
  - £1,190
  - £1,785
  - £1,153

- **STF Funding**
  - £1,083
  - £1,190
  - £1,785
  - £1,153

### 3. Total Cash Receipts

- £31,588
- £31,398
- £29,547
- £31,280
- £30,426
- £36,005
- £34,212
- £35,240
- £24,779
- £29,851
- £42,604
- £31,684

### 4. Total Cash Available

- £42,792
- £43,243
- £41,374
- £39,939
- £39,755
- £46,033
- £51,685
- £46,433
- £38,193
- £35,136
- £43,874
- £43,510

### 5. Cash Paid Out

- **Salary**
  - £11,429
  - £11,479
  - £11,608
  - £11,482
  - £11,663
  - £11,594
  - £11,785
  - £11,800
  - £11,746
  - £11,783
  - £11,807
  - £13,052

- **Tax, NI & Superannuation**
  - £6,463
  - £6,441
  - £6,699
  - £6,685
  - £6,678
  - £6,734
  - £6,654
  - £6,641
  - £6,979
  - £6,770
  - £6,721
  - £6,873

- **Creditor Payments**
  - £10,368
  - £13,175
  - £14,112
  - £11,377
  - £11,199
  - £9,752
  - £15,618
  - £11,678
  - £13,583
  - £13,422
  - £12,010
  - £14,345

**Operational Subtotal**

- £28,260
- £31,095
- £32,419
- £29,544
- £29,540
- £28,080
- £34,057
- £30,119
- £32,308
- £31,975
- £30,538
- £34,270

- **Loan Principal Payment**
  - £490
  - £722
  - £490
  - £722
  - £490
  - £722
  - £490
  - £722
  - £490
  - £722
  - £490
  - £722

- **Interest Payable**
  - £380
  - £418
  - £363
  - £407
  - £52

- **Capital Investment**
  - £301
  - £321
  - £236
  - £74
  - £187
  - £480
  - £3,599
  - £2,900
  - £600
  - £762
  - £1,510
  - £100

- **PDC Dividend**
  - £1,516
  - £1,983

**Total Cash Paid Out**

- £30,947
- £31,416
- £32,715
- £30,610
- £29,727
- £28,560
- £40,492
- £33,019
- £32,908
- £33,866
- £32,048
- £34,538

### 6. Cash Position

- £11,204
- £11,845
- £11,827
- £8,659
- £9,329
- £10,028
- £17,473
- £11,193
- £13,414
- £5,285
- £1,270
- £11,826
- £8,972
## Agenda Item (Ref) B18-19/ Date of Meeting: 26 September 2018

**Report to** Board of Directors

**Report Title** Leadership and Management Development Proposal

**Executive Lead** Ruth Hoyte, Director of Workforce & OD

**Lead Officer** Fleur Flanagan, Interim Head of HR

**Action Required** To review & approve the proposals

<table>
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<th>Acceptable assurance</th>
<th>Partial assurance</th>
<th>No assurance</th>
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<td>General confidence in delivery of existing mechanisms / objectives</td>
<td>Some confidence in delivery of existing mechanisms / objectives</td>
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### Key Messages of this Report (2/3 headlines only)

- Outlines the current leadership challenge
- Highlights existing development activities
- Identifies gap supporting proposed development of new activities
- Sets out timeline for workload and next steps

### Impact (is there an impact arising from the report on the following?)

- Quality
- Finance
- Workforce
- Equality
- Risk
- Compliance
- Legal

### Equality Impact Assessment (if there is an impact on E&D, an Equality Impact Assessment must accompany the report)

- Strategy
- Policy
- Service Change

### Strategic Objective(s)

- Deliver outstanding care
- Achieve best patient outcomes
- Promote research and education
- Deliver sustainable healthcare to meet people’s needs
- Provide strong system leadership
- Be a well-governed and clinically-led organisation

### Governance (is the report a……?)

- Statutory requirement
- Annual Business Plan Priority
- Key Risk
- Service Change
- Other

**rationale for Board submission required:**

### Next Steps (actions following agreement by Board/Committee of recommendation/s)

Agree future reporting framework and actions
## REPORT HISTORY

<table>
<thead>
<tr>
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<th>Agenda Ref</th>
<th>Report Title</th>
<th>Date of submission</th>
<th>Brief summary of key issues raised and actions</th>
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Leadership and Management Development – Proposal

Executive Summary

1. This paper provides a review of the recent current Leadership and Management (L&M) development activity. It makes recommendations for programmes and interventions that will focus on the development of leaders and managers across the organisation. This will support the delivery of the Corporate Strategy and objectives, and support delivery of the Quality Improvement Plan.

2. This report sets out the context of the current environment, and a proposal for the Trust to focus on immediate priorities for leadership and management development over the next 12-18 months. The outputs of Phase 2 of the Clever Together programme and the development of a co-created and People & OD plan and a behaviour framework will inform an agreed leadership competency framework and leadership strategy to support the organisation through transaction and merger.

Key Issues

Current context

3. There are a number of development programmes currently being delivered across the organisation for the various levels of leadership. These are shown in Appendix 1, along with indicative levels of management they are made available to.

4. As an acute provider, the organisation has faced significant challenge to deliver its quality, safety requirements and make effective use of its resources. The cultural assessment undertaken by Clever Together has identified the need to improve the well led and well managed domains of creating a great place to work. Despite investing in a range of leadership programmes, the NSS 2017 results and the cultural assessment would suggest their impact has not been sufficient to improve culture, quality, safety and effective use of resources.

5. A SWOT analysis (see Appendix 2) identifies key issues against our current L&M offerings. This paper identifies Phase one in improving this.

Proposal

Review and enhance existing activities and interventions

- Review and refresh the Management Core Skills Programme (CMSP) by October 2018
- Progress the outcomes of the Clever Together culture assessment and programme of work
- Enhance, promote and signpost internal and external development programmes
- Conduct a review of the ILM and Apprenticeship offerings by January 2019
- Review and improve emphasis on evaluation and outcomes
- Identify opportunities for collaboration with RLBUHT for development and delivery
6. The Core Management Skills Programme for all Senior and Middle managers was developed and has been delivered for around 12 months. The Programme is based on understanding basic principles, practical knowledge of Trust policies/processes/systems; practising & application of fundamental people management. Uptake of the programme has been disparate and, whilst evaluation has been positive, managers from key staff groups have not attended the programme.

