Warrington and Halton Hospital NHS Foundation Trust
Board of Directors
Agenda

Thursday 29th October 2014, 1300 – 1700hrs
Trust Conference Room, Warrington Hospital

1300	***W&HHFT/TB/14/150***	***Welcome, Apologies & Declarations of Interest***		Chairman
	W&HHFT/TB/14/151	***Minutes of the previous meeting held on 2nd October 2014***	Paper	
	W&HHFT/TB/14/152	***Action Plan***	Paper	Chairman
1330	***W&HHFT/TB/14/153***	***Chairman's Report***	Verbal update	Chairman
	W&HHFT/TB/14/154	***Chief Executives Report***	Verbal update	Chief Executive
		People		
1400	***W&HHFT/TB/14/155***	***Workforce and Educational Development Key Performance Indicators***	Paper	Director of Nursing and Organisational Development
	W&HHFT/TB/14/156	***Staffing Levels 6 month Report (including Monthly Staffing level exemption Report – August 2014)***	Paper	Director of Nursing and Organisational Development
		Sustainability		
1420	***W&HHFT/TB/14/157***	***Finance Report to 30 September 2014***	Paper	Director of Finance & Commercial Development
1440	***W&HHFT/TB/14/158***	***Corporate Performance Dashboard & Exception Report***	Paper	Chief Operating Officer
1500	***10 Minute Break***			
1510	***W&HHFT/TB/14/159***	***Corporate Risk Register - not included*** to be updated following Board review on 29 October 2014	Paper	Director of Nursing and Organisational Development
1520	***W&HHFT/TB/14/160***	***Board Assurance Framework - not included*** to be updated following Board Review on 29 October 2014	Paper	Executive
		Quality		
1530	***W&HHFT/TB/14/161***	***Quality Dashboard***	Paper	Director of Nursing and Organisational Development
1545	***W&HHFT/TB/14/162***	***Infection Control Quarterly Report***	Paper	Director of Nursing and Organisational Development
1600	***W&HHFT/TB/14/163***	***Sign Up to Safety***	Presentation	Director of Nursing and Organisational Development
1615	***W&HHFT/TB/14/164***	***Complaints Quarterly Report***	Paper	Director of Nursing and Organisational Development

1630	***W&HHFT/TB/14/165***	***Monitor Governance Statement Q2 2014/15***	Paper	Director of Finance & Commercial Development
1645	***W&HHFT/TB/14/166***	***Board Committee Reports:*** ***Board Committee Verbal Update*** ***a) Finance and Sustainability Committee held on 22nd October 2014*** ***Minutes for Noting:*** ***a) Finance and Sustainability Committee held on 17th September 2014***	Papers	Chair of each Committee
	W&HHFT/TB/14/167	***Any Other Business***		
1700 end		***Dates of next meeting*** *26th November 2014*		

W&HHFT/TB/14/152

TRUST BOARD
ACTION PLAN – Current / Outstanding Actions
Meeting: Trust Board 29th October 2014

Meeting date	Minute Reference	Action	Responsibility & Target Dates	Status	
30 July 2014	TB/14/119	The Director of Nursing and Organisational Development to provide to the Non-Executive Directors details of the categories of incidents and near missed reported in the Head of Midwifery Annual Report 2013.	Director of Nursing and Organisational Development.	The Director of Nursing and Organisational Development issued report to the Board after the Board meeting held on 2nd October 2014	Action discharged

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/153

BOARD OF DIRECTORS

Paper Title	**Chairman's Report**
Date of Meeting	29th October 2014

W&HHFT/TB/14/154

BOARD OF DIRECTORS

Paper Title	**Chief Executive's Report**
Date of Meeting	29th October 2014

W&HHFT/TB/14/155

BOARD OF DIRECTORS

Paper Title	Human Resources / Education & Development Key Performance Indicators (KPIs) Report
Date of Meeting	29 October 2014
Director Responsible	Karen Dawber
Author(s)	Mick Curwen
Purpose	This report focuses on the KPIs which are felt to give a good indication to the Board on progress with the main workforce and governance performance areas within Human Resources and Education and Development.

Paper previously considered	**Committee**	**Date**
HR / E&D KPIs Reports	Trust Board meetings	2 October 2014
HR / E&D KPIs Reports	Strategic People Committee	11 August 2014

Relates to which Trust objectives — **Appropriate**

- Ensure all our patients are safe in our care
- To be the employer of choice for healthcare we deliver √
- To give our patients the best possible experience
- To provide sustainable local healthcare services √

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

	Page/Paragraph Reference
Mandatory training rates are largely unchanged but appraisal rates for both non-medical and medical staff have decreased	**Pages 2 - 3 / Section 2.1 & 2.2**
No change on revalidation rate but 12 more doctors revalidated	**Page 4 / Section 2.3**
Sickness absence – worst in month position for over 12 months	**Pages 4 / Section 2.4**
Turnover rate has reduced and stabilized. Vacancy rate increased. Headcount has decreased.	**Pages 4 - 5/ Section 2.5 & 2.6**
Temporary staffing expenditure – decrease of £104k	**Pages 5 & 6 / Section 2.7**
All main Equality and Diversity targets achieved for 2014 and reasonable progress on training target	**Page 7 / Section 2.8**

Recommendation(s)

The Board is asked to consider the key points above and the detailed report attached (Appendix 1)

Appendix 1

Human Resources / Education & Development
Key Performance Indicators Report October 2014

1.0 Introduction

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

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

The dashboard attached to this report shows the progress on KPIs, focussing on the position at September 2014, where applicable.

2.0 HR and E&D Trust Workforce Standards KPIs Overview

2.1 Mandatory Training

The target for all mandatory training is 85%.

There has been little change to the mandatory training rates with Health and Safety remaining the same; an increase for Fire and a slight reduction for Manual Handling. The trend in recent months of little change has therefore continued. However, individually, some Divisions/areas are meeting the trust target for some parts of the mandatory training.

Completion rates for the Divisions are as follows (figures in brackets denotes the month of August 2014):

Division	Fire Safety	Health & Safety	Manual Handling
Scheduled Care	70% (69%) (Amber)	91% (91%) (Green)	55% (57%) (Red)
Unscheduled Care	70% (68%) (Amber)	87% (88%) (Green)	65% (68%) (Red)
Women's & Children's	76% (75%) (Amber)	91% (91%) (Green)	77% (77%) (Amber)
Estates	87% (87%) (Green)	100% (100%) (Green)	98% (98%) (Green)
Facilities	87% (84%) (Green)	81% (81%) (Amber)	74% (83%) (Amber)
Corporate Areas	86% (84%) (Green)	99% (98%) (Green)	84% (83%) (Amber)

The only area achieving all of the targets is Estates although the Corporate areas are only just below the target for Manual Handling. There was a noticeable reduction for Facilities for Manual Handling.

At a Corporate level the arrangements introduced in September 2012 for Corporate Induction continue to work well and an impressive 100% of staff attended corporate induction during September 2014.

2.1.1 Health & Safety (Green)

There has been no change from the previous month and the rate remains at 90% and green.

The target for 2014/15 is being achieved.

2.1.2 Fire Safety (Amber)

There was an increase of 2% from the previous month and the rate is 76% and amber.

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

There was a slight decrease of 1% from the previous month and the rate is 71% and amber.

2.1.3.1 Manual Handling Patient Training Only (Red)

There was a decrease of 1% from the previous month and the rate is 64% and red.

2.1.3.2 Manual Handling Non-Patient Training Only (Amber)

There was a slight reduction of 2% from the previous month and the rate is 80% and amber.

2.2 Staff Appraisals

The target for completed PDRs is 85%.

During September there were slight reductions for both Non-Medical and Medical and Dental staff.

Completion rates for the Divisions for non-medical staff are as follows (figures in brackets denotes the month of August 2014):

Division	PDR Rate
Scheduled Care	72% (76%) (Amber)
Unscheduled Care	65% (68%) (Red)
Women's and Children's	78% (77%) (Amber)
Estates	79% (79%) (Amber)
Facilities	89% (90%) (Green)
Corporate Areas	75% (67%) (Amber)

Three Areas/Divisions saw a reduction in their rates but the Corporate areas performed particularly well increasing by 8%. The only area achieving the target is Facilities. There is considerable room for improvement within Unscheduled Care which is still showing Red.

2.2.1 Non-Medical Staff (Amber)

For the period up to September 2014 the percentage of non-medical staff having had an appraisal reduced by 1% and is 75% and the status is amber.

2.2.2 Medical & Dental Staff (Amber)

The combined rate for Consultant staff and Middle Grade doctors, up to September 2014 has fallen by 2% to 84%. This is largely explained by the fact that there are 5 more medical staff in post. The rate for Consultants fell by 2% to 88% and other M&D decreased by 3% to 75%.

This means that the target of 85% was not quite achieved and the status is amber.

Divisions have been reminded at the bi-lateral meetings that priority must still be given to appraisal rates despite the financial position and these are regularly reviewed.

2.3 Revalidation for Medical and Dental Staff (Amber)

The Revalidation Decision Making Group met on 6 October 2014 as planned and 12 more doctors were approved for revalidation. Therefore in total 73 doctors have been approved for revalidation by the GMC with 15 doctors deferred, making the rate 82%. The trust has also reported one doctor to the GMC for no-engagement in the process but this doctor is now responding more favorably.

The next meeting of the Decision Making Group is on 18.11.14.

2.4 Sickness Absence

2.4.1 Sickness Absence Rates (Amber)

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

Sickness absence for September 2014 was the highest in month rate for more than 12 months at 4.31% which was on the back of the best month in August since July 2013. This will require further analysis and examination to understand the reasons why. Consequently the cumulative rate for April – September 2014 increased to 4.09%.

Sickness absence continues to be closely monitored and managed in all areas in the Trust in line with the Attendance at Work Policy. The number of staff being managed either through the Short Term Absence or Long Term Absence Sections of the policy, remains high at over 250 staff.

2.4.2 Return to Work Interviews (RTW) (Red)

The target for this KPI is 85% and is only reported on a quarterly basis. The rate for Q2 was 59% which was an increase of 6% from Q1. The rate has consistently increased in every quarter since this has been monitored from being 30% at Q1 in 2013/14 and therefore, has almost doubled.

At training sessions and when completing eSVLs, managers are reminded of the need to undertake RTW interviews and record these on ESR. It is still believed that more RTW interviews are actually taking place but managers are failing to record this on ESR.

2.5 Turnover Rate (Amber)

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

The rate for the previous 12 months up to September 2014 showed a reduction of 0.29% to 9.37% and the status is amber. This is the first time since December 2013 that there has been a reduction as a steady upward trend had been developing. Nonetheless it is of some concern particularly as both Unscheduled Care (11.06%) and Scheduled Care (10.65%) are showing quite high rates. Both of these Divisions are undertaking further analysis of leavers by personal interviews to understand in more detail why staff are leaving.

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

The Trust FE FTE was 3700 and staff in post 3382 FTE. This means the vacancies FTE has deteriorated to 8.59% but the status remains as 'green'. This has resulted in the highest number of vacancies this year at 318.

The headcount of 4152 was a slight reduction of 4 from the previous month.

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

The threshold for this KPI is 4.5% of total pay bill. Total spend in September 2014 decreased by £104k and was £915k, which represents 7.25% of the pay bill for the month and cumulatively for April – September 2014 the rate is 7.22%. Against the agreed threshold for 2014/15 of 4.5% the status, therefore, is 'Red' and was not achieved.

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

Nurse Bank and Agency Nursing - £370k (£465k for August)
Agency (exc Medical & Nursing Agency) - £201k (£267k for August)
Medical Locums and Medical Agency - £343k (£287k for August)

Two areas showed a decrease as follows: Nurse Bank /Agency by £95k and Agency by £66k. Medical Locums/Agency increased by £56k.

Total expenditure for the period April – September 2014 is £5.5m broken down as follows:

Nurse Bank and Agency Nursing - £2.3m
Agency (exc Medical and Nursing Agency) - £1.1m
Medical Locums and Medical Agency - £2.1m

NB In order to staff the additional intermediate care beds which were opened earlier this year the trust had to recruit staff predominantly from agencies and some of these staff have continued to be needed to meet additional staffing pressures. The total additional expenditure which is being met externally from Warrington CCG is now £190k which is included in the above amounts.

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

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

<u>Nurse Bank and Agency Nursing</u>
Elderly and Stroke - £110k (£54k on unqualified staff)
A&E - £74k (£60k on agency)
Acute Medicine – £50k (£29k on agency)
Specialty Medicine - £36k
T&O - £31k
Women's Health - £29k
Critical Care - £28k
Surgery - £27k

<u>Agency</u>
Therapies - £75k
PMO – £51k
Pharmacy - £28k

<u>Medical Locums/Agency</u>

T&O - £96k
A&E - £60k
Surgery - £57k
Elderly and Stroke - £49k
Specialty Medicine - £42k

The Additional Staffing Group did not meet in October as the scheduled date was the same as the trust Strategy Day. However, the Workforce and Controls Group met on 17 October 2014 and were pleased to note progress on some schemes as follows:

Vacancy Control Process
A new vacancy control process has been drafted and is due to be approved at ICIC on 24 October 2014 with the intention that this is implemented from 27 October 2014. This will apply to all posts.

Nursing Recruitment
Rolling adverts are in place in Unscheduled Care with an emphasis on A&E/AMU and Scheduled Care with an emphasis on Theatres. This has been very successful with many qualified nurses being appointed and in relation to the E&Y work stream of recruiting up to 40 wte qualified nurses has easily been surpassed. Additional unqualified staff have also been recruited.

International Recruitment
The trust is working with an agency called Globalmedirec to recruit Consultant Radiologists. From the first round of interviews 2 doctors were offered posts but only one has accepted who is provisionally due to commence on 10.11.14. Another doctor has been interviewed by Skype and has been invited for a traditional interview on 29.10.14. 3 other applications are currently being considered by the Division.

Recruitment Process
The trust is working on a number of initiatives to streamline the recruitment process. Work is continuing on putting in place a revised ECF process using Share Point. Discussions have also taken place externally with a company who have an electronic system for DBS Checks. This is being progressed and it is expected that this could save at least 2 weeks on the average recruitment time to complete recruitment checks.

The Executive Team agreed to recruit to over establishment for Radiography to recognize regular turnover and difficult to fill posts and this has implemented. This approach could be used in other areas such as Pharmacy and Theatres.

E-Rostering
Approximately 15 wards/areas have now gone live with a further 3 areas over the next 3 weeks as part of the planned roll out. This has generally gone well and work continues on quantifying the benefits realisation.

It is worth highlighting that since the intermediate care facility was withdrawn from Daresbury by Warrington CCG, patients have had to be accommodated in escalation areas which has had a detrimental effect on Scheduled Care and WCSS who have constantly been escalating their beds to accommodate these patients which are not funded.

Work is continuing on the Admin Review and the Medical Productivity work streams. A new Job Planning Policy for Consultants has been agreed and the trust is working with Allocate on a pilot in Anesthetics to implement job plans in line with the new policy.

Discussions and monitoring of progress continue on all of the above issues at the bi-lateral divisional review meetings.

2.8 Equality & Diversity

2.8.1 E&D Specialist in place (Green)

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

2.8.2 Annual Workforce Equality Analysis Report published (Green)

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

2.8.3 Annual Equality Duty Assurance report published (Green)

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

2.8.4 Annual Equality Objectives published (Green)

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

2.8.5 Annual Equality Strategy published (Green)

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

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

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

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

There has been an increase of 1% from Q1 to 63% at Q2.

Warrington and Halton Hospitals NHS Foundation Trust

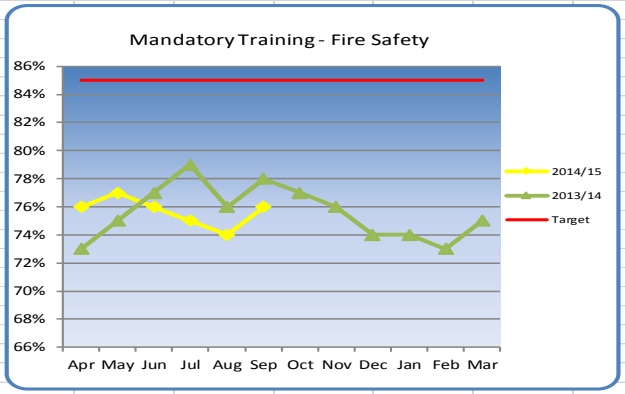
Governance & Workforce Division

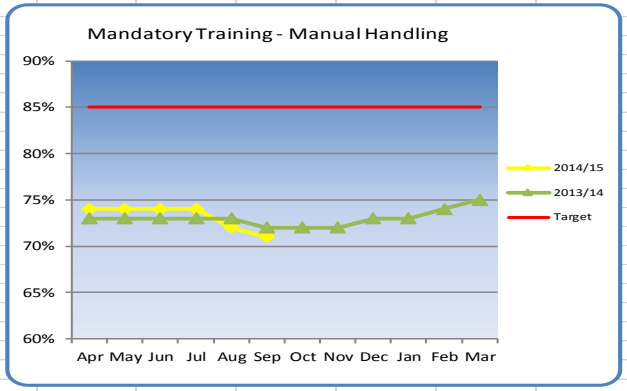
Human Resources / Education & Development Workforce Key Performance Indicators

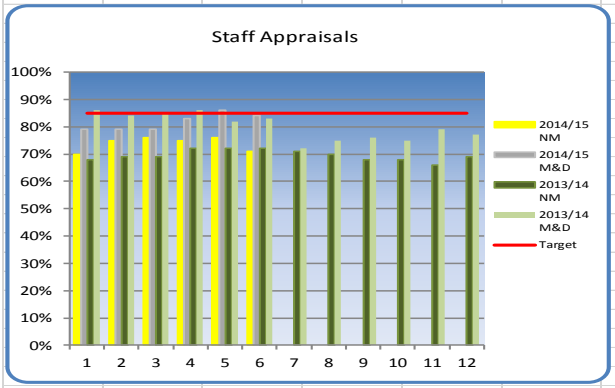
2014/15			Target / Threshold	Frequency	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year to Date	Criteria for RAG Status: Green	Amber	Red
Training & Development	Mandatory Training	Health & Safety	85% staff trained in last 3 years	Monthly	88%	88%	89%	90%	90%	90%							**90%**	85 - 100%	70 - 84%	< 70%
		Fire Safety	85% staff trained in last 12 months	Monthly	76%	77%	76%	75%	74%	76%							**76%**	85 - 100%	70 - 84%	< 70%
		Manual Handling - Patient	85% staff trained in last 2 years	Monthly	67%	67%	67%	68%	65%	64%							**64%**	85 - 100%	70 - 84%	< 70%
		Manual Handling - Non-Patient			86%	85%	85%	83%	82%	80%							**80%**			
		Manual Handling - Total			74%	74%	74%	74%	72%	71%							**71%**			
	Staff Appraisals	Non Medical	85% staff received appraisal in last 12 months	Monthly	70%	75%	76%	75%	76%	75%							**75%**	85 - 100%	70 - 84%	< 70%
		Medical & Dental - consultants & career grades, (exc Jnr Drs)			79%	79%	79%	83%	86%	84%							**84%**			
	Revalidation for Medical & Dental Staff		85% of eligible M& D Staff revalidated	Monthly	81%	81%	82%	82%	82%	82%							**82%**	85 - 100%	70 - 84%	< 70%
Sickness Absence	Sickness Absence Rates		4%	Monthly	4.18%	3.99%	3.98%	3.94%	3.70%	4.31%							**4.09%**	3.75%	3.76-4.49%	> 4.50%
	Return to work interviews (wef 2013/14)		85%	Quarterly			53%			59%							**59%**	85 - 100%	70 - 84%	< 70%
Workforce	Turnover (Leavers)		Min 8% or Max 9%	Monthly	9.0%	9.1%	9.3%	9.3%	9.7%	9.4%							**9.4%**	8 - 9%	5 - 7.9% / 9.1 - 12%	< 5% / > 12%
	Establishment / SIP	Funded WTE (see NB 1 below)	Min 6.5% or Max 10% FE / SIP gap	Monthly	3686	3676	3682	3674	3695	3700							**3700**	6.5 - 10%	5 - 6.4% / 10.1 - 12%	< 5% / > 12%
		Staff in Post WTE (see NB 1 below)			3392	3391	3371	3375	3424	3382							**3382**			
		Staff in Post Headcount (see NB 2 below)			4171	4155	4134	4143	4156	4152							**4152**			
		Vacancies WTE (see NB 1 below)			294	285	311	299	271	318							**318**			
		Vacancies %			7.97%	7.75%	8.44%	8.13%	7.33%	8.59%							**8.59%**			
	Flexible Labour Expenditure (% of total paybill)	Bank / Agency / Medical Locums Total	4.5%	Monthly	6.6%	6.7%	7.6%	6.7%	7.9%	7.25%							**7.22%**	4.5%	4.6 - 5.0%	> 5.0%
	Equality & Diversity	E&D Specialist in place	Achieved	6-monthly						Achieved							**Achieved**	Achieved	Work in progress	No progress
		Annual Workforce Equality Analysis report published	Achieved	Annual													**Achieved**	Achieved	Work in progress	No progress
		Annual Equality Duty Assurance report published	Achieved	Annual													**Achieved**	Achieved	Work in progress	No progress
		Annual Equality Objectives published	Achieved	Annual													**Achieved**	Achieved	Work in progress	No progress
		Annual Equality Strategy published	Achieved	Annual													**Achieved**	Achieved	Work in progress	No progress
		Staff have access to E&D information and resources	Achieved	6-monthly						Achieved							**Achieved**	Achieved	Work in progress	No progress
		Staff have undertaken E&D training	85% staff trained	6-monthly			62%			63%							62%	85 - 100%	70 - 84%	< 70%

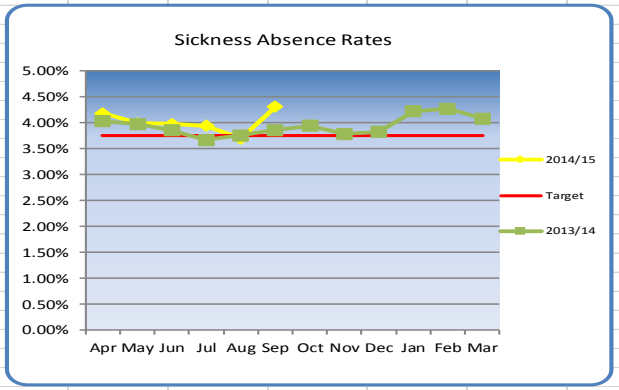
NB 1 Figures from Finance Ledger					**R**	**Red**		**A**	**Amber**		**G**	**Green**								
NB 2 Figures from HR ESR																				

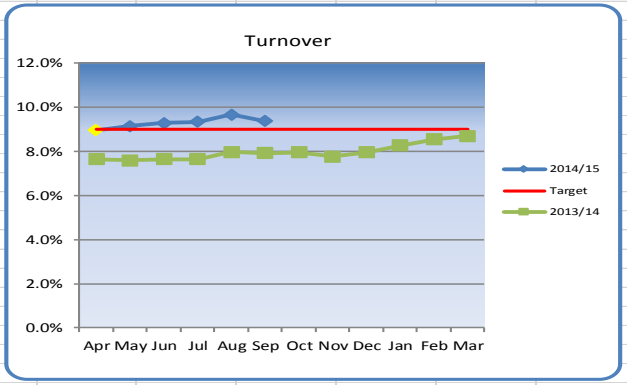

Mandatory Training - Health & Safety
91%
90%
89%
88%
87%
86%
85%
84%
83%
82%
81%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
2013/14
Target

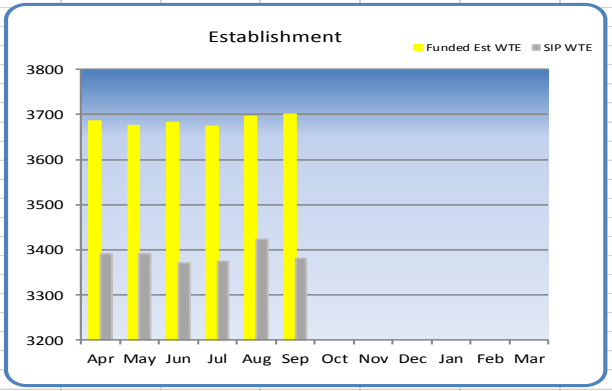

Mandatory Training - Fire Safety
86%
84%
82%
80%
78%
76%
74%
72%
70%
68%
66%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
2013/14
Target

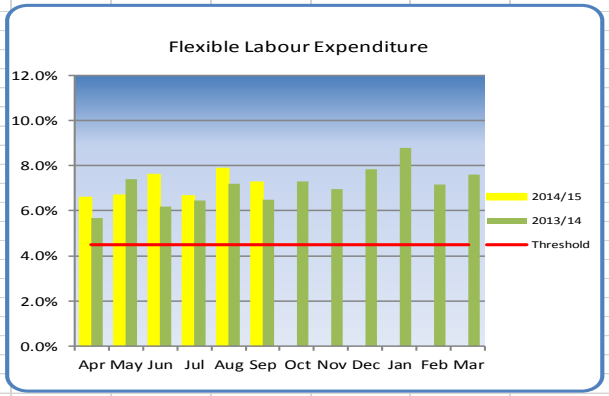

Mandatory Training - Manual Handling
90%
85%
80%
75%
70%
65%
60%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
2013/14
Target


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


Sickness Absence Rates
5.00%
4.50%
4.00%
3.50%
3.00%
2.50%
2.00%
1.50%
1.00%
0.50%
0.00%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
Target
2013/14


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


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


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

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/156

BOARD OF DIRECTORS

Paper Title	6monthy Staffing Report September 2014
Date of Meeting	29th October 2014
Director Responsible	Director of Nursing and Organisational Development
Author(s)	Deputy Director of Nursing
Purpose	This report provides the Board with a review of the actions taken to meet the nurse staffing guidance and includes an in-depth month by month overview of our staffing levels since May 2014, highlighting reasons for shortfalls or overfills. It also provides some analysis of our current position against the NICE Guidance *Safe staffing for nursing in adult inpatient wards in acute hospitals* issued in July 2014. Progress updates are provided against the expectations of the NHS Quality Board and NHS England's guidance *How to ensure the right people, with the right skills, are in the right place at the right time'. (2013)*

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**

Relates to which Trust objectives	√ **appropriate**
• Ensure all our patients are safe in our care	✓
• To be the employer of choice for healthcare we deliver	✓
• To give our patients the best possible experience	✓
• To provide sustainable local healthcare services	✓

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

•	Progress updates against the expectations of the NHS Quality Board and NHS England's guidance *How to ensure the right people, with the right skills, are in the right place at the right time'. (2013).*	
•	Information as to the nurse staffing levels on the wards in the light of the new NICE Guidance for *Safe staffing for nursing in adult inpatient wards in acute hospitals* (2014).	
•	An outline of our future plans for staffing reviews.	
•	Monthly staffing exception report is included as appendix 1	

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

The Trust Board is requested to note:

- the contents of the report and expectations for reporting staffing capability and capacity to the Trust Board.
- the analysis from the month by month analysis, areas of concern via the Safety Thermometer and mitigating actions in progress.
- To agree the progress against the Hard Truths expectations and NICE guidance

Background

In March 2014, a nurse staffing paper was presented to the Board of Directors, which provided a comprehensive review of current staffing levels and skill mix, whilst making clear recommendations to ensure the quality and safety of patient care at Warrington and Halton Hospitals NHS Foundation Trust is upheld. The paper and the associated investment and other recommendations therein was approved by the Board. Since this time the Senior Nursing Team have monitored ward establishments however a formal review has not been undertaken since March as significant investment was made at this time, this included the supervisory status of the ward manager. As this review and associated staff moves including recruitment has taken some time to embed it is more appropriate to undertake the second review during Q3 and Q4 2014/15. We are currently reviewing staffing levels on CMTC. We are testing the Safer Nurse Care Tool approved in October 2014 by NICE in C20, A8 and A6 and plan for establishment review across the wards with this tool once the testing is completed.

