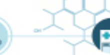

Warrington and Halton Hospital NHS Foundation Trust
Board of Directors
Agenda

Friday 2nd October 2015, time 1300 - 1700 hrs
Lecture Theatre, Education Centre Halton Hospital

1300 *30mins*	***W&HHFT/TB/15/169***	***Welcome, Apologies & Declarations of Interest***		Chairman
	W&HHFT/TB/15/170	***Safeguarding Annual Report 2014/15 Presentation– Adult and Children's *****		Nikki Richardson and Lorraine Smith
1330 *05mins*	***W&HHFT/TB/15/171***	***Minutes of the previous meeting held on 29th July 2015***	Paper	
	W&HHFT/TB/15/172	***Action Plan***	Paper	
1335 *10mins*	***W&HHFT/TB/15/173***	***Chairman's Report***	Verbal	Vice Chair
1345 *20mins*	***W&HHFT/TB/15/174***	***Chief Executives Report***	Verbal	Chief Executive

1405 *10mins*	***W&HHFT/TB/15/175***	***Verbal Report from the Chair of the Finance and Sustainability Committee***	Verbal	Terry Atherton, Non-Executive Director
1415 *20mins*	***W&HHFT/TB/15/176***	***Finance Report – 31 August 2015***	Paper	Director of Finance & Corporate Development
1435 *15mins*	***W&HHFT/TB/15/177***	***Corporate Performance Report – 31 August 2015***	Paper	Deputy Chief Operating Officer
1450 *10mins*	***Break***			

1500 *10mins*	***W&HHFT/TB/15/178***	***Verbal Report from the Chair of the Quality Committee***	Verbal	Mike Lynch, Non-Executive Director
1510 *15mins*	***W&HHFT/TB/15/179***	***Quality Dashboard – 30 June 2015***	Paper	Director of Nursing and Governance
1525 *15mins*	***W&HHFT/TB/15/180***	***Mortality Report Q1***	Paper	Medical Director
1540 *05mins*	***W&HHFT/TB/15/181***	***To Note the Director of Infection Prevention and Control – Annual Report 2014/15 *****		Director of Nursing and Governance (DIPC until 31 March 2015)

1545 *10mins*	***W&HHFT/TB/15/182***	***Verbal Report from the Chair of the Strategic People Committee***	Verbal	Anita Wainwright, Non-Executive Director
1555 *15mins*	***W&HHFT/TB/15/183***	***Workforce and Educational Development Key Performance Indicators***	Paper	Director of HR & OD
1610 *10mins*	***W&HHFT/TB/15/184***	***Monthly Ward Staffing Report***	Papers	Director of Nursing and Governance
1620 *10mins*	***W&HHFT/TB/15/185***	***Monitor Guidance to Boards on Nurse agency staffing levels and Trust response.***		Director of Nursing and Governance

The agenda and minutes of this meeting may be made available to public and persons outside of Warrington and Halton Hospitals NHS Foundation Trust as part of the Trust's compliance with the Freedom of Information Act 2000.

1630	***W&HHFT/TB/15/186***	***Verbal Report from the Chair of the Charitable Funds Committee***		Lynne Lobley, Non-Executive Director
	W&HHFT/TB/15/187	***Other Board Committee Reports:*** ***Minutes for Noting:*** ***a) Finance and Sustainability Committee held on*** ***b) Quality Committee on*** ***c) Strategic People Committee on*** ***d) Audit Committee on***	Paper Paper Paper	
	W&HHFT/TB/15/188	***Any Other Business***		
1700 ends		***Dates of next meeting*** *28th October 2015*		

** to be published at a later date following approval

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WHH/B/2015/ **170**

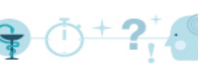
SUBJECT:	**Safeguarding Annual Reports 2014/15**
DATE OF MEETING:	2nd October 2015
DIRECTOR:	Childrens – Nikki Richardson Adult – Lorraine Smith

A presentation will be provided to support the Annual Reports

W&HHFT/TB/15/172

TRUST BOARD
ACTION PLAN – Current / Outstanding Actions
Meeting: Trust Board 2 October 2015

Meeting date	Minute Reference	Action	Responsibility & Target Dates	Status	
29 July 2015	TB/15/148	The Director of Nursing and Governance to liaise with the Communications department regarding stakeholder communications and obtain permission from the patients shown in the video to allow the video to be circulated outside of the Trust.	Director of Nursing and Governance	To be reported at the meeting	
29 July 2015	TB/15/164	Trust Secretary to arrange a workshop with the Board and the Communications team to allow additional understanding on the Communication strategy presented	Trust Secretary	Action ongoing	



WHH/B/2015/ **173**

BOARD OF DIRECTORS

SUBJECT:	**Chairman's Report**
DATE OF MEETING:	2nd October 2015
DIRECTOR:	Chairman

WHH/B/2015/ **174**

BOARD OF DIRECTORS

SUBJECT:	**Chief Executive Report**
DATE OF MEETING:	2nd October 2015
EXECUTIVE DIRECTOR:	Chief Executive

i. Update on the Review of centrally funded improvement and leadership development functions

24 September 2015

Dear colleague

Update on the *Review of centrally funded improvement and leadership development functions*

I am writing on behalf of Monitor, the NHS Trust Development Authority (TDA), Health Education England (HEE), NHS England, Public Health England (PHE) and the Care Quality Commission (CQC) to update you on the next steps to implement the recommendations from my *Review of centrally funded improvement and leadership development functions*.

The review was published in July of this year alongside the NHS reform speech from the Secretary of State for Health and the Better Leadership for tomorrow: NHS leadership review which was led by Lord Rose.

During the review process we heard from stakeholders across the health and care system about the changes required to help build improvement and leadership development capabilities to support the delivery of the Five Year Forward View (5YFV).

The information gathered and views expressed stressed that the transformation journey described in the 5YFV, would require large scale changes at local, regional and national levels. The review recommendations recognised the need for organisations to work together across the local system to drive the level of change required. We are committed to providing support to ensure that the growth of improvement and leadership capabilities are locally owned and delivered.

All of the ALBs are now progressing with implementation of the recommendations from the review, alongside the establishment of NHS Improvement and the delivery of the recommendations of the Rose report. National governing arrangements are being set up to oversee the work; this includes a steering group, which I will chair to oversee the immediate changes that will take effect from April 2016.

At the same time, a new national governing board for improvement and leadership development will meet in October, and monthly thereafter, to steer the development of the national strategies for capability building in improvement and leadership development. The board is jointly chaired by Ian Cumming, Chief Executive of HEE, for leadership development and myself for improvement, pending the appointment of a chief executive for NHS Improvement. The national strategies will set out the national priorities for capability building and support individual provider and commissioner organisations to deliver on both the national and their local priorities.

As we begin to implement the recommendations, we want to continue to draw on the views and experiences of stakeholders across the system and build on the engagement work that took place throughout the review. The success of this work will depend on effective local collaborations to develop improvement and leadership capability and capacity enabled by appropriate regional and national support.

We aim to hold a series of stakeholder events during the remainder of 2015/16. We also welcome your immediate feedback and ideas via this email England.ldiprogramme@nhs.net.

We look forward to hearing from you.

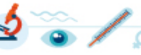
Yours sincerely

Ed Smith
Chair of the steering group for the national implementation programme for improvement and leadership development

BOARD OF DIRECTORS

WHH/B/2015/ **175**

SUBJECT:	**Verbal Report from the Chair of the Finance and Sustainability Committee**
DATE OF MEETING:	2nd October 2015
DIRECTOR:	Terry Atherton, Non-Executive Director



BOARD OF DIRECTORS

WHH/TB/2015/ 176

SUBJECT:	**Finance Report as at 31st August 2015**	
DATE OF MEETING:	2nd October 2015	
ACTION REQUIRED	**For Discussion**	
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 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 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. Choose an item.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:		
EXECUTIVE SUMMARY (KEY ISSUES):	For the period ending 31st August 2015 the Trust has recorded a cumulative deficit of £8,518k, a Financial Sustainability Risk Rating 2 and has a cash balance of £6,608k.	
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	22 September 2015
	Summary of Outcome	Noted

FINANCE REPORT AS AT 31ST AUGUST 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 August 2015.

2. EXECUTIVE SUMMARY

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

Key financial indicators

Indicator	Monthly Plan £m	Monthly Actual £m	Monthly Variance £m	YTD Plan £m	YTD Actual £m	YTD Variance £m
Operating income	17.1	17.8	0.7	87.9	89.6	1.7
Operating expenses	(18.2)	(18.6)	(0.4)	(91.1)	(93.6)	(2.6)
EBITDA	(1.1)	(0.8)	0.3	(3.2)	(4.1)	(0.9)
Non-operating income and expenses	(0.9)	(0.9)	0.0	(4.6)	(4.5)	0.1
I&E surplus / (deficit)	(2.0)	(1.7)	0.3	(7.8)	(8.5)	(0.8)
Cash balance	-	-	-	2.1	6.6	4.5
CIP target	0.4	0.3	(0.1)	1.7	1.3	(0.4)
Capital Expenditure	0.8	0.5	0.3	2.6	3.1	(0.5)
Financial Sustainability Risk Rating	-	-	-	1	2	1

3. OVERVIEW

The August and year to date position is summarized in the table below.

Position = Surplus/(Deficit)	August £000	Year to date £000
Plan	(2,015)	(7,764)
Actual	(1,660)	(8,518)
Variance	**355**	**(755)**

The August and year to date variance by category is summarized in the table below.

Variance = Favourable/(Adverse)	August £000	Year to date £000
Operating income	686	1,694
Operating expenses	(338)	(2,556)
Non-operating income and expenses	7	107
Total	**355**	**(755)**

Financial Sustainability Risk Rating

In August Monitor published the updated Risk Assessment Framework which replaced the Continuity of Services Risk Rating with a new Financial Sustainability Risk Rating. The purpose of the new Risk Rating is to identify whether the financial position of an NHS Foundation Trust that is a provider of Commissioner Requested Services could place its services at risk and whether there may be wider issues relating to financial efficiency.

The financial sustainability rating incorporates the following measures of financial robustness and efficiency:

- Liquidity – days of operating costs held in cash or cash equivalents forms, including wholly committed lines of credit available for drawdown.
- Capital Servicing Capacity – the degree to which the organisation's generated income covers its financing obligations.
- Income and Expenditure Margin – the degree to which the organization is operating at a surplus or deficit.
- Variance from plan in relation to Income and Expenditure Margin – variance between the planned and actual income and expenditure margin within the year.

Each metric is scored between 1 and 4 and carries a 25% weighting to determine the overall financial sustainability risk rating.

Regulatory implications of the Financial Sustainability Risk Ratings are summarized below:

Risk Rating	Description	Regulatory Activity
4	No evident concerns	None
3	Emerging or minor concern potentially requiring scrutiny	Potential Enhanced Monitoring
2*	Level of risk is material but stable	Potential Enhanced Monitoring
2	Material risk	Potential Investigation
1	Significant risk	Likely investigation and potential appointment of contingency planning team

Note 2* is assigned by Monitor based on whether they have a high degree of confidence in the provider maintaining or improving its financial position.

Cash Position

The operating performance continues to have an adverse effect on the amount of cash available to the Trust but in July cash advances were secured from Warrington CCG (£6m) and Halton CCG (£1.2m) which allowed the Trust to clear a number of overdue creditors and have a cash balance at the 31st August of £6,608k. The Trust needs to manage its working balances in order to maintain a cash balance sufficient to pay creditors, meet its PDC Dividends obligation in September and repay both commissioners the cash advances over the remainder of the year.

Operating Income

Year to date operating income is £1,649k above plan due to an over recovery on other operating income (£1,767k), partially offset by an under recovery on NHS clinical income (£63k) and non NHS clinical income (£55k).

Operating Expenses

Year to date operating expenses are £2,556k above plan due to over spends on pay (£1,686k), drugs (£187k), clinical supplies (£425k) and non clinical supplies (£258k).

Non Operating Income and Expenses

Non operating income and expenses is £107k below plan mainly due the underspend against depreciation resulting from the slippage in the capital programme and the profit from the sale of fixed assets.

4. COST IMPROVEMENT PROGRAMME

The Trust has an annual savings target of £10,100k (including the balance from 14/15) and to date the planned value of the schemes equates to £10,528k. However the value of schemes underpinned by detailed plans (evidenced by PIDs) is shown in the table below.

Narrative	**In Year £000**	**Recurrent £000**
Annual Target	10,100	10,100
Value of schemes identified	5,408	6,472
Over / (Under) Achievement against target	**4,692**	**3,628**

For the period to date the planned savings target is £1,664k, with actual savings amounting to £1,298k which results in an under achievement of £369k. The identified cost savings programme and the unidentified balance is materially weighted towards the second half of the year, so it is vital that in the first half of the year the planned savings are identified as it will become more difficult to identify and achieve any shortfalls as the year progresses.

5. CAPITAL

The annual capital programme approved by the Board and submitted to Monitor was £20.3m, with £10.0m included for the current year cost of the Estates Strategy proposal. The funding of the programme

was a combination of internally generated depreciation (£6.8m) and a planned capital loan (£13.5m) from the Department of Health.

The Trust has re-assessed the value of the 15/16 capital programme which has been reduced to £10.6m due to a reduction in the value of the Estates Strategy in year spend and the MRI Scanner that is now funded via a lease. This will reduce the value of the 15/16 loan required from the Department of Health to £4.1m.

Narrative	**£m**
Initial Plan	20.3
Less reduction in Estates Strategy	(8.0)
Less MRI Scanner	(1.4)
Revised Plan	**10.9**

The position below reflects the revision to the capital programme and to date the Trust has spent £3.1m against the budget of £2.6m, which is due to the fact that a number of schemes have started earlier than planned.

Category	**Annual Budget £m**	**Budget to date £m**	**Actual to date £m**	**Variance to date £m**
Estates	5.2	0.9	1.1	(0.2)
IM&T	3.5	1.1	1.3	(0.2)
Medical Equipment	2.2	0.6	0.7	(0.1)
Total	**10.9**	**2.6**	**3.1**	**(0.5)**

6. CASH FLOW

The cash balance is £6,608k which is £4,486k above the planned cash balance of £2,122k, with the monthly movements summarised in the table below.

Cash balance movement	**£000**
Opening balance as at 1st August	5,022
In month deficit	(1,660)
Non cash flows in surplus/(deficit)	905
Decrease in receivables (debtors)	699
Increase in payables (creditors)	1,785
Deferred Income	1,002
Capital expenditure	(470)
Other working capital movements	(675)
Closing balance as at 31st August	**6,608**

The current balance equates to circa 11 days operational cash but as at 31st August the value of trade payables stands at £10.7m, although this is partially covered by the value of trade receivables which stands at £6.3m. Under the financial sustainability risk rating the liquidity metric is -24.1 days which results in a score of 1.

In July the Trust secured cash advances from Warrington CCG (£6m) and Halton CCG (£1.2m) which alleviated some of the cash pressure currently experienced by the Trust and allowed payment of some overdue creditors. Halton CCG have agreed to a £1.2m cash advance in August and September too which will enable the drawn down of the working capital loan to be delayed until November.

The actual cash flow movements for the year to date and the forecast movements for the remainder of the year are attached at Appendix D, however the table below summarises the short term cash flow for the next 3 months.

Cash balance movement	**September £000**	**October £000**	**November £000**
Opening balance	6,608	2,003	2,020
In month deficit	(1,304)	(451)	(420)
CCG Advance / (Repayment)	1,200	(2,200)	(2,200)
Non cash flows in surplus/(deficit)	1,003	995	994
Movement in receivables (debtors)	350	(900)	375
Movement in payables (creditors)	(1,860)	1,703	(722)
Capital expenditure	(678)	(1,024)	(924)
PDC Dividends	(2,138)	0	0
Drawdown of loans	0	0	1,200
Other working capital movements	(1,178)	(1,894)	1,756
Closing balance	**2,003**	**2,020**	**2,080**

The operating performance continues to have an adverse effect on the cash position and creditor payments, with performance against the non NHS Better Payment Practice Code (BPPC) at 32% in the month (24% year to date). This low level of compliance and performance will continue until there is an improvement in the operating position and the resultant cash position.

7. STATEMENT OF FINANCIAL POSITION

Non current assets have decreased by £124k in the month, as the capex spend is lower than the depreciation charge.

Current assets have increased by £1,084k in the month mainly due to the increase in cash and accrued income, partially offset by a decrease in receivables.

Current liabilities have increased by £2,603k in the month mainly due to the increase in payables, deferred income and the PDC creditor, partially offset by a reduction in accruals.

Non current liabilities have increased by £17k in the month.

9. RISK AND FORECAST OUTTURN

For the period ending 31st August the Trust has recorded a deficit of £8,518k, which is £755k worse than the planned deficit of £7,764k. The position remains a significant concern so it is important the trust focuses on the financial risks identified during the budget setting exercise to ensure the deficit is

minimized as much as possible to achieve or better the £15.0m planned deficit, namely:

- Non compliance with contractual data requirements, quality standards, access targets and CQUIN targets resulting in commissioner levied fines or penalties.
- Failure to deliver the revised income target or remain with approved budgets.
- Identified cost savings target not fully identified and delivered in in accordance with profile.
- Failure to manage escalation or partner's inability to provide services to withdraw medically fit patients from the hospital.
- Failure to appropriately reduce bank, agency, locum, overtime and waiting list initiatives.
- Failure to increase clinical efficiency and productivity.
- Failure to secure working capital and capital loans.
- Failure to secure the anticipated level of winter monies.

On the 12th August the Trust was placed in breach of its licence with Monitor and as a result the Trust agreed to a number of Enforcement Undertakings. The basis of the response was approved by the Board of Directors on 22nd September to comply with Section 2.1.1 of the Undertakings that result in a revised forecast deficit of £14.2m.

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

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Financial headlines as at 31st August 2015

Key Financial Metrics	Month			Year to date		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income	17,122	17,763	641	87,862	89,510	1,649
Operating Expenditure	-18,223	-18,561	-338	-91,055	-93,611	-2,556
EBITDA	**-1,101**	**-798**	**303**	**-3,194**	**-4,101**	**-907**
Financing Costs	-914	-862	52	-4,570	-4,418	153
Net Surplus / (Deficit)	**-2,015**	**-1,660**	**355**	**-7,764**	**-8,518**	**-754**
Continuity of Services Risk Rating				1	2	0
Capital Expenditure	750	470	-280	2,563	3,149	586
Cost Savings	401	318	-83	1,664	1,298	-366
Cash Balance				2,122	6,608	4,486

Summary Position

The in month position is an actual deficit of £1,660k which is £355k better than the planned deficit of £2,015k.

The year to date position is an actual deficit of £8,518k which is £754k worse than the planned deficit of £7,764k.

The Financial Sustainability Risk Rating is 2 which is better than the planned Risk Rating of 1.

Year to date income is £1,649k above plan mainly due to an over recovery on other operating income, partially offset by an under recovery on NHS and non NHS clinical income. Year to date expenditure is £2,556k above plan due to overspends on pay, clinical supplies and non clinical supplies, partially offset by underspends on drugs. Year to date non operating income and expenditure is £153k below plan mainly due to an underspend on depreciation.

Key Variances on year to date position

Operating Income
- NHS Clinical Income — £63k below plan.
- Non NHS Clinical income — £55k below plan.
- Other Operating Income — £1,767k above plan.
- **Total** — **£1,649k above plan**

Operating Expenditure
- Pay — £1,686k above plan.
- Drugs — £187k above plan.
- Clinical Supplies — £425k above plan.
- Non Clinical Supplies — £258k above plan.
- **Total** — **£2,556k above plan.**

Non operating income and expenses
- Profit on sale of fixed assets — £45k above plan.
- Depreciation — £112k below plan.
- Net Interest — £5k below plan.
- **Total** — **£153k below plan.**

Capital expenditure — £586k above plan.

Cost Savings — £366k below plan.

Cash balance — £4,486k above plan.

Other matters to be brought to the attention of the Board

The Trust and Warrington CCG were not able to agree a 14/15 year end outturn and as a result formal mediation proceedings commenced that concluded in a mediation day held on 23rd July. No overall agreement was reached on the day but agreeement on a year end settlement has been reached although the legally binding document has yet to be signed.

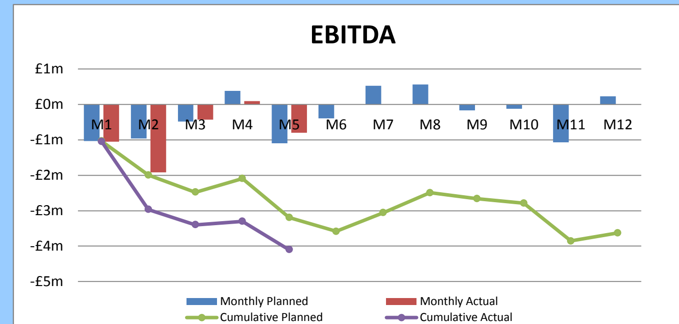
The Trust and Warrington CCG (on behalf of all co-commissioners) signed the national variation agreement to adopt the NHS Standard Contract 15/16 Terms and Conditions on the 4th September 2015.

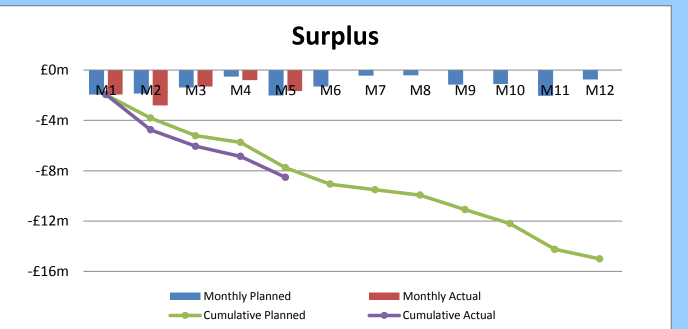
On the 12th August the Trust was placed in breach of it's licence with Monitor and therefore agreed to a number of Enforcement Undertakings which have resulted in the Trust forecasting a 15/16 deficit of £14.2m.

Warrington & Halton Hospitals NHS Foundation Trust

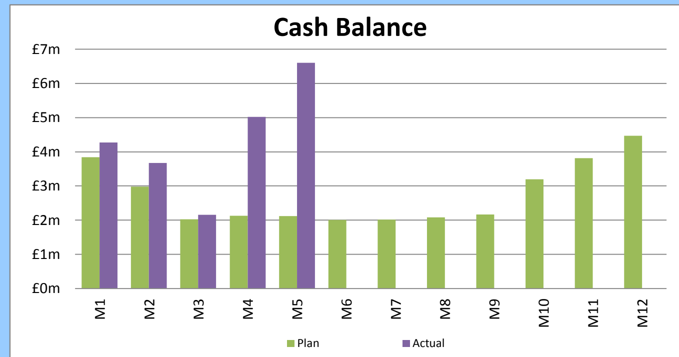
Finance Dashboard as at 31st August 2015 (Part A)

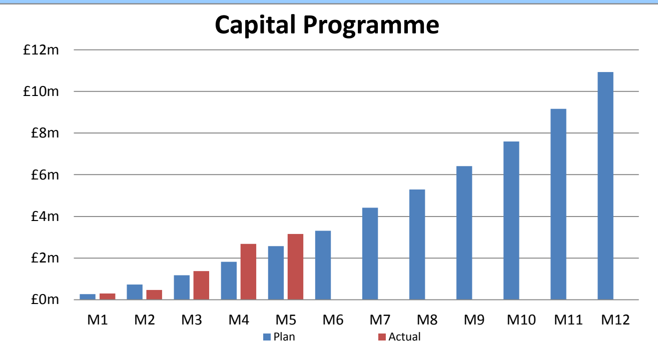
Profitability



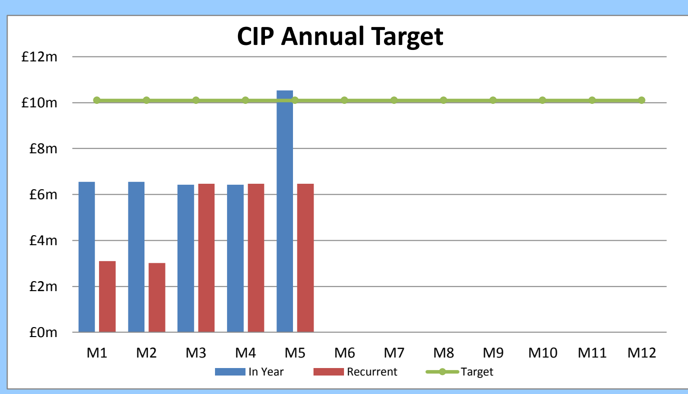


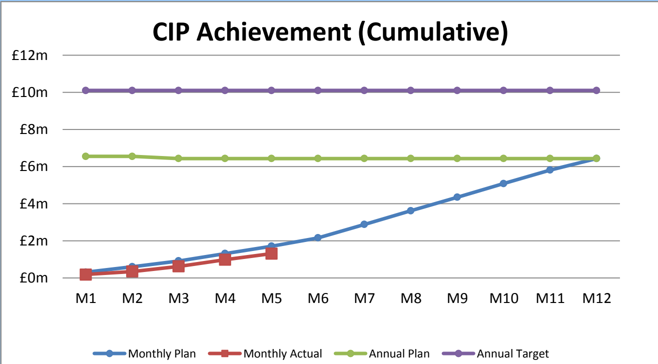
Cash and Investment





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	55,995	4,791	4,903	-111	-2.3	23,842	24,117	-275	-1.2
Unscheduled Care	44,912	3,813	4,065	-251	-6.6	19,458	20,364	-906	-4.7
Womens Children & Support Services	57,876	5,080	4,965	115	2.3	25,530	25,503	27	0.1
Corporate									
Operations - Central	489	41	36	5	12.4	204	134	70	34.4
Operations - Estates	7,440	554	538	17	3.0	2,962	2,970	-8	-0.3
Operations - Facilities	7,847	653	584	69	10.5	3,275	3,115	160	4.9
Finance	12,909	1,075	1,051	25	2.3	5,376	5,269	107	2.0
HR & OD	4,123	343	305	38	11.1	1,713	1,596	116	6.8
Information Technology	4,009	338	235	103	30.5	1,703	1,572	131	7.7
Nursing & Governance	2,881	239	243	-3	-1.4	1,196	1,163	33	2.7
Research & Development	37	2	5	-2	-88.2	15	15	-1	-4.9
Strategy, Partnerships & Comms	616	49	44	5	9.6	274	274	0	0.0
Trust Executive	2,091	169	166	3	2.0	950	993	-43	-4.5
Total	**201,225**	**17,148**	**17,136**	**11**	**0.1**	**86,496**	**87,085**	**-589**	**-0.7**

Positive variance = underspend, negative variance = overspend.

Financial Sustainability Risk Rating

Financial Sustainability Risk Rating	Actual Metric	Actual Rating
Liquidity Ratio (days)	-2.4	1
Capital Servicing Capacity (times)	-24.1	1
Income & Expenditure Margin (%)	-9.6%	1
Income & Expenditure Margin as a % of plan (%)	-0.7%	3
Overall Risk Rating		**2**

Warrington & Halton Hospitals NHS Foundation Trust

Warrington & Halton Hospitals NHS Foundation Trust

Appendix C

Income Statement, Activity Summary and Risk Ratings as at 31st August 2015

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	2,884	2,949	65	15,252	15,734	482
Elective Excess Bed Days	18	1	-18	96	69	-26
Non Elective Spells	4,538	4,210	-328	22,656	21,051	-1,605
Non Elective Excess Bed Days	271	261	-10	1,372	1,303	-68
Outpatient Attendances	2,578	2,716	138	13,917	14,159	241
Accident & Emergency Attendances	821	966	145	4,398	4,723	325
Other Activity	4,517	4,789	272	22,723	23,311	588
Sub total	**15,627**	**15,892**	**264**	**80,413**	**80,351**	**-63**
Non Mandatory / Non Protected Income						
Private Patients	9	13	5	44	65	21
Other non protected	107	67	-40	535	458	-77
Sub total	**116**	**80**	**-36**	**579**	**524**	**-55**
Other Operating Income						
Training & Education	588	595	7	2,940	2,955	15
Donations and Grants	0	0	0	0	0	0
Miscellaneous Income	791	1,196	406	3,929	5,681	1,752
Sub total	**1,379**	**1,792**	**413**	**6,869**	**8,636**	**1,767**
Total Operating Income	**17,122**	**17,763**	**641**	**87,862**	**89,510**	**1,649**
Operating Expenses						
Employee Benefit Expenses (Pay)	-13,070	-13,347	-276	-65,235	-66,921	-1,686
Drugs	-1,141	-1,113	28	-5,765	-5,952	-187
Clinical Supplies and Services	-1,605	-1,744	-139	-8,093	-8,518	-425
Non Clinical Supplies	-2,407	-2,358	49	-11,962	-12,220	-258
Total Operating Expenses	**-18,223**	**-18,561**	**-338**	**-91,055**	**-93,611**	**-2,556**
Surplus / (Deficit) from Operations (EBITDA)	**-1,101**	**-798**	**303**	**-3,194**	**-4,101**	**-907**
Non Operating Income and Expenses						
Profit / (Loss) on disposal of assets	0	45	45	0	45	45
Interest Income	3	2	-1	17	10	-7
Interest Expenses	-4	-4	0	-20	-18	2
Depreciation	-569	-561	9	-2,847	-2,736	112
PDC Dividends	-344	-344	0	-1,719	-1,719	0
Restructuring Costs	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Total Non Operating Income and Expenses	**-914**	**-862**	**52**	**-4,570**	**-4,418**	**153**
Surplus / (Deficit)	**-2,015**	**-1,660**	**355**	**-7,764**	**-8,518**	**-754**
Activity Summary	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**
Elective Spells	3,013	3,022	9	16,183	16,458	274
Elective Excess Bed Days	85	3	-82	442	327	-115
Non Elective Spells	3,112	2,679	-433	15,689	13,998	-1,691
Non Elective Excess Bed Days	1,276	1,219	-57	6,448	6,130	-318
Outpatient Attendances	25,012	26,615	1,603	137,518	138,715	1,197
Accident & Emergency Attendances	8,738	8,747	9	44,798	43,988	-810
Financial Sustainability Risk Ratings	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**
Metrics						
Capital Servicing Capacity (Times)				-1.8	-2.4	-0.5
Liquidity Ratio (Days)				-19.8	-24.1	-4.4
I&E Margin (%)				-0.1	-0.1	0.0
I&E Margin as % of plan (%)				0.0	0.0	0.0
Ratings						
Capital Servicing Capacity (Times)				1	1	0.0
Liquidity Ratio (Days)				1	1	0.0
I&E Margin (%)				1	1	0.0
I&E Margin as % of plan (%)				2	3	1.0
Financial Sustainability Risk Rating				**1**	**2**	**1**

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

Cash Flow Statement as at 31st August 2015

	Actual April £000's	Actual May £000's	Actual June £000's	Actual July £000's	Actual August £000's	Forecast September £000's	Forecast October £000's	Forecast November £000's	Forecast December £000's	Forecast January £000's	Forecast February £000's	Forecast March £000's	Annual Position March £000's
Surplus/(deficit) after tax	**(1,936)**	**(2,811)**	**(1,313)**	**(798)**	**(1,660)**	**(1,304)**	**(451)**	**(420)**	**(1,151)**	**(805)**	**(1,752)**	**(599)**	**(15,000)**
Non-cash flows in operating surplus/(deficit)													
Finance (income)/charges	1	1	3	2	2	0	68	68	67	68	68	63	411
Depreciation and amortisation	543	548	536	548	561	570	569	569	570	569	592	659	6,834
(Gain)/loss on disposal of property plant and equipment					(45)							45	0
PDC dividend expense	344	344	344	344	344	344	344	344	344	344	343	343	4,126
Other increases/(decreases) to reconcile to profit/(loss) from operations	(9)	(4)	8	(9)	(10)	89	14	13	13	26	27	118	276
Non-cash flows in operating surplus/(deficit), Total	**879**	**889**	**891**	**885**	**852**	**1,003**	**995**	**994**	**994**	**1,007**	**1,030**	**1,228**	**11,647**
Operating Cash flows before movements in working capital	**(1,057)**	**(1,922)**	**(422)**	**87**	**(808)**	**(301)**	**544**	**574**	**(157)**	**202**	**(722)**	**629**	**(3,353)**
Increase/(Decrease) in working capital													
(Increase)/decrease in inventories	392	(147)	(132)	(93)	232							(252)	0
(Increase)/decrease in tax receivable													0
(Increase)/decrease in NHS Trade Receivables	1,832	526	(1,082)	(675)	136	250	(650)	250	250	250	250	(36)	1,300
(Increase)/decrease in Non NHS Trade Receivables	303	12	(658)	(280)	16	100	(250)	125	200	200	200	833	800
(Increase)/decrease in other related party receivables	(266)	292	(277)	(256)	548							(41)	(0)
(Increase)/decrease in other receivables	412	(63)	66	19	(3)							(431)	(0)
(Increase)/decrease in accrued income	(390)	(1,518)	523	405	(469)	(208)	(464)	(703)	0	(72)	867	2,027	(0)
(Increase)/decrease in other financial assets													0
(Increase)/decrease in prepayments	(1,302)	(960)	1,692	(51)	50	250	250	350	350	350	350	(530)	800
(Increase)/decrease in Other assets (non chartable assets)													0
(Increase)/decrease in Other assets (charitable assets only)													0
Increase/(decrease) in Deferred Income (excl. Govt Grants.)													0
Increase/(decrease) in Deferred Income (Govt. Grants)	255	2,912	254	5,769	1,002							(10,192)	0
Increase/(decrease) in Current provisions	(71)	1	6	8	7	(20)	(20)	(20)	(20)	(20)	(20)	(69)	(240)
Increase/(decrease) in post-employment benefit obligations													0
Increase/(decrease) in tax payable													0
Increase/(decrease) in Trade Creditors	(1,475)	(80)	474	(439)	1,776	(1,860)	1,703	(722)	(2,771)	(2,407)	(3,291)	5,733	(3,360)
Increase/(decrease) in Other Creditors	(160)	73	(33)	(156)	9							267	0
Increase/(decrease) in accruals	1,402	659	(1,289)	(328)	(482)							38	(0)
Increase/(decrease) in other Financial liabilities (borrowings)	64	3	695	(49)	4							(718)	(0)
Increase/(decrease) in Other liabilities (VAT, Social Security and Other Taxes)	75	11	(47)	51	(133)							43	0
Increase/(decrease) in Other liabilities (charitable assets)													
Increase/(Decrease) in working capital, Total	**1,069**	**1,721**	**192**	**3,924**	**2,694**	**(1,488)**	**569**	**(720)**	**(1,991)**	**(1,699)**	**(1,644)**	**(3,328)**	**(699)**
Increase/(decrease) in Non-current provisions	58	12	(66)	(17)	12							1	0
Net cash inflow/(outflow) from operating activities	**70**	**(188)**	**(296)**	**3,994**	**1,899**	**(1,789)**	**1,113**	**(146)**	**(2,148)**	**(1,497)**	**(2,366)**	**(2,698)**	**(4,051)**
Net cash inflow/(outflow() from investing activities													
Property - new land, buildings or dwellings	(70)	(90)	(18)	(326)	(122)	(150)	(150)	(200)	(200)	(200)	(200)	(296)	**(2,022)**
Property - maintenance expenditure	(150)	(58)	(56)	(28)	(160)	(123)	(335)	(192)	(224)	(275)	(654)	(633)	**(2,888)**
Plant and equipment - Information Technology	(58)	4	(718)	(530)	(80)	(288)	(309)	(294)	(235)	(250)	(216)	(213)	**(3,187)**
Plant and equipment - Other	(23)	(13)	(114)	(431)	(108)	(117)	(230)	(238)	(332)	(320)	(327)	(287)	**(2,540)**
Proceeds on disposal of property, plant and equipment					78								78
Increase/(decrease) in Capital Creditors		(252)	(300)	181	80							370	79
Net cash inflow/(outflow() from investing activities, Total	**(301)**	**(409)**	**(1,206)**	**(1,134)**	**(312)**	**(678)**	**(1,024)**	**(924)**	**(991)**	**(1,045)**	**(1,397)**	**(1,059)**	**(10,480)**
Net cash inflow/(outflow) before financing	**(231)**	**(597)**	**(1,502)**	**2,860**	**1,586**	**(2,467)**	**89**	**(1,070)**	**(3,139)**	**(2,542)**	**(3,763)**	**(3,757)**	**(14,531)**
Net cash inflow/(outflow) from financing activities													
PDC Dividends paid						(2,138)						(2,064)	(4,202)
Interest (paid) on non-commercial loans							(71)	(71)	(71)	(71)	(71)	(96)	(451)
Interest element of finance lease rental payments - other	(2)	(3)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	41	0
Interest received on cash and cash equivalents	3	2	1	2	3	4	3	4	4	4	4	6	40
Drawdown of non-commercial loans	0	0	0					1,200	3,300	3,635	4,450	6,518	19,103
(Increase)/decrease in non-current receivables	(8)	0	(11)	5	0							13	0
Net cash inflow/(outflow) from financing activities, Total	**(7)**	**(1)**	**(14)**	**3**	**(1)**	**(2,138)**	**(72)**	**1,129**	**3,229**	**3,564**	**4,379**	**4,418**	**14,490**
Net increase/(decrease) in cash	**(238)**	**(598)**	**(1,517)**	**2,864**	**1,586**	**(4,605)**	**17**	**59**	**90**	**1,022**	**616**	**661**	**(40)**
Opening cash	**4,511**	**4,273**	**3,675**	**2,159**	**5,022**	**6,608**	**2,003**	**2,021**	**2,080**	**2,171**	**3,193**	**3,810**	**4,511**
Effect of exchange rates													
Closing cash	**4,273**	**3,675**	**2,159**	**5,022**	**6,608**	**2,003**	**2,021**	**2,080**	**2,171**	**3,193**	**3,810**	**4,471**	**4,471**

