Warrington and Halton Hospital NHS Foundation Trust
Board of Directors
Agenda
Wednesday 29th April 2015, time 1300 – 1700 hrs
Trust Conference Room, Warrington Hospital

Papers 2

People

1455 ***05mins***	***W&HHFT/TB/15/076***	***Verbal Report from the Chair of the Strategic People Committee***	Verbal	Anita Wainwright, Non-Executive Director
1500 ***10mins***	***W&HHFT/TB/15/077***	***Workforce and Educational Development Key Performance Indicators***	Paper	Director of HR & OD
1510 ***20mins***	***W&HHFT/TB/15/078***	***i. Monthly Ward Staffing Report*** ***ii. 6 month Ward Staffing Report***	Papers/ Presentation	Director of Nursing and Governance

Sustainability

1530 ***05mins***	***W&HHFT/TB/15/079***	***Verbal Report from the Chair of the Finance and Sustainability Committee*** ***i. Terms of Reference of the Board Oversight Group - Lorenzo***	Verbal	Terry Atherton, Non-Executive Director
1535 ***15mins***	***W&HHFT/TB/15/080***	***Finance Report – 31st March 2015***	Paper	Director of Finance & Corporate Development
1550 ***15mins***	***W&HHFT/TB/15/081***	***Corporate Performance Report – 28th February 2015***	Paper	Chief Operating Officer
1605 ***10mins***	***W&HHFT/TB/15/082***	***Radiology Update***	Paper	Chief Operating Officer
1615 ***10mins***	***W&HHFT/TB/15/083***	***Corporate Risk Register***	Paper	Director of Nursing and Governance
1625 ***10mins***	***W&HHFT/TB/15/084***	***Board Assurance Framework 2014/15 and update on progress for 2015/16 against new agreed strategic objectives.***	Paper	Director of Nursing and Governance
1635 ***15mins***	***W&HHFT/TB/15/085***	***Q4 Monitor Quarterly Reporting Compliance Report***	Paper	Director of Finance & Corporate Development
1650 ***10mins***	***W&HHFT/TB/15/086***	***Other Board Committee Reports:*** ***Minutes for Noting:*** ***a) Minutes of the Strategic People Committee 9 February 2015*** ***b) Minutes of the Quality Governance Committee 13 January 2015*** ***c) Finance and Sustainability Committee held on 17 March 2015***	Paper	
	W&HHFT/TB/15/087	***Any Other Business***		
1700 ***ends***		***Dates of next meeting*** *27th May 2015*		

BOARD OF DIRECTORS

WHH/B/2015/ **076**

SUBJECT:	**Verbal Report from the Chair of the Strategic People Committee**
DATE OF MEETING:	29th April 2015
DIRECTOR:	Anita Wainwright, Non-Executive Director

BOARD OF DIRECTORS

WHH/B/2015/ **077**

SUBJECT:	Human Resources / Education & Development Key Performance Indicators (KPIs) Report	
DATE OF MEETING:	29th April 2015	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Mick Curwen, Associate Director of HR	
EXECUTIVE DIRECTOR:	Roger Wilson, Interim Director of HR and OD	
LINK TO STRATEGIC OBJECTIVES:	SO2: To be the employer of choice for healthcare we deliver	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	• With the exception of Health and Safety, very little change in Mandatory Training and PDR rates • 12 more doctors revalidated • In month reduction in sickness rate • Turnover and Vacancy rates have improved/stabilised. Headcount has increased to its highest rate ever and vacancies continue to be at a low level • Increase in temporary staffing expenditure to highest monthly level • High number of medical staff vacancies but some success with consultant appointments • All main Equality and Diversity targets achieved for 2014	
RECOMMENDATION:	***The Board is asked to:*** Note progress on the achievement of the KPIs and the action being taken to try and address shortfalls where appropriate.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Not Applicable

Appendix 1

Human Resources / Education & Development
Key Performance Indicators Report April 2015

1.0 Introduction

This report focuses on the KPIs which are felt to give a good indication on progress with the main workforce and governance performance areas within Human Resources and Education and Development.

Some KPIs lend themselves to monthly monitoring whilst others are bi-monthly, quarterly, bi-annually or annually and this is indicated on the 'dashboard' attached. With all of the KPIs the performance is shown under the traffic light system of Red, Amber or Green against the target and the threshold criteria. This should enable Board members to see at a glance the progress being made and to allow a greater focus on those areas which are red or amber. This 'dashboard' is part of a wider number of KPIs which are monitored at the Strategic People Committee and their links to CQC/NHSLA compliance.

The dashboard attached to this report shows the progress on KPIs, focussing on the position at March 2015, where applicable.

2.0 HR and E&D Trust Workforce Standards KPIs Overview

2.1 Mandatory Training

The target for all mandatory training is 85%.

There has been very little change to the mandatory training rates for Manual Handling and Fire but following the significant reduction in February for Health and Safety, there has been some recovery in March. However, individually, some Divisions/areas are meeting the trust target for some parts of the mandatory training.

Completion rates for the Divisions are as follows (figures in brackets denotes the month of February 2015):

Division	Fire Safety	Health & Safety	Manual Handling
Scheduled Care	71% (70%) (Amber)	31% (21%) (Red)	62% (63%) (Red)
Unscheduled Care	72% (69%) (Amber)	35% (26%) (Red)	57% (55%) (Red)
Women's & Children's	73% (74%) (Amber)	46% (40%) (Red)	79% (78%) (Amber)
Estates	90% (90%) (Green)	72% (74%) (Amber)	97% (97%) (Green)
Facilities	85% (84%) (Amber)	62% (48%) (Red)	89% (85%) (Green)
Corporate Areas	82% (79%) (Amber)	79% (73%) (Amber)	82% (77%) (Amber)

None of the areas are achieving all of the targets. For Fire and Manual Handling most areas remained similar to the previous month but all areas except Estates have seen increases for Health and Safety. Estates are the only area showing reasonable levels of compliance.

At a Corporate level the arrangements introduced in September 2012 for Corporate Induction continue to work well but there was a slight reduction to 96% of staff who attended corporate induction during March 2015.

2.1.1 Health & Safety (Red)

From the significant drop In February coinciding with the move to annual rather than 3 yearly reporting for Health and Safety, there has been some recovery during March with an increase of 11% to 47%. However, the target for 2014/15 of 85% was not achieved.

2.1.2 Fire Safety (Amber)

There has been no change for the previous 5 months and the rate is 74% and amber which means the target for 2014/15 was not achieved.

2.1.3 Manual Handling – Patient / Non-Patient Combined (Amber)

There was a slight increase of 2% from the previous month and the rate is 72% and the status is amber. The target of 85% for 2014/15 was therefore not achieved.

2.1.3.1 Manual Handling Patient Training Only (Red)

There was no change from the previous month and the rate remains at 64% and red.

2.1.3.2 Manual Handling Non-Patient Training Only (Amber)

There was an increase of 1% from the previous month and the rate is 80% and amber.

2.2 Staff Appraisals

The target for completed PDRs is 85%.

During February there was no change for Non- Medical staff but there was a reduction for Medical and Dental staff.

Completion rates for the Divisions for non-medical staff are as follows (figures in brackets denotes the month of February 2015):

Division	PDR Rate
Scheduled Care	74% (68%) (Red)
Unscheduled Care	62% (65%) (Red)
Women's and Children's	70% (71%) (Amber)
Estates	72% (68%) (Amber)
Facilities	85% (86%) (Green)
Corporate Areas	80% (79%) (Amber)

Only Facilities are meeting the target but with the exception of Unscheduled Care, all other areas are now amber.

2.2.1 Non-Medical Staff (Amber)

For the period up to February 2015 the percentage of non-medical staff having had an appraisal remained the same at 71% (amber) and the target for 2014/15 was not met.

2.2.2 Medical & Dental Staff (Amber)

The combined rate for Consultant staff and Middle Grade doctors, up to March 2015 fell by 3% to 81%. The rate for Consultants reduced by 2% to 87% and other M&D fell by 4% to 69%.

This means that the target of 85% was not achieved and the status remains as amber.

Divisions have been reminded at the bi-lateral meetings that priority must still be given to appraisal rates despite the financial position and these are regularly reviewed. The trust is also introducing a new performance culture with a much greater emphasis on both PDR

rates and mandatory training. This is underpinned by a new 'Performance Improvement Policy' and an 'Incremental Pay Progression Policy'.

2.3 Revalidation for Medical and Dental Staff (Green)

The Revalidation Decision Making Group met as planned on 31 March 2015. A further 12 doctors have now been revalidated which increases the total to 120 with 20 doctors deferred. This maintains the rate at 86% and the status 'Green' which means the target was achieved.

The next meeting of the Decision Making Group has been arranged for 19 May 2015

2.4 Sickness Absence

2.4.1 Sickness Absence Rates (Amber)

The new sickness absence target for 2014/15 is 3.75%.

Sickness absence for March 2015 remains high at 4.78% but this was an improvement of 0.42% from the previous month and is the best month since September 2015. The cumulative rate for April – March 2015 was 4.68% and the target for 2014/15 was not achieved.

Other trusts have experienced similar increases in sickness absence.

Sickness absence continues to be closely monitored and managed in all areas in the Trust in line with the Attendance at Work Policy. The number of staff being managed either through the Short Term Absence or Long Term Absence Sections of the policy, remains high at over 280 staff.

2.4.2 Return to Work Interviews (RTW) (Red)

The target for this KPI is 85% and is only reported on a quarterly basis. The rate for Q4 was disappointing at 47% which was a reduction of 6% from Q3.

At training sessions and when completing eSVLs, managers are reminded of the need to undertake RTW interviews and record these on ESR. It is still believed that more RTW interviews are actually taking place but managers are failing to record this on ESR. This is an issue which will also be addressed as part of the new performance culture.

2.5 Turnover Rate (Amber)

The target for this KPI is min 8% or max 9%. This is designed to reflect that both a high and a low figure could be detrimental to the interests of the trust. A high figure could indicate dissatisfaction with the trust and lead to increased recruitment and training costs. A low figure could indicate a 'stagnant' workforce with potential lack of new ideas and inspiration.

The rate for the previous 12 months up to March 2015 showed a deterioration of 0.49% to 10.41% and the status is amber. The target for 2014/15 of being between 8 – 9% was therefore not met. The turnover rate remains high in both Unscheduled Care and Scheduled Care at 11.57% and 11.29% respectively. As previously reported, both of these Divisions are undertaking further analysis of leavers by personal interviews to understand in more detail why staff are leaving. Scheduled Care results have already been reported but work is still being undertaken within Unscheduled Care.

2.6 Funded Establishment / Staff In-Post / Vacancies (Green)

The Trust FE FTE was 3717 and staff in post 3449 FTE. This means the vacancies FTE has improved to 7.21%, which is the best month of the year. The status remains as 'green' and the target was achieved. The number of vacancies was at its lowest level all year at 268.

The headcount continues to rise at 4234 and is the highest ever in the trust and was an increase of 11 from the previous month.

This is a very positive position for the trust with high staff in post figures, lower vacancy rate and relatively few vacancies.

2.7 Expenditure on NHSP Bank/Agency/Medical Locum (Red)

The threshold for this KPI is 4.5% of total pay bill. Total spend in March 2015 increased by £205k and was £1398k, which represents 12.18% of the pay bill for the month and cumulatively for April – March 2015 the rate is 8.37%. Against the agreed threshold for 2014/15 of 4.5% the status, therefore, is 'Red' and was not achieved.

Details of the main areas of expenditure for March are as follows:

Nurse Bank and Agency Nursing - £526k (£461k for February)
Agency (exc Medical & Nursing Agency) - £550k (£446k for February)
Medical Locums and Medical Agency - £526k (£491k for February)

All three areas show an increase as follows: Nurse Bank/Agency by £65; Agency by £104k and Medical Locums /Agency by £35k. It is important to note that agency expenditure is largely attributable to the Lorenzo project which showed £414k for March but the project as a whole is underspent on budget.

Total expenditure for the period April – March 2015 is £12.9m broken down as follows:

Nurse Bank and Agency Nursing - £5.2m
Agency (exc Medical and Nursing Agency) - £3.1m
Medical Locums and Medical Agency - £4.7m

NB In order to staff the additional intermediate care beds which were opened earlier this year the trust had to recruit staff predominantly from agencies and some of these staff have continued to be needed to meet additional staffing pressures. The total additional expenditure which is being met externally from Warrington CCG is now £494k which is included in the above amounts. However, the CCG have now indicated that funding for therapy staff can be made permanent and the Therapy Departments are in the process of making appointments on AfC contracts but do not expect to have staff in post until March 2015.

During March the unprecedented demand on beds continued with many areas escalated and led to the 'Perfect 14' project commencing in April. This has placed an additional demand for unfunded staffing and many of these have been agency staff.

The main focus of attention remains on Nurse Bank/Agency and Medical Locum/Agency expenditure.

The main 'Hot Spot' areas of expenditure during March were as follows:

<u>Nurse Bank and Agency Nursing</u>
Elderly and Stroke - £145k (£53k on agency) (£130k in Feb)
A&E - £106k (£93k on agency) (£117k in Feb)
Critical Care - £91k (£67k in Feb)

Specialty Medicine - £58k (£52k in Feb)

Acute Medicine – £47k (£17k on agency) (£62k in Feb)
T&O - £40k (£35k in Feb)
Surgery - £39k (£35k in Feb)
Women's - £32k (£28k in Feb)

Agency
Lorenzo - £414k (£387k in Feb)
Pharmacy - £40k (£34k in Feb)
PMO – £25k (£39k in Feb)
Radiology - £25k (£12k in Feb)

Medical Locums/Agency
Elderly and Stroke - £294k (£215k in Feb)
T&O - £74k (£82k in Jan)
Surgery - £53k (£53k in Feb)
A&E - £31k (£40k in Feb)
Child Health - £23k (£29k in Feb)
Specialty Medicine - £20k (£41k in Feb)
Women's Health - £21k (£10k in Feb)

There are a number of workforce initiatives designed to reduce the time taken to recruit staff and reduce temporary staffing expenditure. Progress is as follows:

Nursing Recruitment
Discussions have been held with Nurse Managers in Unscheduled Care and Scheduled Care and it has been agreed to have rolling adverts covering both Divisions and regular interviews on a monthly basis with support from Employment Services, Occupational Health and Nurse Education. In addition, a process is being finalised which will allow some nursing areas to recruit to over establishment. This is 'low risk' given the turnover and sickness and the amount of temporary staffing expenditure being incurred.

International Recruitment
The trust is working with an agency called Globalmedirec to recruit Consultant Radiologists. From the first round of interviews one doctor accepted an offer of employment and commenced on 10.11.14. Traditional advertising has also taken place and from interviews held on 9.4.15 it has been possible to recruit 3 further consultant radiologists who will commence in post later in the year. This is excellent news for radiology.

Unscheduled care have identified a number of consultant posts suitable for international recruitment and a second block advert has been placed in the BMJ as well as this advert appearing in the Indian press. The Division has had more success and is hopeful that a candidate will accept the post of Consultant in Respiratory Medicine.

The trust is in discussion with NHS Professionals to explore the possibility of recruiting c20 nurses from overseas.

Recruitment Process
The trust is working on a number of initiatives to streamline the recruitment process and the first phase has been implemented and publicised in key Divisions. The second phase involves putting in place a revised ECF/Vacancy Control process using Share Point and it is planned to implement this from 4 May 2015. The trust has worked with 'Stirling Cross' to advertise nursing posts in the Nursing Standard and other media including Twitter and Facebook.

E-Rostering
23 Wards/areas are now live including 20 which are fully live through ESR and 3 more planned for May for ESR purposes. This will then be followed by Theatres and Maternity and the roll out will then be complete.

De Poel
Discussions are continuing with De Poel to resolve the contractual difficulties and commencement of the project is imminent.

Work is continuing on the Medical Productivity work stream. There has been some slippage with reviewing job plans but the Divisions are trying to recover this position. The trust is working with Allocate and a business case has now been agreed to roll out e rostering for medical and dental staff across the trust. This business case also covered the implementation of an electronic expenses system.

The number of Medical and Dental vacancies is currently contributing to the expenditure on Medical Locum/Agency and a summary is shown below:

Division/Post	**Closing Date**	**Interview Date**	**Comments**
Womens and Childrens			
LAS Senior Specialty Trainee in Paediatrics	30.4.15		
LAS JST in Paediatrics	26.3.15	27.4.15	
Specialty Doctor in O&G	1.4.15	15.4.15	Dr S Shah appointed
Scheduled Care			
LAS JST in Urology	6.4.15		Shortlisting completed
LAS SST Breast Surgery	14.4.15		Skype interview. Appointment made
LAS JST T&O	30.3.15		Shortlisting completed
Consultant Anaesthetist x 3	26.4.15	1.6.15	
Unscheduled Care			
Consultant Respiratory Medicine	16.3.15	20.4.15	Offer made. Awaiting acceptance
LAS SST Elderly Care	21.4.14		
Consultant in Gastroenterology x 7	26.4.15	29.6.15	
Consultant Elderly Care - Acute	22.2.15	27.4.15	Doctor confirmed attending interview
Consultant Elderly Care - Acute	26.4.15	19.6.15	
Consultant Elderly Care - Orthogeriatric	26.4.15	15.6.15	
Consultant Elderly Care - Dementia	26.4.15	11.6.15	
Locum Consultant in Emergency Care	6.5.15	11.6.15	
Consultant Stroke Medicine	26.4.15	4.6.15	
LAS ST1-2 in Emergency Medicine			Awaiting VCF
Consultant Respiratory Medicine	26.4.15	22.6.15	

LAS SST Gastroenterology Medicine	7.4.15	16.4.15	Doctor appointed

Discussions and monitoring of progress continue on all of the above issues at the bi-lateral divisional review meetings. The Chief Operating Officer has also introduced weekly review meetings with the Associate Divisional Directors and additional controls have been introduced on authorisation levels by the Chief Executive.

2.8 Equality & Diversity

2.8.1 E&D Specialist in place (Green)

A new SLA for an E&D Specialist Adviser SLA with the Countess of Chester Hospital Trust has now been agreed from June 2014 for a period of 2 years.

2.8.2 Annual Workforce Equality Analysis Report published (Green)

This was achieved for 2014 with the Report published on the Trust Website. Therefore, the status is 'green'.

2.8.3 Annual Equality Duty Assurance report published (Green)

This was achieved for 2014 with the Report published on the Trust Website. Therefore, the status is 'green'.

2.8.4 Annual Equality Objectives published (Green)

This was achieved for 2014 and the status is 'green'.

2.8.5 Annual Equality Strategy published (Green)

This was achieved for 2014 and the status is 'green'

2.8.6 Staff have access to E&D information and resources (Green)

Trust staff do have access to E&D information and resources.

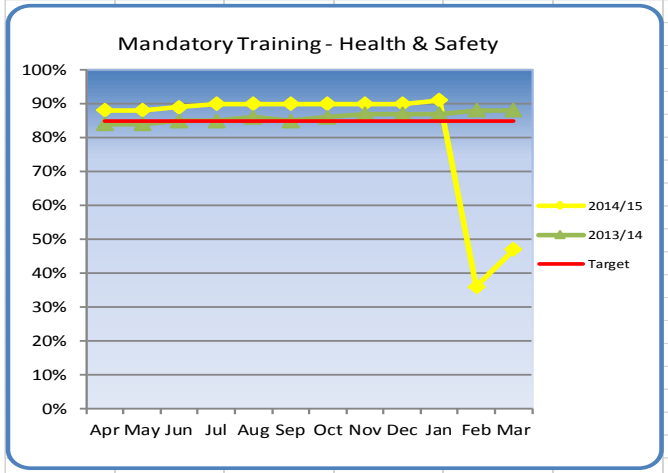
2.8.7 Staff have undertaken E&D Mandatory Training (Red)

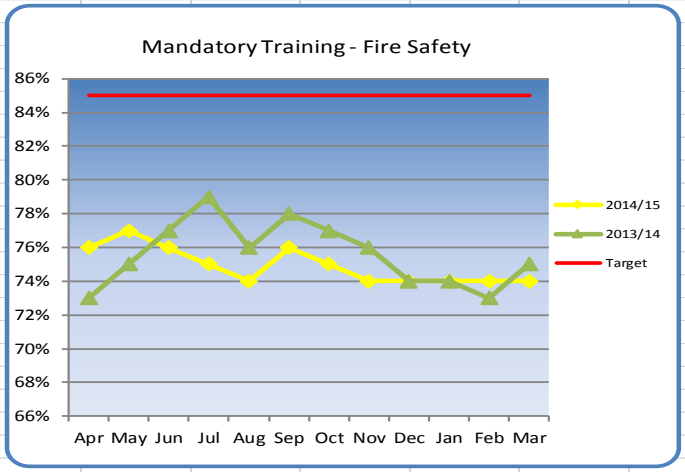
There has been an increase of 3% from Q3 to 67% at Q4.

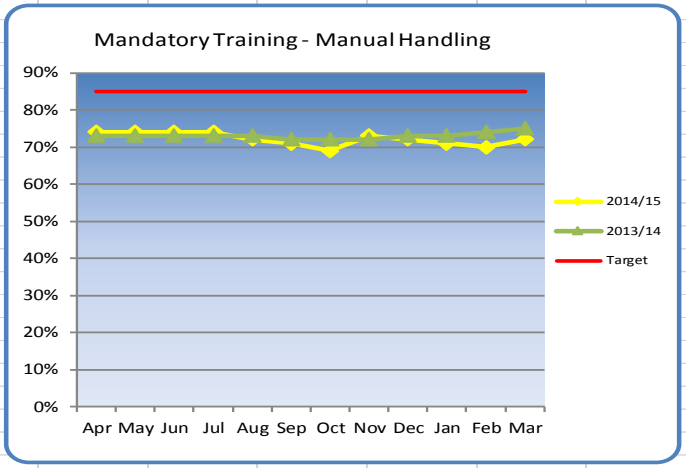
Warrington and Halton Hospitals NHS Foundation Trust
Governance & Workforce Division
Human Resources / Education & Development Workforce Key Performance Indicators