In March 2014, NHS England wrote to Trusts to confirm the requirements for publishing staffing data regarding nursing, midwifery and care staff and give clear guidance on the delivery of the commitments set out in 'Hard Truths'.

Introduction

This paper provides an update on the nurse staffing levels agreed. Additionally it presents a summary of the national guidance 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 expectations relevant to acute hospitals are:

Expectation 1: Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care setting capacity and capability

Expectation 2: Processes are in place to enable staffing establishments to be met on a shift-to-shift basis

Expectation 3: Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability**.**

Expectation 4: Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns

Expectation 5: A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments

Expectation 6: Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties

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**.**

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

Expectation 9*: Providers of NHS services take an active role in securing staff in line with their workforce requirements*

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*

Progress

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

Expectation One	Progress to date
Boards request and receive papers on establishment review	Board received papers in March 2014 Further papers will be supplied to Board in October 2014 and on-going every six months
Boards to agree staffing establishments for all clinical areas	Following a comprehensive review, the new establishments were received and approved by the Board in March 2014
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 under development Staffing levels are reviewed at every bed meeting and staffing meeting throughout the day.
Organisations encourage and support staff to report any occasion where a lack of staff could have, or did harm a patients	Datix Incident reporting for staffing concerns captured. These are triangulated against patient safety incidents and reviewed via Nursing and Midwifery Advisory Council. Whistle blowing policy to be re-launched; professional nursing forum web community under development, led by Associate Director of

	Nursing for Scheduled Care.
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 Organisational Development and Chief Operating Officer have a good oversight between them and escalate concerns and actions to each other. Senior nurses receive the daily staffing log via e mail along with actions being taken

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

Expectation Two	Progress to date
Daily reviews of the actual staffing on a shift-by-shift basis versus planned	This is embedded in practice. Recorded through staffing matrix and undertaken by divisional nursing teams and within the daily staffing meetings
E-rostering policy	In place and ratified in Spring 2014
Escalation / Direct Observations of Care (Specialling) policy	Work in progress, with planning for approval by NMAC in December 2014

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

Expectation Three	Progress to date
Evidence based tools are utilised	Birthrate plus used in Maternity. Awaiting outcome of our review of NICE guidance to decide on tool to use – testing Safe Nurse Staffing toolkit at present . SG1 Toolkit NICE Assessment has been published in October 2014 and we are currently assessing this.

Use of professional judgment	This is used daily and was also a key component when triangulate the investment proposal in March 2014. 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 NMC Code of Conduct Practice Development Forum to be considered to oversee changes to practice and role/guideline/documentation development.
Healthcare assistants to receive the minimum training standards, progression routes to nurse training	Competency workbook in place for all nursing HCA's since August 2014 as part of our response to the Francis 2 report. This will be a core part of our Nursing & Midwifery Strategy during 2014/15. Away Day session planned for December 2014 to progress.

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	Whistle blowing policy to be re-launched. Sign up to Safety to be re-launched as part of professional nursing web community. There is a clear operational management structure with professional accountabilities There is a robust appraisal/PDR process.
The adaptation of technological advances enabling more efficient delivery of patient care	E rostering being rolled out, considering option for Safer Nursing Care tool via allocate. Successful Nurse Technology Fund bid & Safer Hospitals, Safer Care bid which will enable us to build our care metrics systems
Ensuring staff can speak up NMC code of conduct and raising concerns	Whistle blowing policy to be re-launched. Sign up to Safety to be re-launched as part of professional nursing web community. 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 RCN meet with Director of Nursing or Deputy Director of Nursing monthly Director of Nursing is also Director of OD which include workforce/HR and meets weekly with staff side chair.

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

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

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

Expectation Six	Progress to date
Establishment uplifts should reflect realistic expectations - Staff training and development - Supervision and mentorship roles - Planned and unplanned leave	Currently the uplift is 20%, we will review this in March 2015. Supervisory status for ward managers was included within case for investment. Evidence this was supported in March 2014, with the exception of C20.

EXPECTATION 7: Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review. Boards receive monthly updates on workforce

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

Expectation Seven	Progress to date
Board level discussion on: - Establishment review every 6 months - At least twice a year nursing, midwifery & care staffing levels and key quality and outcome measures (public meeting)	Occurred in March 2014 and now ongoing
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 display in place

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 patient areas. This information includes support staff and is updated per shift. It is assessable to patients and their families The person in charge is displayed via the communication boards Uniforms and titles are displayed at ward entrances

EXPECTATION 9: Providers of NHS services take an active role in securing staff in line with their workforce requirements. Providers of NHS services actively manage their existing workforce, and have robust plans in place to recruit, retain and develop all staff. To help determine future workforce requirements, organisations share staffing establishments and annual service plans with their Local Education and Training Board (LETBs), and their regulators for assurance. Providers work in partnership with Clinical Commissioning Groups and NHS England Area Teams to produce a Future Workforce Forecast, which LETBs will use to inform their Education Commissions and the Workforce Plan for England led by Health Education England (HEE).

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

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

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

Current ward staffing levels at Warrington and Halton Hospitals

It is acknowledged that staffing requirements should be determined using an evidence based approach to ensure the right number and level of knowledge and skills in a ward team is available to meet the needs of the patients. Wards should know what their planned levels should be and be able to evidence how their actual staffing levels compare with this. We know that this is the first time that this data has been collated nationally and have worked hard to do this. Over time, it is our expectation that this becomes a routine part of a ward's data pack as the IT strategy is developed over the coming months and years.

We first published our staffing levels on our Open and Honest website in May 2014 in line with NHS England guidance. The Trust Board has received a short paper each month since then which includes these published staffing levels. The data received in the monthly updates does not determine whether a ward is understaffed or unsafe. It is an indicator which, when used in conjunction with other data, over time will build a picture of services on a ward and inform where robust questions need to be asked. We know that regulators already use this data as part of their work and we expect that we may be questioned where patterns emerge.

The next section of this report provides a summary update from these individual reports, including highlighted information / shift by shift analysis to give clarity to what is being presented.

It is recognised that the data presented may provoke a number of areas that require clarification and therefore the following section provides useful information.

Does having an actual level below 100% mean a ward is unsafe?

No. We would expect the actual staffing level to be close to the planned level but in isolation, this data does not determine whether a ward is safe. Safe staffing is much more complex and takes into account key aspects like the type and size of ward, the acuity of patients and the ward team and their experience and expertise. Over time and alongside other information, this data can be used to

build a picture of variation, allow greater scrutiny of services and most importantly drive improvement.

For example, there could be a ward with a planned level but not as many ward attenders that month as normal so not as many staff needed as if the ward was busy, or a ward may be particularly busy and more staff than normal are brought in, so that ward would have higher than planned levels.

Why are some wards over 100 per cent? It seems odd

Where wards are over 100% it means that their actual staffing was on average, higher than their planned level. This is usually due to acuity and dependency with 'specialling' or one to one care being provided to individual or groups of complex patients.

What does the data mean?

Along with increasing wealth of data about local health services, this data suggests areas that should raise questions and inform where improvements are needed. An example of where this has happened has been in Ward A2 where it is noted that there is consistent use of additional healthcare assistants on night duty. The Matron was able to evidence that the acuity in this area (predominantly female acute admissions) is often very high with complex individual patients requiring one to one care. As a result this ward will pilot a sensitive tool to review their staffing requirements, and the information has also confirmed our requirements to review the specialling policy.

What has happened until now – have we not known this information?

We already have this information but this is the first time staffing level data has been published at a national level down to ward level and the first time it has been brought together in one concise place for senior nurses to interrogate.

What about the national picture. Won't Trusts that set a high staffing level look worse than those than set a lower planned level?

Yes, potentially. Trusts must plan their staffing requirements according to the specific needs of the patients on each ward, using evidence.

This is the first time this data has been published and we expected some variation while the process beds in and is refined. For example, a ward's planned level might have been recently increased but the ward is in the process of recruiting so there will be a period where the actual is further from planned. This paper helps to explain the reasons behind why any area varies significantly from their planned levels their website.

Why are wards not RAG rated?

This was something we looked at but at this is the first time this data has ever been collected and published nationally we believed it was important that we let the process bed in. NHS England are looking to refine and improve the way the data is presented over time as well as looking at what other staffing indicators we can include to give a view that can be rated. We decided to include

information relating to harm (VTE, falls, pressure ulcers and catheter associated urinary tract infections) on our wards from the outset.

Why is there such a difference between numbers of staff on at night and on in the day?

For most wards, night time is quieter and the ward therefore won't need as many staff as in the day. Because there are fewer staff on at night, this means that any difference from plan will mean a bigger percentage variation, this is the case with Ward A2 as already described.

Now that Trusts have planned levels does this mean we can bring in a minimum nurse to patient ratio?

We already adhere to RCN guidance around nurse to patient ratio's in all general ward areas. However, it has to be recognised that each ward in each hospital around the country is different in size, number of patients, the type of patients and their needs. A sophisticated approach is required using hard evidence and local professional judgement to determine what staffing is right to provide the best care for patients in every setting. As part of this approach, NHS England commissioned NICE to review and publically consult on nurse staffing. This review was published in July 2014 as Safe Staffing guidance and we have been working toward the recommendations within the guidance since this time. In October 2014, the Safe Nurse Staffing Tool has been approved by NICE for use on hospital wards, and one ward from each division is currently testing this tool for us. It is intended that our next Staffing paper due in April 2015 will provided a detailed analysis following adoption across most ward areas.

Who records the data and when do they do it?

At present, this information is collected manually by the Corporate Nursing Team, and is time consuming to collect, validate and confirm with ward staff. The Allocate system, whilst it does provide some of the information, would require an addition to provide it 'at the touch of a button'. The planned process for roll out of e-rostering across the organisation within the next 12 months, and the adoption of the safe care tool within Allocate will, over time, allow collection of this information to be a routine part of a Trust's systems and processes, and something that informs ward-level and Trust-wide workforce planning.

Do we have plans in place for resolving issues?

It is important that we review our staffing requirements on an ongoing basis. This data is part of that but there are other considerations such as level of skills and expertise and the wider multidisciplinary team. Used with other information, this data is a warning signal that could trigger questions about services. For example, we are trialling the use of 'Red Flags' on wards that identify when issues have occurred or may possible occur. This information will be triangulated with our staffing levels going forward and will replace the current system of reviewing staffing levels against harm data in a more sophisticated and meaningful way.

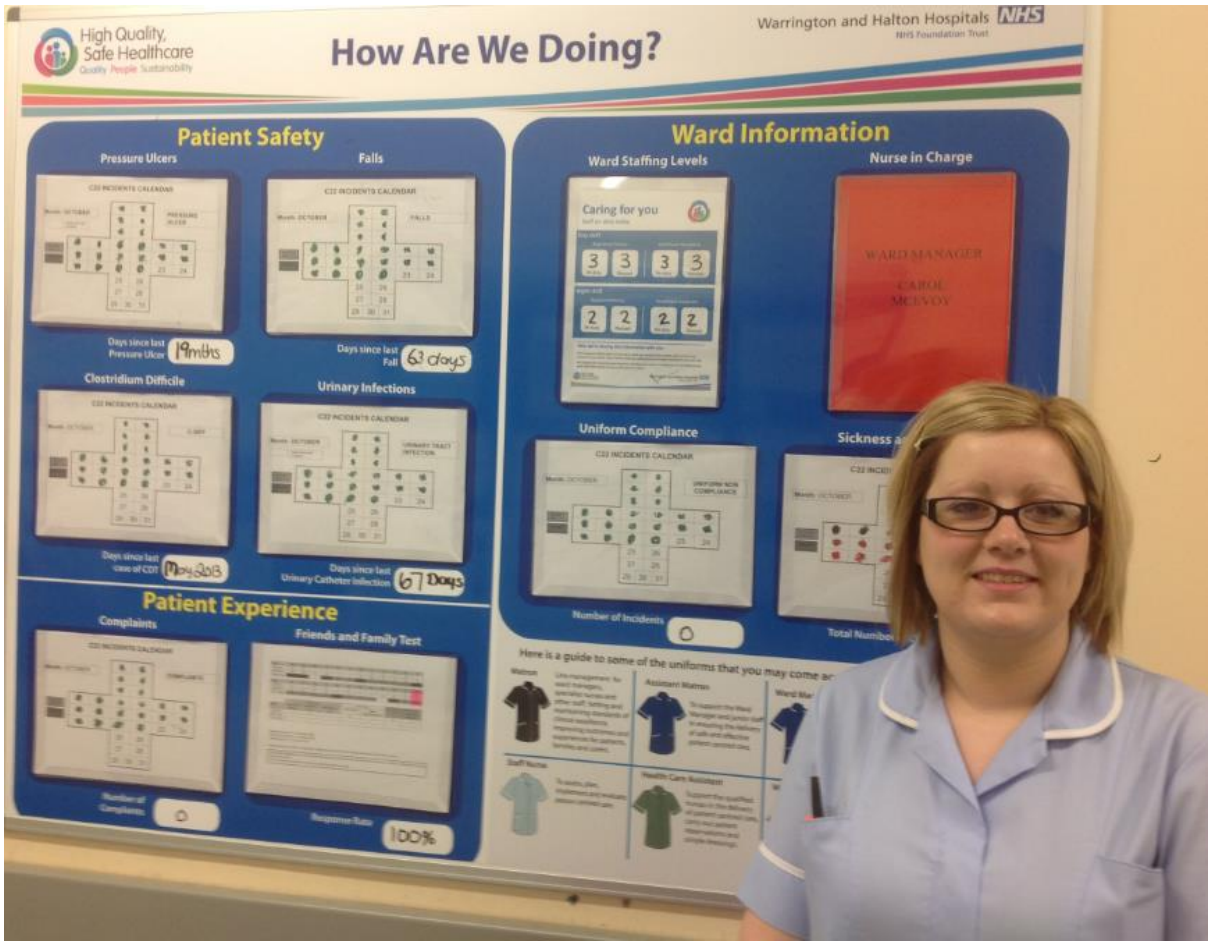
Does the data suggest shortages of nurses/staff nationally, or locally?

While there are more nurses in the NHS than ever before, we know that demand on the NHS has increased and we need to ensure we have the right workforce going forward. NHS England are working closely with Health Education on an ongoing basis to ensure this. At the Trust we are committed to workforce planning for the future.

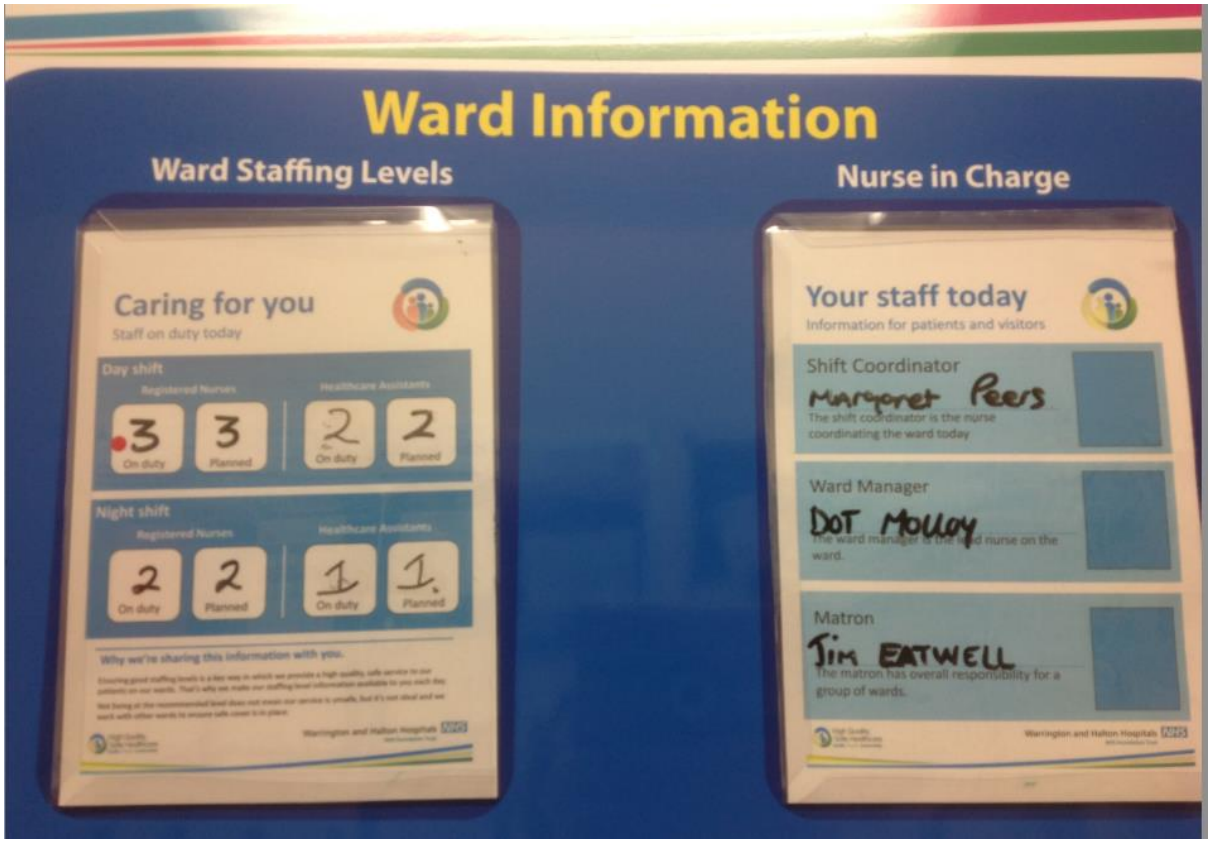
Health Education England has commissioned 13,228 new nursing places for this year, an increase of 9 per cent on 2013/14 which should produce more new nurses for the NHS in 2017 than any year ever recorded before. Health Education England is also leading a campaign to help encourage registered nurses back to work.

Do we provide staffing level information, including who is in charge, at ward entrances on the wards?

Yes, our How Are We Doing Boards were in place from May 2014 in most general ward areas. Boards are now being developed for Intensive Care, AED and Maternity.



We display our staffing levels because we know it's really important for our patients and visiting staff to know 'who's in charge'. It gives a real sense of leadership of the ward, and helps put pride back into 'being in charge'.



What is meant by Safety Thermometer, and how does it measure harm?

The Safety Thermometer is a point of care survey instrument, it provides a **'temperature check'** on harm that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for our patients. The NHS Safety Thermometer allows teams to measure harm and the proportion of patients that are 'harm free' during their working day.

It is important to note that data relating to harms (for example) pressure ulcers reported through the Safety Thermometer may include both new pressure ulcers (ie those that occurred in the month of reporting) and old pressure ulcers (those that occurred in the previous month) if the patient is still in hospital since the first recording. In effect, the pressure ulcer is recorded 'twice' via Safety Thermometer.

NICE Guidance

Nice guidance on safe staffing for nursing in adult inpatient wards in acute hospitals was produced in July 2014. These are being assessed via data pack published in October 2014 by the Senior Nursing Team. Examples of the recommendations and some of our progress are below:

When agreeing the ward nursing staff establishment, ensure capacity to deal with fluctuations in patients' nursing needs (such as seasonal variations indicated by historical records of nursing staff requirements) and staff unplanned leave or absences. We are testing the Safer Nursing Toolkit across 3 wards.

Consider implementing approaches to support flexibility, such as adapting nursing shifts, nursing skill mix, assigned location and employment contract arrangements. We have adopted 12 hour nursing shifts and assessed our skill mix in relation to competencies in both registered nursing and healthcare assistant roles.

Use informed judgement to make a final assessment of nursing staff requirements. This should take account of the local circumstances, variability of patients' nursing needs, and previously reported nursing red flag events. We use the Telford model of professional judgement to make final assessments of nursing staff requirements, additionally we review the staffing requirements on the wards at daily staffing meetings. Red flags are being trialled formally and are included in the DAWES.

Take account of the following factors (commonly known as 'uplift' and likely to be set at an organisational level:

- *planned absence – eg professional development, mandatory training, entitlement for annual, maternity or paternity leave*
- *unplanned absence (such as sickness absence).*

During Q3 and Q4 we will be reviewing the 20% uplift in light of the recommendations for an average of 22.5% uplift taking into account all relevant information in relation to the points above.

Month by month analysis

The following analysis includes all general wards excluding maternity, ITU, AED, CCU and paediatric wards.

May 2014

In May 2014 there were a total of 6,624 (11.5 hour) shifts available.

Of these 5.48% (363.1) shifts were short of either a registered nurse or a healthcare assistant.

The highest number of unfilled shifts were in Ward B18, Cohort and General Medicine Ward in Unscheduled Care, where 19.12% (83) shifts out of 434 planned shifts were short of either a registered nurse. This was a result of continued use of 4 additional beds in this area, and was mitigated by agreed barrier nursing of cohort patients to allow flexibility. The beds had been funded by May, and recruitment was underway. During May the ward had 3 falls (resulting in no harm to any patient); there was one catheter associated urine infection and no other Safety Thermometer recorded harms.

In A7, Respiratory Ward in Unscheduled Care, all shifts were filled. During this period A7 had 3 falls and 2 hospital acquired pressure ulcers.

B4 Day Case/Surgical Short stay ward at Halton experienced shortfalls in their day staffing. This related to assessing acuity and dependency on the wards and the transfer of staff to the Warrington site when it was safe to do so. Ward B4 recorded no Safety Thermometer harms to patients.

In A2 it was noted that there is consistent use of additional healthcare assistants on night duty. The Matron was able to evidence that the acuity in this area (predominantly female acute admissions) is often very high with complex individual patients requiring one to one care. As a result this ward will pilot a sensitive tool to review their staffing requirements, and the information has also confirmed our requirements to review the specialling policy.