<table>
<thead>
<tr>
<th>What works well</th>
<th>What needs improvement</th>
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<td>Co-created through engagement with staff, managers and subject matter aspects</td>
<td>Link programme to behavioural components</td>
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<td>Internal provision and flexible to changing organisational need</td>
<td>Mandate that key roles attend within a defined time period</td>
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<tr>
<td>Well received and feedback positive</td>
<td>Make programme mandatory for new managers</td>
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<tr>
<td></td>
<td>Signposting to programme amongst other development activities</td>
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Enhance, promote and signpost internal and external development programmes

7. The Leadership Academy and other providers offer a wide range of resources and tools for Trusts to access as appropriate e.g. Coaching Programme, Compassionate Leadership, Aspirant Talent, OD and change skills, Mary Seacole and Nye Bevan. These resources could be more widely promoted and used as part of a structured set of development tools as well as the approach to strategy and talent and successional management. The Trust plans to raise awareness and signpost teams and individuals to available development sessions as well as give consideration to how these are articulated and positioned within the appraisal PDR framework and conversations.

Review and improve emphasis on evaluation and outcomes

8. The approach to monitoring and assessing outcomes of programmes is not always clear or demonstrable, and so evaluation of a development activity is often not effectively measured. The desired outcomes should be clearly defined at the start of a project and reviewed at stages throughout the programme and be agile and responsive to organisational need.

Current Gaps in L&M Development

Aintree Leadership Framework

9. A fundamental gap in L&M development is the lack of an agreed competency framework of the competencies and behaviours expected of an Aintree Leader. This has resulted in the development of programmes in an ad hoc manner. Development of a competency framework will be fundamental to the formulation of a Leadership Strategy. This will be informed by the outputs of the Clever Together workshops. This will also be crucial to evolving a safety culture at Aintree.

Development of a Team Based Culture

10. Affina Organisational Development (AOD) work with health & social care organisations to improve performance through team-based working helps teams to improve performance
and recognises that collective team-based working is essential to high quality and compassionate care. This approach is supported by the NHSi Moving to Good programme. The programme develops capability to enable internally trained individuals to support teams to gain new insights and actions they can apply immediately to keep improving and achieving their goals. The approach supports building of team leadership capacity and capability within the organisation and is aligned a safe compassionate leadership culture. The programme will require investment of £28k with the aim to launch this by end of Q3.

**Appraisal and Talent Management**

11. Appraisal compliance within the Trust is approximately 70% against a target of 85% and evidence from NSS2017 suggests staff do not feel they have a meaningful appraisal. Objective setting and PDPs are not consistent. In the short term, work is required to improve the quality of appraisal and in particular objective setting and PDPs. In the longer term, the development of a talent management programme is required.

**Proposed Timeline**

12. The timeline for meeting the needs set out in this paper are included at Appendix 3.

**Implications / Impact**

**Financial**
- The cost implications of the proposals within this report are approximately £48k non-recurring
- This comprises £28k for Affina OD programme and 6 month Band 6 OD/Project support

**Workforce**
13. There are no direct workforce implications of these proposals other than those detailed in the report. Each of the programmes will be assessed for any impact on staff with protected characteristics and adapted accordingly.

**Conclusion**

14. In conclusion, the requirement for compassionate, competent and resilient leaders is essential to support service development and delivery as well as drive and enable transformational change.

15. The proposals outlined in this report are focussed on specifically developing these skills with a particular emphasis on behaviours, understanding and responding to our cultural context and collaborative working.

**Recommendation**

16. The Board is requested to review the report and to approve the progression of the outlined development activities.

17. The Board is asked to approve the proposal for the prioritisation of activities and specifically the funding required to deliver the following activities:

- Affina Team Coaching Programme
- Development of Leadership Competency Framework
- 6 months project support

Leadership and Management Development Proposal: Board of Directors 26 September 2018 5/8
### Appendix 1

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<th>LEADERSHIP LEVEL</th>
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<td>Band 6-7</td>
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<td>System OD and change skills</td>
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## SWOT analysis to identify key issues with current position

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</tr>
<tr>
<td>A range of development programmes on offer</td>
<td>Sparse leadership development programmes</td>
</tr>
<tr>
<td>Refocus on development of leadership at all levels</td>
<td>Lack of clarity of offer / pathways</td>
</tr>
<tr>
<td></td>
<td>No strategic focus</td>
</tr>
<tr>
<td></td>
<td>Too much focus on the ‘what’ and not the ‘how’</td>
</tr>
<tr>
<td></td>
<td>Appraisal process ‘IPDR link with development</td>
</tr>
<tr>
<td></td>
<td>Succession planning</td>
</tr>
<tr>
<td></td>
<td>Clinical ‘leaders’ understanding of role</td>
</tr>
<tr>
<td></td>
<td>No clear strategy</td>
</tr>
<tr>
<td></td>
<td>Limited uptake of programmes</td>
</tr>
<tr>
<td></td>
<td>Lack of competency framework</td>
</tr>
<tr>
<td></td>
<td>Lack of authority and accountability framework</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OPPORTUNITIES</th>
<th>THREATS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transformation agenda</td>
<td>Financial challenge</td>
</tr>
<tr>
<td>Merger with RLUBHT</td>
<td>Unprecedented climate</td>
</tr>
<tr>
<td>Cultural improvement</td>
<td>Change overload / fatigue</td>
</tr>
<tr>
<td>Development of a joint strategy with RLBUHT</td>
<td>Poor attendance / non-mandatory</td>
</tr>
<tr>
<td>Need for managers and leaders to empower</td>
<td>Lack of accountability</td>
</tr>
<tr>
<td>Joint programmes – clinical and non-clinical leadership</td>
<td>Too busy to ‘engage’</td>
</tr>
<tr>
<td>Introduction of SLDP</td>
<td>No Talent Management process (high performers may leave)</td>
</tr>
<tr>
<td>Enhancement of CMS Programme</td>
<td></td>
</tr>
<tr>
<td>Clever Together diagnostic outcomes</td>
<td></td>
</tr>
<tr>
<td>Affina Team coaching programme</td>
<td></td>
</tr>
<tr>
<td>Development of a safety culture</td>
<td></td>
</tr>
<tr>
<td>Greater access to Leadership Academy offerings</td>
<td></td>
</tr>
</tbody>
</table>