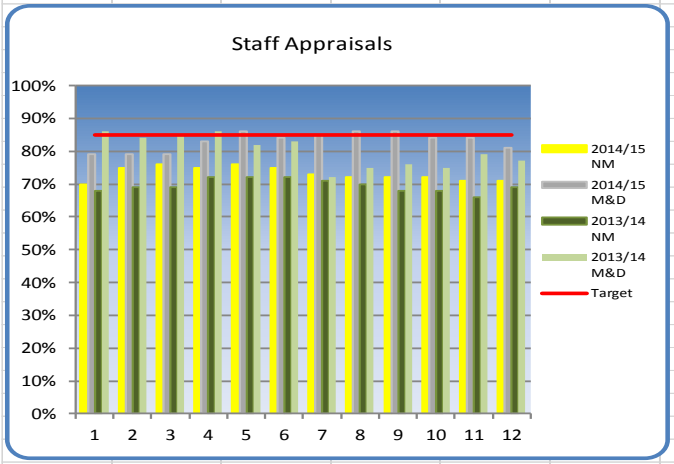
2014/15			Target / Threshold	Frequency	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year to Date	Criteria for RAG Status: Green	Amber	Red
Training & Development	Mandatory Training	Heallth & Safety	85% staff trained in last 3 years	Monthly	88%	88%	89%	90%	90%	90%	90%	90%	90%	91%	36%	47%	**47%**	85 - 100%	70 - 84%	< 70%
		Fire Safety	85% staff trained in last 12 months	Monthly	76%	77%	76%	75%	74%	76%	75%	74%	74%	74%	74%	74%	**74%**	85 - 100%	70 - 84%	< 70%
		Manual Handling - Patient	85% staff trained in last 2 years	Monthly	67%	67%	67%	68%	65%	64%	65%	67%	66%	65%	64%	64%	**64%**	85 - 100%	70 - 84%	< 70%
		Manual Handling - Non-Patient			86%	85%	85%	83%	82%	80%	76%	81%	81%	78%	79%	80%	**80%**			
		Manual Handling - Total			74%	74%	74%	74%	72%	71%	69%	73%	72%	71%	70%	72%	**72%**			
	Staff Appraisals	Non Medical	85% staff received appraisal in last 12 months	Monthly	70%	75%	76%	75%	76%	75%	73%	72%	72%	72%	71%	71%	**71%**	85 - 100%	70 - 84%	< 70%
		Medical & Dental - consultants & career grades, (exc Jnr Drs)			79%	79%	79%	83%	86%	84%	85%	86%	86%	84%	84%	81%	**81%**			
	Revalidation for Medical & Dental Staff		85% of eligible M& D Staff revalidated	Monthly	81%	81%	82%	82%	82%	82%	84%	84%	85%	86%	86%	86%	**86%**	85 - 100%	70 - 84%	< 70%
Sickness Absence	Sickness Absence Rates		4%	Monthly	4.18%	3.99%	3.98%	3.94%	3.70%	4.31%	4.90%	4.82%	5.35%	5.15%	5.20%	4.78%	**4.68%**	3.75%	3.76-4.49%	> 4.50%
	Return to work interviews (wef 2013/14)		85%	Quarterly			53%			59%			53%			47%	**47%**	85 - 100%	70 - 84%	< 70%
Workforce	Turnover (Leavers)		Min 8% or Max 9%	Monthly	9.0%	9.1%	9.3%	9.3%	9.7%	9.4%	9.4%	10.1%	10.2%	10.1%	9.9%	10.4%	**10.4%**	8 - 9%	5 - 7.9% / 9.1 - 12%	< 5% / > 12%
	Establishment / SIP	Funded WTE (see NB 1 below)	Min 6.5% or Max 10% FE / SIP gap	Monthly	3686	3676	3682	3674	3695	3700	3696	3706	3717	3706	3714	3717	**3717**	6.5 - 10%	5 - 6.4% / 10.1 - 12%	< 5% / > 12%
		Staff in Post WTE (see NB 1 below)			3392	3391	3371	3375	3424	3382	3399	3408	3409	3429	3436	3449	**3449**			
		Staff in Post Headcount (see NB 2 below)			4171	4155	4134	4143	4156	4152	4172	4162	4182	4205	4223	4234	**4234**			
		Vacancies WTE (see NB 1 below)			294	285	311	299	271	318	297	298	308	277	278	268	**268**			
		Vacancies %			7.97%	7.75%	8.44%	8.13%	7.33%	8.59%	8.03%	8.04%	8.28%	7.47%	7.48%	7.21%	**7.21%**			
	Flexible Labour Expenditure (% of total paybill)	Bank / Agency / Medical Locums Total	4.5%	Monthly	6.6%	6.7%	7.6%	6.7%	7.9%	7.3%	7.3%	9.1%	7.5%	10.3%	10.46%	12.18%	**8.37%**	4.5%	4.6 - 5.0%	> 5.0%
	Equality & Diversity	E&D Specialist in place	Achieved	6-monthly						Achieved						Achieved	**Achieved**	Achieved	Work in progress	No progress
		Annual Workforce Equality Analysis report published	Achieved	Annual												Achieved	**Achieved**	Achieved	Work in progress	No progress
		Annual Equality Duty Assurance report published	Achieved	Annual												Achieved	**Achieved**	Achieved	Work in progress	No progress
		Annual Equality Objectives published	Achieved	Annual												Achieved	**Achieved**	Achieved	Work in progress	No progress
		Annual Equality Strategy published	Achieved	Annual												Achieved	**Achieved**	Achieved	Work in progress	No progress
		Staff have access to E&D information and resources	Achieved	6-monthly						Achieved						Achieved	**Achieved**	Achieved	Work in progress	No progress
		Staff have undertaken E&D training	85% staff trained	6-monthly			62%			63%			64%			67%	67%	85 - 100%	70 - 84%	< 70%

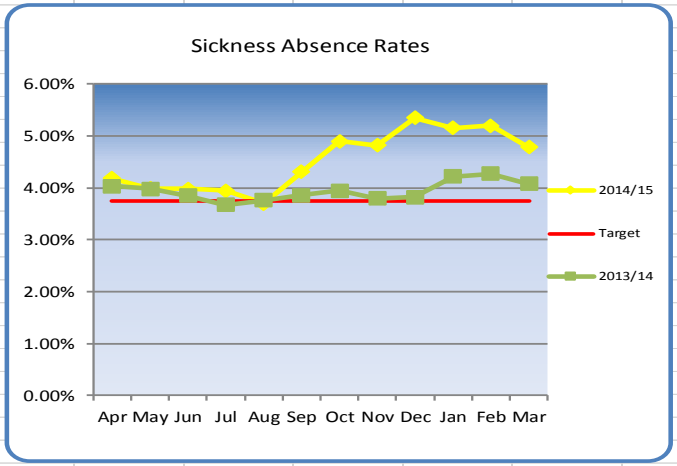
NB 1 Figures from Finance Ledger	**R**	**Red**	**A**	**Amber**	**G**	**Green**
NB 2 Figures from HR ESR						

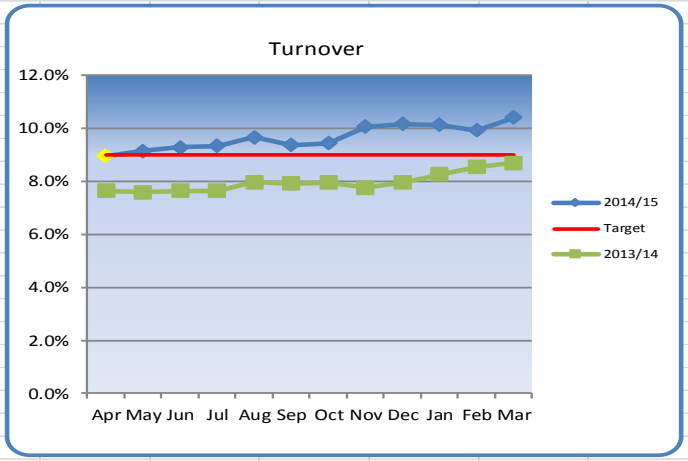

Mandatory Training - Health & Safety
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
2013/14
Target

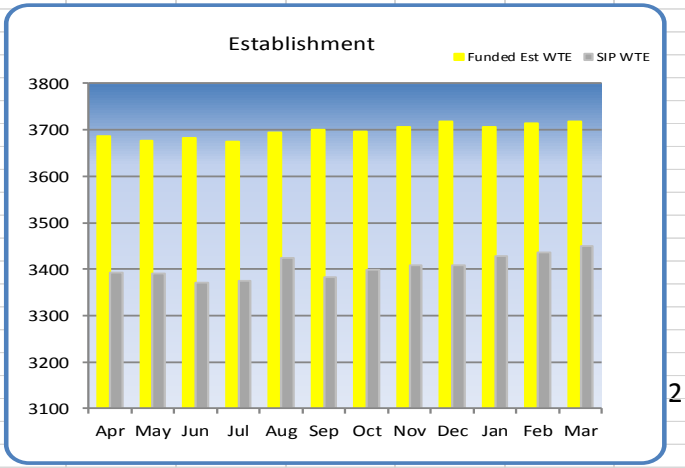

Mandatory Training - Fire Safety
86%
84%
82%
80%
78%
76%
74%
72%
70%
68%
66%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
2013/14
Target

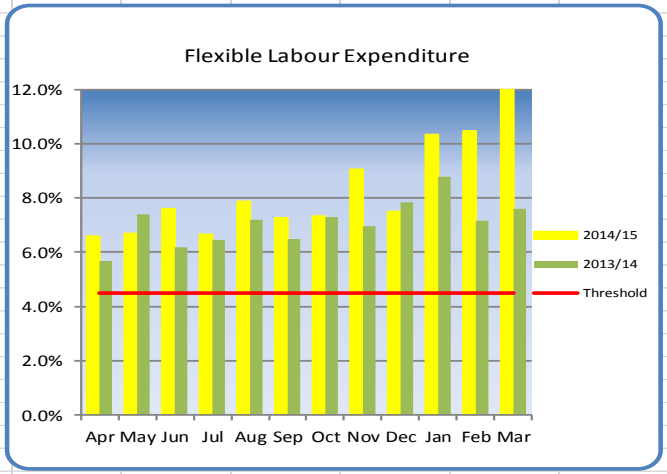

Mandatory Training - Manual Handling
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
2013/14
Target


Staff Appraisals
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
1 2 3 4 5 6 7 8 9 10 11 12
2014/15 NM
2014/15 M&D
2013/14 NM
2013/14 M&D
Target


Sickness Absence Rates
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
Target
2013/14


Turnover
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
Target
2013/14


Establishment
Funded Est WTE
SIP WTE
3800
3700
3600
3500
3400
3300
3200
3100
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar


Flexible Labour Expenditure
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
2013/14
Threshold

BOARD OF DIRECTORS

WHH/B/2015/ **078(i)**

SUBJECT:	**Monthly Staffing Exceptions Report**	
DATE OF MEETING:	29th April 2015	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Alison Lynch (Deputy Director of Nursing Quality and Patient Experience)	
EXECUTIVE DIRECTOR:	Karen Dawber, Director of Nursing and Governance	
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care SO3: To give our patients the best possible experience SO4: To provide sustainable local healthcare services	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework SO3/3.3 Failure to provide staff, public and regulators with assurances post Francis and Keogh review Choose an item.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides an overview of nurse staffing for March 2015. Links to the Safety Thermometer are also included to assist in triangulation of incidents with staffing levels.	
RECOMMENDATION:	***The Board is asked to:*** 1. Note the contents of this report, which describe the progress in the monitoring of complaints and to approve the actions as documented; and 2. Approve the staffing exemption Report	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

1.0 Introduction / Background

From June 2014, NHS England has stipulated that each month, Trusts with inpatient beds are required to publish their staffing levels (planned versus actual) in hours on the NHS Choices website. In addition, Trusts are required to publish this data on their own website, on a ward by ward basis. This information sits alongside a range of other indicators related to the Trust. Patients and members of the public are able to see clearly how hospitals are performing in relation to staffing in an easy and accessible way.

It is also a requirement of NHS England for Trust Board to receive this information on a monthly basis to ensure they are apprised of staffing within the organisation. Shift by shift Staffing data is also displayed outside each ward to ensure that we are open and transparent to the public.

2.0 Staffing Report

The information demonstrates the staffing information per ward and details planned staffing versus actual, stating which shifts have not met their staffing ratio and reasons for this. Where staffing compliance is not at 100%, the paper details the reasons why and the action taken to address the shortfall. On a daily basis professional judgement is used to ensure that the wards have the appropriate staff and skill mix in place to ensure that safe quality care is delivered to patients and their families.

Appendix 1 is a copy of the spread-sheet that is being submitted to UNIFY and uploaded onto NHS Choices for March 2015 data based on the information included in this paper.

3.0 Divisional Breakdown

Ward name	DAY Average fill rate - registered nurses / midwives (%)	DAY Average fill rate - care staff (%)	NIGHT Average fill rate - registered nurses / midwives (%)	NIGHT Average fill rate - care staff (%)	Exception Report Comments with assurance provided by Associate Directors of Nursing
SCHEDULED CARE DIVISION					
A4	**114.0%**	**55.7%**	**67.4%**	**93.7%**	The Surgical Assessment Unit (SAU) is now located on ward A4. The SAU occupies two bays on the ward, which due to trust pressures is escalated overnight. This results in a pressure on the staffing levels, particularly on nights. Current sickness levels 13.39% Consideration to planned Nurse Hours increasing to Days 1891 registered, 713 unregistered, nights 837 registered and 341 un registered when beds are escalated has been given. This will happen when a permanent change to bed base is completed.

Ward name	DAY Average fill rate - registered nurses / midwives (%)	DAY Average fill rate - care staff (%)	NIGHT Average fill rate - registered nurses / midwives (%)	NIGHT Average fill rate - care staff (%)	Exception Report Comments with assurance provided by Associate Directors of Nursing
A5	**75.2%**	**82.6%**	**81.7%**	**100.0%**	Ward A5 has 2.26wte band 5 vacancies and 0.6wte band 2. The staffing levels are influence by the use of the unfunded additional beds, staffing is reviewed on a daily basis to ensure the ward is cover appropriately. Consideration to planned Registered Nurse Hours increasing to 1426 when beds are escalated has been given. This will happen when a permanent change to bed base is completed.
A6	**89.8%**	**95.7%**	**90.3%**	**100.0%**	A6 has a number of escalation beds which are used flexibly, they staffing appropriate using bank and agency to cover shortfalls. The ward has higher trained staff numbers on certain theatre days to reflect the acuity levels. Consideration to planned Registered Nurse Hours increasing to 1508.5 when beds are escalated has been given. This will happen when a permanent change to bed base is completed.
A9	**84.1%**	**82.8%**	**79.6%**	**100.0%**	The majority of the month A9 has been escalated between 2 - 4 beds and this has been on occasions without the required number of staff for the area. Shift are requested via NHSP and staffing levels are reviewed daily by the matron to ensure the ward is adequately covered.
B19	**97.1%**	**100.0%**	**91.9%**	**98.4%**	Trial on B19 of #NOF designated unit and majority of month full use of the escalation beds. Depending on success of trial then changes to adjust A9 and B19 carers establishment to reflect the activity.
B4	**95.7%**	**93.2%**	**95.8%**	**100.0%**	Elective activity is flexed utilising daycase unit to ensure the staffing levels are appropriate.

Ward name	DAY Average fill rate - registered nurses / midwives (%)	DAY Average fill rate - care staff (%)	NIGHT Average fill rate - registered nurses / midwives (%)	NIGHT Average fill rate - care staff (%)	Exception Report Comments with assurance provided by Associate Directors of Nursing
Ward 1 - CMTC	**85.2%**	**87.9%**	**95.2%**	**83.9%**	Staff have on occasions been moved to Warrington to help alleviate the staffing problems and the off duty is adjusted like B4's according to the level of activity.
ICU	**88.4%**	**68.8%**	**87.3%**	**72.6%**	18 beds funded but used flexibly depending on dependency of patients (ie. can be at full capacity at 16 beds if 10 Level 3 and 6 Level 2) 14 RGN nurses required per shift but if dependency/occupancy reduced then less nurses would still provide agreed nurse:patient ratios. Unit Occupancy for March 2015 was 81% therefore even though shifts fell short of 14 RGN there was adequate nurses to provide standard nurse:patient ratios.
UNSCHEDULED CARE DIVISION					
A1	**105.9%**	**71.3%**	**95.7%**	**90.3%**	Due to staff sickness, there has been a shortfall for planned to actual staffing on several shifts. To mitigate against this the assistant practitioner has support the staffing levels currently. The matron for the area takes part in the daily staffing meeting to ensure safety is maintained. Recruitment for Band 5 posts in in progress, although these are proving to be difficult to fill with suitable candidates. An additional band 7 post has been agreed for this area recognising the number of WTE and leadership requirements.

Ward name	DAY Average fill rate - registered nurses / midwives (%)	DAY Average fill rate - care staff (%)	NIGHT Average fill rate - registered nurses / midwives (%)	NIGHT Average fill rate - care staff (%)	Exception Report Comments with assurance provided by Associate Directors of Nursing
A2	**87.1%**	**102.9%**	**90.3%**	**112.9%**	There is excess Care Staff hours worked this month due to the requirement to provide 1:1 care for several patients. There are 2 RN staff currently seconded to other areas in the trust, all shifts are escalated to NHSP however the fill rate can be variable. 24 nursing shifts were lost to sickness absence. The matron for the area takes part in the daily staffing meeting to ensure safety is maintained.
A3	**86.2%**	**93.0%**	**89.2%**	**86.7%**	A number of shifts were not filled due to sickness absence, and being unable to fill for 1:1 nursing care. The matron for the area takes part in the daily staffing meeting to ensure safety is maintained.
A7	**76.2%**	**93.8%**	**80.6%**	**95.2%**	RN shifts were increased to support requirements of individual patients who receive non-invasive ventilation but not all shifts were able to be filled. The matron for the area takes part in the daily staffing meeting to ensure safety is maintained.
A8	**89.6%**	**89.8%**	**90.3%**	**115.8%**	There is excess Care Staff hours worked this month due to the requirement to provide 1:1 care for several patients There were 3 staff absent, 2 long term sick and one with agreed absence and it was not possible to fill these shortfalls with RGN The matron for the area takes part in the daily staffing meeting to ensure safety is maintained.

Ward name	DAY Average fill rate - registered nurses / midwives (%)	DAY Average fill rate - care staff (%)	NIGHT Average fill rate - registered nurses / midwives (%)	NIGHT Average fill rate - care staff (%)	Exception Report Comments with assurance provided by Associate Directors of Nursing
B12	**96.0%**	**109.9%**	**96.8%**	**137.1%**	There is excess Care Staff hours worked this month due to the requirement to provide 1:1 care for several patients The matron for the area takes part in the daily staffing meeting to ensure safety is maintained.
B14	**92.6%**	**87.4%**	**88.5%**	**95.2%**	Staff shortages occurred this month. One patient fell but sustained no harm; there is no suggestion that the staffing levels were contributory. The matron for the area takes part in the daily staffing meeting to ensure safety is maintained.
B18	**82.2%**	**88.7%**	**85.9%**	**83.9%**	We have been unable to match actual to planned staffing on every shift this month. To mitigate against this there is daily review of staffing across Division (Monday to Friday by Matrons and at weekend by Site Manager) to balance staffing. B18 have had to revert to barrier rather than cohort nursing to provide safe care particularly at night
C21	**97.8%**	**100.0%**	**100.0%**	**100.0%**	No staffing issues that went unresolved in March
C22	**97.7%**	**78.5%**	**100.0%**	**100.0%**	There were no staffing issues that went unresolved in March
CCU	**79.7%**	**43.2%**	**100.0%**	**NA**	No staffing issues that went unresolved in March. The HCA from the unit often is moved to support other areas but this is risk assessed to ensure patient safety is not compromised.

WOMEN'S & CHILDREN'S SUPPORT SERVICES					
Ward name	**DAY Average fill rate - registered nurses / midwives (%)**	**DAY Average fill rate - care staff (%)**	**NIGHT Average fill rate - registered nurses / midwives (%)**	**NIGHT Average fill rate - care staff (%)**	**Exception Report Comments with assurance provided by Associate Directors of Nursing**
B11	**89.1%**	**96.4%**	**98.6%**	**NA**	There has been some short term sickness, however the ward dependency was such that replacement was required
Neonatal Unit	**99.1%**	**96.2%**	**99.9%**	**91.7%**	There were no staffing issues that went unresolved in March
C20	**84.2%**	**77.4%**	**103.4%**	**NA**	During March there has been an increase in sickness. One member of staff is on Maternity Leave and one member of staff has taken a career break prior to flexible retirement. There has been use of escalation beds and additional staff required as a result
C23	**100.6%**	**89.3%**	**123.5%**	**87.5%**	NHSP Registered Nurses have been utilised to RMs each night if available when acuity requires

4.0 Assurance provided from the Divisional Associate Directors of Nursing:

Scheduled Care - Staffing in the Division has remained a challenge during the month of February 2015. On the Warrington site we have seen all escalation areas open and a high number of medical outliers which change the cohort of the case mix on the wards.

Number of escalation/medical outliers – February 2015

Total Ecs	**8**	**16**	**24**	**15**	**17**	**25**	**25**	**25**	**24**	**26**	**25**	**27**	**24**	**22**	**25**	**27**	**27**
Outliers	**30**	**30**	**34**	**32**	**34**	**31**	**30**	**40**	**39**	**41**	**41**	**43**	**42**	**36**	**42**	**45**	**47**

Total Esc	**14**	**18**	**21**	**15**	**15**	**14**	**25**	**25**	**15**	**16**	**18**
Outliers	**38**	**39**	**37**	**29**	**24**	**25**	**29**	**28**	**28**	**30**	**27**

Shift fill rates from NHSP and agency have been difficult, half term week was particularly challenging.

On occasions staffing levels have prevented the opening of additional beds, which has created further pressures within the Trust in terms of the performance targets and cancelled operations.

The ADoN is satisfied that staffing levels are reviewed on a shift by shift basis and staff are moved accordingly to cover any shortfalls identified. The additional beds in use across the division and short term sickness has caused some concern however overall all the wards have been covered safely with utilising bank and agency staffing as support.

Unscheduled Care – The Division has continued to experience high levels of vacancies along with raised sickness levels in March 2015. All areas were safely staffed but there are some deficits across the Division.

These were minimised by close observation and monitoring by the Matrons every day, with daily scrutiny by the Associate Director of Nursing ongoing monitoring of complaints/PALS and DATIX reports. All issues were escalated appropriately and registered nurses or carers were moved from other areas. These decisions were made based on the best use of staff at the time, taking account of acuity / dependency and skill mix available.

An ongoing recruitment programme has been strengthened through the proactive recruitment of newly qualified student nursed due to commence in the organisation over the coming months

Women's and Children's Services – A high level of confidence is provided by the Matron for Women's and Neonates and Children's that the wards are staffed safely at all times. In collaboration with the Senior Sisters a continuous daily review takes place which identifies areas which are affected by unplanned staff absence or areas where unplanned urgent care requires a redistribution of the available workforce. The wards were assessed as safe during this period.

Appendix 1

Staffing-Levels-2015
-03-Mar.xls

Staffing Levels

Mar-14

The columns in bold contain the figures that are submitted to the DoH via the Unify portal (A&E figures excluded)