	April	May	June	July	August	September	October	November	December	January	February	March
Forecast cash position as per Original Monitor plan	3,838	2,979	2,028	2,131	2,122	2,003	2,021	2,080	2,171	3,193	3,810	4,471
Actual cash position	4,273	3,675	2,159	5,022	6,608	2,003	2,021	2,080	2,171	3,193	3,810	4,471
Variance	**435**	**696**	**131**	**2,891**	**4,486**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Statement of Position as at 31st August 2015

Narrative	Audited position as at 31/03/15 £000	Actual Position as at 31/07/15 £000	Actual Position as at 31/08/15 £000	Monthly Movement £000	Forecast Position as at 31/03/16 £000
ASSETS					
Non Current Assets					
Intangible Assets	567	1,218	1,200	-18	865
Property Plant & Equipment	143,355	143,210	143,102	-108	156,525
Other Receivables	1,336	1,266	1,269	2	1,336
Impairment of receivables for bad & doubtful debts	-253	-239	-240	0	-253
Total Non Current Assets	**145,005**	**145,455**	**145,331**	**-124**	**158,473**
Current Assets					
Inventories	3,312	3,292	3,059	-232	3,312
NHS Trade Receivables	5,627	5,027	4,891	-136	4,326
Non NHS Trade Receivables	1,364	1,396	1,380	-16	564
Other Related party receivables	585	1,093	544	-548	585
Other Receivables	1,865	1,461	1,462	1	1,864
Impairment of receivables for bad & doubtful debts	-321	-324	-314	10	-321
Accrued Income	882	1,863	2,332	469	882
Prepayments	2,498	3,118	3,068	-50	1,698
Cash held in GBS Accounts	4,486	5,003	6,589	1,586	4,446
Cash held in commercial accounts	0	0	0	0	0
Cash in hand	25	19	19	0	25
Total Current Assets	**20,323**	**21,947**	**23,030**	**1,084**	**17,381**
Total Assets	**165,328**	**167,401**	**168,361**	**960**	**175,854**
LIABILITIES					
Current Liabilities					
NHS Trade Payables	-2,351	-1,202	-2,533	-1,330	-7,284
Non NHS Trade Payables	-8,134	-7,762	-8,208	-446	-301
Other Payables	-1,856	-1,580	-1,589	-9	-1,853
Other Liabilities (VAT, Social Security and Other Taxes)	-2,667	-2,757	-2,624	133	-2,667
Capital Payables	-1,599	-700	-779	-80	-1,599
Accruals	-5,765	-6,209	-5,727	482	-5,765
Interest payable on non commercial int bearing borrowings	0	0	0	0	0
PDC Dividend creditor	-76	-1,451	-1,795	-344	-76
Deferred Income	-974	-10,164	-11,166	-1,002	-974
Provisions	-335	-277	-284	-7	-295
Loans non commercial	0	0	0	0	0
Borrowings	-185	-332	-332	0	-185
				0	
Total Current Liabilities	**-23,942**	**-32,434**	**-35,037**	**-2,603**	**-20,999**
Net Current Assets (Liabilities)	**-3,619**	**-10,487**	**-12,007**	**-1,519**	**-3,618**
Non Current Liabilities					
Loans non commercial	0	0	0	0	-28,468
Provisions	-1,395	-1,382	-1,394	-12	-1,395
Borrowings	-703	-1,155	-1,159	-4	-703
Total Non Current Liabilities	**-2,098**	**-2,537**	**-2,554**	**-17**	**-30,566**
TOTAL ASSETS EMPLOYED	**139,288**	**132,430**	**130,770**	**-1,660**	**124,289**
TAXPAYERS AND OTHERS EQUITY					
Taxpayers Equity					
Public Dividend Capital	90,242	90,242	90,242	0	90,242
Retained Earnings prior year	3,970	3,969	3,969	0	3,970
Retained Earnings current year	0	-6,858	-8,518	-1,660	-15,000
Sub total	**94,212**	**87,354**	**85,693**	**-1,660**	**79,212**
Other Reserves					
Revaluation Reserve	45,077	45,077	45,077	0	45,077
Sub total	**45,077**	**45,077**	**45,077**	**0**	**45,077**
TOTAL TAXPAYERS AND OTHERS EQUITY	**139,289**	**132,430**	**130,770**	**-1,660**	**124,289**

BOARD OF DIRECTORS

WHH/B/2015/ **177**

SUBJECT:	**CORPORATE PERFORMANCE REPORT**	
DATE OF MEETING:	2 October 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 SO1/1.2 Risk of harm through failure to comply with Care Quality Commission National core healthcare standards and maintain registration and failure to achieve minimum requirements for NHSLA Standards within maternity services and wider Trust.	
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 August 2015.	
RECOMMENDATION:	***The Board is asked to:*** Note the content of the Report	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee
	Agenda Ref.	
	Date of meeting	22 September 2015
	Summary of Outcome	Noted

NATIONAL KEY PERFORMANCE INDICATORS

ACCIDENT AND EMERGENCY DEPARTMENT

The overall position for Month 5 remains an improving position with an upward trajectory. Though the Trust has not yet delivered 95% it is now in performing over 94% each month with the inclusion of the UCC activity.

National Indicators		Target	Aug	Qtr1	Qtr2	Qtr3	Qtr4	YTD Position
A&E and MIU	% Departed < 4hrs	95%	93.17%	91.13%	93.55%			92.19%
	Number of patients breaching 4hrs		666	2170	1223			3393

The 4 Hour target will now be adjusted to reflect the category 3 activity in the Urgent Care Centre at Widnes with our Trust receiving 33% of the available attendances. The table below illustrates the impact this has on the performance.

Submitted Position + Walk-in Activity

	Total Attends	Breaches	%
April	11012	1210	89.01%
May	8691	464	94.66%
June	9126	616	93.25%
July	11644	641	94.50%
Qtr1	28829	2290	92.06%

The improvement is 0.93% per quarter This means we will have delivered 94.5% in July and 94.1% in August.

This represents in quarter 2 a shift of over 2% upwards from 92.06% to as of Sept 1st 94.3%.

Seamus McGuire will be undertaking UM training with the Trust Board in the next week or so to support their ability to better understand the deep dive data sets provided on AED performance.

CANCER

National Indicators		Target	Aug	Qtr1	Qtr2	Qtr3	Qtr4	YTD Position
Cancer	2 Week Wait	>=93%	93.30%	93.00%	93.00%			93.08%
	Breast Symptom 2 Week Wait	>=93%	96.60%	93.20%	93.30%			93.43%
	31 Day First Treatment	>=96%	100.00%	100.00%	100.00%			99.33%
	31 Day Subsequent Treatment : Surgery	>=94%	100.00%	98.67%	100.00%			98.90%

	National Indicators	Target	Aug	Qtr1	Qtr2	Qtr3	Qtr4	YTD Position
	31 Day Subsequent Treatment : Drugs	>=98%	100.00%	100.00%	100.00%			100.00%
	62 Day First Treat - Urgent GP - Open Exeter	>=85%	85.00%	85.25%	85.35%			85.18%
	62 Day First Treat - Urgent GP - Reallocation	>=85%	85.00%	86.10%	85.35%			85.95%
	62 Day First Treatment - Screening	>=90%	100.00%	93.80%	100.00%			96.88%
	CRS 62 Day Consultant Upgrade	>=90%	100.00%	100.00%	0.00%			50.00%

18 WEEKS RTT:

National Indicators		Target	Aug	Qtr1	Qtr2	Qtr3	Qtr4	YTD Position
RTT - 18 Weeks	Completed Admitted Pathways <18 Weeks (Adjusted position)	>=90%	93.01%	93.05%	92.49%			92.83%
	Completed Non-Admitted Pathways <18 Weeks	>=95%	97.52%	97.64%	97.62%			97.63%
	All Waiters <18 Weeks	>=92%	93.49%	93.87%	93.31%			93.64%

CONTROL OF INFECTION:

National Indicators		Target	Aug	Qtr1	Qtr2	Qtr3	Qtr4	YTD Position
MRSA Bacteraemia	Hospital Acquired	<=0	1	0	1			1
	Community Acquired		1	0	1			1
	Total		2	0	2			2
Clostridium Difficile	Hospital Acquired	<=27	0	12	1			13
	Community Acquired		3	5	6			11
	Total		3	17	7			24

CONCLUSION

The Performance report illustrates that every national target is being met in full by the Trust with only AED 4 hr. target failing. This has seen a significant improvement in performance since the start of the year when the Trust was operating to 88% and the current position as at September 1st is 94.3%. This upward trajectory suggests that during October the Trust should see the organisation beginning to deliver on 95% if the trajectory for improvement continues.

Contract discussion to secure the STAR unit for a further 6 months have seen the proposal to retain the unit going through WCCG commissioning groups for approval and will form a significant stepping stone in the continued improvement in AED.

RECOMMENDATIONS

To continue to support the senior team in the cultural/behaviour work across emergency medicine and the interim COO as she leads the team in delivery of this remaining target.

APPENDIX 1

Aug-15

Monitor Access Targets & Outcomes - 2015/16

All targets are QUARTERLY

Target or Indicator		Threshold	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%	N/A	92.55%	93.48%	93.14%	93.05%	92.05%	93.01%		92.49%								
	Non-admitted patients	95%	N/A	97.53%	97.18%	98.13%	97.64%	97.71%	97.52%		97.62%								
	Incomplete Pathways	92%	1.0	93.38%	94.30%	93.84%	93.87%	93.10%	93.49%		93.31%								
A&E Clinical Quality	A&E Maximum waiting time of 4 hrs from arrival to admission/transfer/discharge	>=95%	1.0	87.75%	94.05%	92.68%	91.13%	93.96%	93.17%		93.55%								
All Cancers:62-day wait for First treatment	From urgent GP referral - post local breach re-allocation (CCG)	85%	1.0 (Failure for either = failure against the overall target)	88.10%	86.40%	83.80%	86.10%	86.00%	85.00%		85.35%								
	From NHS Cancer Screening Service referral - post local breach re-allocation	90%		100.00%	100.00%	87.50%	93.80%	100.00%	100.00%		100.00%								
	From urgent GP referral - pre local breach re-allocation (Open Exeter - Monitor)	85%		88.10%	86.00%	81.00%	85.25%	85.90%	85.00%		85.35%								
	From NHS Cancer Screening Service referral - pre local breach re-allocation	90%		100.00%	100.00%	87.50%	93.80%	100.00%	100.00%		100.00%								
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)	100.00%	100.00%	96.00%	98.67%	100.00%	100.00%		100.00%								
	Anti Cancer Drug Treatments	>98%		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	100.00%	100.00%	96.00%	100.00%	100.00%	100.00%		100.00%								
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)	93.70%	93.80%	92.00%	93.00%	95.20%	93.30%		93.00%								
	Symptomatic Breast Patients (Cancer Not Initially Suspected)	>93%		92.80%	98.30%	89.70%	93.20%	93.30%	96.60%		93.30%								
Clostridium Difficile - Hospital acquired (CUMULATIVE)	Due to lapses in care	27 (for the Yr)	1.0 **	0	1	4	4	4	4		4								
	Not due to lapses in care			3	7	8	8	8	8		8								
	Total (including: due to lapses in care, not due to lapses in care, and cases under review)			3	8	12	12	13	13		13								
	Under Review			0	0	0	0	1	1		1								
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								

Cumulative
Qtr1: 7 Qtr2: 14
Qtr3: 21 Qtr4: 27

APPENDIX 1

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										
Date of last CQC inspection	N/A		26/01/2015															
CQC compliance action outstanding (as at time of submission)	N/A		No	No	No	No	Yes	Yes										
CQC enforcement action within last 12 months (as at time of submission)	N/A		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										
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission) Breach of regulation 23 (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010 regarding the safety of healthcare provision	N/A		No	No	No	No	Yes	Yes										
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission) Breach of regulation 23 (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010 regarding the safety of healthcare provision	N/A		No	No	No	No	Yes	Yes										
Overall rating from CQC inspection (as at time of submission)	N/A		Not received at the time of reporting				Requires Improvmment											
CQC recommendation to place trust into Special Measures (as at time of submission)	N/A		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										
Trust has not complied with the high secure services Directorate (High Secure MH trusts only)	N/A																	
Service Performance Score			2.0	1.0	3.0	1.0	1.0	1.0		1.0								

NHS foundation trusts failing to meet at least four of these requirements at any given time, or failing the same requirement for at least three quarters, will trigger a governance concern, potentially leading to investigation and enforcement action

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 Risk Assessment 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

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/ **178**

SUBJECT:	**Verbal Report from the Chair of the Quality [Governance] Committee**
DATE OF MEETING:	2 October 2015
DIRECTOR:	Mike Lynch, Non-Executive Director

BOARD OF DIRECTORS

WHH/B/2015/ **179**

SUBJECT:	**QUALITY DASHBOARD (2015/2016) AUGUST 2015**
DATE OF MEETING:	2 October 2015
ACTION REQUIRED	**For Assurance**
AUTHOR(S):	Ros Harvey (Corporate Nursing Programmes Manager) Hannah Gray (Clinical Effectiveness Manager)
EXECUTIVE DIRECTOR:	Karen Dawber, Director of Nursing and Governance Choose an item.
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 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):	The Quality Dashboard (at Appendix 1) includes 2015/2016 quality related KPIs from the:- • CQUINs – National (Local CQUINs will be monitored by the CQUIN monitoring group and reported by exception if required). • Quality Contract • Quality Account - Improvement Priorities and Quality Indicators • Sign up to Safety – national patient safety topics • Open and Honest initiative Please note that VTE and dementia are extracted for the purpose of the QDB in advance of submission via UNIFY at months end and may not show compliance with the threshold. (VTE – 95% and Dementia – 90%). This will be updated in next month's Quality Dashboard.

RECOMMENDATION:	***The Board is asked to:*** 1. Note that the data for a number of indicators can change month on month. This applies to incidents (including pressure ulcers and falls), as incident type and severity can alter once reviewed, complaints and concerns as complaints can become concerns (and vice versa), with the agreement of complainants, and to mortality data which is rebased. 2. Note progress and compliance against the key performance indicators 3. Approve actions planned to mitigate areas of exception	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

Please see Appendix 1 for the quality dashboard data

Details of Exceptions

1. Clostridium difficile

Clostridium difficile - Nil hospital acquired Clostridium difficile cases were reported in August. YTD the Trust has reported 13 hospital apportioned cases of Clostridium difficile. Following review with the CCG 8 cases have been removed from the cases counted for contractual sanctions. Review panel meetings will be held quarterly going forward for any subsequent cases.

2. MRSA bacteraemia

1 hospital apportioned MRSA bacteraemia case was reported in August. A post infection review is in progress.

2. SHMI

The 12 month rolling SHMI has fallen in three consecutive months, from 117 to 116 and now at 115 (for the period June 2014 – May 2015). This reduction is expected to continue into quarter 2 2015/16, in line with fewer crude deaths in the months since winter 2014/15. The trust has had a higher than expected SHMI since October 2014. NB: It was reported in the August 2015 Quality Dashboard, that the Trust had had a higher than expected SHMI since August 2015. This should have stated August 2014, however this has now been rebased and the figures are now as expected in August and September 2014. Further detail is presented in the Mortality Overview Report, presented at this Trust Board meeting (2nd October 2015).

3. Advancing Quality

Advancing Quality (AQ) is a local CQUIN for the trust and we are performance managed for each agreed condition in order to demonstrate an annual improvement against the targets. AQ measures are monitored and reported via a designated monthly AQ Group, which meets to share good practice and explore ways of improving compliance. The latest data is for May 2015 and we are not currently meeting our targets for AMI (94.94% cumulative against a target of 95%) and Heart Failure (69.77% cumulative against a target of 84.1%).

AMI the appropriate Care Score May was 97.14 but cumulatively at 94.94% we did not achieve the 95% threshold for the CQUIN. The CQUIN payment is based on quarterly cumulative data so Q1 compliance will not be available until the June data set is closed.

The AQ measures are extremely sensitive and the May score was affected by the following:-

Referral to cardiac rehabilitation service made - 18 patients out of 19 = 97.74

ACEI or ARB are prescribed at discharge - 16 patients out of 17 patients = 94.12%

Heart Failure – the Appropriate care score May = 68% cumulatively we failed at 69.77% to achieve the threshold of 84.1% for the CQUIN. The CQUIN payment is based on quarterly cumulative data so compliance will not be available until the June data set is closed. The non-compliance issues related to the following:-
HF Specialist review <72 hours of HF documentation 10 patients out of 11 patients received 90.91%
'Written Discharge Instructions Given and Discussed' compliant for 14/22 patients 63.64%
A series of improvement events are planned for August and September 2015, with a pneumonia event having already taken place.

4. Pressure Ulcers
There has been decrease in the number of grade 2 and Grade 3 pressure ulcers reported each month since April 2015. All pressure ulcers have been subject to root cause analysis. Areas for improvement noted have been the introduction of a competency based training package for staff on Trauma and Orthopaedic wards to address a rise in device related pressure ulcers and the review of pressure relieving equipment available in AED and at ward level resulting in the purchase of pressure relieving trolley toppers and pressure relieving aids for backs of chairs.

5. Always Events
Although the target of 100% is not yet being met, we have sustained an improvement each month since April 2015, from 89% in April 2015, to 96% in July 2015, and this has been maintained in August.

6. Care Indicators: risk assessments
The care indicators audit process was developed as part of the High Quality Care CQUIN for 2013/2014 to audit compliance (random sample) with risk assessments for Falls, Waterlow and MUST. The Trust monitored this as a Quality Indicator for the Quality Accounts in 2014/2015 and due to non-compliance at year end (achieving below 95%), has decided to continue monitoring this for 2015/2016. More recently, monitoring has moved from a random sample to monitoring of all patients by ward staff, the results indicate non-compliance issues with all indicators which will be addressed by ward managers and the patient safety champion, with compliance and progress monitored by the Patient Experience Sub Committee. The data shows increasing compliance during quarter 1 2015/16. In July and August the trust was compliant with both Falls and Waterlow risk assessments and although MUST compliance was 91% in July this has reduced to 80% in August.
NB: August data is based on five wards work will continue to ensure that all wards submit a return

7. Friends and Family
August F&F Return was delayed because:-

- Package too heavy therefore too expensive for Royal Mail delivery
- Courier was requested for 24 hour delivery but due to shortage of staff in supplies the return was not dispatched until 7th September which missed the deadline for delivery of the 3rd September 2015.
- We asked I Want Great Care if they could process a late delivery but they stated that there was a charge of £300 so it was decided to decline this option and add the late responses to the September return.

8. VTE Hospital Acquired Thrombosis – Delays in confirming cases.

Cases are confirmed when Consultant review is completed and approved by the Thrombosis Committee. There is a delay in completion of VTE root cause analysis (VTE RCA) due to the number of steps in the process and having to access the case notes. This leads to an unacceptable number of outstanding RCAs and consequent delay in reporting on this data. In an effort to reduce the time from identification to completion of the RCA, a report will be submitted to the Patient Safety Sub-Committee proposing that VTE RCA approaches mirror other Trust RCA processes.

Sep-15

Quality Dashboard 2015/16

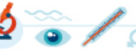
Titles key: IC = Inclusion criteria (See key below), YTD = Year to date
Inclusion criteria key: Improvement priority (IP), National Quality related CQUINs (C), Quality Account indicators (QI), CQC Intelligent Monitoring quality related 'Elevated risks' and 'risks'(CQC), National Patient Safety Priorities (related to Sign up to Safety campaign) (SU2S), Contract KPIs (Quality section only) not considered at other forums (QC), Directive from Sir Bruce Keogh (BK), Open and Honest (OH)
Data key: DC = Data capture system under development, QR = Quarterly Reporting
ST = Safety Thermometer. This is a survey carried out on one day a month on all wards. The survey provides a point prevalence figure e.g. of the number of inpatients who have a hospital acquired pressure ulcer on that day. The figure is NOT the total number of incidents in the month.

Target or Indicator		Target	IC	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD	Trend
INTELLIGENT MONITORING	BANDING	None set	CQC		no banding				NYP												
	NUMBER OF ELEVATED RISKS	None set	CQC		2				NYP												
	NUMBER OF RISKS	None set	CQC		4				NYP												
Safety																					
INCIDENTS	MODERATE, MAJOR OR CATASTROPHIC HARM (APPROVED)	TBC	QC	2	1	0	3	0	0											3	
	MODERATE, MAJOR OR CATASTROPHIC HARM (UNDER REVIEW)	N/A		21	17	58	96	64	64											224	continually changing figures
HEALTHCARE ACQUIRED INFECTIONS	MRSA	0= green, 1-5=amber, >5 red	QC, QI	0	0	0	0	0	1											1	
	CLOSTRIDIUM DIFFICILE (due to lapses in care)	<=27 per year	QC, QI	0	1	3	4	1	0											5	
	CLOSTRIDIUM DIFFICILE (no lapse in care)	None set	N/A	3	4	1	8	0	0											8	
NEVER EVENTS		0	QC	0	1	0	1	0	0											1	
VTE	% OF PATIENTS RISK ASSESSED	>=95%	QC	97.52%	96.21%	96.01%		95.33%	95.77%												
	% OF ELIGBLE PATIENTS HAVING PROPHYLAXIS (SAFETY THERMOMETER)	100%	QC	100.00%	100%	99.82%		100%	100%												
	NUMBER OF PATIENTS WHO DEVELOPED A HOSPITAL ACQUIRED VTE (APPROVED)	TBC	QC	3	0	0	3	0	0											3	
	NUMBER OF PATIENTS WHO DEVELOPED A HOSPITAL ACQUIRED VTE (UNDER REVIEW)	N/A	N/A	4	6	5	15	1	0											16	
HARM FREE CARE	% OF PATIENTS FREE FROM HARM (SAFETY THERMOMETER)	TBC	OH	97.70%	92.60%	98.34%		95.51%	97.33%												
	% OF PATIENTS FREE FROM HARM (MEDICINES SAFETY THERMOMETER)	TBC	QI	100%	97.5%	98.1%		Available end of Q2	Available end of Q2												

Target or Indicator		Target	IC	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD	Trend
Effectiveness																					
MORTALITY	HSMR (12 MONTH ROLLING)	<=100 = G, As expected = A, Higher than expected = R	QI, IP, QC	104	105	106															
	SHMI (12 MONTH ROLLING)	<=100 = G, As expected = A, Higher than expected = R	QI, IP, QC	116	115																
	TOTAL DEATHS IN HOSPITAL	None set	reporting only	92	80	107	279	87	81											447	
	MORTALITY PEER REVIEW (EXCLUDING SPECIALTY REVIEW)	Q1 - 45% Q2 – 55% Q3 – 75% Q4 – 95%	IP, SU2S	73%	71%	62%	64%	59%	Not available until October											66%	
	REGULATION 28 - PREVENTION OF FUTURE DEATHS REPORT	None set	Reporting only	0	0	0	0	0	0											0	
CARDIAC ARRESTS	Annual: <75 = G, 75 – 85 = A, >85 = Red	see left	QC	4	2	11	17	10	5											32	
ADVANCING QUALITY	ACUTE MYOCARDIAL INFARCTION	>=95%	QI, C	93.18%	94.94%															94.94%	
	HIP AND KNEE	>=95%	QI	98.51%	99.22%															99.22%	
	HEART FAILURE	>=84.1%	QI, C	72.22%	69.77%															69.77%	
	PNEUMONIA	>=78%	QI, C	80.00%	78.83%															78.83%	
APPROPRIATE DISCHARGE PLANNING FOR PATIENTS WITH AKI		TBC	C	Quarter one data for establishing baseline				Absence of AKI Calculator in current system resulted in CCG agreeing for baseline to be set at Q2													
SEPSIS SCREENING OF ALL ELIGIBLE PATIENTS ADMITTED TO EMERGENCY AREAS		TBC	C	Quarter one data for establishing baseline				100%	Awaiting results												
SEPSIS SCREENING: ANTIBIOTICS GIVEN WITHIN AN APPROPRIATE TIMESCALE		TBC	C	Quarter 1: establishing indicator detail				Quarter 2: data for establishing baseline. July 16.7% (2 of 12)													
Patient Experience																					
FALLS	ALL FALLS (APPROVED)	913	IP (5% reduction)	81	88	79	248	74	67											389	
	FALLS PER 1000 BED DAYS	<=5.6	IP (national benchmark)	4.97	6.22	5.03		4.97	4.53											5.13	
	MODERATE, MAJOR AND CATASTROPHIC HARM FALLS (APPROVED)	<=13	IP (10% reduction)	1	1	1	3	0	0											3	
	MODERATE, MAJOR AND CATASTROPHIC HARM FALLS (UNDER REVIEW)	N/A		2	1	2	5	1	0											6	
	MODERATE HARM FALLS (APPROVED)	<=12	SU2S (10% reduction)	1	1	1	3	0	0											0	

Target or Indicator		Target	IC	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD	Trend
PRESSURE ULCERS	GRADE 3 AND 4 HOSPITAL ACQUIRED (AVOIDABLE)	<=5	QI, SU2S (10% reduction)	1	1	1	3	0	0											3	
	GRADE 3 AND 4 HOSPITAL ACQUIRED (UNAVOIDABLE)	N/A		0	1	0	1	0	0											0	
	GRADE 3 AND 4 HOSPITAL ACQUIRED (UNDER REVIEW)	N/A		0	0	0	0	0	0											0	
	GRADE 2 HOSPITAL ACQUIRED, AVOIDABLE AND UNAVOIDABLE (APPROVED)	<=63	QI (5% reduction)	14	7	5	26	7	0											33	
	GRADE 2 HOSPITAL ACQUIRED, AVOIDABLE AND UNAVOIDABLE (APPROVED)	<=59	10% reduction internal stretch target	14	7	5	26	7	0											33	
	GRADE 2 HOSPITAL ACQUIRED, AVOIDABLE AND UNAVOIDABLE (UNDER REVIEW)	N/A		1	1	1	3	3	6											12	
TRANSFERS	OUT OF HOURS TRANSFERS	TBC	BK	1	0	1	2	0	0											2	
	NON-ESSENTIAL WARD TRANSFERS	TBC	QI	DC	DC	DC		DC	DC												
	ALWAYS EVENTS	100%	QI	89%	90%	92%	90%	96%	96%											96%	
DEMENTIA	DEMENTIA ASSESSMENT % (PART 1)	>=90%	C	96.85%	97.62%	95.53%		96.80%	94.86%												
	DEMENTIA ASSESSMENT % (PART 2)	>=90%	C	100%	100%	100%		100%	95.12%												
	DEMENTIA ASSESSMENT % (PART 3)	>=90%	C	100%	100%	100%		100%	100.00%												
	DEMENTIA - STAFF TRAINING	Q2 = 42%	C	Compliance established at 27.02% end Q1 plus additional 15% for Q2				Awaiting data	Awaiting data											27.02%	
CARE INDICATORS RISK ASSESSMENTS	FALLS	>=95%	IP	82%	92%	93%	93%	97%	97%												
	WATERLOW (PRESSURE ULCERS)	>=95%	IP	77%	93%	92%	91%	96%	95%												
	MUST (MALNUTRITION)	>=95%	IP	78%	85%	89%	85%	90.80%	80%												
	DIABETIC FOOT	Q1 - 61% Q2 – 71% Q3 – 81% Q4 – 91%	C	QR	QR	77.60%	77.60%	72.00%	81.40%											77.6%	
	MIXED SEX OCCURENCES	0	QC	6	0	1	7	0	0											7	
FRIENDS AND FAMILY (PATIENTS' VIEWS)	STAR RATING	N/A	Reporting only	4.61	4.66	4.70		4.66	4.65												
	% RECOMMENDING TRUST: INPATIENTS	>=95%	IP, QI, QC	97%	98%	98%		98%													
	% RECOMMENDING TRUST: A&E	>=87%	IP, QI, QC	83%	86%	88%		87%													
	RESPONSE RATE: A&E WARRINGTON	Contract target to be agreed	IP, QI, QC	22.03%	19.47%	13.16%		6.96%	6.49%												
	RESPONSE RATE: URGENT CARE CENTRE HALTON	Contract target to be agreed	IP, QI, QC	3.54%	22.81%	24.00%		44.90%	10.86%												

Target or Indicator		Target	IC	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD	Trend
FRIENDS AND FAMILY (PATIENTS' VIEWS)	RESPONSE RATE: A&E COMBINED	Contract target to be agreed	IP, QI, QC	17.42%	20.26%	16.11%		17.62%	7.66%												
	RESPONSE RATE: INPATIENTS	Contract target to be agreed	IP, QI, QC	30.30%	33.80%	31.44%		31.96%	6.13%												
COMPLAINTS AND CONCERNS	NUMBER OF COMPLAINTS RECEIVED	2013/2014 received 478 (No threshold set)	IP	50	23	32	105	24	39											168	
	% OF COMPLAINTS RESOLVED WITHIN THE AGREED TIMESCALE	>=94%	IP, QC	100%	97.50%	97.56%	98.08%	97.67%	100.00%											98.08%	
	NUMBER OF CONCERNS RECEIVED	NOT SET	IP	9	8	25	42	39	15											96	
END OF LIFE STRATEGY: STAFF TRAINING (KPI UNDER CONSTRUCTION)		TBC	IP	Training workshops in development, delivery in Q3				Training workshops in development, delivery in Q3													
REDUCING AVOIDABLE EMERGENCY ADMISSIONS TO HOSPITAL		TBC	C	4 pathways identified, awaiting CCG agreement				4 pathways identified, awaiting CCG agreement													



BOARD OF DIRECTORS

WHH/B/2015/ **180**

SUBJECT:	**Mortality Overview Report** Q1 2015/2016	
DATE OF MEETING:	2 October 2015	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Hannah Gray, Clinical Effectiveness Manager Simon Constable, Medical Director	
EXECUTIVE DIRECTOR:	Simon Constable, Medical Director	
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care Choose an item. Choose an item.	
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	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	This report overviews trust mortality data and provides local and national context. It also outlines the actions in place to ensure robust oversight and monitoring, through a comprehensive mortality peer review process, as well as improvement plans to reduce trust mortality rates and the trust mortality ratio figures.	
RECOMMENDATION:	***The Board is asked to:*** *note the contents of the report and discuss and approve the recommended options*	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

Mortality Overview Report: Q1 2015/2016

EXECUTIVE SUMMARY

The purpose of this paper is firstly to provide the Trust Board with the latest trust mortality data, and provide local and national context. Secondly, it outlines the actions in place to ensure robust oversight and monitoring as well as to continue to reduce both trust mortality and the trust mortality ratio figures.

CONTEXT

- The importance of reporting mortality statistics at Board level was highlighted in the Francis Report into the failures at the Mid-Staffordshire Trust (February 2010) to which Warrington and Halton Hospitals NHS Foundation Trust provided a full position response reported at Board in September 2010.
- On February 6th 2013 the Prime Minister announced that he had asked Professor Sir Bruce Keogh, NHS Medical Director for England, to review the quality of care and treatment provided by those NHS trusts and NHS foundation trusts who were persistent outliers on mortality indicators. A total of 14 hospital trusts were investigated as part of this review. After the reviews, 11 of the 14 trusts were placed into special measures by Monitor and the NHS Trust Development Authority.
- The Secretary of State for Health announced in March 2015 that clinical mortality reviews will be compulsory in all Trusts (date and details not yet confirmed).
- The Care Quality Commission's Intelligent Monitoring process encompasses the monitoring and reporting of around 100 mortality related indicators.
- Reducing the HSMR and SHMI have been identified as local quality indicators for the Trust in 2015/2016 (Quality Report 2014/2015).
- Reducing Mortality is one of three commitments we have made in the national Sign up to safety campaign 2014 - 2017.

