Warrington and Halton Hospital NHS Foundation Trust
Board of Directors
Agenda

Wednesday 28th October 2015, time 1300-1700
Trust Conference Room, Warrington Hospital

1300 ***05mins***	***W&HHFT/TB/15/189***	***Welcome, Apologies & Declarations of Interest***		Chairman
	W&HHFT/TB/15/190	***Minutes of the previous meeting held on 2 October 2015***	Paper	
	W&HHFT/TB/15/191	***Action Plan***	Paper	
1305 ***10mins***	***W&HHFT/TB/15/192***	***Chairman's Report***	Verbal	Vice Chair
1315 ***20mins***	***W&HHFT/TB/15/193***	***Chief Executives Report***	Verbal	Chief Executive

Quality

1335 ***10mins***	***W&HHFT/TB/15/194***	***Verbal Report from the Chair of the Quality Committee***	Verbal	Mike Lynch, Non-Executive Director
1345 ***15mins***	***W&HHFT/TB/15/195***	***Quality Dashboard – 30 June 2015***	Paper	Director of Nursing and Governance
1400 ***10mins***	***W&HHFT/TB/15/196***	***Infection Prevention and Control Q2 Report***	Paper	Medical Director
1410 ***10mins***	***W&HHFT/TB/15/197***	***Dementia Annual Report***	Paper	Director of Nursing and Governance

People

1420 ***10mins***	***W&HHFT/TB/15/198***	***Verbal Report from the Chair of the Strategic People Committee*** - ***Update on Governance reporting arrangements to SPC***	Verbal	Anita Wainwright, Non-Executive Director
1430 ***15mins***	***W&HHFT/TB/15/199***	***Workforce and Educational Development Key Performance Indicators***	Paper	Director of HR & OD
1445 ***10mins***	***W&HHFT/TB/15/200***	***Monthly Ward Staffing Report***	Papers	Director of Nursing and Governance
1455 ***10mins***	***W&HHFT/TB/15/201***	***HENW Enhanced Monitoring of Postgraduate Trainees in medical specialities***	Paper	Medical Director
1505 ***10mins***	***Break***			

Sustainability

1515 ***10mins***	***W&HHFT/TB/15/202***	***Verbal Report from the Chair of the Audit Committee***	Verbal	Ian Jones, Non-Executive Director
1525 ***10mins***	***W&HHFT/TB/15/203***	***Verbal Report from the Chair of the Finance and Sustainability Committee***	Verbal	Terry Atherton, Non-Executive Director
1535 ***25mins***	***W&HHFT/TB/15/204***	***Finance Report – 30 September 2015***	Paper	Deputy Director of Finance

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1600 ***15mins***	***W&HHFT/TB/15/205***	***Corporate Performance Report – 30 September 2015***	Paper	Acting Chief Operating Officer
1615 ***10mins***	***W&HHFT/TB/15/206***	***Corporate Risk Register***	Paper	Director of Nursing and Governance
1625 ***05mins***	***W&HHFT/TB/15/207***	***Update on Lorenzo go live***	verbal	Director of IM&T
1630 ***10mins***	***W&HHFT/TB/15/208***	***Governance Statement Quarter 2 2015/16***	Paper	Director of Finance & Corporate Development

1640	***W&HHFT/TB/15/209***	***Other Board Committee Reports:*** ***Minutes for Noting:*** ***a) Finance and Sustainability Committee held on 22 September 2015*** ***b) Strategic People Committee on 10 August 2015***	 Paper Paper Paper	
	W&HHFT/TB/15/210	***Any Other Business***		
1700 ***ends***		***Dates of next meeting*** *25th November 2015* *Lecture Theatre, Halton Hospital*		

W&HHFT/TB/15/191

TRUST BOARD
ACTION PLAN – Current / Outstanding Actions
Meeting: Trust Board 28th October 2015

Meeting date	Minute Reference	Action	Responsibility & Target Dates	Status	
29 July 2015	TB/15/164	Trust Secretary to arrange a workshop with the Board and the Communications team to allow additional understanding on the Communication strategy presented	Trust Secretary	Action ongoing: a Board Development work plan was currently being formalised.	

BOARD OF DIRECTORS

WHH/B/2015/ **192**

SUBJECT:	**Chairman's Report**
DATE OF MEETING:	28th October 2015
DIRECTOR:	Chairman

BOARD OF DIRECTORS

WHH/B/2015/ **193**

SUBJECT:	**Chief Executive Report**
DATE OF MEETING:	28th October 2015
EXECUTIVE DIRECTOR:	Chief Executive

BOARD OF DIRECTORS

WHH/B/2015/ **194**

SUBJECT:	**Verbal Report from the Chair of the Quality [Governance] Committee**
DATE OF MEETING:	28th October 2015
DIRECTOR:	Mike Lynch, Non-Executive Director

BOARD OF DIRECTORS

WHH/B/2015/ **195**

SUBJECT:	**QUALITY DASHBOARD (2015/2016) SEPTEMBER 2015**
DATE OF MEETING:	28th October 2015
ACTION REQUIRED	**For Assurance**
AUTHOR(S):	Ros Harvey (Corporate Nursing Programmes Manager) Hannah Gray (Clinical Effectiveness Manager)
EXECUTIVE DIRECTOR:	Karen Dawber, Director of Nursing and Governance Choose an item.
LINK TO STRATEGIC OBJECTIVES:	All Choose an item. Choose an item.
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework SO1/1.3 Failure to achieve infection control targets in accordance with the Risk Assessment Framework Choose an item. Choose an item. Choose an item.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED:	None
EXECUTIVE SUMMARY (KEY ISSUES):	The Quality Dashboard (at Appendix 1) includes 2015/2016 quality related KPIs from the:- • CQUINs – National (Local CQUINs will be monitored by the CQUIN monitoring group and reported by exception if required). • Quality Contract • Quality Account - Improvement Priorities and Quality Indicators • Sign up to Safety – national patient safety topics • Open and Honest initiative Please note that VTE and dementia are extracted for the purpose of the QDB in advance of submission via UNIFY at

	months end and may not show compliance with the threshold. (VTE – 95% and Dementia – 90%). This will be updated in next month's Quality Dashboard.	
RECOMMENDATION:	***The Board is asked to:*** 1. Note that the data for a number of indicators can change month on month. This applies to incidents (including pressure ulcers and falls), as incident type and severity can alter once reviewed, complaints and concerns as complaints can become concerns (and vice versa), with the agreement of complainants, and to mortality data which is rebased. 2. Note progress and compliance against the key performance indicators 3. Approve actions planned to mitigate areas of exception	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

Please see Appendix 1 for the quality dashboard data

1. SHMI (Summary Hospital-level Mortality Indicator)
The 12 month rolling SHMI has fallen in three consecutive months, from 117 to 116 and at 115 (for the period June 2014 – May 2015). The data is not yet available for June 2015. This reduction is expected to continue into quarter 2 2015/16, in line with fewer crude deaths in the months since winter 2014/15. The trust has had a higher than expected SHMI since October 2014. NB: It was reported in the August 2015 Quality Dashboard, that the Trust had had a higher than expected SHMI since August 2015. This should have stated August 2014, however this has now been rebased and the figures are now as expected in August and September 2014. The Trust continues to compare well with local peers regarding crude death rates; this is 2.3% to date in 2015/2016. The trust's death rate for the same period in 2014/15 was 2.2% and for whole of 2014/2015 was 2.5%. A small group of senior medics and corporate managers have attended regional reducing mortality events and visited a local trust which has made significant improvements in recent years. Based on the valuable learning from these forums, as well as reassurance that we are developing in the right direction regarding our reporting, mortality reviews, and focus on documentation and coding, a revised 'reducing avoidable mortality action plan' will be taken to the November 2015 Clinical Effectiveness Sub Committee.

2. Advancing Quality
Advancing Quality (AQ) is a local CQUIN for the trust and we are performance managed for each agreed condition in order to demonstrate an annual improvement against the targets. AQ measures are monitored and reported via a designated monthly AQ Group, which meets to share good practice and explore ways of improving compliance.

Heart Failure – the appropriate care score for June = 75.44%, and cumulatively we failed to achieve the threshold of 84.1% for the Q1 CQUIN. The CQUIN payment is based on quarterly cumulative data so we have not achieved the Heart Failure measure with a penalty of £21,888 for Q1.

Cumulative compliance to the end of September 2015 is 78.85% against the target of 84.1%. Although the target is still not being met, cumulative compliance has increased each month in 2015/2016.

The non-compliance issues relate to the following:-

- HF Specialist review <72 hours of HF documentation 7 patients out of 8 patients received 87.50%
- 'Written Discharge Instructions Given and Discussed' compliant for 12/15 patients 80%

3. Always Events

Although the target of 100% is not yet being met, we have sustained an improvement each month since April 2015, from 89% in April 2015, to 96% in both July and August 2015. Quarter 1 compliance is 90%, rising to 93% for quarter 2.

4. Care Indicators: risk assessments

The care indicators audit process was developed as part of the High Quality Care CQUIN for 2013/2014 to audit compliance (random sample) with risk assessments for Falls, Waterlow and MUST. The Trust monitored this as a Quality Indicator for the Quality Accounts in 2014/2015 and due to non-compliance at year end (achieving below 95%), has decided to continue monitoring this for 2015/2016. The audit includes all patients* and any non-compliance issues will be addressed by ward managers and the patient quality and safety champion, with compliance and progress monitored by the Patient Experience Sub Committee. Although not yet meeting the targets for waterlow and MUST, the data shows increasing compliance from quarter 1 to quarter 2 for falls, waterlow and MUST, and the quarter 2 target has been met for diabetic foot.

*August data is based on five wards work will continue to ensure that all wards submit a return

Oct-15

Quality Dashboard 2015/16

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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

Target or Indicator		Target	IC	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD	Trend
INTELLIGENT MONITORING	BANDING	None set	CQC		no banding				NYP	NYP											
	NUMBER OF ELEVATED RISKS	None set	CQC		2				NYP	NYP											
	NUMBER OF RISKS	None set	CQC		4				NYP	NYP											
Safety																					
INCIDENTS	MODERATE, MAJOR OR CATASTROPHIC HARM (APPROVED)	TBC	QC	2	1	0	3	0	0	0	0									3	
	MODERATE, MAJOR OR CATASTROPHIC HARM (UNDER REVIEW)	N/A		21	17	58	96	64	64	82	210									306	continually changing figures
HEALTHCARE ACQUIRED INFECTIONS	MRSA	0= green, 1-5=amber, >5 red	QC, QI	0	0	0	0	0	1	1	2									2	
	CLOSTRIDIUM DIFFICILE (due to lapses in care)	<=27 per year	QC, QI	0	1	3	4	0	0	0	0									4	
	CLOSTRIDIUM DIFFICILE (no lapse in care)	None set	N/A	3	4	1	8	0	0	0	0									8	
	CLOSTRIDIUM DIFFICILE (under review)	None set	N/A	0	0	0	0	1	0	4	5									5	
NEVER EVENTS		0	QC	0	1	0	1	0	0	0	0									1	
VTE	% OF PATIENTS RISK ASSESSED	>=95%	QC	97.52%	96.21%	96.01%		95.33%	95.77%	94.02%											
	% OF ELIGBLE PATIENTS HAVING PROPHYLAXIS (SAFETY THERMOMETER)	100%	QC	100.00%	100%	99.82%		100%	100%	99.82%											
	NUMBER OF PATIENTS WHO DEVELOPED A HOSPITAL ACQUIRED VTE (APPROVED)	TBC	QC	3	0	0	3	0	0	NYP										3	
	NUMBER OF PATIENTS WHO DEVELOPED A HOSPITAL ACQUIRED VTE (UNDER REVIEW)	N/A	N/A	4	6	5	15	1	0	NYP										16	
HARM FREE CARE	% OF PATIENTS FREE FROM HARM (SAFETY THERMOMETER)	TBC	OH	97.70%	92.60%	98.34%		95.51%	97.33%	98.52%											
	% OF PATIENTS FREE FROM HARM (MEDICINES SAFETY THERMOMETER)	TBC	QI	100%	97.5%	98.1%		Available end of Q2	Available end of Q2	Available end of Q2											