This column will automatically calculate the number of shifts

									Day					Night										
									Registered midwives/nurses			Care Staff		Registered midwives/nurses			Care Staff							
Division	Ward	Non-escalation Beds	Budgeted Registered staff	Vacancies including maternity leave	Posts appointed to but not yet started	Budgeted Unregistered staff	Vacancies including maternity leave	Sickness & Absence for Feb-14	Agreed nurse to patient ratios	**Total monthly planned staff hours**	**Total monthly actual staff hours**	**Total monthly planned staff hours**	**Total monthly actual staff hours**	Agreed nurse to patient ratios	**Total monthly planned staff hours**	**Total monthly actual staff hours**	**Total monthly planned staff hours**	**Total monthly actual staff hours**	Number of hours above or below planned	Length of a shift in hours	Number of shifts above or below planned	Variance	Falls	Hospital acquired pressure ulcers	Catheter associated UTIs	New VTEs
Scheduled Care	W-A4 - Ward A4	28	19.38	0.00	0.00	7.70	0.00	13.39%	1:8	1891.0	1625.5	713.0	596.0	1:8	837.0	721.0	341.0	668.0	-171.5	11.5	-14.9	-4.53%	0	1	0	0
	W-A5 - Ward A5	28	18.03	2.76	1.00	14.60	2.81	7.07%	1:7	1426.0	1340.5	1069.5	883.5	1:9	1069.5	874.0	713.0	713.0	-467.0	11.5	-40.6	-10.92%	0	0	0	0
	W-A6 - Ward A6	28	19.57	3.66	1.00	13.60	1.00	5.06%	1:7	1508.5	1280.0	1069.5	1023.0	1:9	1069.5	966.0	713.0	713.0	-378.5	11.5	-32.9	-8.68%	0	0	0	1
	W-A9 - Ward A9	28	18.83	3.56	0.00	15.50	1.75	6.52%	1:7	1426.0	1199.5	1426.0	1181.0	1:9	1069.5	851.0	713.0	713.0	-690.0	11.5	-60.0	-14.89%	0	0	0	0
	W-B19 - Ward B19	18	13.68	1.00	2.00	13.90	2.08	4.88%	1:6	1069.5	1038.5	713.0	713.0	1:6	713.0	655.0	713.0	701.5	-100.5	11.5	-8.7	-3.13%	0	0	0	0
	W-B4-H - Ward B4 - Halton	27	12.20	1.27	0.00	6.00	0.00	7.38%	1:9	874.0	836.0	552.0	514.5	13.5 :1	552.0	529.0	322.0	322.0	-98.5	11.5	-8.6	-4.28%	0	0	0	0
	W-CM1-H - Ward 1 - CMTC Treatment Centre	30	26.60	7.38	1.00	14.00	2.50	1.78%	1:5.5	1987.0	1693.5	1196.0	1050.9	10 : 1	966.0	920.0	644.0	540.5	-588.1	11.5	-51.1	-12.27%	0	0	0	0
	W-ICU - Intensive Care Unit	18	76.74	7.86	5.00	11.52	0.40	6.87%	1:1 Level 3 1:2 Level 2	4991.0	4413.0	1069.5	736.0	1:1 Level 3 1:2 Level 2	4991.0	4358.0	713.0	517.5	-1740.0	11.5	-151.3	-14.79%	0	1	0	0
Total		205	205.03			96.82		8.00											-4234.1		-368.2					
Unscheduled Care	AED			4.70	1.00	13.02	2.90	9.09%		4712.0	4519.5	1238.5	1083.2		3105.3	3137.1	773.5	698.4	-391.1	12.5	-31.3	-3.98%	0	0	0	0
	W-A1A - Ward A1 Asst	29	41.40	10.00	5.00	22.10	5.00	5.95%	5.5	2325.0	2462.5	1550.0	1105.0	0.0	1953.0	1869.0	651.0	588.0	-454.5	12.5	-36.4	-7.01%	0	0	0	0
	W-A2A - Ward A2 Admission	28	18.83	2.00	1.00	12.90	3.00	8.39%	5.6	1426.0	1242.0	1069.5	1101.0	9.3	1069.5	966.0	713.0	805.0	-164.0	11.5	-14.3	-3.83%	1	0	0	0
	W-A3OPAL - Ward A3 Opal	34	18.83	1.12	0.00	15.50	1.12	1.32%	8.5:1	1426.0	1229.5	1621.0	1507.0	0.0	1069.5	954.5	954.5	828.0	-552.0	11.5	-48.0	-10.89%	0	0	0	0
	W-A7 - Ward A7	33	18.80	3.30	1.00	15.50	2.29	13.05%	8.3:1	1782.5	1359.0	1426.0	1337.5	0.0	1426.0	1150.0	736.0	701.0	-823.0	11.5	-71.6	-15.32%	0	0	0	0
	W-A8 - Ward A8	34	18.80	3.00	0.00	14.84	3.00	8.55%	8.5:1	1472.0	1319.0	1645.0	1478.0	0.0	1092.0	986.0	1035.0	1199.0	-262.0	11.5	-22.8	-5.00%	0	0	1	0
	W-B12 - Ward B12 (Forget-me-not)	21	13.68	1.00	0.00	15.50	3.00	0.54%	7.0:1	1069.5	1026.5	1426.0	1567.0	0.0	713.0	690.0	713.0	977.5	339.5	11.5	29.5	8.66%	0	0	0	0
	W-B14 - Ward B14	24	18.80	2.90	1.73	15.82	2.90	7.18%	6.0:1	1426.0	1320.5	1069.5	935.0	8.0	1069.5	946.0	713.0	678.5	-398.0	11.5	-34.6	-9.30%	0	0	0	0
	W-B18 - Ward B18	24	18.80	1.00	0.00	18.00	1.52	8.38%	6.0:1	1426.0	1172.5	1426.0	1264.5	0.0	1069.5	919.0	1069.5	897.0	-738.0	11.5	-64.2	-14.79%	0	0	0	2
	W-C21 - Ward C21	24	13.68	0.5	0.5	11.30	1.81	2.96%	8.0:1	1069.5	1046.5	713.0	713.0	0.1	713.0	713.0	701.5	701.5	-23.0	11.5	-2.0	-0.72%	0	0	0	0
	W-C22 - Ward C22	21	13.68	0.80	1.60	12.90	0.00	11.92%	7.0:1	1069.5	1045.0	1069.5	840.0	0.1	713.0	713.0	713.0	713.0	-254.0	11.5	-22.1	-7.12%	0	0	0	0
	W-CCU - Coronary Care Unit	8	21.2	0.2	0.0	2.6	0.00	8.90%	2.0:1	1782.5	1420.0	356.5	154.0	0.0	1069.5	1069.5	0.0	0.0	-565.0	11.5	-49.1	-17.61%	0	0	0	0
Total		280	216.47			169.99													-4285.1		-366.7					
WCSS	W-B11B/W-B11C - Ward B11	24	29.50	5.20	2.00	15.92	0.00	2.33%	1:1 level3 1:2 Level2	2100.0	1872.0	840.0	810.0	0.0	1488.2	1468.0	0.0	0.0	-278.2	7.5 day 10.63 night		-6.28%	0	0	0	0
	W-NHDU/W-NITU/W-NSC - Neonatal Unit	18	24.38	2.00	2.80	6.52	0.00	1.35%	7.5:18	1092.0	1082.0	798.0	768.0	7.5:18	942.8	942.0	240.0	220.0	-60.8			-1.98%	0	0	0	0
	W-C20 - Ward C20	12	12.63	1.40	1.40	5.00	2.40	10.89%	1:4	1095.0	922.5	855.0	662.0	1:6	581.3	600.8	0.0	0.0	-346.0			-13.67%	0	0	0	0
	W-C23 - Ward C23	22	98.52	2.50	2.50	12.68	11.60		1:7.33	1348.5	1356.5	899.0	802.5	1:11	620.0	765.5	310.0	271.3	18.3			0.58%	0	0	0	0
Total		76	165.03	11.10	8.70	40.12	14.00	6.90											-666.7		0.0		0	0	0	0
Grand Total		561	586.53	11.10	8.70	306.93	14.00	7.60											-9185.9		-734.9		0	0	0	0

BOARD OF DIRECTORS

WHH/B/2015/ **078(ii)**

SUBJECT:	Six Monthly Staffing Update to Board
DATE OF MEETING:	29th April 2015
ACTION REQUIRED	**For Discussion**
AUTHOR(S):	Deputy Director of Nursing, Alison Lynch Associate Directors of Nursing Clare Pratt Rachael Browning Sue Franklin Mel Hudson
EXECUTIVE DIRECTOR:	Karen Dawber, Director of Nursing and Governance
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care SO3: To give our patients the best possible experience SO4: To provide sustainable local healthcare services
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO2/2.1 Failure to engage and involve our workforce in the design and delivery of our services. SO2/2.2 Risk that the Trust does not have the right people with the right skills ie workforce is not competent and cannot deliver as commissioned. SO3/3.3 Failure to provide staff, public and regulators with assurances post Francis and Keogh review
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED:	None
EXECUTIVE SUMMARY (KEY ISSUES):	The aim of this paper is to provide an update on the NHS Quality Board Recommendations – Hard Truths, and describes the reviews of nurse staffing underway as part of a series of assessments using the Safer Nurse Care Tool.
RECOMMENDATION:	The Board is asked to: 1. Note the content of this paper and agree that a robust methodology is in place to provide assurance of safe staffing across the organisation to ensure our hospitals can maintain safe patient care and improve patient and family experience. 2. Agree that the full staffing detail be presented to Strategic Workforce Committee in June 2015 prior to the Board receipt of a further report detailing the analysis of SNCT data and any

	recommendations for changes in requirements for nurse staffing in October 2015.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

1. Introduction

This paper should be read in conjunction with the Monthly Staffing Exceptions Report March 2015, which provides an overview of the staffing in our in-patient wards in line with NHS England requirements. It also provides the Board with assurance that the trust has put in place one of the most important recommendations of the NHS Quality Board Hard Truth's paper; that the use of a Safer Nurse Care Tool (SNCT) is in place to review nurse staffing in general ward areas.

The paper does not provide a report on the results of the SNCT at this stage as it is recommended that 3 sets of data are analysed before recommendations are made to ward establishments.

The paper provides an update on the NHS Quality Board Recommendations – Hard Truths.

Front line nursing staff make up the largest section of our workforce in Warrington and Halton Hospitals. There is a large amount of evidence showing that staffing levels have a direct impact on patient outcomes and experience, quality of care, and the efficacy of the care delivered (RCN, 2011). NICE recommends that organisations use a systematic approach to ensure there are sufficient staff on duty each shift to provide patients with the care they need regardless of the ward, time of day or day of the week.

The National Quality Boards guide to nursing staffing capacity and capability outlines the roles and responsibility of the Trust Board when determining staffing levels and skill mix. This paper provides an update to the paper presented to the Board of Directors in October 2014 in relation to the 10 recommendations contained within this report. An update detailing progress made to meet these recommendations is contained in section 4 of this report.

2. Background

Since 2013 there have been several national reviews regarding staffing that have been published; The Keogh report, the Francis report, and the Berwick review. All of these reports detail the importance of adequate staffing levels to deliver safe care and highlighted that high rates of sickness and high use of bank and agency staff to compensate for high numbers of vacancies were noted in low performing trusts

In 2012 the RCN issued a position statement on its desire to set mandatory staffing level laid out in 2006 that recommended 65:35 registered: unregistered ratio split on adult acute general and surgical in-patient wards. It did not address how many patients a nurse should be allocated.

The National Nursing Research Unit (NNRU) at King's College London undertakes high quality empirical research and reviews to inform policy and practice relevant to the nursing workforce. They have reported that research demonstrates that RN staffing levels on hospital wards affect the ability of staff to deliver care well. Where staffing levels are low, care is compromised. An excessive number of patients per RN is associated with a higher than expected mortality rate and other harms and they recommend that a ratio of more than 8 patients per RN significantly increases the risk of harm and constitutes a breach in patient safety which should be escalated for investigation.

In 2014 NICE issued guidance on safe staffing in adult inpatient wards in acute hospitals; this guidance stated that each ward has to determine their staffing requirement based on the care their patents need and recommend that the Safer Nursing Care Tool be used to review staffing on inpatient adult wards as it incorporates the activity of the ward and the dependency of the patients.

It is widely acknowledged that no tool on its own can be used to determine accurate staffing levels. Instead it requires a triangulation of various methods which will help organisations to arrive at optimal staffing levels along with the use of informed professional judgement (NICE, 2014).

NICE recommended the SNCT developed by the Shelford Group in November 2014, since this time we have piloted its use in three areas, and in February and March 2015 this was rolled out to all general wards. Until we have 3 sets of completed data from the tool, our assurance to Board is based on the professional judgement model and review of nurse sensitive indicators identified through the Safety Thermometer. The professional judgement model requires the senior nursing teams to agree on safe staffing on a shift by shift basis, based on their clinical knowledge and understanding of the unique needs of each ward. Each month the wards collect data reflecting their planned and actual staffing levels, the matrons and associate directors of nursing monitor this and are able to give assurance that staffing is safe and that plans are put in place to ensure that staff are able to deliver safe reliable and excellent care to the patents if staffing dropped below the planned level. This information is sent to Board in a separate paper and publicly available on our website and sent to NHS England also.

3. The Safer Nurse Care Tool Methodology

The Safer Nursing Care Tool (SNCT) has been developed to help NHS Hospital staff measure patient acuity and/or dependency to inform evidence-based decision making on staffing and workforce. The tool, when allied to Nurse Sensitive Indicators, also offers nurses a reliable method against which to deliver evidence-based workforce plans to support existing services or to develop new services.

Following pilots in C20, A8 and CMTC, the safer nursing care tool has been utilised in the trust. In order to collect the data and to assist the Ward Managers to do this, a series of face to face tutorials were given supported by a "how to" guide. As the trust does not have an electronic method of gathering this data (an addition to the Allocate or other system would be required) we are reliant on manually gathering and inputting data which has proved onerous.

Three sets of data from the tool are required throughout a 12 month period. This takes into consideration any seasonal variance in activity. The data was collected for February and March 2015 which was a time of high activity, including a high number of escalation beds in use and a high number of medical outliers.

The Safer Nursing care tool data was been collected on every adult inpatient area for a maximum of 30 consecutive days between February and March 2015 which was during a sustained period of increased activity, high acuity and a high number of delayed discharges within the organisation. All in-patients have been allocated a level of dependency/acuity based on the following levels.

- Data was collected at 3pm every day on each ward. The number of patients who fell into the Care Level Categories described below was noted by either the Ward Manager or one of two designated senior staff to ensure continuity. Patient data should be collected for the 24-hour period leading to the data collection time; e.g., if there was a level 2 patient in a bed - from 6am till 12pm and it was empty at 3pm then the bed would be marked as a level 2 patent as they occupied it for longer than it was empty. However if the bed was only occupied by a level 2 patient in a bed from 6am till 8am and it was empty at 3pm then the bed would be marked as empty.

<u>Care levels</u>

Care Level	Descriptor: patient status, care requirements may include the following:
Level 0 Patient requires hospitalisation andneeds met in a 'normal' ward.	· Elective medical or surgical admission · May have underlying medical condition requiring on-going treatment · Patients awaiting discharge · Post-operative/post-procedure care – observations recorded half-hourly initially then four-hourly. · Regular (two-four hourly) observations · Early Warning Score within normal threshold. · ECG monitoring · Fluid management · Oxygen therapy less than 35% · PCA · Nerve block · Single chest drain · Confused patients not at risk, · Patients requiring assistance with some activities of daily living, requires one person to mobilise · Experiences occasional incontinence
Level 1a Acutely ill patient requiring intervention or those who are unstable and may deteriorate	· Increased observations and therapeutic interventions · Early Warning Score – trigger-point reached and requiring escalation. · Post-operative care following complex surgery · Emergency admission requiring immediate therapeutic intervention. · Instability requiring continual observation/invasive monitoring · Oxygen therapy greater than 35% ; chest physiotherapy two to four hourly · Arterial blood gas analysis – intermittent · Post 24 hours following tracheostomy, central line, epidural or multiple chest or extra ventricular drain · Severe infection or sepsis

Level 1b Patient is stable but is dependant on nurses to meet most or all his/her daily living activities.	Complex wound management requiring more than 1one nurse or procedure takes more than one hour to complete. · VAC therapy, where ward-based nurses undertake the treatment · Patients with spinal instability/spinal cord injury · Mobility or repositioning difficulties requiring two staff · Complex intravenous drug regimes (including prolonged preparatory/ administration/post-administration care) · Patient and/or carers requiring enhanced psychological support owing to poor disease prognosis or clinical outcome. · Patients on end-of-life care pathway · Confused patients at risk **or** requiring constant supervision · Requires assistance with most or all daily living activities · Potential for self-harm and requires constant observation · Complex discharge, which is the ward-based nurse's responsibility.
Level 2 May be managed within clearly designated beds staffed with expert nurses and resources and requires transfer to a dedicated Level 2 unit	· Deteriorating/compromised single organ system · Post-operative optimisation (pre-op invasive monitoring)/extended post-op care. · Patient requiring non-invasive ventilation/respiratory support; CPAP/BiPAP in acute respiratory failure · First 24 hours following tracheostomy · Requires one or more therapeutic intervention, including: · Greater than 50% oxygen continuously · Continuous cardiac monitoring and invasive pressure monitoring · Drug infusion requiring more intensive monitoring; e.g., vasoactive drugs (amiodarone, inotropes, GTN) or potassium, magnesium. · Pain management such as intra-thecal analgesia · CNS depressed airway and protective reflexes · Invasive neurological monitoring
Level 3 Patient needing advanced respiratory support and/or therapeutic interventions for multiple-organ problems.	· Monitoring and supportive therapy for compromised/collapse of two or more organ/systems · Respiratory or CNS depression/compromise requiring mechanical/invasive ventilation · Invasive monitoring, vasoactive drugs, hypovolaemia/haemorrhage/sepsis treatment or neuro-protection

The number of nurse sensitive indicators or red flags were also recorded. Red flags are used to highlight times when patient care may have been compromised. If a red flag event occurs this should prompt immediate escalation to the registered nurse in charge and this should be actioned as necessary ie escalate to matron, site manager. Below are a list of red flags

Red flags are one of the following:

- Unplanned omission in providing patient medications.
- Delay of more than 30 minutes in providing pain relief.

- Patient vital signs not assessed or recorded as outlined in the care plan

- Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as:
    - Pain: asking patients to describe their level of pain level using the local pain assessment tool.
    - Personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration.
    - Placement: making sure that the items a patient needs are within easy reach.
    - Positioning: making sure that the patient is comfortable and the risk of pressure ulcers is assessed and minimised.

- A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. For example, if a shift requires 40 hours of registered nurse time, a red flag event would occur if less than 32 hours of registered nurse time is available for that shift. If a shift requires 15 hours of registered nurse time, a red flag event would occur if 11 hours or less of registered nurse time is available for that shift (which is the loss of more than 25% of the required registered nurse time). We need to re-write this

- Less than 2 registered nurses present on a ward during any shift.

The data was inputted into a database that calculates whole time equivalent (WTE) staffing requirements for that ward based on the information provided. The SNCT requires that a minimum uplift of 22% is applied to calculate the required WTE. In our trust, nursing establishments are set with an uplift of 20% in place to reflect annual leave requirements, mandatory training and to allow for a threshold of sickness. The 20% uplift in place is in variance to the minimum of 22% stipulated by and applied to the SNCT and this in, some part, contributes to the differing staffing levels recommended when using the different models. The 20% uplift is currently under review due to this variance.

For each of the wards the ward clerk, house keeper and 0.8 of the ward manager's time was not included in the data as this time is not dedicated to providing direct patient care.

The data has been collated and has been reviewed by the Associate Directors of Nursing against the current nursing establishments. The information collated does show some variance in some of our ward areas, but as more than one set of data is required the information will be agreed within the divisions prior to be being presented at the Strategic Workforce Committee.

In line with recommendations the tool was not applied in ITU and CCU, however will now be included following testing in those areas in other pilot sites. Similarly, paediatrics and maternity are not included but do use similar tools (for example Birthrate+) and are currently reviewing these.

We are pleased to have been selected as a pilot site for the Accident and Emergency SNCT and will take part in this later in the year.

Format of the Safer Nurse Care Tool report

The SNCT report reflects each division by ward and provides a narrative about each area, to ensure closer scrutiny of the staffing data relating to each ward. The divisional associate directors of nursing provide an assurance statement or escalate concerns in relation to staffing within their areas of responsibility.

4. NHS Quality Board Recommendations and update

In October 2014 the Board of Directors received a position statement on the Trusts compliance with the 10 recommendations published by the NHS Quality Board and NHS England, 'How to ensure the right people, with the right skills, are in the right place at the right time'. (2013). This guidance not only clearly articulates individual Board member's responsibilities in relation to ensuring safe staffing levels but also outlines a number of expectations to support providers in taking complex and difficult decisions to secure safe staffing.

EXPECTATION 1: *Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care setting capacity and capability.* Boards ensure there are robust systems and processes in place to assure themselves that there is sufficient staffing capacity and capability to provide high quality care to patients on all wards, clinical areas, departments, services or environments day or night, every day of the week.

Expectation One	Progress to date
Boards request and receive papers on establishment review	Board received papers in March 2014, October 2014 and April 2015 Further papers will be supplied to Board every six months
Boards to agree staffing establishments for all clinical areas	Following a comprehensive review, the new establishments were received and approved by the Board in March 2014. Assurance and further recommendations are contained within this report and will be re-evaluated following the full implementation of the SNCT.
Regular updates to the Board • Actual staff versus planned staffing levels shift by shift • Impact on quality and safety (via Safety Thermometer results) • Reasons for shortfalls, impact and action taken	Monthly reporting to the Board commenced May 2014 , and have been included at every Board from this point
Appropriate policies and contingency plans in place where capacity and capability falls short	Direct Observation and Individual Patient (specialling) guideline is approved following consultation. Staffing levels are reviewed at every bed meeting and staffing meeting throughout the day.
Organisations encourage and support staff to report any occasion where a lack of staff could have, or did harm a patients	Datix Incident reporting for staffing concerns captured. These are triangulated against patient safety incidents and reviewed via Nursing and Midwifery Advisory Council. Raising Concerns and Whistle blowing policy

	have been re-launched; professional nursing forum web community has been developed.
Boards should ensure that the executive team is supported and enabled to take decisive action when necessary where all potential solutions are exhausted	Director of Nursing and Governance and Chief Operating Officer have a good oversight between them and escalate concerns and actions to each other. Senior nurses receive the daily staffing log via e mail along with actions being taken

EXPECTATION 2: *Processes are in place to enable staffing establishments to be met on a shift-to-shift basis.* The Executive team should ensure that policies and systems are in place, such as e-rostering and escalation policies, to support those with responsibility for staffing decisions on a shift-to-shift basis. The Director of Nursing and their team routinely monitor shift-to-shift staffing levels, including the use of temporary staffing solutions, seeking to manage immediate implications and identify trends. Where staffing shortages are identified, staff have escalation plans which outline the actions needed to mitigate any problems identified

Expectation Two	Progress to date
Daily reviews of the actual staffing on a shift-by-shift basis versus planned	This is embedded in practice and is recorded through staffing matrix and undertaken by divisional nursing teams and within the daily staffing meetings. Staffing concerns are discussed at each bed meeting.
E-rostering policy	In place
Escalation / Direct Observations of Care (Specialling) policy	In place

EXPECTATION 3: *Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability.* As part of a wider assessment of workforce requirements, evidence-based tools, in conjunction with professional judgement and scrutiny, are used to inform staffing requirements, including numbers and skill mix. Senior nursing and midwifery staff and managers actively seek out data that informs staffing decisions, and they are appropriately trained in the use of evidence-based tools and interpretation of their outputs. Staff use professional judgement and scrutiny to triangulate the results of tools with their local knowledge of what is required to achieve better outcomes for their patients

Expectation Three	Progress to date
Evidence based tools are utilised	Birthrate plus used in Maternity. Safer Nursing Care tool had been utilised to assess staffing across all Adult in- patient wards and will be reported to DIGG's and Strategic Workforce Committee prior to presentation to the Board. ITU, Paediatrics, CCU, Combined in-pt and day case wards, day case are not currently included in this review but will be reported on in subsequent reports

Expectation Three	Progress to date
	The Trust has been selected to pilot AED Safer Nursing tool later this year
Use of professional judgment	This is used daily and is a component of triangulation incorporated into April 2015 report. This is embedded in practice.
Nursing and Midwifery workforce governance on accountability, appropriate delegation of care and training for their role	Included in Job descriptions and NMC Code of Conduct Practice Development Forum to be considered to oversee changes to practice and role/guideline/documentation development. Will be included in Nurse Revalidation documentation to be introduced 2016
Healthcare assistants to receive the minimum training standards, progression routes to nurse training	The training department are actively working to improve the completion figures, and are in the process of developing an implementation plan for the Care Certificate. At present 72% of all HCA are in the process of completing their booklet, and 20% have completed (8% who completed have since left the Trust). It has been agreed to trial the question of HCA completion of competencies into the DAWES assessment and will provide further update in our next 6 monthly report.