Aintree University Hospital NHS Foundation Trust

Leadership and Management Development Proposal: Board of Directors 26 September 2018

Appendix 2

Page 189 of 214
Leadership and Management Proposal Actions Timeline

NOW – DECEMBER 2018
1. Refresh CMSP offerings (October 2018)
2. Launch Team Coaching Affina Programme
3. Develop L&M Competency Framework (using Clever Together diagnostics to inform process)
4. Promote /target offers and priorities

JANUARY 2019
1. Mapping exercise to understand cultural diagnostic outcomes & current programme offerings alongside safety culture, competency framework & behavioural standards identified
2. Present TNA based on the above with recommendation for next steps
3. The above work will feed the People &OD Strategy

SUMMER 2019
1. Develop a talent management framework
2. Embed Leadership and Management Development programme that is values and behaviour led
3. Introduce a succession plan
4. Fully evaluate all processes and strategies
Organ Donation Annual Report 2017-18 and Operational Plan 2018-19

Agenda Item (Ref) B18-19/ Date of Meeting: 26 September 2018
Report to Board of Directors
Report Title Organ Donation Annual Report 2017/18 and Operational Plan 2018/19
Executive Lead Dr Tristan Cope, Medical Director
Lead Officer Dr Robert Parker, Clinical Lead (CLOD)
Catherine D’Albertanson, Specialist Nurse - Organ Donation, North West Organ Donation Team, NHS Blood and Transplant (SNOD)
Action Required To note the annual report & approve the proposed plan (2018-19)

Substantial assurance
High level of confidence in delivery of existing mechanisms / objectives
Acceptable assurance
General confidence in delivery of existing mechanisms/ objectives
Partial assurance
Some confidence in delivery of existing mechanisms / objectives
No assurance
No confidence in delivery

Key Messages of this Report
• There has been an improvement in referral rates for 2017/18
• More approaches to families were made with the Specialist Nurse present in 2017/18 (despite staffing issues)
• There were two missed donation opportunities in 2017/18

Impact
• Quality ☒
• Finance ☐
• Workforce ☐
• Equality ☐
• Risk ☒
• Compliance ☒
• Legal ☒

Equality Impact Assessment: Not applicable
• Strategy ☐
• Policy ☐
• Service Change ☐

Strategic Objective(s)
• Deliver outstanding care ☒
• Achieve best patient outcomes ☐
• Promote research and education ☐
• Deliver sustainable healthcare to meet people’s needs ☐
• Provide strong system leadership ☐
• Be a well-governed and clinically-led organisation ☐

Governance (is the report a……?)
• Statutory requirement ☐
• Annual Business Plan Priority ☐
• Key Risk ☐
• Service Change ☐
• Other ☒

rationale for Board submission required:
Annual performance update to Quality Committee and Trust Board

Next Steps (actions following agreement by Board/Committee of recommendation/s)
Annual Report and Operational Plan to be submitted to the Trust Board in September 2018
<table>
<thead>
<tr>
<th>Committee / Group Name</th>
<th>Agenda Ref</th>
<th>Report Title</th>
<th>Date of submission</th>
<th>Brief summary of key issues raised and actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Committee</td>
<td>QC18-19/109</td>
<td>Organ Donation Annual Report 2017/18 and Operational Plan 2018/19</td>
<td>17 Sept 2018</td>
<td>Agreed to recommend approval to the Board. Suggestions made to increase awareness</td>
</tr>
</tbody>
</table>
Executive Summary

1. Organ donation is when a person allows an organ of theirs to be removed, legally, either by consent while the donor is alive or after death with the assent of the next of kin. Donation may be for research, or, more commonly healthy transplantable organs and tissues may be donated to be transplanted into another person.

2. Arrangements for the facilitation of organ donation by patients at Aintree Hospital have demonstrated improvement in 2017/18 as compared to 2016/17 when there was a SNOD vacancy for a significant period of months.

3. Referral rates, whilst not achieving the national target of 100%, have shown improvement.

4. Two missed donation opportunities were recorded as a result of non-referral. There were a further eight patients not referred but they did not have donor potential.

Key Issues / Proposal

5. Key areas of activity and performance in 2017/18 are as follows;

   - Aintree reported a Donation after Brain Death (DBD) consent rate of 100%, which is above the UK average, and in keeping with the targets set by NHSBT

   - Aintree reported a Donation after Cardiac Death (DCD) consent rate 41% which is below UK average, however interpretation of this is done with caution due to small numbers

   - There were 8 proceeding organ donors in 17/18 which resulted in 23 solid organ transplants. This is the same as 2015-16 and as such is the highest number in a year at Aintree.

   - Improvement in referral rates for all patients meeting referral criteria. Combined referral rates were 88% compared to 86% in the previous financial year. The national target is 100%

   - 21 families were approached for potential organ donation. 86% of the approaches were made with the SNOD present (compared to 70% in 2016/17). The national target is 100%. This parameter is important because the consent rate in the UK is much higher when a SNOD is present.

   - There have been 2 missed donation opportunities as a result of non-referral recorded in the last financial year. There were a further 8 patients not referred however they did not have donor potential

   - A feedback email to clinicians for non-referrals identified on the potential donor audit has been introduced.

   - Quarterly data feedback in ICU’s M&M and Clinical Governance meetings have been introduced.
The Organ Donation policy has been ratified and is live

Quarterly organ donation newsletters to ICU, ED and Theatre staff have been commenced; these contain information about current referral rates and donor activity

An Organ Donation memorial has been created, ‘lift wraps’ have been sited in the multi-storey car park and Transplant story boards outside ICU completed

**Please note: figures have been obtained by data collected locally. These vary from the NHSBT Annual Report due to the age cut off for the report being 80 years. Referrals from patients age >80 years who meet the referral criteria are included within the local data**

The 2018/19 annual plan

- Key objectives focus on improving the Trust’s performance via the engagement of the Emergency Department team in activities to improve referral rates and subsequent successful donations.