June 2014

In June 2014 there were a total of 6,624 (11.5 hour) shifts available.

Of these 5.48% (362.7) shifts were short of either a registered nurse or a healthcare assistant.

The highest number of unfilled shifts were again in Ward B18, Cohort and General Medicine Ward in Unscheduled Care, where 14% (62) shifts out of 434 planned shifts were short of either a registered nurse or healthcare assistant. This was a result of continued use of 4 additional beds in this area, and was mitigated by agreed barrier nursing of cohort patients to allow flexibility. The beds had been funded by May, and recruitment was underway. During June the ward had no harms recorded via the Safety Thermometer and the ward manager was included in the nursing 'numbers' (ie she was working clinically on the ward rather than working in her supervisory role).

In B19, Orthopaedic rehabilitation ward, only one shift was not filled. During this period B19 had no harms recorded.

Ward A9 was escalated over 50% of the time and had 2% (6.3) of their shifts not filled. This was a very difficult time for the ward, and we are pleased to note that there were no harms recorded via the Safety Thermometer.

July 2014

In July 2014 there were a total of 6,624 (11.5 hour) shifts available.

Of these 2.72% (180.1) shifts were short of either a registered nurse or a healthcare assistant.

The highest number of unfilled shifts were again Ward B18 as new staff came into post. Ward C21, Cardiology Ward had 14% (42) shifts underfilled. This was whilst staff were being recruited to following agreed investment in healthcare assistant staff at night. The Matron provided assurance that safety was assessed on a shift by shift basis. During this time there was 1 fall, 1 hospital acquired pressure ulcer and 3 patients with VTE events (staffing levels were not seen to be a contributory factor to the events).

The Cheshire and Merseyside Treatment Centre had 6% (23.7) shifts unfilled. The Matron explains that the staffing levels alter according to activity and flexes up and down accordingly. Staff are moved to support the wards at Warrington, but only when it is safe to do so. At the CMTC there is also a forward wait are which is staffed as a day ward in order that there are no breaches of DSSA requirements. This required 3 RN's to staff the area.

Similarly Ward A5 had 6% (25.2) shifts unfilled due to 4.6 RN vacancies, and 7.89% sickness. A Care Review was undertaken which assured the senior nursing team of the safety within the ward following two isolated but serious events on the ward in 2014. During July no harm was recorded via the Safety Thermometer.

August 2014

In August 2014 there were a total of 6,624 (11.5 hour) shifts available.

Of these 3% (198.5) shifts were short of either a registered nurse or a healthcare assistant.

Ward A8 had 11% (50.2) shifts unfilled, there were 4.21 vacancies and 3.3% sickness rate. The shifts that were unfilled were mainly during the day in both registered nursing and healthcare assistant roles. The more isolated night shifts were filled the vast majority of the month. During July, there were no falls and one VTE.

September 2014

In September 2014 there were a total of 6,609.8 (11.5 hour) shifts available.

Of these 3.65% (241.3) shifts were short of either a registered nurse or a healthcare assistant.

The highest number of unfilled shifts was C21, with 11% (42.6) shifts unfilled. There were 2.09 vacancies and 7.26% sickness during this time. During this time there no harms recorded via the Safety Thermometer.

Ward A5 had 9% (34.9) shifts unfilled, which similarly to the previous month had a high sickness rate (8.03%) and 4.6 vacancies. There was one catheter associated urinary tract infection during this time.

Supervisory ward manager status

Many reports, including Francis and the more recent National Quality Board, have highlighted the need for supervisory status of ward manager to enable closer monitoring and scrutiny of quality and safety in the ward area. The Francis recommendations make it clear that supervisory ward manager role is essential if we are to ensure the delivery of safe, high quality care. The supervisory ward manager is about having the time to lead, to support staff, to act as a role model and to be visible to both patients and staff.

The ward managers are supported to achieving 80% supervisory status. This role is impossible if he or she is included in the patient allocation per shift. Our data does not specifically capture this data as there may be last minute requirement for the ward manager to work in their clinical role, predominantly to support higher acuity, activity or frailty. Going forward an electronic solution to this will assist in calculating this information. We are now working on a suite of performance indicators for ward managers that relate specifically to their responsibilities within the ward area.

Work in progress in other areas

Safety and Quality

The DAWES

Throughout 2014/15 the Senior Nursing Team, supported by the Patient Quality and Safety Champion, have reviewed the existing systems (including NAAS) by which quality and safety are measured in our wards and departments. This review has taken into consideration a number of key drivers to ensure that we continue to improve whilst delivering high quality, safe care in line with our QPS frameworks. Out of this review we have developed our DAWES (Department and Ward Evaluation Scheme).

The DAWES framework is designed around 14 standards (most with Environment, Care and Leadership criteria).

- Organisation and Management of the Clinical Area
- Safeguarding Patients,

- Pain Management
- Patient Safety
- Environmental Safety
- Nutrition and Hydration
- End of Life Care
- Medicines Management
- Person Centred Care
- Pressure Ulcers
- Elimination
- Communication
- Infection control
- Ward Organisation and Administration

The DAWES is designed to support nurses in practice to understand how they deliver care, identify what works well and where further improvements are needed. Our nursing strategy takes us from "Essential to Excellent." This assessment document has been developed to allow us to measure progress against this journey. The process is as follows:

1. The DAWES Assessor will select a day to assess the ward, this will be unannounced.
2. On the day of the assessment, which will include a period when meals are served to patients; the nursing assessment will cover the following areas and will involve at a minimum, one third of patients and two thirds of staff.
   - Observation of care given and patients documentation
   - Discussion with patients and staff members
3. Each ward will have an assessment completed and will be accredited with a Level 0 to Level 3. Reassessment will take place at a time interval dependent upon the results:

Red	**5 red standards or more in total**	**Level 0**	**Reassess in 2 months**
Amber	**3 - 4 red standards in total**	**Level 1**	**Reassess in 4 months**
Green	**1- 2 red standards in total**	**Level 2**	**Reassess in 8 months**

4 Following the assessment and accreditation the Ward Manager and Matron will be required to formulate an action plan. The action plan will be prepared on a standard template used throughout the organisation.
5 The Ward Manager and the Matron will be given a week to develop their action plan. The date for completion will be noted on the front sheet of the assessment document.
6 A copy of each assessment and action plan will be sent to the Associate Director of Nursing of that specific area to approve and endorse in practice.
7 A copy of the assessment and action plan will be provided to the Deputy Director of Nursing, Associate Director of Nursing (via their PA) and the Patient Quality Safety Champion for a record to be maintained of progress of the DAWES across the whole organisation.
8 Action plans must then form part of every ward team meeting and Ward Manager meeting to track progress.
9 If the ward achieves red status then the Ward Manager will have an appraisal completed by the Matron, with clear objectives set.
10 Progress reports will be received by the Nursing and Midwifery Advisory Council.
11 Wards maintain green status for over a 12 month period will be marked as exemplar ward

Six wards have been assessed to date under this scheme to date, with a further six planned for Q3. In Q4 we will be rolling out the DAWES scheme to include A&E, Maternity and paediatrics.

Level 0 (Red) Wards Wards that achieve Level 0 (Red) consequently will be given an appropriate level of support to improve their status.

Level 1 (Amber) Wards Wards that fail to achieve above Level 1 (Amber) on two consecutive assessments, will be reviewed by the Deputy Director of Nursing and the Associate Director of Nursing

Level 2 (Green) Wards Wards that maintain green status for over a 12 month period will be marked as exemplar wards

Care and Quality Reviews

It is recognised that sometimes there will be variation in the quality of care received; in this case our response is pivotal to making improvement and re-aligning a ward or department to ensure that our overall aim can be achieved. Central to our response may be a Care and Quality Review, and this guideline sets out the framework by which a review should be undertaken.

It is vital that reviews place any perceived concern in a factual context. The purpose of undertaking a Care and Quality Review is to provide an opportunity for a senior team to examine the care and quality of service in any given area by investigating a number of key practices, processes or focus areas. The review will result in the production of a report with recommendations for action to improve where they are identified.

Reviews must also include the reviewers professional judgement to determine as accurately as possible whether there is a basis for concern. It is also important to identify that if concerns are raised whether these are individual, systemic or if these relate only to a specific element of care or care as a whole.

The guideline provides an indicator as to what may trigger a Care and Quality Review, and to the information that must be collected in order to base recommendations on the evidence found during investigation.

The decision to undertake a Care and Quality Review will be taken by the Associate Director of Nursing following agreement by the Director of Nursing. The triggers for placing a ward/department in special measures can be varied, but it is fundamentally that there is a level of concern about the standards of care delivery in that area. The concern may be focused specifically e.g. on infection control, or more generally as highlighted in a complaint.

The rationale to undertake the review may be any of the following triggers:

- An isolated event that effects patient care or safety
- Infection control issues (for example following a period of increased incidents of hospital associated infection)
- A cluster or series of complaints where the theme may be similar
- A cluster or series of patient safety incidents
- Information received following Open and Honest or other patient experience audit

- A responsive review following an external inspection, for example a Care Quality Commission visit, Healthwatch visit, or governor observational visit.
- Where a number staff have raised concern
- Intelligence received via governance or audit process which suggests that the provision of care is of concern

The Care and Quality Review may result in a ward/department being placed in Special Measures. The purpose of placing a ward/department in special measures is twofold. It is to understand by objective analysis whether there is a systemic problem in that area, as opposed to an isolated incident, and also to ensure that increased scrutiny, combined with increased training, improves the quality and safety within that ward/department. It is important that the whole ward/department team comes under scrutiny, not just the nursing team, and so the audit and scrutiny process will include all healthcare professional staff and operation teams, across the 24 hour cycle.

In 2014/15 there have been 2 Care and Quality reviews carried out. These were in Ward A5 following 2 serious clinical incidents, and in Accident and Emergency following concerns raised about patient safety in the department. Neither of these reviews resulted in special measures being undertaken, and although a series of recommendations were made there were no immediate concerns that either clinical area was compromising patient safety.

Next Steps (October – March 2015)

Over the next six months the plan to develop the assurance around staff capability and capacity will include:

- Building upon this report to ensure we meet national guidance. Through its development and evolvement, we will continue to triangulate with additional outcomes like the safety thermometer, healthcare associated infections and patient experience measures to provide a comprehensive overview
- Continuing to report shift by shift staffing levels on a daily basis and review all DATIX incidents in relation to staffing issues, falls and medication incidents, supporting staff to provide more vigorous explanations around the impact of staffing shortfalls. Develop the Red Flag system formally.
- Monitor trends and seek assurance from Matrons re actions taken to mitigate patient safety risks including progress on developing and implementing outcomes from the establishment investment
- Reviewing and implementing pending national technical guidance on reporting and NICE guidance.
- Developing a new escalation policy to support responsibility for staffing decisions on a shift by shift basis
- Developing a specialling policy
- Reviewing the Safer Nursing Care Tools on three wards, and roll out thereafter.
- Reviewing ward establishments at the CMTC
- Ensuring we are following national guidance in terms of public display of information, whilst ensuring the displayed information is clear and user friendly for the public.

Recommendations to the Board

The Trust Board is requested to note:

- the contents of the report and expectations for reporting staffing capability and capacity to the Trust Board.
- the analysis from the month by month analysis, areas of concern via the Safety Thermometer and mitigating actions in progress.
- To agree the progress against the Hard Truths expectations and NICE guidance

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Appendix 1

BOARD OF DIRECTORS

Paper Title	Publication of Staffing Data and Exception Report September 2014
Date of Meeting	29th October 2014
Director Responsible	Director of Nursing and Organisational Development
Author(s)	Deputy Director of Nursing
Purpose	The purpose of this paper is to provide an overview of the monitoring and management of nursing and midwifery staffing during August 2014. In addition it provides information as to the occurrence of harm related to VTE, falls, hospital acquired pressure ulcers and catheter associated urinary tract infections. It must be noted that the data related to harm is subject to change following final approval: it is the Quality Dashboard that the Board must use for this assurance.

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**

Relates to which Trust objectives	√ **appropriate**
• Ensure all our patients are safe in our care	✓
• To be the employer of choice for healthcare we deliver	✓
• To give our patients the best possible experience	✓
• To provide sustainable local healthcare services	✓

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

- There are no real exceptions to note in this report. This report is for information only.
- This month the Board will receive a full six month update report

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

The Board to note the publication of Staffing Data and Exception Report September 2014

Publication of Staffing Data and Exception Report September 2014

Introduction

This is our third staffing data and exception report, the first followed receipt by the Board relating to its commitments regarding its collective responsibility for managing nursing, midwifery and healthcare assistant staffing capacity and capability. This briefing paper also outlined process for publishing and displaying staffing data as described in Hard Truths the government response to the Mid Staffordshire NHS Foundation Trust Public Inquiry and the National Quality Board (NQB) guidance issued in November 2013.

The research shows that staffing levels are linked to the safety of care and that staff shortfalls increase the risks of patient harm and poor quality care. Furthermore it stipulates that patients and the public have a right to know how the hospitals they are paying for are being run.

Publication of Staffing Data - recommendations and actions

As stated the Board is required to receive a report which describes, the staffing capacity and capability, following an establishment review, using evidence based tools where possible every six months. The Trust is compliant with this recommendation in that the Board has already received several reports covering elements of these requirements and it is agreed that the next full report will be in September 2014 which will ensure compliance with the required full six monthly staffing review and report to Board going forward.

The Trust is also required to provide information about the nurses, midwives and care staff deployed for each shift compared to what has been planned and this is to be displayed at ward level. Again this action has been implemented, in that all areas have been involved in the production of the How Are We Doing? Boards. All general wards are now displaying their data, with the rollout continuing to critical care and other areas.

This report is normally presented to Board every month, but as it is planned that there will be no Board in August, this report is issued to Trust Board members to comply with recommendations detailed above.

The report as attached, is published on the Trust website, and is available to the public via NHS Choices. The report provides information on our staffing levels - looking at the staff hours assigned to each ward and how many hours were worked in that month.

We are committed to ensuring that levels of nursing staff, which include registered nurses, midwives and unregistered health care assistants (HCA's), match the acuity and dependency needs of patients within clinical ward areas in the trust. This includes an appropriate level and skill mix of nursing staff to provide safe and effective care. These staffing levels are viewed along with reported outcome measures, 'registered nurse to patient ratios' and the number of staff per shift required to provide safe and effective patient care.

Real time management of staffing levels to mitigate risk

In the event of shortfalls of staff or unexpected increases in patient acuity and dependency requirements, the agreed staffing levels are reviewed with escalation actions specified if levels are not as expected. Please note that the term 'ward' includes critical care areas, and accident and emergency department for ease of understanding. The report contains information of variance from expected staffing levels.

Safe staffing levels are managed on a daily basis. At the daily staffing meetings, the matrons and ward managers, supported by the associate director of nursing discuss the overall view of their wards for the next 3 shifts by registered and unregistered workforce numbers and ratios. Consideration is given to acuity and dependency on the wards, as well as bed capacity and operational activity within the trust which may impact on safe staffing. The detailed report is attached at Appendix 1.

Recommendation

The Board are asked to note this report

Appendices

Appendix 1

Safer Staffing Exception Report September 2014

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Staffing Levels

Sep-14

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 Aug-14	Agreed nurse to patient ratios	**Total monthly planned staff hours**	**Total monthly actual staff hours**	**Total monthly planned staff hours**	**Total monthly actual staff hours**	Agreed nurse to patient ratios	**Total monthly planned staff hours**	**Total monthly actual staff hours**	**Total monthly planned staff hours**	**Total monthly actual staff hours**	Number of hours above or below planned	Length of a shift in hours	Number of shifts above or below planned	Variance	Falls	Hospital acquired pressure ulcers	Catheter associated UTIs	New VTEs	Associate Director of Nursing/Matrons Assurance Statement
																						This column will automatically calculate the number of shifts					
Scheduled Care	W-A4 - Ward A4	28	12.90	0.00	0.00	7.70	0.00	7.51	1:8	1069.5	1069.5	713.0	713.0	1:8	713.0	713.0	356.5	356.5	0.0	11.5	0.0	0.00%	0	0	0	0	
	W-A5 - Ward A5	28	21.10	4.60	0.00	14.60	0.00	8.03	1:7	1782.1	1499.6	1069.5	1020.0	1:9	1069.5	1000.5	713.0	713.0	-401.0	11.5	-34.9	-8.65%	0	0	1	0	
	W-A6 - Ward A6	28	18.60	0.60	0.00	13.60	1.40	5.36	1:7	1426.0	1392.0	1069.5	1035.0	1:9	1069.5	1023.5	713.0	690.0	-137.5	11.5	-12.0	-3.21%	1	2	0	0	
	W-A9 - Ward A9	28	17.80	3.51	1.60	15.50	1.00	4.27	1:7	1426.0	1323.5	1426.0	1376.5	1:9	1069.5	1046.5	713.0	690.0	-198.0	11.5	-17.2	-4.27%	0	0	0	0	
	W-B19 - Ward B19	18	14.30	2.60	1.60	13.90	2.00	7.09	1:6	1069.5	1035.0	713.0	713.0	1:6	713.0	713.0	713.0	713.0	-34.5	11.5	-3.0	-1.08%	0	1	1	0	
	W-B4-H - Ward B4 - Halton	27	12.20	0.85	0.00	6.00	0.00	5.34	1:9	874.0	1308.0	552.0	962.6	13.5 :1	552.0	356.5	322.0	356.5	683.6	11.5	59.4	29.72%	0	0	0	0	
	W-CM1-H - Ward 1 - CMTC Treatment Centre	30	26.60	3.38	0.80	14.00	1.80	4.10	1:5.5	1978.0	1320.5	1196.0	851.0	10 : 1	966.0	954.5	644.0	621.0	-1037.0	11.5	-90.2	-21.68%	0	0	0	0	
	W-ICU - Intensive Care Unit	18	76.74	6.91	3.00	12.52	1.00	3.03	1:1 Level 3 1:2 Level 2	4830.0	3996.0	1035.0	908.5	1:1 Level 3 1:2 Level 2	4830.0	3979.0	690.0	483.0	-2018.5	11.5	-175.5	-17.73%	0	1	1	0	18 beds funded but used flexibly depending on dependency of patients (i.e.. 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 September 2014 was 74% there were 540 bed days and 398 were occupied
Total		205	200.24	22.45	7.00	97.82	7.20	5.04											-3142.9		-273.3		1	4	3	0	
Unscheduled Care	AED			5.77	2.00	13.02	13.02	4.97		4320.0	4016.7	1125.0	983.0		3101.7	3128.0	837.6	582.5	-674.1	12.5	-53.9	-7.18%	0	0	0	0	Ambulatoy catre open for 20 days needing RN and CSW for 7.5hours a day. CDU2 opend one eveing and night. One staff member sent to another ward to cover. Escalated for one day
	W-A1A - Ward A1 Asst	29	41.40	15.68	8.00	22.10	22.10	7.81	5.5	2250.0	2300.5	1500.0	1455.0	0.0	1890.0	2200.5	630.0	782.4	468.4	12.5	37.5	7.47%	0	0	0	0	DVT clinic was staffed for 172.5 hours. APP on ward for 540 hours
	W-A2A - Ward A2 Admission	28	18.83	1.10	0.00	12.90	12.90	3.14	5.6	1380.0	1357.0	1035.0	1097.0	0.0	1035.0	1035.0	690.0	1000.5	349.5	11.5	30.4	8.44%	0	0	0	1	
	W-A3OPAL - Ward A3 Opal	34	18.83	2.28	0.00	15.50	0.16	16.03	8.5:1	1426.0	1226.5	1426.0	1367.0	0.0	1069.5	885.5	713.0	943.0	-212.5	11.5	-18.5	-4.59%	0	0	1	0	
	W-A7 - Ward A7	33	18.80	-0.10	2.20	15.50	15.50	3.30	8.3:1	1426.0	1391.5	1426.0	1298.0	0.0	1069.5	977.5	713.0	989.0	21.4	11.5	1.9	0.46%	0	0	0	0	
	W-A8 - Ward A8	34	18.80	1.00	0.00	15.50	15.50	3.02	8.5:1	1426.0	1373.0	1552.5	1338.5	0.0	1069.5	1069.5	874.0	770.5	-370.5	11.5	-32.2	-7.53%	0	0	0	0	
	W-B12 - Ward B12 (Forget-me-not)	21	13.68	0.00	0.00	15.50	15.50	8.84	7.0:1	1035.0	1027.0	1552.5	1423.5	0.0	690.0	690.0	690.0	894.0	67.0	11.5	5.8	1.69%	0	0	0	0	
	W-B14 - Ward B14	24	18.80	3.00	0.00	12.90	12.90	2.47	6.0:1	1380.0	1233.5	1035.0	985.0	0.0	1035.0	908.5	690.0	678.5	-334.5	11.5	-29.1	-8.08%	0	0	0	0	
	W-B18 - Ward B18	24	18.84	3.00	0.00	18.00	3.75	7.54	6.0:1	1380.0	1140.0	1380.0	1325.5	0.0	1035.0	920.0	1035.0	954.5	-490.0	11.5	-42.6	-10.14%	0	1	1	0	
	W-C21 - Ward C21	24	13.68	-0.90	0.00	11.30	2.09	7.26	8.0:1	1035.0	954.5	690.0	678.5	0.1	690.0	690.0	690.0	402.5	-379.5	11.5	-33.0	-12.22%	0	0	0	0	vacancy for CSW on night awaiting interviews
	W-C22 - Ward C22	21	13.68	0.80	1.60	12.90	0.00	1.05	7.0:1	1069.5	1069.5	1069.5	987.0	0.1	713.0	713.0	713.0	713.0	-82.5	11.5	-7.2	-2.31%	0	0	0	0	
	W-CCU - Coronary Care Unit	8	21.17	0.90	0.00	2.60	1.00	4.76	2.0:1	1380.0	1361.5	345.0	239.0	0.0	1035.0	1012.0	0.0	11.5	-136.0	11.5	-11.8	-4.93%	0	0	0	0	
Total		280	216.51	32.53	13.80	167.72	114.42	6.00											-1773.2		-152.8		0	1	2	1	
WCSS	W-B11B/W-B11C - Ward B11	24	29.50	1.40	0.00	9.20	4.66	1.84	1:1 level3 1:2 Level2	2100.0	2100.0	840.0	840.0	0.0	1488.2	1462.0	0.0	0.0	-26.2	7.5 day 10.63 night		-0.59%	0	0	0	0	
	W-NHDU/W-NITU/W-NSC - Neonatal Unit	18	24.38	2.00	0.00	6.52	0.00	5.11	7.5:18	1092.0	1092.0	798.0	798.0	7.5:18	942.8	942.8	240.0	240.0	0.0			0.00%	0	0	0	0	
	W-C20 - Ward C20	12	12.63	2.40	2.40	5.00	0.00	4.11	1:4	1065.0	1065.0	675.0	630.0	1:6	581.3	581.4	0.0	48.5	3.6			0.16%	0	0	0	0	
	W-C23 - Ward C23	22	97.92	4.60	4.60	18.93	11.60		1:7.33	1348.5	1313.5	899.0	869.8	1:11	581.3	553.2	290.6	588.0	205.1			6.57%	0	0	0	0	
Total		76	164.43	10.40	7.00	39.65	16.26	3.07											182.5		0.0		0	0	0	0	
Grand Total		561	581.18	65.38	27.80	305.19	137.88	5.23											-4733.6		-426.1		1	5	5	1	

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/157

BOARD OF DIRECTORS

Paper Title	Finance Report as at 30th September 2014
Date of Meeting	29th October 2014
Director Responsible	Tim Barlow, Director of Finance & Commercial Development
Author(s)	Steve Barrow, Deputy Director of Finance
Purpose	To provide a performance update against the annual financial plan.

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**

Relates to which Trust objectives **appropriate**

- Ensure all our patients are safe in our care √
- To be the employer of choice for healthcare we deliver
- To give our patients the best possible experience √
- To provide sustainable local healthcare services √

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

Page/Paragraph Reference

- Please refer to Executive Summary.

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

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

Finance Report as at 30th September 2014

1. Purpose

The purpose of the report is to advise the Board of Directors on the financial position of the Trust as at 30th September 2014.

2. Executive Summary

Year to date performance against key financial indicators is provided in the table below further supplemented by 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	17.5	17.5	0.0	103.9	104.5	0.6
Operating expenses	(17.2)	(17.2)	0.0	(103.7)	(104.4)	(0.7)
EBITDA	0.3	0.3	0.0	0.2	0.1	(0.1)
Non-operating income and expenses	(0.9)	(0.9)	0.0	(5.1)	(5.1)	0.0
I&E surplus / (deficit)	(0.6)	(0.6)	0.0	(4.9)	(5.0)	(0.1)
Cash balance	-	-	-	3.8	5.1	1.3
CIP target	0.4	0.5	0.1	2.2	2.0	(0.2)
Capital Expenditure	0.6	0.5	0.1	3.4	2.1	1.3
Continuity of Services Risk Rating	2	2	0	2	2	0

3. Income and Expenditure (Appendix C)

In month the Trust recorded a deficit of £587k which results in a year to date deficit of £5,056k, which is £147k worse than the planned deficit of £4,910k.