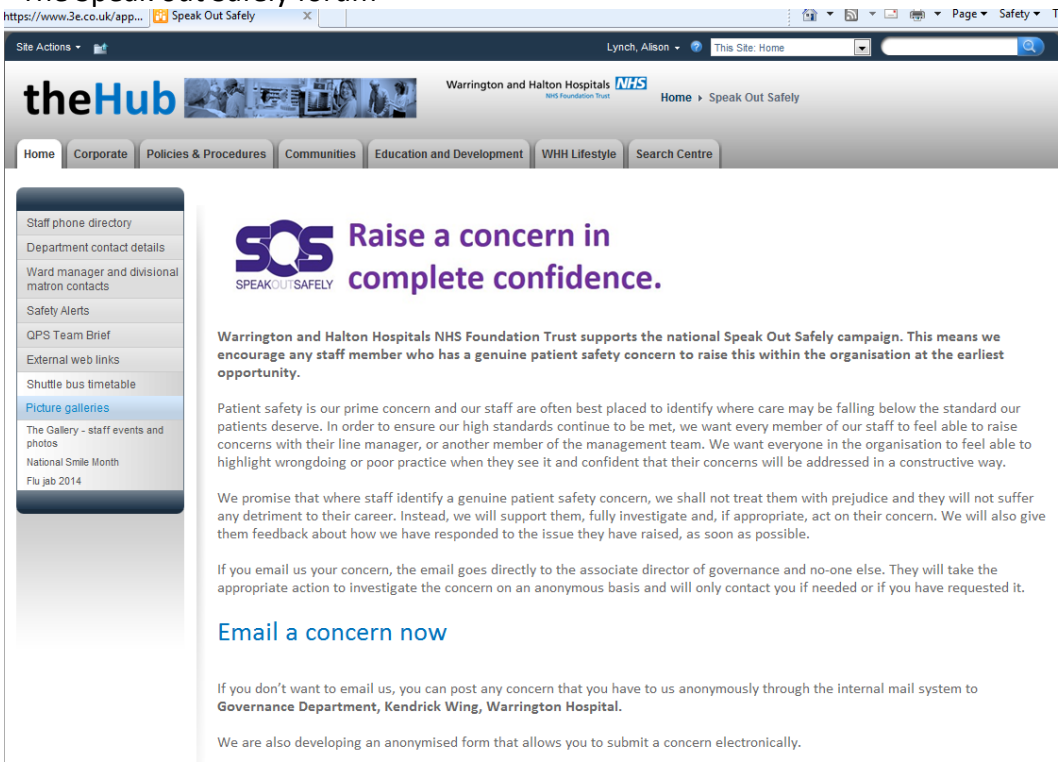
***EXPECTATION 4**: Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns.* The organisation supports and enables staff to deliver compassionate care. Staff work in well-structured teams and are enabled to practice effectively, through the supporting infrastructure of the organisation
(such as the use of IT, deployment of ward clerks, housekeepers and other factors) and supportive line management. Nursing, midwifery and care staff have a professional duty to put the interests of the people in their care first, and to act to protect them if they consider that they may be at risk, including raising concerns. Clinical and managerial leaders support this duty, have clear processes in place to enable staff to raise concerns (including about insufficient staffing) and they seek to ensure that staff feel supported and confident in raising concerns. Where substantiated, organisations act on concerns raised

. Expectation Four	Progress to date
Organisational Culture - Staff able to raise concerns - Clear line management structure - Constructive appraisals	We have pledged our support of the national Speak Out Safely campaign. This means we encourage any staff member who has a genuine patient safety concern to raise this within the organisation at the earliest opportunity, of course we also encourage them to use the existing systems and policies too. Patient safety is our prime concern and our staff are often best placed to identify where care may

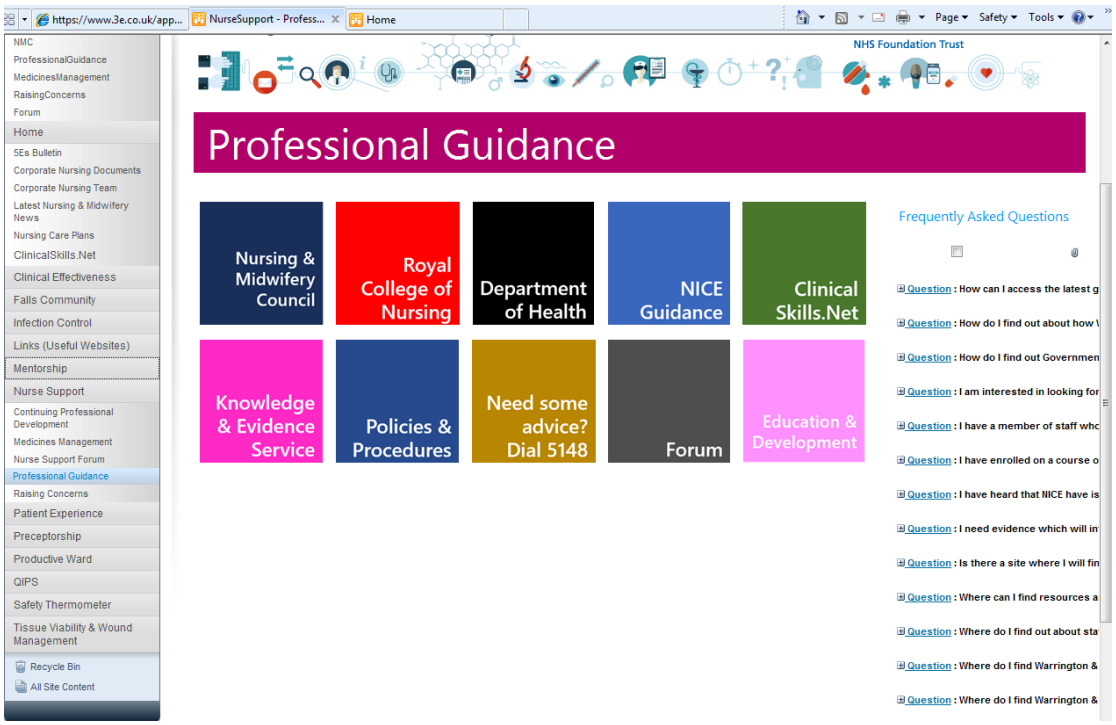
. Expectation Four	Progress to date
	be falling below the standard our patients deserve. In order to ensure our high standards continue to be met, we want every member of our staff to feel able to raise concerns with their line manager, or another member of the management team. We want everyone in the organisation to feel able to highlight wrongdoing or poor practice when they see it and confident that their concerns will be addressed in a constructive way We promise that where staff identify a genuine patient safety concern, we shall not treat them with prejudice and they will not suffer any detriment to their career. Instead, we will support them, fully investigate and, if appropriate, act on their concern. We will also give them feedback about how we have responded to the issue they have raised, as soon as possible. If staff email their concern, the email goes directly to the Associate Director of Governance and no-one else. They will take the appropriate action to investigate the concern on an anonymous basis and will only contact the emailer if needed or if it has been specifically requested. Concerns raised this way will be reported to Board via the Governance report. **see below* We also launched our professional nursing web community, where a menu of professional guidance is available to our nursing staff. ***see below* There is a clear operational management structure with professional accountabilities and a robust appraisal/PDR process which is being developed to take into account the requirements of nurse revalidation.
The adaptation of technological advances enabling more efficient delivery of patient care	The E-Rostering roll out continues, 23 wards and departments are live in the system. A paper will be presented to the Hospital Management Board considering option for an electronic Safer Nursing Care tool, as our current method of manually collating the information is very onerous. The successful bid for mobile devices for midwives has led to the purchase of 159

. Expectation Four	Progress to date
	tablet/laptops, the Maternity department will soon be able to boast that all midwives have a networked computer 24/7. This will release a significant amount of time for the direct care of our Mums & babies. The Lorenzo Regional Care project is well underway with senior nurse representation.
Ensuring staff can speak up NMC code of conduct and raising concerns	Raising Concerns and Whistle blowing policy have been re-launched; professional nursing forum web community has been development. There is a clear operational management structure with professional accountabilities to the Director of Nursing & OD, and CEO drop in sessions.
Duty of candour requirements- Trusts to publish an annual declaration of a commitment to telling patients if something goes wrong	Embedded in practice
Staff side representatives can act on behalf of staff and can represent views and concerns during meetings with organisation's management team	Embedded in practice Staff Side Reps meet with Director of Nursing or Deputy Director of Nursing monthly

*The Speak out Safely forum



**The professional nursing forum



EXPECTATION 5: *A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments.* Directors of Nursing lead the process of reviewing staffing requirements, and ensure that there are processes in place to actively involve sisters, charge nurses or team leaders. They work closely with Medical Directors, Directors of Finance, Workforce (HR), and Operations, recognising the interdependencies between staffing and other aspects of the organisations' functions. Papers presented to the Board are the result of team working and reflect an agreed position

Expectation Five	Progress to date
Board should be clear on individual roles and responsibilities	Included within job descriptions, staffing policies

EXPECTATION 6: *Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties.* Staffing establishments take account of the need to allow nursing, midwifery and care staff the time to undertake continuous professional development, and to fulfil mentorship and supervision roles. Providers of NHS services make realistic estimations of the likely levels of planned and unplanned leave, and factor this into establishments. Establishments also afford ward or service sisters, charge nurses or team leaders time to assume supervisory status and benefits are reviewed and monitored locally.

Expectation Six	Progress to date
Establishment uplifts should reflect realistic expectations - Staff training and development - Supervision and mentorship roles - Planned and unplanned leave	Currently the uplift is 20%, we will review this in August 2015. Supervisory status for ward managers was included within case for investment. Evidence

	this was supported in March 2014, with the exception of C20.

EXPECTATION 7: *Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review.* Boards receive monthly updates on workforce information, including the number of actual staff on duty during the previous month, compared to the planned staffing level, the reasons for any gaps, the actions being taken to address these and the impact on key quality and outcome measures. At least once every six months, nursing, midwifery and care staffing capacity and capability is reviewed (an establishment review) and is discussed at a public Board meeting. This information is therefore made public monthly and six monthly. This data will, in future, be part of CQC's Intelligent Monitoring of NHS provider organisations

Expectation Seven	Progress to date
Board level discussion on: - Establishment review every 6 months - At least twice a year nursing, midwifery & care staffing levels and key quality and outcome measures (public meeting)	Occurred in March 2014, October 2014 and April 2015
Monthly reporting - Report on actual staffing versus planned on a shift-by-shift basis including impact and actions - Display via website the staffing data collated alongside an integrated safety dataset information down to ward level where appropriate	Commenced May 2014. This paper is a public board paper published on the public website. Monthly Information is displayed on Trust website

EXPECTATION 8*: NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift.* Information should be made available to patients and the public that outlines which staff are present and what their role is. Information displayed should be visible, clear and accurate, and it should include the full range of support staff available on the ward during each shift

Expectation Eight	Progress to date
Organisations to display - Number of staff on duty shift by shift basis - Who is in charge - Different roles and responsibilities - Different uniforms and titles used	The Trust clearly displays information about actual and planned in all in-patient areas. This information includes support staff and is updated per shift. It is accessible to patients and their families The person in charge is displayed via the communication boards Uniforms and titles are displayed at ward entrances

EXPECTATION 9*: Providers of NHS services take an active role in securing staff in line with their workforce requirements.* Providers of NHS services actively manage their existing workforce, and have robust plans in place to recruit, retain and develop all staff. To help determine future workforce

requirements, organisations share staffing establishments and annual service plans with their Local Education and Training Board (LETBs), and their regulators for assurance. Providers work in partnership with Clinical Commissioning Groups and NHS England Area Teams to produce a Future Workforce Forecast, which LETBs will use to inform their Education Commissions and the Workforce Plan for England led by Health Education England (HEE).

Expectation Nine	Progress to date
Organisations to have robust recruitment, retention and development strategies	Recruitment strategy in place
Each provider is required to have a member or be represented at Local Education and Training Board (LETB) - Share establishments with LETB - Produce a future workforce forecast	Head of clinical education and workforce is a member of the LETB Workforce plan produced and submitted to HENW

EXPECTATION 10: *Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract***.** Commissioners specify in contracts the outcomes and quality standards they require and actively seek to assure themselves that providers have sufficient nursing

Our commissioners recognise that they may have a contribution to make in addressing staffing-related quality issues, where these are driven by the configuration of local services or the setting of local prices in contract.

5. Summary

Staffing establishments have received scrutiny over the past 12 months and monthly position statements on planned to actual staffing levels have been presented to the Board with associate directors of nursing giving assurance that care is safe and effective even in times of extreme pressure.

This is the first time we have used triangulation of SNCT information with professional judgement tool and quality indicators.

This report will be produced on a 6 monthly basis to allow for trend analysis and early identification of any risks associated with nurse staffing.

6. Recommendations

The Board is asked to:

- Note the content of this paper and agree that a robust methodology is in place to provide assurance of safe staffing across the organisation to ensure our hospitals can maintain safe patient care and improve patient and family experience.
- Agree that the full staffing detail be presented to Strategic Workforce Committee in June 2015 prior to the Board receipt of a further report detailing the analysis of SNCT data and any recommendations for changes in requirements for nurse staffing in October 2015.

BOARD OF DIRECTORS

WHH/B/2015/ **079**

SUBJECT:	**Verbal Report from the Chair of the Finance and Sustainability Committee**
DATE OF MEETING:	29th April 2015 2015
DIRECTOR:	Terry Atherton, Non-Executive Director

BOARD OF DIRECTORS

WHH/B/2015/ **079(i)**

SUBJECT:	**Finance and Sustainability Committee: Board Overview Group – Lorenzo Implementation**	
DATE OF MEETING:	29th April 2015	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Chair of the FSC/Trust Secretary/Lead Executive	
EXECUTIVE DIRECTOR:	To be presented by Terry Atherton Chair of the FSC	
LINK TO STRATEGIC OBJECTIVES:	SO4: To provide sustainable local healthcare services SO1: Ensure all our patients are safe in our care	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO3/3.2 Failure to develop a fit for purpose clinical and business information systems to support delivery of high quality patient care	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	The Finance and Sustainability Committee agreed at its meeting on 23 April 2015 to establish a task and finish group that would provide assurance to the Committee on the implementation of the Lorenzo Project, one of the biggest IT projects the Trust had undertaken. The Committee felt that the establishment of the Group would provide the audit and formal assurance it needed to assure the Board.	
RECOMMENDATION:	***The Board is asked to:*** Note the establishment of the Board oversight Group – Lorenzo, and the terms of reference that had been approved by the FSC.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee
	Agenda Ref.	
	Date of meeting	23 April 2015
	Summary of Outcome	Approved

BOARD OVERVIEW GROUP

LORENZO IMPLEMENTATION

TERMS OF REFERENCE

Document Title	Board Overview Group – Lorenzo implementation
Document Reference	
Author	Trust Secretary/ Director of IM&T
Intranet Location	TBC
Lead Executive Director	Director of IM&T
Reporting to	Finance and Sustainability Committee
Date Ratified	23 April 2015
Review Date	March 2016
Mandatory/ Statutory Standards or Requirements/related documents	Provider Licence Board Assurance Framework Trust Quality Strategy CQC Outcome 16 Monitor Quality Governance Framework
Issue Date	
Issue No.	

1. PURPOSE

The Board Overview Group – Lorenzo (Group) is a time limited group and is accountable to the Finance and Sustainability Group (FSC) for providing assurance on all aspects of implementation, delivery and post-delivery of the Lorenzo project.

2. AUTHORITY

The Group is authorised by the Board of Directors through the FSC to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Group.

The Group is authorised by the Board of Directors through the FSC to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.

3. REPORTING ARRANGEMENTS

The Group will have the following reporting responsibilities:

- The minutes of the Group's meetings will be formally recorded and circulated to the FSC. The Chair of the Group shall draw to the attention of the FSC, Audit Group and thereafter Board of Directors any issues that require disclosure to it, or require executive action.

- The Lead Executive of the Group will report to the FSC monthly following each meeting providing the relevant assurances the FSC requires.

- The Trust standing orders and standing financial instructions apply to the operation of the Group.

4. DUTIES & RESPONSIBILITIES

In order for the Group to review and garner assurances surrounding the Lorenzo project and any associated programmes and projects, the areas of review include (but not limited to);

Financial

- Actual expenditure against budget
- Cash position
- HSCIC funding

Project Plan Delivery

- Project Plan Targets/ Milestones against work streams
- Roll out of hardware for delivery of project
- Data migration
- Legacy systems impact
- Contingency planning
- Effectiveness of a soft go live plan
- Effectiveness of the tasks undertaken

Governance

- Triangulate effectiveness across the Trust
- Any decisions taken off plan outside of the governance arrangements for the Project
- Evidence of decisions reached against such things as historic hindsight

- Risks of delivery to the project and the Trust
- Management of unintended consequences

Operational/ People
- Trust wide System integration - Go live
- Benefits Realisation and Clinical Governance aspects
- Staff Engagement and Communication including clinical engagement - medical, nursing and AHP
- Duplication of effort within the projects and wider trust;
- Linkage between the various trust wide change programmes
- Interface with external partners
- Staff Training/ involvement

An internal User Group will be established which will report to the Lorenzo Project Board to allow feedback from staff in regard to progress and concerns. The Chair of the internal users group will attend the Group and report any issues that would give rise to concerns on delivery of the Project.

5. MEMBERSHIP

The Group's membership will be appointed by the FSC and will consist of:

Chair:	- Non-Executive Director (TBC)
Responsible Executive:	- Director of IM&T
Other Core Members:	- Chief Operating Officer - Director of Finance and Commercial Development - Medical Director - Director of Nursing and Governance - Director of Human Resources and Organisational Development
In Attendance:	- Trust Secretary/ Executive Secretary - Lorenzo Assurance Manager reporting to Non-Executive Director Chair - Chair of the User Group - Lorenzo Project Manager - Co-opted attendees from the organisation as required

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. Should the need arise, the Group may approve a matter in writing by receiving written approval from ***all*** the members of the Group, such written approval may be by email from the members Trust email account.

The FSC will appoint one of the Non-Executive Director of the Board of Directors to be Chair of the Group, this should not include a Non-Executive Director appointed to the FSC. Should the Chair be

absent from the meeting the Group may appoint a Chair of the meeting from amongst the Directors present.

Core members who are unable to attend a meeting of the Group may appoint a deputy who will attend in their stead. It is the responsibility of the core member to inform the secretary of the Group if they are unable to attend and who will attend as their deputy.

6. ATTENDANCE

a. Members

Members will be required to attend a minimum of 75% of all meetings.

b. Officers

Other executive directors and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed.

7. QUORUM

A quorum shall be 4 members and shall include wherever possible the Chair of the Group. The Chair of the Trust may be included in the quorum if present at a meeting.

All Core members shall have one vote. In the event of a tie, the Chairman of the Group shall have the casting vote.

8. FREQUENCY OF MEETINGS

Meetings shall be held monthly. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Group.

9. REPORTING GROUPS

The Lorenzo Project Board shall report to the Group.

10. ADMINISTRATIVE ARRANGEMENTS

The Trust Secretary or his delegate will be secretary of the Group.

Unless prior agreement is reached with the Chair of the Group the Agenda and Papers will be sent out 5 working days before the date of the meeting. No Papers will be tabled at the meeting without prior approval of the Chair.

11. REVIEW / EFFECTIVENESS

The Group is a task and finish Group and as such will not be required to undertake an annual review of its performance. These terms of reference will be reviewed at key stages in the Project life to make sure they are appropriate.

BOARD OF DIRECTORS

WHH/B/2015/ **080**

SUBJECT:	**Finance Report as at 31st March 2015**	
DATE OF MEETING:	29th April 2015	
ACTION REQUIRED	**For Decision**	
AUTHOR(S):	Steve Barrow, Deputy Director of Finance	
EXECUTIVE DIRECTOR:	Tim Barlow, Director of Finance and Commercial Development Choose an item.	
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care SO2: To be the employer of choice for healthcare we deliver SO3: To give our patients the best possible experience	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO4/4.2 Failure to: Maintain a liquidity ratio and capital servicing capacity necessary to deliver a continuity of services risk rating of at least 3 on a quarterly basis; remain a going concern at all times remain solvent; and Comply with section G6 of th Choose an item. SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework SO4/4.3 Failure to manage key contracts appropriately resulting in contract penalties or reduction in service standards; and failure of operational processes to deliver service to agreed contract targets, outputs or standard Choose an item.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	For the period ending 31st March 2015 the Trust has recorded an actual deficit of £6,490k, a Continuity of Services Risk Rating 2 and has a cash balance of £4,511k.	
RECOMMENDATION:	***The Board is asked to:*** ***note the contents of the report.***	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee
	Agenda Ref.	
	Date of meeting	23rd April 2015
	Summary of Outcome	Approved

FINANCE REPORT AS AT 31st MARCH 2015

1. PURPOSE

The purpose of the report is to advise the Board of Directors on the financial position of the Trust as at 31st March 2015.

2. EXECUTIVE SUMMARY

Year to date performance against key financial indicators is provided in the table below and further supplemented by Appendices A to E attached to this report.

The original 14/15 plan approved by the Board and submitted to Monitor was based on an in year deficit of £1.5m. Monitor required the Trust to produce a reforecast that was completed and approved by the Board in December that revised the deficit to £5.9m. The year to date performance is based on the original plan and the performance against the reforecast is in Section 9.

The final year end position is a deficit of £6.5m but this includes an impairment of £0.7m for assets that have either reduced in value or are no longer in use. This impairment is charged to the income statement but is classed as a technical adjustment and excluded from the calculation of the Continuity of Services Risk Rating and the operating position for the year. The year end deficit excluding impairments is £5.8m which is £4.3m worse than the original planned deficit of £1.5m but £0.1m better than the reforecast deficit of £5.9m.

Key financial indicators

Indicator	Monthly Plan £m	Monthly Actual £m	Monthly Variance £m	YTD Plan £m	YTD Actual £m	YTD Variance £m
Operating income	18.3	21.3	3.0	213.7	218.7	5.0
Operating expenses	(16.9)	(19.3)	(2.4)	(205.0)	(214.2)	(9.2)
EBITDA	1.5	2.0	0.6	8.7	4.5	(4.2)
Non-operating income and expenses	(0.9)	(1.7)	(0.8)	(10.3)	(11.0)	(0.7)
I&E surplus/(deficit) including impairments	0.6	0.2	(0.4)	(1.5)	(6.5)	(5.0)
I&E surplus/(deficit) excluding impairments	0.6	0.9	0.3	(1.5)	(5.8)	(4.3)
Cash balance	-	-	-	6.7	4.5	(2.2)
CIP target	2.4	1.4	(1.0)	11.9	7.5	(4.4)
Capital Expenditure	1.8	2.0	0.2	10.9	7.0	(3.9)
Continuity of Services Risk Rating	4	4	0	3	2	(1)

3. INCOME AND EXPENSES

The March and year to date position (including impairment expenses) is summarized in the table below.

Position = Surplus/(Deficit)	**March £000**	**Year to date £000**
Plan	625	(1,500)
Actual	235	(6,490)
Variance	**(390)**	**(4,990)**

The March and year to date variance by category (including impairment expenses) is summarized in the table below.

Variance = Favourable/(Adverse)	**March £000**	**Year to date £000**
Operating income	2,961	4,992
Operating expenses	(2,493)	(9,239)
Non-operating income and expenses	(859)	(741)
Total	**(390)**	**(4,990)**

The planned Continuity of Services Risk Rating for the period is a 3 but performance to date results in a rating of 2.

The operating performance continues to have an adverse effect on the amount of cash available to the trust and even though the cash balance is controlled through the management of working balances, a continuation of the current operating performance will mean a severe reduction in the internally funded capital programme or a significant increase in creditors to avoid the Trust running out of money next financial year.

Operating Income

Year to date operating income is £4,992k above plan due to an over recovery on NHS Clinical Income (£1,543k), Other Operating income (£3,456k) partially offset by an under recovery on non NHS clinical income (£7k).

Operating Expenses

Year to date operating expenses are £9,239k above plan due to over spends on pay (£6,707k), clinical supplies (£1,985k) and non clinical supplies (£1,124k), partially offset by under spends on drugs (£577k).

Non Operating Income and Expenses

Non operating income and expenses is £741k above plan mainly due to the impairment costs (£715k) and additional PDC Dividends (£207k), partially offset by an underspend on depreciation (£197k) resulting from the slippage in the capital programme.

4. COST IMPROVEMENT PROGRAMME

The Trust has an annual savings target of £11,931k and value of schemes identified to date is shown in the table below.

Narrative	**In Year £000**	**Recurrent £000**
Annual Target	11,931	11,931
Planned value of schemes identified	11,276	13,063
Over / (Under) Achievement against target	**(655)**	**1,132**

For the year the planned savings for the identified schemes equate to £11,276k, with actual savings amounting to £7,476k which results in an under achievement against the plan of £3,800k.

The level of in year and recurrent savings achieved in the year results is a significant under achievement against the target, as shown in the table below:

Narrative	**In Year £000**	**Recurrent £000**
Annual Target	11,931	11,931
Forecast Outturn	7,476	8,943
Over / (Under) Achievement against target	**(4,455)**	**(2,988)**

The under achievement in the current financial year is a significant contributor to the annual deficit but the recurrent under achievement will need to be recovered, which therefore increases the cost savings required next financial year.

5. CASH FLOW

The cash balance is £4,511k which is £2,220k below the planned cash balance of £6,731k, with the monthly movements summarised in the table below.

Cash balance movement	**£000**
Opening balance as at 1st March	7,499
In month surplus	233
Non cash flows in surplus/(deficit)	1,247
Decrease in receivables	613
Increase in payables	1,934
Capital expenditure	(2,008)
PDC Dividends Payment	(2,141)
Other working capital movements	(2,866)
Closing balance as at 31st March	**4,511**

The planned cash balances detailed in the cashflow were based on a forecast year end cash balance as at 28th February 2014 but the actual cash balance was higher as a number of commissioners settled outstanding invoices in March.

The current balance equates to circa 8 days operational cash, however the value of trade creditors as at 31st March stands at £9.2m, the majority of which are overdue. Under the continuity of services risk rating the liquidity metric is -11.5 days which results in a score of 2. The calculation of the metric includes all current assets and liabilities excluding inventories, so masks the challenging cash position which is managed through working balances.

The operating performance continues to have an adverse effect on the cash position and creditor payments. This operating position, coupled with the non payment to suppliers during the upgrade of the financial systems, resulted in performance against the non NHS Better Payment Practice Code (BPPC) of 29% in the month (41% year to date). This low level of compliance and performance will continue until there is an improvement in the cash position, either through an improved operating position or a working capital loan.

6. STATEMENT OF FINANCIAL POSITION

Non current assets have increased by £10,843k in the month due to the impact of the District Valuer revaluation exercise and the capital spend.

Current assets have decreased by £4,391k in the month mainly due to the decrease in cash, receivables and accrued income.

Current liabilities have decreased by £4,065k in the month mainly due to the decrease in deferred income, PDC Dividend creditor (paid in March) and accruals, partially offset by an increase in payables.

7. CAPITAL

The capital programme has been increased from the original plan as a result of Halton CCG's agreement to fund the costs associated with the development of the Urgent Care Centre, although this has been partially offset by the reduction in contingency funding to cover the funding shortfall. It has been confirmed that national funding available for the Integrated Digital Care Fund has been severely reduced and no funding will be allocated to the trust this financial year and no decision has been for future funding.

The approved programme for the year now stands at £10.9m and for the year the Trust has spent £7.0m, which is mainly due to delays in the commencement of various schemes.