- A period of maternity leave cover will be required from November 2018; arrangements are in place to minimise the impact of this on the level of service currently provided.

**Conclusion**

6. Despite in-year staffing challenges, performance in most areas has improved. The proposed annual plan for 2018/19 intends to build on 2017/18 performance. Efforts will be focussed on Emergency Department engagement as a strategy for increasing referrals.

7. Arrangements are in place to ensure minimal service disruption during a period of maternity leave for the SNOD.

**Recommendation**

8. The Board is requested to note the Annual Report for 2017/18 and approve the plan for 2018/19.

**References and further reading**

9. Appendices

- Summary report*; actual and potential organ donors 1 April 2017 to 31 March 2018
- Annual Organ Donation Plan 2018 - 2019

* Full report available on request

**Author:** L. Matthew, Assistant Director to the Medical Director

**Date:** 12 September 2018
Taking Organ Transplantation to 2020

In 2017/18, from 12 consented donors the Trust facilitated 8 actual solid organ donors resulting in 23 patients receiving a life-saving or life-changing transplant.

In addition to the 8 proceeding donors there were 4 additional consented donors that did not proceed.

Best quality of care in organ donation

Referral of potential deceased organ donors

Goal: Every patient who meets the referral criteria should be identified and referred to NHS Blood and Transplant’s Organ Donation Service

Aim: There should be no purple on the chart

The Trust referred 58 potential organ donors during 2017/18. There were 10 occasions where potential organ donors were not referred.
Presence of Specialist Nurse for Organ Donation

Goal: A Specialist Nurse for Organ Donation (SNOD) should be present during every organ donation discussion with families

Aim: There should be no purple on the chart

A SNOD was present for 18 organ donation discussions with families during 2017/18. There were 2 occasions where a SNOD was not present.

Why it matters

- If suitable patients are not referred, the patient's decision to be an organ donor is not honoured or the family does not get the chance to support organ donation.

- The consent rate in the UK is much higher when a SNOD is present.

- The number of patients receiving a life-saving or life-changing solid organ transplant in the UK is increasing but patients are still dying while waiting.

Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

<table>
<thead>
<tr>
<th></th>
<th>North West*</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 April 2017 - 31 March 2018</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decoased donors</td>
<td>218</td>
<td>1,574</td>
</tr>
<tr>
<td>Transplants from deceased donors</td>
<td>467</td>
<td>4,012</td>
</tr>
<tr>
<td>Deaths on the transplant list</td>
<td>53</td>
<td>426</td>
</tr>
<tr>
<td>As at 31 March 2018</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active transplant list</td>
<td>575</td>
<td>6,045</td>
</tr>
<tr>
<td>Number of NHS ODR opt-in registrations (% registered)**</td>
<td>2,560,422 (36%)</td>
<td>24,941,804 (38%)</td>
</tr>
</tbody>
</table>

*Regions have been defined as per former Strategic Health Authorities
**% registered based on population of 7.17 million, based on ONS 2011 census data
Further information

Further information on potential donors after brain death (DBD) and potential donors after circulatory death (DCD) at the Trust are shown below, including a UK comparison.

<table>
<thead>
<tr>
<th>Key numbers comparison with UK data, 1 April 2017 - 31 March 2018</th>
<th>DBD</th>
<th>DCD</th>
<th>Deceased donors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust</td>
<td>UK</td>
<td>Trust</td>
<td>UK</td>
</tr>
<tr>
<td>Patients meeting organ donation referral criteria*</td>
<td>13</td>
<td>1954</td>
<td>60</td>
</tr>
<tr>
<td>Referred to Organ Donation Service</td>
<td>13</td>
<td>1929</td>
<td>50</td>
</tr>
<tr>
<td>Referral rate %</td>
<td>99%</td>
<td>89%</td>
<td>92%</td>
</tr>
<tr>
<td>Neurological death tested</td>
<td>8</td>
<td>1676</td>
<td>6</td>
</tr>
<tr>
<td>Testing rate %</td>
<td>86%</td>
<td>86%</td>
<td>86%</td>
</tr>
<tr>
<td>Eligible donors*</td>
<td>8</td>
<td>1582</td>
<td>47</td>
</tr>
<tr>
<td>Family approached</td>
<td>8</td>
<td>1471</td>
<td>12</td>
</tr>
<tr>
<td>Family approached and SNOD present</td>
<td>8</td>
<td>1394</td>
<td>10</td>
</tr>
<tr>
<td>% of approaches where SNOD present</td>
<td>95%</td>
<td>88%</td>
<td>90%</td>
</tr>
<tr>
<td>Consent ascertained</td>
<td>8</td>
<td>1066</td>
<td>6</td>
</tr>
<tr>
<td>Consent rate %</td>
<td>72%</td>
<td>60%</td>
<td>66%</td>
</tr>
<tr>
<td>Actual donors (PDA data)</td>
<td>6</td>
<td>955</td>
<td>2</td>
</tr>
<tr>
<td>% of consented donors that became actual donors</td>
<td>90%</td>
<td>55%</td>
<td>72%</td>
</tr>
</tbody>
</table>

* DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, i.e. a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

* DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

For further information, including definitions, see the latest Potential Donor Audit report at www.odt.nhs.uk/statistics-and-reports/potential-donor-audit/
### Achievements in 2017 – 2018