Target or Indicator		Target	IC	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD	Trend
Effectiveness																					
MORTALITY	HSMR (12 MONTH ROLLING)	<=100 = G, As expected = A, Higher than expected = R	QI, IP, QC	104	105	107		109													
	SHMI (12 MONTH ROLLING)	<=100 = G, As expected = A, Higher than expected = R	QI, IP, QC	116	115																
	TOTAL DEATHS IN HOSPITAL	None set	reporting only	92	80	107	279	87	81	78	246									525	
	MORTALITY PEER REVIEW (NB figures change as reviews are conducted)	Q1 - 45% Q2 – 55% Q3 – 75% Q4 – 95%	IP, SU2S	74%	78%	58%	70%	70%	59%	45%	58%									64%	
	REGULATION 28 - PREVENTION OF FUTURE DEATHS REPORT	None set	Reporting only	0	0	0	0	0	0	1	1									1	
CARDIAC ARRESTS	Annual: <75 = G, 75 – 85 = A, >85 = Red	see left	QC	4	2	11	17	10	5	6	21									38	
ADVANCING QUALITY	ACUTE MYOCARDIAL INFARCTION	>=95%	QI, C	93.18%	94.94%	96.83%		97.16%												97.16%	
	HIP AND KNEE	>=95%	QI	98.51%	99.22%	98.97%		98.85%												98.85%	
	HEART FAILURE	>=84.1%	QI, C	72.22%	73.17%	75.44%		78.85%												78.85%	
	PNEUMONIA	>=78.1%	QI, C	80.00%	78.83%	78.65%		78.00%												78.00%	
APPROPRIATE DISCHARGE PLANNING FOR PATIENTS WITH AKI		TBC	C	Absence of AKI Calculator in current system resulted in CCG agreeing for baseline to be set at Q2				Achieved 20.7% for Q2 need to establish baseline with CCG for Q3			20.70%										
SEPSIS SCREENING OF ALL ELIGIBLE PATIENTS ADMITTED TO EMERGENCY AREAS		TBC	C	Quarter one data for establishing baseline				100%	Awaiting results	Awaiting results											
SEPSIS SCREENING: ANTIBIOTICS GIVEN WITHIN AN APPROPRIATE TIMESCALE		TBC	C	Quarter 1: establishing indicator detail				Quarter 2: data for establishing baseline. July 16.7% (2 of 12)													
Patient Experience																					
FALLS	ALL FALLS (APPROVED)	913	IP (5% reduction)	82	89	80	251	75	69	56	200									451	
	FALLS PER 1000 BED DAYS	<=5.6	IP (national benchmark)	4.97	6.22	5.03		4.97	4.53	3.88										4.93	
	MODERATE, MAJOR AND CATASTROPHIC HARM FALLS (APPROVED)	<=13	IP (10% reduction)	2	2	2	6	1	0	1	2									8	
	MODERATE, MAJOR AND CATASTROPHIC HARM FALLS (UNDER REVIEW)	N/A		1	0	1	2	0	0	3	3									5	
	MODERATE HARM FALLS (APPROVED)	<=12	SU2S (10% reduction)	2	2	2	6	1	0	1	2									8	

Target or Indicator		Target	IC	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD	Trend
PRESSURE ULCERS	GRADE 3 AND 4 HOSPITAL ACQUIRED (AVOIDABLE)	<=5	QI, SU2S (10% reduction)	1	1	1	3	0	0	0	0									3	
	GRADE 3 AND 4 HOSPITAL ACQUIRED (UNAVOIDABLE)	N/A		0	1	0	1	0	0	0	0									1	
	GRADE 3 AND 4 HOSPITAL ACQUIRED (UNDER REVIEW)	N/A		0	0	0	0	0	0	0	0									0	
	GRADE 2 HOSPITAL ACQUIRED, AVOIDABLE AND UNAVOIDABLE (APPROVED)	<=63	QI (5% reduction)	14	7	5	26	7	2	3	12									38	
	GRADE 2 HOSPITAL ACQUIRED, AVOIDABLE AND UNAVOIDABLE (APPROVED)	<=59	10% reduction internal stretch target	14	7	5	26	7	2	3	12									38	
	GRADE 2 HOSPITAL ACQUIRED, AVOIDABLE AND UNAVOIDABLE (UNDER REVIEW)	N/A		1	1	1	3	3	4	3	10									13	
TRANSFERS	OUT OF HOURS TRANSFERS	TBC	BK	1	0	1	2	0	0	DC											
	NON-ESSENTIAL WARD TRANSFERS	TBC	QI	DC	DC	DC		DC	DC	DC											
ALWAYS EVENTS		100%	QI	89%	90%	92%	90%	96%	96%	88%	93%									92%	
DEMENTIA	DEMENTIA ASSESSMENT % (PART 1)	>=90%	C	96.85%	97.62%	95.53%		96.80%	94.86%	94.36%											
	DEMENTIA ASSESSMENT % (PART 2)	>=90%	C	100%	100%	100%		100%	95.12%	100%											
	DEMENTIA ASSESSMENT % (PART 3)	>=90%	C	100%	100%	100%		100%	100.00%	100%											
	DEMENTIA - STAFF TRAINING	Q2 = 42%	C	Compliance established at 27.02% end Q1 plus additional 15% for Q2							42%									42%	
CARE INDICATORS RISK ASSESSMENTS	FALLS	>=95%	IP	82%	92%	93%	93%	97%	97%	93%	96%										
	WATERLOW (PRESSURE ULCERS)	>=95%	IP	77%	93%	92%	91%	96%	95%	92%	94%										
	MUST (MALNUTRITION)	>=95%	IP	78%	85%	89%	85%	90.80%	80%	87%	86%										
	DIABETIC FOOT	Q1 - 61% Q2 – 71% Q3 – 81% Q4 – 91%	C	QR	QR	77.60%	77.60%	72.00%	81.40%		76.80%									77.2%	
MIXED SEX OCCURENCES		0	QC	6	0	1	7	0	0	0	0									7	
FRIENDS AND FAMILY (PATIENTS' VIEWS)	STAR RATING	N/A	Reporting only	4.61	4.66	4.70		4.66	4.65	TBC											
	% RECOMMENDING TRUST: INPATIENTS	>=95%	IP, QI, QC	97%	96%	97%		98%	98%	96%											
	% RECOMMENDING TRUST: A&E	>=87%	IP, QI, QC	83%	83%	83%		88%	87%	90%											
	RESPONSE RATE: A&E WARRINGTON	Contract target to be agreed	IP, QI, QC	22.03%	19.47%	13.16%		6.96%	6.49%	20.29%											
	RESPONSE RATE: URGENT CARE CENTRE HALTON	Contract target to be agreed	IP, QI, QC	3.54%	22.81%	24.00%		44.90%	10.86%	17.77%											

Target or Indicator		Target	IC	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD	Trend
FRIENDS AND FAMILY (PATIENTS' VIEWS)	RESPONSE RATE: A&E COMBINED	Contract target to be agreed	IP, QI, QC	17.42%	20.26%	16.11%		17.62%	7.66%	19.58%											
	RESPONSE RATE: INPATIENTS	Contract target to be agreed	IP, QI, QC	30.30%	33.80%	31.44%		31.96%	6.13%	66.10%											
COMPLAINTS AND CONCERNS	NUMBER OF COMPLAINTS RECEIVED	2014/2015 received 478 (No threshold set)	IP	50	23	32	105	24	38	34	96									201	
	% OF COMPLAINTS RESOLVED WITHIN THE AGREED TIMESCALE	>=94%	IP, QC	100%	97.50%	97.56%	98.08%	97.67%	100%	100%	98.90%									98.46%	
	NUMBER OF CONCERNS RECEIVED	NOT SET	IP	9	8	25	42	39	16	5	60									102	
END OF LIFE STRATEGY: STAFF TRAINING (KPI UNDER CONSTRUCTION)		TBC	IP	Training workshops in development, delivery in Q3				Training workshops in development, delivery in Q3													
REDUCING AVOIDABLE EMERGENCY ADMISSIONS TO HOSPITAL		TBC	C	4 pathways identified, awaiting CCG agreement				4 pathways identified, awaiting CCG agreement													

BOARD OF DIRECTORS

WHH/B/2015/ **196**

SUBJECT:	**Infection Prevention and Control**	
DATE OF MEETING:	28th October 2015	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Lesley McKay Associate Director of Infection Prevention and Control	
EXECUTIVE DIRECTOR:	Simon Constable, Medical Director Choose an item.	
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care SO3: To give our patients the best possible experience SO4: To provide sustainable local healthcare services	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.3 Failure to achieve infection control targets in accordance with the Risk Assessment Framework Choose an item. Choose an item. Choose an item. Choose an item.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None Choose an item. Choose an item.	
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides a summary of infection control activity in quarter 2 (Q2) 2015/16 and highlights the Trust's progress against infection prevention and control key performance indicators.	
RECOMMENDATION:	***The Board is asked to:*** be assured that all actions are being taken to address the Clostridium difficile position.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item. Or type here if not on list:
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

Infection Prevention and Control Report

EXECUTIVE SUMMARY

This report provides a summary of infection control activity in quarter 2 (Q2) 2015/16 and highlights the Trust's progress against infection prevention and control key performance indicators Year to date (YTD).

The Trust reported 17 hospital apportioned cases of Clostridium difficile against the annual threshold of 27 cases. Partnership working with the Clinical Commissioning Group has resulted in setting up a review process. YTD 12 cases have been submitted and 8 removed from cases counted for contractual sanctions purposes.

The Trust has reported 2 hospital acquired cases of MRSA bacteraemia.

CONTEXT

The Trust has developed healthcare associated infection (HCAI) reduction action plans for MRSA & MSSA bacteraemias and Clostridium difficile. These action plans are updated quarterly to ensure local and national priorities relating to HCAI are addressed and meet the requirements specified in the NHS Standard Contract for 2015/16.

Monitor uses Clostridium difficile infection rates as one of a number of metrics to assess Trust performance. Both avoidable and unavoidable cases of Clostridium difficile are taken into account for regulatory purposes. The *de minimis* limit for cases of C. difficile is set at 12.

Monitor will assess the Trust for breaches of the Clostridium difficile objective each quarter using a cumulative YTD trajectory. Monitor will consider whether the Trust is in breach of its licence if the Care Quality Commission reports serious concerns about Trust performance or third parties raise concerns about infection outbreaks.

HEALTHCARE ASSOCIATED INFECTIONS

CLOSTRIDIUM DIFFICILE

The CCG review of the 12 cases from Q1 resulted in the removal of 8 cases from contractual sanctions. Learning from the cases with lapses in care is being shared across the Divisions.

During Q2 the Trust reported 17 cases of *Clostridium difficile*, 5 of which are initially hospital apportioned (appendix 1).

The Trust is currently on trajectory with 9 cases against the mid-year trajectory of 13 cases. A meeting is scheduled with the CCG in November to assess the 5 cases from Q2 for lapses in care.

Progress continues against the recovery plan as detailed in appendix 2.

BACTERAEMIAS

MRSA bacteraemia

During Q2, 3 cases of MRSA bacteraemia have been reported, 2 of which are hospital acquired. The 2 hospital acquired cases occurred on the same ward and are linked (different antibiotic sensitivity patterns). The post infection reviews have identified:-

- Case 1 – likely contaminant
- Case 2- wound or IV device associated

The Ward has been given additional infection control training, is undergoing a Quality in Care review and is receiving additional support to correct areas identified for care improvement.

MSSA bacteraemia

During Q2, the Trust reported 10 cases of MSSA bacteraemia 3 of which were hospital apportioned. The cases are under review and finding so far indicates the patients were incubating this infection on admission.

E. coli bacteraemias

In Q2, a total of 38 cases of E. coli bacteraemia were reported making a total of 83 cases YTD. The Medical Microbiologists review all cases of E. coli bacteraemia and the majority of cases are deemed unlikely to be associated with healthcare.

OUTBREAKS/INCIDENTS/NEW DEVELOPMENTS

Viral Gastroenteritis

In Q2 a total of 8 wards were monitored for reported problems with diarrhoea and vomiting amongst patients. Causative organisms were not identified. The Microbiology laboratory is reviewing testing methodology with a view to conducting a trial on in house testing for gastroenteritis viruses. This will provide more timely results to inform decision making on re-opening facilities.

Pseudomonas aeruginosa - Neonatal Unit

The Infection Control Team is currently investigating 4 infant cases of Pseudomonas aeruginosa in the neonatal unit. Water sampling identified the bacterium in low numbers from 1 water outlet. Action has been taken to disinfect the water outlet and repeat testing is negative.

The Consultant for Communicable Disease Control at Public Health England has been involved and is satisfied that all appropriate action is being taken.

Genetic testing has shown:-

- Case 1 & 2 are identical indicating transmission has occurred
- Case 3 is genetically different
- Case 4 – typing result awaited (process takes approx. 14 days)

Case 3 and 4 have been identified from the additional screening implemented as part of the incident management plan and could be sporadic cases.

NEXT STEPS

Further work is required to:-

- Complete the actions detailed in the Clostridium difficile recovery action plan
- The Neonatal Unit is under surveillance
- Action to be taken as appropriate following the Quality in Care review

RECOMMENDATIONS

The Board is asked to be assured that all actions are being taken to address the current incident in the Neonatal Unit.

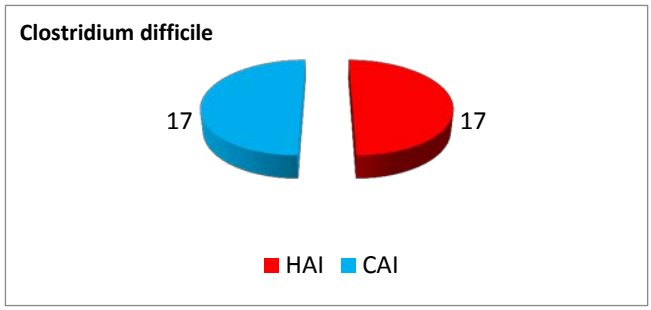
CONCLUSION

The Board is asked to note the contents of the report and note the progress made.