MORTALITY DATA

The crude death total and rates (unadjusted figures of total deaths and deaths as % of discharges) are presented below, as well as the mortality ratios, Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Mortality Indicator (SHMI). These ratios calculate the risk adjusted mortality following hospital admission using Hospital Episode Statistics (HES); this is data which trusts capture and provide. They are an indicator of trust mortality and allow us to compare our position against other trusts. The ratios are complex and their robustness and usefulness is the subject of debate, particularly when looking at trends over time. Despite this, the trust will continue to monitor them and use them as a benchmarking indicator to drive focussed reviews to identify areas for improvement and provide assurance around the quality of care we provide. However, we will also closely and contemporaneously monitor absolute crude death total figures and rates.

The data and charts within this report are from one of the following sources - the trust's information department, the HED (Healthcare Evaluation Data) system or AQuA (Advancing Quality Alliance). The AQuA charts (labelled AQuA) use the latest published data from the Health and Social Care Information Centre and the HED system. All other charts, except where otherwise stated, are produced internally using the HED system.

a) Trust Crude Mortality

Crude mortality is the actual, unadjusted number of deaths. Crude death rates (the % of patients who die in hospital), rather than numbers of deaths, are used to compare trusts, as there is a large variation in the volume of patients seen by trusts across England, and also therefore, in the numbers of deaths at each Trust. The trust generally compares favourably with local trusts, as well as the North West and England averages. This is closely monitored monthly to identify any concerning trends.

Chart 1: WHHNHSFT, England average and North West Acute Trusts per year.

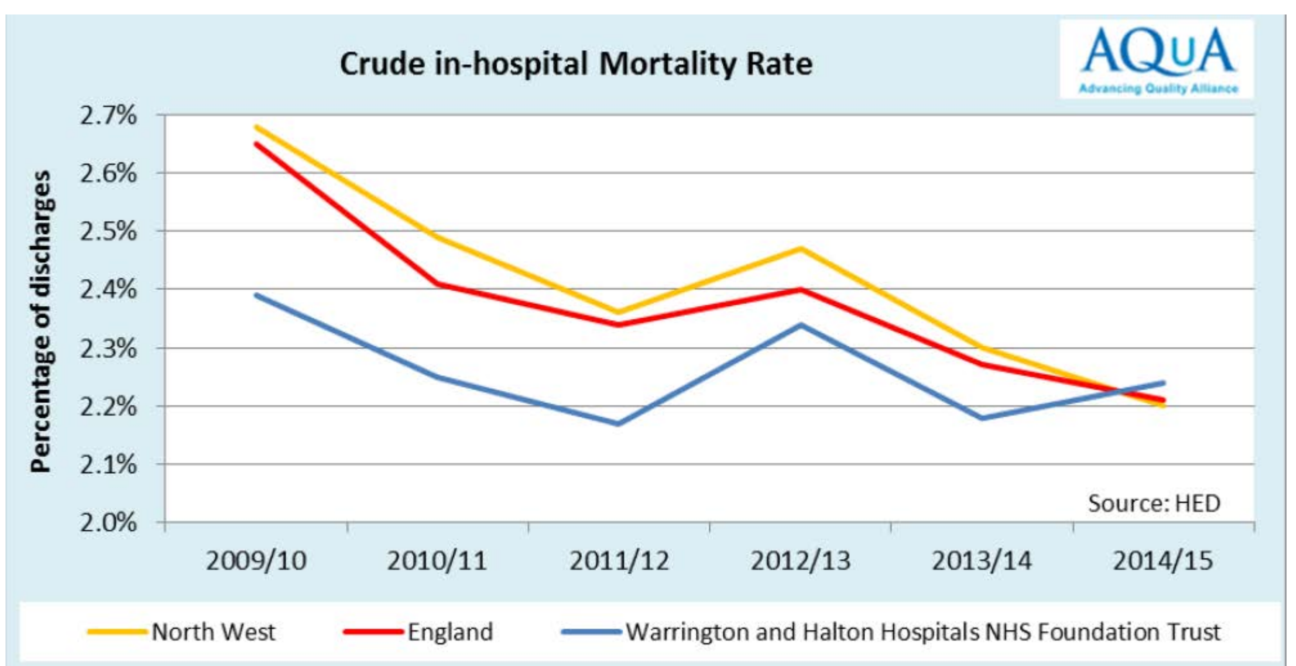


Chart 2: WHHNHSFT, England average and North West Acute Trusts January 2014 – December 2014 (latest available national data).

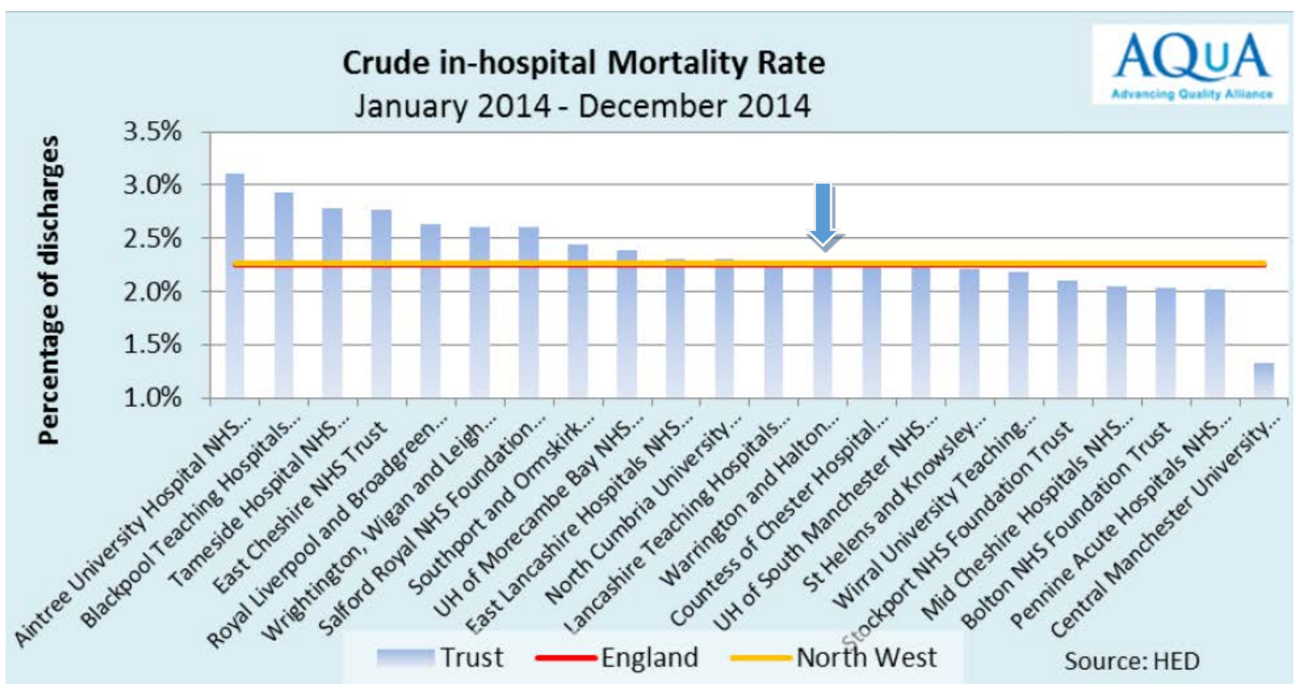


Chart 3: Crude Mortality Rates for WHHNHSFT and local peers (HSMR patients only), July 2014 – June 2015 (latest data available).

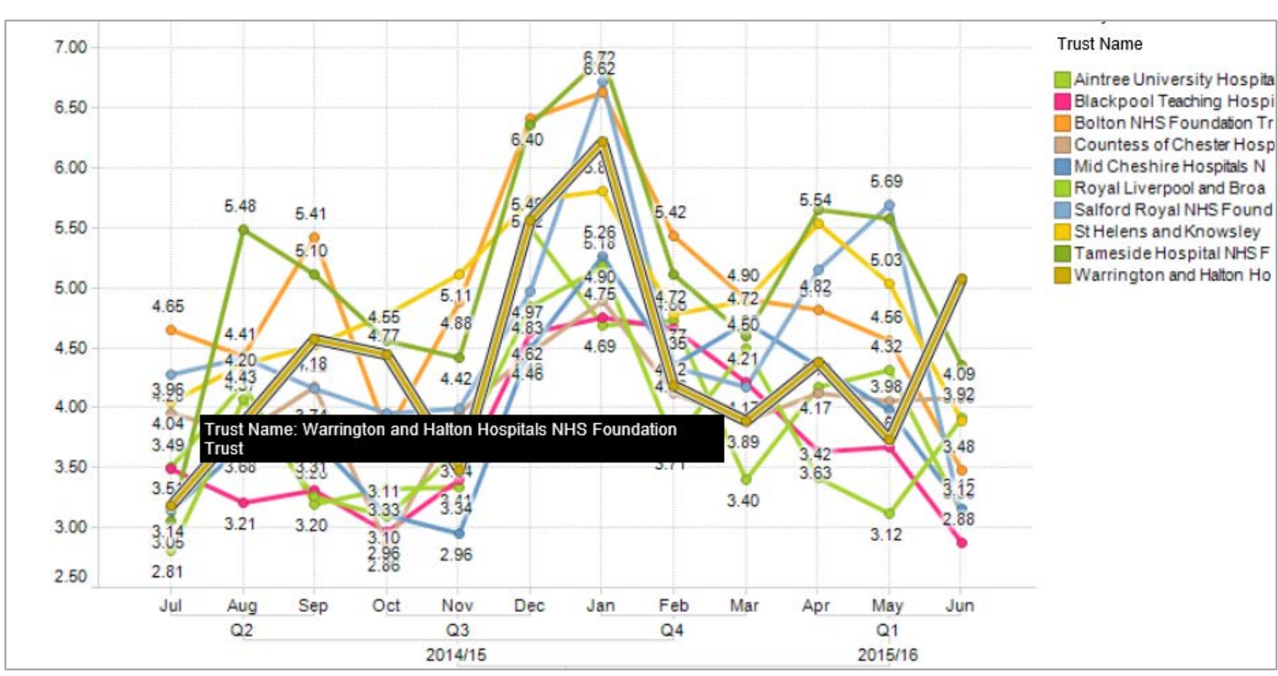
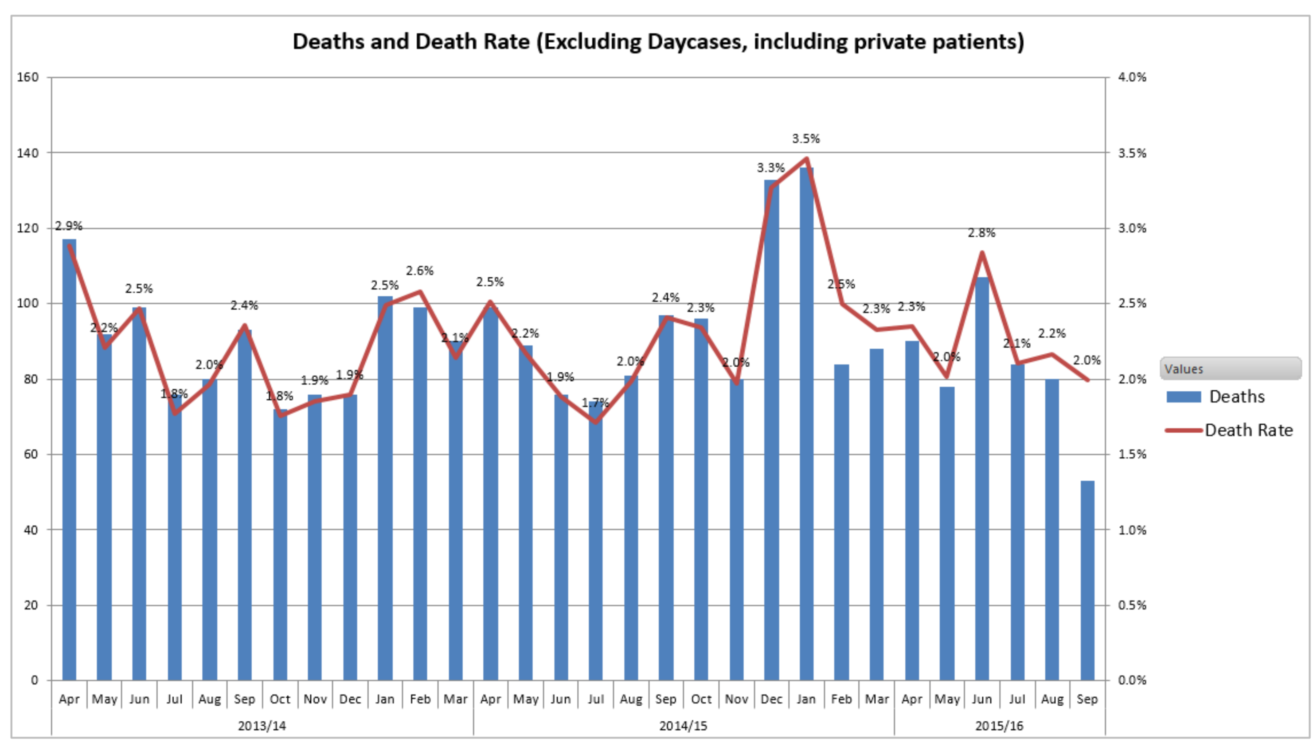


Chart 4: WHHNHSFT total deaths and death rate (deaths as a % of all discharges) per month (as at 21st September 2015).



Source: WHHNHSFT Information Department

Charts 3 and 4 show a rise in deaths and death rate at WHH in June 2015. The death rate for June 2015 is higher than that of other local Acute Trusts, however our rates were lower than most trusts in the preceding three months. To provide assurance, the Clinical Effectiveness Sub Committee requested a review, to take into consideration factors including mortality review findings, staffing levels and incidents during this period. Early findings (including staffing) indicate no significant differences during this period and a full report will be presented at the October meeting.

In December 2014, when close monitoring identified an apparent marked increase in the number of deaths (prior to the availability of national statistics), the Chief Executive commissioned an internal review into the care of these patients. A review of all deaths in December 2014 and early January 2015 was conducted in January 2015 by the former Medical Director, consultants, senior nurses and two invited members of the CCG (for transparency and to utilise their expertise and to review the whole patient journey) and the findings were presented to the Hospital Management Board (HMB) in January 2015. Progress against the outstanding recommendations is as follows:

Recommendation	Assurance Forum	Deadline	Progress
The trust should review its policy for Admission to ICU, to ensure that there is clarity regarding which patients	Acute Care Group	Q3 2015/16	Complete. The revised policy was ratified at the Clinical

should be referred and that grounds for refusal of admission are appropriate.			Effectiveness Sub Committee.
All deaths in the hospital should be reviewed on an ongoing basis.	Clinical Effectiveness Sub-Committee	Q4 2015/16	A revised system of peer review will be launched on 1/10/15. The target for Q1, for the % reviewed, was met.

Trust deaths by ward and year

Numbers of deaths and death rates on wards in 2013/2014, 2014/2015 and Q1 2015/2016.

		Number of deaths			Death Rate		
Ward	**Lead Speciality**	**2013/14**	**2014/15**	**Q1 2015/16**	**2013/14**	**2014/15**	**Q1 2015/16**
A1	Acute Medicine	101	105	24	2.2%	2.3%	2.6%
A2	Acute Medicine	92	88	18	5.1%	5.5%	4.2%
A3	Elderly Medicine	76	103	30	8.3%	13.6%	14.2%
A4	General Surgery	36	10	4	2.9%	0.6%	1.8%
A5	General Surgery	14	38	11	1%	2.4%	2.1%
A6	Colorectal Surgery	25	29	3	1.3%	1.9%	0.7%
A7	Respiratory Medicine	138	133	39	10.4%	13.6%	15.1%
A8	General Medicine/ Neuro-rehab/Elderly	82	96	26	10.4%	13.2%	13.3%
A9	Trauma & Orthopaedics	32	33	7	2.7%	2.6%	2.4%
B11	Paediatrics	1	1	0	0.1%	0.1%	0%
B12	Elderly Care/Dementia	56	52	13	11.7%	14%	19.7%
B14	Stroke	67	81	18	10.1%	10.9%	10.1%
B18	General Medicine and infection control cohort ward	44	45	9	8.2%	9.5%	6.8%
B19	Trauma & Orthopaedics	7	10	4	1.2%	1.9%	2.6%
C20	Gynaecology & Women's Health	3	6	1	0.1%	0.3%	0.2%
C21	Cardiology	36	47	11	3.3%	4.7%	4.1%
C22	Gastroenterology	43	60	16	4.1%	6.3%	6.2%
Coronary Care Unit	Cardiology	33	30	6	8%	6.5%	5.9%
Clinical Decisions Unit	Emergency Medicine	1	2	1	0.02%	0.04%	0.1%

CMTC	Trauma & Orthopaedics	0	1	0	N/A	0.1%	0%
Intensive Care Unit	Critical Care Medicine	152	131	28	59.4%	63.6%	51%
Labour Ward (including still births)	Obstetrics & Paediatrics	14	9	2	0.67%	0.46%	0.4%
Neonatal Unit	Neonatology	7	4	0	3.02%	1.69%	0%
Surgical Assessment Unit	General Surgery	1	3	2	0.05%	0.1%	0.4%
Theatre Recovery	General Surgery	7	11	1	36.8%	45.8%	50%
Urgent Care Centre	General Medicine	1	3	0	0.2%	1.3%	0%
Halton Intermediate Care Unit	Intermediate Care	1	2	0	1.1%	0.8%	0%
Total		**1076**	**1134**	**275**	**2.3%**	**2.5%**	**2.5%**

Source: WHHNHSFT Information Department

Deaths by day of admission

This table shows a weekday / weekend split for crude numbers of deaths (patients who died in hospital or within 30 days of discharge), and SHMI* figures for WHHNHSFT and other local trusts with a higher than expected SHMI for weekday or weekend admissions or both, for the period June 2014 – May 2015 (latest available on HED). The SHMI for all 22 NW acute trusts for this period is 110 for weekend admissions and 104 for weekday admissions. Both these figures are statistically significantly high. 20 of the 22 Acute Trusts in the NW have a weekend SHMI over 100. Although other trusts have a similar gap between their weekday and weekend SHMI, and we have identified no concerns regarding weekend care in general (as part of any focussed or general mortality review to date), we will continue to investigate this further to better understand the reason for this difference, and take action as required.

*Please see the next section; 'section b' for an explanation of the SHMI measure.

Trust Name	Day of admission	SHMI	Statistically significant?	Expected number of deaths	Number of patients discharged who died in hospital or within 30 days	% of mortalities occurring in hospital	% of admissions with palliative care coding	Average comorbidity score per spell
RBN - ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	Weekday	103.41	N	1666.1	1723	67.60%	1.17%	3.76
RBN - ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	Weekend	112.41	Y	486.6	547	72.80%	1.29%	3.85
RMC - BOLTON NHSFT	Weekday	105.8	Y	1250.5	1323	75.10%	1.16%	2.92
RMC - BOLTON NHSFT	Weekend	109.74	Y	431	473	71.20%	1.38%	3.03
RMP - TAMESIDE HOSPITAL NHSFT	Weekday	118.95	Y	919.7	1094	68.60%	1.72%	3.85
RMP - TAMESIDE HOSPITAL NHSFT	Weekend	121.89	Y	310.9	379	64.40%	1.71%	4.01
RQ6 - ROYAL LIVERPOOL AND BROADGREEN UHNHST	Weekday	106.84	Y	1435.7	1534	72.90%	2.08%	4.25
RQ6 - ROYAL LIVERPOOL AND BROADGREEN UHNHST	Weekend	109.57	N	440.8	483	72.50%	2.32%	4.37
RRF - WRIGHTINGTON, WIGAN AND LEIGH NHSFT	Weekday	110.16	Y	1123.8	1238	67.30%	1.82%	4.3
RRF - WRIGHTINGTON, WIGAN AND LEIGH NHSFT	Weekend	122.46	Y	376.5	461	69.00%	2.35%	5
RVY - SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	Weekday	107.59	Y	905.3	974	65.60%	1.21%	3.35
RVY - SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	Weekend	106.77	N	283.8	303	70.00%	1.15%	3.46
RWW - WARRINGTON AND HALTON HOSPITALS NHSFT	Weekday	111.83	Y	1048	1172	69.40%	1.51%	3.26
RWW - WARRINGTON AND HALTON HOSPITALS NHSFT	Weekend	126.53	Y	321.7	407	73.00%	1.85%	3.39
RXL - BLACKPOOL TEACHING HOSPITALS NHSFT	Weekday	116.71	Y	1565.4	1827	72.40%	1.17%	4.2
RXL - BLACKPOOL TEACHING HOSPITALS NHSFT	Weekend	121.95	Y	511.7	624	72.30%	1.22%	3.97

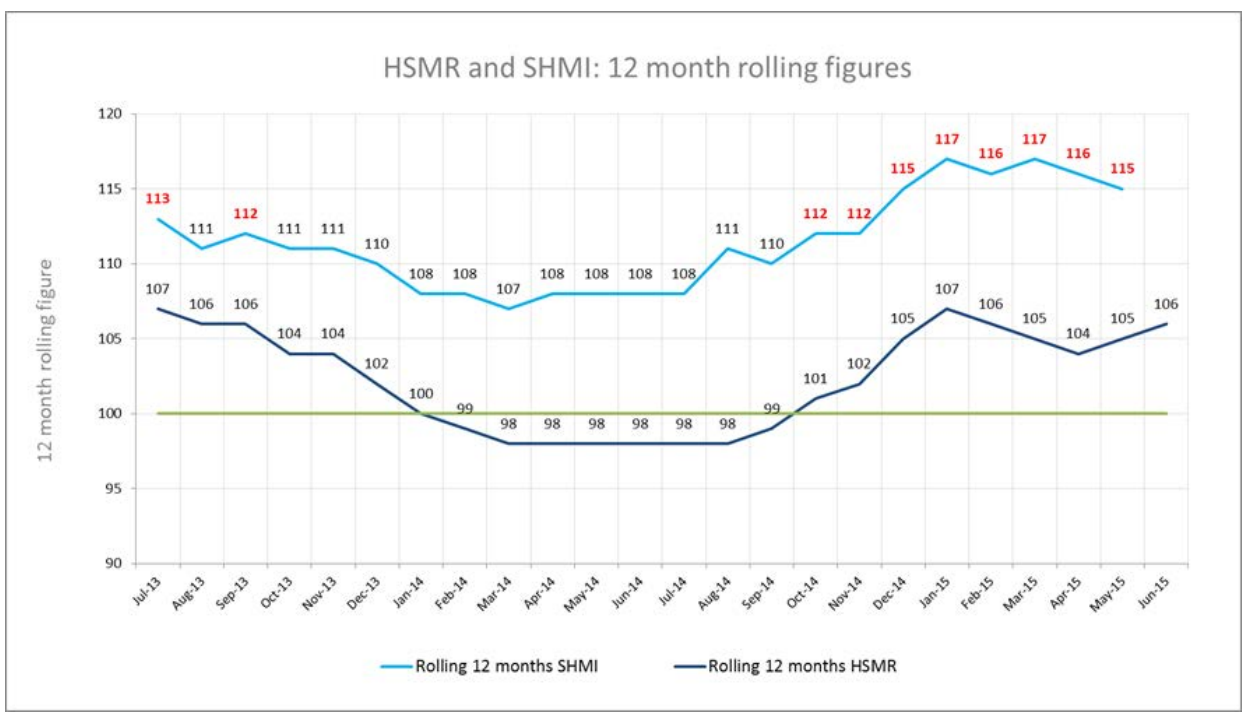
b) SHMI and HSMR

These indicators are produced and published quarterly as an experimental official statistic by the Health and Social Care Information Centre (HSCIC) with the first publication in October 2011. The SHMI is the ratio between the actual number of patients who die at the trust, or within 30 days of being discharged, and the number that would be expected to die, on the basis of average England figures. A number below 100 indicates fewer than the expected numbers of deaths and a number above 100 would suggest a higher than expected number of deaths. The HSMR is another ratio, based on different criteria, and including deaths in hospital only. The table below provides detailed HSMR and SHMI criteria.

	HSMR	SHMI
Numerator	All spells culminating in death at the end of the patient pathway, defined by specific diagnosis codes for the primary diagnosis of the spell: uses 56 diagnosis groups which contribute to approx 80% of in hospital deaths in England*.	Total number of observed deaths (in-hospital and 30 day post discharge deaths)
Denominator	Number of in hospitals admissions where the primary diagnosis at the beginning of the spell i.e. the first or second episode is one of those from the 56 diagnosis groups known to be responsible for around 80% of in hospital mortality. (percentage will vary dependent on the case mix of the hospital)	Total number of patient admissions
Adjustments	• Sex • Age in bands of five up to 90+ • Admission method • Source of admission • History of previous emergency admissions in last 12 months • Month of admission • Socio economic deprivation quintile (using Carstairs) • Primary diagnosis based on the clinical classification system • Diagnosis sub-group • Co-morbidities based on Charlston score • Number of previous emergency admissions • Palliative care • Year of discharge	Risk-adjusted, based on age, sex, admission method, co-morbidity
Exclusions	None	• Specialist, community, mental health and independent sector hospitals. • Stillbirths • Day cases, regular day and night attenders
* HSMR does not exclude 20% of deaths, it looks for the diagnosis groups that account for the majority of deaths, hence the figure of 80% is quite variable dependent on the case mix of the trust.		

Following a significant focus on mortality reduction in the trust, we improved from a previously 'higher than expected' SHMI score, to having an 'as expected' score between October 2013 and September 2014. The latest SHMI figure published on the HSCIC website is 'higher than expected' at 116, for the period January 2014 – December 2014. We monitor mortality ratios on a monthly basis using the HED system and have reported internally a 'higher than expected' score in the rolling 12 month periods ending October 2014 (112) - May 2015 (115). The latest HSMR is 106, for July 2014 – June 2015, this is 'as expected'.

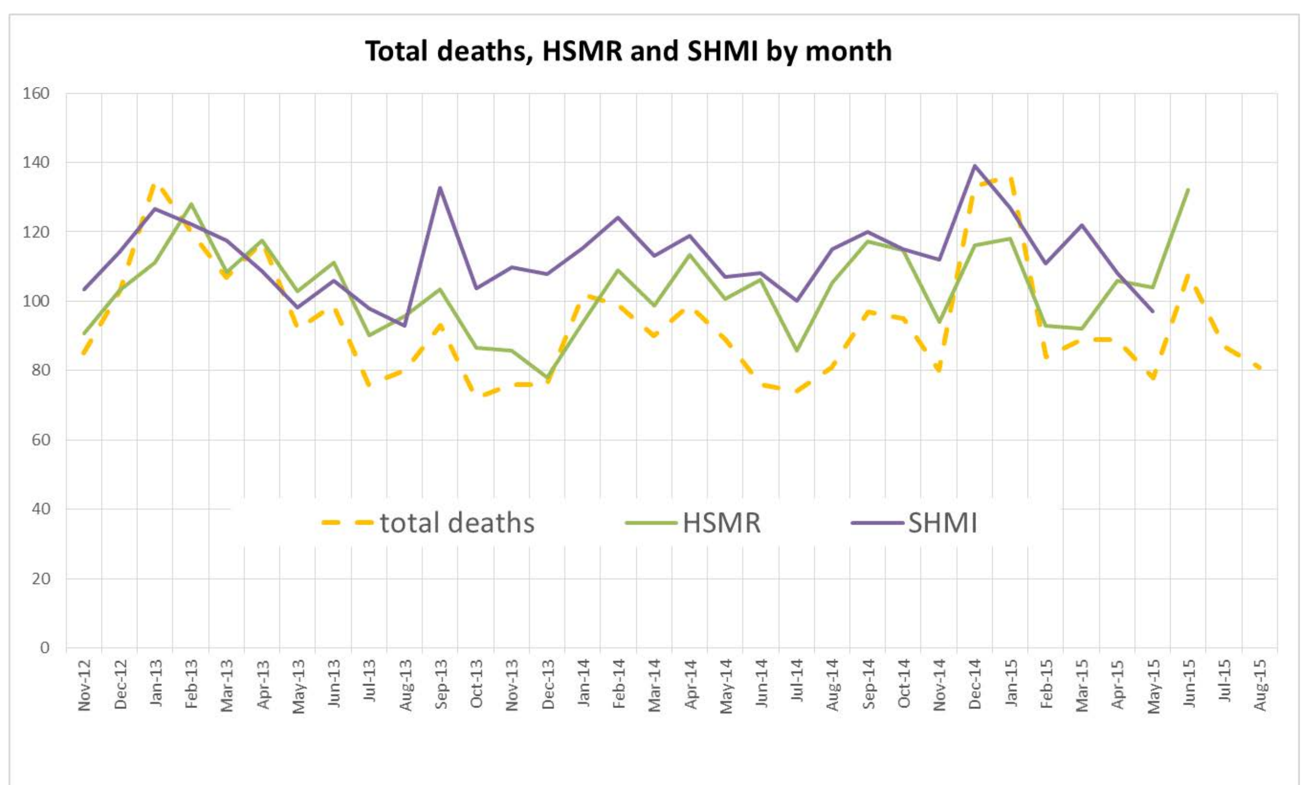
Chart 5: Rolling 12 month HSMR and SHMI figures (i.e. the February 2015 HSMR of 106 is for the period March 2014 - February 2015).



c) Crude death rate compared with mortality ratios

A strong correlation between crude death and mortality ratio figures has been identified. Chart 6 suggests that the SHMI will rise in June 2015 before falling again. If the HSMR and SHMI were perfect measures, this would suggest that a rise in crude deaths always equates to an increase in avoidable deaths. Consultation with experts at HED reveals otherwise; they confirm that it is far more likely to be a flaw in the methodology of the ratio than an actual increase in avoidable deaths. Similar correlations at other trusts further support this view.

Chart 6: Trust total deaths, monthly HSMR and monthly SHMI.



d) Documentation and coding

<u>Signs and symptom codes</u>

The level of Signs and Symptoms coding (R codes) is important because it has inferences on the quality of care and has an impact on the calculations used to create the SHMI. High levels of R codes *may* imply lower access to senior medical opinion and later commencement of appropriate treatment. If R codes remain as the primary diagnosis through the first few episodes of a patient's pathway then this could be indicative of multiple hand-overs within a short period of time i.e. during the period of diagnostic investigation.

R codes remaining as the primary diagnosis for the first two episodes affects the calculation of the SHMI, often in an adverse way. SHMI uses the primary diagnosis of the first episode to assign the CCS Group of that admission. If the primary diagnosis of the first episode is an R code then the primary diagnosis of the second episode is used. However, should the diagnosis of the second episode also be an R code then SHMI will revert back to the first episode's primary diagnosis.

The CCS groups that R codes map to have relatively low mortality rates and, therefore, low numbers of expected deaths. If a trust has a high level of R coding then it is more likely to have a higher level of deaths with an R code as the primary diagnosis (first and second episode). Charts 7 and 8 show that our use of R codes is higher than the NW average and the England average.

Chart 7: Non-elective Finished Consultant Episodes with an R code as the primary diagnosis (WHHNHSFT and England and NW average per financial year)

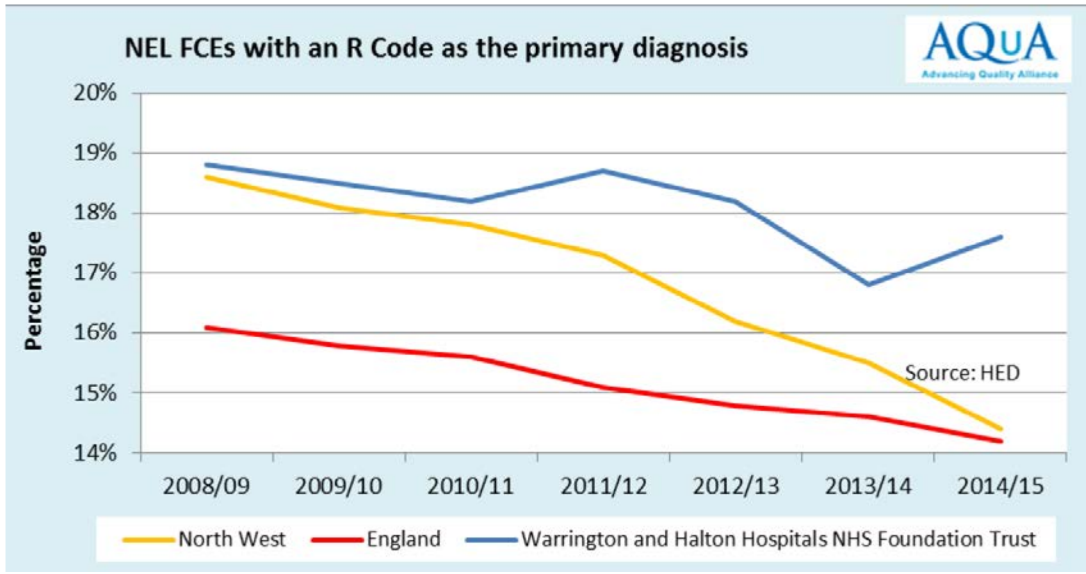
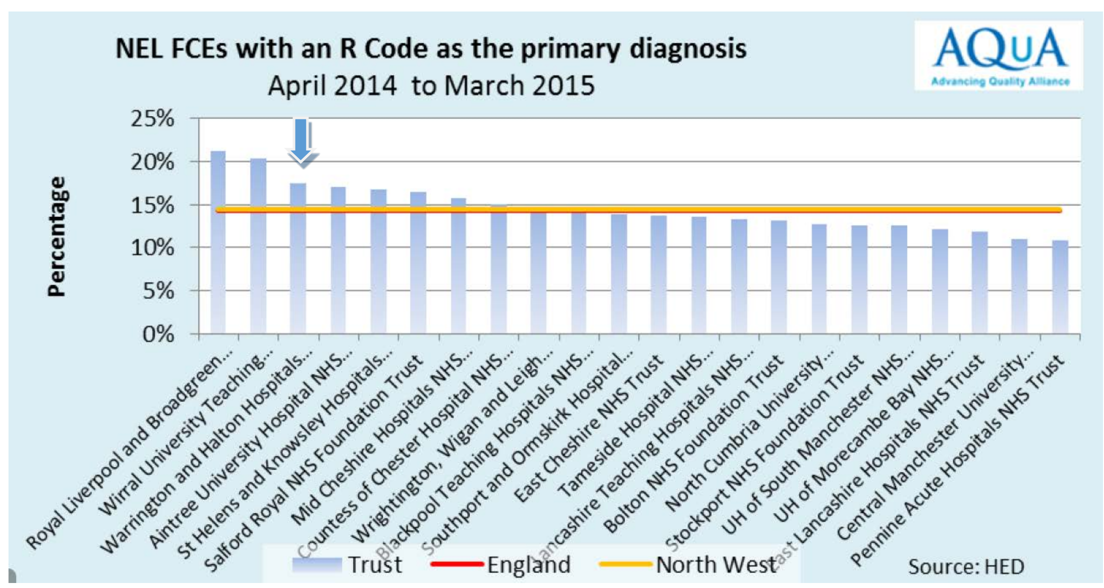


Chart 8: Non-elective finished consultant episodes with an R code as the primary diagnosis (NW Acutes).