- 8 proceeding organ donors in 17-18 resulting in 23 solid organ transplants. This is the same as 2015-16 and as such is the highest number in a year at Aintree
- Improvement in referral rates for all patients meeting referral criteria. Combined referral rates were 88% compared to 86% in the previous financial year. The national target is 100%
- 21 families were approached for potential organ donation. 86% of the approaches were made with the SNOD present. The national target is 100%
- DBD consent rate of 100%, which is above the UK average, and in keeping with the targets set by NHSBT
- DCD consent rate 41% which is below UK average, however interpretation of this is done with caution due to small numbers
- There have been 2 missed donation opportunities as a result of non-referral recorded in the last financial year. There were a further 8 patients not referred however they did not have donor potential
- Introduction of a feedback email to clinicians for non-referrals identified on the potential donor audit
- Quarterly data feedback in ICU M&M and Clinical governance meetings
- Organ Donation policy has been agreed and is live
- Implementation of quarterly organ donation newsletters to ICU, ED and Theatre staff with information about current referral rates and donor activity
- Opening of Organ Donation memorial, application of lift wraps in the multi-story car park and Transplant story boards outside ICU completed

**Please note: figures have been obtained by data collected locally. These vary from the NHSBT Annual Report due to the age cut off for the report being 80 years. Referrals from patients age >80 years who meet the referral criteria are included within the local data**
Issues identified for 2018-19

- Embedded SNOD Catherine D’Albertanson will be going on maternity leave November 2018. Cover will be provided by a trained SNOD, however may only be part time cover.
- Allocation of an ED representative at the organ donation committee meetings as there has been no attendance in the last 12 months and to encourage training in the ED department. Missed referrals in 2017-18 and continuing into this financial year have originated in ED.

Actions identified for 2018-19

- Identification of ED representative
- Implementation of National NHSBT ED Strategy – remains outstanding due to inability to deliver training in ED
<table>
<thead>
<tr>
<th>Short Term – 3 Months</th>
<th>Medium term 3-6 month</th>
<th>Long Term 6-12 months</th>
</tr>
</thead>
</table>
| C.D’Albertanson to hand over to covering SNOD to ensure team engagement is continued. | Identification of an ED representative to help with engagement in the department and training in the ED department  
  
  Required to develop a strategy for discussion following non-referral and to implement the strategy below:  
  
  Implementation of NHSBT ED Strategy  
  
  **AIMS:**  
  
  For all end of life decisions in ED to be made by 2 senior doctors to reduce the risk of early prognostication.  
  
  All approaches in ED to have a SNOD present  
  
  All patients that meet the NICE 135 referral criteria in ED, are referred.  
  
  SNOD/CLOD to attend consultant meetings in ED to give organ donation update and distribute |  
  
  Ensure teams are aware of reduced SNOD presence, and need for early referral |  
  
  |
### Ongoing Objectives

- Continuous review of the potential donor audit data to be carried out by SNOD and CLOD team. Feedback of non-referrals to be given directly to clinician involved via agreed email format and to be discussed at the Organ Donation Committee, and with the clinical teams via the M&M or Clinical Governance meetings (ICU). To identify strategy for discussion in ED.

- National Brain Stem Death testing guidance to be followed – All patients assessed as likely BSD should have death confirmed by neurological criteria (where possible) irrespective of the potential for organ donation.

- Best Practice to be followed in all donation situations, specifically; early notification of patients fulfilling referral criteria to NHSBT via the SNOD and involvement of the SNOD in all family donation conversations.

- Ensure that every member of staff, who may be involved with the care of a potential donor, is aware of the SNOD’s role, and their own role in the identification and referral of potential donors.

- The Organ Donation information board on critical care should be kept up to date with current guidance and benchmarking data to ensure all staff have access to this information.

- The Organ Donation Committee will continue to meet quarterly to discuss the data, and any issues arising. Support the SNOD and CLOD and feedback to the Board.

- The Organ Donation Team at Aintree should work to identify and develop opportunities to increase the profile of donation within the Trust and within the wider community.
Report to: Board of Directors
Report Title: Workforce Race Equality Standard (WRES) 2018
Executive Lead: Ruth Hoyte, Director of Workforce & OD
Lead Officer: Diane Haddock, Head of Organisational Health and Effectiveness
Action Required: To approve

Substantial assurance
High level of confidence in delivery of existing mechanisms / objectives

Acceptable assurance
General confidence in delivery of existing mechanisms / objectives

Partial assurance
Some confidence in delivery of existing mechanisms / objectives

No assurance
No confidence in delivery

Key Messages of this Report (2/3 headlines only)

- Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS provider organisations and commissioners and also forms part of the CQC ‘Well Led’ inspection.
- To be compliant with the WRES requirements, the Trust needs to submit data annually to NHS England, commissioners and to publish this information online. The data has been submitted within the timescale required; this report once approved will be published with the accompanying action plan and circulated to commissioners for compliance.
- The Board is requested to note the content and approve

Impact (is there an impact arising from the report on the following?)
- Quality
- Finance
- Workforce
- Equality
- Risk
- Compliance
- Legal

Equality Impact Assessment (if there is an impact on E&D, an Equality Impact Assessment must accompany the report)
- Strategy
- Policy
- Service Change

Strategic Objective(s)
- Deliver outstanding care
- Achieve best patient outcomes
- Promote research and education
- Deliver sustainable healthcare to meet people’s needs
- Provide strong system leadership
- Be a well-governed and clinically-led organisation

Governance (is the report a……?)
- Statutory requirement
- Annual Business Plan Priority
- Key Risk
- Service Change
- Other

Rationale for Board submission required:

Next Steps (actions following agreement by Board/Committee of recommendation/s)
Once approved the information will be submitted to NHS England and published on the website
## REPORT HISTORY

<table>
<thead>
<tr>
<th>Committee / Group Name</th>
<th>Agenda Ref</th>
<th>Report Title</th>
<th>Date of submission</th>
<th>Brief summary of key issues raised and actions</th>
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</thead>
<tbody>
<tr>
<td>HMB</td>
<td>HMB18-19/115</td>
<td>Workforce Race Equality Standard (WRES) 2018</td>
<td>12 Sept 2018</td>
<td>For comments before submission to Board of Directors for approval</td>
</tr>
</tbody>
</table>
Executive Summary

1. Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS provider organisations and commissioners.

2. This report provides the HMB with the 2018 data against the nine indicators within the WRES and accompanying action plan.

Background

3. In April 2015, NHS England introduced the WRES in response to consistent findings over 20 years that black and minority ethnic (BME) applicants and staff consistently fared worse in employment outcomes and satisfaction surveys.