This cumulative deficit is comprised of the following variances:

- operating income is £560k above plan (favourable).
- operating expenses are £707k above plan (adverse).
- non operating income and expenses are £1k below plan (favourable).

The Continuity of Services Risk Rating is a 2 which is in line with plan.

The September position is very much aligned to plan for both income and expenditure, although pay was overspent by £208k in the month. The monthly deficit of £587k is only £5k better than the planned deficit of £592k so the cumulative deficit remains a major concern, given that there is a significant increase in the cost savings target from October onwards.

Operating Income

Year to date operating income is £560k above plan due to an over recovery on other operating income (£718k) partially offset by an under recovery on NHS clinical income (£151k) and non NHS clinical income (£7k).

Operating Expenses

Year to date operating expenses are £707k above plan due to over spends on pay and clinical supplies, partially offset by under spends on drugs and non clinical supplies.

Non Operating Income and Expenses

Non operating income and expenses are broadly in line with plan.

4. Cost Improvement Programme

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

Narrative	**In Year £000**	**Recurrent £000**
Annual Target	11,931	11,931
Value of schemes identified	10.542	13.364
Over / (Under) Achievement against target	**(1.389)**	**1.433**

For the period to date the planned savings for the identified schemes equate to £2,199k, with actual savings amounting to £2,016k which results in an under achievement of £183k. The cost savings programme is materially skewed towards the second half of the year, so in the period October to March savings equating to £9,915k are required for the Trust to achieve the full annual target.

5. Cash Flow (Appendix D)

The cash balance is £5,076k which is £1,237k above the planned cash balance of £3,839k, with the monthly movements summarised in the table below.

Cash balance movement	**£000**
Opening balance as at 1st September	7,070
Cash related EBITDA	(587)
Increase in receivables	(696)
Increase in payables	1,277
Capital expenditure	(556)
Payment of PDC Dividends	(2,065)
Other working capital movements	633
Closing balance as at 30th September	**5,076**

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

The cash balance of £5,076k equates to circa 9 days operational cash. Under the continuity of services risk rating the liquidity metric is -7.1 days which now reduces the scores to a 2. The calculation of the metric includes all current assets and liabilities excluding inventories, so masks the challenging cash position which is managed through working balances.

The operating performance continues to have an adverse effect on the cash position and creditor payments. In order to maintain a reasonable cash balance payments to creditors must be extended, however performance against the non NHS Better Payment Practice Code (BPPC) increased slightly to 71% in the month (53% 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.

The Board needs to be aware that until there is a significant improvement in the operating position of the Trust, the management of cash and the prompt payment of creditors will continue to be problematic. This may result in interest charges, refusal to provide goods and services by suppliers and the need to reduce the planned capital expenditure next year.

5. Statement of Financial Position (Appendix F)

Non current assets have increased by £59k in the month, as the monthly capital expenditure has exceeded the depreciation cost.

Current assets have decreased by £1,109k mainly due to the reduction in cash and accrued income, partially offset by the increase in receivables.

Current liabilities have decreased by £480k in the month mainly due to the reduction for the PDC Dividend Creditor (paid in September) and accruals, partially offset by the increase payables.

Non current liabilities have increased by £15k in the month.

6. Capital

The capital programme has been increased as a result of Halton CCG's agreement to fund the costs associated with the development of the Urgent Care Centre, although this has been partially offset by the reduction in contingency funding to cover the funding shortfall. The approved programme for the year now stands at £10.4m and to date the Trust has spent £2.1m against the budget of £3.4m, which is mainly due to delays in the commencement of various schemes.

Category	**Annual Budget £m**	**Budget to date £m**	**Actual to date £m**	**Variance to date £m**
Estates	5.6	1.8	0.9	0.9
IM&T	2.8	1.3	0.8	0.5
Medical Equipment	1.3	0.2	0.4	(0.2)
Contingency	0.7	0.1	0.0	0.1
Total	**10.4**	**3.4**	**2.1**	**1.3**

7. Financial Risk

For the period ending 30th September the Trust has recorded a deficit of £5,056k and although this is only £147k worse than plan, there are still a number of financial risks that need to be avoided or mitigated, namely:

- Non compliance with contractual data requirements, quality standards, access targets and CQUIN targets resulting in commissioner levied fines or penalties.
- Divisions fail to deliver services within available resources.
- Clinical divisions unable to deliver income targets based on agreed activity plans or deliver additional activity and income identified in budget setting process e.g. spinal or repatriation.
- Cost savings target not fully identified and delivered in in accordance with profile.

- Increase in readmissions resulting in bed blockages and payment to commissioners for exceeding current agreed threshold.
- Failure to manage escalation or partner's inability to provide services to withdraw medically fit patients from the hospital.
- Failure to continue to reduce bank, agency, locum, overtime and waiting list initiatives.
- Failure to increase clinical efficiency and productivity.

8. Forecast Outturn

Monitor wrote to all Foundation Trusts on 15th September stating that due to the emerging signs of pressures on NHS finances during the current year all trusts are now required to provide Monitor with its forecast yearend outturn position in respect of:

- Surplus / deficit (before any impairments).
- Capital expenditure (on an accruals basis).

An assessment of the year end forecast for both the surplus / (deficit) and capital expenditure has been completed and is subject to a separate report.

Tim Barlow
Director of Finance & Commercial Development
23rd October 2014

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Finance headlines as at 30th September 2014

Key Financial Metrics	Month			Year to date			Forecast		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income	17,469	17,457	-12	103,949	104,509	560	213,746	213,746	0
Operating Expenditure	-17,205	-17,187	18	-103,724	-104,431	-707	-204,977	-204,977	0
EBITDA	**264**	**270**	**6**	**225**	**78**	**-147**	**8,769**	**8,769**	**0**
Financing Costs	-856	-856	0	-5,134	-5,134	0	-10,269	-10,269	0
Net Surplus/(Deficit)	**-592**	**-586**	**6**	**-4,909**	**-5,056**	**-147**	**-1,500**	**-1,500**	**0**
Continuity of Services Risk Rating	2	2	0	2	2	0	3	3	0
Capital Expenditure	597	556	-41	3,444	2,135	-1,309	10,377	10,377	0
Cash Balance				3,839	5,056	1,217	6,731	6,731	0
Cost Savings	408	462	54	2,199	2,016	-183	11,931	11,931	0

Summary Position

The reported position for the period is an actual deficit of £5,056k which is £147k worse than the planned deficit of £4,909k and this delivers a Continuity of Services Risk Rating 2 which is in line with plan. Year to date income is £560k above plan mainly due to overperformance on elective activity that is 602 spells (£272k) above plan, non elective activity that is 1,037 spells (£401k) above plan, outpatients that is 7,713 attendances (£471k) above plan and miscellaneous income that is £720k above plan, although this is partially offset by other NHS activity that is £1,135k below plan. Year to date expenditure is £707k above plan mainly due to overspends on pay (£658k) and clinical supplies (£707k), althought this is partially offset by an underspend on drugs (£554k) and non clinical supplies (£105k). Year to date non operating income and expenditure is in line with plan.

Cost savings performance is below plan by £183k, which is a concern as the target is backdated towards the second half of the financial year.

Forecast Outturn

The forecast outturn is considered in the forecast outturn 14/15 paper.

Key Variances

Operating Income - £560k above plan (favourable).
Operating Expenditure - £707k above plan (adverse).
Cost savings - £183k below plan (adverse)
Cash balances - £1,217k above plan but the plan was based on a forecast year end cash balance of £10.3m (actual cash balance as at 31st March was £13.0m).
Capital expenditue - £1,309k below plan due to slippage but forecasting that all slippage is recovered by year end.

Key Risks

Divisions unable to deliver income targets based on agreed activity plans or deliver additional activity and income identified in the budget setting process.
Non compliance with contractual data requirements, quality standards, access targets and CQUIN targets resulting in commissioner levied fines and penalties.
Cost savings target not fully identified and delivered in accordance with profile.
Failure to significantly reduce bank, agency, locum, overtime and waiting list initiative expenditure.

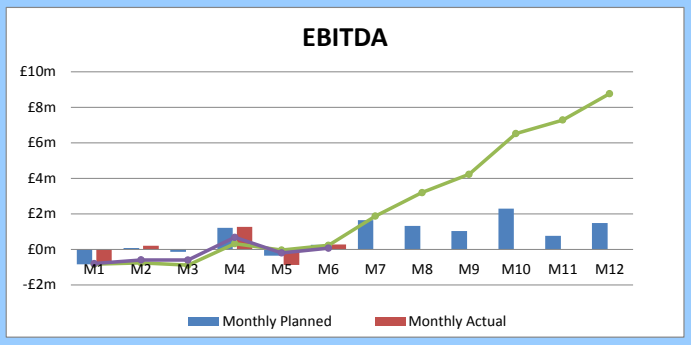
Other matters to be brought to the attention of the Board

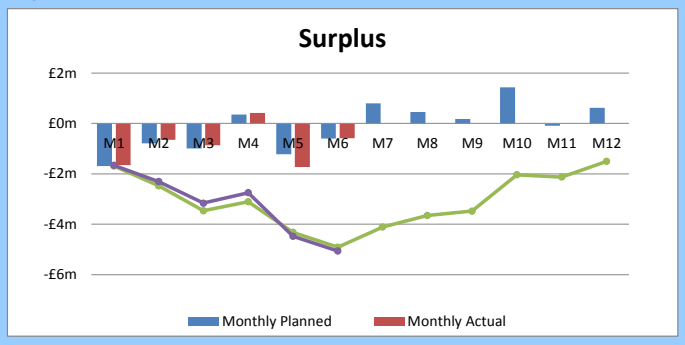
Monitor now require all trusts to submit forecast revenue and capital outturns on a monthly basis.
The trust has agreed a contract with Betsi Caldwaladr for the provision of cataract activity.
EY have now finished the contract but the trust must ensure that the initiatives identified to maximise opportunities for cost reduction are realised.

Warrington & Halton Hospitals NHS Foundation Trust

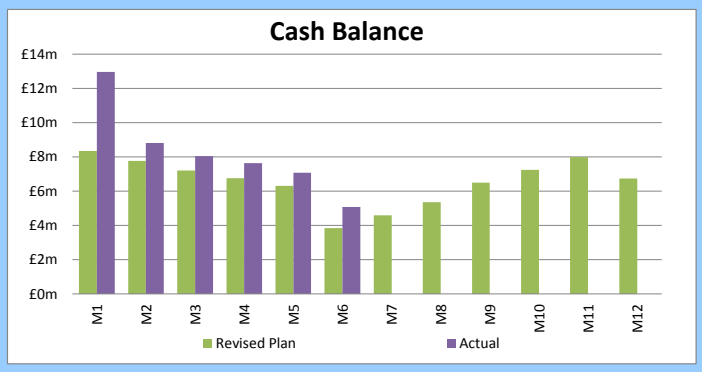
Finance Dashboard as at 30th September 2014 (Part A)

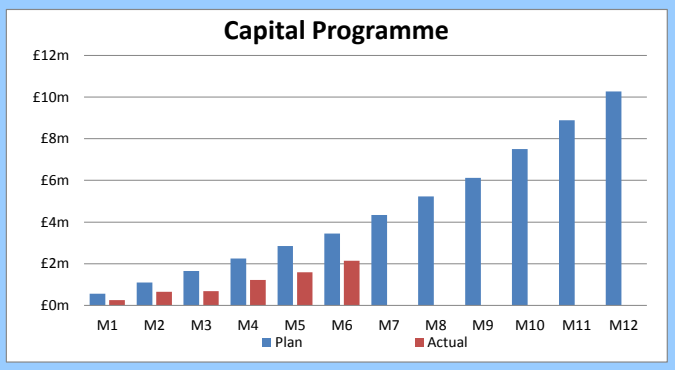
Profitability



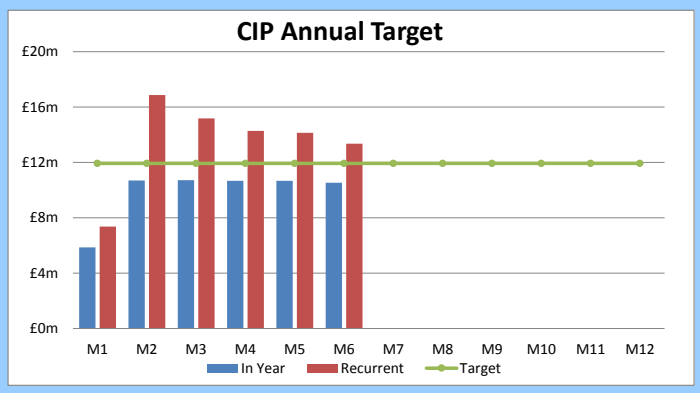


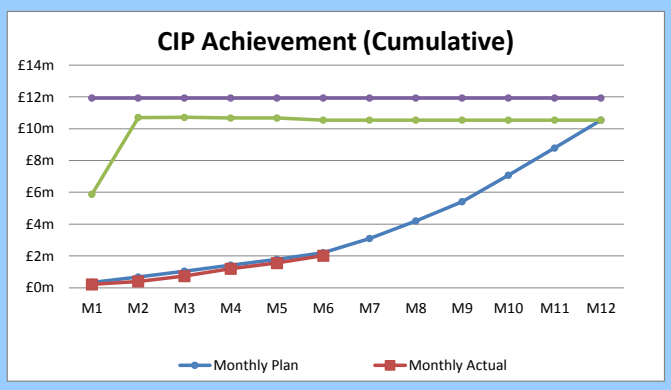
Cash and Investment





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	55,902	4,644	4,582	62	1.3	28,258	28,380	-122	-0.4
Unscheduled Care	43,233	3,655	3,721	-66	-1.8	21,975	22,430	-455	-2.1
Womens, Children & Support Services	57,774	4,953	4,951	2	0.0	30,005	29,755	250	0.8
Corporate									
Operations - Central	418	70	61	9	12.9	279	232	47	16.8
Operations - Estates	7,551	575	526	49	8.5	3,540	3,411	129	3.6
Operations - Facilities	8,036	666	652	14	2.1	4,024	3,993	31	0.8
Commercial Development	569	47	42	5	10.6	283	240	43	15.2
Finance	9,340	779	782	-3	-0.4	4,669	4,663	6	0.1
Governance & Workforce	4,705	406	377	29	7.1	2,366	2,151	215	9.1
Information Technology	3,985	336	331	5	1.5	2,012	1,945	67	3.3
Nursing	1,865	155	156	-1	-0.6	930	926	4	0.4
Trust Executive	2,102	148	127	21	14.2	1,213	1,169	44	3.6
Total	**195,480**	**16,434**	**16,308**	**126**	**0.8**	**99,554**	**99,295**	**259**	**0.3**

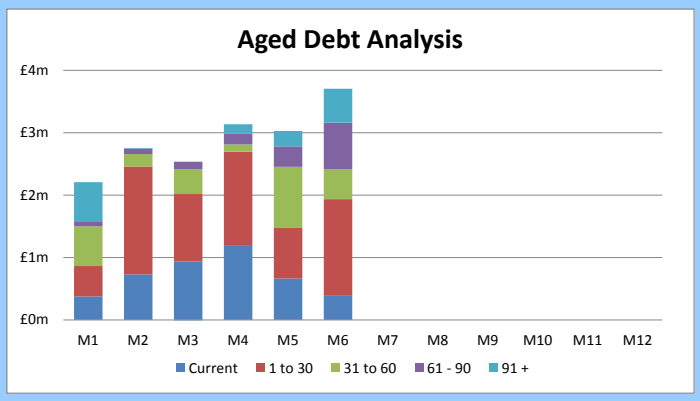
Positive variance = underspend, negative variance = overspend.

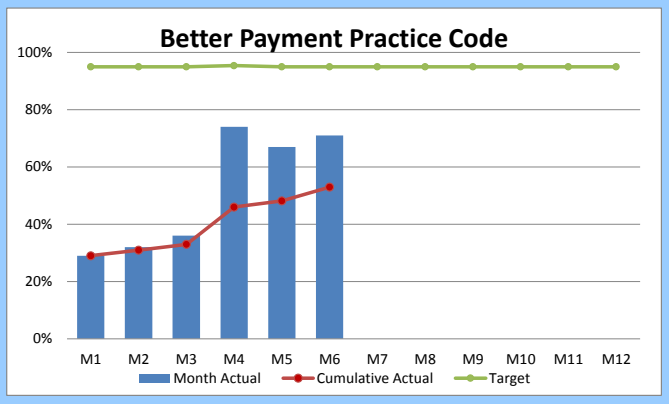
Continuity of Services Risk Rating

Continuity of Services Risk Rating	Actual Metric	Actual Rating
Liquidity Ratio (days)	-7.1	2
Capital Servicing Capacity (times)	0.0	1
Overall Risk Rating		**2**

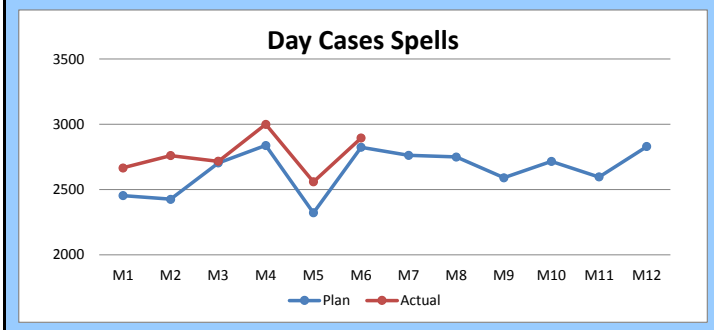
Finance Dashboard as at 30th September 2014 (Part B)

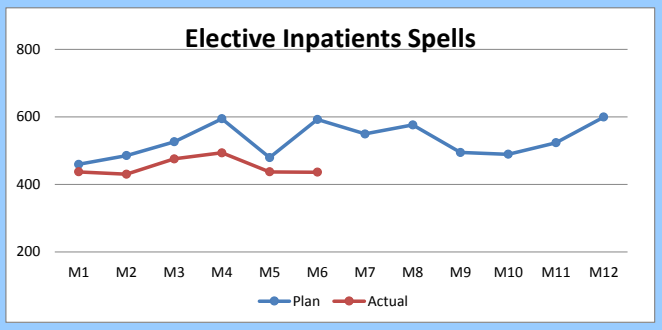
Balance Sheet and Liquidity

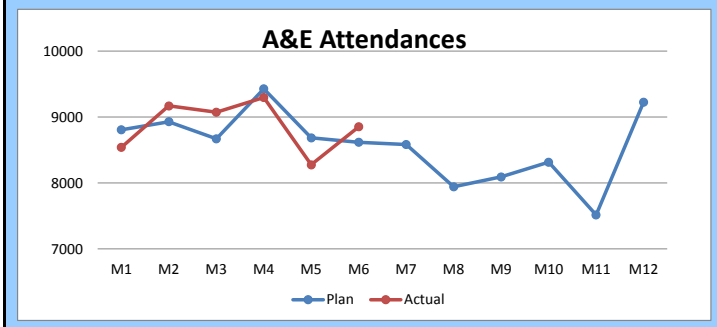


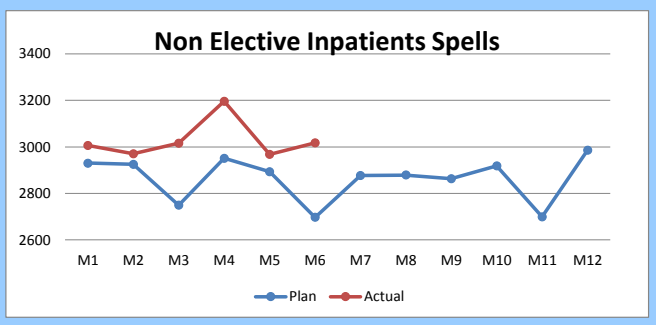


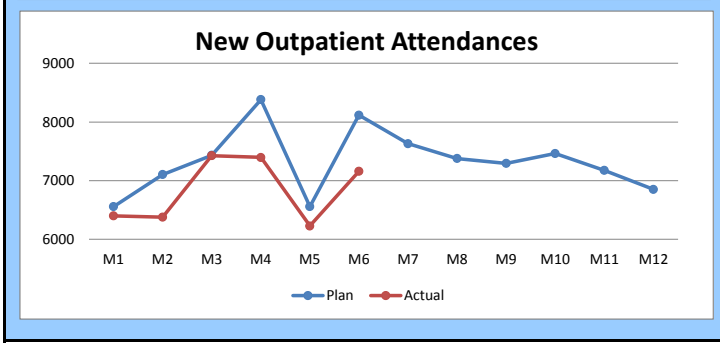
Activity Analysis

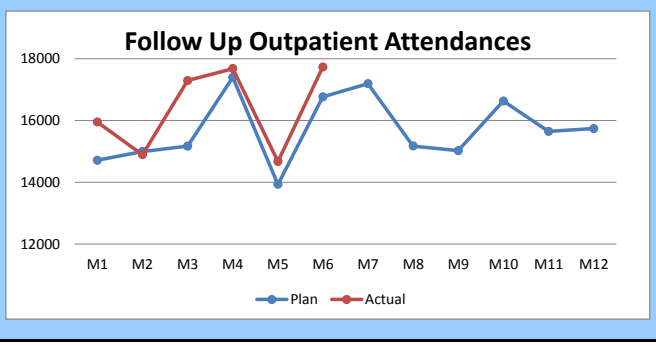












Income Statement, Activity Summary and Risk Ratings as at 30th September 2014

Income Statement	Month			Year to date			Forecast		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income									
NHS Activity Income									
Elective Spells	3,489	3,113	-375	18,627	18,899	272	39,884	39,884	0
Elective Excess Bed Days	23	11	-12	118	162	44	242	242	0
Non Elective Spells	4,155	4,353	197	26,150	26,551	401	52,145	52,145	0
Non Elective Excess Bed Days	293	267	-26	1,865	1,609	-256	3,701	3,701	0
Outpatient Attendances	2,903	2,890	-13	16,011	16,482	471	33,480	33,480	0
Accident & Emergency Attendances	854	900	47	5,263	5,315	52	10,184	10,184	0
Other Activity	4,419	4,419	1	27,911	26,776	-1,135	58,103	58,103	0
Sub total	**16,135**	**15,953**	**-182**	**95,945**	**95,794**	**-151**	**197,738**	**197,738**	**0**
Non Mandatory / Non Protected Income									
Private Patients	13	2	-11	76	38	-38	152	152	0
Other non protected	107	93	-14	642	673	31	1,284	1,284	0
Sub total	**120**	**94**	**-25**	**718**	**711**	**-7**	**1,436**	**1,436**	**0**
Other Operating Income									
Training & Education	641	638	-4	3,848	3,846	-1	7,696	7,696	0
Donations and Grants	0	0	0	0	0	0	0	0	0
Miscellaneous Income	573	771	198	3,438	4,157	720	6,876	6,876	0
Sub total	**1,214**	**1,409**	**195**	**7,286**	**8,004**	**718**	**14,572**	**14,572**	**0**
Total Operating Income	**17,469**	**17,457**	**-12**	**103,949**	**104,509**	**560**	**213,746**	**213,746**	**0**
Operating Expenses									
Employee Benefit Expenses (Pay)	-12,507	-12,716	-208	-75,377	-76,035	-658	-147,753	-147,753	0
Drugs	-1,168	-1,054	114	-7,018	-6,464	554	-14,243	-14,243	0
Clinical Supplies and Services	-1,557	-1,493	64	-9,422	-10,129	-707	-19,154	-19,154	0
Non Clinical Supplies	-1,972	-1,924	48	-11,907	-11,802	105	-23,827	-23,827	0
Total Operating Expenses	**-17,205**	**-17,187**	**18**	**-103,724**	**-104,431**	**-707**	**-204,977**	**-204,977**	**0**
Surplus / (Deficit) from Operations (EBITDA)	**264**	**269**	**5**	**225**	**77**	**-147**	**8,769**	**8,769**	**0**
Non Operating Income and Expenses									
Interest Income	3	3	-1	20	21	1	40	40	0
Interest Expenses	0	0	0	0	0	0	0	0	0
Depreciation	-524	-524	0	-3,141	-3,142	0	-6,283	-6,283	0
PDC Dividends	-336	-336	0	-2,013	-2,013	0	-4,026	-4,026	0
Restructuring Costs	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Total Non Operating Income and Expenses	**-856**	**-856**	**-1**	**-5,134**	**-5,134**	**1**	**-10,269**	**-10,269**	**0**
Surplus / (Deficit)	**-592**	**-587**	**5**	**-4,910**	**-5,056**	**-147**	**-1,500**	**-1,500**	**0**
Activity Summary	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**
Elective Spells	3,416	3,331	-85	18,705	19,307	602	38,181	38,181	0
Elective Excess Bed Days	94	28	-66	490	710	220	1,003	1,003	0
Non Elective Spells	2,695	3,017	322	17,136	18,173	1,037	34,367	34,367	0
Non Elective Excess Bed Days	1,292	1,206	-86	8,238	7,164	-1,074	16,354	16,354	0
Outpatient Attendances	28,714	29,663	948	159,341	167,053	7,713	283,035	283,035	0
Accident & Emergency Attendances	8,618	8,852	234	53,135	53,210	75	102,814	102,814	0
Continuity of Services Risk Ratings	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**
Liquidity Ratio - Metric (Days)	-1.2	-0.7	0.5	-11.7	-7.1	4.6	-9.0	-9.0	0.0
Liquidity Ratio - Rating	3	3	0	2	2	0	2	2	0
Capital Servicing Capacity - Metric (Times)	0.8	0.8	0.0	0.1	0.0	-0.1	2.2	2.2	0.0
Capital Servicing Capacity - Rating	1	1	0	1	1	0	3	3	0
Continuity of Services Risk Rating	**2**	**2**	**0**	**2**	**2**	**0**	**3**	**3**	**0**