Quality of documentation and coding

The diagnosis coding depth (diagnosis detail) and the numbers of comorbidities recorded for patients both have an impact on the mortality ratios. Failing to record in the notes, and subsequently code all the patient's diagnoses and comorbidities will mean that:

- the acuity of the patient is understated,
- their mortality risk will then be inaccurately low,
- and the ratio will be adversely affected if they die.

The accuracy of coding is checked as standard during all focussed mortality reviews coordinated by the Clinical Effectiveness Team, and involving coding managers. These checks have revealed some minor inaccuracies in coding, which have been fed back to the coding team. It is more difficult however, to assess the accuracy of the documentation of diagnoses and comorbidities made by the clinician. The charts below show how we compare with local trusts. Again, it is difficult to determine whether we are an 'outlier', as, without detailed analysis of local morbidity data (excluding our own diagnosis and comorbidity data, if we cannot prove its robustness), we do not know whether these figures reveal any underrepresentation of the acuity of our patients. General coding audits and benchmarking are likely to provide the most useful data, which is reviewed by our Information Department. Alongside this is continuing education of clinicians at all levels of the importance of accurate and comprehensive documentation.

Chart 9: WHHNHSFT and local peers' average diagnosis coding depth.

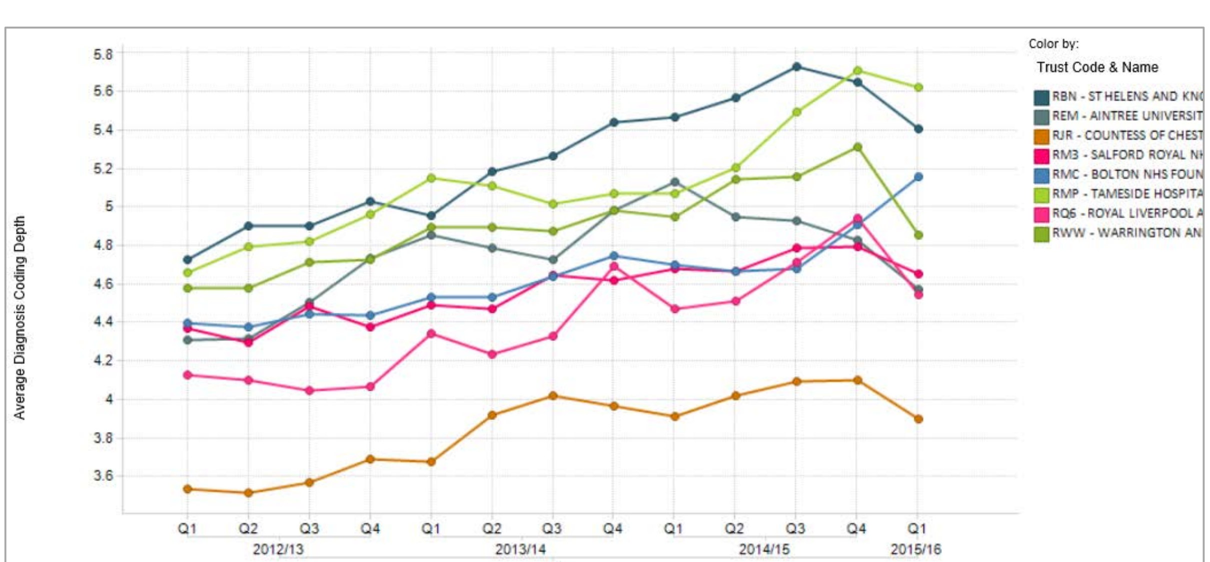
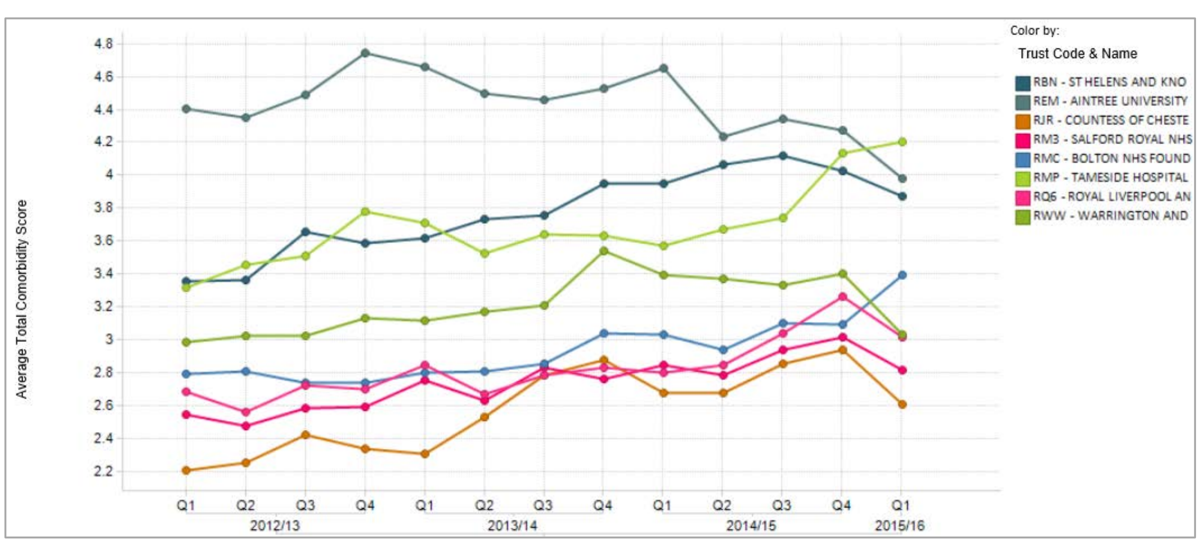


Chart 10: WHHNHSFT and local peers' average total comorbidities



e) Specialist Palliative Care

The coding of the provision of this service is included in the HSMR criteria but not the SHMI. Through investigating the detail behind the ratio numbers, we identified that our rate of service provision was the lowest in the North West prior to 2012/2013, and we have worked hard to now be in a position in which we compare favourably with local peers. Chart 12 shows a recent reduction which will be monitored.

Chart 11: NW Acutes' Specialist Palliative Care service rates January 2014 – December 2014

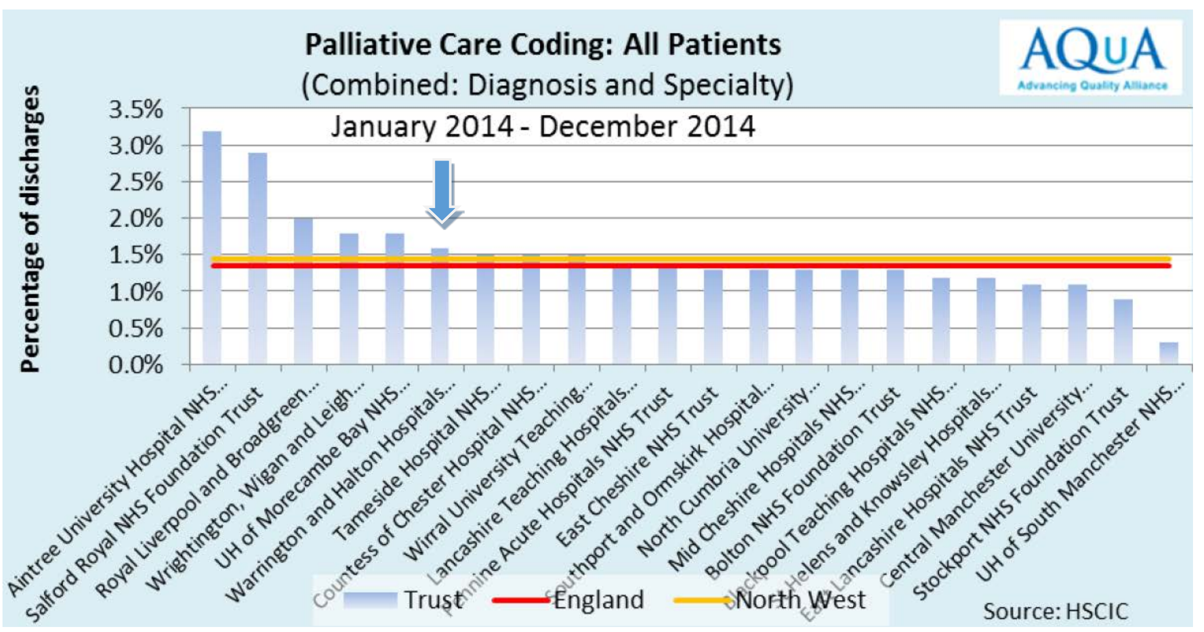
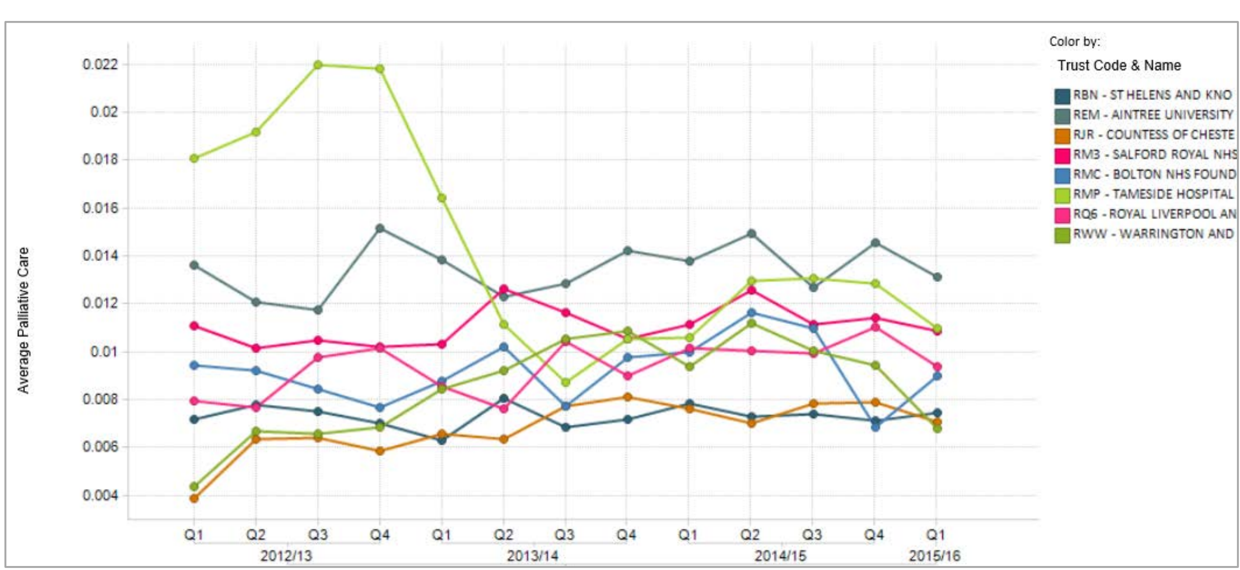


Chart 12: Local trusts' Specialist Palliative Care service provision rates April 2012 – May 2015
(NB: Q1 2015/2016 includes April 2015 and May 2015 only. June 2015 data is not yet available)



f) CQC monitoring

There are no open CQC outliers for the trust, the last one related to UTI in 2012. The CQC have so far published 3 Trust level Intelligent Monitoring reports, 2 of which have included mortality related indicators with a 'risk' status. These were for Haematological conditions and Cardiological conditions (December 2014), and Conditions associated with mental health, Endocrinological conditions and Nephrological conditions (August 2015). Although none of these new 'risks' have instigated contact from the CQC requesting a response from the trust, we have investigated the details to provide internal assurance and found minor documentation / coding issues but no areas of concern regarding the quality of care.

g) ICNARC (Intensive Care National Audit and Research Centre) data

ICNARC monitor the performance of Intensive Care Units across England. The latest quarterly ICNARC data, published in September 2015, reveals that the trust continues to have a low standardised mortality rate; 86 for Q1 2015/1, the lowest in the UK for all similar sized units, and one of the lowest overall. To provide further assurance, alongside the routine review of all in-unit deaths, a review of all cases of post-discharge deaths is in progress.

ACTIONS

All of the above; crude death figures and rates as well as the mortality ratios, will continue to be monitored (and further investigated as necessary) through our clinical governance structure and reported to Trust Board via the Quality Committee (crude death rates and figures are reported by ward and month with as much historical data as is relevant, given ward reconfigurations etc). The following constitutes an improvement plan which will be monitored through the Clinical Effectiveness Sub-Committee (unless otherwise stated).

External Assurance:

We have invited AQuA's Reducing Mortality Lead to meet with the Medical Director to discuss how AQuA can provide external assurance regarding the efficacy of our approaches.

We have arranged to meet key contacts at Aintree University Hospitals NHS FT who have agreed to talk through their reducing mortality journey which was supported by an AQuA 'deep dive' into mortality at the Trust.

1. Mortality Peer Review

A review conducted by Mersey Internal Audit Agency in 2015 reflects our own internal knowledge, that despite there being clear processes in place, full compliance is not being achieved with our own mortality review process. There are some areas of good practice but there is not yet a standardised system embedded across the organisation. This then impacts on the amount and value of information gleaned from the reviews, to then drive forward focussed improvement. Thus we are establishing a high quality and effective mortality review process which is both trust-wide and standardised in a way that is helpful. This will also be capable of being individualised to meet the specific needs of any given speciality. We have therefore started (as of 1st October 2015) mortality peer review (MPR) where every death is reviewed by a colleague through a straightforward process which is escalated to the Mortality Review Group (MRG) as necessary and where learning and improvement is the underlying rationale. Such a process need not necessarily be cumbersome or disproportionately time-consuming. Arguably something can be learned from every patient and every death – the nature of that learning may be clinical/technical. Equally it could be about documentation, adherence to policy and best practice or indeed issues of care and compassion. This key element of clinical governance has important implications for quality of care, death certification and clinical coding and will form the basis for key improvement work which incorporates the care of the acutely unwell patient as well as end-of-life care (and thus the other elements of this action plan detailed below). We are making good progress in developing a process that is robust. The MRG is developing into an effective multidisciplinary group, with a strong medical presence, chaired by Dr Phil Cantrell, in her role as Associate Medical Director: Quality Governance, within the new Medical Cabinet. We have developed a NW mortality review network to enable the share and spread of good practice in this area.

2. Focussed Reviews

The following reviews, which have been identified as a priority, are in progress. Oversight is provided by the Mortality Review Group.

- Review the care of a sample of patients who died after being admitted at the weekend, and those discharged at the weekend. The aim of this is to better understand the difference between the weekday and weekend mortality ratios, to provide assurance of the quality of care for these patients and to check the accuracy of documentation and coding.
- Review the care of a sample of patients who had an R code (signs and symptoms) as the primary diagnosis, to provide assurance of timely and accurate diagnosis, and better understand the detail behind our above average use of these codes. Early findings from this review are being used by the Clinical Information Engagement Manager to raise awareness with clinicians of the impact of documentation on coding.
- Review of SHMI out of hospital deaths, to provide assurance that the patients were safely and appropriately discharged.
- Review of the care of patients who have died, having a primary diagnosis on the WHO's list of comorbidities unlikely to cause death. The aim of this is to provide assurance of the quality of care for these patients and to check the accuracy of documentation and coding.

3. Care Pathways and Care Bundles

A care bundle is basically a checklist of evidence pertaining to a particular condition. It describes the outcomes of a complex process that the health care system must bring to bear for each patient with a particular condition. The process of implementing and then auditing a bundle provides a consistent and evidence based approach to improvement.

The Medical Director, Clinical Effectiveness Manager and Knowledge and Evidence Service Manager are working to identify key pathways for development in line with best practice. The focus is on high volume, high mortality and high HSMR and SHMI diagnoses. A successful pneumonia workshop was held in August 2015, leading to the development of a standardised care bundle for patients who present with community acquired pneumonia.

The Trust is working hard to continually achieve the existing Advancing Quality measures, and is committed to complying with the new measures of Hip Fracture, Sepsis, Acute Kidney Injury, Diabetes and Alcoholic Liver Disease. These care bundles are based on the best available evidence and in ensuring we comply with them, we continue to strive for the best available care to patients with these conditions. Workshops such as that focussing on Pneumonia are planned for all other AQ measures.

4. Management of the Deteriorating Patient

A review of the Acute Care Team has now taken place, with the outcomes being utilised to underpin the direction of development for the service.

The Acute and Critical Care of the Patient Group, renamed Acute Care Group, continues to be an effective forum, with activity including the development of a Child and Young Persons Do Not Attempt Resuscitation Policy alongside the ongoing activity of continuously improving data, for example on MET activity, transfers from Halton and deteriorating patients incidents, with service improvements following.

An external review of Critical Care has taken place, which identified some actions which are being taken forward.

5. Staffing

Like many trusts, we are working toward a number of workforce priorities to drive forward quality of care provision 7 days a week. We plan to build on previously successful international and local recruitment as well as skill mix adjustments and changes to what have, to date, been seen as traditional medical or nursing roles. Consultant Physician presence for at least 12 hours 7 days a week is being implemented as a key initiative for quality. We are working closely with Health Education North West to align training programmes to deliver roles such as Physician's Associates who may be drawn from a variety of health care backgrounds, and also with local universities to provide advanced and assistant practitioners. Additionally, in line with national drivers, we are seeking to review where 7 day working would most benefit our patients

and provide seamless care from assessment, admission and discharge. Access to senior decision-makers is especially relevant given the apparent difference in outcomes associated with a weekend admission.

6. End of Life Care

Following the retirement of the Palliative Care Nurse Consultant in March, a new post of Matron in Palliative Care has been established and was recruited to in July. This will enable the Palliative Medicine Consultant to continue to review the team structure with support of senior nursing staff. The current team has staffing vacancies and recruitment for a clinical educator is ongoing. The team participated in the pilot data collection for the Royal College of Physicians Care of the Dying adult in Hospital Biannual national audit and are in the process of collecting the data for the main audit. Results of this major national audit will not be available until May 2016 at the earliest. Members of the trust's nursing teams have attended Core Communication Skills courses and more are planned for the autumn. A number of nursing staff are also participating in the Intermediate Skills in Palliative Care 4 day programme run by St Rocco's Hospice. The Palliative Medicine Consultant is an active member of the Mortality Review Group. The bereavement data continues to be collected and fed back to wards and via the re-established End of Life Steering Group. The revised Individual Plan of Care for the Last Days of Life is nearing completion and should be available for wards to utilise in the next couple of months along with associated training updates. End of life care reports through the Clinical Effectiveness Sub-Committee.

7. Documentation and coding

There is opportunity to further develop the relationship between medics and coders, so that they can jointly better understand the impact of how they document and then code this information. The new Clinical Information and Engagement Manager is already developing strong links with the Clinical Effectiveness Team and Medics for example via the Mortality Review Group.

The Trust has an above average use of ‘signs and symptom’ codes, the detail of which is provided on pages 10 and 11 of this report. The DIGG lead for Unscheduled Care is aware of this issue and is working with colleagues to address this. A review into a sample of cases is underway and will identify any issues regarding patients’ care and any areas for improvement.

NEXT STEPS

The Clinical Effectiveness Sub-Committee (unless otherwise stated) will monitor progress against the actions identified and report to the Quality Committee.

RECOMMENDATIONS

Close monitoring of crude deaths rates and mortality ratios will continue, and progress against identified actions will be monitored. It is recommended that the Trust Board receive a quarterly mortality report. All deaths are now subject to mortality peer review and compliance with this process is reported. In the interests of continuous improvement such a report, and the processes underpinning it, shall be monitored closely to ensure that is provides the most useful information from board to ward.

CONCLUSION

The Board is asked to note the contents of the report and discuss and approve the recommended options.

Acknowledgements:

All charts with AQuA Analytics stated in the top right corner of the chart were produced by the Advancing Quality Alliance and are taken from the latest quarterly report detailed in the references section. Sections of text from AQuA's quarterly report have also been used in this report, with thanks.

References:

Advancing Quality Alliance (March 2012) Blackpool Teaching Hospitals NHS Foundation Trust: Mortality Review. Initial Findings and Recommendations
http://www.bfwh.nhs.uk/about/performance/docs/AQuA%20Mortality%20report%20for%20Blackpool%20FINAL%20March%202012.pdf

Morgan, Dr. RJM, (December 2014) Blackpool Teaching Hospitals NHS Foundation Trust: Health Scrutiny Report (presentation)
http://democracy.blackpool.gov.uk/documents/s3534/Appendix%204a%20mortality%20presentation.pdf

Advancing Quality Alliance (September 2015) Warrington Hospitals NHS Foundation Trust: Quarterly Mortality Report: Issue 9, September 2015

Advancing Quality Alliance (May 2013) Reducing In-Hospital Mortality: Observations arising from AQuA's work.

Appendix 1: AQuA Mortality Report – please see following pages

Quarterly Mortality Report

Report No. 09

September 2015

Edition p repared for:

Warrington and Halton Hospitals NHS Foundation Trust

Author: Paul Hawgood

Version: 1.0

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AQuA Quarterly Mortality Report, Issue 09 Version 1.0 1st September 2015

INTRODUCTION

This is the eighth quarterly report on Mortality produced by AQuA Analytics for the benefit of its members.

The report provides information on mortality rates, quality of care indicators and system/process measures that may affect the quality of care. The report does focus on the data, however, this is only one part of understanding the issues that may affect a Trust's mortality rate. They are an indicator, a sign-post, a prompt to looking at the wider system issues; these issues and themes are explored in detail in AQuA's Mortality Lessons Learned publication (May 2013).

Many of the indicators contained within this report relate to Standardised Mortality Ratios. There are several different methodologies available for the calculation of these ratios – see Appendix A for a summary of the differences between the three main methodologies. Throughout this report, data relating to the Summary Hospital-level Mortality Indicator [SHMI] has been used. This is because this methodology is used and published by the NHS Health and Social Care Information Centre [HSCIC].

This report is set out in four sections:

- Section 1 compares the North West with other regions of England.
- Section 2 looks at the differences in data for the 22 Trusts in the North West for which the NHS HSCIC produces a SHMI.
- Section 3 provides more detailed information for your trust.
- Section 4 focuses on a particular subject. This quarter it weekend mortality.

Some inferences and conclusions have been drawn from the data, however, this needs to be set in the context of the wider health-economy. AQuA has a rolling programme of Mortality Reviews in order to support the understanding of issues surrounding mortality and the quality of care provided in a Trust and the health economy that it serves. Detailed trust-level analysis and inferences are best placed within this programme.

This report has been prepared following the publication of the SHMI for the period October 2013 to September 2014; Appendix B details the metadata for the information contained within this report.

SECTION 1 – The North West

1.1 Crude Mortality Rate

The North West has the third lowest crude in-hospital mortality rate in England with a rate that is similar to the overall rate for England – see chart 1. The rates for both England and the North West had been reducing over the past few years and now stand at around 2.2% – see chart 2.

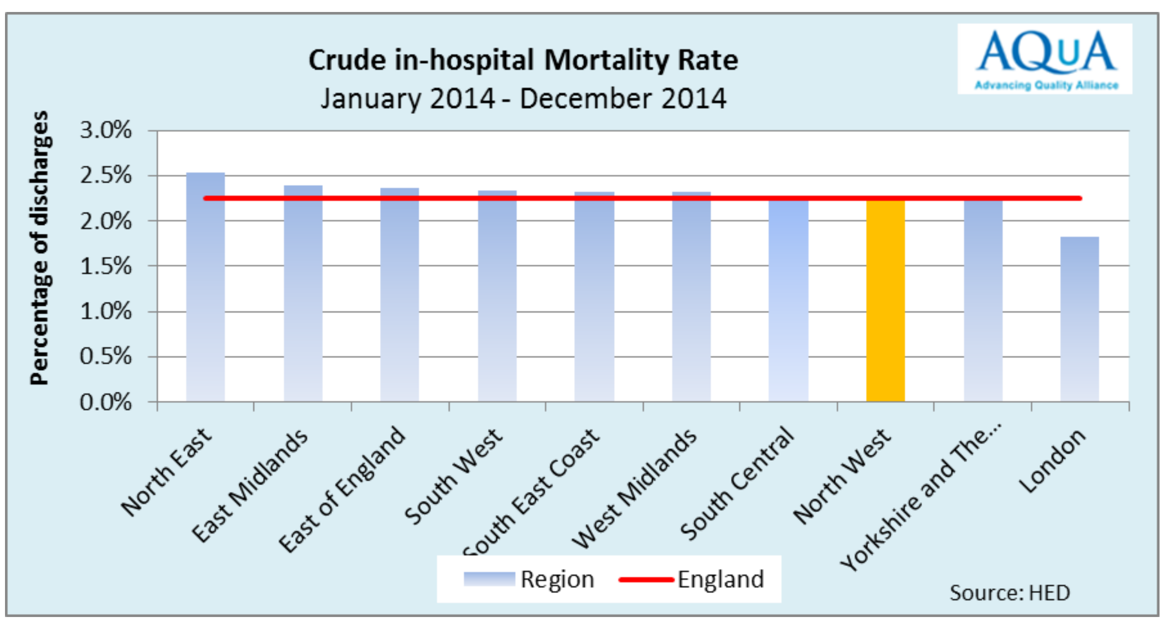


Chart 1 – crude in-hospital mortality rate

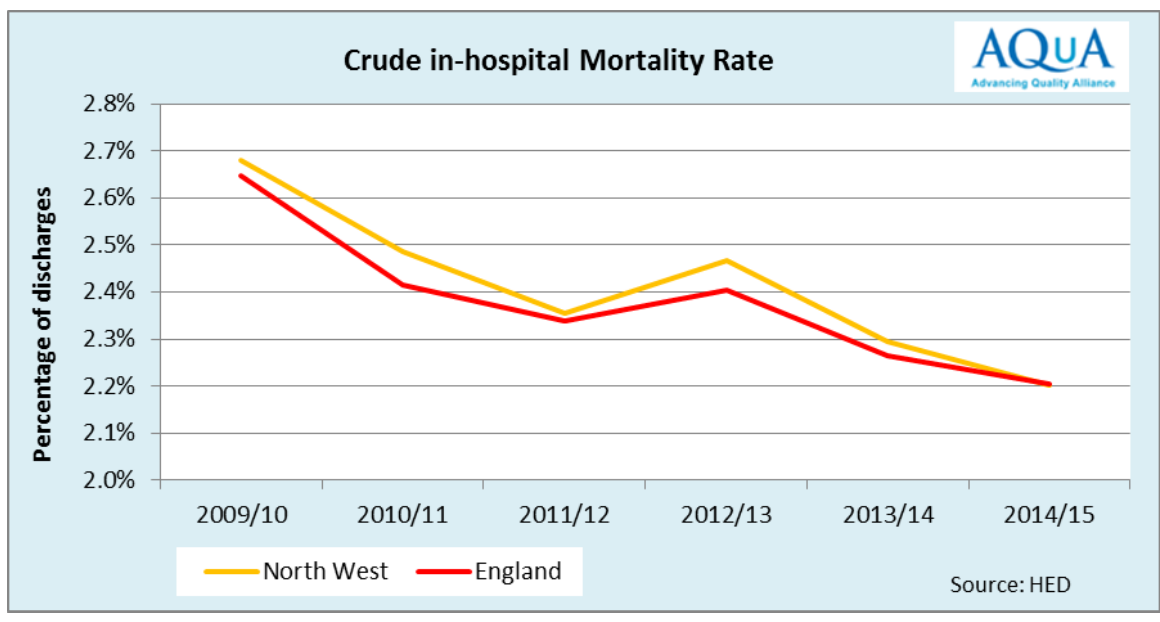


Chart 2 – crude in-hospital mortality rate time-series

Across the former SHAs, crude mortality rates for non-elective [NEL] activity are between four and a half and eleven and a half times higher than for elective [EL] activity; the crude NEL mortality rate for England being 2.6% and the crude EL mortality rate for England being 0.4% (seven times higher) – see chart 3. For deaths occurring within 30 days of discharge, there is a five-fold difference between those following a non-elective admission and those following an elective admission [1.1% and 0.2%, respectively] with less regional variation (three to six and a half fold difference). When reviewing the underlying causes of high(er) mortality rates, it would, therefore, be beneficial to explore pathways relating to emergency care.

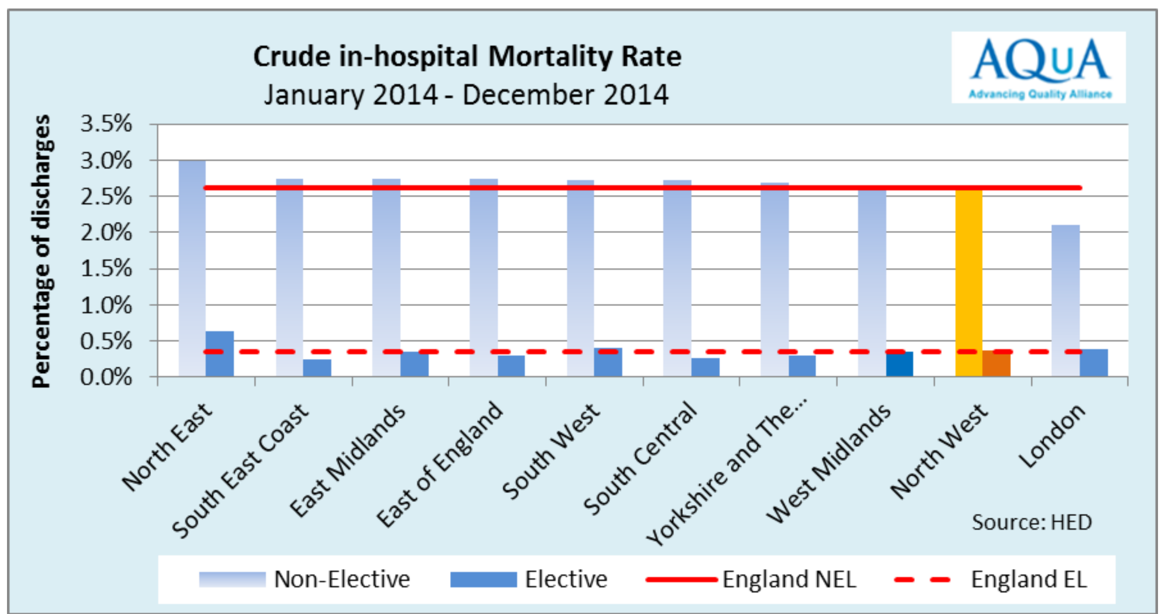


Chart 3 – crude in-hospital mortality rate, NEL & EL split

1.2 SHMI

This report does not aim to describe the SHMI methodology in detail, nor to compare the SHMI methodology to other methodologies e.g. HSMR. Appendix A shows a summary of the differences between the three main methodologies and further information is available from AQuA Analytics.

Although the North West has a crude mortality rate that is very similar to the England rate, it has the second highest SHMI [1.05] – see chart 4a. In essence, this means that, given our demographic make-up, the case-mix that we treat and the other illnesses that our patients have, it is to be expected that our crude rate would be lower than it is.

A regional SHMI is, of course, constructed from its constituent trusts. Chart 4b is a funnelplot chart showing the position of each of our trusts alongside all trusts in England. This chart shows the Upper and Lower Dispersal Limits which are used to determine the SHMI band that each trust is in – see Section 4 for more detail on these bandings and Chart 11 for a version showing trust codes.