Appendix 1 - HCAI Surveillance data April – September 2015

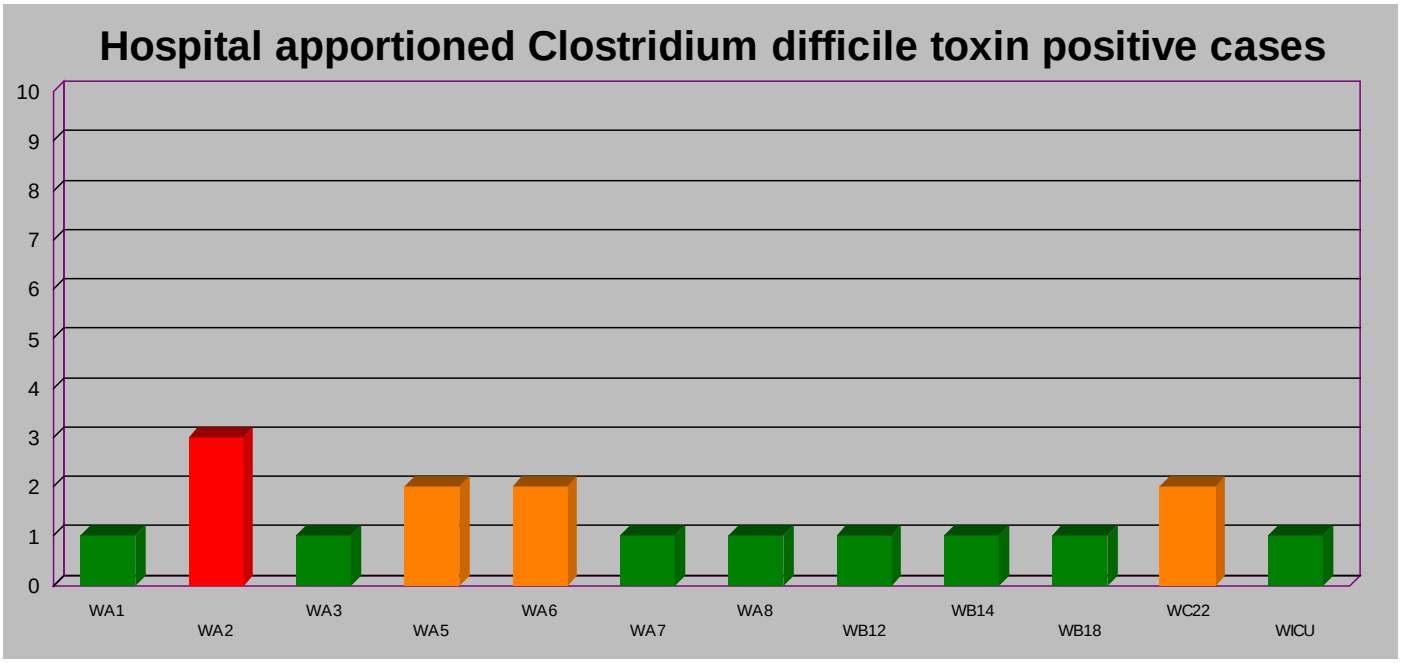
CLOSTRIDIUM DIFFICILE

	CAI	HAI	Total
Apr	1	3	4
May	3	5*	8
Jun	1	4	5
Jul	3	1	4
Aug	3	0	3
Sep	6	4	10
Total	17	17	34



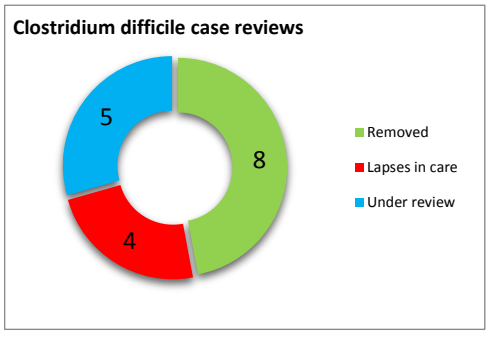
*** 1 Community apportioned Clostridium difficile case reported in May due to Pseudomembranous colitis identified by CT scan**

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



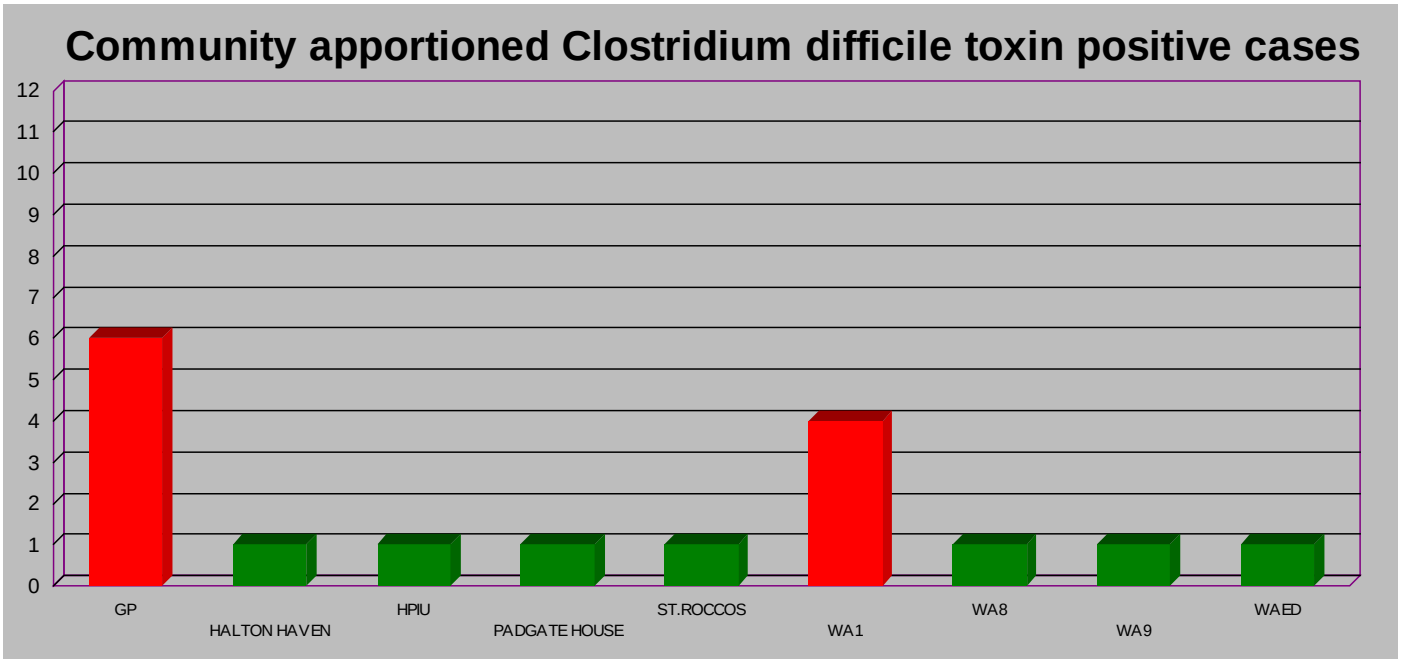
8 hospital apportioned case (April - June 2015) have been removed from cases counted for contractual sanctions

2015/16	Apr	May	Jun	Jul	Aug	Sep	YTD
Total HAI C difficile	3	5	4	1	0	4	17
Cases under Review	0	0	0	1	0	4	5
Not due to lapse in care	3	4	1		0		8
Due to lapses in care	0	1	3		0		**4**

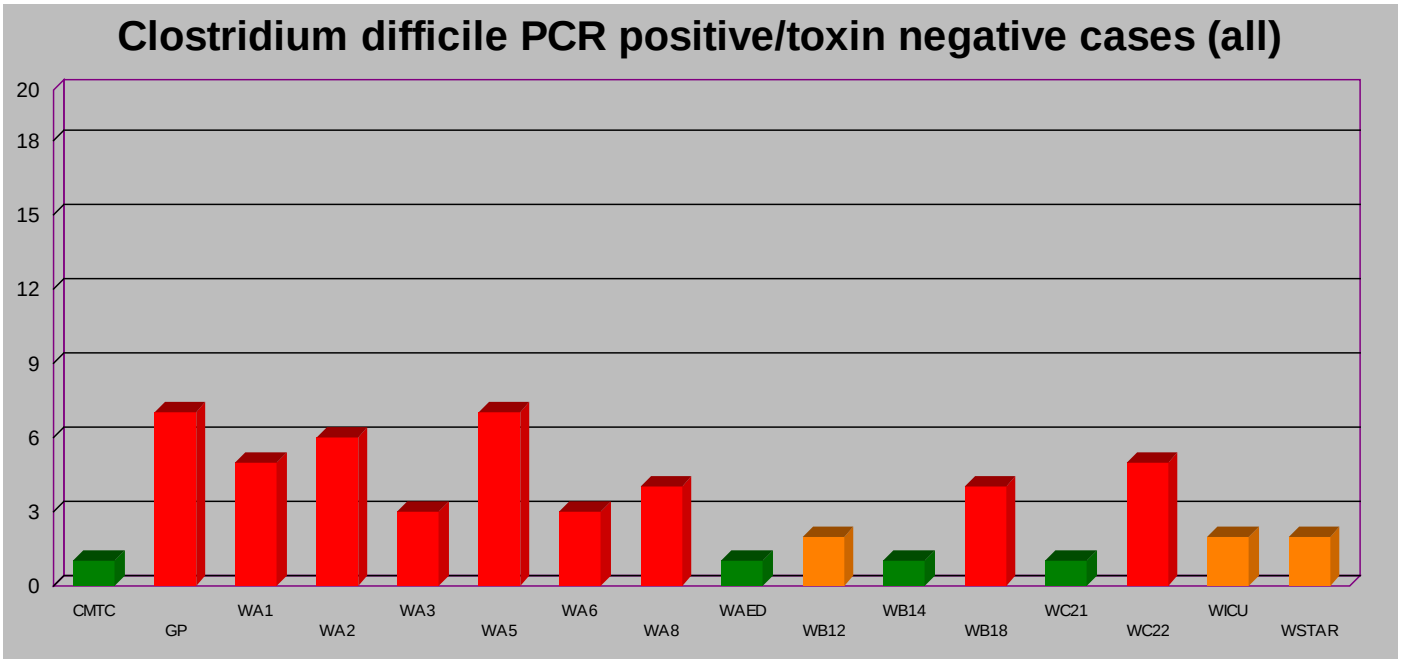


Community apportioned Clostridium difficile *toxin positive* cases by location when detected

*1 case reported due to PMC identified by CT scan



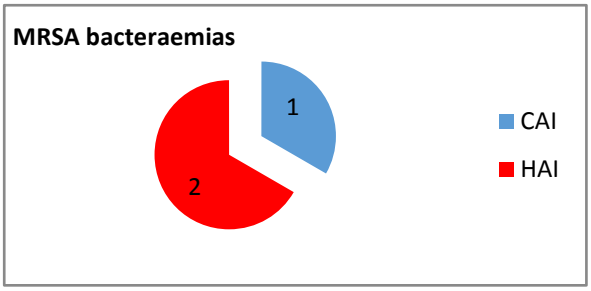
Clostridium *difficile PCR positive/toxin negative* cases by location when detected (Local surveillance)



BACTERAEMIAS

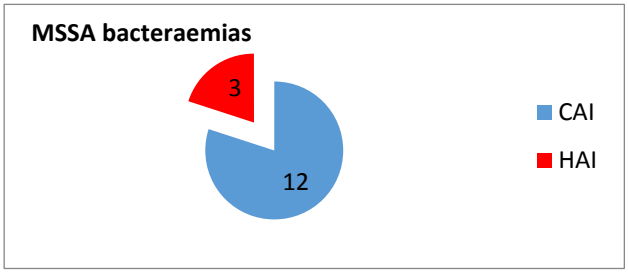
MRSA bacteraemia

Month	CAI	HAI	Total
Apr	0	0	0
May	0	0	0
Jun	0	0	0
Jul	0	0	0
Aug	1	1	2
Sep	0	1	1
Total	1	2	3



MSSA bacteraemia

Month	CAI	HAI	Total
Apr	2	0	2
May	2	0	2
Jun	1	0	1
Jul	2	2	4
Aug	3	0	3
Sep	2	1	3
Total	12	3	15



E. coli bacteraemia – no apportionment

Month	Total
Apr	13
May	17
Jun	15
Jul	11
Aug	14
Sep	13
Total	83

Appendix 2

Clostridium difficile Infection

Recovery Action Plan

2015 – 2016

Situation

The annual threshold for Clostridium difficile cases for this financial year has been set at 27 cases. Year to date (7th October 2015) the Trust has reported 17 hospital apportioned cases. The latest available comparative data for other Trusts in Cheshire and Merseyside is included at appendix 1.

Background

Mandatory reporting of patient level data was introduced in 2007 and reduction targets were set by the Department of Health (DH). The Trust implemented a number of actions and made significant case reductions from 2008 - 2013. Over the last 2 years the thresholds have been extremely challenging and have been exceeded by the Trust. The DH is continuing its culture of zero tolerance to this infection and Clostridium difficile continues to be a key performance indicator.

Assessment and Risk

Clostridium difficile infection is a risk to patient safety. Antibiotics and use of Proton Pump Inhibitor medications are common contributory factors in the vast majority of cases. There are recognised risks from environmental reservoirs as Clostridium difficile is a spore forming organism.

There is a risk of adverse publicity for the Trust and contractual penalties if the threshold is exceeded (£10,000 per case above threshold).

Recommendations

There is a requirement to ensure correct assessment, isolation, sampling/testing of patients with diarrhoea and to ensure compliance with infection control policies occurs to reduce the risk of transmission and promote patient safety.

This recovery plan, which has been designed to tackle key areas of concern in relation to Clostridium difficile, should be implemented. To succeed the plan requires support from staff across the organisation. This recovery plan should be read in conjunction with the existing Clostridium difficile action plan 2015 - 2016.

The Trust in collaboration with the CCG has set up a case review panel and 8 of the cases from quarter 1 have been removed from cases that count towards contractual sanctions.