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

Cash Flow Statement as at 30th September 2014

	Actual April £000's	Actual May £000's	Actual June £000's	Actual July £000's	Actual August £000's	Actual 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	**(1,655)**	**(647)**	**(858)**	**414**	**(1,726)**	**(587)**	**798**	**461**	**172**	**1,441**	**(90)**	**777**	**(1,500)**
Non-cash flows in operating surplus/(deficit)													
Depreciation and amortisation	523	525	523	523	524	524	524	524	523	524	524	523	6,284
PDC dividend expense	336	335	336	335	336	336	335	335	335	336	335	334	4,024
Other increases/(decreases) to reconcile to profit/(loss) from operations	(16)	9	(3)	(19)	6	(16)	13	13	13	13	13	14	40
Non-cash flows in operating surplus/(deficit), Total	**843**	**869**	**856**	**839**	**866**	**844**	**872**	**872**	**871**	**873**	**872**	**871**	**10,348**
Operating Cash flows before movements in working capital	**(812)**	**222**	**(2)**	**1,253**	**(860)**	**257**	**1,670**	**1,333**	**1,043**	**2,314**	**782**	**1,648**	**8,848**
Increase/(Decrease) in working capital													
(Increase)/decrease in inventories	(36)	(93)	68	52	141	(254)							(122)
(Increase)/decrease in NHS Trade Receivables	775	(332)	869	(991)	504	(618)							207
(Increase)/decrease in Non NHS Trade Receivables	154	(430)	(121)	203	(257)	(47)							(497)
(Increase)/decrease in other related party receivables	(235)	(75)	181	(237)	206	(11)							(170)
(Increase)/decrease in other receivables	(1)	303	144	(102)	137	(20)							460
(Increase)/decrease in accrued income	261	417	(231)	(542)	(220)	364	(607)	(270)	395	(49)	657	(174)	0
(Increase)/decrease in prepayments	(1,833)	507	(386)	(165)	872	(291)	171	171	171	171	171	441	(0)
Increase/(decrease) in Deferred Income (excl. Govt Grants.)	(243)	612	(14)	18	344	64							782
Increase/(decrease) in Current provisions	5	(11)	12	7	8	8	(11)	(11)	(11)	(11)	(11)	(11)	(37)
Increase/(decrease) in Trade Creditors	2,508	(3,205)	(351)	(1,190)	(1,086)	1,182	(202)	498	225	609	318	(322)	(1,016)
Increase/(decrease) in Other Creditors	167	(407)	61	(27)	85	95	(904)	(367)	(92)	(1,272)	259	1,349	(1,053)
Increase/(decrease) in accruals	(189)	(568)	(645)	1,702	7	(448)							(141)
Increase/(decrease) in Other liabilities (VAT, Social Security and Other Taxes)	(4)	94	(120)	64	(62)	15							(13)
Increase/(Decrease) in working capital, Total	**1,329**	**(3,188)**	**(533)**	**(1,208)**	**679**	**38**	**(1,553)**	**21**	**688**	**(552)**	**1,394**	**1,283**	**(1,602)**
Increase/(decrease) in Non-current provisions	(27)	13	14	(27)	16	15							4
Net cash inflow/(outflow) from operating activities	**490**	**(2,953)**	**(521)**	**18**	**(165)**	**310**	**117**	**1,354**	**1,731**	**1,762**	**2,176**	**2,931**	**7,250**
Net cash inflow/(outflow() from investing activities													
Property - new land, buildings or dwellings	0	0	0	0	0	0	(323)	(323)	(323)	(342)	(625)	(663)	**(2,599)**
Property - maintenance expenditure	(158)	(115)	(35)	(207)	(241)	(132)	(362)	(362)	(363)	(500)	(816)	(924)	**(4,215)**
Plant and equipment - Information Technology	(39)	(165)	(23)	(283)	(92)	(245)	(167)	(167)	(168)	(223)	(187)	(754)	**(2,513)**
Plant and equipment - Other	(45)	(119)	27	(61)	(23)	(179)	(40)	(40)	(41)	(241)	(93)	(195)	**(1,050)**
Increase/(decrease) in Capital Creditors	(171)	(865)	(171)	124	(58)	315							**(826)**
Net cash inflow/(outflow() from investing activities, Total	**(413)**	**(1,264)**	**(202)**	**(427)**	**(414)**	**(241)**	**(892)**	**(892)**	**(895)**	**(1,306)**	**(1,721)**	**(2,536)**	**(11,203)**
Net cash inflow/(outflow) before financing	**77**	**(4,217)**	**(723)**	**(409)**	**(579)**	**69**	**(775)**	**462**	**836**	**456**	**455**	**395**	**(3,953)**
Net cash inflow/(outflow) from financing activities													
Public Dividend Capital received	0												0
PDC Dividends paid	0					(2,065)						(1,959)	(4,024)
Interest (paid) on non-commercial loans	0												0
Interest received on cash and cash equivalents	4	2	6	3	3	3	3	3	3	3	3	4	40
Drawdown of non-commercial loans							266	267	267	266	267	267	1,600
Repayment of non-commercial loans	0												0
(Increase)/decrease in non-current receivables	(84)	65	(38)	(4)	9	(2)	27	27	27	27	27	31	112
Net cash inflow/(outflow) from financing activities, Total	**(80)**	**67**	**(32)**	**(1)**	**12**	**(2,064)**	**296**	**297**	**297**	**296**	**297**	**(1,657)**	**(2,272)**
Net increase/(decrease) in cash	**(3)**	**(4,150)**	**(755)**	**(410)**	**(568)**	**(1,994)**	**(479)**	**759**	**1,133**	**752**	**752**	**(1,262)**	**(6,225)**
Opening cash	**12,956**	**12,953**	**8,803**	**8,048**	**7,638**	**7,070**	**5,076**	**4,597**	**5,356**	**6,489**	**7,241**	**7,993**	**12,956**
Closing cash	**12,953**	**8,803**	**8,048**	**7,638**	**7,070**	**5,076**	**4,597**	**5,356**	**6,489**	**7,241**	**7,993**	**6,731**	**6,731**

Forecast cash position as per Monitor plan	8,342	7,772	7,202	6,751	6,301	3,839	4,597	5,356	6,489	7,241	7,993	6,731
Actual cash position	12,953	8,803	8,048	7,638	7,070	5,076	4,597	5,356	6,489	7,241	7,993	6,731
Variance	4,611	1,031	846	887	769	1,237	0	0	0	0	0	0

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

Statement of Position as at 30th September 2014

Narrative	Audited position as at 31.03.14 £000	Actual Position as at 31.08.14 £000	Actual Position as at 30.09.14 £000	Monthly Movement £000	Forecast Position as at 31.3.15 £000
ASSETS					
Non Current Assets					
Intangible Assets	316	374	376	3	155
Property Plant & Equipment	132,588	131,631	131,685	54	134,972
Other Receivables	1,233	1,295	1,297	2	1,900
Impairment of receivables for bad & doubtful debts	-195	-205	-205	0	-465
Total Non Current Assets	**133,942**	**133,095**	**133,154**	**59**	**136,562**
Current Assets					
Inventories	2,769	2,637	2,891	254	2,569
NHS Trade Receivables	3,052	2,227	2,845	618	1,164
Non NHS Trade Receivables	573	1,024	1,070	47	338
Other Related party receivables	200	360	370	11	606
Other Receivables	1,960	1,479	1,500	20	1,153
Impairment of receivables for bad & doubtful debts	-355	-341	-335	6	-188
Accrued Income	884	1,199	836	-364	764
Prepayments	1,727	2,732	3,023	291	1,016
Cash held in GBS Accounts	12,937	7,040	5,032	-2,008	6,720
Cash held in commercial accounts	0			0	0
Cash in hand	19	30	44	14	11
Total Current Assets	**23,766**	**18,386**	**17,277**	**-1,109**	**14,153**
Total Assets	**157,708**	**151,481**	**150,430**	**-1,051**	**150,715**
LIABILITIES					
Current Liabilities					
NHS Trade Payables	-1,513	-1,327	-1,260	66	-1,732
Non NHS Trade Payables	-5,728	-2,590	-3,839	-1,249	-2,694
Other Payables	-1,755	-1,634	-1,729	-95	-800
Other Liabilities (VAT, Social Security and Other Taxes)	-2,678	-2,650	-2,665	-15	-2,678
Capital Payables	-1,386	-245	-560	-315	-1,124
Accruals	-5,986	-6,439	-6,009	430	-6,222
Interest payable on non commercial int bearing borrowings	0	0	0	0	0
PDC Dividend creditor	-49	-1,727	3	1,730	0
Deferred Income	-1,353	-2,070	-2,135	-64	-1,140
Provisions	-282	-303	-311	-8	-317
Loans non commercial	0			0	0
Total Current Liabilities	**-20,730**	**-18,983**	**-18,503**	**480**	**-16,707**
Net Current Assets (Liabilities)	**3,036**	**-598**	**-1,227**	**-629**	**-2,554**
Non Current Liabilities					
Loans non commercial		0	0	0	-1,600
Provisions	-1,510	-1,499	-1,514	-15	-1,471
Total Non Current Liabilities	**-1,510**	**-1,499**	**-1,514**	**-15**	**-3,071**
TOTAL ASSETS EMPLOYED	**135,468**	**130,999**	**130,413**	**-586**	**130,937**
TAXPAYERS AND OTHERS EQUITY					
Taxpayers Equity					
Public Dividend Capital	90,063	90,063	90,063	0	90,014
Retained Earnings prior year	12,446	9,597	9,597	0	8,743
Retained Earnings current year	-2,849	-4,470	-5,055	-586	-1,500
Sub total	**99,660**	**95,190**	**94,605**	**-586**	**97,257**
Other Reserves					
Revaluation Reserve	35,808	35,808	35,808	0	33,680
Sub total	**35,808**	**35,808**	**35,808**	**0**	**33,680**
TOTAL TAXPAYERS AND OTHERS EQUITY	**135,468**	**130,999**	**130,413**	**-586**	**130,937**

W&HHFT/TB/14/158

Board of Directors

Paper Title	Corporate Performance Report
Date of Meeting	29th October 2014
Director Responsible	Simon Wright – Chief Operating Officer/Deputy Chief Executive
Author(s)	Simon Wright – Chief Operating Officer/Deputy Chief Executive
Purpose	To update the Board on the Trust's operational performance for the month of September 2014

Paper previously considered	**Committee**	**Date**

Relates to which Trust objectives	√ **appropriate**
• Ensure all our patients are safe in our care	√
• To be the employer of choice for healthcare we deliver	√
• To give our patients the best possible experience	√
• To provide sustainable local healthcare services	√

Key points arising from the Report/Paper

Page/Paragraph Reference

- AED 4hr target performance failed to deliver Q2
- C.Diff slightly above YTD trajectory

Recommendation(s)

The Board is asked to note the contents of this paper

Warrington and Halton Hospitals NHS
NHS Foundation Trust

CORPORATE PERFORMANCE REPORT
September 2014

EXECUTIVE SUMMARY

1.0 Introduction

This corporate report updates the Board on the progress of the Trust in relation to activity, performance and workforce targets to 30th September 2014.

2.0 Performance

In overall terms, based on the performance in month 6, the Trust has an **Amber/Green** rating, as highlighted in Appendix 1.

3.0 National Key performance indicators

3.1 Accident and Emergency Department

In September the Trust declared an AED 4 hour target performance of 93.26% which continues to be below the threshold of 95%.

The Trust board has seen the review of performance in the September papers for the Board and the following provides the summary actions being taken:

- Professor Higgins AED consultant and ECIST have visited the AED department to observe clinical pathways and practice. Report pending.
- CCG have issued formal contract variation and initiated a joint investigation into the current difficulties across our system.
- Divisional Director for Unscheduled care has commenced her two year secondment into the director of transformation post with the local authority and across our wider health and social care system. Dawn Wood has been appointed into this post with immediate effect.
- Main areas for improvement include:
  - Demand management by CCG
  - Complex delays in transfer of patients out of hospital following completion of their acute care (90 per week)
  - Delays in junior doctor decision making at night
  - Internal flow problems due to discharge levels not keeping pace with the rise in emergency admissions within a bed base 42 beds less than last year.
  - Insufficient capacity in Intermediate care bed base
  - Delays in Home of Choice transfers
  - D&V outbreaks closing bed capacity.
- Weekly performance meetings with the Trust wide Transforming Hospital

Emergency Performance group feeding progress to the Finance and sustainability Committee.

- **Recovery of performance expected to be achieved in November**

3.2 Clostridium Difficile

Q1 and Q2 performance delivering 16 cases against an unweighted trajectory of 13 (26 for the entire four quarters)

Simon Wright

Chief Operating Officer

October 2014

Sep-14

Monitor Governance Risk Rating - 2014/15

Warrington and Halton Hospitals NHS
NHS Foundation Trust

All targets are QUARTERLY

Target or Indicator		Target	Weighting	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4
Referral to treatment waiting time	Admitted patients	90%	1.0	92.61%	93.21%	93.58%	92.91%	90.70%	90.34%	92.04%	91.04%								
	Non-admitted patients	95%	1.0	98.03%	97.63%	98.54%	97.83%	97.79%	97.72%	98.14%	97.89%								
	Incomplete Pathways	92%	1.0	94.55%	94.56%	94.94%	94.55%	94.88%	95.29%	94.94%	95.03%								
A&E Clinical Quality	A&E Maximum waiting time of 4 hrs from arrival to admission/transfer/discharge	>=95%	1.0	94.54%	92.66%	95.01%	93.97%	91.74%	93.54%	93.26%	92.74%								
All Cancers:62-day wait for First treatment	From urgent GP referral - **post** local breach re-allocation (CCG)	85%	1.0	90.00%	82.14%	85.07%	85.45%	83.16%	85.23%	86.90%	85.05%								
	From NHS Cancer Screening Service referral - **post** local breach re-allocation	90%	1.0	100.00%	100.00%	98.00%	99.33%	100.00%	98.00%	99.00%	99.00%								
	From urgent GP referral - **pre** local breach re-allocation (Open Exeter - Monitor)	85%		90.00%	88.46%	85.07%	87.91%	87.50%	86.51%	86.75%	86.51%								
	From NHS Cancer Screening Service referral - **pre** local breach re-allocation	90%		100.00%	100.00%	98.00%	99.33%	100.00%	98.00%	100.00%	99.00%								
All Cancers:31-day wait for second or subsequent treatment	Surgery	>94%	1.0 (Failure for any of the 3 = failure against the overall target)	96.00%	98.00%	97.00%	97.00%	100.00%	100.00%	100.00%	100.00%								
	Anti Cancer Drug Treatments	>98%		100.00%	100.00%	98.00%	99.33%	100.00%	100.00%	100.00%	100.00%								
	Radiotherapy (not performed at this Trust)	>94%																	
All Cancers: 31-Day Wait From Diagnosis To First Treatment		>96%	1.0	96.00%	96.00%	98.00%	96.67%	98.00%	99.00%	100.00%	99.00%								
Cancer: Two Week Wait From Referral To Date First Seen	Urgent Referrals (Cancer Suspected)	>93%	1.0 (Failure for either = failure against the overall target)	93.10%	92.90%	93.05%	93.00%	93.80%	92.70%	93.80%	93.50%								
	Symptomatic Breast Patients (Cancer Not Initially Suspected)	>93%		93.05%	93.00%	93.10%	93.05%	93.75%	91.90%	93.90%	93.30%								
Clostridium Difficile	Hospital Acquired (Cumulative Qtr1: 6.5 Qtr2: 13 Qtr3: 19.5 Qtr4: 26)	26	1.0 **	2	3	2	7	1	7	1	9								
Failure to comply with requirements regarding access to healthcare for people with a learning disability		N/A	1.0	No	No	No	No	No	No	No	No								

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

Additional Notes:

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

**** Clostridium Difficile**
Monitor's annual de minimis limit for cases of C-Diff is set at 12.
Monitor will assess NHS foundation trusts for breaches of the C. difficile objective against their objective at each quarter using a cumulative year-to-date trajectory.

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

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

W&HHFT/TB/14/161

BOARD OF DIRECTORS

Paper Title:	Quality Dashboard (2014/2015) October 2014
Date of Meeting	
Director Responsible	Karen Dawber (Director of Nursing and Organisational Development)
Author(s)	Ros Harvey (Corporate Nursing Programmes Manager) Hannah Gray (Clinical Effectiveness Manager)
Purpose	To monitor performance against the KPIs within the Trust's Improving Quality: Patient Safety, Experience and Clinical Effectiveness Strategy

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**

Relates to which Trust objectives

	appropriate
• Ensure all our patients are safe in our care	√
• To be the employer of choice for healthcare we deliver	√
• To give our patients the best possible experience	√
• To provide sustainable local healthcare services	√

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

Page/Paragraph Reference

- Exception reports are included for non-compliant indicators including Care Indicators; Friends and Family; Pressure Ulcer CQUIN; Catheter Acquired UTI; AQ Stroke and Heart Failure; PROMS and C.Difficile & MRSA.
- Please note that VTE and Dementia (compliant) were extracted on the 22nd October 2014 and are therefore provisional until final submission to UNIFY.

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)
The Board is asked to:

- Note that the Pressure Ulcer and falls data has been refreshed for inclusion in the Pressure Ulcer and Falls Reports. The detail of the new Out of Hours transfers indicator has been reviewed; inaccuracies in categorisation on the datix system have been identified, the incidents have been re-categorised and the figures have been amended accordingly.
- Note progress and compliance against the revised key performance indicators
- Approve actions planned to mitigate areas of exception

1. Key Performance Indicators

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
Safety																			
Mortality																			
HSMR (12 month rolling)	<=100 = G, As expected = A, Higher than expected = R	QI, IP, QC	98	98	98		98												98
SHMI (12 month rolling)	<=100 = G, As expected = A, Higher than expected = R	QI, IP, QC	108	108	107														107
Total deaths in hospital	Not set		98	89	76	263	74	81	95	250									513
Regulation 28 - Prevention of future deaths report	Not set		0	0	0	0	0	0	0	0									0
Incidents resulting in Moderate, Major or Catastrophic harm																			
Incidents resulting in moderate, major or catastrophic harm	TBC	QC	6	7	6	19	3	6	3	12									31
Incidents of moderate, major or catastrophic harm under investigation	N/A		4	3	2	9	9	4	22	35									44
Falls																			
All falls (approved)	Not set		91	78	87	256	88	78	73	239									495
Moderate, major and catastrophic harm falls (approved)	<=13 per year	IP	1	2	2	5	2	3	0	5									10
Moderate, major and catastrophic harm falls (awaiting approval)	N/A		0	0	0	0	0	0	2	2									2

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
Major and catastrophic harm falls (approved)	<=2 per year	QC	0	0	1	1	0	0	0	0									1
Pressure Ulcers																			
Grade 3 and 4 Hospital Acquired (Avoidable)	<=6 per year	IP	1	1	0	2	0	0	0	0									2
Grade 3 and 4 Hospital Acquired (Unavoidable)	<=10	QC	0	0	0	0	1	0	1	2									2
Grade 3 and 4 Hospital Acquired (Under review)	N/A		0	0	0	0	0	0	1	1									1
Grade 2 Hospital Acquired	<=101 per year	IP	3	8	2	13	12	3	3	18									31
Grade 2 Hospital Acquired – stretch target (20% reduction)	<=90 per year	IP	3	8	2	13	12	3	3	18									31
Grade 2 Hospital Acquired (under review)	N/A		0	0	0	0	0	0	0	0									0
% RCA / mini investigation completed	100%	IP	100	100	100	100	100	100	100	100									100
% of patients with a pressure ulcer (Community or hospital acquired) (ST)	<=3.99% (November 2014 – March 2015) (median YTD)	C	4.92	3.99	3.73		3.37	6.25	4.95										
Health Care Acquired Infections																			
MRSA	0= green, 1-5=amber, >5 red	QC, IP	0	1	0	1	0	0	1	1									2
Clostridium difficile	<=26 per year	QC, IP	2	3	2	7	1	7	1	9									16

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
MSSA	Not set		1	0	1	2	1	0	1	2									4
Out of hours transfers	TBC	BK	1	2	5	8	1	5	1	7									15
Never Events	0 per year	QC	0	0	0	0	0	0	0	0									0
Number of cardiac arrests in hospital wards, outside A&E, Theatres, CCU and ICU'.	Annual: <75 = G 75 – 85 = A >85 = Red	QC	8	11	7	26	3	13	6	22									48
Medicines Safety Thermometer % harm free (ST)	TBC	IP	PILOT	PILOT	PILOT		PILOT	PILOT	PILOT										
VTE																			
% of patients risk assessed	>=95%	QC	95.55	95.92	95.61		95.33	95.30	95.31										
% of eligible patients having prophylaxis (ST)	100%	QC	92	99.8	93		100	99.6	100										
Number of patients who developed a VTE	Baseline TBC	QC	7	10	4	21	9	Unavailable until November											30
Number of patients who developed a VTE (under review)			0	0	0	0	5	Unavailable until November											5
% free from harm (ST)		OH	97.3	99.2	97.8		98	96.4	98										
Catheter Acquired Urinary Tract Infections																			
CA – UTI: Number of catheterised patients who developed a UTI (ST)	<=3 per month	IP	4	2	2		2	4	5										

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
CA – UTI % of catheterised patients who developed a UTI (ST)	<=0.6% each month	IP	0.76	0.38	0.39		0.40	0.89	0.99										
Dementia																			
Dementia Assessment % (Part 1)	>=90%	C	94.55	95.69	95.43*		94.26	96.59	92.45										
Dementia Assessment % (Part 2)	>=90%	C	100	100	100*		100	100	91.89										
Dementia Assessment % (Part 3)	>=90%	C	100	100	100*		100	100	100										
Care Indicators																			
Falls - risk assessment % compliance	>=95%	IP	100	95	95	96.6	98.8	98.9	98	98.7									
Waterlow - risk assessment % compliance	>=95%	IP	98	92.7	88.3	93	95.6	93.3	83	90.6									
MUST - risk assessment measures	>=95%	IP	57.2	59.4	60	58.9	81.6	71.1	75	75.9									
Effectiveness																			
Advancing Quality % compliance (cumulative scores)																			
Acute MI	>=95%	IP, C	100	98.4	98.9		98.4												98.4
Hip and Knee	>=95%	IP, C	95.2	96.5	95		96.4												96.4
Heart failure	>=90.2%	IP, C	100	90.9	87.9		83.1												83.1
Pneumonia	>=73.9%	IP, C	68.6	72.8	74.4		75.1												75.1
Stroke	>=60.4%	IP, C	69.7	61.4	57		58.3												58.3
COPD (data not yet released)	>=50%	IP, C																	
Patient Reported Outcome Measures (PROMS)																			
Hip replacement (Average health gain)	0.44 (latest England average Mar 2014)	IP,QC															0.41		0.40

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
Knee replacement (Average health gain)	0.32 (latest England average Mar 2014)	IP,QC															0.34		0.34
Groin surgery (Average health gain)	0.085 (latest England average Mar 2014)	IP,QC															0.065		0.065
Patient Experience																			
Staff friends and family question (needing care) (Extremely likely and likely responses from F&F quarterly staff survey)	TBC Q3 Staff survey results	C				70.9				72									
Staff F&F place to work (as above)	Q3 Staff survey results					66.8				67									
Always events (Q1&2 implementation, Q3 data collection)	TBC	IP																	
Mixed sex occurrences	0	QC	6	3	0		0	0	0	0									9
Friends and family test																			
Friends and Family Test (Trust score, out of maximum 5)	TBC		4.54	4.5	4.58		4.53	4.6	4.58										
Friends and Family Test Inpatients NP score	>=70 (National average)	OH	76	74	81		76	77											
Friends and Family Test A&E NP score	>=50 (National average)	OH	42	35	41		40	45											
Friends and family response rate (A&E)	Q1 – >=15% Q4 - >=20%	C	23.08	18.52	20.79	20.75	19.55	17.58	14.51	17.26									19.01
Friends and family response rate (inpatients)	Q1 – >=25% Q4 - >=30% March 2015 achieve >=40%	C	27.32	26.83	34.62	29.55	32.20	30.02	26.39	29.55									29.55

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
Complaints and concerns																			
Number of concerns received	Not set	IP	1	5	3	9	10	8	4	22									31
Number of complaints received	2013/2014 received 422 (No threshold set)	IP	32	43	39	114	57	33	33	123									239
% of complaints resolved within the agreed timescale	>=94%	IP	94.44	95.24	100	96.51	96.88	100	97.50	98.23									97.49

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.