4. The WRES provides a framework for NHS Trusts to report, demonstrate and monitor progress against a number of indicators of workforce equality and to ensure that employees from BME backgrounds receive fair treatment in the workplace and have equal access to career opportunities.

5. From April 2016, the WRES is considered as part of the ‘well led’ domain in the CQC’s inspection programme.

6. There are nine WRES indicators. Four of the indicators focus on workforce data, four are based on data from national NHS Staff survey questions and one indicator focuses upon BME board representation.

7. To be compliant with the WRES requirements, the Trust needs to submit data annually to NHS England, commissioners and to publish this information online. The data has been submitted within the timescale required; this report once approved will be published and circulated to commissioners for compliance.

8. The CQC has launched guidance for NHS organisations called ‘Equally Outstanding’. The document draws upon multiple pieces of research that found clear links between staff satisfaction with being treated with respect and experiencing equality of opportunity at work with outstanding care in organisations.

Key Issues/Proposals

Summary of the WRES data 2018

9. A full breakdown of the data for 2018 and 2017 can be found in Appendix 1.

Indicator 1 – BME representation within the Trust

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Workforce</td>
<td>6.8%</td>
<td>6.7%</td>
</tr>
<tr>
<td>Non Clinical</td>
<td>1.1%</td>
<td>0.5%</td>
</tr>
<tr>
<td></td>
<td>(15/1323)</td>
<td>(28/1639)</td>
</tr>
<tr>
<td>Clinical</td>
<td>9.9%</td>
<td>9.4%</td>
</tr>
<tr>
<td></td>
<td>(297/2988)</td>
<td>(289/3081)</td>
</tr>
</tbody>
</table>
10. For this indicator, NHS England advises that organisations should undertake calculations separately for clinical and non-clinical staff. The data is based on substantive and fixed term contracts, bank staff are not included.

**Indicator 2 – Relative likelihood of staff being appointed from shortlisting across all posts**

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relative likelihood of white staff being appointed from shortlisting compared to BME staff is <strong>1.38</strong> times greater</td>
<td>Relative likelihood of white staff being appointed from shortlisting compared to BME staff is <strong>1.67</strong> times greater</td>
<td></td>
</tr>
</tbody>
</table>

**Indicator 3 – Relative likelihood of staff entering the formal disciplinary process as measured by entry into a formal disciplinary investigation**

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relative likelihood of BME staff entering the disciplinary procedure compared to white staff is <strong>1.73</strong> times greater</td>
<td>Not available</td>
<td></td>
</tr>
</tbody>
</table>

**Indicator 4 - Relative likelihood of staff accessing non-mandatory training and CPD**

11. The Trust currently is unable to record this data as it is stored at a local level and not through ESR. This is being addressed in the accompanying action plan.

**The following indicators relate to the staff survey**

**Indicator 5 – Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months**

12. For this reporting year, there has been an increase of 5% in BME staff experiencing bullying, harassment and abuse from people other than staff in the last 12 months. There has also been a slight increase for White staff at 0.4%.

13. **28%** of BME staff stated they experienced harassment, bullying or abuse from patients or the public in the last 12 months, compared to **25.4%** for White staff.

**Indicator 6 – Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months**

14. There has been a decrease in the number of both White and BME staff experiencing harassment, bullying or abuse in the last 12 months. There has been an overall decrease of 0.8% for BME staff and 4.3% for White staff.

15. For this reporting year, **21.7%** of White staff reported that they had experienced harassment, bullying or abuse from other staff compared to **18.2%** of BME staff.
Indicator 7 – Percentage believing that the Trust provides equal opportunities for career progression or promotion

16. There has been an increase in the number of BME staff who believes the Trust provides equal opportunities for career progression/promotion of 6.3%. However, the number of White staff who believes the Trust provides equal opportunities has decreased slightly by 1.6%.

17. However 80.3% of BME staff believes the Trust provides equal opportunities compared to 82.4% of White staff.

Indicator 8 – In the last 12 months have you personally experienced discrimination at work from any of the following – management/team leader or other colleagues?

18. Data suggests there has been a decrease in the number of BME staff experiencing discrimination at work. There has also been a slight decrease in the number of White staff experiencing discrimination.

19. For BME staff, there has been a decrease of 5.5% to 11.5%, for White staff there has been a slight decrease of 0.4% to 6.6%.

Indicator 9 – Board Representation indicator, comparing the difference for White and BME staff

20. BME Board representation is 6.8% below the overall workforce representation.

Benchmarking

21. Ahead of the upcoming merger, benchmarking against the Royal Liverpool Hospital WRES 2018 submission has been included in Appendix 3 to compare the composition of each Trusts workforce.

Conclusion

21. Although the Trust is demonstrating compliance with the NHS contract by publishing this report and action plan, it is imperative that proactive action is taken around gathering data, monitoring trends and implementing actions where interventions are required in line with our staffing needs.

Recommendation

22. The Board is asked to approve the Workforce Race Equality Standard and accompanying action plan.

Author: Tracey Lowry, Equality and Diversity Facilitator

Date: 5 September 2018
### Appendix 1 – WRES Data 2018

Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BME</td>
<td>White</td>
</tr>
<tr>
<td>Under Band 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Band 1</td>
<td>1.1%</td>
<td>97%</td>
</tr>
<tr>
<td>Band 2</td>
<td>0.7%</td>
<td>95.3%</td>
</tr>
<tr>
<td>Band 3</td>
<td>0.7%</td>
<td>95%</td>
</tr>
<tr>
<td>Band 4</td>
<td>3.4%</td>
<td>96.6%</td>
</tr>
<tr>
<td>Band 5</td>
<td>1.6%</td>
<td>92%</td>
</tr>
<tr>
<td>Band 6</td>
<td>1.9%</td>
<td>93%</td>
</tr>
<tr>
<td>Band 7</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>Band 8a</td>
<td>0%</td>
<td>95.8%</td>
</tr>
<tr>
<td>Band 8b</td>
<td>0%</td>
<td>93%</td>
</tr>
<tr>
<td>Band 8c</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>Band 8d</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>Band 9</td>
<td>0%</td>
<td>85.2%</td>
</tr>
<tr>
<td>VSM</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