Antimicrobial Stewardship and PPI use							
Action required	***Lead***	***Supported by***	***Due by date***	***Completion date***	***Priority***	***Evidence***	***RAG***
Provide additional resources to the Antibiotics Pharmacist	DM	SC	12/15		1		
Review staffing level in Medical Microbiology	SC	HMB	12/15		2	Added to risk register	
Assess requirement to limit use of Co-amoxiclav	ZQ	AMSG	12/15		1		
Highlight use of Trust formulary to guide prescribing	RC	ADC	12/15		2		
Review and introduce antibiotic prescribing competency assessments	SC	CMM	12/15		2		
Produce and roll out guidance on use of PPI medication	SC	GC/ARob	12/15		2		
Appoint medical champions to promote prudent prescribing	SC	DMD	12/15		2		

Environmental hygiene/equipment							
Action required	***Lead***	***Supported by***	***Due date***	***Completion date***	***Priority***	***Evidence***	***RAG***
Develop a deep cleaning programme based on priority	LMcK	Facilities	12/15		2		
Re-establish the task and finish group to review cleanliness standards/staffing/cover for annual leave/absences	LMcK	Facilities	06/15	15/07/15	1	Meeting minutes	
Revise terminal cleaning guidelines and sign off checklist	LMcK	Facilities	06/15	16/06/15	1	Guideline document	
Develop a rolling programme to decontaminate all side rooms with HPV	LMcK	Facilities	12/15		2		
Review condition of all commodes and replace if required	Matrons	Ward staff	12/15		1		
Trust wide mattress audit scheduled for July 2015	JH	External company	12/15	08/2015	1	Audit findings report	
Trust wide pillow audit	Matrons	HK	12/15		2		

Diarrhoea management, sampling and isolation							
Action required	***Lead***	***Supported by***	***Due date***	***Completion date***	***Priority***	***Evidence***	***RAG***
Review RCN guidance on management of acute diarrhoea	LMcK	IPCNs	07/15	01/07/15	1	NMAC presentation	
Review introduction of diarrhoea management plan	LMcK	IPCNs	12/15		2		
Re-circulate ratified algorithm for stool sampling	LMcK	IPCNs	06/15	09/07/15	1	Email	
Develop robust follow up process for patients with diarrhoea to ensure correct assessment, isolation, sampling/testing and policy compliance	LMcK	IPCNs	12/15		2		
Review isolation door notices/signage	LMcK	IPCNs	12/15		2		
Ensure actions taken when unable to isolate symptomatic patients are documented	Matrons	Ward staff	12/15		2		
Review use of Daresbury Unit with en-suite facilities	LMcK	ADN	12/15		2		
Carryout Trust wide inpatient isolation audit	LMcK	Matrons	12/15		1		
Complete a Trust wide audit to identify current and potential side room resources	LMcK	KS	10/15	15/09/15	1	Completed audit report	

Hand hygiene and use of personal protective equipment							
Action required	***Lead***	***Supported by***	***Due date***	***Completion date***	***Priority***	***Evidence***	***RAG***
Revise questions on the hand hygiene facilities auditing tool	LMcK	MT	07/15	10/06/15	1	Audit tool	
Re-provide training programme to hand hygiene auditors	IPCNs	Ward staff	12/15		2		
Ensure peer audits are being carried out	Matrons	Ward staff	07/15	To be kept under review	1	Matron reports	
Plan additional hand hygiene promotion events	IPCNs	Suppliers	11/15	15th & 16th October	2		
Provide C difficile education session to link staff	IPCNs	Ward staff	07/17	17/07/15	1	CDT Presentation	
All clinical staff to have hand hygiene competency assessment	Matrons	Ward staff	03/16		2	Hand hygiene training figures	
Improve compliance with hand hygiene training strategy (UV light box)	Matrons	Ward staff	09/15	01/08/2015	2	Matron reports	
Review patient appointment letters with a view to including information on hand hygiene – ok to ask campaign	IPCNs	GR	12/15		2		

Case review and shared learning							
Action required	***Lead***	***Supported by***	***Due date***	***Completion date***	***Priority***	***Evidence***	***RAG***
Benchmarking with RLBUHT on Clostridium difficile management and action accordingly	SC	IPCNs	06/15	03/07/15	1	RLBUHT benchmarking report	
Review recommendations made by RLBUHT	LMcK		08/15	12/08/2015	1	Report	
Strengthen partnership working with the CCG for timely case reviews	LMcK	CCG	06/15	03/09/2015	1	Case review process	
Monitor effectiveness of the revised investigation toolkit and adapt as necessary	IPCT	CCG	03/16	Keep under review	1	Case review meetings and CCG review panel outcome	
Improve action plan monitoring to ensure all actions are completed	ADNs	Matrons	12/15	Keep under review	1	Action plans are added to Matron reports submitted to ICSC	
Revise CDI/ Infection risk assessment tools	LMcK	IPCT	12/15		2		
Provide education on CDI/infection risk assessment at the Divisional Infection Control Meetings and request reporting of training provided in all wards/departments	IPCNs	DICG	12/15		2		
Consultant level infection control engagement	SC	DMDs	06/15	10/06/15	1	DIPC letter	

RAG Legend	
Action not commenced	
Action in progress	
Action completed	

Personnel		
ADNs	Associate Directors of Nursing	Mel Hudson, Rachael Browning, Sue Franklin
ARob	Dr Anne Robinson	AED Consultant
CCG	Clinical Commissioning Group	Dawn Chalmers/ John Wharton
CMM	Consultant Medical Microbiologists	Dr Zaman Qazzafi, Dr Thamara Nawimana
DICG	Divisional Infection Control Groups	As per terms of reference
DM	Diane Matthew	Chief Pharmacist
DMD	Divisional Medical Directors	Dr Anne Robinson, Mr Mark Halliwell, Dr Al-Jafari
GC	Gastroenterology Consultant	
GR	Gordon Robinson	Outpatients Service Manager
HMB	Health Management Board	
JH	Joshua Hennighan	Medical Devices Coordinator
IPCNs	Infection Prevention and Control Nurses	Lesley McKay; Karen Smith; Andrew Sargent
IPCT	Infection Prevention and Control Team	Dr Thamara Nawimana, Dr Zaman Qazzafi, Rachael Cameron, Lesley McKay, Karen Smith, Andrew Sargent
MT	Martin Thatcher	Data Warehouse Manager IT
RC	Rachael Cameron	Antibiotics Pharmacist
SC	Dr Simon Constable	Executive Medical Director/DIPC
ZQ	Dr Zaman Qazzafi	Consultant Medical Microbiologist

Priority 1 – Urgent action within 3 months

Priority 2 – Medium term action within 6 – 12 months

Appendix 1 – Cheshire and Merseyside comparative data

Public Health England

C. difficile monthly tables: Trust apportioned cases (by Trust) & non-Trust apportioned cases (by CCG)

***C. difficile* : Trust Apportioned Cases**													
Acute Trust Name	2014 September	2014 October	2014 November	2014 December	2015 January	2015 February	2015 March	2015 April	2015 May	2015 June	2015 July	2015 August	Total
Aintree University Hospitals NHS Foundation Trust	6	5	2	6	6	5	5	6	4	0	3	4	52
Alder Hey Children's NHS Foundation Trust	0	0	0	0	0	0	0	0	0	0	2	0	2
Clatterbridge Centre for Oncology NHS Foundation Trust	0	0	0	0	0	0	0	0	1	0	0	0	1
Countess of Chester Hospital NHS Foundation Trust	0	1	4	2	4	7	8	2	1	3	0	1	33
East Cheshire NHS Trust	3	2	2	2	0	0	2	1	4	2	6	1	25
Liverpool Heart & Chest Hospital NHS Trust	1	1	0	0	0	0	0	0	0	0	1	0	3
Liverpool Women's NHS Foundation Trust	0	0	0	0	0	0	0	0	0	0	0	0	0
Mid Cheshire Hospitals NHS Foundation Trust	2	3	1	1	3	2	4	5	6	6	2	4	39
Royal Liverpool & Broadgreen Hospitals University NHS Trust	4	6	10	2	1	6	1	0	4	4	1	6	45
Southport & Ormskirk Hospital NHS Trust	3	3	2	3	1	1	4	6	3	3	3	2	34
St Helen's & Knowsley Hospitals NHS Trust	7	4	3	0	6	2	2	4	5	4	3	6	46
The Walton Centre NHS Foundation Trust	1	0	4	1	2	0	2	1	3	0	0	0	14
Warrington and Halton Hospitals NHS Foundation Trust	1	3	1	3	1	2	5	3	5	4	1	0	29
Wirral University Teaching Hospital NHS Foundation Trust	4	0	4	0	6	2	2	4	5	2	5	3	37
Cheshire and Merseyside	32	28	33	20	30	27	35	32	41	28	27	27	360

BOARD OF DIRECTORS WHH/B/2015/ **197**

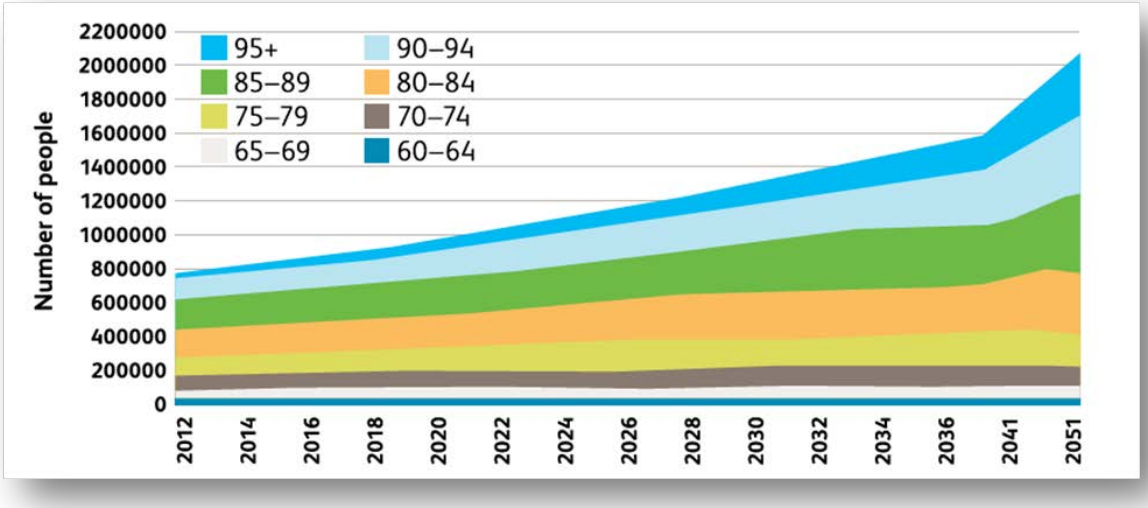
SUBJECT:	Update to Trust Board on progress of the Dementia Strategy and national and local Dementia CQUINs	
DATE OF MEETING:	28th October 2015	
ACTION REQUIRED	**For Discussion**	
AUTHOR(S):	Clare Pratt, Associate Director of Nursing, Corporate Nursing Debra Carberry – Nurse Specialist, Older People Deborah Hatton - Matron, Unscheduled Care	
EXECUTIVE DIRECTOR:	Karen Dawber, Director of Nursing and Governance	
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care SO3: To give our patients the best possible experience SO3: To give our patients the best possible experience	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO3/3.3 Failure to provide staff, public and regulators with assurances post Francis and Keogh review SO4/4.3 Failure to manage key contracts appropriately resulting in contract penalties or reduction in service standards; and failure of operational processes to deliver service to agreed contract targets, outputs or standard	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	This paper provides the Board with an update on the 10 Key areas identified within the Dementia Strategy and progress to achieving national and local Dementia CQUINs targets	
RECOMMENDATION:	***The Board is asked to:*** Note the updates on the ten work-streams related to the Dementia Strategy, the work of the Dementia Steering Group (Forget Me Not) and National and Local CQUINs.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Or type here if not on list:
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

1. Introduction

The Trust Board approved the Dementia Strategy in October 2013, and has received 6 monthly updates in relation to the work of the dementia teams within the organisation. Significant progress has been made towards achieving the targets laid out in the original strategy. This paper provides an update to the Trust Board on current achievements and progress made by Trust Dementia Steering Group (Forget Me Not) against the ten key areas of the strategy. It also updates on progress made in relation to the local and national dementia CQUINs in implementing work against the agreed timelines. As good progress has been made towards meeting the targets and will be subject to ongoing security through the Patient Experience Committee it is proposed that this report be produced on an Annual basis in future.

2. Background

According to the projections below, there will be over 850,000 (855,700) people with dementia in the UK by 2015; over 1 million (1,007,485) by 2021; and 2 million (2,092,945) by 2051.



The Government identified Dementia as a National priority and within the Department of Health's "National Dementia Strategy" (2009). Following on from this National Strategy a new commissioning framework for Dementia was launched in July 2011. Since this time the Trust has worked on various work-streams toward ensuring that those patients with Dementia receive the best possible care.

The "Prime Ministers Challenge on Dementia", launched in March 2012, its focus being to "drive improvements in health and social care, to create Dementia friendly communities and to undertake better research". Increasing diagnosis rates has been highlighted as a National objective.

3. Trust Dementia Strategy

At Warrington and Halton Hospitals our staff are dedicated to providing the best possible care for patients with Dementia, our Dementia Strategy sets out the framework by which we will achieve this with ten key areas identified which are underpinned by action plans monitored by the Dementia Steering Group.

3.1 Ten Key Areas of the Dementia Strategy

3.1.1 Dementia Champions

Champions are in place at board level and the dementia ward champion role is in place in clinical areas, with specific roles and responsibilities for improving the care of dementia patients within Warrington and Halton Hospitals

We have developed dementia champions to include trained non-clinical and clinical staff in place at

ward and department levels who have all received additional training. We also have active senior medical and senior nursing leads for dementia within the Trust. We are pleased to report that a dementia champion is in place in almost every clinical area and we therefore report that this key area of the strategy has been achieved

The ward/department based champions come together regularly to gain up to date knowledge and skills in relation to patients with dementia in our hospital. They then cascade and disseminate that information in their own clinical area. An example of the work of the dementia champions is to ensure that the ward and department dementia information boards are up to date, and to ensure that carers of patients with Dementia are issued with a Careres Card encouraging them to make use of our open visiting policy for this group of patients.