Key: YTD = Year to date, ST = Safety Thermometer (monthly point prevalence survey), IC = Inclusion criteria

Inclusion criteria key: Improvement priority (IP), National Quality related CQUINs (C), Local quality related CQUINs by exception*(CE), 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) (SS), Contract KPIs (Quality section only) not considered at other forums (QC), Directive from Sir Bruce Keogh (BK), Open and Honest (OH)

2. Exception reporting

Care Indicators

High Quality Care was a local CQUIN for 2013/2014. The care indicators audit was a process which was developed as part of this CQUIN to audit compliance with risk assessments for Falls, Waterlow and MUST Risk Assessments. The Trust identified this as an important aspect of quality of care and thus agreed to continue monitoring as a Quality Indicator for the Quality Accounts in 2014/2015. The results (random sample) indicate sustained compliance with the falls risk assessment however both Waterlow and MUST have reduced compliance in September. The Patient Quality & Safety Champion has increased surveillance and feedback around risk assessments in order to improve compliance going forward.

Friends and Family

The A&E response rate for F&F has fallen below the required 15% however the overall quarterly position remains compliant. Agreed that we will refocus efforts to ensure that the Trust achieves >=15% on a monthly basis in order to achieve 20% by Q4.

MRSA and Clostridium Difficile

MRSA bacteraemia

The Trust reported 1 hospital apportioned MRSA bacteraemia in September. There were several learning points from this case and an action plan is being produced to address finding. Issues were identified in relation to MRSA screening, antibiotic treatment and communication.

Clostridium difficile

7 cases of Clostridium difficile were reported in September, 1 of which was hospital apportioned. The total number of hospital apportioned cases is 16 YTD. The business case for increase in hours for the Antibiotic Pharmacist role has been approved and is awaiting appointment. A number of proactive initiatives are being planned for European antibiotic awareness day in November. 2 cases are being submitted to Commissioners for appeal.

Advancing Quality – Heart failure and Stroke

Heart Failure

Relevant patients are required to be seen by the heart failure nurses in order to pass all of the measures. The number of heart failure patients monitored by this AQ measure is low and therefore just 1 or 2 missed opportunities can mean non-compliance. The patients that are missed (i.e. not seen by the heart failure nurses) are often those that have been in and out within a short time frame, out of hours, at weekend or during the evenings (in June 2014, 2 patients did not have a specialist review; both had 0 day LOS and 1 of these was admitted at the weekend). On 2 occasions the information packs were not supplied to the patient, thus failing this measure. The specialist nurses are continuing to encourage clinicians to refer and consistently raise awareness of the program through ward teaching and study days. All incidences of non-compliance are audited and feedback is given to the appropriate clinicians.

Stroke

Processes to monitor non-compliance have been improved and if any measures are missed they raise this with the individual nurse. The issue with inappropriate use of ring fenced stroke beds for non-stroke patients still remains but they stress that staff are trying hard to keep these beds available for stroke patients but that with the general bed situation this is not always possible. AQ Adjudicators have also stated that the timing for the 4 hour stroke measure is to be taken from the notes when the patient reaches the ward and not MEDITECH which results in breaches for the 4 hour Stroke measure. These KPIs are monitored by the AQ Group and the CQUIN Group.

4. KPI Updates

SHMI

The latest rebase of the SHMI has resulted in an increase in the SHMI of over three points for the period April 2013 – March 2014 for all Trusts. Overall SHMI values during July 2013 - June 2014 will be expected to increase by 1.9 points on average nationally.

According to the HED team:
This is due to an unusual change in the underlying data used for calculating the SHMI model. The crude mortality rate seen nationally was 3.14% (265,179/8,455,873) during Apr 2013 - Mar 2014, this is a decrease of 3.4% relative to the previous SHMI period Jan 2013 - Dec 2013 (274,491/8,441,462=3.25%). As a result of this large decrease in mortality rate at national level, the number of expected deaths calculated from the new modelling period will be 3.4% less than that calculated from previous modelling period. As a result SHMI values will be seen to increase by 3.4 points (SHMI average score is 100) on average nationally.

Despite this change, the Trust still has a SHMI within expected range for the period April 2013 – March 2014, and for each rolling 12 month period since.

Pressure ulcer (Community or hospital acquired) (ST)

This indicator is in place to monitor progress with the national CQUIN - The number of patients recorded as having a category 2-4 pressure ulcer (old or new) as measured using the NHS Safety Thermometer on the day of each monthly survey / Total number of patients surveyed on the day.
The Trust median baseline for October to March 2014 was established at 3.99. We have agreed improvement value of <=3.99 with commissioners.
to show improvement in the period November 2014 to March 2015. The Trust is currently over the target of 3.99. The main issue is old PU (known as community). Analysis of “old to new” shows that the rate has increased due to the number of old PU’s Work being undertaken to identify the patients who are admitted from care homes and directly from home and we will then identify themes e.g. location of PU and long term conditions to share with care homes and GP’s. Report will be sent to the CCG.

Catheter Acquired Urinary Tract Infections

This indicator is being monitored for inclusion in the Quality Report. A baseline was established based on last year’s data which established a threshold of <=3 per month suggested, we are currently above threshold.

W&HHFT/TB/14/162

BOARD OF DIRECTORS

Paper Title	Infection Prevention and Control Trust Board Report
Date of Meeting	29th October 2014
Director Responsible	Karen Dawber Director of Nursing and Organisational Development/Director of Infection Prevention and Control
Author	Lesley McKay Associate Director Infection Prevention and Control
Purpose	To inform and update the Board on issues relating to infection prevention and control in the Trust

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**

Relates to which Trust objectives	√ **Appropriate**
• Ensure all our patients are safe in our care	√
• To be the employer of choice for healthcare we deliver	√
• To give our patients the best possible experience	√
• To provide sustainable local healthcare services	

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

	Page/Paragraph Reference
• Clostridium difficile cases	**2**
• MRSA bacteraemia case	**2**
• Ebola preparations	**3**
• Community Infection Control Service Tender	**3**

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

The Board is asked to receive the infection control report, note the progress made.

Infection Prevention and Control Trust Board Report

Executive Summary

This report provides a summary of infection control activity in quarter 2 (Q2), 2014 and highlights the Trust's progress year to date against infection prevention and control key performance indicators.

Clostridium difficile

During Q2 the Trust reported 22 cases of *Clostridium difficile,* 9 of which were hospital apportioned with 7 cases occurring in August (appendix 1). Further investigation of these cases identified 5 different ribotypes. No geographical links could be identified from cases with the same ribotypes.

Periods of increased incidence occurred on Ward A6 and Ward A8 (2 cases within a 28 day period in each location). Testing identified different ribotypes for the cases on A6 therefore the cases were not connected and this was not an outbreak. The cases on Ward A8 are under investigation.

Year to date (YTD) the Trust has reported 34 cases of *Clostridium difficile*, 16 of which are hospital apportioned against the financial year threshold of 26 cases. The Trust is 3 cases above planned trajectory at the end of Q2.

Discussions have taken place with the CCG and 2 cases from Q1 have been submitted for appeal against contractual sanctions as no lapses in care were identified. The CCG review meeting is scheduled to take place in early November.

It should be noted that both community apportioned cases of Clostridium difficile (toxin positive) and all cases of Clostridium difficile PCR positive/toxin negative (local surveillance only) cared for within the Trust present a background incidence of cases and associated transmission risk.

Bacteraemias

MRSA bacteraemia

During Q2 the Trust reported 2 cases of MRSA bacteraemia, 1 of which was hospital apportioned. The post infection review identified the bacteraemia was linked to a diabetic foot ulcer. A variety of learning points were identified which included: delay in obtaining the blood culture specimen; antibiotic choice was not in line with the formulary and patient factors (tampering with the dressings). A meeting is being established with community partners to review management of diabetic foot ulcers for outpatients.

YTD the Trust has reported 3 MRSA bacteraemia cases, 2 of which are hospital apportioned against the target of zero.

MSSA bacteraemia

During Q2, the Trust reported 5 cases of MSSA bacteraemia, 1 of which was hospital apportioned. The post infection review identified the patient had a deep seated spinal abscess.

YTD the Trust has reported 14 MSSA bacteraemia cases, 3 of which are hospital apportioned. This is a positive position compared to the last financial year when the Trust flagged as an outlier both regionally and nationally for higher than average number of hospital apportioned cases.

E. coli bacteraemias

In Q2 a total of 49 cases were reported. The Medical Microbiologists review all cases of E. coli bacteraemia and the majority of cases are deemed unlikely to be associated with healthcare. YTD the Trust has reported 89 cases of E. coli bacteraemia.

Outbreaks/Incidents/New developments

Viral Gastroenteritis

In Q2, 6 wards were under surveillance and part or fully closed due to symptoms of viral gastroenteritis. All the wards were re-opened as soon as it was safe to do so. The Microbiology laboratory is reviewing testing methodology for gastroenteritis viruses to provide more timely results to inform decision making.

Ebola preparedness

The Infection Control Team has undertaken a number of actions to prepare the Trust for managing suspected cases of Ebola and other viral haemorrhagic fever. The Trust policy has been revised in line with the latest national guidance and information provided on Trust actions at Grand Round.

The Trust processes were tested when a suspect case attended the Trust in August. A number of areas were identified for improvement action. A wealth of information is being circulated by Public Health England and a planning exercise was held in October (appendix 2). This meeting highlighted that the situation in Africa poses a long term threat of cases being imported into the UK.

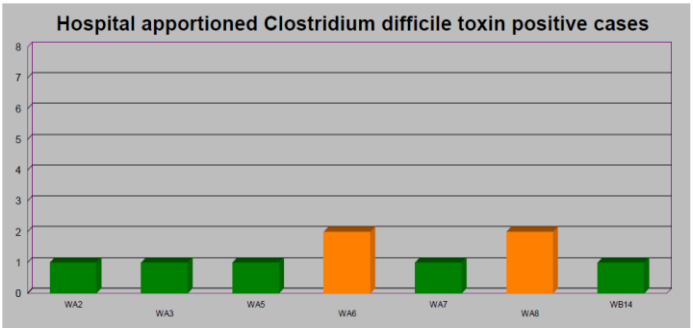
New Developments

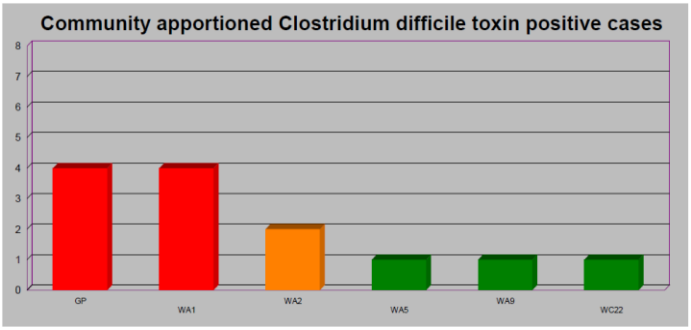
An opportunity has arisen to tender for the provision of Community Infection Prevention and Control services for Halton, St Helens and Warrington Boroughs. The Infection Control Team is working in partnership with the Commercial Development Team to evaluate this opportunity with a view to submitting a bid.

Appendix 1 HCAI Surveillance data April – September 2014

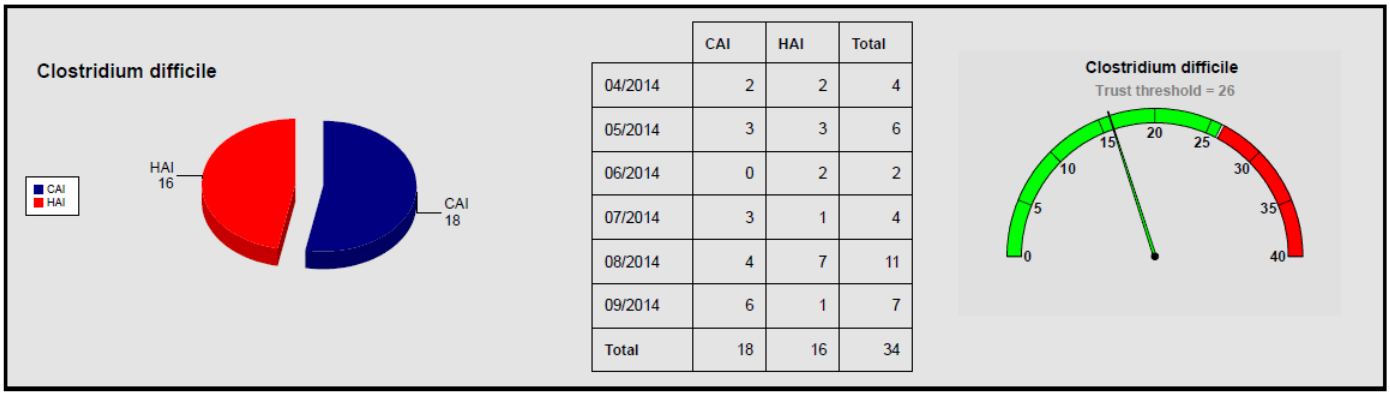
CLOSTRIDIUM DIFFICILE

Q2 Clostridium difficile <u>toxin positive</u> cases by location when detected





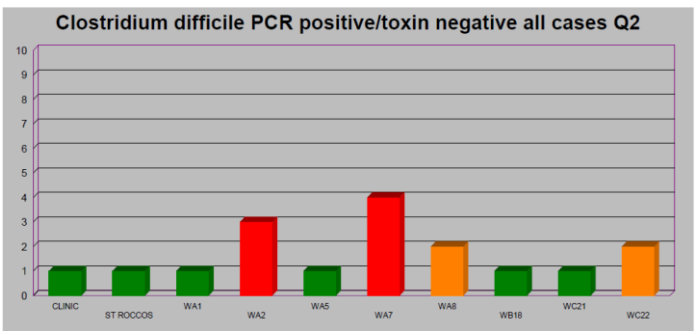
Clostridium difficile year to date position

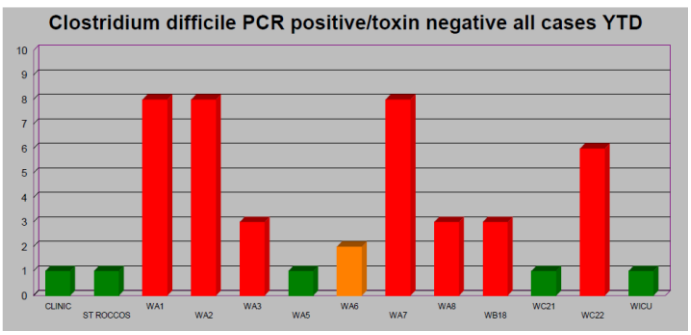


	CAI	HAI	Total
04/2014	2	2	4
05/2014	3	3	6
06/2014	0	2	2
07/2014	3	1	4
08/2014	4	7	11
09/2014	6	1	7
Total	18	16	34

Clostridium difficile <u>PCR positive/toxin negative</u> cases by location when detected

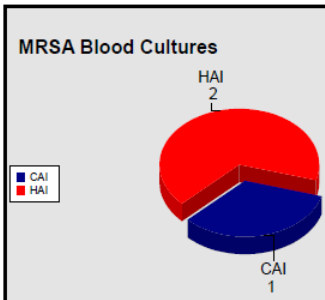
(Local surveillance only)





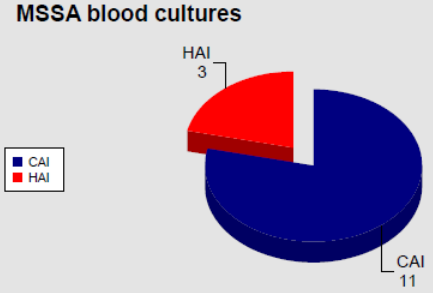
BACTERAEMIAS

MRSA bacteraemias

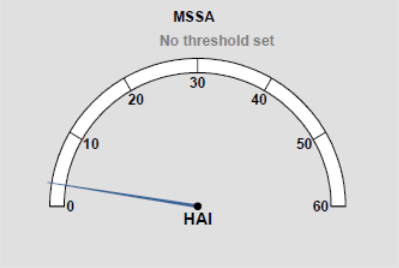


	BLOODSTREAM			Total
	CAI	HAI	Total	
05/2014	0	1	1	1
09/2014	1	1	2	2
Total	1	2	3	3

MSSA bacteraemia



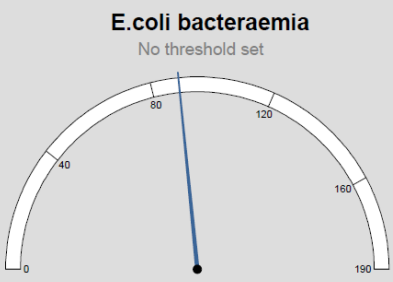
	CAI	HAI	Total
04/2014	4	1	5
05/2014	3	0	3
06/2014	0	1	1
07/2014	0	1	1
08/2014	3	0	3
09/2014	1	0	1
Total	11	3	14



E Coli Bacteraemia

E Coli blood cultures

	Total
04/2014	16
05/2014	14
06/2014	10
07/2014	20
08/2014	18
09/2014	11
Total	89



Appendix 2 Ebola Preparedness Exercise October 2014

Situation

The Ebola virus disease (EVD) outbreak (December 2013 – present) is now being perceived as a global threat. A number of people are travelling to the affected areas in direct response to the outbreak which brings an increased risk of cases being imported into their respective countries when people are repatriated.

Known cases have been medically evacuated from Africa to a number of countries including the USA and Europe (1 case to the UK) for treatment. The risk of EVD to the general public in the UK remains low however, local transmission of EVD has occurred in healthcare settings in both the USA and Europe (Spain). This raises concern on the state of preparedness for receipt and safe management of cases within healthcare settings.

Background

Ebola virus is a category 4 pathogen for which there is no effective prophylaxis or cure. Case fatalities rates have been recorded between 25 and 90%. There have been a number of outbreaks in Africa since the virus was identified in 1976. The current outbreak has affected more cases than all previously known outbreaks and the fatality rate is currently estimated at 70%.

Public Health England (PHE) have produced a wealth of information in relation to Ebola and provided a multi-agency preparedness exercise to test our collective preparedness across Cheshire and Merseyside.

Feedback from the exercise

- Summary information on EVD (history, vectors, mode of transmission, signs and symptoms):-
    - most likely diagnosis for returning travels will still be malaria despite the current outbreak
    - co-infection of confirmed malaria cases with EVD should be considered and managed on a case by case basis
- Preparation at the Regional Infectious Diseases Unit (RIDU) for receipt of cases
    - concern about practicality of personal protective equipment detailed in guidance documents
- There is also an outbreak of Marburg (another viral haemorrhagic fever) in Uganda
- A number of actions are being taken by PHE
    - Airport screening

  - Setting up a national database for healthcare workers returning from Africa
- Establishment of escalation phases with actions linked to each:
    1. Phase 1 – situation normal
    2. Phase 2 – PHE experiencing an increased number of calls
    3. Phase 3 – Ebola Team (Essex PHE Unit) operationalised to follow-up all returning healthcare workers for duration of the incubation period (21 days)
    4. Phase 4 - PHE will be setting up an additional phone number for EVD calls (0344 225 1295 option 7)
- Personal Protective Equipment (PPE) and adherence to correct use is an overriding concern. A patient contact and buddy system should be used – both should wear appropriate levels of PPE. A request has been made for PHE to produce a video on safe donning and removal
- There will be a decrease in other Public Health activity to accommodate the EVD demands
- 3 scenarios were discussed to review local preparedness and response arrangements to a suspected EVD case:-
  - GP surgery - attender vomiting in the waiting room
  - Cargo ship - docking in Liverpool from Liberia with an ill crew member
  - Hospital – a patient informs staff of a recent travel history to Africa several hours after admission
- Partners are at a variety of stages in their preparedness
- Initial advice for GPs was to dial 999 and refer to hospital. This has changed to initial algorithm assessment being performed by GPs and discussion with PHE/CCDC prior to calling an ambulance. A suggestion was made to close the GP surgery if a suspect case attends
- Travel history is an important part of patient assessment to inform decision making in all healthcare settings
- Suspect cases reviewed with PHE at healthcare locations other than the acute Trust will be taken directly to an AED at a hospital with an Infectious Disease Unit (Liverpool). Revised guidance to follow
- A suggestion was made to use an AED action card
- Contradictory information is being circulated by different agencies. Weekly briefings will be circulated by PHE
- Concerns evident amongst some attendees in relation to cleaning and waste disposal

- This is an evolving situation and advice is subject to change to meet demand/situations
- Plans are good – but need to be adhered to

The Infection Control Team has already undertaken a number of proactive actions, including some of the suggestions made in this workshop. The Trust Policy has been revised and reflects the latest evidence based guidance. The Trust's state of preparedness has already been tested by a suspect case and a number of action areas were highlighted in the SBAR report embedded below (appendix 1).

Management of a suspected case of VH

Additional actions

Signage has been put produced and put up within the AED department advising patient to report any recent history of travel to Africa (within last 3 weeks).

Specimen packaging information has been produced and circulated to AED and AMU and all Microbiology staff have been made of arrangements for VHF screening specimens.

Medical staff will be reminded of their legal duty to notify suspect cases at the time suspect cases are identified.

A presentation was made to Grand Round advising staff of actions being put in place within the Trust.

Recommendations

1. Ensure all recommendations from the SBAR report are completed. Outstanding actions are:-
    a) Ensure screening questions have been added to Symphony and the Bed Bureau patient assessment sheet so that patients are identified at the time of arrival and are not left in communal waiting areas
    b) Laboratory SOPs to be reviewed to ensure all required procedures are in place

2. An internal communication strategy is required to ensure messages do not incite panic and there is a balanced response to management of suspect cases.

3. Liaison with community partners is required to provide assurance that patients being assessed at other healthcare facilities e.g. GP surgeries, Out of Hours etc. will be assessed to ensure transfer to an AED with an Infectious Disease Unit if appropriate.

4. Further training in respect of putting on and safely removing PPE is required.

5. Confirmation of arrangement for safe management of Category A clinical waste is required.

6. A number of awareness raising actions are being undertaken at senior level meetings.

7. An e-learning package is being produced to provide more convenient access to training.

It should be noted this situation will pose a long term threat of cases being imported into the UK.

Appendix 1

SBAR report on the Management of a case of suspect VHF

Situation

On Sunday morning 31st August 2014 a patient attended the Accident and Emergency Department (AED) with a recent history of travel to Africa. A risk assessment was undertaken and the patient was identified as possibility of viral haemorrhagic fever (VHF).

Background

Currently there is a large scale Ebola outbreak affecting Africa. Guidance has been published by the Department of Health on patient assessment and infection control requirements including personal protective equipment.

The Infection Control Team has revised the Trust's Policy for VHF and a draft of the document has been circulated for comment (awaiting ratification at the September 2014 Infection Control Sub-Committee). In addition, the Infection Control Nurses have attended a Safety Briefing in the AED and provided a VHF quick reference guide for all emergency care staff. A stock of additional personal protective equipment has been located within the AED for staff to have convenient and timely access.