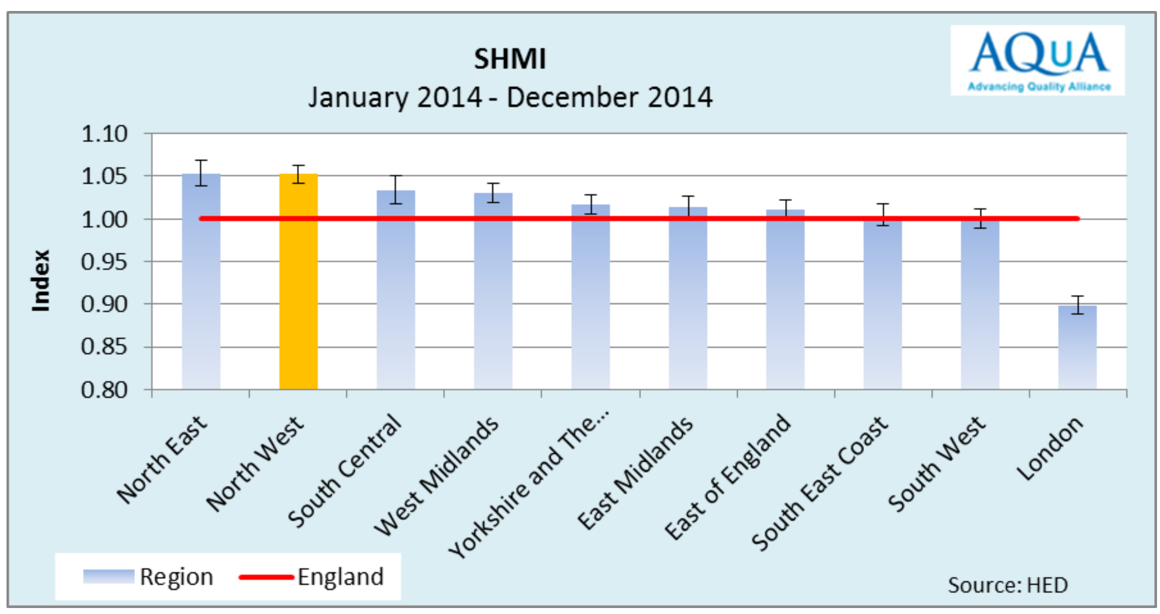


Chart 4a – latest SHMI

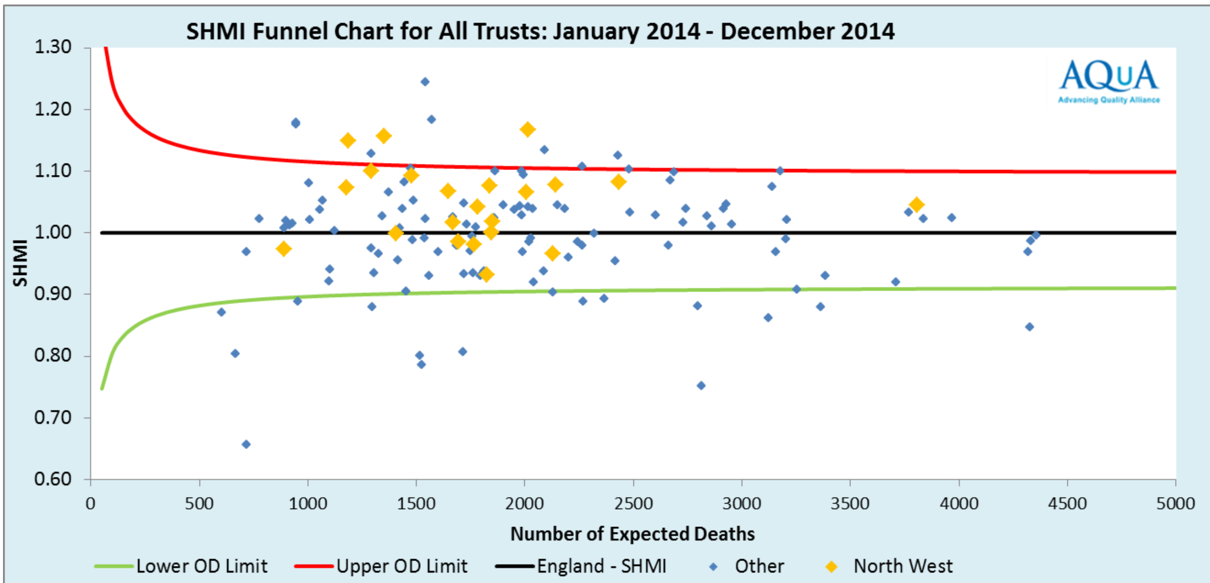


Chart 4b – latest SHMI Funnel Plot

The SHMI for the North West had been worsening since the indicator was first published for the period April 2010 to March 2011 until the period October 2011 to September 2012 - see chart 5. Small improvements have then been observed in each of the subsequent five releases of SHMI with a 'levelling off' in the latest five releases.

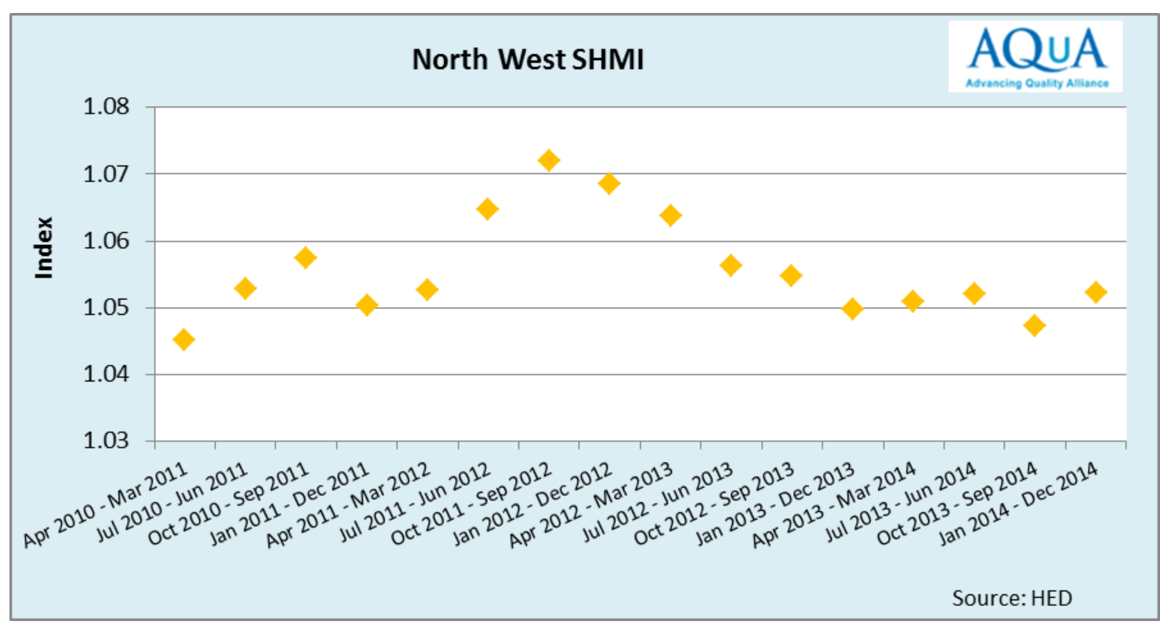


Chart 5 – NW SHMI time-series

As shown in chart 2, the crude mortality rate for the North West has been falling but no faster than it is for England. The SHMI is a relative-risk model centered around England having a value of 1.00 for each publication. The fact that our SHMI had been increasing over time [against a back-drop of a reducing crude mortality rate] means that the SHMI-constructed risk model was expecting relatively fewer deaths in the North West each time the SHMI was published and that our reduction in Observed deaths was not keeping pace with the reduction in Expected deaths.

Factors that affect this risk model such as Signs and Symptoms coding and levels of comorbidity are described later in the report.

The impact of the modelling is illustrated further in chart 6. The number of Observed deaths had been reducing but not as quickly as the number of Expected deaths [first pair of green arrows], hence a rise in the SHMI. During 2012, there was a reverse in the trend of Observed deaths with increases being seen in each release of SHMI betwwen April 2011 – March 2012 and July 2012 – June 2013.

A time lag of two periods in the increase of the number of Expected deaths casued the SHMI to continue to rise but since then [October 2011 – September 2012] the rate of increase in the Expected number of deaths has been higher than the rate of increase in the number of Observed deaths [blue arrows], hence a reduction in the North West's SHMI.

Following this was a 'third phase' with a return to reducing Observed and Expected values [second pair of green arrows]. The Observed number of deaths was falling faster than the Expected number of deaths and, consequently, our SHMI continued its downward trend. In the previous three SHMI releases there has been an increase in the number of Expected deaths and in the number of Observed deaths. As the rate of increase in the Expected number of deaths has been higher than the rate of increase in the number of Observed deaths this has led to a continued reduction in the North West SHMI.

We now appear to be entering a 'fourth phase' with increases in both the number Observed and Expected deaths; Observed increasing at a slightly higher rate which has resukted in a small increase in the latest North West SHMI.

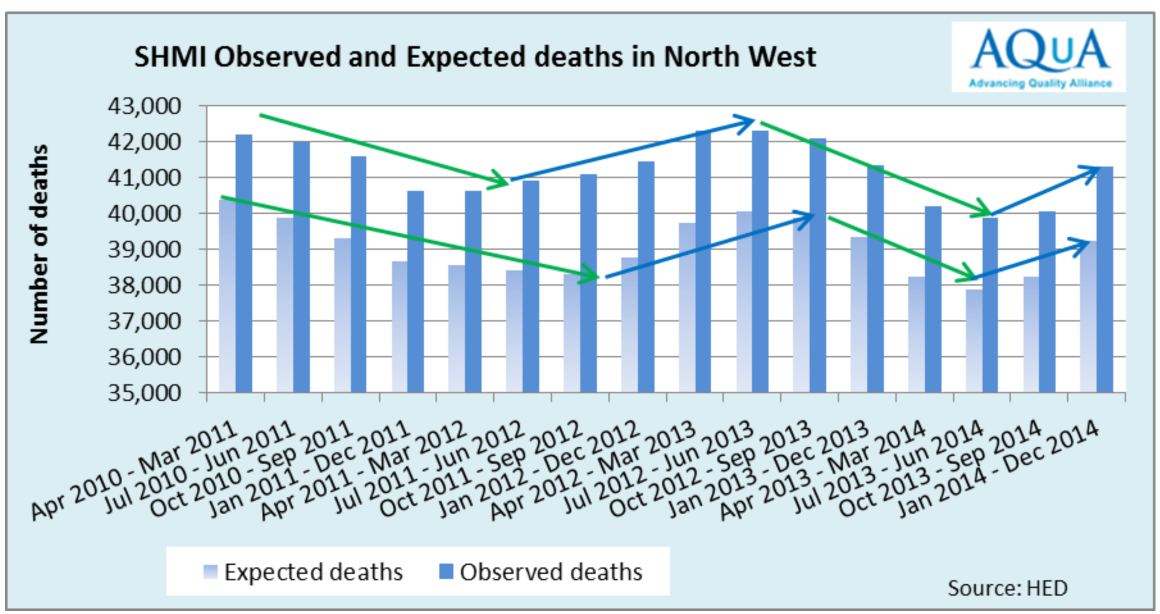


Chart 6 – NW SHMI Observed & Expected deaths

1.3 SHMI – proportion of deaths that occur in-hospital

The SHMI is calculated using deaths that occurred in-hospital and those that occurred within 30 days of discharge. Chart 7 shows the proportion of the total number of deaths that have occurred in-hospital. Low levels of in-hospital deaths could be due to several factors including patients being discharged too early and high levels of nursing, residential and hospice care. The North West has a similar rate to the England average. This topic was covered in more detail in Section 4 of Issue 07.

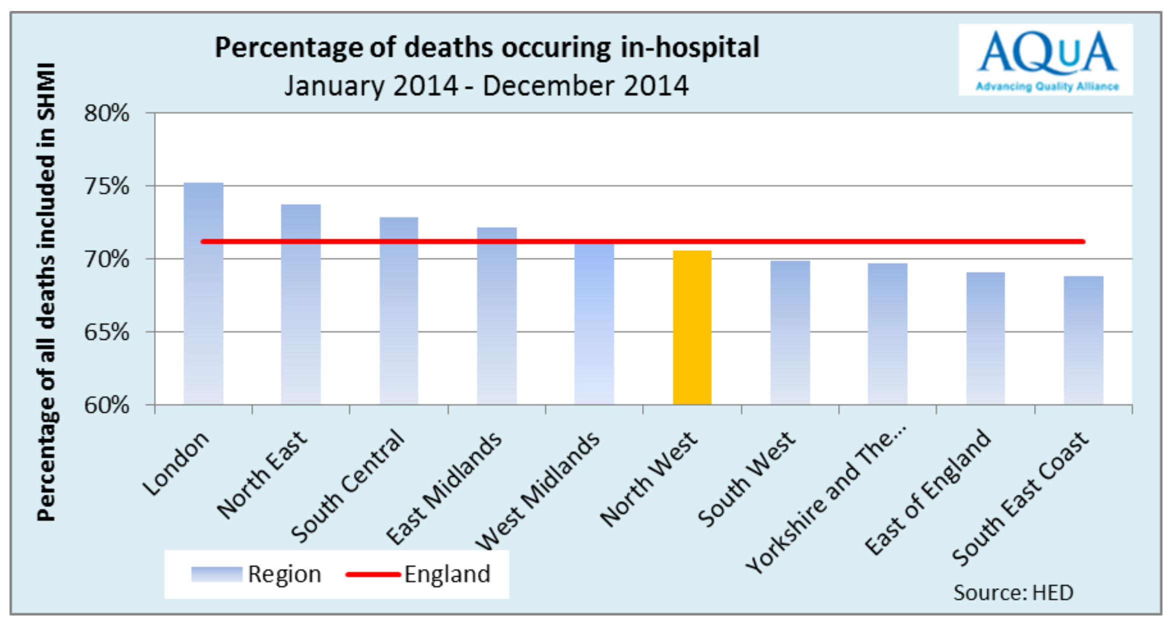


Chart 7 – Percentage of deaths occurring in-hospital

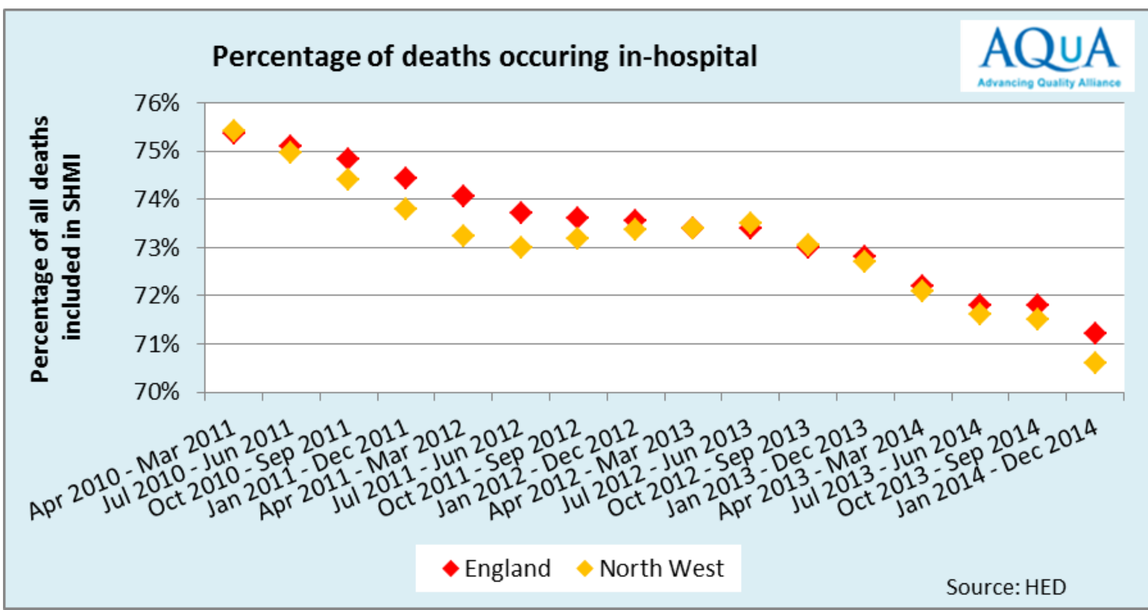


Chart 8 – Percentage of deaths occurring in-hospital time-series

SECTION 2 – Trusts in the North West

2.1 Crude Mortality Rate

Based upon the latest published SHMI data, crude in-hospital mortality rates in North West hospitals varies from 1.3% to 3.1% - a two-fold difference – see chart 9.

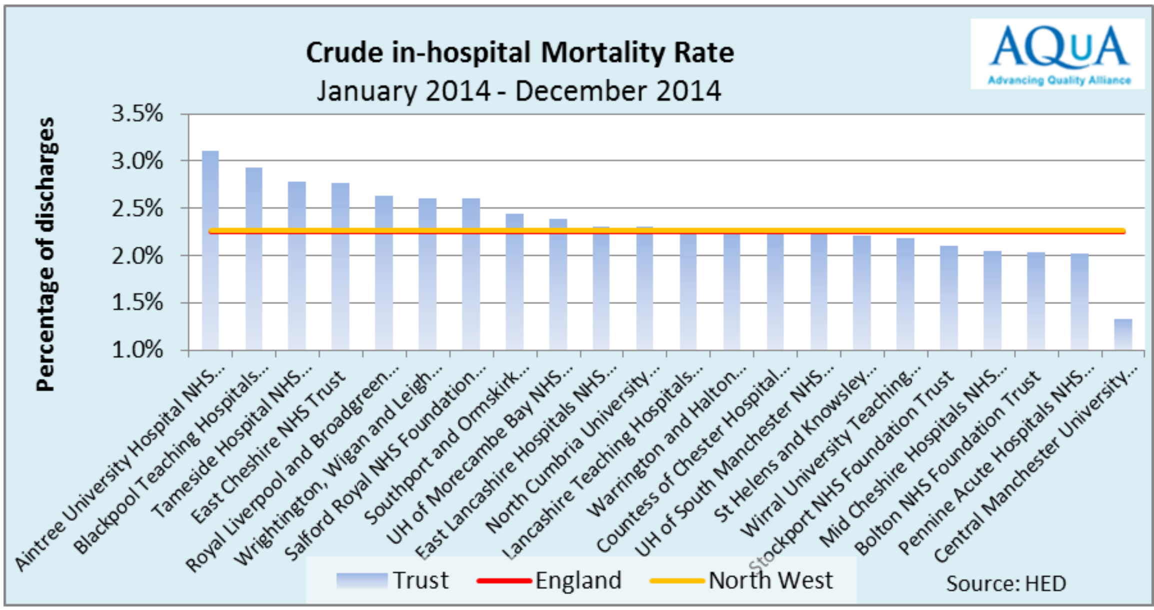


Chart 9 – crude in-hospital mortality rate by trust

There is a similar degree of variance for in-hospital deaths for non-elective admissions – from 1.5% to 3.7% - see chart 10. Although crude rates are a useful starting point in understanding the situation regarding a trust's mortality, direct comparisons between trusts should be treated with caution due to potential differences in case-mix and the age-profile of the patients treated. Case-mix variables may be subtle or as fundamental as either not providing a relatively low-risk service [e.g. paediatrics] or of providing a relatively high-risk service [e.g. sub-regional trauma centre] (both examples having the effect of increasing the crude rate). These are, of course, some of the very differences that standardised rates adjust for.

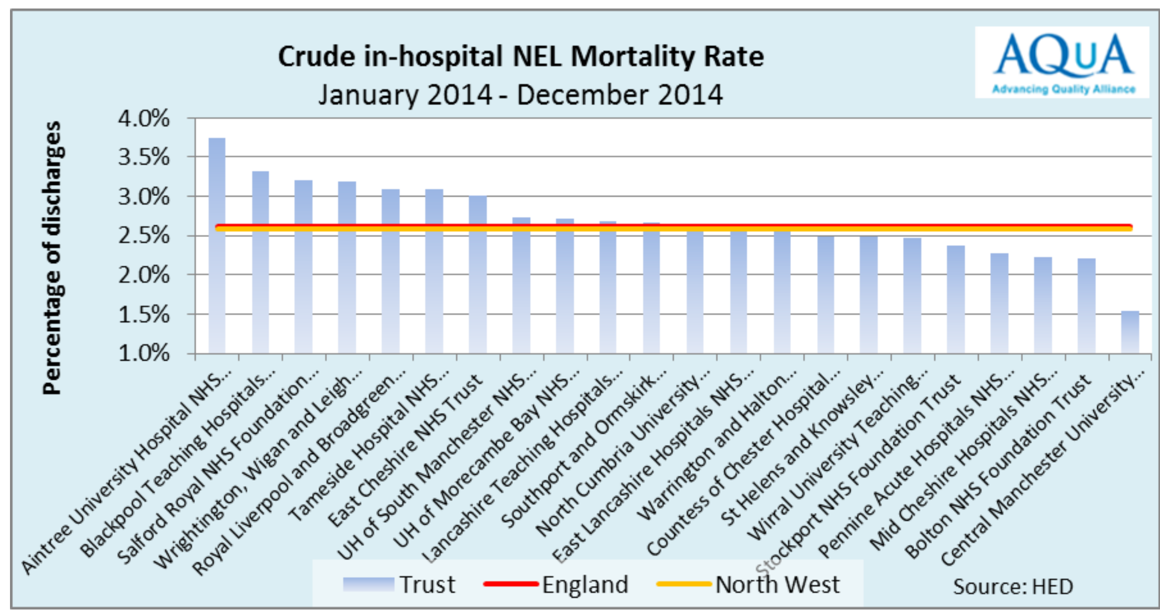


Chart 10 – crude in-hospital NEL mortality rate by trust

2.2 SHMI

Chart 11 shows a funnel-plot chart of the latest SHMI for the 22 Trusts in the North West of England The red (upper) and green (lower) lines show the limits beyond which variance is deemed to be statistically significant and unlikely to be due to random variation [chance]. Trusts within the range of red and green lines / control limits fall within Band 2 – "As expected"; trusts below the lower control limit fall within Band 1 – "Lower than expected" and trusts above the upper control limit fall within Band 3 – "Higher than expected". Beyond the three bandings, there is no inference to be taken from different SHMI values.

Appendix C provides lookup between three digit code to the Trust name.

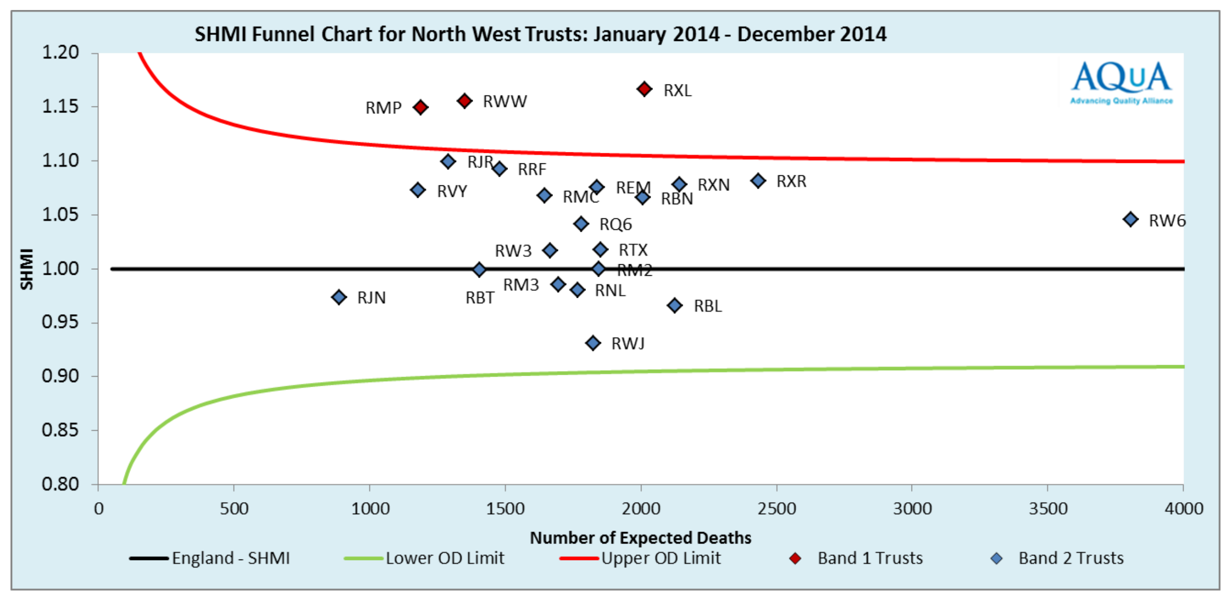


Chart 11 – latest SHMI by trust

2.3 Palliative Care coding

The Health and Social Care Information Centre releases contextual information alongside the SHMI – one of these domains is Palliative Care. A patient can be deemed to have received Palliative Care by virtue of Specialty Code 315 being present in any other their episodes or by having ICD10 Code Z515 in any diagnosis in any episode. The charts below [12 and 13] show the rate of coding where either the Specialty Code or the Diagnosis Code is present during the Spell; chart 12 is for all patients and chart 13 is where the patient died.

As can be seen, there is quite a variance in the levels of the recording of Palliative Care. This variance is repeated nationally and is one of the main reasons why Palliative Care is not adjusted for in SHMI.

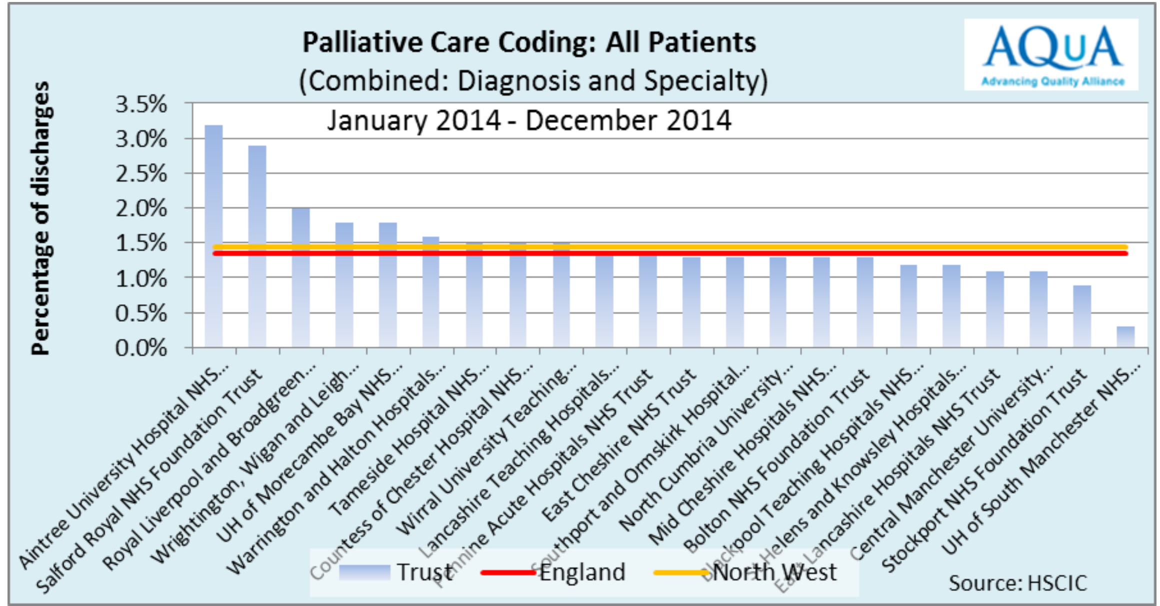


Chart 12 – Palliative Care coding by trust, all patients

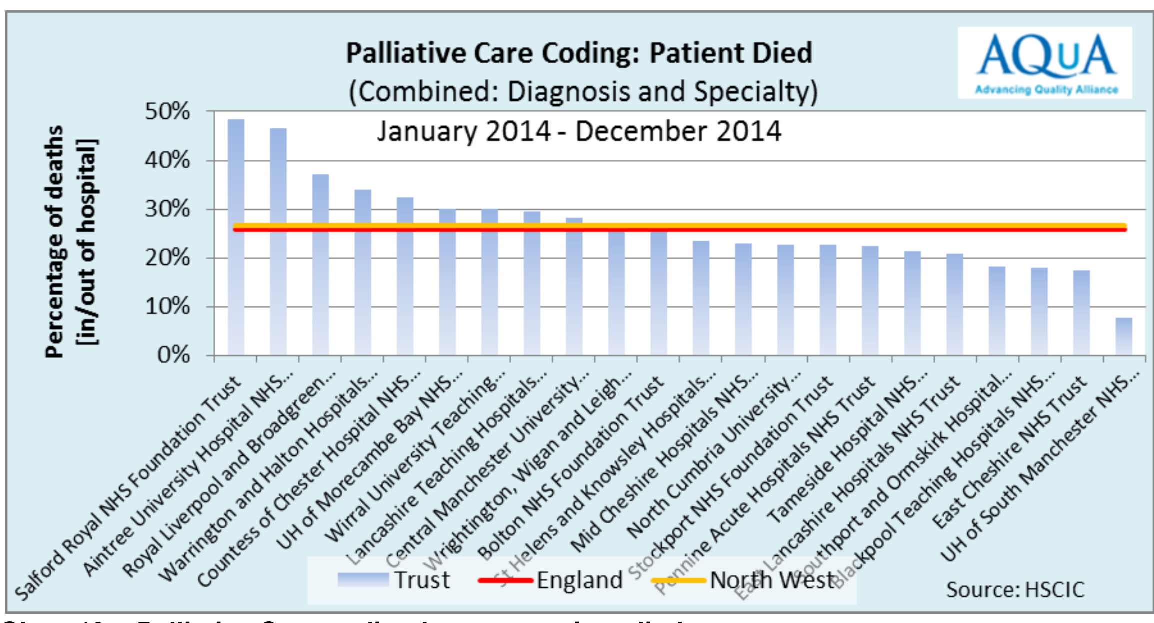


Chart 13 – Palliative Care coding by trust, patient died

2.4 Signs and Symptoms coding

The level of Signs and Symptoms coding [R codes] is important because it has inferences on the quality of care and has an impact on the calculations used to create the SHMI.

High levels of R codes may imply lower access to senior medical opinion and later commencement of appropriate treatment. If R codes remain as the primary diagnosis through the first few episodes of a patient's pathway then this could be indicative of multiple hand-overs within a short period of time i.e. during the period of diagnostic investigation.

R codes remaining as the primary diagnosis for the first two episodes affects the calculation of the SHMI, often in an adverse way. SHMI uses the primary diagnosis of the first episode to assign the CCS Group of that admission. If the primary diagnosis of the first episode is an R code then the primary diagnosis of the second episode is used. However, should the diagnosis of the second episode also be an R code then SHMI will revert back to the first episode's primary diagnosis.

The CCS groups that R codes map to have relatively low mortality rates and, therefore, low numbers of expected deaths. If a trust has a high level of R coding then it is more likely to have a higher level of deaths with an R code as the primary diagnosis (first and second episode).

Chart 14 shows the general use of R Codes – there is a two-fold difference between the trust with the highest usage of R codes in the primary diagnosis [21%] (all episodes of a Spell where the first episode was non-elective) and the trust with the lowest [11%].

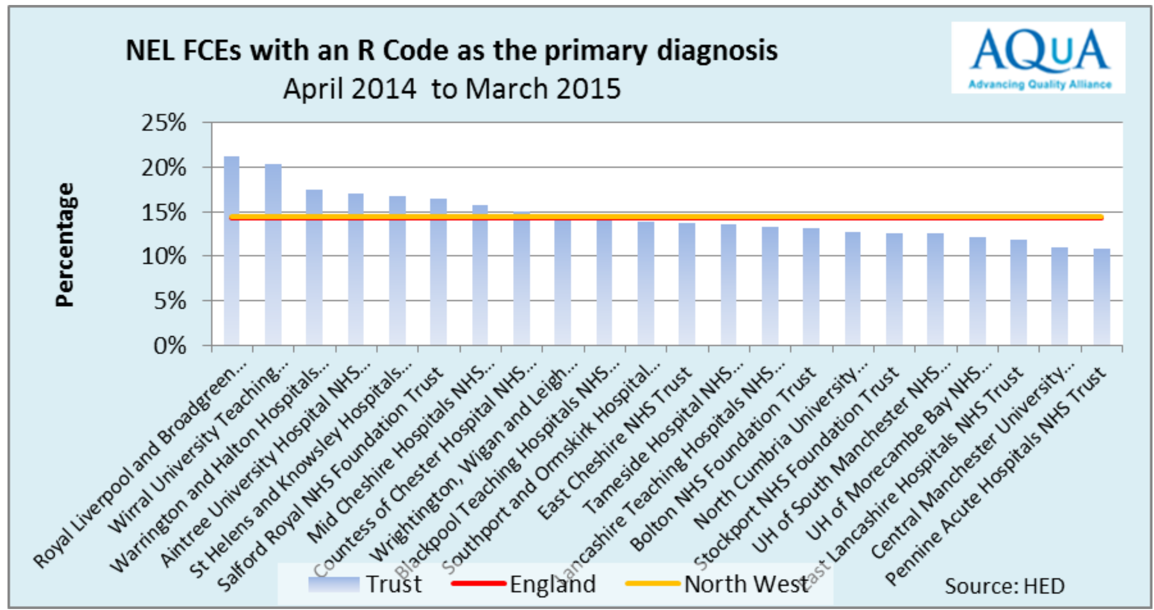


Chart 14 – Signs & Symptoms coding by trust, NEL, all episodes, all patients

Chart 15 shows the use of R Codes in the first episode – here, there is more than a two-fold difference between the trust with the highest usage of R codes in the primary diagnosis [27%] and the trust with the lowest [12%].

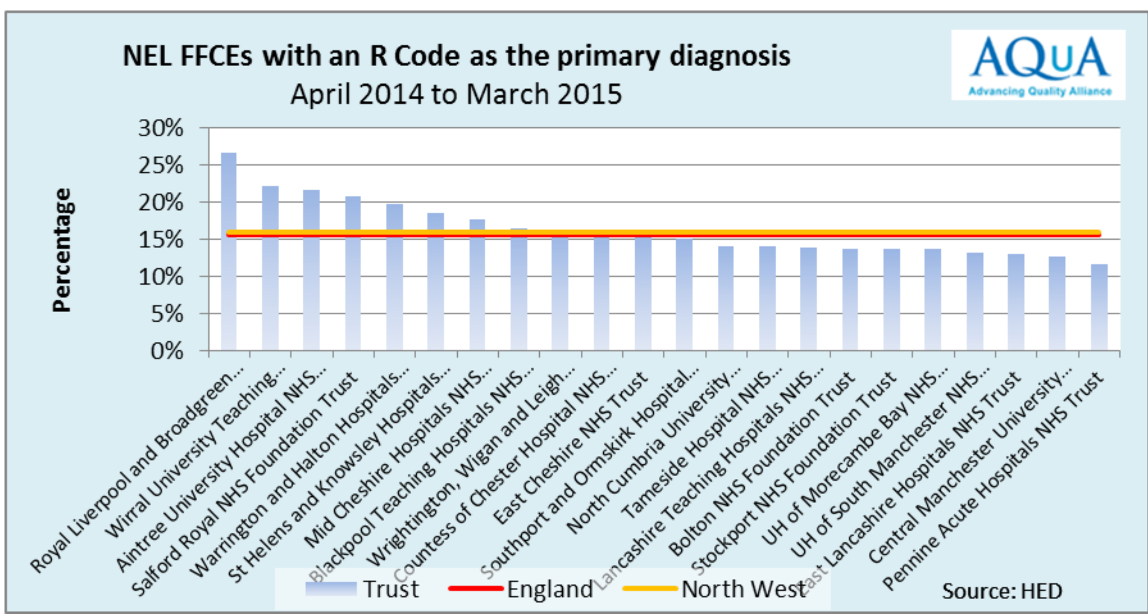


Chart 15 – Signs & Symptoms coding by trust, NEL, first episode, all patients

The number of expected deaths for a trust is calculated on all discharges so, whilst the data shown in Chart 16 has no greater effect on the SHMI than the data shown in Chart 16 [indeed, the patients reported in chart 16 will also have been reported in charts 14 & 15] higher levels of patients who died and had an R Code as their primary diagnosis in the last episode of their care might warrant further investigation. In this area, a much greater variance between trusts is observed [from 0.3% to 3.1%].