In Accident and Emergency our dementia champion is working closely with the Patient Safety and Quality Champion and Specialist Nurse for Older People and they have produced a series of "special considerations" for dementia care in the department. The special considerations included initial contact (with particular reference to training and education for the reception staff). For clinical staff the special considerations provide essential information for reasonable adjustments, including a higher triage priority required for patients with dementia. A department specific DAWES (Department and Ward Assessment Scheme) has been developed and includes a section of standards expected from all staff in A&E staff caring for patients with dementia and their families and carers. Recent results demonstrate that staff questioned were aware of the need for early identification of vulnerable patients and the reasonable adjustments they should make for this group.

3.1.2 Dementia information

A dementia information leaflet has been produced for patients and their families. Warrington and Halton hospitals recognise the vital role that family members and unpaid carers have as 'experts' in the care of their loved one. We are committed to improving how we work with and support carers to create a care partnership between the person with dementia, their family and Professionals. . The booklet provides information about what patients and carers can expect from the staff here at Warrington and Halton Hospitals Trust with suggested websites and contact details of organisations which can provide more detailed information and support. The booklet also contains a carer feedback survey to assist us with improvements in the care and experience of people with dementia.
A delirium information leaflet for patients and their families is also being developed to provide support and guidance to those patients who have had/are having an episode of acute confusion. Delirium should be treated as a medical emergency whereby the underlying causes are identified and managed as soon as possible. NICE guidance advocates better information for patients and their carers on what can be a distressing experience. Patients who develop delirium often have underlying risk factors such as dementia and therefore the two are inextricably linked.

A delirium prevention and management advice sheet for staff is currently being ratified for use on the adult wards to help deliver tailored interventions and care planning. Raising awareness of delirium as well as dementia is necessary in order to deliver optimal care.

The clinical librarian continues to produce the dementia current awareness bulletin on a monthly basis. This bulletin includes recent evidence based research within the dementia community and is disseminated to staff via e mail.

Many wards continue to have dementia information boards within the ward area. The information board contains contact general information for patients and their families together with contact details for voluntary and support agencies and information regarding new services such as the dementia legal service which has recently set up in the local area.

3.1.3 Dementia Training

A dementia training framework has been developed to provide awareness and training for all staff within the Trust. Awareness sessions will be initially be delivered through e-learning and form part of the essential training requirement for all Trust staff. Training will include the use of non-medication methods of addressing behavioural problems.

The Trust offers a variety of different training schemes for clinical and non-clinical staff. Clinical staff access and undertake training on e-learning through the NHS e-learning portal. Staff can also undertake a level 2 national qualification in the principles of dementia care. This award is achieved through completion of workbooks approved by the Northern Council for Further Education (NCFE).

A number of Trust staff have completed dementia champions training in order to raise awareness amongst our colleagues in specific departments that require a general overview and understanding of the particular issues people with dementia face in less familiar surroundings. Focussed training has been provided to areas within the Trust were patients or staff have raised concern regarding staffs lack of knowledge in relation to the needs of patients with Dementia.

Front of house shops and services within the hospitals will also be offered dementia awareness training. This will have less clinical content but with a focus on identifying people with dementia and being confident in providing practical assistance whilst creating a more dementia friendly environment.

In November 2015 the Trust will hold the second part of a Dementia Education Conference at Warrington Education Centre. The focus will be on patient's experience of hospital care. We anticipate that approximately 60+ clinical staff attend this conference, together with our partner agencies and patient representative groups. Previous conference feedback has been excellent and clinical staff have found the sessions to be most helpful in providing practical support to them in caring for patients with dementia and delirium.

3.1.4 Personalised Care Planning

Following individual patient assessment, the care plan will reflects the needs of the patient relating to:

- *Privacy and dignity*
- *Nutrition and hydration*
- *Pain assessment and control*
- *Communication*
- *Continence*

- *Carer and family involvement*

Our new nursing care booklet includes individual patient assessment relating to the above, however we recognised that a more bespoke care planning method is required. Therefore our Specialist Nurse for Older People has produced a suite of care plans for patients with Dementia, delirium or cognitive impairment which were launched in November 2014. Compliance with these standards will be monitored through the DAWES Dementia section, due to be completed later this month.

3.1.5 Patient Experience

We continue to ascertain levels of satisfaction with care from patients and their families and address areas for improvement as well as share good practice with other areas of the Trust. The dementia carers' survey is now accessible on the hospitals website.

The particular skills held by the Cognitive Assessment Team are proving invaluable to the staff and families in understanding the specific requirements or needs of dementia patients in a hospital environment. The skills of this team also contribute greatly to smooth patient journey in the interface between community and acute care. The development of the Cognitive Assessment Team has enabled plans to trial a telephone survey for a six month period in order to raise the response rate from carers. The survey has also been amended to include families of patients who have experienced delirium in line with the expansion of the Dementia and Delirium CQUIN for 2016. The team has recruited Registered Psychiatric nurses with experience of older person's mental health issues specifically in dementia care and management. This is enabling the Cognition Assessment Team to support patients and their families and to also support staff in the clinical management of patients who are not transferred to the 'Forget Me Not unit'.

The Initial data analysis from The Forget Me Not care audit conducted from December 2014 – May 2015, reveals a significant reduction in the stress and agitation experienced by patients who have transferred to the Forget Me Not Ward. Following further data analysis we aim to quantify the impact of the care approach on the Forget Me Not ward and disseminate good practice to other wards and departments. The evidence and results will be presented at medical audit in November 2015

We have introduced a 'carers card' to the Trust which is offered to all main carers of patients with memory problems to facilitate unrestricted visiting and if appropriate to support in the delivery of care as recommended in our dementia guidance.

Carers are welcome Here 1.docx

This and other 'carer aware' initiatives have established the Trusts involvement with a national campaign called 'Johns List' which is a campaign for the right of people with dementia to be supported by their carers in hospital. The Observer newspaper supports John's Campaign and has established a dedicated page on the Guardian website which will lists all the hospitals in the UK

where carers are welcome, WHHFT is included in the first 100 trusts on this list and the founders of the campaign have agreed to speak at our forthcoming dementia conference.

3.1.6 Enhancing the Healing Environment

We continue to arrange social sessions for the patients on the Forget me not ward and have secured permanent funding for the activities coordinator role. This enables us to provide meaningful activity and occupation for the patients. Providing a sense of achievement and pleasure through person-centred activities can help the person maintain their skills and feel better about themselves and we know that boredom and frustration are common causes of challenging behaviour. This care approach is part of our 'toolbox' of strategies to manage 'challenging behaviour' in a non-pharmacological way as recommended by best practice in NICE guidance.

We regularly undertake an environmental survey when we ask next of kin or family members to use their "own words" to describe each of the areas in the Forget Me Not Ward. The results from the August 2015 survey are displayed below

Reception	Garden	Toilets/ensuite	Lounge/dining area	Patient bay/side room	Quiet room
I have a moan there	N/a	Alright nice and white	A bit dark had a good dance	I live here	N/a
Welcoming	Very pleasant to sit in	Very clean	Nice place to relax	Staff made it pleasant to be in	Could live in this room
Very nice reassuring	Very nice	Top notch very clean	N/a	Nice	N/a
Very good	Lovely	Very good	Good	Lovely	N/a
Relaxed welcoming peaceful	N/a	Good size clean environment	Bright inviting stimulating comfy	Clean and comfy	N/a
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!	Overall	Wonderful	!!!!!!!!!!!	!!!!!!!!!!	!!!!!!!!!!!
Nice	N/a	Couldn't remember	Nice	Nice	N/a
Alright	N/a	Just a toilet	Suitable	Ok	N/a
Looks nice decoration excellent	I like lawns great for children	It is not finished off very bare	Like the tv nice area, can see the garden.	Girls try their best	N/a
Busy Communal	Calming Peaceful Relaxing Good escape route	Clean Functional	Quiet nice area to relax Peaceful	Busy Controlled Communal	Comfortable Calming
Alright	N/a	Alright clean	Alright for everybody	Alright clean tidy	N/a
All very good to me	Great	All nice and as it should be	Very nice	Each	Was quiet

3.1.7 Early identification of Patients with Dementia

We continue to achieve our target of screening over 90% of patients aged >75 admitted as an emergency who are confused on admission or who have memory loss. With the expansion of the Cognitive Assessment Team the Trust is able to include patients >70 within the screening process and have successfully incorporated the identification and clinical management of delirium into Parts 1, 2 and 3 of the CQUIN together with the provision of information to the G.P. and inclusion of a

patient care plan. The revised CQUIN criteria follows the findings and recommendations of the Care Quality Commissions report 'Cracks in the Pathway' (communication between secondary and primary care) and we continue to achieve >90% for part 1 and almost 100% for parts 2 and 3.

3.1.8 Reduction of movement of Patients with Dementia

With the introduction of the 'electronic white board' (Lorenzo) in November, the patients who have a diagnosis of dementia will be identified and the patient flow team will be alerted to minimise the number of bed moves these patients are subject to. The enhanced reporting ability provided by the ewhiteboard will allow us to measure, manage and improve the appropriate placement of this group of patients.

3.1.9 Identification System

An agreed system will be in place across the Hospital so that staff are aware of the person's dementia (visual identifier behind the bed or in the notes). This will result in easy identification of patients with dementia on the ward so that appropriate responses can be provided to their needs.

We have launched the use of the Forget Me Flower symbol behind the patient's bed. The symbol reminds staff that the patient either has a diagnosis of dementia or has cognitive impairment and that they should ensure that their approaches to the patient are appropriate. This is accompanied by information to staff, carers and families about what this means for the patient.

The identification of this group of patients on the ewhiteboard will to enable us to make 'reasonable adjustments to care'. This initiative will enable identification from the point of admission to ensure appropriate measures are put in place immediately.

3.1.10 Forget Me Not Campaign

Our campaign continues to spread at pace, and we are regular hosts to visitors from other trusts and organisations who are in the early stages of developing their units and strategies and wish to learn from us – it is great to know that *We Are What Good Looks Like* for other organisations.

4 Trust Dementia Steering Group (Forget Me Not) and National and Local Dementia CQUIN

The Trust Dementia Steering Group (Forget Me Not) has responsibility for delivery of the Trust's Dementia Strategy and the objectives of the Dementia 2015/2016 Strategy work plan, against agreed timelines. The Dementia Steering Group (Forget-Me-Not Group) meets monthly (at least 9 times per year) to provide a strategic direction to developing Dementia services within the Trust. The group has representatives from across professions including Estates, together with representatives from carers, and Alzheimer's UK local representatives.

A National Dementia Commissioning for Quality and Innovation (CQUIN) payment framework for was Dementia launched in April 2012. Its aim is to incentivise the identification of patients with Dementia and other causes of cognitive impairment alongside their other medical conditions, to promote appropriate investigations and to prompt appropriate referral at discharge. The CQUIN objectives form part of Trust Strategic Objectives. The Trust agreed a local CQUIN with Warrington Clinical Commissioning Group.

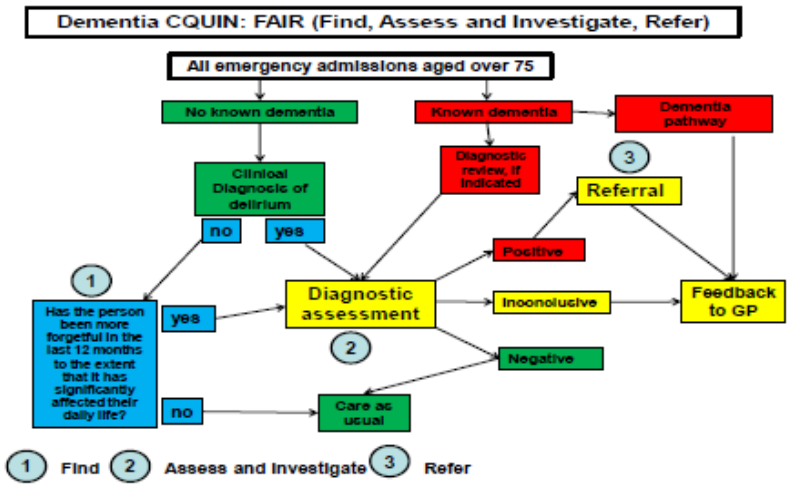
Overview of achievements and progress in National CQUIN requirements from target initiation to date follows:

4.1 National Dementia CQUIN (Financial Impact 2015/2016 – £428,059)

Part 1 Find, Assess and Refer (Achieve >=90%)

The value of this part of the CQUIN to the Trust is £256,835. We are achieving this to date as demonstrated in the table below.

i. The proportion of patients aged 75 years and over to whom case finding is applied following an episode of emergency, unplanned care to either hospital or community services;
ii. The proportion of those identified as potentially having dementia or delirium who are appropriately assessed;
iii. The proportion of those identified, assessed and referred for further diagnostic advice in line with local pathways agreed with commissioners, who have a written care plan on discharge which is shared with the patient's GP.