### Non Clinical

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BME</td>
<td>White</td>
</tr>
<tr>
<td>Under Band 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Band 1</td>
<td>1%</td>
<td>88.7%</td>
</tr>
<tr>
<td>Band 2</td>
<td>6%</td>
<td>97.1%</td>
</tr>
<tr>
<td>Band 3</td>
<td>1.2%</td>
<td>89.2%</td>
</tr>
<tr>
<td>Band 4</td>
<td>12.4%</td>
<td>78%</td>
</tr>
<tr>
<td>Band 5</td>
<td>3.7%</td>
<td>89.2%</td>
</tr>
<tr>
<td>Band 6</td>
<td>7.6%</td>
<td>92.8%</td>
</tr>
<tr>
<td>Band 7</td>
<td>6%</td>
<td>96%</td>
</tr>
<tr>
<td>Band 8a</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>Band 8b</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>Band 8c</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>Band 8d</td>
<td>0%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Appendix 1 – WRES Data 2018

Relative likelihood of staff being appointed from shortlisting across all posts

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>BME</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Relative likelihood</td>
<td>1.38 times</td>
<td>1.67 times</td>
</tr>
<tr>
<td>compared to BME</td>
<td>greater</td>
<td>greater</td>
</tr>
</tbody>
</table>

A figure below “1” would indicate that white candidates are less likely than BME candidates to be appointed from shortlisting.

Relative likelihood of staff entering the formal disciplinary process as measured by entry into a formal disciplinary investigation.

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BME</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>White</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Relative likelihood</td>
<td>1.73 times</td>
<td></td>
</tr>
<tr>
<td>compared to white</td>
<td>greater</td>
<td></td>
</tr>
</tbody>
</table>

Data not available for this reporting period.

Relative likelihood of staff accessing non-mandatory training and CPD

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data is collected at</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a local level and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>not on ESR. This is</td>
<td></td>
<td></td>
</tr>
<tr>
<td>being addressed in</td>
<td></td>
<td></td>
</tr>
<tr>
<td>the accompanying</td>
<td></td>
<td></td>
</tr>
<tr>
<td>action plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data not available</td>
<td></td>
<td></td>
</tr>
<tr>
<td>for this reporting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>period.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>BME</td>
<td>28%</td>
<td>23%</td>
</tr>
<tr>
<td>White</td>
<td>25.4%</td>
<td>25%</td>
</tr>
</tbody>
</table>

### Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>BME</td>
<td>18.2%</td>
<td>19%</td>
</tr>
<tr>
<td>White</td>
<td>21.7%</td>
<td>26%</td>
</tr>
</tbody>
</table>

### Percentage believing that the Trust provides equal opportunities for career progression promotion

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>BME</td>
<td>80.3%</td>
<td>74%</td>
</tr>
<tr>
<td>White</td>
<td>82.4%</td>
<td>84%</td>
</tr>
</tbody>
</table>

### In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/team leader or other colleagues

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>BME</td>
<td>11.5%</td>
<td>17%</td>
</tr>
<tr>
<td>White</td>
<td>6.6%</td>
<td>7%</td>
</tr>
</tbody>
</table>

### Percentage difference between the organisations’ Board voting membership and its overall workforce

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Board BAME representation is <strong>6.8%</strong> below the overall workforce representation</td>
<td>Board BAME representation is <strong>7.1%</strong> below the overall workforce representation</td>
</tr>
</tbody>
</table>
## Percentage of staff in each of the ACG Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce.

The data shows that BME staff are under-represented in the upper bands. This is a similar pattern to previous years.

**Action Planned**
- Develop BME staff network
- Contact all BME staff in both non-clinical and clinical in Bands 8a and above to make them aware of development opportunities available.
- Target BME staff in Band 5 and above to encourage them to attend courses within the Leadership Academy.
- Look at alternative methods of advertising jobs in the community and through specific BME forums

**Lead**
- E&D Facilitator
- Learning & Development
- Learning & Development
- Recruitment Manager/E&D Facilitator

**Review Date**
- December 2018
- December 2018
- December 2018
- December 2018

**Status**

## Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts

To address that non BME staff are 1.38 times more likely to be appointed than BME shortlisted applicants.

**Action Planned**
- Undertake equality analysis of current recruitment process'
- Unconscious bias training to be delivered to all decision makers on recruitment panels
- Spot check to be completed as to why BME staff not appointed

**Lead**
- E&D Facilitator
- Learning & Development
- Recruitment Manager

**Review Date**
- December 2018
- March 2019
- December 2018

## Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process

To address that BME staff are 1.73 times more likely to enter the disciplinary process compared to White staff.

**Action Planned**
- Undertake an in depth analysis of qualitative and quantitative data to identify issues and trends by department, profession and band
- Develop EDI staff network

**Lead**
- HR Business Partner
- E&D Facilitator

**Review Date**
- February 2019
- December 2018

## Relative likelihood of White staff accessing non mandatory training and CPD as compared to BME staff

To address that currently the Trust collects training data at a local level and not centrally through ESR.

**Action Planned**
- Consider methodology of capturing this information centrally on ESR

**Lead**
- Workforce Systems

**Review Date**
- January 2019

## KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

To address that there has been an increase in the percentage of BME staff who have experienced bullying and harassment from patients, relatives and the public in the last 12 months.

**Action Planned**
- Develop and promote support available for victims of bullying and harassment i.e. EDI champions, Freedom To Speak Up Guardian, BME staff network through staff induction, desktop message, Trust intranet pages

**Lead**
- E&D Facilitator/FTSUG

**Review Date**
- January 2019

## KF 19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

There has been a decrease in both BME and White staff reporting they have experienced harassment and bullying from staff in the last 12 months.