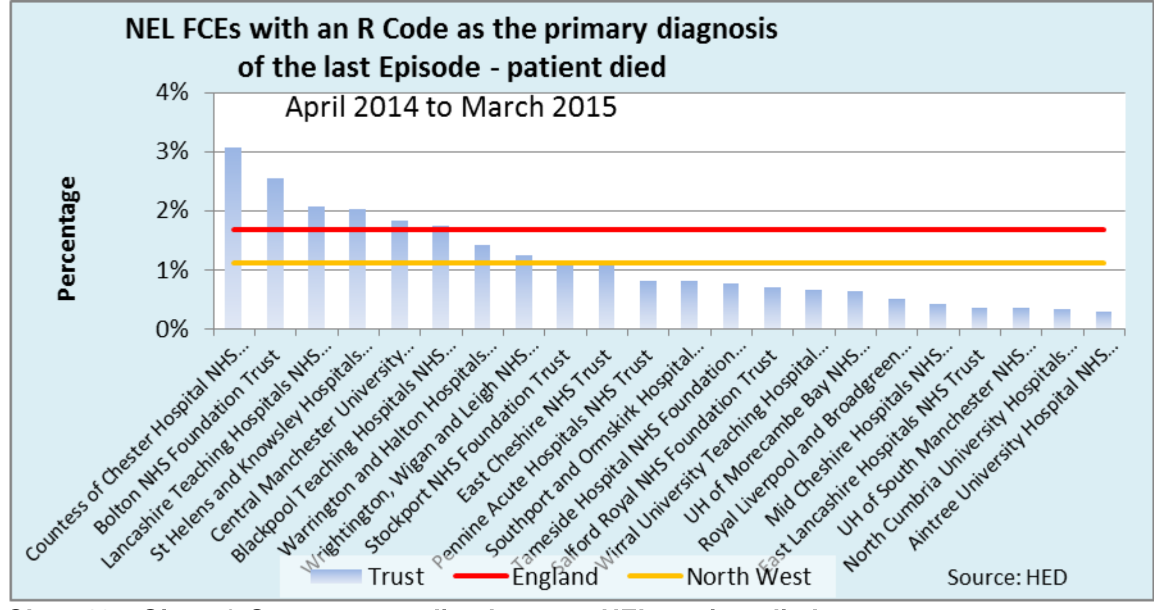


Chart 16 – Signs & Symptoms coding by trust, NEL, patient died

2.5 Co-morbidity

Levels of coding are important for several reasons. Accurate and comprehensive recording of co-morbidities will better reflect the state of health of the patients that the trust is treating. Lower levels may be due to:

- this information not being recorded by the clinician in the patient's notes
- this information not being recorded clearly enough
- this information not being recorded fully on the Trust's PAS ☐healthier patients

Levels of co-morbidity are used in both the SHMI and HSMR. A relatively high level of comorbidity increases the expected number of deaths in these calculations and so has the effect of reducing the standardised mortality ratio.

Comparative levels of co-morbidity are arrived at using the Charlson Co-morbidity Index. This Index assigns a weighting to 17 different conditions – the higher the weighting, the higher the perceived impact of that co-morbidity on a patient's risk of dying. A full list of these conditions, their weighting and the underlying ICD10 codes used are available on request from AQuA Analytics.

For non-elective episodes, there is a fair range of average Charlson values per episode* between trusts in the North West [from 2.3 to 4.7] – see chart 17. This may be a reflection of the relative health of the population that each trust serves but it could also reflect more comprehensive coding processes.

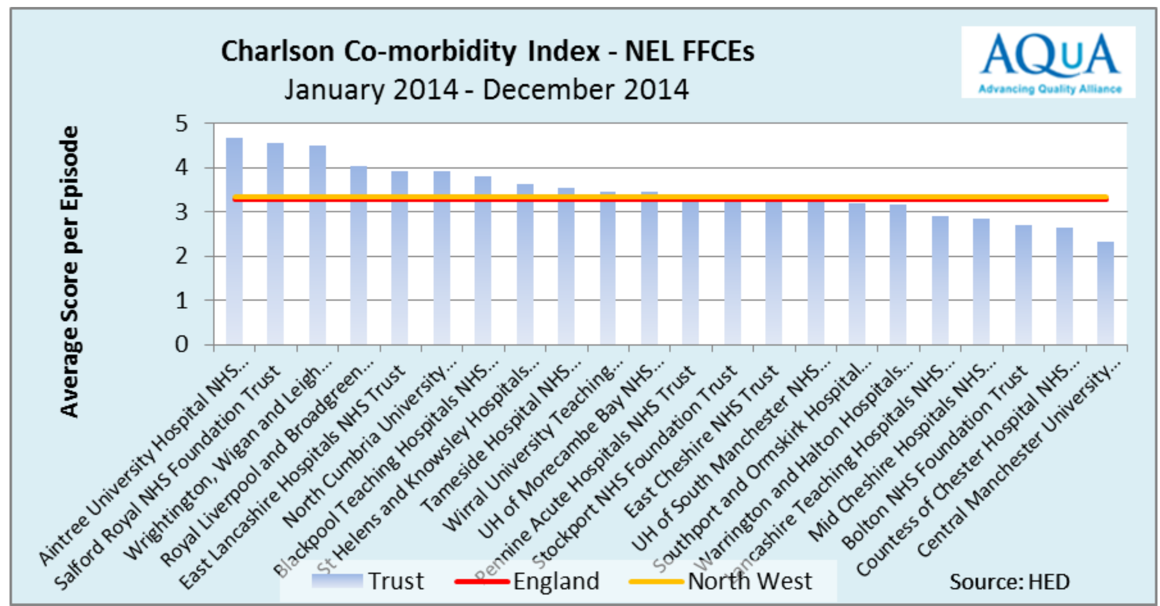


Chart 17 – Co-morbidity score by trust, NEL

The HSCIC SHMI Technical Working Group are currently reviewing options for adjusting for co-morbidity, including the adoption of the Elixhauser Index.

* This data shows the Index Score for the first episode only as, in the vast majority of cases, it is the score for this episode that is used in the SHMI calculation.

SECTION 3 – Your Trust

This section shows information for your Trust. The *North West* edition of this report is not specific to any particular trust; there is, therefore, no data to show in the "Trust" row of the tables below.

The data relates to the same domains as in Section 2 but shows a time-series in order to show whether areas are showing improvement or deterioration.

Trust Name	Warrington and Halton Hospitals NHS Foundation Trust
Trust Code	RWW

3.1 Crude Mortality Rate

Fin. Year	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Trust	**2.39%**	**2.25%**	**2.17%**	**2.34%**	**2.18%**	**2.24%**
North West	2.68%	2.49%	2.36%	2.47%	2.30%	2.20%
England	2.65%	2.41%	2.34%	2.40%	2.27%	2.21%

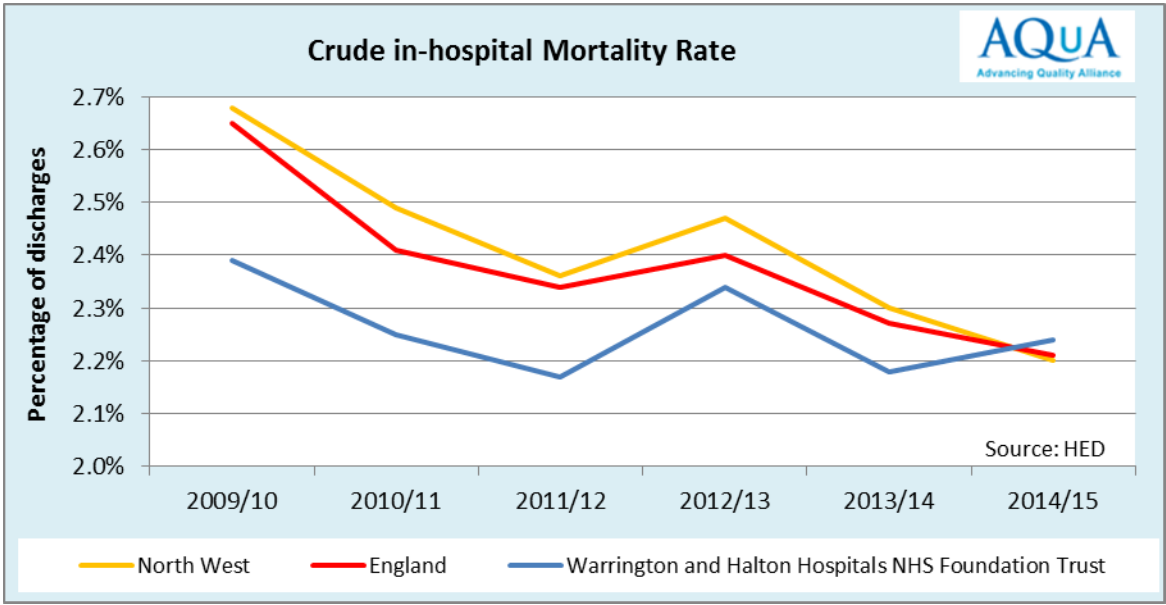


Chart 18 – trust crude in-hospital mortality rate time-series

3.2 SHMI

Period	Apr 10 - Mar 11	Jul 10 - Jun 11	Oct 10 - Sep 11	Jan 11 - Dec 11	Apr 11 - Mar 12	Jul 11 - Jun 12	Oct 11 - Sep 12	Jan 12 - Dec 12
Trust	**1.02**	**1.02**	**1.03**	**1.05**	**1.07**	**1.10**	**1.11**	**1.11**
North West	1.05	1.05	1.06	1.05	1.05	1.06	1.07	1.07

Period	Apr 12 - Mar 13	Jul 12 - Jun 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 – Jun 14	Oct 13 - Sep 14	Jan 14 - Dec 14
Trust	**1.13**	**1.12**	**1.10**	**1.09**	**1.08**	**1.09**	**1.11**	**1.16**
North West	1.06	1.06	1.06	1.05	1.05	1.05	1.05	1.05

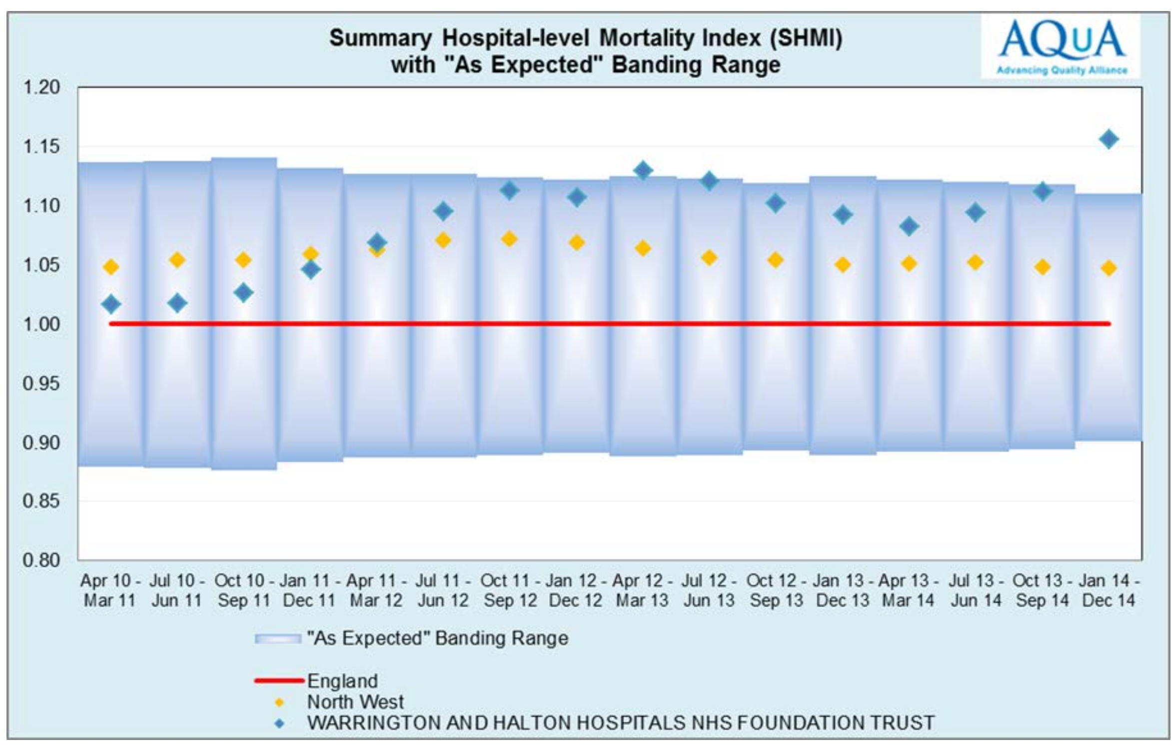


Chart 19 – trust SHMI time-series

3.3 Palliative Care Coding

The first table and chart relate to all patients admitted; the second table and chart relate to patients that died.

Period	Apr 10 - Mar 11	Jul 10 - Jun 11	Oct 10 - Sep 11	Jan 11 - Dec 11	Apr 11 - Mar 12	Jul 11 - Jun 12	Oct 11 - Sep 12	Jan 12 - Dec 12
Trust	**0.5%**	**0.5%**	**0.5%**	**0.4%**	**0.4%**	**0.5%**	**0.6%**	**0.8%**
North West	0.89%	0.87%	0.88%	0.95%	0.92%	0.95%	1.00%	1.04%
England	0.89%	0.88%	0.91%	0.95%	0.99%	1.02%	1.04%	1.06%

Period	Apr 12 - Mar 13	Jul 12 - Jun 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 – Jun 14	Oct 13 - Sep 14	Jan 14 - Dec 14
Trust	**0.9%**	**1.1%**	**1.2%**	**1.3%**	**1.4%**	**1.5%**	**1.6%**	**1.6%**
North West	1.23%	1.24%	1.28%	1.31%	1.36%	1.38%	1.42%	1.44%
England	1.12%	1.14%	1.18%	1.22%	1.27%	1.29%	1.31%	1.34%

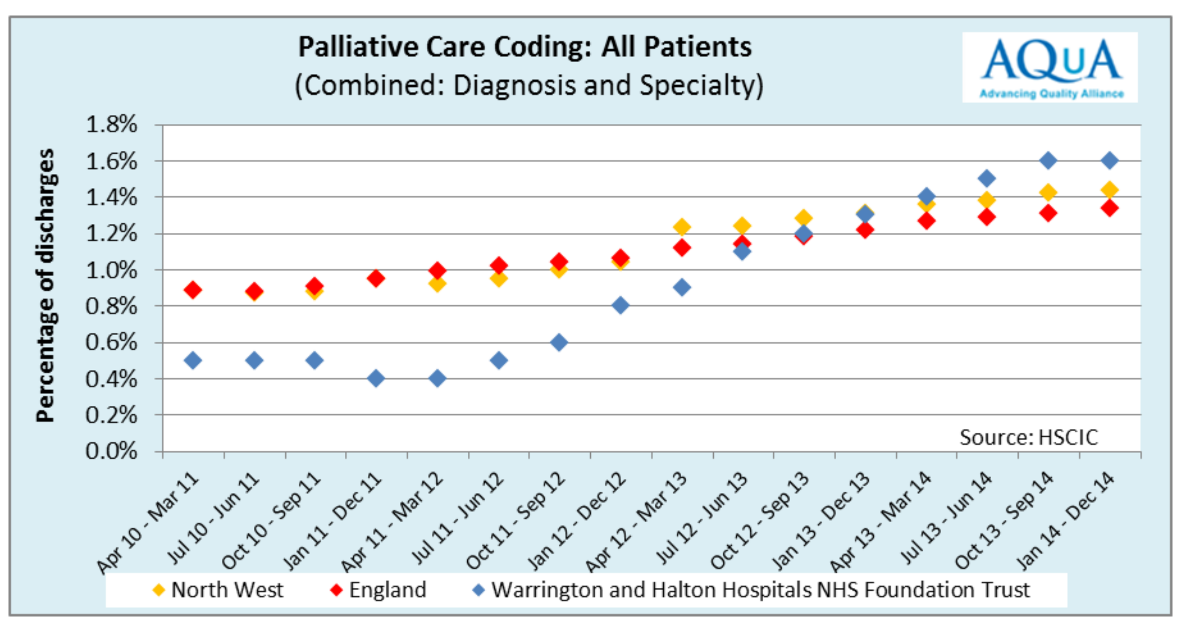


Chart 20 – trust Palliative Care coding time-series, all patients

Period	Apr 10 - Mar 11	Jul 10 - Jun 11	Oct 10 - Sep 11	Jan 11 - Dec 11	Apr 11 - Mar 12	Jul 11 - Jun 12	Oct 11 - Sep 12	Jan 12 - Dec 12
Trust	**9.6%**	**9.1%**	**8.9%**	**8.2%**	**7.9%**	**9.1%**	**11.6%**	**14.4%**
North West	16.4%	15.9%	15.7%	15.8%	16.7%	17.1%	18.1%	18.7%
England	16.6%	16.0%	16.4%	17.2%	17.9%	18.4%	18.9%	19.1%

Period	Apr 12 - Mar 13	Jul 12 - Jun 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 – Jun 14	Oct 13 - Sep 14	Jan 14 - Dec 14
Trust	**17.2%**	**18.9%**	**19.9%**	**22.8%**	**27.7%**	**30.4%**	**33.5%**	**33.8%**
North West	21.3%	21.4%	22.0%	22.9%	24.4%	25.4%	26.2%	26.6%
England	19.9%	20.2%	20.9%	22.0%	23.6%	24.6%	25.3%	25.7%

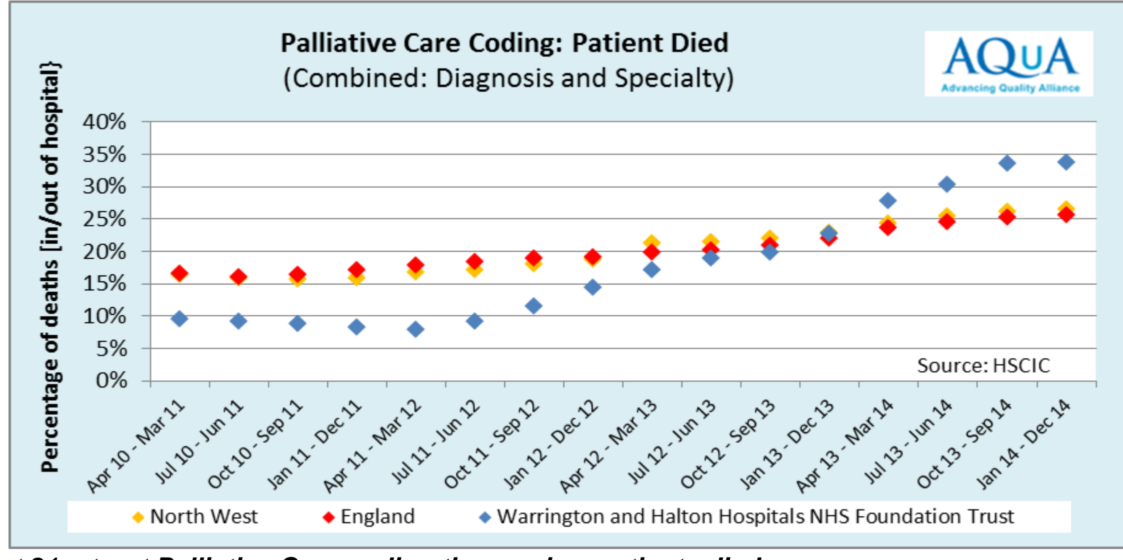


Chart 21 – trust Palliative Care coding time-series, patients died

3.4 Signs and Symptoms coding All

non-elective FCEs.

Fin. Year	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Trust	**18.8%**	**18.5%**	**18.2%**	**18.7%**	**18.2%**	**16.8%**	**17.6%**
North West	18.6%	18.1%	17.8%	17.3%	16.2%	15.5%	14.4%
England	16.1%	15.8%	15.6%	15.1%	14.8%	14.6%	14.2%

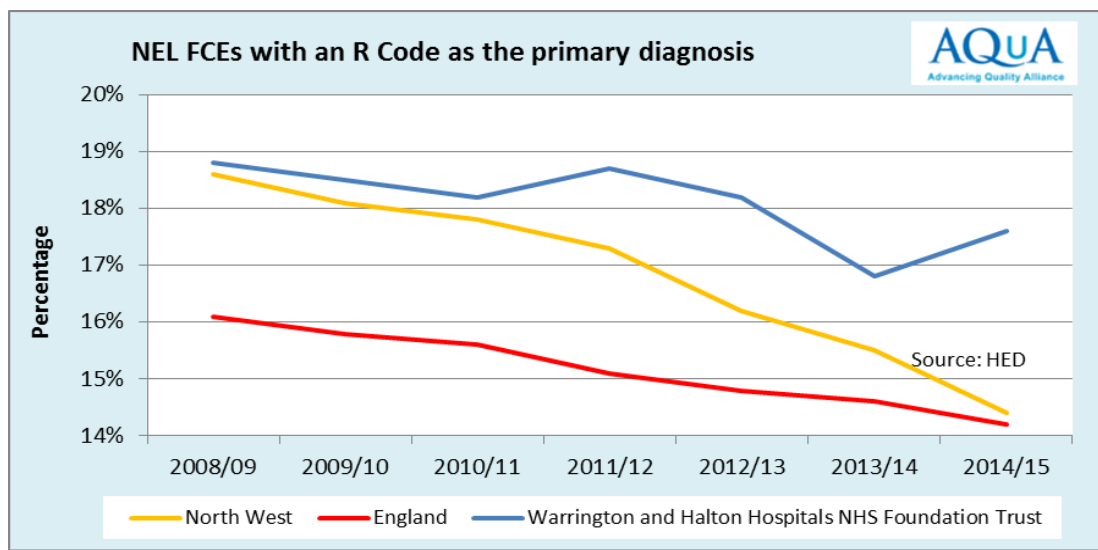


Chart 22 – trust Signs & Symptoms coding time-series, NEL, all patients First Episode of the non-elective Spell.

Fin. Year	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Trust	**20.1%**	**19.8%**	**19.6%**	**20.4%**	**20.0%**	**18.6%**	**19.7%**
North West	19.4%	19.1%	18.8%	18.4%	17.4%	17.0%	15.9%
England	17.0%	16.5%	16.5%	16.0%	15.9%	16.0%	15.6%

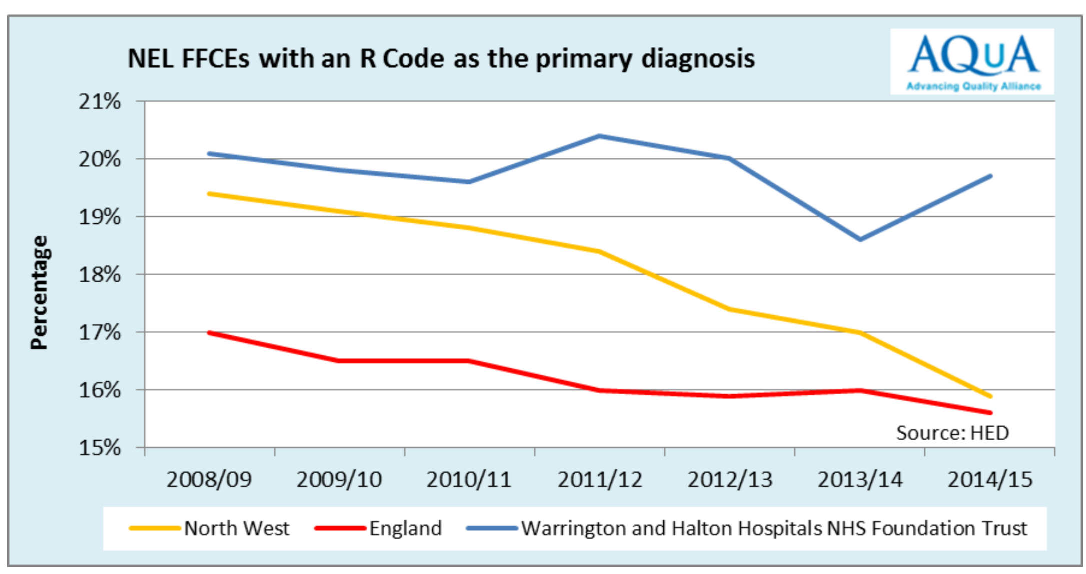


Chart 23 – trust Signs & Symptoms coding time-series, NEL, all patients

Last Episode of the non-elective Spell where the patient has died.

Fin. Year	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Trust	**3.1%**	**2.8%**	**2.9%**	**2.5%**	**2.6%**	**2.9%**	**1.4%**
North West	4.7%	3.3%	2.6%	2.2%	1.8%	1.3%	1.1%
England	4.1%	3.4%	2.8%	2.3%	2.1%	2.1%	1.7%

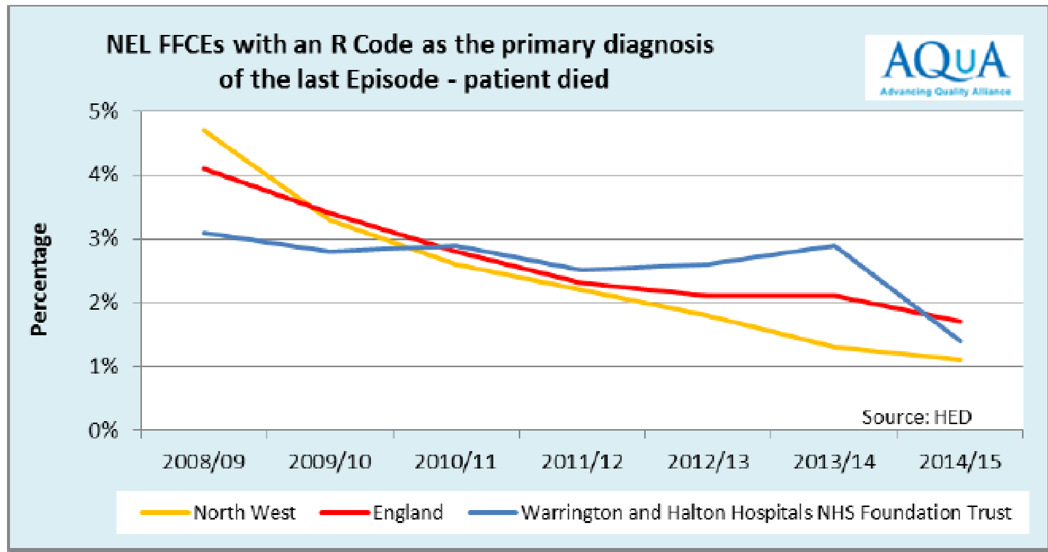


Chart 24 – trust Signs & Symptoms coding time-series, NEL, patient died

3.5 Co-morbidity

Fin. Year	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Trust	**2.3**	**2.6**	**2.8**	**2.8**	**2.9**	**3.1**	**3.1**
North West	2.3	2.5	2.7	2.8	3.0	3.2	3.4
England	2.1	2.4	2.6	2.8	3.0	3.1	3.3

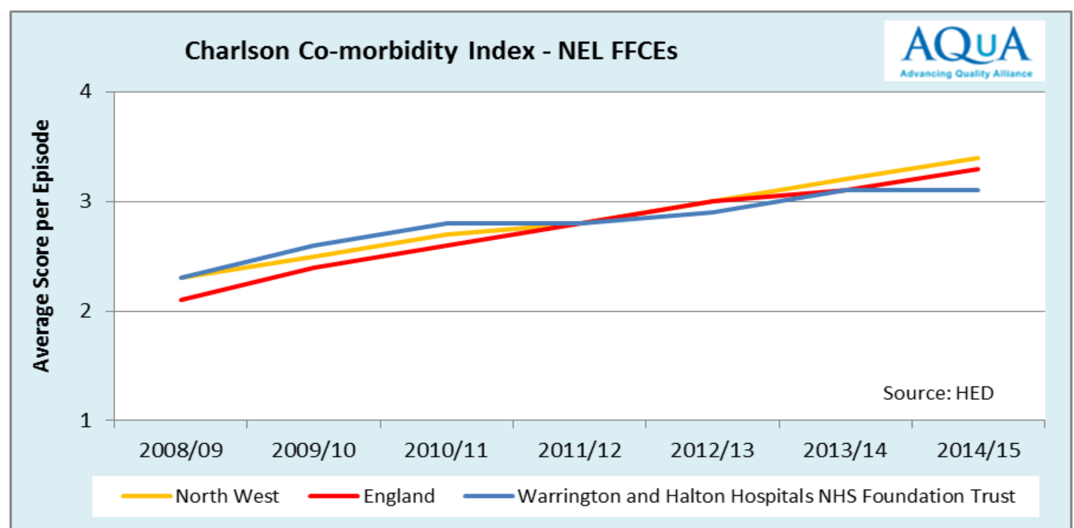


Chart 25 – Charlson Co-Morbidity Index time-series, NEL

SECTION 4 – Quarterly Focus

This quarter we explore the issue of "week-end" mortality rates – are they higher than weekday rates? And, more importantly, are they statistically significantly higher having taken into account the differences in case-mix etc. at a week-end.

Our analysis, and the observations in this report, is based upon splitting the week into two parts, namely admissions that take place Monday to Friday, inclusive ["week-day"] and admissions that take place on Saturday and Sunday ["week-end"]. There are differences between the individual days of the week but the statistical significances observed when breaking data into seven rather than two groups is non-existent.

All analysis regarding Day of Week must be based upon the day of admission, not the day of discharge. There are two reasons for this. The first is a data artefact; the number of deaths per day [the numerator] is constant, however the number of discharges per day [the denominator] is not (many more patients are discharged on a Friday and very few are discharged at the week-end). This uneven change in the denominator set against a constant numerator creates a mirrored change in the apparent mortality rate – a change that is not real. The second is around care pathways; the hypothesis of higher mortality rates at the week-end is predicated on the belief that there is less access to senior medical decision makers, support services etc. during this time and, notably, during the period after admission. The whole cohort of admissions does, therefore, need to be split into two discrete groups based upon day of admission.

That said, a patient admitted late on Friday and discharged Sunday has spent most of their time in hospital at the week-end, yet will be classed as a week-day admission. And a patient admitted late on a Sunday and discharged on a Friday has spent most of their time in hospital during the week-days, yet will be classed as a week-end admission. Furthermore, if the issue is perceived to be around access to senior decision makers, support services etc., then perhaps the time of admission [i.e. outside 'normal' working hours] bears examination as much as the day of admission. Unfortunately, Time of admission is not a data item that is available to us.

Despite all the above uncertainties and caveats, the following information is shared on the basis that it is useful to know what the available data are telling us, particularly as this is reported widely elsewhere.

Chart 26 shows the crude in-hospital mortality rates for the acute trust for weekday admissions and weekend admissions alongside the corresponding rates for the North West and England. Chart 27 shows the SHMI for both weekday and weekend alongside their respective 95% confidence intervals to demonstrate if there is any statistically significant difference between weekday and weekend mortality. Chart 28 shows the SHMI for inhospital deaths only again with their respective 95% confidence intervals.