Dementia	A	M	J	J	A	S	O	N	D	J	F	M
Part 1 FIND **2013/2014**	90.43	93.14	91.3	92.87	95.12	95.12	95.2	95.13	96.1	97.76	97.36	94.57
Part 1 FIND **2014/2015**	94.55	95.69	95.43	94.26	96.59	92.45	92.7	96.61	96.29	96.93	94.81	N/A
Part 1 FIND **2015/2016**	96.85	97.62	95.53	96.80	94.86	94.36						
Part 2 INVESTIGATE **2013/2014**	96.77	100	100	100	100	93.3	100	96.43	96.88	100	100	100
Part 2 INVESTIGATE **2014/2015**	100	100	100	100	100	91.89	100	100	97.22	96.77	100	N/A
Part 2 INVESTIGATE **2015/2016**	100	100	100	100	95.12	100						
Part 3 REFER **2013/2014**	100	100	100	100	100	100	100	100	100	100	100	100
Part 3 REFER **2014/2015**	100	100	100	100	100	100	100	100	100	100	100	N/A
Part 3 REFER **2014/2015**	100	100	100	100	100	100						

Part 2 Staff Training

To determine that appropriate Dementia training is available to staff through locally determined training programme.

The value of this part of the CQUIN to the Trust is £42,806.

We provide the Commissioners with quarterly reports to provide assurance that:

- Numbers of staff who have completed the training are improving each quarter;
- We regularly review overall percentage of staff training.

Dementia Awareness training is now a requirement for all staff and the training can be completed via e-learning by accessing the e-Dementia: Introduction to Dementia (Learning Certification). This course is a nationally agreed e-learning tool which provides an introduction to dementia and guidance on supporting those living with dementia, along with their carers. The training enables staff to :-

- Describe dementia, its effect on the brain, and its common signs and symptoms
- Identify some of the complex difficulties experienced by people with dementia
- Challenge some of the common myths and negative attitudes about dementia
- Identify ways of communicating effectively with someone with dementia
- Describe the importance of living well with dementia and how the HCP can facilitate this
- Discuss other sources of support for those with dementia and their carers
- Outline the elements of best quality practice in caring for the individual with dementia, to include end-of-life care

Current results demonstrate compliance with dementia awareness training, a 15% improvement for Q2 has been agreed with CCG and the Training department. Q2 resulted in an overall of 41.99% staff trained which is sufficient to meet the Target. A further increase to 57% in number of staff trained is required by end of Q3 and individual wards and departments will be manages to achieve this.

	Dementia Awareness			**Dementia Awareness**		
	Q1 (30/06/2015)			Q2 (30/09/2015)		
	Heads	**Number Completed**	**% Completed**	**Heads**	**Number Completed**	**% Completed**
TRUST TOTAL	**3945**	**1066**	**27.02%**	**3958**	**1662**	**41.99%**

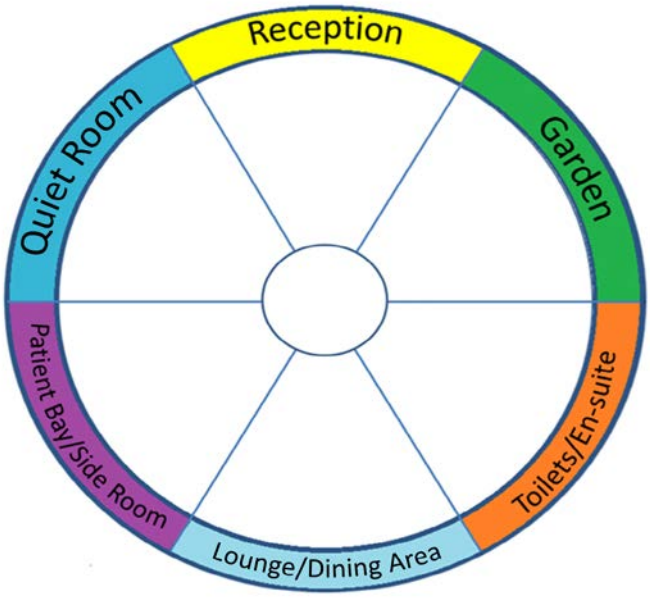
Part 3 Supporting carers of people with dementia - monthly audit of carers.

The value of this part of the CQUIN to the Trust is £128,418.

The Trust sends out an audit proforma to carers requesting feedback on all aspects of the service and importantly how carers viewed care of their relatives. The results are compiled into monthly qualitative and quantitative reports which are reviewed by staff in order to change and improve practice across the service. Postal returns of carer's questionnaire although low at approximately 20% do reflect the average return rate for a postal survey. To improve the level of feedback the

team are trialling a telephone carer feedback service and the internet to increase the number of responses.

We have also developed a tool called the "forget me not circle/wheel" to encourage further feedback from patients. Please see 3.1.5 for a detailed analysis of responses.



4.2 Local CQUIN – - Improvement in the care and experience of patients with dementia. (Year 2 of 2 year CQUIN)

This local CQUIN has a financial value of £273,958.

We wish to consolidate the work undertaken in 2014/15 to improve patient care, treatment and the support and advice offered to carers of patients where there is a diagnosis of dementia. It has also been agreed that we will introduce a local stretch target for the National Dementia CQUIN to ascertain the % of patients >70yrs (not >75yrs - National) who receive the (FAIRI) assessment. A new dementia dashboard has been constructed for review by the Patient Experience Sub Committee. Throughout the second year we wish to measure the following to evidence an improvement in the care and experience of patients with dementia. To do this we have agreed to:-

- Establish baseline for improvement for all / FMN patients with commissioners
- Improve process by which data will be collected on all dementia patients
- Continue with monthly data collection and reporting to FMN steering group on broad Dementia Care indicators outlined above.
- Provide Patient Experience Committee with monthly reports of progress to achieve year 2 CQUIN targets by Q4.

Quarter 2 Targets are outlined below

- Establish % of patients across the Trust aged 70 and over with a clinically coded diagnosis of dementia will have a 'This is Me' document completed. (Improvement Target)
- Maintain the level / reduce the number of patients cared for on the FMN unit who develop a pressure ulcer (grade 2 and above) whilst under our care and / or who sustain harm as a result of a fall whilst under our care

- Achieve a reduction in LOS of patients admitted to FMN unit. Baseline to be agreed Exclusions will be agreed on a case by case basis with the CCG. (Sustainability Target)
- Provide Patient Experience Committee with monthly reports of performance against CQUIN targets
- Agree target for % of staff within the organisation who have attended Dementia Friends and Dementia Champions training and produce action plan to ensure compliance.
- In line with DoH request enclosed within the "Continuing the Dementia-friendly hospitals journey" we will work with patients and their carers to introduce a formal "Partners in Care" agreement as part of the "this is me document" (Innovation Target)
- Report to be provided to Board and shared with commissioners describing progress made.
- Agree % and action plan for increasing the number of staff within the organisation who have attended Dementia Friends and Dementia Champions training

The following table provides results for the above from April to August 2015

	Apr-15	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**
Sickness (RN)	0.3	0.75	3.22	0.55	0.9
Sickness (CSW)	1.2	0.39	0.92	0.96	0.4
Specialling 1:1 (RN)	0	0	0	0	0
Specialling 1:1 (CSW)	R 11.8 U 8.4	R 1.3 U 1.0	R 15.02 U 6.6	R4.83 U3.71	R 6.71
Slips/Trips/ Falls	10	12	12	5	7
Incidents of violence/aggression	5	9	9	5	16
Readmission within 7 days - FMN Unit	1	0	1	0	1
Readmission within 30 days - patients with suspected dementia	8	19	TBC	N/A	N/A
Average LOS on FMN Unit	30.85	24.27	27.26	25	29.67
Pressure ulcers developed whilst a patient on FMN Unit	0	0	0	0	0
Relative complaints from FMN Unit	0	2	0	0	0
Permanent admissions to care homes from FMN Unit	9	3	9	8	8
Completed "This is Me" documents on FMN Unit	19	18	21	18	18
Completed "This is Me" documents across rest of the Trust	N/A	N/A	N/A	N/A	N/A
Patients where FMN Unit admission criteria not met	1	1	0	0	0

A Dementia Dashboard which includes national and local CQUIN indicators and local indicators has been constructed and reviewed by the team, minor changes have been made and has been signed off at the next Patient Experience Sub Committee. (Appendix 2)

Update on other areas of work

5.1 Dementia Education Conference April 2015

We hosted our first ever dementia education conference in April 2015. Over 50 Trust staff were joined by expert regional speakers, patients and carers to learn and share best practice and to hear the impact that high quality, compassionate staff interaction has on patients and families. The next one is planned for the 11th November 2015.

5.2 Awards and Recognition

We are proud to have recently attended the prestigious Alzheimer's Society Dementia Friendly Awards in Tower Hill, London on the 16th September. The Trust were finalists in the 'Best Dementia Friendly Organisational Initiative' category, but unfortunately did not win the award. However, giving that there were just over 300 nominations for the awards. To be one of the 26 finalists chosen was a real honour.

The day itself was an ideal opportunity to network with other likeminded people and there were a number of people who will be arranging future visits to the Forget Me Not Unit. To be seen as a leading hospital in creating dementia friendly environments and principles, shows the Trust in a wonderful light.

5.3 Early identification

As part of the current pre-operative review the team have looked at their systems and processes of patient assessment and in order to improve screening and optimisation of patients plan to include a dementia/delirium screen. Those patients who are found to have risk factors will then be highlighted to anaesthetists, their consultant, ward and where necessary the GP so that we can make the post-

operative care as appropriate to the needs of the patient as possible within the time frame of assessment to surgery.

5.4 Fundraising

We aim to continue to raise funds for dementia care at the trust. The fund has been set up this year and received over £6,000. The newly appointed charitable funds manager is working on a formal launch of the 'Dig Deep for Dementia' forget me not garden campaign in Q3 of 2015-2016 as part of the revitalised hospital charity function. The aim is to complete the work around the dementia garden adjacent to the unit.

5.5 Dementia friendly environment

We continue to share our knowledge regarding dementia friendly environments with other trusts. Recent visits to the Forget Me Not Ward from the staff at Bolton NHS FT, Salford NHS FT and Kingston hospital have facilitated exchange of ideas and best practice to enhance the hospital experience.

We have planned upgrades for ward refurbishment follow dementia friendly principles with regards to improved way finding and signage and upgrade of audio equipment in all areas.

5.6 Dementia media and promotion

Since opening the ward we have continued to build a strong media and promotional presence around the unit to maximise publicity and share the best practice across the service.

Articles and promotion have appeared in:

- Warrington Guardian – pre launch, opening and several detailed follow up articles
- Runcorn World
- Runcorn Weekly News
- Liverpool Post
- Warrington Worldwide
- BBC Radio Merseyside
- BBC North West Tonight
- Nursing Times
- Nursing Standard
- Alzheimer's Magazine
- Health Estates Journal
- Journal of Dementia Care
- Alzheimer's Research UK
- Foundation Trust Network
- Knit and Crochet Magazines (we have received twiddle muffs from as far afield as Canada)

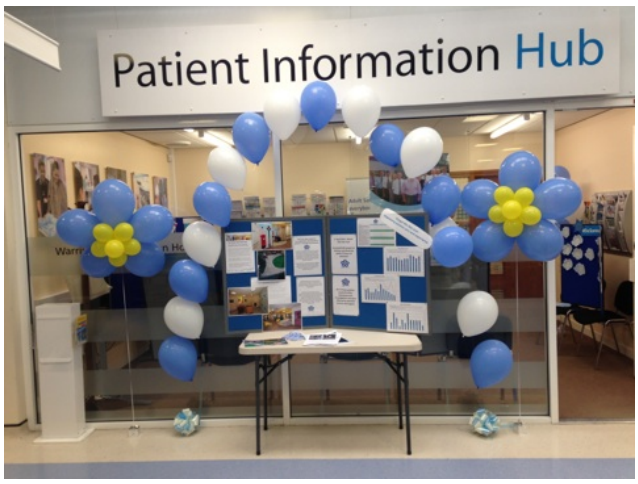
National broadcast media also have the unit on their radars. We have been approached to feature in several possible national news dementia pieces over the last few months through links built with media planning desks at MediaCity Salford.

The unit also has its own social media channel through the @forgetmenot_whh twitter handle – the first of our wards to pilot a ward specific twitter account. Training is being rolled out to staff to allow them to use the account rather than depend on communications.

5.7 Dementia Awareness Week

May 2015 saw Dementia Awareness Week take place nationally and we were delighted to take the opportunity to showcase the fantastic work that we have done at the hospitals to improve acute care for patients who have dementia. Representatives from our local Flagship Dementia Friendly School St Gregory's, Halton & Warrington Carers Association, Dementia Alliance, Alzheimer's Society and the Red Cross joined trust staff in promoting the work of the organisation and the agencies that support patients with dementia and their families.

Staff and visitors to the stand were invited to pledge to "Do something new" to help raise awareness and offer support to people with Dementia and their families.



Actress Sally Lindsay of Coronation Street, Mount Pleasant and recent Warrington based Ordinary Lies fame, joined us on the Forget Me Not unit as we celebrated our first anniversary since opening.

Sally is an ambassador for the Alzheimer's Society and spent time with patients, visitors and staff whilst with us.

The unit has helped us transform how we care for patients, reducing length of stay, falls and other incidents amongst this vulnerable group of patients.

The unit is only one part of the work we do around dementia and we also showcased the services that our estates, therapies, nursing, training and Knowledge and Evidence Service teams perform in supporting high quality dementia care.

5.8 Stakeholder events

The trust has also used its events programme to publicise the ward:

- We were very proud to be chosen to host a stand at the Foundation Trust Network Conference in November2014 – the trust bid was awarded a showcase slot at this national FT event and we shared learning from our work to over 700 delegates with 60 positive contacts from trusts across the country.
- At the Halton Carers conference in 2015, a display was manned by our senior team and this enabled us to develop effective networking and enhanced communication with carers
- The organisation actively networks and shares best practice through regular attendance at the Dementia Alliance Meetings.