Category	Annual Budget £m	Budget to date £m	Actual to date £m	Variance to date £m
Estates	6.2	6.2	3.9	(2.3)
IM&T	2.5	2.5	2.0	(0.5)
Medical Equipment	1.3	1.3	1.1	(0.2)
Contingency	0.9	0.9	0.0	(0.9)
Total	**10.9**	**10.9**	**7.0**	**(3.9)**

8. ASSET REVALUATION AND IMPAIRMENTS

In accordance with accounting standards the Trust is required to undertake an annual revaluation exercise for all land and buildings so that the Trust asset base reflects the current value rather than the historic value. The District Valuer has completed the valuation exercise and as at 31st March 2015 the value of land and buildings has increased by a net £9.5m (gross increase of £10.1m and gross decrease of £0.6m). The gross increase (£10.1m) is reflected by an increase in the revaluation reserve, whilst the gross decrease (£0.6m) is classed as an impairment expense within the income statement. As a result of the overall increase in asset value the PDC Dividends have increased by £0.1m.

The annual asset verification exercise has resulted in a number of equipment assets that are no longer in use and accounting standards require that the net book value of the asset is charged to the income statement as an impairment expense. The value of these equipment asset impairments is £0.6m.

Therefore this results in an overall £0.7m impairment charge to the income and expenditure statement but is classed as a "technical adjustment" and excluded from the calculation of the Continuity of Services Risk Rating and the operating position for the year.

9. REFORECAST OUTTURN

The Board will be aware that all Foundation Trusts were required to submit a year end forecast and a forecast annual capital spend in December 2014. The reforecast exercise resulted in the Trust submitting a year end deficit of £5.9m which is a deterioration of £1.9m when compared to the previous forecast deficit of £4.0m. The reasons for the increase in the deficit where detailed in the presentation to the Board on 17th December.

In addition to the forecast position as at 31st March 2015 the Trust profiled the planned monthly surpluses and deficits between January and March. The March and year to date position (including impairment expenses) compared to the reforecast is summarized in the tables below.

Position = Surplus/(Deficit)	March £000	Year to date £000
Plan	427	(5,875)
Actual	235	(6,490)
Variance	**(192)**	**(615)**

The March and year to date variance by category (including impairment expenses) is summarized in the table below.

Variance = Favourable/(Adverse)	**March £000**	**Year to date £000**
Operating income	1,810	1,625
Operating expenses	(1,040)	(934)
Non-operating income and expenses	(963)	(1,304)
Total	**(192)**	**(615)**

The revised annual capital spend was calculated at £7.2m.

A change in the year end forecast position and reduced capital spend impacts on the Continuity of Services Risk Rating and the cash balance. The Continuity of Services Risk Rating reduced to a 2 and the revised cash balance has reduced to £3.1m, which is a reduction of £3.6m compared to the original planned balance of £6.7m.

The Board needs to be aware that Warrington CCG do not agree to the forecast activity value included in the Trust forecast outturn of £5.9m and unless a satisfactory agreement is reached then arbitration remains a possibility.

10. SUMMARY

For the year ending 31st March the Trust has recorded a deficit of £5,775k excluding impairments, which is £4,275k worse than the original planned deficit and £100k better than the revised reforecast.

This performance generates a Continuity of Services Risk Rating score of 2 which is below the original risk rating score of 3 but in line with the reforecast risk rating score of 3.

Tim Barlow
Director of Finance & Commercial Development
24th April 2015

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Finance headlines as at 31st March 2015

Key Financial Metrics	Month			Year to date		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income	18,339	21,300	2,961	213,746	218,738	4,992
Operating Expenditure	-16,858	-19,351	-2,493	-204,977	-214,216	-9,239
EBITDA	**1,481**	**1,950**	**469**	**8,769**	**4,522**	**-4,247**
Financing Costs	-856	-1,715	-859	-10,269	-11,010	-741
Net Surplus / (Deficit)	**625**	**235**	**-390**	**-1,500**	**-6,490**	**-4,990**
Continuity of Services Risk Rating	4	4	-1	3	2	-1
Capital Expenditure	1,800	2,008	208	10,900	7,710	-3,190
Cash Balance				6,731	4,511	-2,220
Cost Savings	2,517	1,375	-1,142	11,931	7,476	-4,455

Summary Position

The original 14/15 plan approved by the Board and submitted to Monitor was based on an in year deficit of £1.5m. Monitor required the Trust to produce a reforecast that was approved by the Board in December that revised the deficit to £5.9m. The in month and year to date performance is based on the original plan.

The reported position for the period is an actual deficit of £6,490k which is £4,990k worse than the planned deficit of £1,500k and an actual Continuity of Services Risk Rating 2 which is below the planned rating of 3. This position includes impairment expenses of £715k so the position excluding impairments expenses is £5,775k, which is £4,275k worse than the planned deficit, althought this still results in a Continuity of Services Risk Rating of 2. Year to date income is £4,992k above plan mainly due to overperformance on non elective activity, outpatients, donations and grants and other operating income, although this is partially offset by underperformance on elective and other NHS activity. Year to date expenditure is £9,239k above plan due to overspends on pay, clinical supplies and non clinical supplies, althought this is partially offset by an underspend on drugs. Year to date non operating income and expenditure is £741k above plan due to impairment expenses and PDC dividends, partially offset by an underspend on depreciation.

Cost savings performance is below plan by £4,455k, as schemes to achieve the annual target have not been identified and there has been slippage against a number of those identified schemes.

Key Variances

Operating Income - £4,992k above plan (favourable).
Operating Expenditure - £9,239k above plan (adverse).
Non operating income and expenses - £741k above plan (adverse).
Cost savings - £4,455k below plan.
Cash balances - £2,220k below plan.
Capital expenditue - £3,564k below plan.

Other matters to be brought to the attention of the Board

Following Monitors decision to open a formal investigation into the Trust's compliance with its licence, KPMG have been appointed as the external support team.

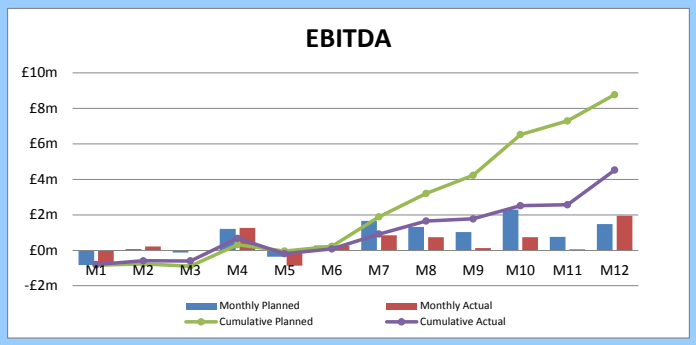
Monitor require all trusts to submit forecast revenue and capital outturns on a monthly basis.
The Trust and Warrington CCG have not been able to agree a year end forecast outturn position so the Trust has notified the Commissioner of its intention to go to Dispute Resolution.

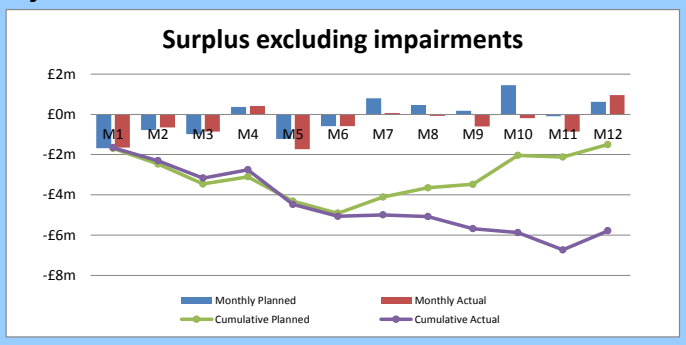
15/16 contract discussions with commissioners continue but no contract values have yet been agreed.

Warrington & Halton Hospitals NHS Foundation Trust

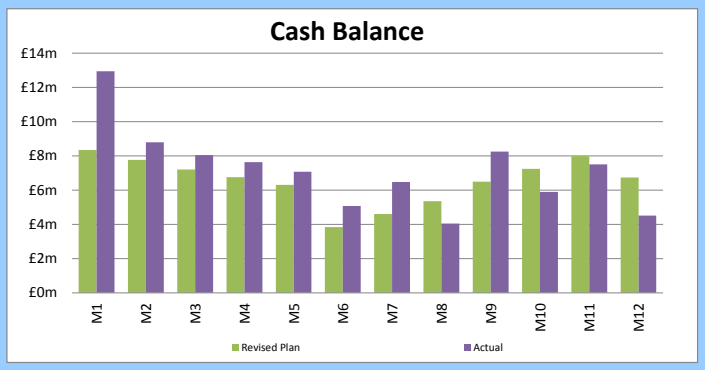
Finance Dashboard as at 31st March 2015 (Part A)

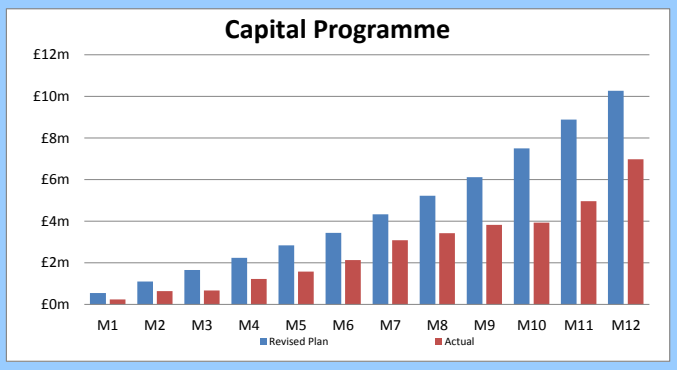
Profitability



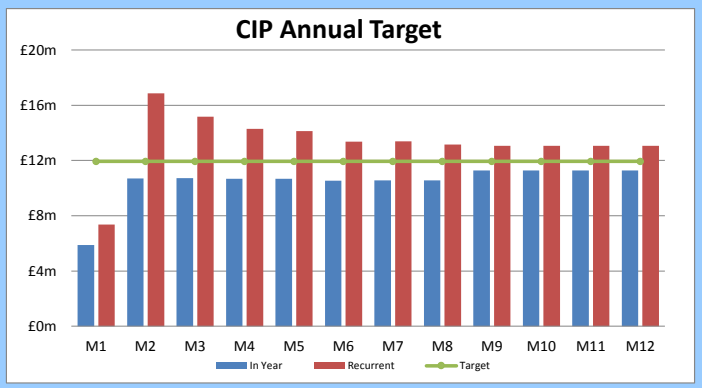


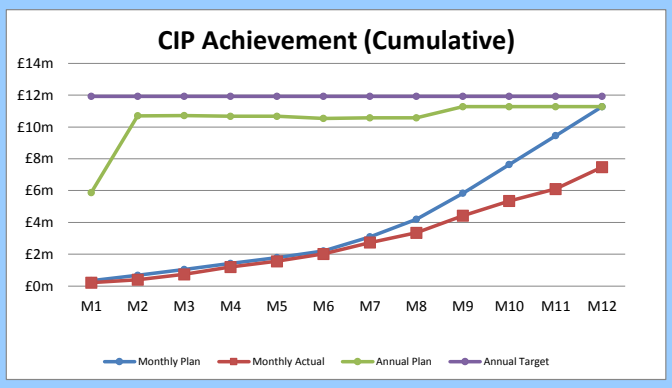
Cash and Investment





Cost Improvement Analysis





Divisional Position (net divisional income and expenditure)

Division	Annual Budget £000	Budget in month £000	Actual in month £000	Variance in month £000	Variance in month %	Budget to date £000	Actual to date £000	Variance to date £000	Variance date %
Clinical									
Scheduled Care	56,520	4,748	5,175	-427	-9.0	56,520	57,183	-663	-1.2
Unscheduled Care	44,525	3,803	4,067	-264	-6.9	44,525	45,856	-1,331	-3.0
Womens, Children & Support Services	61,022	5,079	5,053	26	0.5	61,022	60,686	336	0.6
Corporate									
Operations - Central	540	23	33	-10	-41.7	540	498	42	7.9
Operations - Estates	7,551	679	766	-86	-12.7	7,551	7,473	79	1.0
Operations - Facilities	8,014	661	663	-2	-0.3	8,014	7,899	115	1.4
Commercial Development	1,310	188	202	-13	-7.1	1,310	1,261	50	3.8
Finance	9,345	776	788	-12	-1.6	9,345	9,297	48	0.5
Governance & Workforce	4,708	391	307	84	21.5	4,708	4,186	522	11.1
Information Technology	4,107	338	245	93	27.6	4,107	4,571	-464	-11.3
Nursing	1,908	173	188	-15	-8.7	1,908	1,934	-26	-1.4
Trust Executive	2,161	152	148	4	2.6	2,161	2,102	59	2.7
Total	**201,712**	**17,012**	**17,634**	**-622**	**-3.7**	**201,712**	**202,945**	**-1,233**	**-0.6**

Positive variance = underspend, negative variance = overspend.

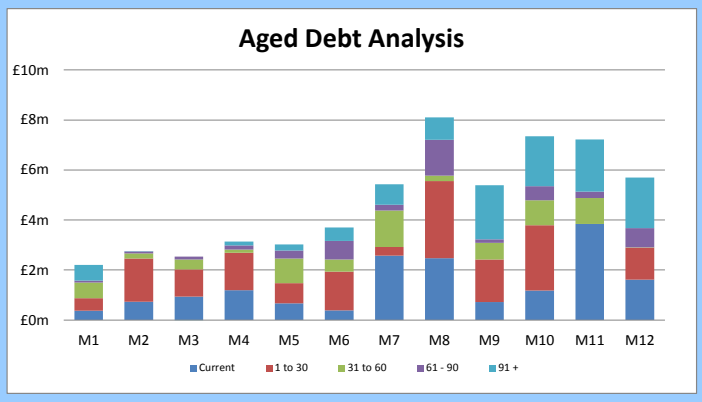
Continuity of Services Risk Rating

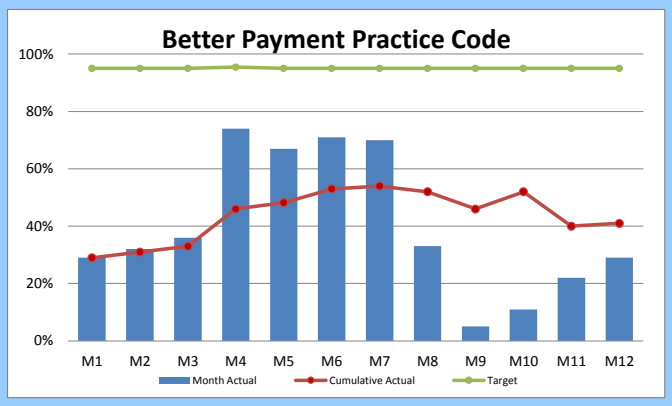
Continuity of Services Risk Rating	Actual Metric	Actual Rating
Liquidity Ratio (days)	-11.5	2
Capital Servicing Capacity (times)	0.9	1
Overall Risk Rating		**2**

Warrington & Halton Hospitals NHS Foundation Trust

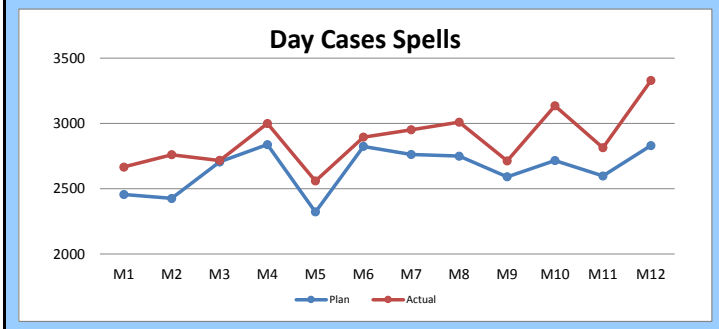
Finance Dashboard as at 31st March 2015 (Part B)

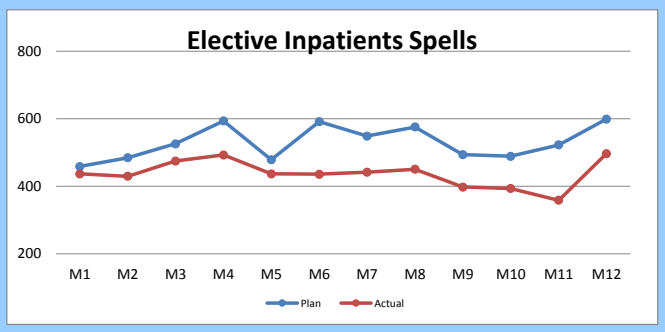
Balance Sheet and Liquidity

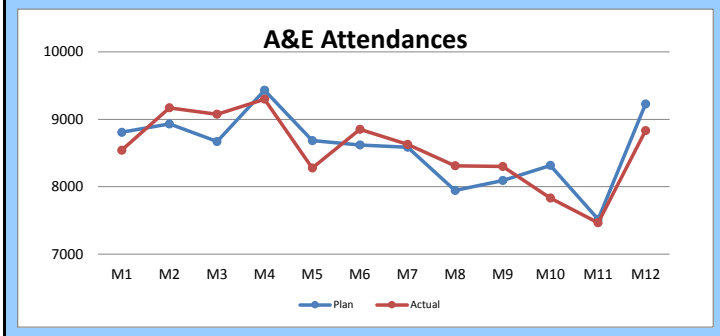


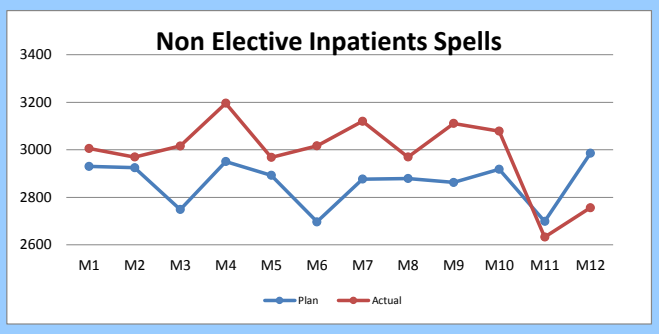


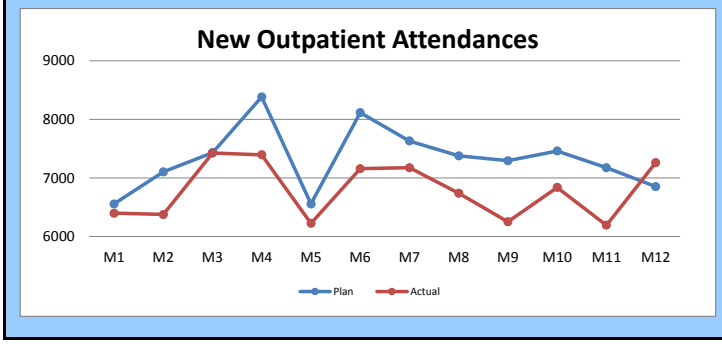
Activity Analysis

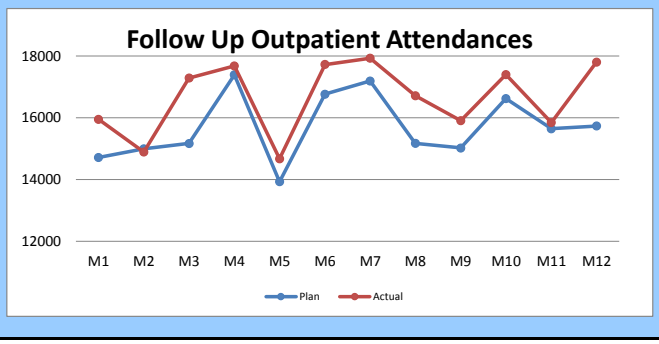












Income Statement, Activity Summary and Risk Ratings as at 31st March 2015 (Based on original plan)

Income Statement	Month			Year to date		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income						
NHS Activity Income						
Elective Spells	3,826	3,807	-19	39,884	38,666	-1,218
Elective Excess Bed Days	22	11	-11	242	219	-23
Non Elective Spells	4,549	4,273	-276	52,145	53,578	1,433
Non Elective Excess Bed Days	316	310	-6	3,701	3,233	-468
Outpatient Attendances	2,787	3,099	313	33,480	33,794	314
Accident & Emergency Attendances	914	899	-15	10,184	10,280	96
Other Activity	4,591	7,090	2,500	58,103	59,512	1,409
Sub total	**17,004**	**19,488**	**2,484**	**197,738**	**199,282**	**1,543**
Non Mandatory / Non Protected Income						
Private Patients	13	6	-6	152	77	-75
Other non protected	107	113	6	1,284	1,352	68
Sub total	**120**	**119**	**0**	**1,436**	**1,429**	**-7**
Other Operating Income						
Training & Education	641	242	-400	7,696	7,450	-246
Donations and Grants	0	50	50	0	869	869
Miscellaneous Income	574	1,401	828	6,876	9,708	2,832
Sub total	**1,215**	**1,693**	**478**	**14,572**	**18,027**	**3,456**
Total Operating Income	**18,339**	**21,300**	**2,961**	**213,746**	**218,738**	**4,992**
Operating Expenses						
Employee Benefit Expenses (Pay)	-12,049	-13,093	-1,044	-147,753	-154,460	-6,707
Drugs	-1,204	-1,221	-17	-14,242	-13,666	577
Clinical Supplies and Services	-1,619	-2,466	-846	-19,154	-21,139	-1,985
Non Clinical Supplies	-1,985	-2,571	-586	-23,827	-24,951	-1,124
Total Operating Expenses	**-16,858**	**-19,351**	**-2,493**	**-204,977**	**-214,216**	**-9,239**
Surplus / (Deficit) from Operations (EBITDA)	**1,481**	**1,950**	**469**	**8,769**	**4,522**	**-4,247**
Non Operating Income and Expenses						
Interest Income	3	2	-1	40	37	-3
Interest Expenses	0	-3	-3	0	-14	-14
Depreciation	-524	-532	-8	-6,283	-6,086	197
PDC Dividends	-336	-467	-132	-4,026	-4,233	-207
Restructuring Costs	0	0	0	0	0	0
Impairments	0	-715	-715	0	-715	-715
Total Non Operating Income and Expenses	**-856**	**-1,715**	**-859**	**-10,269**	**-11,010**	**-741**
Surplus / (Deficit)	**625**	**235**	**-390**	**-1,500**	**-6,489**	**-4,989**
Activity Summary	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**
Elective Spells	3,431	3,827	396	38,181	39,802	1,621
Elective Excess Bed Days	91	48	-43	1,003	963	-40
Non Elective Spells	3,005	2,756	-250	34,367	35,842	1,475
Non Elective Excess Bed Days	1,394	1,422	28	16,354	14,386	-1,968
Outpatient Attendances	25,954	29,781	3,827	320,888	340,144	19,256
Accident & Emergency Attendances	9,225	8,830	-395	102,814	102,571	-243
Continuity of Services Risk Ratings	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**
Liquidity Ratio - Metric (Days)	0.2	-0.5	-0.7	-9.0	-11.5	-2.5
Liquidity Ratio - Rating	4	3	-1	2	2	0
Capital Servicing Capacity - Metric (Times)	4.4	4.0	-0.4	2.2	0.9	-1.3
Capital Servicing Capacity - Rating	4	4	0	3	1	-2
Continuity of Services Risk Rating	**4**	**4**	**0**	**3**	**2**	**0**

Warrington & Halton Hospitals NHS Foundation Trust **Appendix C2**

Income Statement, Activity Summary and Risk Ratings as at 31st March 2015 (Based on reforecast)