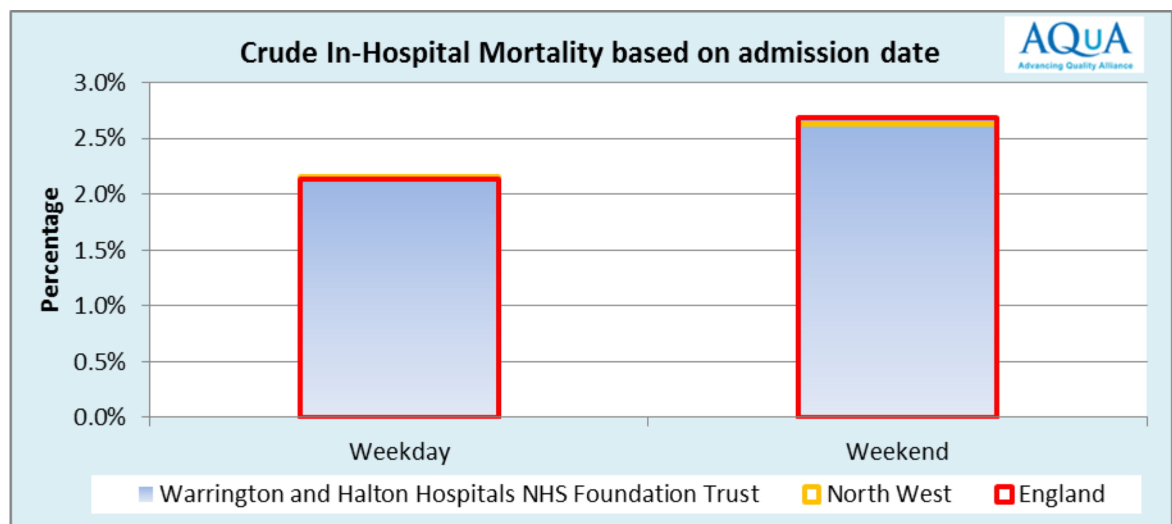


Chart 26: Crude In-Hospital Mortality for Weekday and Weekend Admissions

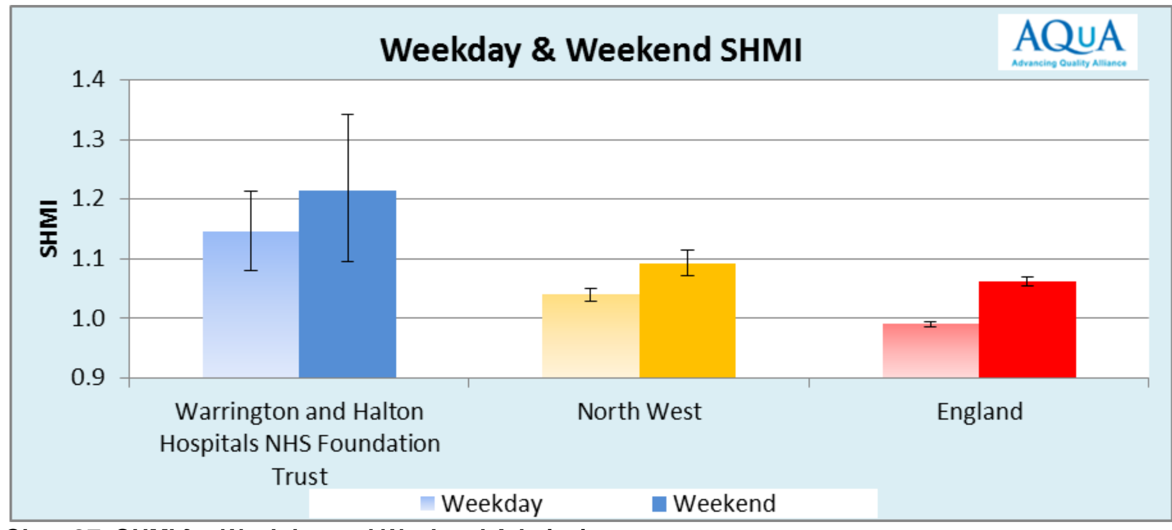


Chart 27: SHMI for Weekday and Weekend Admissions

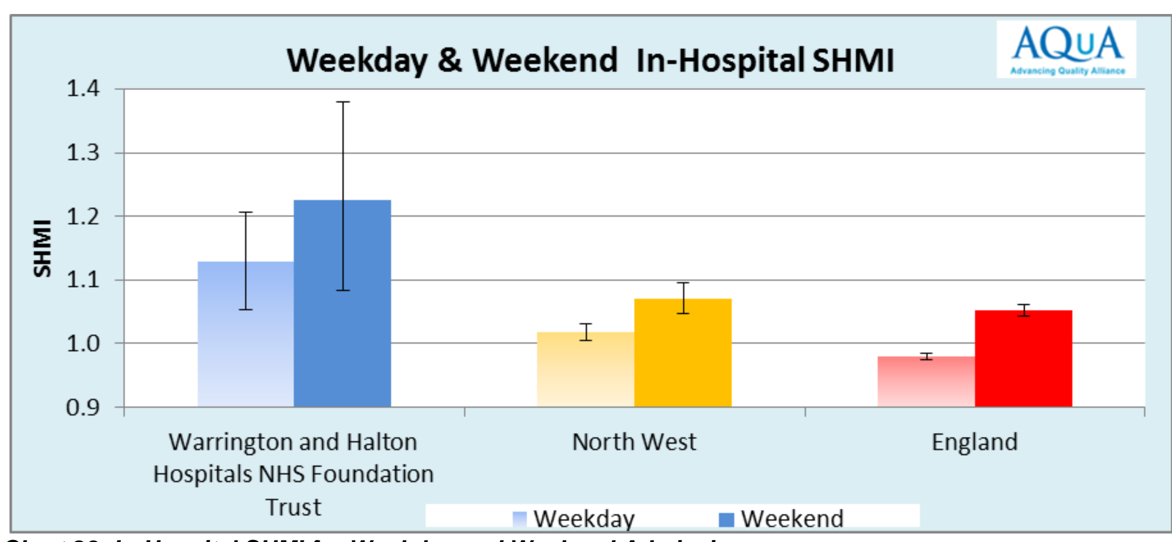


Chart 28: In-Hospital SHMI for Weekday and Weekend Admissions

Appendix A: Differences between HSMR, RAMI and SHMI

	Hospital Standardised Mortality Rate (HSMR)	Risk Adjusted Mortality Index (RAMI)	Summary Hospital-level Mortality Indicator (SHMI) **
Observed	All spells culminating in death at the end of the patient pathway, defined by specific diagnosis codes for the primary diagnosis of the spell: uses 56 diagnosis groups which contribute to approx. 80% of in hospital deaths in England*	Total number of observed inhospital deaths	Number of observed inhospital deaths plus deaths out of hospital within 30 days of discharge
Expected	Expected number of deaths	Expected number of deaths *Calculated using a 10 year data set (as of 2012) to get the risk estimate*	Expected number of deaths *Calculated using a 36 month data set to get the risk estimate*
Adjustments	▪ Sex ▪ Age in bands of five up to 90+ ▪ Admission method ▪ Source of admission ▪ History of previous emergency admissions in last 12 months ▪ Month of admission ▪ Socio economic deprivation quintile (using Carstairs) ▪ Primary diagnosis based on the clinical classification system ▪ Diagnosis sub-group ▪ Co-morbidities based on Charlson score ▪ Palliative care ▪ Year of discharge	▪ Sex ▪ Age ▪ Clinical grouping (HRG) ▪ Primary and secondary diagnosis ▪ Primary and secondary Procedures ▪ Hospital type ▪ Admission method Further detailed methodology information is included in CHKS products, or specific enquiries to CHKS www.chks.co.uk	▪ Sex ▪ Age group ▪ Admission method ▪ Co-morbidity ▪ Year of dataset ▪ Diagnosis group Details of the categories above can be referenced from the methodology specification document at http://www.ic.nhs.uk/services/summary-hospital-levelmortality-indicator-shmi
Exclusions	Excludes day cases and regular attendees	Excludes mental illness, obstetrics, babies born in or out of hospital, day cases, and patients admitted as emergencies with a zero length of stay discharged alive and spells coded as palliative care (Z515)	▪ Specialist, community, mental health and independent sector hospitals. ▪ Stillbirths ▪ Day cases, regular day and night attenders
Whose data is being compared and how much data is used for comparison e.g. all trusts or certain proportion etc.	All England provider trusts via SUS Data attributed to all Trusts within a 'super-spell' of activity that ends in death	UK database of Trust data and HES Data attributed to Trust in which patient died	All England non-specialist acute trusts except mental health, community and independent sector hospitals. Data attributed to Trust in which patient died or was discharged from

*HSMR does not exclude 20% of deaths, it looks for the diagnosis groups that account for the majority of deaths, and the figure of 80% is quite variable dependent on the case mix of the trust. HSMR could just as easily cover 100% of activity. It covers 80% of activity mostly for historical reasons and the fact that you get little extra value from the other 20%.

** The HSCIC publishes the SHMI indicator as observed, expected, denominator, value, upper control limits, lower control limits and banding. The term numerator is not used in the publication.

Appendix B: Metadata

Resource type	Title	Description	Coverage	Numerator	Denominator	Date	Source
Mortality	Charts 1 & 9	Crude inhospital mortality rate	137 SHMI Trusts	Discharge Method = 4	All discharges	Latest published SHMI (12 month period)	HED
Mortality	Charts 2 & 18	Crude inhospital mortality rate	137 SHMI Trusts (22 in North West)	Discharge Method = 4	All discharges	1.4.2009 – 31.03.2014	HED
Mortality	Charts 3 & 10	Crude inhospital mortality rate	137 SHMI Trusts	Discharge Method = 4	All discharges	Latest published SHMI (12 month period)	HED
				Split as per Appendix B.3 of the SHMI Indicator Specification i.e. Elective = Admission Method 11, 12, 13 Acute [NEL] = 21, 22, 23, 24, 28, 31, 32, 81, 82, 83, 84, 89, 98			
Mortality	Chart 4a	SHMI - SHA	137 SHMI Trusts	Observed deaths	Expected deaths	Latest published SHMI (12 month period)	HED
Mortality	Chart 4b	SHMI – Funnel Plot	137 SHMI Trusts	Observed deaths	Expected deaths	Latest published SHMI (12 month period)	HSCIC
Mortality	Charts 5 & 19	NW SHMI	22 Trusts in North West	Observed deaths	Expected deaths	Latest published SHMI (12 month period)	HED

Resource type	Title	Description	Coverage	Numerator	Denominator	Date	Source
Mortality	Chart 6	Observed and Expected deaths	22 Trusts in North West	N/A	N/A	October 2009 – March 2014	HED

Resource type	Title	Description	Coverage	Numerator	Denominator	Date	Source
Mortality	Chart 7	% Deaths occurring inhospital	137 SHMI Trusts	Discharge Method = 4	Discharge Method = 4 plus deaths from the HES-ONS linked mortality data file	Latest published SHMI (12 month period)	HED
Mortality	Chart 8	% Deaths occurring inhospital	137 SHMI Trusts (22 in North West)	Discharge Method = 4	Discharge Method = 4 plus deaths from the HES-ONS linked mortality data file	October 2009 – March 2014	HED
Clinical Coding	Chart 12 & 20	Palliative Care coding	22 Trusts in North West	Patients with ICD10 Code Z515 in any position of any episode or Specialty Code 315 in any episode	All discharges	Latest published SHMI (12 month period)	HSCIC
Clinical Coding	Chart 13 & 21	Palliative Care coding	22 Trusts in North West	Patients with ICD10 Code Z515 in any position of any episode or Specialty Code 315 in any episode (where Discharge Method = 4)	Discharge Method = 4 plus deaths from the HES-ONS linked mortality data file	Latest published SHMI (12 month period)	HSCIC

Clinical Coding	Charts 14 & 22	Signs & Symptoms coding	22 Trusts in North West	ICD10 "R" code in primary diagnosis of any episode. Admission Method = 21 – 28, 31, 32, 81 – 89, 98.	Number of episodes	Latest FY for which data has been published	HED
Clinical Coding	Charts 15 & 23	Signs & Symptoms coding	22 Trusts in North West	ICD10 "R" code in primary diagnosis of the first episode. Admission Method = 21 – 28, 31, 32, 81 – 89, 98	Number of first episodes [i.e. Spells]	Latest FY for which data has been published	HED
Resource type	**Title**	**Description**	**Coverage**	**Numerator**	**Denominator**	**Date**	**Source**
Clinical Coding	Charts 16 & 24	Signs & Symptoms coding	22 Trusts in North West	ICD10 "R" code in primary diagnosis of last episode. Admission Method = 21 – 28, 31, 32, 81 – 89, 98 (where Discharge Method = 4)	Number of last episodes [i.e. Spells] Discharge Method = 4	Latest FY for which data has been published	HED
Clinical Coding	Chart 17 & 25	Charlson Comorbidity Index	22 Trusts in North West	Total co-morbidity score for all relevant codes[1] in Diag02 – Diag20 for the first episode[2]	Number of first episodes [i.e. Spells]	Latest published SHMI (12 month period)	HED

[1] See Appendix D.1 of SHMI Methodology

[2] This most closely reflects the episodes that are used in the SHMI calculation. Only a small proportion of second episodes are used [i.e. where the primary diagnosis of the first episode is an "R" code and the second episode has a primary diagnosis other than an "R" code].

Weekday vs Weekend Mortality	Chart 26	% Deaths occurring inhospital	137 SHMI Trusts (22 in North West)	All in-hospital deaths	All discharges	Latest published SHMI (12 month period)	HED
Weekday vs Weekend Mortality	Chart 27	SHMI by weekday and weekend	137 SHMI Trusts (22 in North West)	Observed deaths	Expected deaths	Latest published SHMI (12 month period)	HED
Weekday vs Weekend Mortality	Chart 28	In-hospital SHMI by weekday and weekend	137 SHMI Trusts (22 in North West)	Observed deaths (occurring in-hospital)	Expected deaths (occurring in-hospital)	Latest published SHMI (12 month period)	HED

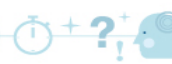
Appendix C: Trust Code and Name Lookup

Trust Code	Trust Name
REM	Aintree University Hospital NHS Foundation Trust
RXL	Blackpool Teaching Hospitals NHS Foundation Trust
RMC	Royal Bolton NHS Foundation Trust
RW3	Central Manchester University Hospitals NHS Foundation Trust
RJR	Countess of Chester Hospital NHS Foundation Trust
RJN	East Cheshire NHS Trust
RXR	East Lancashire Hospitals NHS Trust
RXN	Lancashire Teaching Hospitals NHS Foundation Trust
RBT	Mid Cheshire Hospitals NHS Foundation Trust
RNL	North Cumbria University Hospitals NHS Trust
RW6	Pennine Acute Hospitals NHS Trust
RQ6	Royal Liverpool and Broadgreen University Hospitals NHS Trust
RM3	Salford Royal NHS Foundation Trust
RVY	Southport and Ormskirk Hospital NHS Trust
RBN	St Helens and Knowsley Hospitals NHS Trust
RWJ	Stockport NHS Foundation Trust
RMP	Tameside Hospital NHS Foundation Trust
RM2	University Hospital of South Manchester NHS Foundation Trust
RTX	University Hospitals of Morecambe Bay NHS Foundation Trust
RWW	Warrington and Halton Hospitals NHS Foundation Trust
RBL	Wirral University Teaching Hospital NHS Foundation Trust
RRF	Wrightington, Wigan and Leigh NHS Foundation Trust

BOARD OF DIRECTORS

WHH/B/2015/ **181**

SUBJECT:	**Director of Infection Prevention and Control – Healthcare Associated Infection - Annual Report April 2014 – March 2015**	
DATE OF MEETING:	2 October 2015	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Lesley McKay – Associate Director of Infection Prevention and Control	
EXECUTIVE DIRECTOR:	Karen Dawber, Director of Nursing and Governance As DIPC for 2014/15	
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):	SO1/1.3 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):	This report outlines the arrangements, activities and achievements of the Trust relating to infection prevention and control for the April 2014 to March 2015 financial year	
RECOMMENDATION:	***The Board is asked to:*** ***Note and approve the content of the Annual Report***	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item. Infection Control Sub-Committee
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Not Applicable



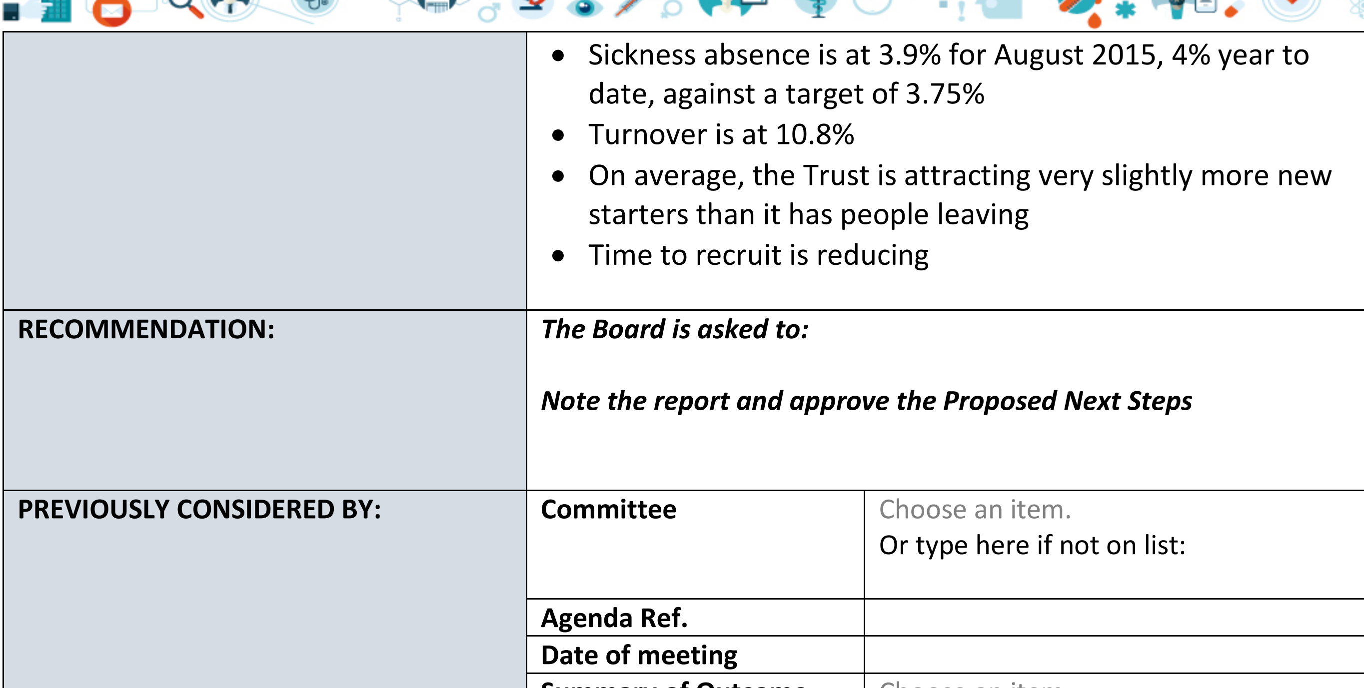
BOARD OF DIRECTORS

WHH/B/2015/ **182**

SUBJECT:	**Verbal Report from the Chair of the Strategic People Committee**
DATE OF MEETING:	2 October 2015
DIRECTOR:	Anita Wainwright, Non-Executive Director

BOARD OF DIRECTORS WHH/B/2015/ **183**

SUBJECT:	**Human Resources and Organisational Development Key Performance Indicators**
DATE OF MEETING:	2 October 2015
ACTION REQUIRED	**For Assurance**
AUTHOR(S):	Roger Wilson/Carl Roberts
EXECUTIVE DIRECTOR:	Roger Wilson, Director of HR&OD
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):	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 SO2/2.1 Failure to engage and involve our workforce in the design and delivery of our services. SO1/1.2 Risk of harm through failure to comply with Care Quality Commission National core healthcare standards and maintain registration and failure to achieve minimum requirements for NHSLA Standards within maternity services and wider Trust. 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):	• 78% of staff have had or have a plan to have their PDR completed in 15/16. • Only 4% of staff definitely do not have a plan to have their PDR completed in 15/16 • 80% of staff have completed or have a plan to complete their mandatory training • Only 2% of staff definitely do not have a plan to complete their mandatory training • Overall staffing budget is underspent



	• Sickness absence is at 3.9% for August 2015, 4% year to date, against a target of 3.75% • Turnover is at 10.8% • On average, the Trust is attracting very slightly more new starters than it has people leaving • Time to recruit is reducing	
RECOMMENDATION:	***The Board is asked to:*** ***Note the report and approve the Proposed Next Steps***	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item. Or type here if not on list:
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

Human Resources and Organisational Development Key Performance Indicators

In March 2015, the Executive Team put in place clear expectations in relation to the minimum standards required in terms of People Management.

For the purposes of the 2nd October 2015 Trust Board meeting, we will focus on PDR and Mandatory Training compliance within Clinical Divisions. The reason for this is that PDR and Mandatory Training compliance is one of the areas the CQC has identified as in need of improvement.

1. Background and Information for Mandatory Training

As an aide memoire, from a People Management perspective, our minimum requirements for Mandatory Training and PDRs are: -

- PDR rates – 100% PDR coverage for those staff available to have a PDR. The RAG rating breakdown will be as follows: Green - 100% of staff with completed PDR
  Amber - 100% of staff with planned date for PDR
  Red - Less than 100% of staff with completed or planned date for PDR or non-compliance with the plan

- Mandatory Training compliance - 100% Mandatory Training Compliance completion for those staff available to undertake Mandatory Training. For the purposes of this exercise, Mandatory Training will be defined as follows:
  - Health and Safety
  - Fire
  - Manual Handling
  - Infection Control
  - SEMA
  - Safeguarding
  - Equality and Diversity

  All of the above are the modules available through e-learning.

  The RAG rating breakdown will be as follows:
  Green - 100% of staff have completed Mandatory Training
  Amber - 100% of staff have either completed or have a planned date for Mandatory Training

Red - Less than 100% of staff who have completed or there is no planned date for completion of Mandatory Training or non-compliance with their plan

2. Position as at 31st August 2015

The Trust overall Clinical Division position on PDR and Mandatory Training completion (for the measures being assessed and based on self-assessment) as at 31st August 2015 is as follows: -

Trust Summary % (Excluding Corporate)								
RAG Rating	PDR	H&S	M&H	Fire	SEMA	Infection Control	Safeguarding	Equality & Diversity
Red	4%	1%	2%	1%	1%	1%	4%	5%
Amber	61%	43%	60%	60%	53%	63%	58%	53%
Green	17%	37%	20%	21%	27%	18%	20%	23%
Not Submitted	18%	19%	18%	18%	19%	18%	18%	19%
Total	100%	100%	100%	100%	100%	100%	100%	100%

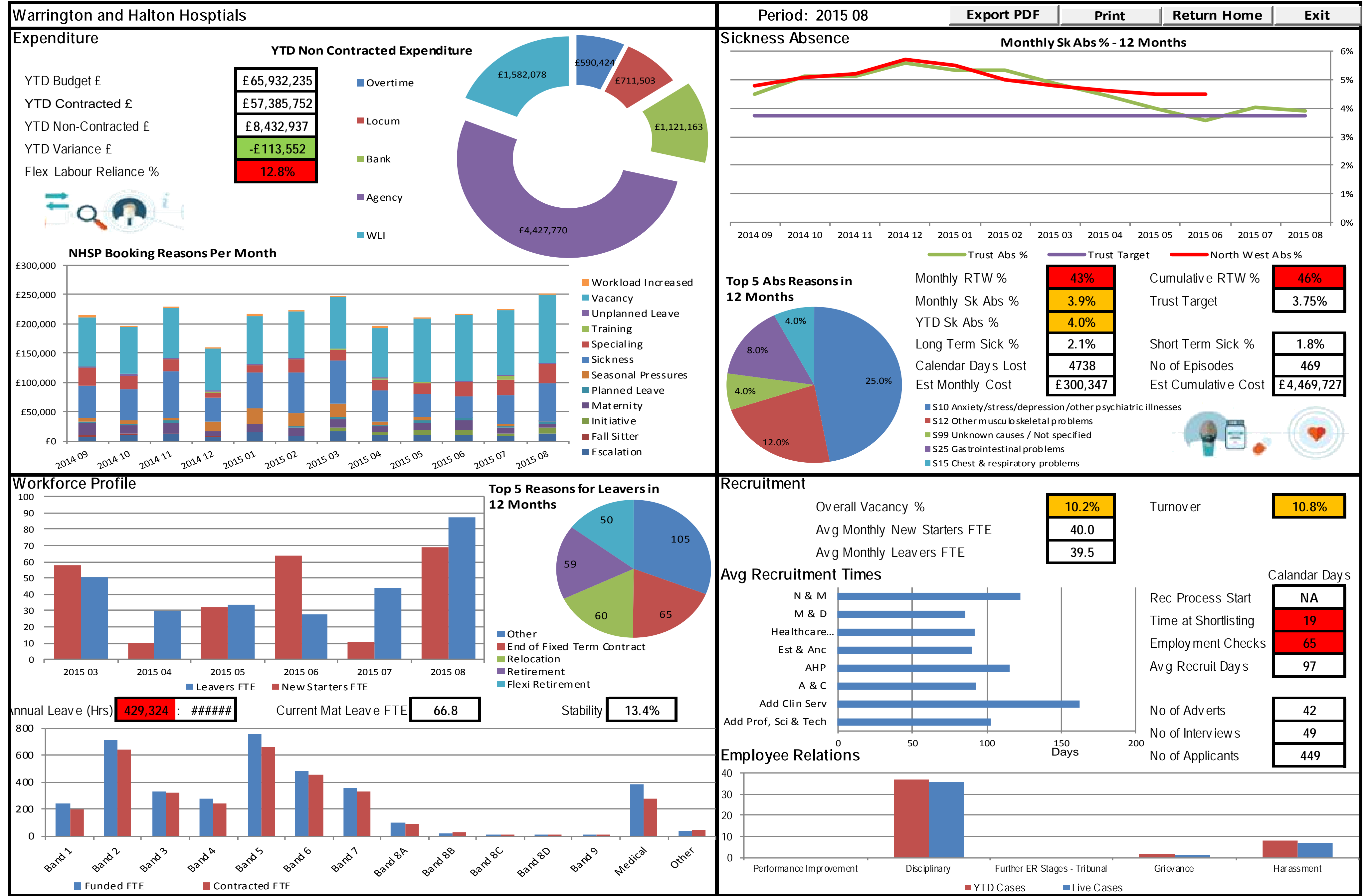
The summary of the above table is as follows: -

- 78% of staff have had or have a plan to have their PDR completed in 15/16.
- Only 4% of staff definitely do not have a plan to have their PDR completed in 15/16
- 80% of staff have completed or have a plan to complete their mandatory training
- Only 2% of staff definitely do not have a plan to complete their mandatory training
- 18% of areas did not submit a self-assessment.

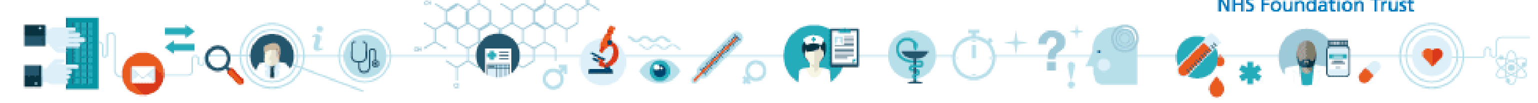
3. Further Analysis and Proposed Next Steps

- For those areas which did not submit a self-assessment - their RAG rating across all measures will be considered to be red. It is proposed that the manager for that area will be managed under the Performance Improvement Policy.
- For those areas which have self-declared a Red in an area, it is proposed that the manager for that area will be managed under the Performance Improvement Policy.
- A clear timetable for submission of self-assessments has been developed for the Divisions
- Strategic People Committee will deep dive into the Divisional Position at its' October meeting.
- For those areas who are performing well, i.e. they have all green ratings, then they will automatically be considered for Team of the Month
- Peer to Peer validations will continue on a monthly basis.

4. Position as at 31st August 2015



Division/Directorate/Department Name	Period: Monthly date the data is produced
Expenditure **YTD Budget £:** Year to Date Budget from Finance **YTD Contracted £:** Year to date amount spent on contracted employees **YTD Non-Contracted £:** Year to date amount spend on non-contracted employees, such as locums, other agency, overtime, NHSP, additional hours, WLIs etc **YTD Variance £:** Difference between Budget and actual spend on the budget **YTD Non Contracted Expenditure:** Breakdown of non-Contracted expenditure **Flex Labour Reliance %:** Percentage of hours worked through non-contracted agreements compared to the contracted hours within the Division/ Directorate/Department - demonstrating reliance on non contracted hours **NHSP Booking Reasons:** Further breakdown of NHSP spend by reason, grade and month	Sickness Absence **RTW % :** Percentage of Return to Work interviews completed monthly and annually **Monthly Sk Abs %:** The in month sickness percentage with the graph showing the monthly sickness percentages for the last 12 months, comparing it with the Trust and the Trust Target **Trust Target:** Sickness absence percentage target set by the Trust **Cumulative Sk Abs %:** Cumulative sickness absence percentage for the last 12 months **Divisional Sk Abs %:** Divisional sickness absence monthly percentage **Long Term Sick %:** Percentage of employees absent for 28 days or more in the month **Short Term Sick %:** Percentage of employees absent of 28 days or less in the month **Calendar Days Lost:** Number of calendar days lost due to sickness in the month **No of Episodes:** Number of sickness episodes within the month **Est Monthly Cost:** Estimated monthly cost due to sickness absence, only takes into account the cost of salary **Est Cumulative Cost:** Estimated 12 month costs due to sickness absence, only takes into account the cost of salary **Top 5 Abs Reasons:** Chart showing the top 5 sickness absence reasons for the last 12 months
Workforce Profile **Leavers/Starters:** Graph showing the number of monthly leavers and new starters **Top 5 Reasons for Leavers:** Chart showing the top 5 reasons for employees leaving the Division/Directorate/Department in the last 12 months **Annual Leave:** Amount of annual leave taken compared to the target amount **Mat Leave FTE:** Current number of employees on Maternity leave in FTE **Stability %:** A percentage indication of how stable the workforce is within the selected Division/Directorate/Department, by reviewing the number of permanent leavers with less than 12 months service, 0% being very stable **Staff Profile:** Graph showing the make up of staff within the Division/Directorate by banding comparing the funded (budget) FTE and contracted (actual) FTE.	Recruitment **Overall Vacancy %:** Percentage difference between Budgeted FTE and Actual Staff in Post FTE **Avg Monthly New Starters FTE:** Average number of new starters each month (12 month period) **Avg Monthly Leavers FTE:** Average number of leavers each month (12 month period) **Turnover:** Turnover percentage, the number of leavers in the last 12 months as a percentage against the average headcount **Rec Process Start:** Average calendar days taking to start the recruitment process **Time at Shortlisting:** Average calendar days between advert closing and interview **Employment Checks:** Average calendar days between interview date and agreeing the start date (excluding notice period) **Avg Recruit Days:** Average total number of calendar days taken to recruit (includes notice period) **No of Adverts:** Number of adverts published within the month **No of Interviews:** Number of interviews taken place within the month **No of Applicants:** Number of candidates currently ungoing pre-employment clearances **Average Recruitment Times:** A graph showing the average number of days taken to recruit, by staff group **Employee Relations:** A graph showing, by Division the number of Employee Relation Cases, both year to date and currently live



Expenditure

The flexible labour reliance (Percentage of hours worked through non-contracted agreements compared to core workforce contracted hours - demonstrating our level of reliance on non-contracted hours) is, as expected higher than we would want, the reasons for this can be seen throughout the Dashboard, Turnover, Vacancy Rate, Sickness and Stability (A percentage indication of how stable the workforce is by reviewing the number of permanent leavers with less than 12 months service - 0% being very stable).

Pleasingly year to date we are below our budget for staffing spend, however this isn't the whole picture as the £8,432,937 spent on non-contracted labour does not represent best value for money and is being addressed through a variety of interventions.

The two main actions being taken to review the non-contracted spend are the emergence of a Nursing Agency Spend Task and Finish group which is tasked with reducing our Nursing agency spend in line with Monitors request/requirements and working with De Poel to embed e-Tips into the organisation for booking and managing/monitoring locum agency spend.

With regards to Augusts' NHSP spend, the spend was higher in August 2015 than any of the last 12 months, and we have not seen an attendant reduction in Agency spend in the same period. The main reasons for NHSP usage are Sickness and Vacancy; actions to address these issues are outlined below.

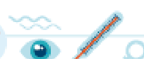
Sickness Absence

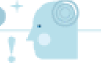
Sickness absence percentage is currently just above the Trust target of 3.75%. Interestingly the Trust mirrored the North Wests sickness absence percentage month on month until April 2015, where as a Trust we continued to reduce our sickness absence and with the exception of a slight increase in July 2015, each month since April 2015 has seen a reduction in our absence %.

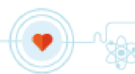
Disappointingly, we are reporting a very low Return to Work Interview compliance (this now includes data from the E-Rostering system so managers no longer are required to duplicate the entry in both ESR and E-Rostering). Return to Work interviews are a key component to reducing sickness absence and therefore an audit will be carried out to assess if this is a data recording issue or they are actually not being completed. The Board are reminded that this is also one of our key performance measures for acceptable performance for managers.

The main reason for sickness absence is Stress, which is consistent with previous periods. The top 10 areas where Stress is most prevalent will now be approached, in order to undertake an analysis on the reasons for them having high recorded stress levels and what support they require from HR and/or Occupational Health to ensure the stress levels in that department are reduced. Early results of an initial analysis would suggest that the areas with high stress levels are also the areas with high vacancies, therefore a causal link is demonstrated.

Other Musculoskeletal Problems makes up 12% of the sickness absence in the last 12 months, as an action point we will be undertaking cross analysis with the areas most affected against their Manual Handling







compliance and again working with HR and/or Occupational Health to understand what support can be offered.

Workforce Profile

The Trust is still experiencing issues with retention and turnover and as seen for 4 of the last 6 months, we are not keeping pace with the number of leavers per month, despite high numbers of new starters joining us each month (40 FTE on average). This has been seen especially in the months of March, June and August. However, on balance, over the last 12 months we have recruited on average 0.5 FTE more staff than have left.

It is clear we need to be better at recording reasons for leaving as there have been 105 people in the last 12 months who have left our employment and the reason they left us has not been recorded. Managers will be reminded of the importance of recording the reasons for leaving on the termination forms. We are due to launch a new and improved Exit Interview which will be sent out to every leaver and should enable us to collect more information about reasons why individuals choose to leave the Trust.

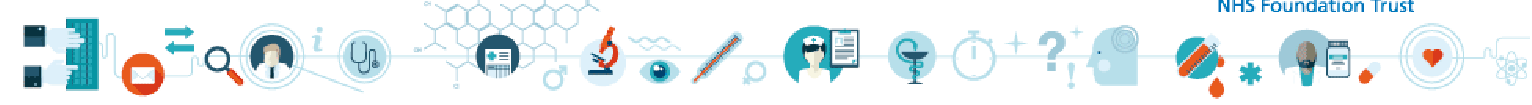
An analysis of leavers is also being performed in each of clinical divisions, initial findings are suggesting that 30% of leavers have less than 2 years' service with the Trust, this is obviously a concern and it would appear greater focus needs to be on retention in all areas, with a particular focus on the areas with the worst retention rates.

As part of our response to this challenge, we will be launching a simple "On-Boarding" analysis which will initially involve asking individuals how they found their first 6 months working for us, giving them an opportunity to provide areas for improvement and an option to be part of group discussions to we can really focus on making that first great impression. Recently, we have done work place visits to new starters to understand how their early months in the Trust have been

Recruitment

We are recruiting more staff at the current time than we have in the last 3 years, but as previously outlined this is not keeping pace with turnover. The changes to the recruitment processes that were put in place at the turn of the year are now paying dividends as the average recruitment times are quickly reducing. Emphasis still needs to be placed on managers adhering to the agreed timescales and ensuring they are following the best practices as outlined by our recruitment team. Again, this is a measure we are assessing managers against.

A focus on recruiting Staff Nurses has been in place for the last 4 months, and we have taken on 33 Staff Nurses during this period, compared to 14 Staff Nurses in the previous 4 months. This focus will continue, all be it the Divisions have asked it to look and work differently, to ensure we are recruiting the Staff Nurses to the areas with the highest vacancies, A&E, AMU etc. Similarly, we are working hard to address Medical Staff shortages.

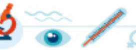


We have agreed to work with NHS Professionals to undertake Staff Nurse International recruitment, we are in the early stages of this, but the bottom line is that we aiming to have a minimum of 15-20 Nurses from Romania joining us between February 2016 and May 2016.

5. Recommendations

That the Board notes the contents of the report and approves the Proposed Next Steps outlined in Section 3 above.

Roger Wilson
Director of Human Resources and Organisational Development
24th September 2015



BOARD OF DIRECTORS

WHH/B/2015/ **184**

SUBJECT:	**Monthly Staffing Exceptions Report**	
DATE OF MEETING:	2 October 2015	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Clare Pratt. Associate Director of Nursing , Corporate Services	
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	
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 June 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.

As there was no Meeting of the Board of Governors in August, this report contains 2 months information relating to Nurse Staffing Levels.

Appendix 1 is a copy of the spread-sheet that has been submitted to UNIFY and uploaded onto NHS Choices website for July 2015 and Appendix 2 is the spreadsheet for August 2015.

3.0 Divisional Breakdown – July 2015

SCHEDULED CARE DIVISION					
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**
A4	79.9%	85.9%	100.0%	203.2%	HCA uplift on nights due to SAU being bedded down every night and assessment area not funded as should close overnight. There has been an increase in unfilled shifts due to the vacancies and sickness. A twilight is rostered for SAU every night but this has not been filled. 14 beds on A4 are now medical.