6.0 Areas for continued focus & further development

- The dementia web community holds information for staff, and this area and that of the Trust website is to be an area of focus in 2015/2016
- Training figures to be improved
- Further development of the Cognitive Assessment Team since the Trust investment
- Information Technology development
- 3rd Sector collaboration
- Implementation of key carer partners in care project
- To continue to work with individual departments who have direct contact with dementia patients to ensure that all staff are dementia aware and the department dementia friendly

7.0 Recommendations

The Trust Board is requested to:-

- Note progress on achieving the 10 key principle laid out in the Dementia Strategy
- Note progress of the Dementia Steering Group (Forget Me Not) in progressing achievement of National and Local CQUINs
- Agree the contents of the Quality Dashboard
- Agree to a move from Bi-Annual to Annual reports being presented in future

Appendix 1 – Dementia Quality Dashboard

Sep-15

Dementia Dashboard 2015/16

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Improvement in the care and experience of patients with dementia. This is Part 2 of a 2 year CQUIN. Introduction - Dementia is a significant challenge for the NHS with an estimated 25% of acute beds occupied by people with Dementia, their length of stay is longer than people without dementia and they are vulnerable to experiencing harm during their stay. We have worked toward setting an effective foundation for appropriate management of patients allowing significant improvements in the quality of care and substantial savings in terms of shorter lengths of stay. This effective foundation is further supported by the successful King's Fund bid under the "Improving Environment of Care for People with Dementia" to refurbish ward B12. We wish to consolidate the work undertaken in 2014/15 to improve patient care and treatment and the support and advice offered to carers of patients where there is a diagnosis of dementia and we wish to measure the following:-

Lead	Target or Indicator		Target	Data Collection	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD
SK	GENERIC	STAFF TRAINING	Baseline 27%. Q2-42%	E-learning L and D				27%	33.52%	37.22%		41.99%									
DC		SUPPORTING CARERS	None set	Postal / telephone					19.40%	18.40%											
	Admission – The admission process was managed effectively to enhance the patient's experience.																				
DC	COMPLETED "THIS IS ME" DOCUMENT	Patients >70yrs and older nursed on the FMN unit who have a completed "This is me" document stored within their health records	90% by Q3	Built into LORENZO					86%	86%											
DC		Patients diagnosed with dementia >70yrs and older not on the FMN unit who have a completed "This is me" document stored within their health records	80% by Q4	Built into LORENZO																	
DC	DEMENTIA AND DELIRIUM - FIND, ASSESS, INVESTIGATE, REFER AND INFORM (FAIRI) National CQUIN	FARI - Find. Patients aged >=75 years to whom finding is applied following an unplanned admission	90%	BIS	97%	98%	96%	97%	97%	95%	94%										
DC		FARI - Asses Patients aged >=75 years to whom finding is applied following an unplanned admission	90%	BIS	100%	100%		100%	100%	100%	96%										
DC	DEMENTIA AND DELIRIUM - FIND, ASSESS, INVESTIGATE, REFER AND INFORM (FAIRI)	FARI - Find. Patients aged >=70 years to whom finding is applied following an unplanned admission	SET BASELINE	BIS					92%	92%	90%										
DC		FARI - Asses Patients aged >=70 years to whom finding is applied following an unplanned admission	SET BASELINE	BIS					100%	95%	100%										
DC	ADMISSION TO THE FMN UNIT	Patients admitted to unit who do not meet the admission criteria	NUMBER ONLY	MANUAL					0	0											
DC		Patients discharged from Trust who were listed for, but never admitted to, the FMN unit	NUMBER ONLY	MANUAL																	
DHam	"PARTNER IN CARE" OFFERED	In line with DoH request we will work with patients and their families to introduce a formal "Partners in Care" agreement for patients nursed on FMN unit	IMPLEMENT BY YEAR END	INCLUDE IN THIS IS ME	**ONGOING DEVELOPMENT**																
	Target or Indicator		**Target**	**Data Collection**	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD
	Treatment - High Quality, Safe Healthcare was delivered																				

DHam	PATIENT HARMS FMN UNIT	ALL FALLS (APPROVED)	TBA	DATIX	10	12	4	26	12	10											
		FALLS PER 1000 BED DAYS	TBA	DATIX																	
DHam		MODERATE, MAJOR AND CATASTROPHIC HARM FALLS (APPROVED)	TBA	DATIX	0	0	0	0	0	0											
DHam		MODERATE, MAJOR AND CATASTROPHIC HARM FALLS (UNDER REVIEW)		DATIX	0	0	0	0	0	0											
DHam		GRADE 2 HOSPITAL ACQUIRED, AVOIDABLE AND UNAVOIDABLE (APPROVED)	BASELINE Q1	DATIX	0	0	0	0	0	0											
DHam		GRADE 3 AND 4 HOSPITAL ACQUIRED (AVOIDABLE)	BASELINE Q1	DATIX	0	0	0	0	0	0											
DHam		GRADE 3 AND 4 HOSPITAL ACQUIRED (UNAVOIDABLE)	BASELINE Q1	DATIX	0	0	0	0	0	0											
DHam		GRADE 3 AND 4 HOSPITAL ACQUIRED (UNDER REVIEW)	BASELINE Q1	DATIX	0	0	0	0	0	0											
DC	LENGTH OF STAY	LENGTH OF STAY OF PATIENTS IN HOSPITAL PRIOR TO ADMISSION ONTO FMN																			
Dham	LENGTH OF STAY	REDUCTION IN AVERAGE LENGTH OF STAY OF PATIENTS NURSED ON FMN UNIT	BASELINE Q1	DATIX																	
Dham	READMISSION TO FMN	READMISSION TO FMN WITHIN 7 DAYS																			
	Discharge - Patients discharge or end of life plan is managed to ensure all their needs and the needs of their family are met																				
DC	DEMENTIA AND DELIRIUM - FIND, ASSESS, INVESTIGATE, REFER AND INFORM (FAIRI) National CQUIN	The proportion of those assessed and referred for further diagnostic advice who have a written care plan on discharge which is shared with GP, National CQUIN >=75 years.	90%	BIS							100%										
DC		The proportion of those assessed and referred for further diagnostic advice who have a written care plan on discharge which is shared with GP, Local CQUIN >=70 years	SET BASELINE	BIS							100%										
LV	PALLIATIVE CARE	% Patients appropriately placed on Amber Pathway	TBA	6 monthly Case note review																	
LV		% Patients appropriately receiving on end of life care	TBA	6 monthly Case note review																	

BOARD OF DIRECTORS

WHH/B/2015/ **198**

SUBJECT:	**Verbal Report from the Chair of the Strategic People Committee**
DATE OF MEETING:	28th October 2015
DIRECTOR:	Anita Wainwright, Non-Executive Director

- Update on Governance reporting arrangements to SPC

SUBJECT:	Human Resources / Education & Development Key Performance Indicators (KPIs) Report	
DATE OF MEETING:	28th October 2015	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Mick Curwen, Associate Director of HR	
EXECUTIVE DIRECTOR:	Roger Wilson, Interim Director of HR and OD	
LINK TO STRATEGIC OBJECTIVES:	SO2: To be the employer of choice for healthcare we deliver	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	• Positive declarations received from Divisions indicating that staff either have completed their mandatory training/PDRs or have a plan to do so • No self-declarations are outstanding • Only a few areas are declaring red and will be managed through the Performance Improvement Policy • Slight increase for in-month sickness rate and cumulative rate remains almost static. RTW rates still low • Turnover, Vacancy rates and headcount remain stabilised. • Increase in temporary staffing expenditure over budget to over £2m • On average, more starters than leavers. Almost 70 new starters in September • Recruitment times have fallen	
RECOMMENDATION:	***The Board is asked to:*** Note progress on the achievement of the KPIs and the action being taken to try and address shortfalls where appropriate.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Not Applicable

Trust Board Update

HR Performance Management Update

At the Trust Board meeting held on 2 October 2015 the focus was on PDR and Mandatory Training compliance rates within the Clinical Divisions. This focus remains given that PDR and Mandatory Training compliance are areas the CQC identified as in need of improvement.

In addition, the PDR and Mandatory training compliance is part of the minimum standard package in relation to People Management. Other areas relate to attendance management, induction and personal standards of performance and conduct. The first part of this report deals with PDR and Mandatory Training compliance and the second part covers other HR KPIs through the dashboard and the narrative which follows.

1. Background and Information for Mandatory Training

It is worth repeating from the previous meeting, that from a People Management perspective, our minimum requirements for Mandatory Training and PDRs are: -

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

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

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

  The RAG rating breakdown will be as follows:
  Green - 100% of staff have completed Mandatory Training
  Amber - 100% of staff have either completed or have a planned date for Mandatory Training
  Red - Less than 100% of staff who have completed or there is no planned date for completion of Mandatory Training or non-compliance with their plan

2. Position as at 30 September 2015

The Trust overall Clinical Division position on PDR and Mandatory Training completion (for the measures being assessed and based on self-assessment) as at 30 September 2015 is as follows: -

TRUST SUMMARY % (Excluding Corporate)

RAG Rating	PDR	H&S	M&H	Fire	SEMA	Infection Control	Safeguarding	Equality & Diversity
Red	7%	3%	2%	7%	6%	8%	9%	7%
Amber	61%	39%	69%	65%	66%	69%	64%	60%
Green	32%	58%	29%	28%	28%	23%	27%	33%
Not Submitted	0%	0%	0%	0%	0%	0%	0%	0%
Total	100%	100%	100%	100%	100%	100%	100%	100%

The summary of the above table is as follows (the figures in brackets denotes the previous month): -

- 93% (78%) of staff have had or have a plan to have their PDR completed in 15/16.
- Only 7% (4%) of staff definitely do not have a plan to have their PDR completed in 15/16
- 94% (80%) of staff have completed or have a plan to complete their mandatory training
- Only 6% (2%) of staff definitely do not have a plan to complete their mandatory training
- 0% of areas did not submit a self-assessment.

3. Further Analysis and Proposed Next Steps

- All areas have now submitted a self-assessment, so there is no necessity to manage any managers through the Performance Improvement Policy for non-compliance.
- However, for those areas which have self-declared a Red in an area, the manager for that area will be managed under the Performance Improvement Policy.
- A clear timetable for submission of self-assessments has been developed for the Divisions
- Strategic People Committee did discuss in detail the Divisional Position at its' October meeting.
- For those areas who are performing well, i.e. they have all green ratings, then they will automatically be considered for Team of the Month
- Peer to Peer validations will continue on a monthly basis.

4. Position as at 30 September 2015

Please see table below for the trust wide position.

Warrington and Halton Hosptials

Period: 2015 09

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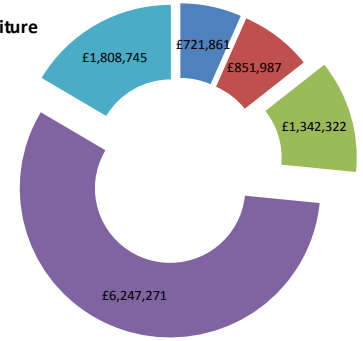
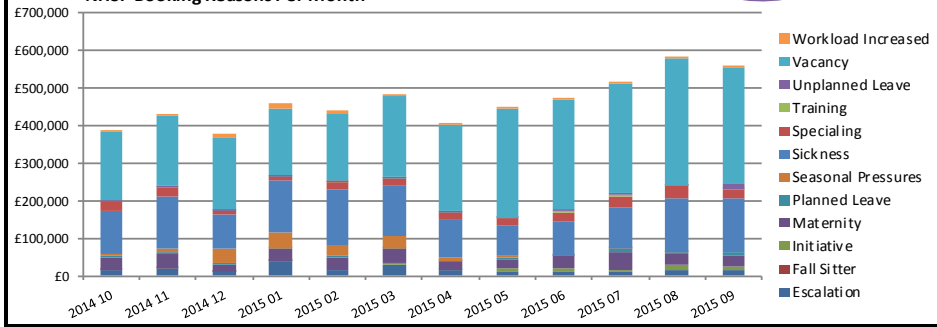
Expenditure

YTD Budget £	£78,421,343
YTD Contracted £	£69,518,397
YTD Non-Contracted £	£10,972,185
YTD Variance £	£2,069,246
Flex Labour Reliance %	13.6%