Assessment

Suspect cases of VHF are rare in the UK and therefore staff have limited experience in dealing with these cases. Whilst on the whole the case was managed well, issues were identified in relation to patient assessment and management as follows:-

- **The patient was not identified at triage and remained in the AED waiting room with other AED attenders for 2 hours and 18 minutes**
- Once identified the patient was isolated in cubicle E as per infection control advice
- Restrictions of the number of staff coming into contact with the patient were put in place
- The Trust's Consultant Microbiologist and the Infection Control Nurse (ICN) were notified of the suspected case as per the AED quick reference guide
- **Confusion was evident in relation to the outcome of the VHF risk assessment in terms of low/high possibility. The outcome of this risk assessment was not clearly documented within the patient's Case Notes**
- **Specimen containers for safe transport of the samples to the laboratory were not available in the AED department**
- The specimens were transported by hand and not in the pneumatic tube as per the advice provided
- Effective liaison took place between the ICN and the laboratory staff (haematology, biochemistry and microbiology) in relation to the high risk nature of the specimens and processing of the malaria antigen testing in the safety cabinet in the category 3 laboratory

- Concerns were identified in relation to re-capping of the sample in biochemistry and segregation of the sample waste. Advice on personal protective equipment was provided by the ICN
- **AED staff placed specimen request forms in the same compartment as the blood samples**
- Effective liaison took place between the Consultant Microbiologist and the Imported Fever Service in relation to requirement for a VHF screen following negative malarial antigen result
- **The SOP for transport of specimens off site, including courier contact details were not known by the Microbiology BMS**
- **Incorrect information was provided to the ICN in relation to risk from bleeding** (patient menstruating)
- When the ICN attended the Trust and reviewed the patients risk assessment the patient was categorised as high risk (travel to an area of Nigeria with an endemic Lassa fever problem)
- **The Consultant for Communicable Disease Control (CCDC)/ on call person for public health was not informed of the suspect case as per the algorithm and the AED quick reference guide**
- The Consultant Microbiologist contacted the CCDC and this was followed up by a further call from the ICN
- The on-call person for public health agreed with the actions taken by the trust and informed the CCDC
- **The patient was prescribed an anti-coagulant despite being assessed as high risk for VHF.** This had not been administered, the prescription was reviewed and this drug withheld/crossed off
- The ICN attended ward A1 and provided information on Infection Control precautions, requirements for specimen collection and availability of the on-call ICN at any time for advice
- Handover of information to night staff on A1 may not have occurred as a subsequent specimen **(MRSA screen) was sent to the laboratory without any danger of infection labels**
- There was a delay in obtaining the VHF screening results due to an issue with the analysers at the reference laboratory
- The VHF screening result was negative and the patient was discharged on 2nd September 2014
- Due to the high profile nature of the suspected case, information was appropriately escalated to the on call management teams to Executive level. In addition the DIPC and Associate Director of Communications were made aware of the suspected case in the event of any media enquiries

Recommendations

1. Improvements are required to identify patients at risk of VHF at triage to ensure timely isolation. This should include asking attendees for information on a recent history of travel (last 21 days) to an area affected by VHF. **Responsibility AED Matron/Interim Manager.**

2. Clearer documentation and communication of the outcome of the VHF risk assessment is required (including bleeding risks), to ensure all required actions and appropriate level of infection control precautions are implemented. **Responsibility medical staff conducting the patient review.**
3. Specimen containers and stringent guidance on packaging (including labelling as danger of infection, location of transfer form and transporting by hand) to be made available within the AED department. **Microbiology Laboratory Services Manager.**
4. An SOP is required within biochemistry in relation to storage of specimen remnants from high risk VHF specimens. **Responsibility Biochemistry Laboratory Services Manager.**
5. All Microbiology Laboratory staff must be made aware of the specimen processing and specimen packaging requirements for suspected VHF cases (both on and off site). **Responsibility Microbiology Laboratory Services Manager.**
6. Medical staff should be reminded of their legal responsibility to notify suspected cases of VHF to the CCDC. **Responsibility Emergency Care/Medical Consultant.**
7. Closer attention is required in respect of VTE assessment in patients suspected to have VHF. **Responsibility Emergency Care/Medical Consultant.**
8. Review effective handover of information and ensure all staff are aware of the responsibility to label high risk specimens as danger of infection. **Responsibility A1 Ward Manager/Matron.**
9. This SBAR report will be shared with relevant personal to provide positive feedback on areas of compliance and for actions to be taken where issues were identified. **Responsibility ADIPC.**
10. The Draft VHF guidance will be submitted to the Infection Control Sub-Committee in September for ratification. **Responsibility ADIPC.**

Please do not hesitate to contact me should you wish to discuss any of the content of this report or require any further advice.

Lesley McKay

Associate Director for Infection Prevention and Control

5th September 2014

W&HHFT/TB/14/163

BOARD OF DIRECTORS

Presentation	Sign Up to Safety
	Deputy Director of Nursing
Date of Meeting	29th October 2014

Warrington and Halton Hospitals NHS
NHS Foundation Trust

High Quality, Safe Healthcare
Quality People Sustainability

W&HHFT/TB/14/164

BOARD OF DIRECTORS

Paper Title:	Complaints Quarterly Report 2014/15 Quarter 2: July – September 2014
Date of Meeting	29 October 2014
Director Responsible	Karen Dawber, Director of Nursing and Organisational Development
Author(s)	Michele Lord, Patient Experience Matron
Purpose	To provide the Board with an overview of complaints and feedback that the Trust has received from patients, relatives and other service users from July to September 2014. The report is written in accordance with the NHS Complaints Regulations (2009).

Paper previously considered	**Committee**	**Date**
	none	

Relates to which Trust objectives

- Ensure all our patients are safe in our care ✓
- To be the employer of choice for healthcare we deliver ✓
- To give our patients the best possible experience ✓
- To provide sustainable local healthcare services ✓

Key points arising from the Report/Paper

	Page/Paragraph Reference
○ This is the second quarterly report providing an overview of complaints received by the Board.	2
○ The Trust received a total of 118 formal complaints between 1 July and 30 September 2014, which is an increase of 8 on the previous quarter.	3
○ Four complaint files were requested by the PHSO for review.	4
○ 469 people contacted PALS in Quarter 2, a slight increase on the previous quarter. Of these, twelve became formal complaints.	4
○ NHS Choices hospital ratings	5
○ 9 formal compliment letters were sent to the Chief Executive.	8
○ Graphs demonstrate the subjects of complaints for the Trust and by division.	9
○ 98.12% of complaints were closed within agreed timescales.	11
○ Examples of learning from complaints from divisions.	13
○ Update on actions identified in Annual Report, May 2014	16

Recommendation(s)

The Board is asked to:

- ○ Note progress in the management of complaints
- ○ Review other forms of feedback collected, e.g. NHS Choices, compliments, PALS

Executive Summary

This is the second quarterly report providing an overview of complaints received by the Trust from 1 July to 30 September 2014. The report is written in accordance with the NHS Complaints Regulations (2009).

In addition to numbers and categorisation of complaints received by the Trust, this report provides an opportunity to identify themes or trends overall and within divisions. Feedback from the more detailed theming of complaints has been positive and better support teams and divisions in having an overview of the complaints they have received. The last two quarters reflect a more settled and organised complaints handling process in place. An established Patient Experience Team and the developing relationships with divisional teams have proven effective, though there is still work to be done to provide a fully responsive and professional service to our patients and their families.

Key points:

1. Background

In accordance with the *NHS Complaints Regulations* (2009), this report sets out a detailed analysis of the nature and number of formal complaints. A responsive inspection by the CQC did include some review of the complaints system, at divisional and corporate level. The report on this inspection raised no issues with the complaint handling associated with maternity care that prompted the CQC visit.

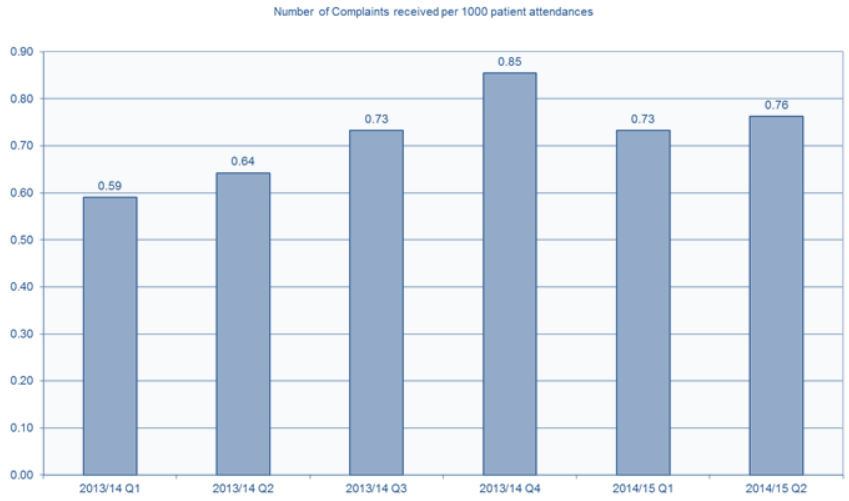
1.1 Complaints overview

During Quarter 1 there were 155,128 attendances to our services.

Table 1: Trust activity 1 July – 30 September 2014

Activity	Type									
2014	Day case	Inpatient	Non-elective	New	Follow up	A&E	MIU	Ward attender	Outside clinic attend-ance	**Grand Total**
July	2,886	516	3,606	11,127	26,572	7,673	1,629	1,338	86	55,433
August	2,425	465	3,384	9,111	21,811	6,889	1,392	1,100	63	46,640
September	2,736	451	3,386	10,598	25,696	7,294	1,560	1,241	93	53,055
Total	8,047	1,432	10,376	30,836	74,079	21,856	4,581	3,679	242	155,128

Figure 1: Complaints received per 1000 patient attendances for Quarter 2



The Trust received a total of 118 formal complaints between 1 July and 30 September 2014, which is an increase of eight on the previous quarter. **Please note that at the time of the last quarterly report the total number of complaints for quarter 1 was 117. This has been adjusted because seven complaints were withdrawn and are no longer included in total complaint numbers.** The complaints figures are updated within the Patient Experience Team as there are changes to the number of formal complaints. The figures submitted monthly as part of the KPI, which informs the Quality Dashboard Report will be subsequently updated a month later. This means that the initial KPI is subject to some changes.

Table 2: Formal complaints received in Quarter 2

Quarter	Formal complaints received
Quarter 2, July – September 2014	118
Quarter 1, April – June 2014	110
Quarter 4, Jan – March 2014	128
Quarter 3, Oct – December 2013	106

Table 3: Risk rating of complaints, by quarter

	2013/14 Q2	2013/14 Q3	2013/14 Q4	2014/15 Q 1	2014/15 Q2	Change from last Quarter
Complaints Received	**101**	**106**	**128**	**110**	**118**	↑
Low	31	35	54	50	46	↓
Moderate	51	56	60	41	62	↑
High	19	15	14	19	10	↓

All formal complaints were received in the English language with no requests made by a complainant (or enquirers) for the use of the Trust Interpreter Service. There was one formal complaint from the carer of a woman with learning disabilities. There was one patient reporting a physical or sensory disability and three patients with mental health issues.

Parliamentary Health Service Ombudsman (PHSO)

During Quarter 2 there were four requests from the PHSO for complaint files and associated medical records. These are currently with the PHSO for deliberation. Six PHSO cases were resolved. Four were not upheld, one was partly upheld and one was upheld. The partly/upheld complaints are with the divisions to identify appropriate action plans in line with PHSO recommendations. There are seven PHSO cases from complaints closed by the Trust in 2013/2014 that are still open. One of these was upheld by the PHSO, but the Trust is contesting the recommendations of the report having sought advice from Trust solicitors and a national clinical expert in relation to the PHSO report.

In November 2014, a representative of the PHSO will meet with the Patient Experience Team to discuss the work of the PHSO and to strengthen working relationships.

1.2 Patient Advice and Liaison Service (PALS)

469 people contacted PALS in Quarter 2, compared to 441 for the same quarter in 2013. Of these, twelve became formal complaints. The PALS service continues to be well utilised by patients and members of the public. Though the Patient Experience Officers continue to offer some support in the PALS Officer's absence, the complaints workload makes it difficult to offer the extent of support needed and the response time for PALS continues to be longer than desirable. The very time-consuming public interface part of the role does have a knock on effect on other aspects of the role, including the day to day management of the volunteer service. In addition, the number of office drop-ins has increased over the past year. These contacts tend to be more time-consuming and an increase in these does put more time pressures on the PALS/Volunteer Coordinator.

Feedback on the PALS service is unsolicited at the moment and has been both positive and negative. Most of the negative feedback concerns waiting for call backs and delays in receiving information. There is a need to introduce a patient feedback tool in order to capture people's experiences of the PALS service. This will inform the way the service is taken forward.

Table 4: Number of PALS contacts in Quarter 2

Month	Number of contacts
July	154
August	140
September	175

Table 5: Examples of PALS contacts from Quarter 2

PALS Enquiry	Outcome
Patient had a bad fall whilst on holiday in Blackpool and had been admitted to Blackpool Victoria Hospital. The patient's wife had been travelling to Blackpool on a daily basis and was finding it very difficult as she has restricted mobility.	PALS Officer liaised daily with the patient flow team, seeking bed availability to accommodate the patient's transfer. The infection control team also became involved and as the patient did not require a cubicle he was allocated a bed. The family were delighted as a transfer took place within 3 days.
Family live in the South of England, therefore they were not able to visit their elderly mother regularly.	Arrangements were made for a hospital volunteer to visit the patient on a daily basis and to also assist the patient during meal times. The family were

PALS Enquiry	Outcome
	delighted to have received this additional assistance/reassurance.
Parents of a one year old baby were extremely worried about their baby's weight loss and the possibility of the baby having oral thrush.	Arrangements were made for the parents to discuss their concerns with Matron on the day they contacted PALS. The parents felt relieved to have received an immediate response to their concerns.
Family were concerned as they did not know if the patient was on the correct ward. Also, the family said the patient's stitches had not been removed.	PALS Officer contacted the ward manager and made arrangements for them to meet with the family to discuss all concerns. The family were pleased and felt relieved following the outcome of their ward meeting as they had misunderstood the treatment plan.
Elderly patient had been awaiting an appointment with her GP to have her blocked ear cleared. The patient was concerned as she had not received her appointment and was struggling to cope with her day to day duties due to being completely deaf in the affected ear. Also, the patient could not have her hearing test with the audiology team until the blocked ear had been treated.	PALS Officer contacted the patient's GP, as requested by the patient, to find out when she will have an appointment. The GP practice had mistakenly placed a 'no action' notice on the patient's referral letter; this being the reason why the patient did not receive an appointment for treatment. Following the GP appointment arrangements were made for the patient to receive an urgent appointment with the audiology team.

1.3 NHS Choices

Patients and visitors can post comments about their experience in our hospitals on the *NHS Choices* website. *NHS Choices* calculate a star rating for each site, based on the feedback, with 5 stars being the highest. Comments posted on this site are monitored by the Communications team and responses are passed to the appropriate service for action if needed.

Users of the NHS Choices site can compare ratings for key quality indicators and those of neighbouring Trusts.

Table 6: Rating of hospitals on *NHS Choices* website

Hospital	NHS Choices users rating	CQC national standards	Recommended by staff	Open and honest reporting	Infection control and cleanliness	Mortality rate	Food: Choice and Quality
Warrington	★★★★ 127 ratings	! Some standards not met	Ok Within expected range with a value of 65.25%	√ Among the best	Ok As expected	Ok As expected in hospital and up to 30 days after discharge	Ok 87.9% within the middle range
Halton	★★★★★ 63 ratings	√ All standards met	Ok Within expected range with a value of 65.25%	√ Among the best	√ Among the best	Ok As expected in hospital and up to 30 days after discharge	Ok 90.6% within the middle range

Cont'd…

Hospital	NHS Choices users rating	CQC national standards	Recommended by staff	Open and honest reporting	Infection control and cleanliness	Mortality rate	Food: Choice and Quality
Whiston	★★★★ 88 ratings	√ All standards met	√ Among the best with a value of 77.41%	! Among the worst	! Among the worst	Ok As expected in hospital and up to 30 days after discharge	Ok 93.7% within the middle range
St Helens	★★★★½ 19 ratings	√ All standards met	√ Among the best with a value of 77.41%	! Among the worst	√ Among the best	Ok As expected in hospital and up to 30 days after discharge	N/A Data not available
Royal Liverpool University Hospital	★★★★ 204 ratings	! Some standards not met	Ok Within expected range with a value of 71.38%	! Among the worst	Ok As expected	Ok As expected in hospital and up to 30 days after discharge	N/A Data not available

Table 7: Number of patient comments left on *NHS Choices* for Quarter 1, by site

Star rating	Warrington	Halton	CMTC
★★★★★	13	6	6
★★★★	0	0	0
★★★	2	0	0
★★	2	0	0
★	4	1	0
Total for Quarter 2 = 34	21	7	6

Feedback left on the *NHS Choices* website

Excellent care

Went to A & E yesterday with chest pains. I was seen promptly by the assessment nurse and taken through for ECG and blood tests. The care I received was beyond excellent. Everything was explained clearly. I felt totally at ease in the hands of a very professional team. Please convey my appreciation to all those who looked after me.

Maternity Facilities

This is a reasonable service. The actual labour experience was positive and well-staffed but it took quite a while for my induction to take place. Unfortunately, I had to wait around a long time. The aftercare in the wards was not good and midwives are too busy, understaffed and some are rude. In my time here I met a wonderful student midwife and I am glad to hear that she will be staying on with the hospital. They need more midwives

like her - caring people. Sometime you wonder why certain individuals have bothered to train for the profession. The support staff is really great and keep the place ticking along.

Stay in ward C21

After being referred by my GP following a dizzy spell to the assessment unit at Warrington Hospital I was admitted to the cardiology unit C21. There I was kept under observation and various tests carried out over a 7 day period. The ward staff were great and went about their work in a professional manner. Meals during my stay were excellent, choice as ordered and always hot. C21 is a comfortable and airy ward with adjacent facilities. Downside for me was in wearing a 6 lead monitor for a week, so no shower!

Pleasantly surprised

I had my gallbladder removed on 02/09/14 and was admitted to ward B4. All staff were very pleasant and friendly and nothing was ever too much trouble for them. I ended up staying overnight and the night staff were equally as good as the daytime staff. I've never been admitted to Halton hospital before and can only compare it to Warrington Hospital but given the choice I'd choose Halton again every time. Thank you to all the staff on ward B4. You looked after me extremely well!

Excellent care from every staff member....thank you so much!

After initially being referred to Warrington General gynaecology department, where excellent service was given I was then given an appointment to attend Halton General to carry out a Hysteroscopy under a general anaesthetic. I was so nervous before going in, however the nurse looking after me was fabulous and put me at ease with her sense of calm. The Dr and anaesthetist were just lovely along with his staff, even making me laugh before drifting off to sleep. I felt fine when I woke up and when I was ready a nurse brought me coffee and due to being coeliac, a gluten free jam butty. Everything was explained to me before and after the procedure by the Dr and fingers crossed all OK. The ward was really clean and every single member of staff I came into contact with were lovely, with happy smiley faces!!! Thank you so much, you made a big "scaredy cat" feel so safe! With lots of luck I hope to not be coming to see you for a while. Never under estimate your worth...you do an Amazing Job!! Thank you so much to all the staff on Day Case Unit Halton General.

Shoulder operation

I was admitted on 6th September as a day case for an operation on my right shoulder. From the start of my day I was treated with the utmost respect and care by all members of staff. Nothing was too much trouble and everything was done to make me feel at ease during my stay. I was however unable to undergo the procedure that I had been admitted for and had to have an alternative one. I will have to come back at a later date to have the original procedure done the prospect of which causes me no concern due to the first class treatment and care that I have received at the CMTC I would like to give a big thank you to all the staff involved in my operation on the 6th September. I look forward to my return for further treatment because I am in safe and reliable hands. Thank you all again.

Really Helpful and efficient

I had fallen and I was in a lot of pain and I couldn't walk on it. I was seen to really quickly. Everyone was really polite. The nurse who assessed my foot was absolutely lovely, and was very efficient and I had an x-ray, my wound cleaned and dressed and my ankle in support within an hour. Excellent service from all of the staff and really quick. I will be recommending the service.

1.4 Compliments

The Trust received nine formal compliments through letters sent directly to the Chief Executive.

Table 7: Compliments by division, July - September 2014

Division	July	August	September	
Scheduled	0	1	1	
Unscheduled	3	1	3	
WCSS	0	0	0	
Total	3	2	4	9

Excerpts from compliment letters

On Thursday August 28th 2014 I was taken into A&E having difficulty breathing, a short time later without any warning my heart stopped and it is only due to the fantastic skill and dedication of the staff on A&E that I am here to write this letter, a consultant later told me that had I been anywhere else the outcome would have been very different.

During my stay at Warrington everyone in-between were superb, nothing was too much trouble. I was kept informed at every stage of my treatment and everyone was polite and helpful and I doubt you could find a better group of people if you tried and I would like to express my heartfelt thanks to everyone.

I *am writing with regards to the recent care of my late aunt on intensive care unit. I can only sing the praises of the staff on the ward. My auntie was rushed in suddenly and unexpectedly and her children found it hard to leave their mum, the staff accommodated them to allow them to stay the night in the waiting room, provided blankets and pillows as well as refreshments also.*

The care they gave to my auntie was second to none and although she was in a coma they treated her as if she could hear and see everything they did. Combing her hair, telling her every time they carried out any treatments and at all time keeping her dignity. The staff on this ward not only look after the patients but also the relatives with compassion and understanding, explaining developments in her condition in ways we could understand.

Would you please pass on my grateful thanks to all staff, doctors, consultants, ambulance drivers and all those who recently attended to me whilst I was in your care, firstly in Accident & Emergency and then in the Coronary Care Unit at Warrington Hospital. The care and attention that I received was outstanding and I cannot compliment your organisation enough.

2. Formal Complaints

2.1. Data collection and analysis

Utilising the more detailed subject choices in the Datix system has provided much better intelligence, not only on the themes, but the sub-themes. These are being reported in the monthly triangulation reports.