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	96.5%	95.7%	91.1%	109.7%	Escalation beds open x2 for majority of July
A6	90.7%	102.2%	96.7%	103.2%	2-4 Escalation beds open occasionally in July.
A9	89.4%	83.6%	101.1%	103.2%	There has been a continued reduced rate of escalation beds throughout the month, which has reduced the risk. Patient acuity has been at times high due to need to bay tag and this has been covered 50% of the time. Nurse sensitive indicators have continued with some falls due to high risk patients and inability to cover all bay tagging. The ward has continued to utilise carers and staff to observe patients at risk.
B19	95.1%	144.1%	100.0%	96.8%	Escalation beds open for 86% of the 30days in June and over on HCA due to escalation and NOF unit. Nurse sensitive indicators have been satisfactory.
B4	95.7%	93.2%	95.8%	100.0%	
Ward 1 - CMTC	98.7%	100.0%	100.0%	100.0%	Difference in planned and actual due to staff movement to support shortfalls in staffing at Warrington. Assessed as safe by Matron
ICU	85.0%	91.9%	82.9%	87.1%	

UNSCHEDULED CARE DIVISION					
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**
A1	107.5%	86.3%	95.7%	103.2%	There are still vacant posts across AMU and further band 5 interviews planned for 11/09/2015 (13.8) 4 going through recruitment process. The matrons have a staffing meeting each day and staff within the Division are moved to maintain patient safety on the wards.
A2	99.4%	97.8%	100.0%	100.0%	Rolling Trust advert for band 5's (3.07) 1 RN suspended. 1 RN recruited, await start date and there are plans to re advertise Band 2's. The Matrons have a staffing meeting each day and staff within the Division are moved to maintain patient safety on the wards.
A3	96.0%	109.3%	98.9%	137.0%	Rolling Trust advert for band 5's (1.39). Band 2 advert closed 31/07/2015. Interviews set for the 14/09/2015 (3.24).. The Matrons have a staffing meeting each day and staff within the Division are moved to maintain patient safety on the wards.
A7	100.0%	99.2%	96.8%	98.4%	Variance due to sickness. Risk assessed and safe.
A8	82.3%	98.9%	137.0%	113.0%	The variance between planned and actual is the requirement for one to one staffing on the ward which is not funded. The Trust has a rolling recruitment that A8 is part of and they are also having a stand-alone advert too. Also the ward is re-looking at their skill mix and are going to recruit to Band 4 Assistant practitioner posts.
B12	95.8%	113.0%	100.0%	143.5%	Trained nurse off long term sick and dependency on ward challenging at times risk assessment completed for extra carer day and night

B14	91.7%	89.6%	88.2%	98.4%	Variance due to sickness in July. 3.0 WTE RN's on Maternity leave. The matrons have a staffing meeting each day and staff within the Division are moved to maintain patient safety on the wards.
B18	82.8%	96.9%	88.2%	97.5%	There is some staff sickness on B18 that is assessed by the matrons who have a staffing meeting each day and staff within the Division are moved to maintain patient safety on the wards.
C21	98.9%	100.0%	100.0%	100.0%	
C22	100.0%	94.0%	100.0%	96.8%	Risk assessed and safe, backfill to support 2.0 WTE current vacant posts. Out to recruitment.
CCU	96.6%	75.7%	98.2%	-	The variance is due to the staff sickness and staff can be deployed to support other areas once risk assessed as safe.

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	106.5%	130.4%	87.4%	-	
Neonatal Unit	169.2%	32.3%	119.3%	93.8%	
C20	71.8%	93.3%	103.4%	-	
C23	99.1%	90.9%	128.4%	103.4%	

Divisional Breakdown – August 2015

SCHEDULED CARE DIVISION					
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**
A4	79.2%	100.8%	100.0%	203.2%	HCA uplift on nights due to SAU being bedded down every night and assessment area not funded as should close overnight. There has been an increase in unfilled shifts due to the vacancies and sickness. A twilight is rostered for SAU every night but this has not been filled. 14 beds on A4 are now medical. Extra HCA shifts due to change of speciality.
A5	96.0%	94.3%	85.6%	103.2%	Escalation beds open x4 for majority of August. one to one booked on occasions.
A6	87.9%	106.3%	92.7%	109.7%	2-4 Escalation beds open occasionally in August. On occasion One to one was booked for night shift .
A9	86.5%	89.8%	83.9%	100.0%	60% of escalation beds open throughout the month, which has raised the risk when staff reduced to 3, this has been required to support medical outliers by the Trust. There is still a significant vacancy level and this is in the most being covered by agency as NHSP trained has not been able to fill. Nurse senitive indicators have continued with some falls due to high risk patients and inability to cover all bay tagging. The ward has continued to utilise carers and staff to observe patients at risk.
B19	92.1%	138.8%	100.0%	98.4%	Escalation beds still remain open throughout August2015 with an increase in HCA due to escalation and NOF unit. Nurse sensitive indicators have been satisfactory. The ward has also supported A9 staffing at times to ensure safe staff levels.
B4	80.1%	151.6%	151.6%	87.1%	Variance in numbers is due to staff movement to support surgical wards at Warrington. This has been assessed as safe by the Matron

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	78.5%	64.6%	79.8%	87.5%	The Variance in numbers this month is much greater due to staff movement to support the Wards at Warrington due to the reduced activity in August. This has been assessed as safe by the Matron
ICU	82.9%	85.5%	82.9%	82.3%	8 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 Q nurses required per shift but if dependency/occupancy reduced then less nurses would still provide agreed nurse:patient ratios. Unit Occupancy for August 2015 was 66% therefore even though shifts fell short of 14 Q there was adequate nurses to provide standard nurse:patient ratios.

UNSCHEDULED CARE DIVISION					
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**
A1	104.7%	87.9%	94.6%	97.1%	Difficulties have been experienced in recruiting into vacant posts for this are. It has been agreed that an extra advert can go out for AMU alongside the current Trust band 5 advert.
A2	95.9%	100.0%	96.8%	106.5%	There are two RN posts vacant and being recruited to, the matrons have a staffing meeting each day and staff within the Division are moved to maintain patient safety on the wards.

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
A3	95.9%	99.4%	93.5%	100.0%	New band 2 starting 21/09/2015. Bay C tagged for the majority of the month, day and night requiring extra one to one support from carers. The matrons have a staffing meeting each day and staff within the Division are moved to maintain patient safety on the wards.
A7	100.0%	95.5%	98.9%	100.0%	Variance due sickness. Risk assessed and safe.
A8	84.7%	88.6%	90.6%	94.4%	The variance between planned and actual is due to 2.0 WTE RN's on suspension and 1.0 RN on LT sick. There is also the requirement for one to one staffing on the ward which is not funded. The Trust has a rolling recruitment and also the ward is re-looking at their skill mix and are going to recruit to Band 4 Assistant practitioner posts.
B12	93.5%	123.9%	100.0%	100.0%	There is long term sickness on B12 and the dependency on the ward is challenging at times. This necessitates the need for extra one to one support from carers for day and night shifts.
B14	86.3%	95.3%	84.9%	93.5%	Unit had number of very high risk patients 2 required 1:1 supervision and 4 other patient required close supervision. Twilight ordered to help night shift settle patients rather than booking two HCA overnight
B18	77.9%	93.5%	83.9%	89.2%	1.0 WTE Rn on long term sick and 2.0 WTE RN's on maternity leave impacting on staffing. This is assessed by the ward manager and Matron and extra staffing to support is used when required.
C21	98.9%	100.0%	100.0%	100.0%	
C22	99.3%	90.4%	100.0%	100.0%	
CCU	90.7%	68.7%	97.1%	-	Unit not always fully occupied so RN redeployed. HCA moved as acuity higher elsewhere in trust after risk assessment.

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	83.6%	94.6%	93.1%	-	Beds closed for replacement and actual staffing levels reduced in accordance with reduced pt numbers.
Neonatal Unit	97.3%	95.4%	97.9%	100.0%	
C20	74.8%	92.1%	103.4%	-	The level of staffing on ward is currently under review. The ward is regularly escalated with medical or surgical patients and staff are asked to escalate and Datix all incidents where it is felt the staff:patient ratio is perceived to be unsafe. During the month of August it is felt that the levels of staffing although challenged at times due to acuity of patients, was safe.
C23	101.7%	89.3%	126.7%	103.4%	

4.0 Assurance provided from the Divisional Associate Directors of Nursing:

Scheduled Care - Staffing has improved during July and August which has largely been related to a reduction in the number of escalation beds in use.

Shift fill rates from NHSP and agency have improved slightly which has helped with cover for the wards

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.

An ongoing recruitment programme is underway in the Division and we have seen some improvement in the number of candidates attending for interview and subsequently recruited which is pleasing.

The ADNS 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 sickness levels in July and more so in August 2015. Vacancies are being recruited into and the division has been a part of the Trust rolling recruitment. There are however, some specialised areas in the division that have not benefitted from the

rolling recruitment and they are now going out on a stand-alone advert to recruit to their posts. 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 ADNS 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.

Recruitment programme with the proactive recruitment of newly qualified student nurses has commenced in the organisation with some success for the division. The unscheduled care division is looking at reviewing the skill mix in some wards and recruiting to Assistant practitioner posts where RN posts have been harder to fill.

The ADNS is satisfied that staffing levels are reviewed on a shift by shift basis and staff are moved accordingly to cover any shortfalls identified.

Women's and Children's Services – There are some anomalies between planned and actual staffing on data collected for July and August within the paediatric areas. This was mainly due to a data collection error which has now been rectified. The ADNS is assured that these figures do not represent overstaffing (or understaffing in the case of carers on Neonates). There is a reporting issue which will be addressed prior to next month's data collection

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
July 2015

Appendix 2
August 2015

Staffing Levels

Jul-15

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

									Day					Night				
									Registered midmives/nurses			Care Staff		Registered midmives/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 Jun-15	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**
Scheduled Care	W-A4 - Ward A4	28	19.38	3.60	1.00	7.73	0.0		1.7	1726.5	1379.0	931.5	800.0	1.7	713.0	713.0	356.5	724.5
	W-A5 - Ward A5	28	18.03	5.96	3.00	12.88	0.0		1:7	1380.0	1332.3	1035.0	991.0	1:9	1035.0	943.0	713.0	782.0
	W-A6 - Ward A6	28	19.57	4.45	1.00	13.62	0.0		1:7	1481.5	1344.4	1031.0	1054.0	1:9	1035.0	1000.5	713.0	736.0
	W-A9 - Ward A9	28	18.83	3.27	3.00	15.50	1.0		1:7	1380.0	1234.0	1380.0	1154.0	1:9	1035.0	1046.5	713.0	736.0
	W-B19 - Ward B19	18	13.68	2.00	1.00	13.90	0.6		1:6	1035.0	984.5	678.5	978.0	1:6	713.0	713.0	713.0	690.0
	W-B4-H - Ward B4 - Halton	27	12.20	2.03	1.00	6.00	1.00		1:9	874.0	836.0	552.0	514.5	13.5 :1	552.0	529.0	322.0	322.0
	W-CM1-H - Ward 1 - CMTC Treatment Centre	30	26.60	5.23	1.92	14.00	2.59		1:5.5	1795.0	1772.0	1014.0	1014.0	10 : 1	954.5	954.5	529.0	529.0
	W-ICU - Intensive Care Unit	18	76.74	9.41		11.52	0.00		1:1 Level 3 1:2 Level 2	4991.0	4243.5	1069.5	983.3	1:1 Level 3 1:2 Level 2	4991.0	4140.0	713.0	621.0
Total		205	205.03			95.15		0.00										
Unscheduled Care	AED			7.00	5.00	13.02				4712.0	4445.0	1238.5	1110.5		3105.3	3094.8	773.5	3222.6
	W-A1A - Ward A1 Asst	29	41.40	10.80	6.00	22.10	4.70		5.5	2325.0	2500.0	1550.0	1337.5	0.0	1953.0	1869.0	651.0	672.0
	W-A2A - Ward A2 Admission	28	18.83			12.90			5.6	1426.0	1417.0	1069.5	1046.5	9.3	1069.5	1069.5	713.0	713.0
	W-A3OPAL - Ward A3 Opal	34	18.83	1.39		15.48	3.24		8.5:1	1426.0	1368.5	1426.0	1558.0		1069.5	1058.0	713.0	977.0
	W-A7 - Ward A7	33	18.80	3.30	1.00	15.46	0.37		8.3:1	1426.0	1426.0	1426.0	1414.5	0.0	1092.5	1058.0	713.0	701.5
	W-A8 - Ward A8	34	18.80	0.92	2.00	15.46	0.00	0.13	8.5:1	1426.0	1174.0	1426.0	1411.0		1069.5	1465.0	713.0	805.5
	W-B12 - Ward B12 (Forget-me-not)	21	13.68	0.00	0.00	15.00	1.24	0.06	7.0:1	1069.5	1024.5	1426.0	1611.0	0.0	713.0	713.0	713.0	1023.5

	W-B14 - Ward B14	24	18.80	2.00	3.00	12.88	0.00	0.13	6.0:1	1429.0	1310.5	1069.5	958.0	8.0	1069.5	943.0	713.0	701.5
	W-B18 - Ward B18	24	18.80	3.00	1.00	18.00	1.00		6.0:1	1426.0	1180.5	1426.0	1381.5	0.0	1069.5	943.0	1069.5	1042.5
	W-C21 - Ward C21	24	13.68	0.5	0.5	11.30	0.00		8.0:1	1069.5	1058.0	713.0	713.0	0.1	713.0	713.0	713.0	713.0
	W-C22 - Ward C22	21	13.68	2.00	1.00	12.90	1.15		7.0:1	1069.5	1069.5	1069.5	1005.5	0.1	713.0	713.0	713.0	690.0
	W-CCU - Coronary Care Unit	8	21.2	2.2	0.0	2.6	0.0		2.0:1	1426.0	1377.5	356.5	269.7	0.0	1069.5	1050.0	0.0	0.0
Total		280	216.50			167.10		0.32										
WCSS	W-B11B/W-B11C - Ward B11	24	29.50			15.92			1:1 level3 1:2 Level2	2100.0	2237.0	930.0	1213.0	0.0	1488.2	1301.2	0.0	96.8
	W-NHDU/W-NITU/W-NSC - Neonatal Unit	18	24.38			6.52			7.5:18	1092.0	1848.0	798.0	257.5	7.5:18	942.8	1125.0	240.0	225.0
	W-C20 - Ward C20	12	12.63			5.00			1:4	1232.5	885.0	675.0	630.0	1:6	581.3	600.8	0.0	0.0
	W-C23 - Ward C23	22	97.92			18.93			1:7.33	1348.5	1336.1	899.0	817.5	1:11	581.3	746.1	290.6	300.4
Total		76	164.43	0.00	0.00	46.37	0.00	0.00										
Grand Total		561	585.96	0.00	0.00	308.62	0.00	0.32										

Staffing Levels

Aug-15

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 midmives/nurses			Care Staff		Registered midmives/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 Jul-15	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
Scheduled Care	W-A4 - Ward A4	28	19.38	3.60	1.00	9.57	7.7	0.00	1:7	1726.5	1368.0	931.5	938.5	1:7	713.0	713.0	356.5	724.5	16.5	11.5	1.4	0.44%
	W-A5 - Ward A5	28	18.03	4.96	2.00	12.88	0.0		1:7	1380.0	1325.0	1035.0	976.5	1:9	1035.0	885.5	713.0	736.0	-240.0	11.5	-20.9	-5.77%
	W-A6 - Ward A6	28	19.57	4.45	1.00	13.62	0.0		1:7	1481.5	1301.9	1031.0	1096.0	1:9	1035.0	959.0	713.0	782.0	-121.6	11.5	-10.6	-2.85%
	W-A9 - Ward A9	28	18.83	3.27	3.00	15.50	1.0		1:7	1426.0	1234.0	1426.0	1281.0	1:9	1069.5	897.0	713.0	713.0	-509.5	11.5	-44.3	-10.99%
	W-B19 - Ward B19	18	13.68	2.00	1.00	13.90	0.6		1:6	1069.5	984.5	713.0	989.5	1:6	713.0	713.0	713.0	701.5	180.0	11.5	15.7	5.61%
	W-B4-H - Ward B4 - Halton	27	12.20	2.03	1.00	6.00	1.00		1:9	1069.5	857.0	356.5	540.5	13.5 :1	356.5	540.5	356.5	310.5	109.5	11.5	9.5	5.12%
	W-CM1-H - Ward 1 - CMTC Treatment Centre	30	26.60	5.23	1.92	14.00	2.59		1:5.5	1978.0	1552.6	1196.0	772.5	10 : 1	966.0	770.5	644.0	563.5	-1124.9	11.5	-97.8	-23.51%
	W-ICU - Intensive Care Unit	18	76.74	9.41	1.00	11.52	0.00		1:1 Level 3 1:2 Level 2	4991.0	4140.0	1069.5	914.3	1:1 Level 3 1:2 Level 2	4991.0	4140.0	713.0	586.5	-1983.7	11.5	-172.5	-16.86%
Total		205	205.03			96.99		0.00											-3673.7		-319.5	
	AED			12.00	6.00	13.02				4464.0	4017.3	1162.5	911.3		3205.1	3107.2	896.5	707.4	-984.9	12.5	-78.8	-10.12%

Unscheduled Care	W-A1A - Ward A1 Asst	29	41.40	8.80	4.00	22.10	3.90		5.5	2325.0	2435.0	1550.0	1362.5	0.0	1953.0	1848.0	651.0	632.0	-201.5	12.5	-16.1	-3.11%
	W-A2A - Ward A2 Admission	28	18.83	3.10	0.00	12.90	2.94		5.6	1426.0	1368.0	1069.5	1069.5	9.3	1069.5	1035.0	713.0	759.0	-46.5	11.5	-4.0	-1.09%
	W-A3OPAL - Ward A3 Opal	34	18.83	139.00	1.00	15.50	3.24		8.5:1	1426.0	1368.0	1426.0	1416.8	0.0	1069.5	1000.5	713.0	713.0	-136.2	11.5	-11.8	-2.94%
	W-A7 - Ward A7	33	18.80	3.22	1.00	15.50	2.03		8.3:1	1426.0	1426.0	1426.0	1362.0	0.0	1069.5	1058.0	713.0	713.0	-75.5	11.5	-6.6	-1.63%
	W-A8 - Ward A8	34	18.80	1.95		15.50			8.5:1	1472.0	1247.0	1645.0	1457.5	0.0	1092.0	989.0	1035.0	977.0	-573.5	11.5	-49.9	-10.94%
	W-B12 - Ward B12 (Forget-me-not)	21	13.68	0.92	0.92	15.50	1.24	300.56	7.0:1	1069.5	1000.0	1426.0	1767.5	0.0	713.0	713.0	713.0	713.0	272.0	11.5	23.7	6.94%
	W-B14 - Ward B14	24	18.80	1.41		12.90	0.92		6.0:1	1426.0	1230.0	1069.5	1019.5	8.0	1069.5	908.5	713.0	667.0	-453.0	11.5	-39.4	-10.59%
	W-B18 - Ward B18	24	18.80	3.00		18.00	1.00		6.0:1	1426.0	1111.5	1426.0	1334.0	0.0	1069.5	897.0	1069.5	954.0	-694.5	11.5	-60.4	-13.92%
	W-C21 - Ward C21	24	13.68	1.6	1.0	11.30	0.40		8.0:1	1069.5	1058.0	816.5	816.5	0.1	713.0	713.0	713.0	713.0	-11.5	11.5	-1.0	-0.35%
	W-C22 - Ward C22	21	13.68	2.00	1.00	12.90	2.00		7.0:1	1069.5	1062.0	1069.5	967.0	0.1	713.0	713.0	713.0	713.0	-110.0	11.5	-9.6	-3.09%
	W-CCU - Coronary Care Unit	8	21.2	1.1	0.0	2.6	0.0		2.0:1	1426.0	1294.0	356.5	245.0	0.0	1069.5	1038.5	0.0		-274.5	11.5	-23.9	-9.62%
Total		280	216.47			167.73		300.56											-3289.6		-277.8	
WCSS	W-B11B/W-B11C - Ward B11	24	29.50	3.60	2.00	15.92	5.66		1:1 level3 1:2 Level2	2100.0	1756.0	930.0	880.0	0.0	1488.2	1385.0	0.0	0.0	-497.2	7.5 day 10.63 night		-11.00%
	W-NHDU/W-NITU/W-NSC - Neonatal Unit	18	24.38	3.00	1.00	6.52	3.60		7.5:18	1092.0	1063.0	798.0	761.0	7.5:18	942.8	922.8	240.0	240.0	-86.0			-2.80%
	W-C20 - Ward C20	12	12.63	2.23	0.00	5.00	0.43		1:4	1232.5	922.5	675.0	621.5	1:6	581.3	600.8	0.0	0.0	-344.0			-13.82%
	W-C23 - Ward C23	22	97.92			18.93			1:7.33	1348.5	1370.9	899.0	802.5	1:11	581.3	736.4	290.6	300.4	90.8			2.91%
Total		76	164.43	8.83	3.00	46.37	9.69	0.00											-836.4		0.0	
Grand Total		561	585.93	8.83	3.00	311.09	9.69	300.56											-7799.7		-597.3	

BOARD OF DIRECTORS

WHH/B/2015/ **185**

SUBJECT:	Monitor Guidance – Nurse Agency Spend
DATE OF MEETING:	2 October 2015
ACTION REQUIRED	**For Discussion**
AUTHOR(S):	Alison Lynch, Deputy Director of Nursing Clare Pratt, Associate Director of Nursing, Corporate Nursing Sue Franklin, Associate Director of Nursing, Unscheduled Care
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 to the Board on Appendix A of the Monitor & TDA Nurse Agency Rules publication (September 2015). It also provides an update on the National Quality Boards - Hard Truths (2013). Additionally, information is provided to concerns raised relating to staffing levels via the Speak out Safely system in place
RECOMMENDATION:	The Board is asked to: 1. The Board is asked to note the content of this report and assurance given regarding: a. Monitor rules regarding agency usage b. Monitors request that boards are made aware of a number of safeguards in place c. Increased amount of concerns raised regarding nurse staffing levels and the action taken/ being taken by the Director of Nursing to address

	2. The Director of Nursing will bring a further update to board as part of the monthly staffing assurance paper	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee
	Agenda Ref.	
	Date of meeting	22 September 2015
	Summary of Outcome	

1. Executive Summary

Trusts face increasing workforce cost pressures because shortages in certain staff groups have significantly increased agencies' bargaining power. These shortages have been compounded by rising demand for NHS nurses in response to the sector's heightened emphasis on service quality and safety; the movement towards seven-day access for patients to hospital and GP services increasing demand for nurses; the rate of nurses leaving the profession rising by 29% over the past two years; and limits to the supply of nurses from UK training and other sources.

Monitor and the NHS Trust Development Authority (TDA) have set Trusts challenging Targets to reduce Nurse Agency spend by end of financial year.

They have developed a set of rules intended to increase trusts' bargaining power when they procure from agencies and encourage nurses to return to permanent and bank working. Their success should enable trusts to manage their workforce in a more sustainable way, reduce reliance on temporary staffing, raise quality and improve the working environment for their staff.

The rules are rules launched are:

- an annual ceiling for total nursing agency spending for each trust, and
- mandatory use of approved frameworks for procuring agency staff.

The rules are designed to bring:

- greater transparency on nursing agency spend
- greater assurance on quality of nursing agency supply
- control on cost of nursing agency spend

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.

2. Update to Appendix 2 of the Nurse Agency Rules publication

Trusts subject to these rules are expected to have formal governance procedures, with the appropriate clinical and financial input, to authorise spending on agency staff, taking into account any impact of the rules on care quality. We expect this to be consistent with the NICE and NQB guidance (including 10 expectations published in November 2013). Specifically, Trust Boards should take full responsibility for nursing staffing capacity and capability. This includes managing spend effectively and ensuring the spending rules outlined in this document are kept to.

Trusts have an important role working with commissioners to monitor performance. Where problems with staff capacity and capability pose a threat to quality, they must use commissioning and contractual levers to bring about improvements

Monitor and TDA will expect trust boards to give assurance and evidence to the oversight bodies on request that the following best practice is undertaken in the short term:

- *Assessing patient acuity and dependency to see how far the existing nursing skill mix could be flexed to meet patients' needs cost-effectively*

  The Trust uses a recommended staffing tool on a formal basis bi-annually. In the short term there is oversight and scrutiny of staffing levels regularly throughout the day, where the flexibility of the nursing staff availability in relation to patient needs at ward and department level are taken into account and acted upon.

- *Considering not filling shifts when there is a short-term staff shortage and it is safe to do so*

  The senior nurse team do consider whether shifts can safely be left unfilled. Where this is safe to do, they ensure additional measures are in place, such as regular visit by either the Matron, ADoN or Acute Care Nurse Practitioner.

- *Depending on the level of patient risk, engaging on a temporary and fixed basis professionally qualified staff such as allied health professionals, pharmacists, clinical psychologists and paramedics to supplement the nursing workforce*

  The trust has therapy workers working within the Forget Me Not unit, and has also utilised pharmacy staff undertaking medication administration. A review of whether other staff can be deployed to supplement the nursing workforce is required to explore this area further.

- *Allocating support staff such as ward clerks, pharmacy technicians, house keepers, health records staff, etc, to help maximise nurse-patient contact time and improve the level of services for patients*

  Support staff such as housekeepers and ward clerks already work in this capacity. The trust is looking to develop further the large pool of volunteers already in past and working in this capacity.

- *Flexibly deploying existing nursing staff to undertake work beyond their usual area (provided they are competent to do so)*

  Registered nursing staff or healthcare assistants are redeployed between clinical areas of the trust. These decisions are made based on the best use of staff at the time, taking account of acuity / dependency and skill mix available.

- *Redeploying suitably qualified and experienced nursing staff from non-frontline duties*

  The trust utilises specialist nurses / education and training staff and other non-frontline staff in order to support wards. This is part of the escalation policy.

- *Assessing nursing staff availability on all frameworks that have been approved*

The trust does not use any agency outside those that have been approved on the framework.

3. National Quality Board's 10 Recommendations

The National Quality Board's guide to nursing staffing capacity and capability outlines the roles and responsibility of the Trust Board when determining staffing levels and skill mix. The Trust Board has received papers every six months since March 2014 in relation to staffing reviews. 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. The Board was set to receive an update of these 10 expectations in October 2015 (last received an update in April 2015), however it is timely in the light of Monitor & TDA's Nurse Agency Rules publication to provide an update within this paper.

The 10 expectations, as at September 2015 are as below:

<u>EXPECTATION 1:</u> *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, next due Octobe 2015
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. There is oversight and scrutiny of staffing levels regularly throughout the day, where the flexibility of the nursing staff availability in relation to patient needs at ward and department level are taken into account and acted upon.
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

<u>EXPECTATION 2</u>: *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

<u>EXPECTATION 3</u>: *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, review completed in August 2015 and recommendations are being made. 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 The AED Safer Nursing tool has been developed by Associate Director of Nursing, Corporate Nursing in conjunction with the AED team and this is being tested.
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. This is assessed as part of the DAWES scheme.

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 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

. Expectation Four	Progress to date
	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 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

Speak out Safely concerns received since April 2015

Ward / Department	Theme	Response given by
Accident and Emergency	Concern about patient care, busyness of the department and use of CDU	Medical Director
Ward A6	Staffing shortages	Associate Director of Nursing
Scheduled Care	Staffing shortages and staff being moved to cover other areas	Associate Director of Nursing
Ward C20 x 2	Staffing levels and shortages	Interim Associate Director of Nursing
Childrens Safeguarding x 2	Staffing levels, capacity and expectations	Associate Director of Nursing
Ward A7 x 2	Staffing levels, acuity of patients, staff being moved to cover other areas	Associate Director of Nursing Matron

Ward A8	Staffing levels, acuity of patients, staff being moved to cover other areas	Associate Director of Nursing Matron
Ward A1	Staffing levels, acuity of patients, and overnight use of GPAU	Associate Director of Nursing Matron

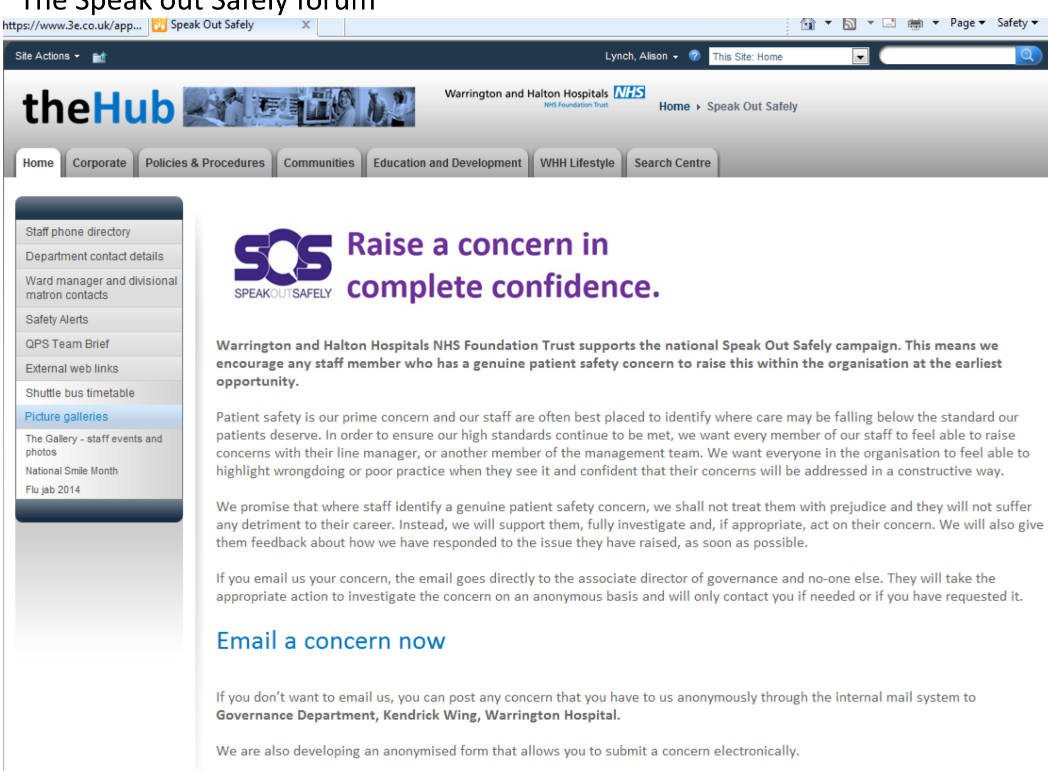
In addition to the concerns raised via the SOS route there have been a number of other triggers

- Article in Warrington Guardian following letter from a nurses partner
- Letter to the RCN following guardian article
- Increasing number of concerns being raised directly re out of hours staffing

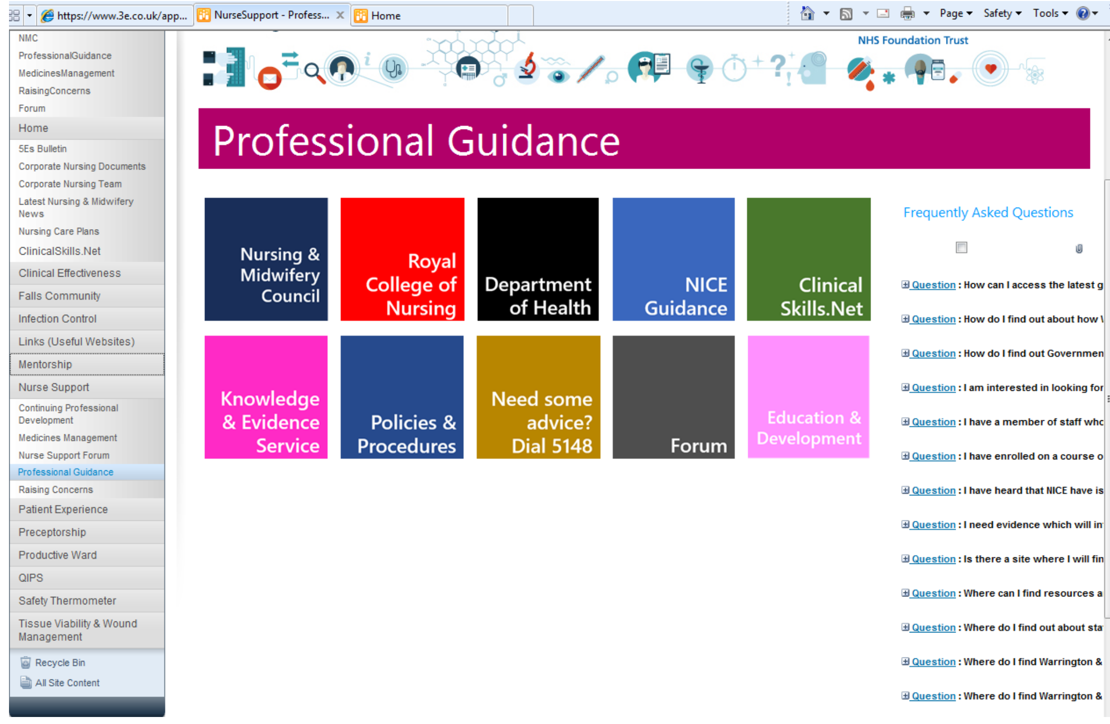
Actions taken led by Director of Nursing as a result of concerns (in addition to the staffing work streams) raised:

- Series of meetings in place over the next few weeks at both Warrington and Halton site, at differing times of day to enable both night and day staff to attend
- Senior nurse visibility at ward level to help alleviate concerns
- Royal College of Nursing visited the hospital in September 2015 to meet with staff and to visit ward areas
- Regular updates from the Associate Directors of Nursing including vacancies, sickness and absence monitoring
- Meetings with individuals and wards
- Regular out of hours contact
- Reviews of skill mix (carer / registered ratio)
- Meeting with the RCN – Including Regional Director and the Deputy Director of Nursing (Dame Donna Kinnair)

*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%, this is currently under review and will be presented to the executive team in due course. 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, next paper due October 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: EU recruitment to Romania Rolling adverts for recruitment Recruitment for winter pressure
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.

4. Recommendations

1 The Board is asked to note the content of this report and assurance given regarding:
   a. Monitor rules regarding agency usage
   b. Monitors request that boards are made aware of a number of safeguards in place
   c. Increased amount of concerns raised regarding nurse staffing levels and the action taken/ being taken by the Director of Nursing to address

2 The Director of Nursing will bring a further update to board as part of the monthly staffing assurance paper

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BOARD OF DIRECTORS WHH/B/2015/ **186**

SUBJECT:	**Verbal Report from the Chair of the Charitable Funds Committee**
DATE OF MEETING:	2 October 2015
DIRECTOR:	Lynne Lobley, Non-Executive Director

Minutes for Noting

1. Finance and Sustainability Committee dated 20 August 2015

2. Quality Committee dated 7 July 2015