**Action Planned**
- Develop and promote support available for victims of bullying and harassment i.e. EDI champions, Freedom To Speak Up Guardian, BME staff network through staff induction, desktop message, Trust intranet pages

**Lead**
- E&D Facilitator

**Review Date**
- January 2019
### WRES Action Plan 2018/19

<table>
<thead>
<tr>
<th>KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion</th>
<th>To further increase the number of BME staff who believe the Trust provides equal opportunities for career progression or promotion</th>
<th>HRBPs</th>
<th>November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Communicate the 2017/18 WRES position through Divisional meetings</td>
<td></td>
<td>E&amp;D Facilitator</td>
</tr>
<tr>
<td></td>
<td>Communicate the 2017/18 WRES position through Trust Wide comms channels</td>
<td></td>
<td>E&amp;D Facilitator</td>
</tr>
<tr>
<td></td>
<td>Target BME staff in Band 5 and above to encourage them to attend courses within the Leadership Academy.</td>
<td></td>
<td>E&amp;D Facilitator</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In the last 12 months have you personally experienced discrimination at work from any of the following – management/team leader or other colleagues</th>
<th>The data shows that BME staff are more likely to experience discrimination at work from managers, team leaders or other colleagues</th>
<th>E&amp;D Facilitator</th>
<th>January 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Empower the BME network in partnership with the EDI staff champions to become a safe place for staff to discuss discrimination and access support</td>
<td></td>
<td>E&amp;D Facilitator</td>
</tr>
<tr>
<td></td>
<td>Review E&amp;D training provision for line managers</td>
<td></td>
<td>E&amp;D Facilitator</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage difference between the organisation’s Board voting membership and its overall workforce. Note: Only voting members of the Board should be included</th>
<th>The data shows that the Trusts Board does not yet fully reflect BME representation within the overall workforce</th>
<th>E&amp;D Facilitator</th>
<th>January 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Conduct an E&amp;D Board session to include a section on WRES in conjunction with the CCG.</td>
<td></td>
<td>E&amp;D Facilitator</td>
</tr>
</tbody>
</table>
### Appendix 3 WRES Data 2018 Comparison between RLBUHT and Aintree

<table>
<thead>
<tr>
<th></th>
<th>Aintree</th>
<th>RLBUHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of BME Staff employed at July 2018</td>
<td>6.8%</td>
<td>11.38%</td>
</tr>
</tbody>
</table>

#### Indicator

1. **Percentage of BME staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce**

<table>
<thead>
<tr>
<th>Band</th>
<th>Aintree Non–Clinical</th>
<th>Aintree Clinical</th>
<th>RLBUHT Non–Clinical</th>
<th>RLBUHT Clinical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 2</td>
<td>1.1%</td>
<td>3.1%</td>
<td>3.82%</td>
<td>10.66%</td>
</tr>
<tr>
<td>Band 3</td>
<td>0.7%</td>
<td>0.6%</td>
<td>4.32%</td>
<td>6.43%</td>
</tr>
<tr>
<td>Band 4</td>
<td>0.7%</td>
<td>1.2%</td>
<td>4.55%</td>
<td>14.96%</td>
</tr>
<tr>
<td>Band 5</td>
<td>3.4%</td>
<td>12.4%</td>
<td>3.85%</td>
<td>23.08%</td>
</tr>
<tr>
<td>Band 6</td>
<td>1.6%</td>
<td>7.7%</td>
<td>4.17%</td>
<td>10.95%</td>
</tr>
<tr>
<td>Band 7</td>
<td>1.9%</td>
<td>3.6%</td>
<td>4.49%</td>
<td>6.69%</td>
</tr>
<tr>
<td>Band 8a</td>
<td>0%</td>
<td>3.2%</td>
<td>1.19%</td>
<td>4.15%</td>
</tr>
<tr>
<td>Band 8b</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>11.48%</td>
</tr>
<tr>
<td>Band 8c</td>
<td>7%</td>
<td>0%</td>
<td>3.23%</td>
<td>4.35%</td>
</tr>
<tr>
<td>Band 8d</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>14.29%</td>
</tr>
<tr>
<td>Band 9</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Relative likelihood of staff being appointed from shortlisting across all posts**

A figure below “1” would indicate that white candidates are less likely than BME candidates to be appointed from shortlisting.

- Relative likelihood of white staff being appointed from shortlisting compared to BME staff is **1.38** times greater
- Relative likelihood of white staff being appointed from shortlisting compared to BME staff is **1.36** times greater

**Relative likelihood of staff entering the formal disciplinary process as measured by entry into a formal disciplinary investigation.**

A figure below 1 would indicate that BME staff member are less likely than white staff to enter the formal disciplinary process.

- Relative likelihood of BME staff entering the disciplinary procedure compared to white staff is **1.73** times greater
- BME staff are **0.77 times less likely** to enter the disciplinary process compared to white staff
<table>
<thead>
<tr>
<th><strong>Relative likelihood of staff accessing non-mandatory training and CPD</strong></th>
<th>Data unavailable for Aintree</th>
<th>Likelihood of white staff accessing non-mandatory training compared to BME staff is 1.19 times greater</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key Finding 25. Percentage of staff experiencing harassment, bullying or abuse form patients, relatives or the public in the last 12 months</strong></td>
<td>BME: 28% White: 25.4%</td>
<td>BME: 29% White: 22%</td>
</tr>
<tr>
<td><strong>Key Finding 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.</strong></td>
<td>BME: 18.2% White: 21.7%</td>
<td>BME: 26% White: 22%</td>
</tr>
<tr>
<td><strong>Key Finding 21. Percentage believing that the trust provides equal opportunities for career progression or promotion.</strong></td>
<td>BME: 80.3% White: 82.4%</td>
<td>BME: 72% White: 85%</td>
</tr>
<tr>
<td><strong>Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/team leader of other colleagues</strong></td>
<td>BME: 11.5% White: 6.6%</td>
<td>BME: 16% White: 7%</td>
</tr>
<tr>
<td><strong>Percentage difference between the organisations’ Board voting membership and its overall workforce.</strong></td>
<td>Board BAME representation is 6.8% below the overall workforce representation</td>
<td>Board BAME representation is 11.38% below the overall workforce representation</td>
</tr>
</tbody>
</table>

**NB.** Only voting members of the Board should be included when considering this indicator