Income Statement	Month			Year to date		
	Forecast	Actual	Variance	Forecast	Actual	Variance
	£000	£000	£000	£000	£000	£000
Operating Income						
NHS Activity Income						
Elective Spells	3,812	3,807	-5	39,823	38,666	-1,157
Elective Excess Bed Days	34	11	-23	264	219	-45
Non Elective Spells	4,623	4,273	-350	53,302	53,578	276
Non Elective Excess Bed Days	306	310	4	3,456	3,233	-223
Outpatient Attendances	2,829	3,099	270	34,018	33,794	-224
Accident & Emergency Attendances	923	899	-24	10,284	10,280	-4
Other Activity	5,367	7,090	1,723	57,082	59,512	2,430
Sub total	**17,894**	**19,488**	**1,594**	**198,229**	**199,282**	**1,053**
Non Mandatory / Non Protected Income						
Private Patients	8	6	-2	86	77	-9
Other non protected	117	113	-4	1,397	1,352	-45
Sub total	**125**	**119**	**-6**	**1,483**	**1,429**	**-54**
Other Operating Income						
Training & Education	747	242	-505	8,327	7,450	-877
Donations and Grants	0	50	50	500	869	369
Miscellaneous Income	724	1,401	677	8,574	9,708	1,134
Sub total	**1,471**	**1,693**	**222**	**17,401**	**18,027**	**626**
Total Operating Income	**19,490**	**21,300**	**1,810**	**217,113**	**218,738**	**1,625**
Operating Expenses						
Employee Benefit Expenses (Pay)	-13,057	-13,093	-36	-154,546	-154,460	86
Drugs	-1,108	-1,221	-113	-13,307	-13,666	-359
Clinical Supplies and Services	-1,736	-2,466	-730	-20,189	-21,139	-950
Non Clinical Supplies	-2,410	-2,571	-161	-25,240	-24,951	289
Total Operating Expenses	**-18,311**	**-19,351**	**-1,040**	**-213,282**	**-214,216**	**-934**
Surplus / (Deficit) from Operations (EBITDA)	**1,179**	**1,950**	**771**	**3,831**	**4,522**	**691**
Non Operating Income and Expenses						
Interest Income	2	2	0	36	37	1
Interest Expenses	-1	-3	-2	-12	-14	-2
Depreciation	-429	-532	-103	-5,770	-6,086	-316
PDC Dividends	-324	-467	-143	-3,960	-4,233	-273
Restructuring Costs	0	0	0	0	0	0
Impairments	0	-715	-715	0	-715	-715
Total Non Operating Income and Expenses	**-752**	**-1,715**	**-963**	**-9,706**	**-11,010**	**-1,304**
Surplus / (Deficit)	**427**	**235**	**-192**	**-5,875**	**-6,489**	**-614**
Activity Summary	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**
Elective Spells	3,877	3,827	-50	40,507	39,802	-706
Elective Excess Bed Days	149	48	-101	1,153	963	-190
Non Elective Spells	3,160	2,756	-405	36,436	35,842	-594
Non Elective Excess Bed Days	1,364	1,422	58	15,405	14,386	-1,019
Outpatient Attendances	28,593	29,781	1,188	343,820	340,144	-3,676
Accident & Emergency Attendances	9,264	8,830	-434	103,215	102,571	-644
Continuity of Services Risk Ratings	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**
Liquidity Ratio - Metric (Days)	0.7	-0.5	-1.2	-13.0	-11.5	1.4
Liquidity Ratio - Rating	4	3	-1	2	2	0
Capital Servicing Capacity - Metric (Times)	3.6	4.0	0.4	0.8	0.9	0.0
Capital Servicing Capacity - Rating	4	4	0	1	1	0
Continuity of Services Risk Rating	**4**	**4**	**0**	**2**	**2**	**0**

Warrington and Halton Hospitals NHS Foundation Trust **Appendix D**

Cash Flow Statement as at 31st March 2015

	Actual April £000's	Actual May £000's	Actual June £000's	Actual July £000's	Actual August £000's	Actual September £000's	Actual October £000's	Actual November £000's	Actual December £000's	Actual January £000's	Actual February £000's	Actual March £000's	Annual Position March £000's
Surplus/(deficit) after tax	**(1,655)**	**(647)**	**(858)**	**414**	**(1,726)**	**(587)**	**72**	**(81)**	**(607)**	**(195)**	**(856)**	**235**	**(6,491)**
Non-cash flows in operating surplus/(deficit)													
Donations & grants received of PPE & intangible assets (not cash)												(231)	(231)
Depreciation and amortisation	523	525	523	523	524	524	438	476	429	545	525	532	6,087
Impairment losses/(reversals)												1,207	1,207
(Gain)/loss on disposal of property plant and equipment												4	4
PDC dividend expense	336	335	336	335	336	336	336	336	302	391	390	391	4,160
Other increases/(decreases) to reconcile to profit/(loss) from operations	(16)	9	(3)	(19)	6	(16)	40	(85)	62	(32)	(1)	(28)	(83)
Non-cash flows in operating surplus/(deficit), Total	**843**	**869**	**856**	**839**	**866**	**844**	**814**	**727**	**793**	**904**	**914**	**1,875**	**11,144**
Operating Cash flows before movements in working capital	**(812)**	**222**	**(2)**	**1,253**	**(860)**	**257**	**886**	**646**	**186**	**709**	**58**	**2,110**	**4,653**
Increase/(Decrease) in working capital													
(Increase)/decrease in inventories	(36)	(93)	68	52	141	(254)	(68)	(32)	(108)	147	(377)	17	(543)
(Increase)/decrease in NHS Trade Receivables	775	(332)	869	(991)	504	(618)	(346)	(3,643)	(445)	1,107	1,183	672	(1,265)
(Increase)/decrease in Non NHS Trade Receivables	154	(430)	(121)	203	(257)	(47)	248	(446)	471	(403)	(89)	(75)	(791)
(Increase)/decrease in other related party receivables	(235)	(75)	181	(237)	206	(11)	(161)	(36)	185	11	(111)	(103)	(385)
(Increase)/decrease in other receivables	(1)	303	144	(102)	137	(20)	(35)	467	(353)	(137)	(11)	119	510
(Increase)/decrease in accrued income	261	417	(231)	(542)	(220)	364	(647)	(175)	(668)	841	28	575	2
(Increase)/decrease in prepayments	(1,833)	507	(386)	(165)	872	(291)	253	9	463	(364)	(74)	238	(771)
Increase/(decrease) in Deferred Income (excl. Govt Grants.)	(243)	612	(14)	18	344	64	1,359	1,325	1,883	(2,988)	799	(3,539)	(379)
Increase/(decrease) in Current provisions	5	(11)	12	7	8	8	0	(47)	10	(72)	4	50	(26)
Increase/(decrease) in Trade Creditors	2,508	(3,205)	(351)	(1,190)	(1,086)	1,182	2,944	(1,175)	1,939	(1,816)	(62)	2,246	1,934
Increase/(decrease) in Other Creditors	167	(407)	61	(27)	85	95	(63)	(93)	20	355	(195)	(312)	(314)
Increase/(decrease) in accruals	(189)	(568)	(645)	1,702	7	(448)	(2,162)	1,672	476	846	684	(1,562)	(187)
Increase/(decrease) in other Financial liabilities									734	2	71	82	889
Increase/(decrease) in Other liabilities (VAT, Social Security and Other Taxes)	(4)	94	(120)	64	(62)	15	35	2	30	(64)	73	(74)	(11)
Increase/(Decrease) in working capital, Total	**1,329**	**(3,188)**	**(533)**	**(1,208)**	**679**	**38**	**1,359**	**(2,171)**	**4,636**	**(2,534)**	**1,922**	**(1,667)**	**(1,338)**
Increase/(decrease) in Non-current provisions	(27)	13	14	(27)	16	15	(177)	20	41	54	113	(91)	(36)
Net cash inflow/(outflow) from operating activities	**490**	**(2,953)**	**(521)**	**18**	**(165)**	**310**	**2,068**	**(1,505)**	**4,863**	**(1,771)**	**2,093**	**352**	**3,279**
Net cash inflow/(outflow() from investing activities													
Property - new land, buildings or dwellings	0	0	0	0	0	0	0	0	(258)	(117)	(76)	(163)	**(614)**
Property - maintenance expenditure	(158)	(115)	(35)	(207)	(241)	(132)	(444)	(143)	(6)	(223)	(739)	(817)	**(3,260)**
Plant and equipment - Information Technology	(39)	(165)	(23)	(283)	(92)	(245)	(322)	(150)	(814)	138	(76)	(649)	**(2,720)**
Plant and equipment - Other	(45)	(119)	27	(61)	(23)	(179)	(194)	(37)	(56)	85	(135)	(379)	**(1,116)**
Increase/(decrease) in Capital Creditors	(171)	(865)	(171)	124	(58)	315	271	(201)	80	(469)	574	784	213
Net cash inflow/(outflow() from investing activities, Total	**(413)**	**(1,264)**	**(202)**	**(427)**	**(414)**	**(241)**	**(689)**	**(531)**	**(1,054)**	**(586)**	**(452)**	**(1,224)**	**(7,497)**
Net cash inflow/(outflow) before financing	**77**	**(4,217)**	**(723)**	**(409)**	**(579)**	**69**	**1,379**	**(2,036)**	**3,809**	**(2,357)**	**1,641**	**(872)**	**(4,218)**
Net cash inflow/(outflow) from financing activities													
Public Dividend Capital received	0												0
PDC Dividends paid	0					(2,065)						(2,141)	(4,206)
Interest (paid) on non-commercial loans	0							(5)	(1)	(2)	(2)	(3)	(13)
Interest received on cash and cash equivalents	4	2	6	3	3	3	3	3	3	3	3	2	38
Drawdown of non-commercial loans							0	0	0	0	0	0	0
Repayment of non-commercial loans	0												0
(Increase)/decrease in non-current receivables	(84)	65	(38)	(4)	9	(2)	24	(398)	399	(13)	(30)	26	(46)
Net cash inflow/(outflow) from financing activities, Total	**(80)**	**67**	**(32)**	**(1)**	**12**	**(2,064)**	**27**	**(400)**	**401**	**(12)**	**(29)**	**(2,116)**	**(4,227)**
Net increase/(decrease) in cash	**(3)**	**(4,150)**	**(755)**	**(410)**	**(568)**	**(1,994)**	**1,406**	**(2,436)**	**4,210**	**(2,370)**	**1,613**	**(2,988)**	**(8,445)**
Opening cash	**12,956**	**12,953**	**8,803**	**8,048**	**7,638**	**7,070**	**5,076**	**6,482**	**4,046**	**8,256**	**5,886**	**7,499**	**12,956**
Closing cash	**12,953**	**8,803**	**8,048**	**7,638**	**7,070**	**5,076**	**6,482**	**4,046**	**8,256**	**5,886**	**7,499**	**4,511**	**4,511**

Forecast cash position as per Original Monitor plan	8,342	7,772	7,202	6,751	6,301	3,839	4,597	5,356	6,489	7,241	7,993	6,731
Actual cash position	12,953	8,803	8,048	7,638	7,070	5,076	6,482	4,046	8,256	5,886	7,499	4,511
Variance	4,611	1,031	846	887	769	1,237	1,885	-1,310	1,767	-1,355	-494	-2,220

Forecast cash position as per Re-Forecast Monitor plan	8,342	7,772	7,202	6,751	6,301	3,839	4,597	5,356	4,995	5,125	4,304	3,102
Actual cash position	12,953	8,803	8,048	7,638	7,070	5,076	6,482	4,046	8,256	5,886	7,499	4,511
Variance	4,611	1,031	846	887	769	1,237	1,885	-1,310	3,261	761	3,195	1,409

Warrington and Halton Hospitals NHS Foundation Trust **Appendix E**

Statement of Position as at 31st March 2015

Narrative	Audited position as at 31.3.14 £000	Actual Position as at 28.02.15 £000	Actual Position as at 31.03.15 £000	Monthly Movement £000
ASSETS				
Non Current Assets				
Intangible Assets	316	572	567	-5
Property Plant & Equipment	132,588	132,480	143,355	10,875
Other Receivables	1,233	1,369	1,336	-33
Impairment of receivables for bad & doubtful debts	-195	-259	-253	6
Total Non Current Assets	**133,942**	**134,162**	**145,005**	**10,843**
Current Assets				
Inventories	2,769	3,329	3,312	-17
NHS Trade Receivables	3,052	4,989	4,317	-672
Non NHS Trade Receivables	573	1,289	1,364	75
Other Related party receivables	200	482	585	103
Other Receivables	1,960	1,569	1,450	-119
Impairment of receivables for bad & doubtful debts	-355	-361	-321	40
Accrued Income	884	1,457	882	-575
Prepayments	1,727	2,736	2,498	-238
Cash held in GBS Accounts	12,937	7,479	4,486	-2,993
Cash held in commercial accounts	0		0	0
Cash in hand	19	20	25	5
Total Current Assets	**23,766**	**22,989**	**18,598**	**-4,391**
Total Assets	**157,708**	**157,151**	**163,603**	**6,452**
LIABILITIES				
Current Liabilities				
NHS Trade Payables	-1,513	-1,412	-1,041	371
Non NHS Trade Payables	-5,728	-5,517	-8,134	-2,617
Other Payables	-1,755	-1,753	-1,441	312
Other Liabilities (VAT, Social Security and Other Taxes)	-2,678	-2,741	-2,667	74
Capital Payables	-1,386	-815	-1,599	-784
Accruals	-5,986	-7,327	-5,765	1,562
Interest payable on non commercial int bearing borrowings	0	0	0	0
PDC Dividend creditor (maunally input)	-49	-1,750	-76	1,674
Deferred Income	-1,353	-4,513	-974	3,539
Provisions	-282	-206	-256	-50
Loans non commercial	0		0	0
Borrowings	0	-169	-186	-17
Total Current Liabilities	**-20,730**	**-26,203**	**-22,138**	**4,065**
Net Current Assets (Liabilities)	**3,036**	**-3,214**	**-3,540**	**-326**
Non Current Liabilities				
Loans non commercial			0	0
Provisions	-1,510	-1,565	-1,474	91
Borrowings	0	-638	-703	-65
Total Non Current Liabilities	**-1,510**	**-2,203**	**-2,177**	**26**
TOTAL ASSETS EMPLOYED	**135,468**	**128,745**	**139,288**	**10,543**
TAXPAYERS AND OTHERS EQUITY				
Taxpayers Equity				
Public Dividend Capital	90,063	90,063	90,242	179
Retained Earnings prior year	12,446	9,597	10,459	862
Retained Earnings current year	-2,849	-6,723	-6,490	233
Sub total	**99,660**	**92,937**	**94,211**	**1,274**
Other Reserves				
Revaluation Reserve	35,808	35,808	45,077	9,269
Sub total	**35,808**	**35,808**	**45,077**	**9,269**
TOTAL TAXPAYERS AND OTHERS EQUITY	**135,468**	**128,745**	**139,288**	**10,543**

SUBJECT:	**CORPORATE PERFORMANCE REPORT**	
DATE OF MEETING:	29th April 2015	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Simon Wright	
EXECUTIVE DIRECTOR:	Simon Wright, Chief Operating Officer and Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	This corporate report updates the Board on the progress of the Trust in relation to activity, performance and workforce targets to 31st of March 2015. In overall terms, based on the performance in month 12, the Trust has an **Amber**/**Green** rating, as highlighted in Appendix 1. The Finance and Sustainability committee agreed that the monitor risk rating for March was amber/green, as the cancer target would not be confirmed for a further 4 weeks and the access policy describes a 4 week process for review of any under performance requiring validation before submission.	
RECOMMENDATION:	***The Board is asked to:*** ***Note the report***	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee
	Agenda Ref.	
	Date of meeting	23 April 2015
	Summary of Outcome	Recommended for Approval

NATIONAL KEY PERFORMANCE INDICATORS

ACCIDENT AND EMERGENCY DEPARTMENT

The Trust response to AED performance recovery has been captured under 4 key headings to illustrate the efforts being made.

1. Preventing Emergency Admission
2. Bed Capacity and Flow
3. Delays in Discharge
4. Process Change

I am acutely aware that we have our 'Don't Panic Just do 5 things' theme but clearly there is considerably more work than this required to turn this situation around. Already this year we have actually made a significant amount of change in process, technology, personnel whilst changing divisional leadership and invested heavily in developing relationships and partnerships across our system.

Preventing Emergency Admission:

- Securing agreement and funding from Warrington CCG, to establish a partnership with Bridgewater community Trust, UC24 , 5 Boroughs in developing a new primary care streaming model with GP treatment for medical illness and 14 ambulatory pathways to reduce emergency admissions through AED. The Trust already has the lowest conversion to admission rate in the region at 20% (July 2015)
- The Trust has increased the AED consultant numbers to 10 (achieved)
- Following a period of long term sickness the Trust has now been able to conclude the changes in leadership in the AED culminating with the new AED manager appointment (Starts June 2015)
- The Trust has led on the development of two Urgent Care Units managing minor injuries and medical illness with full diagnostic suites in Runcorn and Widnes (July 2015)
- The Trust is extending the Warrington site medical assessment unit doubling its size and medical input to increase the ambulatory pathways and impact by 50% (May 2015)
- The Trust will be undertaking a system case note review for recent emergency admissions to try and identify why they deteriated and whether a more timely intervention might have avoided AED and the requirement for an admission. (June-July 2015)

Bed Capacity and Flow:

- The Trust was been working with partners to identify the shortfall in Intermediate care bed capacity outside the Trust this has culminated in the agreement for the Trust to provide 30 intermediate care beds through our Daresbury facility for the next 6 months whilst the independent review is worked up and substantive provision agreed. (April 2015)
- A surgical ward has been 'flipped' across to medicine (A4, 32 beds max) to provide additional bed capacity (April 2015)
- Planning is in place to further recalibrate bed models which should identify escalation capacity of a further 9 beds on site for medicine later this summer (June 2015)
- Surgical work continues to look at transferring the final third phase of elective pats across to Halton from Warrington releasing further bed capacity and avoiding elective cancellations (August)

Delays in Discharge:

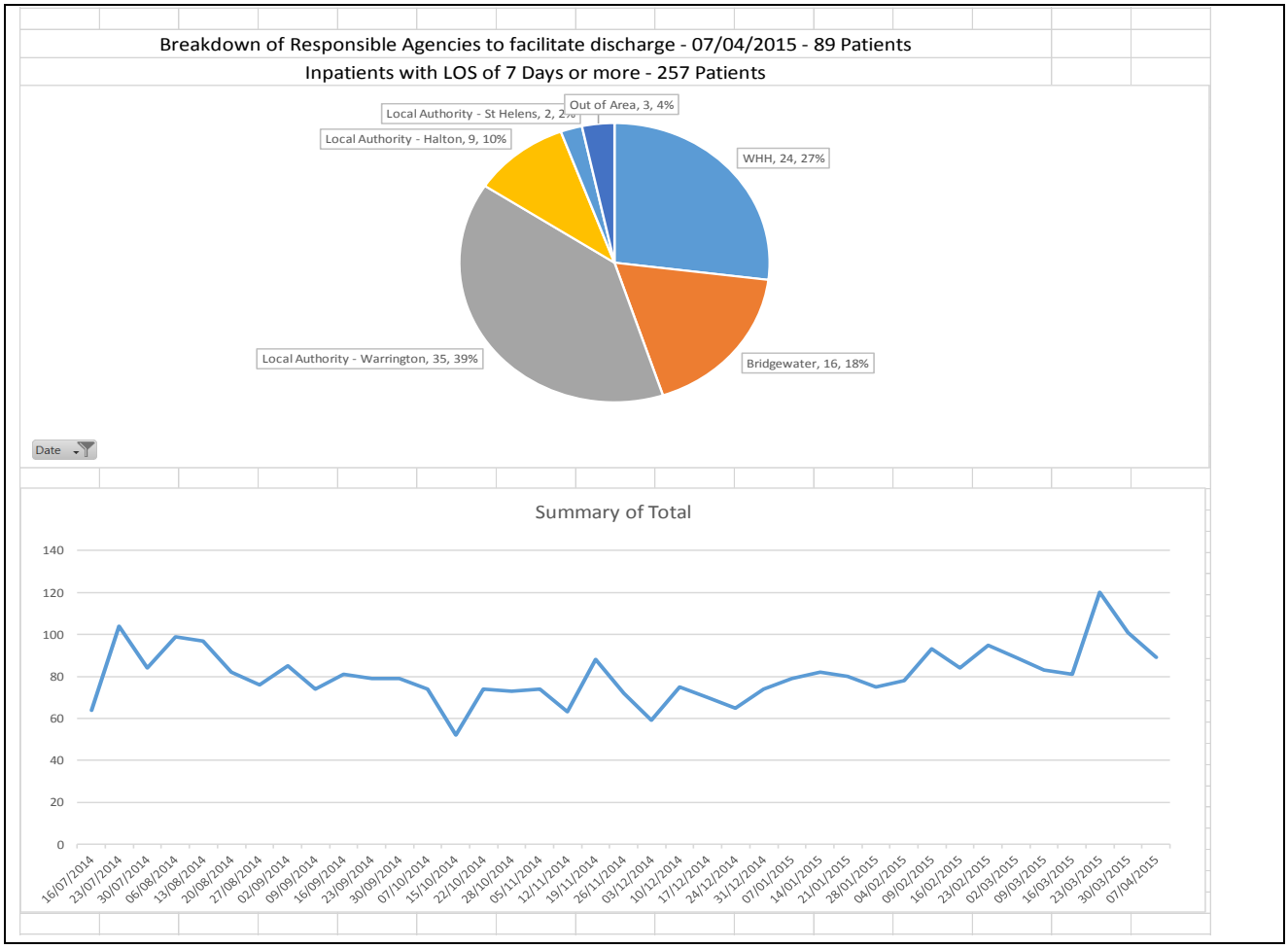
- The Trust has been undertaking Point Prevalence in line with ECIST guidance for over 9 months on a weekly basis. (Achieved)
- A target list of patients is identified every day and a 'silver control' meeting takes place with partners to discuss the timely transfer of this group from secondary care. (Achieved)

- The trust is working with the wider system on an 'umbrella employer' scheme to support the staffing pressures in nursing homes and the Trust by targeting appointees for all interested providers through one central vehicle (August 2015)
- Work is underway with Age Uk to look at 'home angels' scheme which if supported will wrap care around LTC pats who have a high risk of readmission preventing this from happening through support, telemedicine and intervention by primary community and secondary care to maintain independence and avoid AED visits (Sept 2015)
- Warrington LA are looking to renegotiate the domiciliary care contract such that this will once again be attractive to employers and secure the correct capacity with staff to prevent the current delays in providing packages of care in a timely fashion. (September 2015)
- The Trust has undertaken three Perfect Week exercises and will be undertaking a perfect mini (3 days) before all 3 day weekends and a perfect week before any 4 day weekends when bank holidays occur to focus the system on the transfers out of hospital needed to manage the lack of a systemic 7 day operating model across Warrington and Halton at present. (Achieved)
- A senior manager has been appointed by the Trust to lead on this work (start in July 2015).

Process Change:

- The trust is introducing a 'full capacity protocol' to support surge management (April 2015)
- Live ADT will be achieved with full Lorenzo implementation in (November 2015)
- Ward Rounds and Board rounds Monday to Friday (Achieved)
- Developing an integrated assessment protocol with LA and Bridgewater (Sept 2015)
- Formal fortnightly system AED recovery group meetings (ongoing)
- New accountabilities for shift co-ordinators in AED with new appointments occurring (May-Sept 2015)
- 'Discharge to Assess' being explored and aim to have in place (before winter 2015/6)
- Process redesign sessions for discharge pathways established (may-June 2015)
- Patient discharge information booklet from the ECIST care bundle (achieved)
- Further develop nurse led discharge (May 2015)
- Generic Frail Elderly pathway including case note review at day 20 (june-july 2015)
- Direct access to refer from AED to GP OOH in escalation phase (achieved)
- Check system DOS up-to-date with alternatives to AED (achieved)
- 'Focus on 5 things' campaign (ongoing)

The summary position remains that the Trust has seen a 25 bed increase in emergency demand via admissions into the hospital. The 'slipping of A4 from surgery into Medicine addresses this increase. The DTOC remains a national outlier at around 80-90 with the trend going upwards as you can see below.



Whilst the Trust is working hard to secure the funding to establish additional Intermediate care beds (following the independent review for Warrington which confirmed at least 16 were needed), at present the winter funded capacity nationally mandated to be kept open throughout April means in reality the CCG/LA have only actually commissioned the same capacity as in winter when the performance has been very poor.

Several meetings have taken place to try and ensure that from May an additional 30 intermediate care beds are made available in Daresbury for a number of months to help begin to address the delays present in our system for over 10 months now.

In a nationally mandated return for Monitor on AED performance comparing 2014/15 with 2013/14 the following 5 aspects were identified against a complex data set as standing out as being different in this last year:

1. The Trust had more delayed transfers of care due to a reduction in the availability of domiciliary care by community care providers
2. The Trust had more delayed transfers of care due to reductions in the number of step-down beds/rehabilitation capacity in the community
3. The Trust had more delayed transfers of care due to reductions in local social care capacity
4. The Trust had more patients who were considered medically fit for discharge, but not formally reported as delayed transfers of care in the department of health's monthly Delayed Transfers of Care SITREPs
5. The Trust non clinical managers in the AED department had less capacity to help identify and manage patient flow problems

The Chief Operating Officer, Medical Director and Director of Nursing and Governance have cleared their diaries to support the Perfect 14 exercise running from April 1-15th and the last two weeks of April to drive through some of the system change which is proving to be too slow in being realised.

The next board will have a worked trajectory for the above schemes to illustrate their impact on the Trust performance and if all realised the timeline for 95% recovery to be realised.

Accident and Emergency National Indicators:

National Indicators		Target	Mar	Qtr1	Qtr2	Qtr3	Qtr4	YTD Position
A&E and MIU	% Departed < 4hrs	95%	79.81%	93.97%	92.74%	89.67%	81.98%	89.75%
	Number of patients breaching 4hrs		1608	1605	1895	2593	4370	10463

The Trust will from 2015/16 be subject to penalties if it fails to achieve 85% HAS screen compliance for ambulance journeys via AED with a penalty of £200 per occasion, any ambulance waiting over 30mins in AED will generate a £200 fine, and over 60mins a £1000 fine.