2.2 *Formal complaints by division and by subject for Quarter 2*

Figure 2: Graph showing all complaints by subject

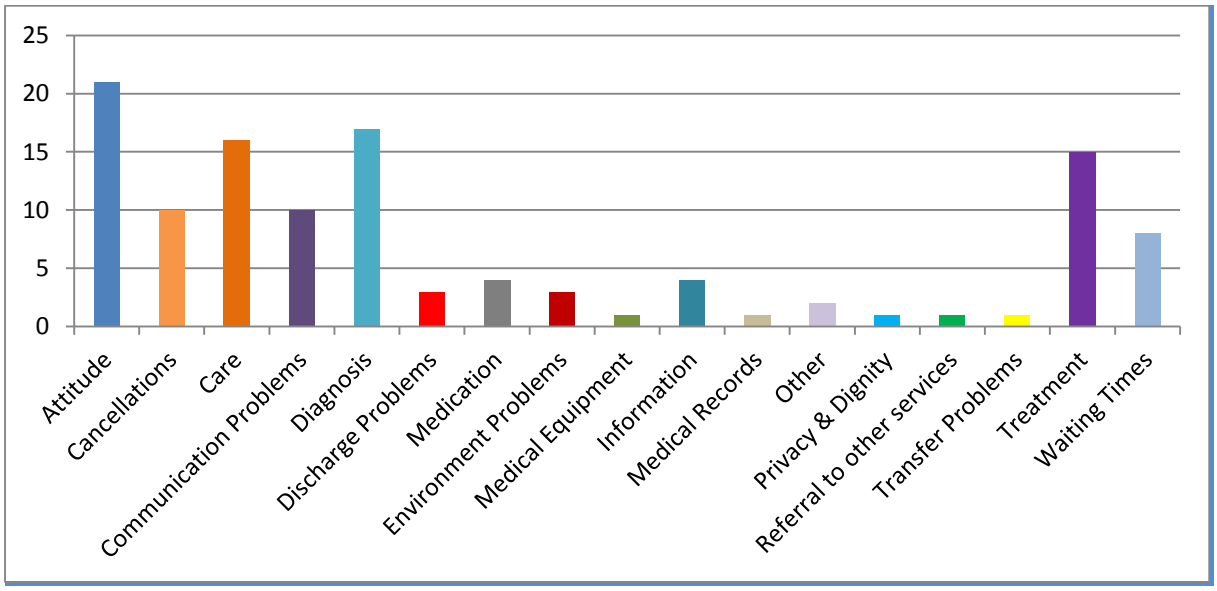


Figure 3: Graph showing top 5 subjects for Unscheduled Care, Quarter 2

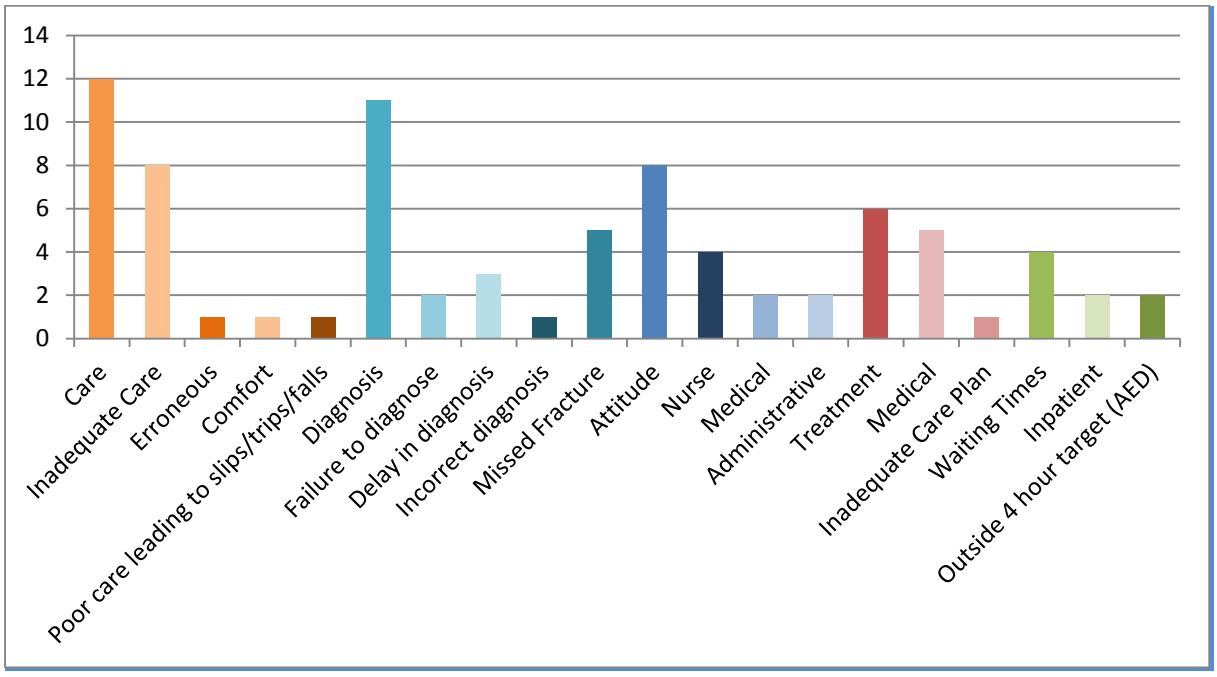


Figure 4: Graph showing top 5 subjects for Scheduled Care, Quarter 2

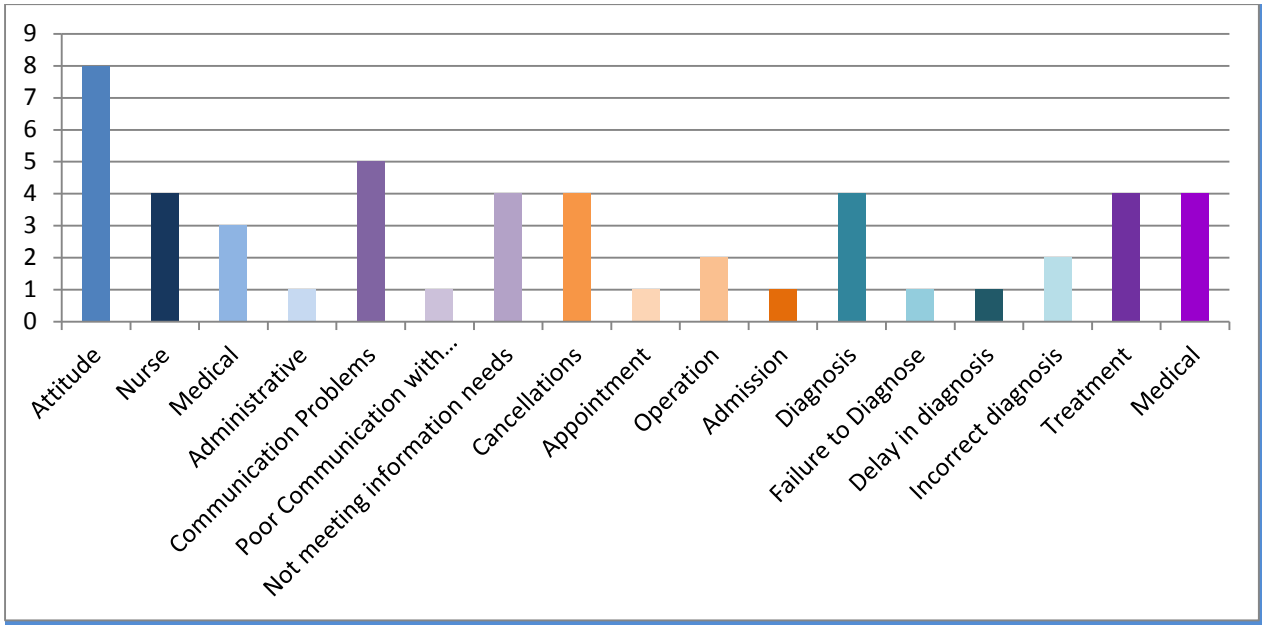
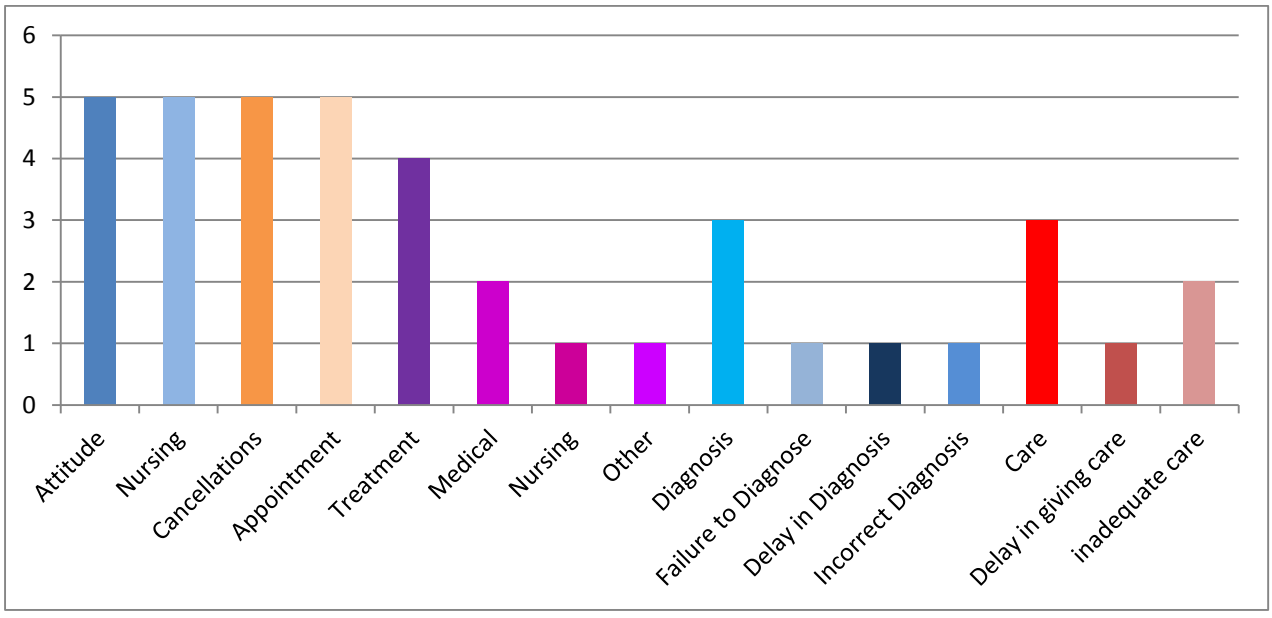


Figure 5: Graph showing top 5 subjects for WCSS, Quarter 2



2.3 Concerns raised in Quarter 2

Some patients prefer to raise a concern rather than a formal complaint. At other times the Patient Experience Team will be able to get an answer to a patient's concerns quickly and log the issue as a concern, rather than a formal complaint. In addition, all withdrawn complaints are re-categorised as concerns.

Figure 6: Concerns by division for Quarter 2

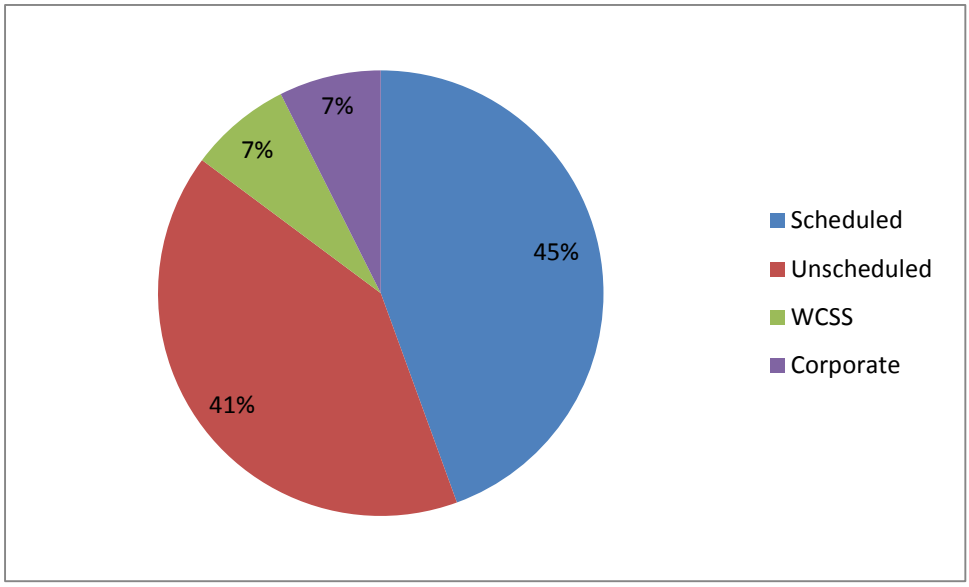


Table 8: Examples of the themes from concerns in Quarter 2:

Themes	Number received
Communication Problems	4
Waiting Times	4
Transfer Problems	4
Environment Problems	4
Care	3
Attitude	2
Cancellations	2
Treatment	2
Diagnosis	1
Information	1
Total	27

2.4 *Responding to people who want to tell us about their experience in a timely manner*

In Quarter 2 we responded to 98.12% of our complaints within agreed timescales. Provision of high quality, well investigated and thorough responses is equally important to both complainants and the Trust. Though we are responding to agreed timescales in a high number of cases, this can be improved. Currently a holding letter or telephone call is made to the complainant if we are not going to meet the original deadline. The process of compiling and quality assuring responses before they are signed by the chief executive can be protracted if there are issues with the answers provided. If the response from division is delayed, the Patient Experience Team has to negotiate a new date for the letter to be received. If at any point the divisional investigator realises that the investigation and response to a complaint is going to be protracted or delayed, she/he can contact the Patient Experience team to ask that a new date be agreed with the complainant. This does not tend to happen and often the PET are reacting to a much later realisation that there is a delay. Training and feedback to staff should help to embed a more proactive service over time.

Table 9: Complaints closed in agreed timescales for Quarter 2

	July	August	September
Number of complaints closed in month, resolved within the required timescale	32	41	40
Number of complaints closed in month, not resolved within the required timescale	1	0	1
Number of complaints closed in the month	31	41	39
% complaints closed in month, resolved within required timescale	96.88%	100.00%	97.50%

2.5 Complaints withdrawn

During the period from July – September 2014 a total of nineteen complaints were withdrawn. Complaints can be withdrawn for a variety of reasons, but generally it is because the service user had the opportunity to discuss their issues with a member of the service or a member of staff from the divisional team had contacted them to discuss their concerns and they had been resolved, for example this could be an appointment confirmed, or clarity of information provided satisfactorily. Sometimes complainants do not return completed consent forms and the complaint may be withdrawn, after providing the complainant with a final date for sending the consent.

2.6 Returned complaints

During Quarter 2, 15 people were unhappy with their initial responses and contacted us asking for further information, to meet with us, or to provide clarification. These previously closed complaints, where the complainant has raised further questions with us we refer to as a 'return complaint'.

At the time of reporting, there are 19 outstanding return complaints from 2013/2014 and meetings are being held and further responses prepared.

Table 10 - Returned Complaints by division for Quarter 2 and whether upheld, partially upheld or not upheld

Division	Not upheld	Partially upheld	Upheld
Unscheduled Care	2	3	3
Scheduled Care	3	2	0
WCSS	0	1	1
Corporate	0	0	0
Total	5	6	4

2.7 Complaints linked to serious untoward incidents

During Quarter 2, no complaints had been the subject of a serious untoward incident investigation. A total of 10 complaints were linked to reported incidents that included falls and other patient safety incidents already reported and acted upon.

2.8 Formal meetings organised

In recognition of the need to meet complainants early, meetings are being offered where appropriate. This helps complainants to clarify concerns, to develop a relationship with and "humanise" the people involved in the services they have concerns about.

Despite this, there has been a decrease in the number of meetings from Quarter 1. During Quarter 2 a total of 14 meetings were held with complainants. Of these 5 were return meetings, i.e. the complainant has received a final response letter but is unhappy with it and asks for/is offered a meeting to discuss ongoing issues. This is a decrease of 12 on the previous quarter. A major factor is the holiday season, in particular August, which has made it difficult to coordinate meetings with two or more healthcare professionals, as well as fitting in around the complainants holiday and other commitments.

3. Lessons learned

The following table provides examples of closed complaints and actions taken by the divisions who are responsible for implementing and monitoring lessons learned. Each division has specific systems in place to feedback learning from complaints, firstly during/after the investigations and then through divisional groups, e.g. Divisional Integrated Governance Groups (DIGG, senior nurse/ward manager meetings.

Examples of complaints, action taken and learning

Description of Complaint	Actions	Learning
WCSS: OPD A patient complained because of cancellations and changes to appointment dates in OPD	The complaint was upheld. Review of patient's clinic appointments was done. Two cancellations due to consultant leave and no registrar cover. Apologies were made to complainant and changes to system were explained.	The Trust recognises that this situation is not acceptable and from November 2014 it will be launching a new system for booking follow up appointments which will cut down on the number of cancelled and rescheduled appointments, e.g. introduction of a system where patients are contacted shortly before their appointment to agree a mutually convenient time and date. It is expected that this will significantly improve the patient experience and cut out the frustration and annoyance that patients currently may experience.
WCSS: Radiology Patient was unhappy with the Trust's admission process. Was also unhappy that when admitted to the ward for a radiology	This complaint was partly upheld. Complaint was investigated and responded to. Apologies were given for poor communication	The appointment letters were changed at the time but there have since been more changes and the letters have been

procedure, no time was added to the letter.	and staff attitude. Complainant was informed of a review of appointment letters was underway. At the time of this complaint the new radiology procedure unit was in the planning stages. This complaint was returned as the complainant didn't feel assured that action had been taken. The return response reflects the improvements made to the service.	amended once again this is due to • Radiology now have their own ward where patients are admitted to for these examinations • Patients no longer need to phone the ward to see if there is a bed as the beds are now guaranteed and are situated next to the room that the examinations are performed. No more cancellations due to lack of beds. • Letters have changed to accommodate the new ward and state what time to arrive, where it is situated and what time the procedure will take place. • The ward is manned by Radiology staff, who ensure that pre-examinations checks are valid and relevant to the examination being performed.
Scheduled Care: Surgery Patient was dissatisfied that he was required to stop all food and fluid intake from 12 midnight the day before surgery as he is diabetic. Patient was planned to go to theatre in the morning. There was no bed available that morning. A bed was allocated later in the day and the patient went to theatre late afternoon. He was unhappy that he waited in the ward area for a bed without clinical care or any supervision.	Apologies made for the poor patient experience Investigation carried out by Surgical Matron into the bed pressures and availability that day, the ward staffing levels and the patient's management pre-surgery. Review of the pre-surgery care pathway for diabetic patients	Review of the patient fasting and hydration policy led by consultant anaesthetist has produced a new policy for the fasting of elective surgical patients. This includes new changing national guidelines to allow patients to take fluids up to 2 hours before surgery. Following agreement and ratification, new instruction will be drafted for patient information letters. A review of bed utilisation has taken place. A separate surgical admission area will be created so that all patients can be admitted into a bed within 30 minutes of arrival. The admissions area will be fully staffed and patients' care allocated. pre-operative monitoring of patients will be carried out by staff dedicated to this area. The monitoring and

		treatment of diabetic patients will form part of this care. Opening off this new area is pending.
Scheduled Care: OPD Patient raised concern that when she attended the clinic her notes contained information relating to another patient. She felt this could have serious consequences if it had not been identified and wanted to know what system will be put in place to prevent a recurrence Patient's clinic consultation was delayed until the correct information was made available.	Apology made for delay in clinic appointment and for the anxiety experienced. Incident investigated by ICU Matron. Incorrect referral document had been filed into patient's notes. Document removed and filed correctly. Patient's optician contacted and referral information was re- faxed to department. Patient was informed of new checking process.	Filing process reviewed. Both administrative and clinical teams have instituted changes to the checking process for filing. Before a document is filed, a check will be made first of the personal data set in the front of the notes folder rather than data labels. Process discussed at staff safety briefings and monthly ophthalmic governance meeting.
Unscheduled Care: Medical ward A very lengthy letter of complaint from the father of a young man who died of cancer. The complainant was unhappy with several aspects of treatment and care. He also had concerns about nursing staff attitudes and discharge medication.	The only issue upheld was that of late discharge due to a delay in getting discharge medications and the pain the patient had suffered while waiting for his prescription. An investigation was done by the divisional matron. Apologies were made for the patient's suffering on the day of discharge. It was explained that the prescription chart has to go to pharmacy for discharge medication to be dispensed and unfortunately. Any delay in the process has an effect on the patient who can't be given medication without the prescription chart. As a consequence, the patient was then discharged late in the day.	An action plan was developed for ward staff. Staff were reminded the importance of planning ahead for discharge. This was communicated at safety brief and at the ward team meeting. New process introduced where all discharge medications are requested the day before discharge. Medical team made aware of the planned date of discharge so they can allocate time to complete the prescription.
Unscheduled Care: Medical OPD Patient complained about the attitude of her consultant at a	This complaint was upheld.	Consultant, as part of reflection on this complaint has booked

consultation. Patient has been affected negatively by the experience.	The consultant reflected on the consultation explaining the advice and actions taken but also acknowledging the patient's feelings and made an apology.	onto a communication course in order to ensure learning from this complaint.

4. Actions

The current focus of the Patient Experience Team is supporting divisional staff to embed the complaints and concerns policy in practice and to meet deadlines with fully investigated and compassionate responses to all formal complaints and concerns. Divisional leads have identified and established systems of governance around complaints handling to ensure that where there are lessons to learn this is done and all evidence is correctly recorded, shared and archived. Each division now understands that any action plans must be owned and completed by the appropriate member of staff and that this must be recorded on the CIRIS system to provide evidence of learning from complaints.

The following points highlight progress on actions/improvements identified in the Annual Report in May 2014:

- Developing this skills and knowledge of the new Patient Experience Team
  Patient Experience Team PDRs completed and development action plans are in place. Recruitment to replace a member of staff who is leaving the organisation is about to begin.

- Developing a responsive, combined service – making it easy.
  In the next two quarters there will be a review of PALS, including the way the PALS/Voluntary Service Coordinator works and the systems in place to support her. PALS is a very valuable part of the patient experience team and consideration of how it develops in order to cope with the higher demands made by patients and their families, how it utilises resources, for example volunteers and how well it demonstrates what it does and the quality of what it does is needed.

- Monitoring and performance management in place.
  Policy audit completed in October 2014 and will be tabled at Clinical Governance, Audit and Quality Sub-committee.

- Focus on return complaints to understand underlying root causes and better identification of outcome.
  A thirty day deadline for returns has been implemented.

- Improved complaints monitoring through updating complaint category information collected – making data meaningful.
  Review of updated subjects in complaints module will be done at end of Quarter 4. Update of PALS module of Datix planned for Quarter 3.

- Newly updated patient information leaflets for PALS and complaints are completed and will be available soon. Easy read version of both leaflets have been developed working with *Speak Up* a local self-advocacy group for people with learning disabilities.

- Completion and assurance for action plans developed as a result of complaints.

  The CIRIS system provides a repository for governance, risk and compliance information and it was agreed that the action plans for complaints would be recorded on the system to facilitate reporting and monitoring of action plans generated by upheld and partially upheld complaints. The divisions have each identified clear processes for ensuring that all action plans developed as a part of the investigation and response to a complaint are recorded on CIRIS and these will be reported locally within divisions, at the appropriate sub-committees and at Board. The six monthly policy audit in October 2014 will monitor how effective these systems are.

- A feedback form for the PALS system to be developed and rolled out by end of quarter 4. This will proved intelligence to support the development of PALS.

5. Recommendations

The Board is asked to note the contents of this report, which describe the progress in the monitoring of complaints and to approve the actions as documented above.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/165

BOARD OF DIRECTORS

Paper Title	Governance Statement Quarter 2 14/15
Date of Meeting	29th October 2014
Director Responsible	Tim Barlow, Director of Finance & Commercial Development
Author(s)	Steve Barrow, Deputy Director of Finance
Purpose	To approve the Quarter 2 14/15 governance statement for submission to Monitor.

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**

Relates to which Trust objectives

	√ appropriate
• Ensure all our patients are safe in our care	√
• To be the employer of choice for healthcare we deliver	
• To give our patients the best possible experience	√
• To provide sustainable local healthcare services	√

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

	Page/Paragraph Reference
• To review and agree the recommended Board Statements for Q2.	Pages 1-3

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

The Board is asked to approve governance statement for submission to Monitor.

Warrington and Halton Hospitals NHS Foundation Trust

Monitor In Year Governance Statement

Quarter 2 2014/15 (1st April 2014 – 30th September 2014)

1. Background

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

2. Statements (per Quarter 3 Monitoring Returns)

2.1 Finance Statement

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

2.2 Governance Statement

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

2.3 Otherwise

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

3. Conclusion and recommendations

Finance

The planned continuity of services risk rating as at 30th September 2014 is 2 and the actual risk rating achieved to date is 2.

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

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

The finance statement requires the Board to confirm that it anticipates it will maintain a continuity of services risk rating of 3 for “at least over the next 12 months” which therefore runs to Quarter 2 15/16. The table above shows that based on current

projections it will achieve not achieve a risk rating of 3 until quarter 4 14/15 but will then return to a risk rating of 2 in Q1 15/16.

Therefore based on current and planned performance it is recommended that the Board states that whilst it is has plans to deliver a continuity of services risk rating of 3 by the end 14/15, at this stage, it cannot confirm that it anticipates maintaining a risk rating of at least 3 over the next 12 months.

Governance

In Quarter 2 all targets and indicators were achieved with the exception of A&E Clinical Quality – total time in A&E under 4hours. This target scores 1 point against the governance risk rating.

To date the trust has had 16 cases of C Diff. In Quarter 1 the trust declared 7 cases as under review but it has been confirmed that 3 cases were due to lapses in care and 4 are under review. In Quarter 2 there have been 9 cases but this are all under review. The reason for the delay in confirmation of status of the cases is that the first appeal panel set up by the commissioner is scheduled for November. The latest position is summarized in the table below:

Narrative	Q1	Q2	Total
Cases due to lapses in care	3	0	3
Cases not due to lapses in care	0	0	0
Cases under review	4	9	13
Total	**7**	**9**	**16**

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

Otherwise / Exception reporting

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

Tim Barlow
Director of Finance & Commercial Development
23rd October 2014

Worksheet "Targets and Indicators"

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

These targets and indicators are set out in the Risk Assessment Framework
Definitions can be found in Appendix A of the Risk Assessment Framework
NOTE: If a particular indicator does not apply to your FT then please enter "Not relevant" for those lines.

Key: must complete / may need to complete

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

Worksheet "Governance Statement"

Click to go to index

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

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

		Board Response
	For finance, that:	
4	The board anticipates that the trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months.	Not Confirmed
	For governance, that:	
11	The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards.	
	Otherwise:	
	The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework page 22, Diagram 6) which have not already been reported.	Confirmed
	Consolidated subsidiaries: Number of subsidiaries included in the finances of this return. This template should not include the results of your NHS charitable funds.	0

Signed on behalf of the board of directors

Signature		Signature	
Name	Mel Pickup	**Name**	Tim Barlow
Capacity	Chief Executive	**Capacity**	Director of Finance
Date	30.10.14	**Date**	30.10.14

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

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

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

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

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

A

B

C

Attachment 3

Risk Assessment Framework page 21, diagram 6

Examples of exception reports

Continuity of Services (all licensees)

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

Financial Governance (NHS Foundation Trusts)

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

Governance (NHS Foundation Trusts)

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

Other risks

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

W&HHFT/TB/14/166(i)

BOARD OF DIRECTORS

Paper Title	Verbal update on activity of Board Committees
Date of Meeting	29th October 2014

Board Committee Verbal Update

a) Finance and Sustainability Committee held on 22nd October 2014 - Rory Adam

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/166(ii)a

BOARD OF DIRECTORS

Paper Title	Board Committee Minutes for noting only
Date of Meeting	29th October 2014
Director Responsible	Chair of Board Committees
Author(s)	
Purpose	The Board had received verbal updates from the Chair of each Committee regarding the meetings held. The minutes are for noting only

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**

Relates to which Trust objectives	√ **appropriate**
• Ensure all our patients are safe in our care	
• To be the employer of choice for healthcare we deliver	
• To give our patients the best possible experience	
• To provide sustainable local healthcare services	

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

		Page/Paragraph Reference
•	None	

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

The Board is asked to note the Board Committee minutes:

a) Finance and Sustainability Committee held on 17th September 2014