The current pressures if continuing equate to an approximate £120,000 a month fine with NWAS fines for the same aspects totalling £7500.

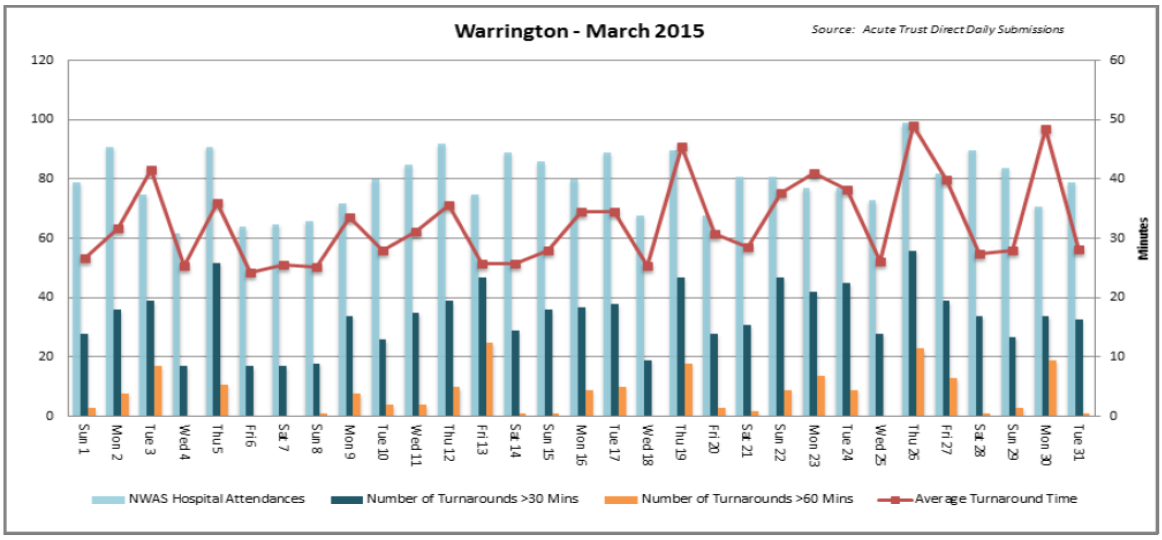
The Trust has until very recently been very proud of having the best reported turnaround times in the region, the above congestion throughout the trust is now also putting this at serious risk resulting in upto 10 patients on AED corridors during peak times.

This is acknowledged as totally at odds to the care and experience we would want for our patients and all CCG discussions are sharing the clinical impact of the ongoing DTOC pressure with Monitor and NHS E organising a meeting with the Warrington system on May 5th to discuss what is preventing progress in this area. The Trust has already submitted information to Monitor and NHS E in particular on the subject of the declared DTOC position and the scale of its impact.

Ambulance Handovers:

Local Indicators		Target	Mar	Qtr1	Qtr2	Qtr3	Qtr4	YTD Position
Ambulance Handovers	Number handed over >30 mins	0	221	82	132	408	561	1183
	Number handed over >60 mins	0	91	5	10	107	193	315
	Number handed over >2 hours	0		1	0	12	21	34
	HAS Compliance Score	85%	71.29%	77.06%	69.85%	72.22%	70.08%	71.69%

Extract from UCAT report on NWAS performance in WHFT

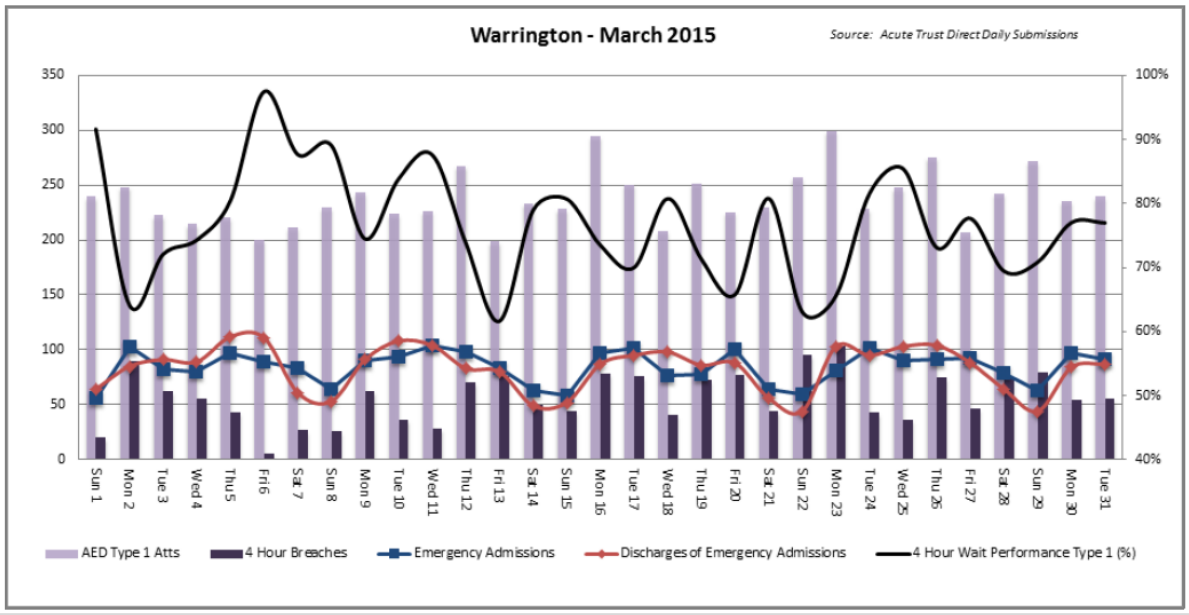


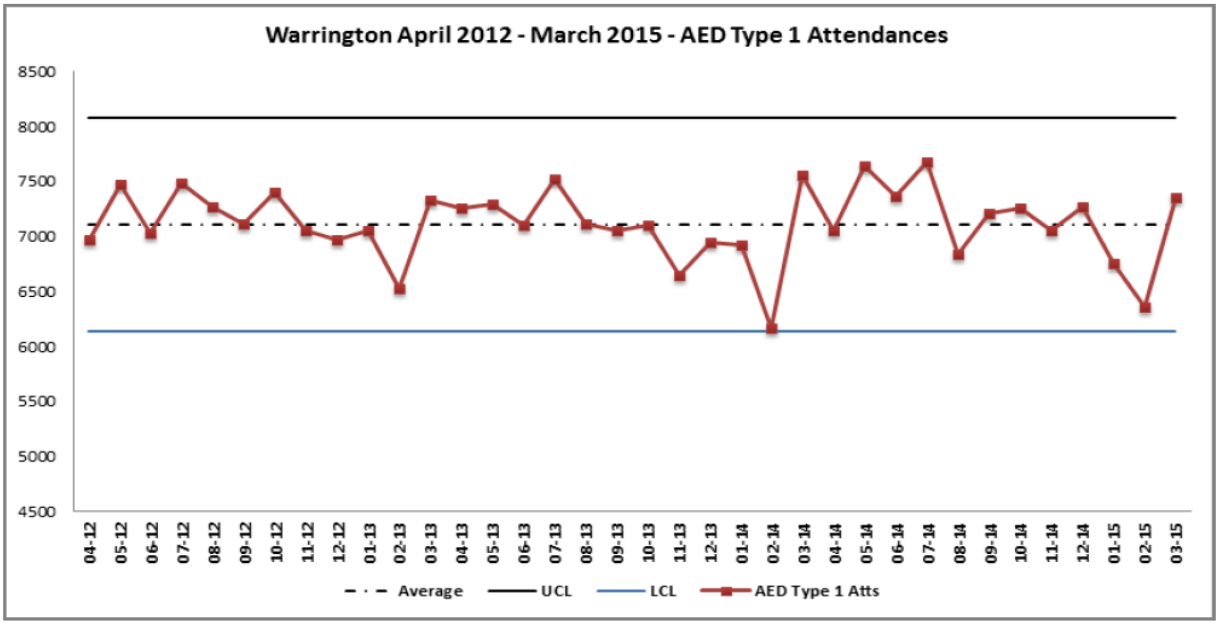
- The highest daily average turnaround time of 49.1 minutes occurred on Thursday 26th March 2015. There were 56 ambulance turnarounds greater than 30 minutes and 23 in excess of one hour, the former being the highest daily total during the month.
- A comparable daily average turnaround time of 48.5 minutes occurred on Monday 30th March 2015 at Warrington. There were 34 ambulances with turnarounds greater than 30 minutes and 19 ambulances with turnarounds greater than 60 minutes on this day.
- Thursday 26th March 2015 saw the highest number of NWAS ambulance attendances to the Trust (99) although comparable ambulance attendances were reported on a number of other days.
- Across the month, Warrington/NWAS averaged a turnaround time of 33.7 minutes. This is an increase to the previous month and is also the highest monthly average from April 2012 onwards.

UCAT information for our Trust for March 2015.

Warrington March 2015	Sun 1st	Mon 2nd	Tue 3rd	Wed 4th	Thu 5th	Fri 6th	Sat 7th	Sun 8th	Mon 9th	Tue 10th	Wed 11th	Thu 12th	Fri 13th	Sat 14th	Sun 15th	Mon 16th	Tue 17th	Wed 18th	Thu 19th	Fri 20th	Sat 21st	Sun 22nd	Mon 23rd	Tue 24th	Wed 25th	Thu 26th	Fri 27th	Sat 28th	Sun 29th	Mon 30th	Tue 31st	Total	Avg
AED Atts *	239	248	222	214	220	200	211	229	243	223	226	267	198	233	228	294	250	208	251	225	229	257	299	228	247	275	206	242	271	235	239	7357	237
Breaches *	20	89	62	55	43	5	26	25	62	36	28	70	76	49	44	78	75	40	72	77	44	95	103	42	36	74	46	74	79	54	55	1734	56
AED Adms *	42	54	53	58	67	48	66	55	59	58	57	72	64	52	49	60	68	58	49	75	40	47	54	71	53	63	53	62	44	55	63	1769	57
Direct Adms *	14	49	29	22	30	41	17	9	31	36	47	26	19	11	9	37	34	19	29	26	24	13	27	31	37	28	39	17	19	42	28	840	27
Emer Adms *	56	103	82	80	97	89	83	64	90	94	104	98	83	63	58	97	102	77	78	101	64	60	81	102	90	91	92	79	63	97	91	2609	84
Emer Dischs *	64	85	91	89	112	111	61	53	91	108	104	83	80	49	52	87	95	98	86	88	56	44	103	95	103	104	88	64	44	84	87	2559	83
% 4 Hr Wt	92%	64%	72%	74%	80%	98%	88%	89%	74%	84%	88%	74%	62%	79%	81%	73%	70%	81%	71%	66%	81%	63%	66%	82%	85%	73%	78%	69%	71%	77%	77%	76%	
>30 Mins Trnrnds *	28	36	39	17	52	17	17	18	34	26	35	39	47	29	36	37	38	19	47	28	31	47	42	45	28	56	39	34	27	34	33	1055	34
>60 Mins Trnrnds *	3	8	17	0	11	0	0	1	8	4	4	10	25	1	1	9	10	0	18	3	2	9	14	9	0	23	13	1	3	19	1	227	7
AEDs > Emer Adms	4.3	2.4	2.7	2.7	2.3	2.2	2.5	3.6	2.7	2.4	2.2	2.7	2.4	3.7	3.9	3.0	2.5	2.7	3.2	2.2	3.6	4.3	3.7	2.2	2.7	3.0	2.2	3.1	4.3	2.4	2.6	90.51	2.9
Dischs v Emer Adms	8	-18	9	9	15	22	-22	-11	1	14	0	-15	-3	-14	-6	-10	-7	21	8	-13	-8	-16	22	-7	13	13	-4	-15	-19	-13	-4	-50	-2
AED Adm Rate	18%	22%	24%	27%	30%	24%	31%	24%	24%	26%	25%	27%	32%	22%	21%	20%	27%	28%	20%	33%	17%	18%	18%	31%	21%	23%	26%	26%	16%	23%	26%	24%	

* One Standard Deviation Above the Mean (SD = average difference to the mean - for the month)
* Two Standard Deviation Above the Mean (2SD = twice average difference to the mean - for the month)


Warrington - March 2015
Source: Acute Trust Direct Daily Submissions
350
300
250
200
150
100
50
0
100%
90%
80%
70%
60%
50%
40%
Sun 1
Mon 2
Tue 3
Wed 4
Thu 5
Fri 6
Sat 7
Sun 8
Mon 9
Tue 10
Wed 11
Thu 12
Fri 13
Sat 14
Sun 15
Mon 16
Tue 17
Wed 18
Thu 19
Fri 20
Sat 21
Sun 22
Mon 23
Tue 24
Wed 25
Thu 26
Fri 27
Sat 28
Sun 29
Mon 30
Tue 31
AED Type 1 Atts
4 Hour Breaches
Emergency Admissions
Discharges of Emergency Admissions
4 Hour Wait Performance Type 1 (%)


Warrington April 2012 - March 2015 - AED Type 1 Attendances
8500
8000
7500
7000
6500
6000
5500
5000
4500
04-12
05-12
06-12
07-12
08-12
09-12
10-12
11-12
12-12
01-13
02-13
03-13
04-13
05-13
06-13
07-13
08-13
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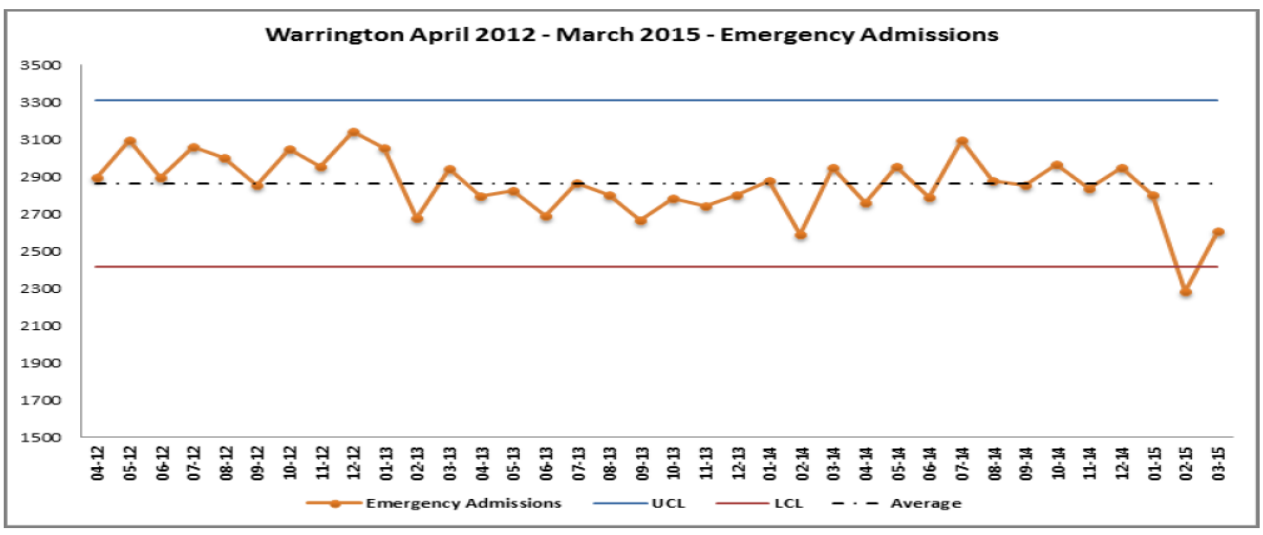
01-14
02-14
03-14
04-14
05-14
06-14
07-14
08-14
09-14
10-14
11-14
12-14
01-15
02-15
03-15
Average
UCL
LCL
AED Type 1 Atts


Warrington April 2012 - March 2015 - Emergency Admissions
3500
3300
3100
2900
2700
2500
2300
2100
1900
1700
1500
04-12
05-12
06-12
07-12
08-12
09-12
10-12
11-12
12-12
01-13
02-13
03-13
04-13
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04-14
05-14
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08-14
09-14
10-14
11-14
12-14
01-15
02-15
03-15
Emergency Admissions
UCL
LCL
Average

Warrington April 2013 - March 2015	04-13	05-13	06-13	07-13	08-13	09-13	10-13	11-13	12-13	01-14	02-14	03-14	04-14	05-14	06-14	07-14	08-14	09-14	10-14	11-14	12-14	01-15	02-15	03-15
AED Attendances *	7,255	7,289	7,098	7,519	7,110	7,052	7,104	6,644	6,940	6,923	6,168	7,555	7,047	7,639	7,358	7,671	6,837	7,208	7,257	7,055	7,262	6,749	6,354	7,357
4 Hour Breaches *	516	298	173	436	428	395	414	398	357	507	282	279	453	654	458	836	486	583	607	698	1,398	1,219	1,348	1,734
AED Admissions *	1,930	1,973	1,854	2,002	2,002	1,859	1,912	1,824	1,899	1,896	1,650	1,834	1,760	1,921	1,730	2,044	1,873	1,837	1,965	1,873	1,960	1,870	1,563	1,769
Direct Emergency Adms *	866	849	836	864	796	804	872	920	899	981	936	1,113	1,001	1,032	1,056	1,049	1,007	1,017	999	961	987	932	723	840
Total Emergency Adms *	2,796	2,822	2,690	2,866	2,798	2,663	2,784	2,744	2,798	2,877	2,586	2,947	2,761	2,953	2,786	3,093	2,880	2,854	2,964	2,834	2,947	2,802	2,286	2,609
Emer Discharges *	2,833	2,847	2,689	2,852	2,788	2,653	2,795	2,762	2,749	2,858	2,623	2,903	2,751	2,986	2,776	3,097	2,849	2,831	2,953	2,759	2,940	2,812	2,273	2,559
% 4 Hr Wait Performance	92.9%	95.9%	97.6%	94.2%	94.0%	94.4%	94.2%	94.0%	94.9%	92.7%	95.4%	96.3%	93.6%	91.4%	93.8%	89.1%	92.9%	919%	916%	90.1%	80.7%	819%	78.8%	76%
>30 Mins NWAS Trnrnds *	581	503	487	585	619	668	648	491	493	489	433	435	467	578	495	632	642	606	737	748	1,143	987	891	1,055
>60 Mins NWAS Trnrnds *															6	37	24	26	44	54	231	155	170	227
AED Atts > Emer Adms	2.6	2.6	2.6	2.6	2.5	2.6	2.6	2.4	2.5	2.4	2.4	2.6	2.6	2.6	2.6	2.5	2.4	2.5	2.4	2.5	2.5	2.4	2.8	2.8
Discharges v Emer Adms	37	25	-1	-14	-10	-10	11	18	-49	-19	37	-44	-10	33	-10	4	-31	-23	-11	-75	-7	10	-13	-50
AED Admission Rate	27%	27%	26%	27%	28%	26%	27%	27%	27%	27%	27%	24%	25%	25%	24%	27%	27%	25%	27%	27%	27%	28%	25%	24%

* One Standard Deviation Above the Mean (SD = average difference to the mean - for the month) - Excludes >60 Mins Turnarounds

* Two Standard Deviation Above the Mean (2SD = twice average difference to the mean - for the month) - Excludes >60 Mins Turnarounds

- Discharges of emergency admissions have followed a similar trend to emergency admissions throughout 2014/15.

- A large decrease in 'emergency discharges' has occurred in early 2015. Although the 2,559 discharges in March 2015 is an increase to the previous month, this remains well below an overall average for Warrington.

CLOSTRIDIUM DIFFICILE

See infection control report

MRSA

See Infection Control Report

Cancer

The cancer performance for post reallocations is unconfirmed with expectations that as historically evidenced the Trust will deliver the quarter performance. The final position for this will be declared in two months time.

NEXT STEPS

May Board will be provided with a performance trajectory that reflects the actions above and translates this into improvements in the overall 95% performance over time.

RECOMMENDATIONS

To support the direction of travel and apply pressure on system partners to agree a trajectory of improvement for DTOC down to 30 whilst building capacity substantively in Intermediate care and domiciliary care to deliver this change recurrently.

APPENDIX 1

Please note the cancer targets will not be confirmed for a further 4 weeks and the access policy describes a 4 week process for review of any underperformance requiring validation before submission

Mar-15

Monitor Governance Risk Rating - 2014/15

Warrington and Halton Hospitals NHS
NHS Foundation Trust

All targets are QUARTERLY

Target or Indicator		Target	Weighting	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4
Referral to treatment waiting time	Admitted patients	90%	1.0	92.61%	93.21%	93.58%	93.14%	90.70%	90.34%	92.04%	91.04%	92.07%	92.73%	92.99%	92.60%	92.93%	92.18%	92.54%	92.57%
	Non-admitted patients	95%	1.0	98.03%	97.63%	98.54%	98.07%	97.79%	97.72%	98.14%	97.89%	97.62%	96.99%	97.51%	97.38%	96.99%	97.27%	97.21%	97.15%
	Incomplete Pathways	92%	1.0	94.55%	94.56%	94.94%	94.68%	94.88%	95.29%	94.94%	95.03%	94.50%	94.33%	93.96%	94.27%	93.49%	93.87%	93.60%	93.66%
A&E Clinical Quality	A&E Maximum waiting time of 4 hrs from arrival to admission/transfer/discharge	>=95%	1.0	94.54%	92.66%	95.01%	93.97%	91.74%	93.54%	93.26%	92.74%	93.00%	91.23%	83.75%	89.67%	84.08%	81.82%	79.81%	81.98%
All Cancers:62-day wait for First treatment	From urgent GP referral - **post** local breach re-allocation (CCG)	85%	1.0	90.00%	87.65%	85.51%	85.45%	85.90%	84.81%	90.41%	85.19%	90.24%	80.28%	85.26%	86.38%	81.54%	83.00%	86.00%	83.51%
	From NHS Cancer Screening Service referral - **post** local breach re-allocation	90%	1.0	100.00%	100.00%	98.00%	99.33%	100.00%	98.00%	99.00%	99.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	From urgent GP referral - **pre** local breach re-allocation (Open Exeter - Monitor)	85%		87.80%	92.21%	88.06%	87.91%	88.57%	89.04%	91.67%	85.45%	92.50%	93.00%	90.91%	89.10%	85.48%	89.33%	88.61%	87.81%
	From NHS Cancer Screening Service referral - **pre** local breach re-allocation	90%		100.00%	100.00%	98.00%	99.33%	100.00%	98.00%	100.00%	99.00%	100.00%	98.00%	100.00%	99.00%	100.00%	100.00%	100.00%	98.00%
All Cancers:31-day wait for second or subsequent treatment	Surgery	>94%	1.0 (Failure for any of the 3 = failure against the overall target)	96.00%	98.00%	97.00%	97.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Anti Cancer Drug Treatments	>98%		100.00%	100.00%	98.00%	99.33%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Radiotherapy (not performed at this Trust)	>94%																	
All Cancers: 31-Day Wait From Diagnosis To First Treatment		>96%	1.0	96.00%	96.00%	98.00%	96.67%	98.00%	99.00%	100.00%	99.00%	98.00%	98.00%	97.00%	97.70%	98.00%	100.00%	97.00%	98.33%
Cancer: Two Week Wait From Referral To Date First Seen	Urgent Referrals (Cancer Suspected)	>93%	1.0 (Failure for either = failure against the overall target)	93.10%	92.90%	93.05%	93.00%	93.80%	92.70%	93.80%	93.50%	93.50%	95.20%	94.70%	94.80%	94.80%	94.80%	93.00%	94.40%
	Symptomatic Breast Patients (Cancer Not Initially Suspected)	>93%		93.05%	93.00%	93.10%	93.05%	93.75%	91.90%	93.90%	93.30%	92.99%	94.20%	94.20%	93.10%	93.50%	92.90%	93.0%	93.13%
Clostridium Difficile - Hospital acquired **(CUMULATIVE)**	Due to lapses in care	26 (for the Yr)	1.0 **	1	3	4	4	4	4	4	4	4	4	4	4	5	5	5	5
	Total (including: due to lapses in care, not due to lapses in care, and cases under review)			2	5	7	7	8	15	16	16	19	20	23	23	24	26	31	31
	Under Review			1	2	3	3	4	11	12	12	15	16	19	19	19	21	26	26
Failure to comply with requirements regarding access to healthcare for people with a learning disability		N/A	1.0	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No

Cumulative
Qtr1: 7 Qtr2: 13
Qtr3: 20 Qtr4: 26

APPENDIX 1

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Target or Indicator	Target	Weighting	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4
Risk of, or actual, failure to deliver commissioner requested services	N/A	Report by Exception	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
CQC compliance action outstanding (as at time of submission)	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
CQC enforcement action within last 12 months (as at time of submission)	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
CQC enforcement action (including notices) currently in effect (as at time of submission)	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A		No	No	No	No	No	No	No	No	Yes	No	No	No	No	No	No	No
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Unable to maintain, or certify, a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Score of 7 or less in standard 1 assessment at last NHSLA CNST inspection (maternity or all services)	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Overall Governance Risk Rating **Total Points 0 - 0.9 Green, 1 - 1.9 Amber-Green, 2 - 4 Amber-Red, 4 or above Red)**			1.0	2.0	0.0	1.0	1.0	3.0	1.0	1.0	2.0	2.0	1.0	1.0	1.0	1.0	1.0	1.0

All Cancers: The reporting position for Qtr4 does not close until 05/05/2015

Additional Notes:

18 Weeks Referral to Treatment
Performance is measured on an aggregate (rather than specialty) basis and NHS foundation trusts are required to meet the threshold on a monthly basis.
Consequently, any failure in one month is considered to be a quarterly failure for the purposes of the Compliance Framework.
Failure in any month of a quarter following two quarters' failure of the same measure represents a third successive quarter failure and should be reported via the exception reporting process.
Failure against any threshold will score 1.0, but the overall impact will be capped at 2.0

**** Clostridium Difficile**
Monitor's annual de minimis limit for cases of C-Diff is set at 12. However, Monitor may consider scoring cases of <12 if Public Health England indicates multiple outbreaks
Monitor will assess NHS foundation trusts for breaches of the C. difficile objective against their objective at each quarter using a cumulative year-to-date trajectory.

Criteria	Will a score be applied
Where the number of cases is less than or equal to the de minimis limit	No
If a trust exceeds the de minimis limit, but remains within the in-year trajectory# for the national objective	No
If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective	Yes
If a trust exceeds its national objective above the de minimis limit	Yes (and a red rating will be applicable)

Assessed at: 25% of the annual centrally-set objective at quarter 1; 50% at quarter 2; 75% at quarter 3; and 100% at quarter 4 (all rounded to the nearest whole number, with any ending in 0.5 rounded up).
Monitor will not accept a trust's own internal phasing of their annual objective or that agreed with their commissioners.

BOARD OF DIRECTORS

WHH/B/2015/ **082**

SUBJECT:	**'Partnering for Success'** **A New Strategy for Radiology Services**	
DATE OF MEETING:	29th April 2015	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Mr R M Brown	
EXECUTIVE DIRECTOR:	Simon Wright, Chief Operating Officer and Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO2/2.2 Risk that the Trust does not have the right people with the right skills ie workforce is not competent and cannot deliver as commissioned. SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	The Radiology Service at WHHFT undertakes over 650 scans and x-rays each day to support clinical decision making in both primary and secondary care. Back in 2012 the Department was faced with a significant number of risks which were seriously compromising our ability to deliver a high quality service. The purpose of this report is to assure the Trust Board that these risks have been largely mitigated and a strong and sustainable department is emerging by pursuing a strategy of partnerships and collaboration.	
RECOMMENDATION:	***The Board is asked to:*** note the contents of this report and endorse the approach being taken by the Radiology Service.	
PREVIOUSLY CONSIDERED BY:	**Committee**	
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

"PARTNERING FOR SUCCESS"

A NEW STRATEGY FOR RADIOLOGY SERVICES

1. The Radiology Service in 2012

Warrington Hospital
Plain Film MRI Scans CT Scans Intervention Radiology Nuclear Medicine Ultrasound DEXA
Halton Hospital
MRI Scans CT Scans Plain Film Ultrasound
Primary Care (GP Practice in Stockton Heath)
Ultrasound Scans

In 2012 the Radiology Department provided a very traditional hospital service on both the Warrington and Halton sites together with a weekly Ultrasound scanning list at a GP Practice in Stockton Heath.

Recruitment of both Consultant Radiologists and Radiographers started to become problematic at this time and, due to national shortages, the market became very competitive. Demand for GP Direct Access work (MRI, CT, Ultrasounds) was increasing year on year by 10% and the service was becoming increasingly reliant on Waiting List Initiatives to maintain capacity but at a premium cost.

Our ability to attract new staff was made very difficult by strategic discussions around the future of Vascular Surgery which had historically been provided at WHHFT.

Consultation lasted over 18 months and, once the decision was made to centralise In-patient Vascular Surgery work in only two centres (Chester and the Royal Liverpool) this weakened our position considerably because Vascular Surgery and Interventional Radiology are inextricably linked.

The immediate impact of the protracted Vascular Surgery consultation was the withdrawal of a candidate who had been appointed to a Consultant Interventional Radiologist post in favour of an appointment at the Royal Liverpool.

A QPS Assessment of the Radiology Service in 2012 confirms that the Department had several risks:

Quality		People		Sustainability	
Consistent achievement of Diagnostic Waiting Time National Target	✓	Vacancies at Consultant Radiologist level	**X**	Order books continually full with 10% increase in demand year on year for scans/x-rays	✓
Significant clinical risk of only one CT Scanner on the Warrington site. At times of breakdown seriously ill patients had to be transferred to Whiston	**X**	Low morale in Department and in particular the Radiographers who collectively expressed their concerns by 'whistle blowing'	**X**	Direct Access Radiology Services were very 'profitable' and achieving a margin of over 25% despite reliance on Waiting List Initiatives	✓
Regular cancellation of IR Procedures due to lack of beds	**X**	Grievances from staff regarding grading issues	**X**	Radiology Service consistently over performs against income plan year on year	✓
Some concerns raised by Breast Screening QA team	**X**	SpR rota had regular gaps filled by Locums	**X**	Loss of Vascular Surgery Service to Chester was undermining the future of the Interventional Radiology Service	**X**
Ageing equipment in need of replacement	**X**	Service pressures due to staff being unwilling to cover empty shifts on a voluntary basis	**X**	Referral of tests and scans to tertiary providers was increasing and at very high cost	**X**
Privacy and Dignity issues in Radiology at Warrington with male and female patients waiting in the same area	**X**	Negative behaviours were evident throughout the department	**X**	Increasing reliance on WLIs to maintain capacity	**X**

2. Years 2013-14 – A Period of Major Change and Thinking

The acquisition of the CMTC during this period was a tremendous boost for the Trust but a mixed blessing initially for the Radiology Service. A CT Scanner and MRI Scanner in the CMTC became our assets but the equipment was already 7 years old at this time and staffing had to spread even thinner than ever to operationalise this extra capacity which was on the Halton site. Thus, the issues, facing Radiology at this time were complex and needed to be resolved by a combination of approaches as follows:

- **Leadership**

  A new Radiology Manager was appointed in November 2013 who was a professional Radiographer by background but had the added value of excellent business management skills. This appointment was welcomed by both medical staff and Radiographers who specifically asked to be managed by a trained Radiographer in their whistleblowing letter. The Radiology Manager and newly appointed Clinical Lead made a conscious effort to raise the profile of the department at all Regional meetings.

- **Investment**

  Business Cases were submitted and supported by the Executive Team to replace many pieces of ageing equipment totalling over £3M. This included a new Interventional Radiology suite (£1M), purchase of a new CT Scanner for Warrington and transfer of the Halton CT Scanner to Warrington (£600k), resolution of Privacy and Dignity issues (£300k) and 2 new digital x-ray rooms, one in main and one in A&E (£500k).

- **Collaboration and Partnership Working**

  Raising the profile of the department prompted discussion with Aintree Hospital regarding our Interventional Radiology Service and this developed into an offer of support from Aintree. Two Aintree Consultants expressed a wish to undertake a session each week at Warrington. This development was not welcomed by our only full-time Interventional Radiologist who moved to a similar post at Whiston Hospital in September 2014.

  Discussion had also commenced with Halton CCG to provide Community based Radiology services in the new Urgent Care Centre at Halton Hospital and Widnes Healthcare Resource Centre. These services will commence in early May 2015.

  In November 2014 an approach was made by the Royal Liverpool Hospital and Whiston to join an innovative new scheme for SpR grade doctors reporting scans out of hours. Historically, each Trust had an SpR on-call rota but this was becoming increasingly burdensome with more and more requests for CT Scans out of hours. Under the new arrangements an SpR is based each night at Broadgreen Hospital just reporting scans for the 3 Trusts in the collaborative. This commenced in February 2015 and is made possible because all Trusts have the same IT systems for easy transfer of images.

- **Workforce**

  A fundamental change was made in 2013 to the recruitment of Radiographers with an agreement to over recruit when Radiographers have just completed their training. The profile of the service has been raised through a series of Open Days prior to the posts being advertised. With regard to Consultant Radiologists, the department had 5 vacancies in September 2014 and a further Consultant on Maternity Leave. This represented 37% of the Consultant workforce. A new

approach was taken and the overseas recruitment market was tented using a specialist agency. This had limited success with the appointment of a Radiologist from Croatia but all the signs are that he is looking to settle down with his family in this country.

3. 2015 and Beyond

Significant further progress has been made in 2015 to strengthen the Department with several more partnerships about to be signed off or at the negotiation stage. This includes Paediatric Radiology with Alder Hey, Neuro-Radiology with the Walton Neuro Centre and Cardiac CT with either Liverpool Heart and Chest or South Manchester. Our agreement with Aintree Hospital for Interventional Radiology has been extended to two full days per week.

Thus we have strengthened the department considerably creating our own network of partnerships. The most positive sign of our development is the good response to a recent advertisement for Consultant Radiologists. Three Consultants were appointed including two who have only just recently qualified. All new appointees will be in post by late summer.

However, the Department still has issues to resolve and the top priority in 2015/16 is to reduce the spend on Waiting List Initiatives which exceeded £1M in 2014/15. The plan is to outsource the excess demand to an external private provider at less cost than WLIs and the initial Business Case has been approved and progressing to the EU Procurement Stage.

The service will always be capital intensive and a new MRI Scanner has just been signed off at a cost of £1.65M. This will improve throughput and ensure that we have capacity to meet the ever growing demands. The department is also now in a strong position to bid for any external work which is tendered.

4. Conclusion

The Board is asked to note the contents of this report and endorse the approach being taken by the Radiology Service. The vast majority of risks detailed on the 2012 QPS Assessment have now been either addressed or mitigated. By the end of 2015 the Radiology Service will have become even stronger and much different than the traditional service in 2012 as shown in the diagram below. Two further Trusts (Chester and Whiston) have approached us only this week offering to collaborate on Interventional Radiology Services and this is being considered.

CORE SERVICE

WARRINGTON
Plain film
MRI scans
CT scans
Interventional Radiology
Nuclear Medicine
Ultrasound
Dexa
HALTON
Plain film
MRI scans
CT scans
Ultrasound
HALTON URGENT CARE CENTRE
Plain film
Ultrasound
WIDNES URGENT CARE CENTRE
Plain film
Ultrasound
PRIMARY CARE (GP Practice in Stockton Heath)
Ultrasound

PARTNERSHIPS

- Partnership with Royal Liverpool & Whiston Hospital for Out-of-Hours SpR cover
- Partnership with Aintree Hospital on Interventional Radiology service. New treatments introduced e.g. Fibroid Embolisation
- Partnership with Alder Hey for In-Reach Paediatric Radiology sessions
- Partnership with Walton Neuro Hospital for an In-Reach Neuro CT session
- Partnership with Liverpool Heart & Chest Hospital or South Manchester for an In-Reach Cardiac CT list
- Partnership with Countess of Chester hospital to repatriate vascular surgery IR procedures which they do not have capacity for
- Contract with external company to outsource our excess demand of report which is currently being undertaken as WLIs

K E Y

	Partnership in place and working well
	Partnership will commence on 1 May 2015
	Potential partnership at discussion stage but expected to progress
	Contract subject to EU procurement which will take six months

BOARD OF DIRECTORS

WHH/B/2015/ **085**

SUBJECT:	**Governance Statement Quarter 4 14/15**	
DATE OF MEETING:	29th April 2015	
ACTION REQUIRED	**For Decision**	
AUTHOR(S):	Steve Barrow, Deputy Director of Finance	
EXECUTIVE DIRECTOR:	Tim Barlow, Director of Finance and Commercial Development Choose an item.	
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care SO3: To give our patients the best possible experience SO4: To provide sustainable local healthcare services	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework SO1/1.3 Failure to achieve infection control targets in accordance with the Risk Assessment Framework	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	In accordance with the Risk Assessment Framework published by Monitor on 27th August 2013, Boards of NHS Foundation Trusts are required to respond to statements that relate to compliance for Finance, Governance and otherwise (those outside of Finance and Governance). The report sets out the requirements and seeks the board view on the appropriate Q4 statements to be submitted to Monitor by 30 April 2015.	
RECOMMENDATION:	***The Board is asked to approve the Financial, governance and otherwise statement for submission to Monitor***	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable Or type here if not on list:
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST

MONITOR GOVERNANCE STATEMENT

QUARTER 4 2014/15 (1st APRIL 2014 – 31st MARCH 2015)

1. BACKGROUND

In accordance with the Risk Assessment Framework published by Monitor on 27th August 2013, Boards of NHS Foundation Trusts are required to respond to the following statements (see attachment 1).

2. STATEMENTS

2.1 FINANCE STATEMENT

The Board anticipates that the Trust will continue to maintain a continuity of services risk rating of at least 3 over the next 12 months.

2.2 GOVERNANCE STATEMENT

The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework and a commitment to comply with all known targets going forwards (see attachment 2).

2.3 OTHERWISE

The Board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per Compliance Framework page 16 diagram 8 and the Risk Assessment Framework page 21 diagram 6) which have not already been reported (see attachment 3).

3. RECOMMENDATIONS

Finance

The annual plan submitted to Monitor on 4th April 2014 covering the two financial years 14/15 and 15/16 showed that in both years the planned risk rating for quarters 1 to 3 is 2 but this increases in quarter 4 to 3, as summarized in the table below:

Rating	Q1	Q2	Q3	Q4
14/15	2	2	2	3
15/16	2	2	2	3

However the actual continuity of services risk rating as at 31st March 2015 is 2, which is below that planned for the period.

The 15/16 Annual Plan approved by the Board and submitted to Monitor is a planned annual deficit of £15m and an annual continuity of services risk rating of 1, with a quarterly risk rating of 1 in each and every quarter.

The finance statement requires the Board to confirm that it anticipates it will maintain a continuity of services risk rating of 3 for "at least over the next 12 months" which therefore runs to Quarter 4 15/16.

Therefore based on current and planned performance it is recommended that the Board states that it cannot confirm that it anticipates maintaining a risk rating of at least 3 over the next 12 months.

Governance

In Quarter 4 all targets and indicators were achieved with the exception of A&E Clinical Quality – total time in A&E under 4 hours and the cancer 62 day wait for first treatment (from urgent GP referral) – post local breach re-allocation (even though the reporting period for this target does not close until 5th May 2015) . Both of these targets score 1 point against the governance risk rating and is therefore reported as "not met" in the Quarter 4 return. The trust will notify Monitor of the final quarterly performance for the cancer target once the reporting period has closed and the performance has been confirmed.

To date the trust has had 31 cases of C Diff. It has been confirmed that 5 cases are due to lapses in care and 26 cases are under review. The reason for the delay in confirmation of status of the cases is the delay in the appeals process arranged by the commissioner. The latest position is summarized in the table below:

Narrative	Q1	Q2	Q3	Q4	Total
Cases due to lapses in care	4	0	0	1	5
Cases not due to lapses in care	0	0	0	0	0
Cases under review	3	9	7	7	26
Total	**7**	**9**	**7**	**8**	**31**

Therefore the Board is requested to consider and recommend whether it declares confirmed or not confirmed as to whether it is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets and a commitment to comply with all known targets going forwards.

Otherwise / Exception Reporting

- Based on the fact that there are no actual or prospective material changes which may affect the ability to comply with any aspect of authorization and which have not been previously notified to Monitor, it is proposed that the board confirms the otherwise statement.

Tim Barlow
Director of Finance & Commercial Development, 22nd April 2015

Worksheet "Governance Statement"

Click to go to index

In Year Governance Statement from the Board of Warrington and Halton Hospitals

The board are required to respond "Confirmed" or "Not confiirmed" to the following statements (see notes below)

		Board Response
	For finance, that:	
4	The board anticipates that the trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months.	Not Confirmed
	For governance, that:	
11	The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards.	
	Otherwise:	
	The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework page 22, Diagram 6) which have not already been reported.	
	Consolidated subsidiaries: Number of subsidiaries included in the finances of this return. This template should not include the results of your NHS charitable funds.	

Signed on behalf of the board of directors

Signature		Signature	
Name	Mel Pickup	**Name**	Tim Barlow
Capacity	Chief Executive	**Capacity**	Director of Finance
Date	29th April 2015	**Date**	29th April 2015

3

Notes: *Monitor will accept either 1) electronic signatures pasted into this worksheet or 2) hand written signatures on a paper printout of this declaration posted to Monitor to arrive by the submission deadline.*

In the event than an NHS foundation trust is unable to confirm these statements it should NOT select 'Confirmed' in the relevant box. It must provide a response (using the section below) explaining the reasons for the absence of a full certification and the action it proposes to take to address it.

This may include include any significant prospective risks and concerns the foundation trust has in respect of delivering quality services and effective quality governance.

Monitor may adjust the relevant risk rating if there are significant issues arising and this may increase the frequency and intensity of monitoring for the NHS foundation trust.

The board is unable to make one of more of the confirmations in the section above on this page and accordingly responds:

A

B

C

Worksheet "Targets and Indicators"

Declaration of risks against healthcare targets and indicators for 2014-15 by Warrington and Halton Hospitals

These targets and indicators are set out in the Risk Assessment Framework

Definitions can be found in Appendix A of the Risk Assessment Framework

NOTE: If a particular indicator does not apply to your FT then please enter "Not relevant" for those lines.

Key: must complete / may need to complete

Target or Indicator (per Risk Assessment Framework)	Threshold or target YTD	Scoring under Risk Assessment Framework	Risk declared at Annual Plan	Scoring under Risk Assessment Framework	Quarter 1 Actual: Performance	Quarter 1 Actual: Achieved/Not Met	Scoring under Risk Assessment Framework	Quarter 2 Actual: Performance	Quarter 2 Actual: Achieved/Not Met	Scoring under Risk Assessment Framework	Quarter 3 Actual: Performance	Quarter 3 Actual: Achieved/Not Met	Scoring under Risk Assessment Framework	Quarter 4 Actual: Performance	Quarter 4 Actual: Achieved/Not Met	Any comments or explanations	Scoring under Risk Assessment Framework
Referral to treatment time, 18 weeks in aggregate, admitted patients	90%	1.0	No		92.9%	Achieved		91.0%	Achieved		92.6%	Achieved		92.6%	Achieved		
Referral to treatment time, 18 weeks in aggregate, non-admitted patients	95%	1.0	No		97.8%	Achieved		97.9%	Achieved		97.4%	Achieved		97.2%	Achieved		
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	1.0	No	0	94.6%	Achieved	0	95.0%	Achieved	0	94.3%	Achieved	0	93.7%	Achieved		0
A&E Clinical Quality- Total Time in A&E under 4 hours	95%	1.0	No	0	94.0%	Not met	1	92.7%	Not met	1	89.7%	Not met	1	82.0%	Not met		1
Cancer 62 Day Waits for first treatment (from urgent GP referral) - post local breach re-allocation	85%	1.0	No		85.5%	Achieved		85.1%	Achieved		88.3%	Achieved		83.5%	Not met		
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - post local breach re-allocation	90%	1.0	No	0	99.3%	Achieved	0	99.0%	Achieved	0	100.0%	Achieved	0	100.0%	Achieved		1
Cancer 62 Day Waits for first treatment (from urgent GP referral) - pre local breach re-allocation					87.9%			86.5%			86.7%			87.8%			
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - pre local breach re-allocation					99.3%			99.0%			99.0%			98.0%			
Cancer 31 day wait for second or subsequent treatment - surgery	94%	1.0	No		97.0%	Achieved		100.0%	Achieved		100.0%	Achieved		100.0%	Achieved		
Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	1.0	No		99.3%	Achieved		100.0%	Achieved		100.0%	Achieved		100.0%	Achieved		
Cancer 31 day wait for second or subsequent treatment - radiotherapy	94%	1.0	No	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant		0
Cancer 31 day wait from diagnosis to first treatment	96%	1.0	No	0	96.7%	Achieved	0	99.0%	Achieved	0	97.7%	Achieved	0	98.3%	Achieved		0
Cancer 2 week (all cancers)	93%	1.0	No		93.0%	Achieved		93.5%	Achieved		94.8%	Achieved		94.4%	Achieved		
Cancer 2 week (breast symptoms)	93%	1.0	No	0	93.1%	Achieved	0	93.3%	Achieved	0	93.1%	Achieved	0	93.1%	Achieved		0
Care Programme Approach (CPA) follow up within 7 days of discharge	95%	1.0	No		0.0%	Not relevant		0.0%	Not relevant		0.0%	Not relevant		0.0%	Not relevant		
Care Programme Approach (CPA) formal review within 12 months	95%	1.0	No	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant		0
Admissions had access to crisis resolution / home treatment teams	95%	1.0	No	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant		0
Meeting commitment to serve new psychosis cases by early intervention teams	95%	1.0	No	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant		0
Ambulance Category A 8 Minute Response Time - Red 1 Calls	75%	1.0	No	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant		0
Ambulance Category A 8 Minute Response Time - Red 2 Calls	75%	1.0	No	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant		0
Ambulance Category A 19 Minute Transportation Time	95%	1.0	No	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant		0
C.Diff due to lapses in care	26	1.0	No	0	0	Achieved	0	3	Achieved	0	4	Achieved	0	5	Not relevant		0
Total C.Diff YTD (including: cases deemed not to be due to lapse in care and cases under review)					7			16			23			32			
C.Diff cases under review					7			13			19			27			
Minimising MH delayed transfers of care	<=7.5%	1.0	No	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant		0
Data completeness, MH: identifiers	97%	1.0	No	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant		0
Data completeness, MH: outcomes	50%	1.0	No	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant		0
Compliance with requirements regarding access to healthcare for people with a learning disability	N/A	1.0	No	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Achieved	0	N/A	Achieved		0
Community care - referral to treatment information completeness	50%	1.0	No		0.0%	Not relevant		0.0%	Not relevant		0.0%	Not relevant		0.0%	Not relevant		
Community care - referral information completeness	50%	1.0	No		0.0%	Not relevant		0.0%	Not relevant		0.0%	Not relevant		0.0%	Not relevant		
Community care - activity information completeness	50%	1.0	No	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant		0
Risk of, or actual, failure to deliver Commissioner Requested Services	N/A	Report by Exception	No			No			No			No			No		
CQC compliance action outstanding (as at time of submission)	N/A		No			No			No			No			No		
CQC enforcement action within last 12 months (as at time of submission)	N/A		No			No			No			No			No		
CQC enforcement action (including notices) currently in effect (as at time of submission)	N/A		No			No			No			No			No		
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A		No			No			No			No			No		
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A		No			No			No			No			No		
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A		No			No			No			No			No		
Results left to complete			0			0		0	0		0	0			0		
Total Score			0			1			1			1			2		

RISK ASSESSMENT FRAMEWORK (PAGE 21, DIAGRAM 6)

EXAMPLES OF EXCEPTION REPORTS

CONTINUITY OF SERVICES (ALL LICENSEES)

- Unplanned significant reductions in income or significant increases in costs
- Discussions with external auditors which may lead to a qualified audit report
- Future transactions potentially affecting the continuity of services risk rating
- Risk of a failure to maintain registration with the Care Quality Commission (CQC) for Commissioner Requested Services (CRS)
- Loss of accreditation of a CRS
- Proposals to vary CRS provision or dispose of assets including
  - cessation or suspension of CRS
  - variation of asset protection processes
- Proposed disposals of CRS related assets

FINANCIAL GOVERNANCE (NHS FOUNDATION TRUSTS)

- Requirements for additional working capital facilities
- Failure to comply with the statutory reporting guidance
- Adverse report from internal auditors
- Significant third party investigations that suggest potential material issues with governance
- CQC responsive or planned reviews and their outcomes
- Other patterns of patient safety issues which may reflect poor governance (eg serious incidents, complaints)
- Performance penalties to commissioners

GOVERNANCE (NHS FOUNDATION TRUSTS)

- Third party investigations that could suggest material issues with governance (eg fraud, CQC concerns, Medical Royal Colleges' reports)
- CQC responsive or planned reviews and its outcomes / findings
- Other patient safety issues which may impact compliance with the license (eg serious incidents)

OTHER RISKS

- Enforcement notices or sanctions from other bodies implying potential or actual significant breach of a license condition (eg Office of Fair Trading)
- Patient group concerns
- Concerns from whistleblowers or complaints