YTD Non Contracted Expenditure

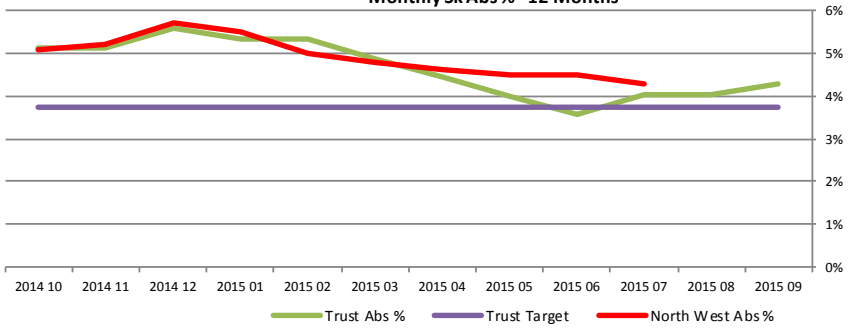


NHSP Booking Reasons Per Month

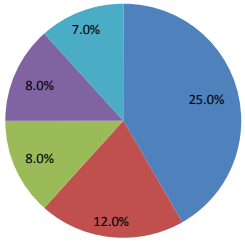


Sickness Absence

Monthly Sk Abs % - 12 Months



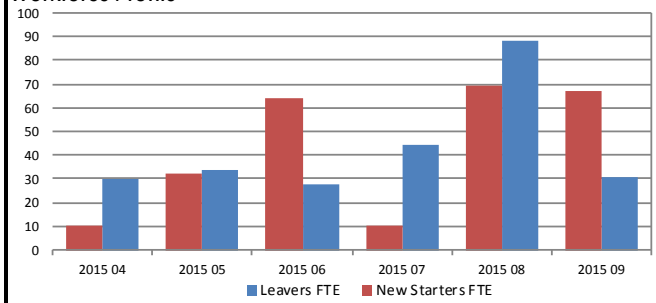
Top 5 Abs Reasons in 12 Months



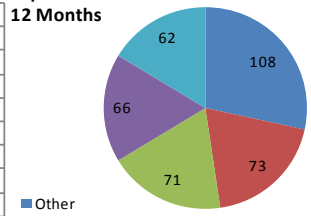
Monthly RTW %	47%	Cumulative RTW %	48%
Monthly Sk Abs %	4.3%	Trust Target	3.75%
YTD Sk Abs %	4.1%		
Long Term Sick %	2.4%	Short Term Sick %	1.9%
Calendar Days Lost	5117	No of Episodes	538
Est Monthly Cost	£311,701	Est Cumulative Cost	£4,431,855

S10 Anxiety/stress/depression/other psychiatric illnesses
S12 Other musculoskeletal problems
S11 Back Problems
S25 Gastrointestinal problems
S98 Other known causes - not elsewhere classified

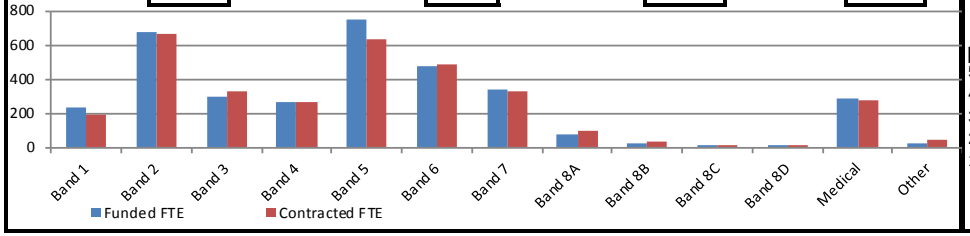
Workforce Profile



Top 5 Reasons for Leavers in 12 Months



Annual Leave (Hrs)	472,803 : 476,468	Current Mat Leave FTE	64.2	Stability	13.3%
Headcount	4044	Contracted FTE	3474.6	Funded FTE	3754.1	Vacant FTE	279.5

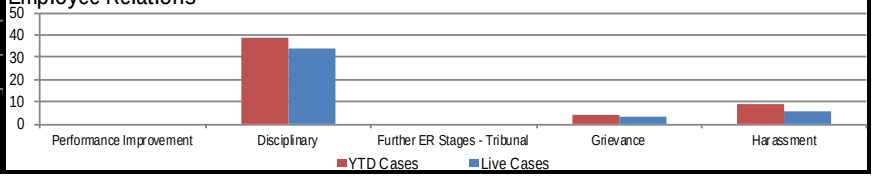


Recruitment

Overall Vacancy %	7.4%	Turnover	10.8%
Avg Monthly New Starters FTE	41.5		
Avg Monthly Leavers FTE	37.5		

Avg Recruitment Times

Employee Relations



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

Expenditure

The flexible labour reliance (Percentage of hours worked through non-contracted agreements compared to core workforce contracted hours - demonstrating our level of reliance on non-contracted hours) is, as expected, remains higher than we would want, the reasons for this can be seen throughout the Dashboard, Turnover, Vacancy Rate, Sickness and Stability.

Since the last Board meeting it has been realised that the financial position shown on the Dashboard did not include the full trust position and excluded such lines as trust reserves and PMO. Had these elements been included, the position would have shown an overall over spend of £1,683,176 rather than an under spend of £113,552. This month has seen a further deterioration to £2,069,246 with agency expenditure of £6,247,271 largely accounting for the total non-contracted labour spend of £10,972,185. Clearly the amount spent on non-contracted labour does not represent best value for money and is being addressed through a variety of interventions as follows:

- Establishment of an Agency Nurse Spend Task and Finish Group designed to reduce reliance on agency nurses and to comply with the new national Monitor requirements on nurse agency spend
- International nurse recruitment in conjunction with NHSP with a visits planned to Romania from 23 – 26 November 2015 and Spain from 1 – 4 December 2015
- Working directly in conjunction with Monitor which has resulted in an extensive Action Plan which is reviewed regularly with Monitor
- Discussion with Medacs who are our Tier 1 supplier of Medical and Dental agency staff, to ensure that framework rates are maintained at all times
- Roll out of the Allocate system for job planning commenced with awareness sessions on 19 October 2015
- Nationally there has been a cap set on agency rates which is the subject of further consultation with a view to full implementation from 1 April 2016
- Discussions are continuing with De Poel in relation to the e-Tips system which was launched in September 2015 but has been paused for Medical Locums whilst further development work is completed. The AHP Locum pilot continues to operate.

With regards to NHSP spend in September, expenditure was lower than in August 2015 which was mainly due to the reduction in vacancies as shown by the reason for the booking.

Sickness Absence

Sickness absence did increase during September to 4.3% and this did also increase the cumulative rate for April – September to 4.1% against the trust target of 3.75%. However, the trust does still compare favourably with the North West average percentage.

There was a marginal improvement with the RTW rate at 47% (43% for August) for September and 48% for the last 12 months. Return to Work interviews are a key component to reducing sickness absence and a recent MIAA audit showed that in many cases these are being undertaken but not recorded on ESR. Managers will be reminded to undertake both RTW interviews and to record this information on ESR. The

Board are reminded that this is also one of our key performance measures for acceptable performance for managers.

The main reason for sickness absence is Stress, which is consistent with previous periods. The top 10 areas where Stress is most prevalent is being addressed by Divisional Managers and the SPC will review progress at its February 2016 meeting. Early results of an initial analysis would suggest that the areas with high stress levels are also the areas with high vacancies, therefore a causal link is demonstrated.

Other Musculoskeletal Problems makes up 12% of the sickness absence in the last 12 months although many staff do access the Staff Physiotherapy service in a timely manner and report good outcomes rather than wait for referrals from their GP. In addition, we will be undertaking cross analysis with the areas most affected against their Manual Handling compliance working with HR and/or Occupational Health to understand what support can be offered.

Workforce Profile

September was an extremely good month for the number of new starters compared with leavers. Almost 70 staff commenced which was more than twice the number of leavers. Although the trust is still experiencing issues with retention and turnover, the monthly average position has improved significantly with more starters (41.5 wte) than leavers (37.5 wte).

It is clear we need to be better at recording reasons for leaving as there have been 108 people in the last 12 months who have left our employment and the reason they left us has not been recorded. This facility on the leaver form has now been removed and managers will now need to record the real reason for leaving. We are due to launch a new and improved Exit Interview which will be sent out to every leaver and should enable us to collect more information about reasons why individuals choose to leave the Trust.

An analysis of leavers is also being performed in each of clinical divisions, initial findings are suggesting that 30% of leavers have less than 2 years' service with the Trust, this is obviously a concern and it would appear greater focus needs to be on retention in all areas, with a particular focus on the areas with the worst retention rates. It was agreed at the last SPC that a special focus on retention and labour turnover would be given at the next meeting in December 2015.

The ratio of annual leave taken compared with the proportion expected has narrowed and is much closer to the target. This probably reflects the leave taken over the summer months.

Following comment at the previous Board meeting, the funded establishment compared with the staff in post has been included. This shows that the differential is 279.5 wte vacancies.

The analysis of the Staff in Post shows that the biggest differential is at Band 5 where there are significantly more vacancies that staff in post. The greatest proportion of these are nursing vacancies and the position should improve depending upon the success of the international recruitment and the trusts local rolling adverts.

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

Recruitment

There has been no change to labour turnover at 10.8% and there has been a marginal change to the vacancy rate at 10.4%.

The average time taken to recruit has fallen in Q2 ending 30 September 2015 in comparison with the previous 3 quarters. The time taken is now under 100 days whereas previously it was c 110 days and reflects the work done by the Employment Services Team and the new measures introduced to encourage managers to advertise vacancies and shortlist much quicker. A target of 80 days has been set to measure progress.

In respect of Employee Relations, the greatest amount of activity relates to disciplinary cases and these are largely concentrated within Unscheduled Care and WCSS. The number of dignity at work cases is also beginning to rise.

A focus on recruiting Staff Nurses has been in place for the last 5 months, and we have taken on 40 Staff Nurses during this period. This focus will continue, albeit the Divisions have asked it to look and work differently, to ensure we are recruiting the Staff Nurses to the areas with the highest vacancies, A&E, AMU etc. Similarly, we are working hard to address Medical Staff shortages.

As mentioned above we are working with NHS Professionals on International recruitment for staff nurses in Romania and Spain and aim to recruit 15 – 20 nurses from each country.

5. Recommendations

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

Roger Wilson
Director of Human Resources and Organisational Development
20 October 2015

BOARD OF DIRECTORS

WHH/B/2015/ **200**

SUBJECT:	**Monthly Staffing Exceptions Report**	
DATE OF MEETING:	28th October 2015	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Clare Pratt (Associate Director of Nursing – Corporate Nursing) Grace Delaney-Segar (Patient Quality and Safety Champion)	
EXECUTIVE DIRECTOR:	Karen Dawber, Director of Nursing and Governance	
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care SO3: To give our patients the best possible experience SO4: To provide sustainable local healthcare services	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework SO3/3.3 Failure to provide staff, public and regulators with assurances post Francis and Keogh review Choose an item.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides an overview of nurse staffing for June 2015. Links to the Safety Thermometer are also included to assist in triangulation of incidents with staffing levels.	
RECOMMENDATION:	***The Board is asked to:*** 1. Note the contents of this report, which describe the progress in the monitoring of complaints and to approve the actions as documented; and 2. Approve the staffing exemption Report	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

1.0 Introduction / Background

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

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

2.0 Staffing Report

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

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

3.0 Divisional Breakdown

SCHEDULED CARE DIVISION					
Ward name	**DAY Average fill rate - registered nurses / midwives (%)**	**DAY Average fill rate - care staff (%)**	**NIGHT Average fill rate - registered nurses / midwives (%)**	**NIGHT Average fill rate - care staff (%)**	**Exception Report Comments with assurance provided by Associate Directors of Nursing**
A4	79.6%	144.9%	100.0%	200.0%	CSW uplift on nights due to SAU being bedded down every night and assessment area not funded as it should close overnight. There has been an increase in unfilled shifts due to the vacancies and sickness. Twilight is roistered for SAU every night but this has not been filled. 14 beds on A4 are now medical. Increase in sickness throughout the month. Extra csw shifts required due to change of speciality. To ensure safety any gaps on erostering are requested on NHSP and escalated to agency if not covered. It is very difficult to get accurate staffing levels since 14 beds are now medical. This has had required an increase in CSW. The SAU and A4 have been running on separate establishments ready for the move of SAU

Ward name	DAY Average fill rate - registered nurses / midwives (%)	DAY Average fill rate - care staff (%)	NIGHT Average fill rate - registered nurses / midwives (%)	NIGHT Average fill rate - care staff (%)	Exception Report Comments with assurance provided by Associate Directors of Nursing
A5	96.8%	92.0%	93.3%	101.7%	Escalation beds open x4 for majority of September. one to one shifts booked on occasions. Unable to fill night shift so there is often only 2 RN. Unable to fill escalation shifts. To ensure safety any gaps on erostering are requested on NHSP and escalated to agency if not covered.
A6	78.3%	101.1%	93.3%	105.0%	Escalation beds open 2-4 occasionally in September On occasion One to one was booked for night shift. Short term sickness impacted on staffing levels throughout the month. To ensure safety any gaps on erostering are requested on NHSP and escalated to agency if not covered.
A9	89.4%	93.3%	96.7%	105.0%	There has been an increase in the requests for escalation beds throughout the month, which has maintained an element of risk when numbers are below core beds and added amount of patients from 1-4. This alters the nurse:patient ratio. Staff levels are discussed at daily bed meetings and a whole corporate approach to reducing risk and staffing areas for escalation is reviewed. There is still a significant vacancy level and this is in the most being covered by agency as NHSP trained has very poor fill rate. The acuity has been at times high due to need to bay tag and special 1:1 patients and not always covered. Nurse sensitive indicators have continued with some falls due to high risk patients and inability to cover all bay tagging. The ward has continued to utilise carers and staff to observe patients at risk.

B19	94.0%	140.4%	100.0%	96.9%	Escalation beds have been open for the majority of the 30days in September and we are over on CSW due to escalation and NOF unit. Nurse sensitive indicators have shown falls has been an issue due to the nature of high risk patients and is being monitored by the ward manager.
B4	95.7%	93.2%	95.8%	100.0%	
Ward 1 - CMTC	86.9%	78.0%	90.5%	91.1%	The variance in numbers continues to be due to staff movement to support the wards at Warrington.
ICU	83.6%	87.8%	82.3%	91.7%	18 beds funded but used flexibly depending on dependency of patients (ie. can be at full capacity at 16 beds if 10 Level 3 and 6 Level 2) 14 Q nurses required per shift but if dependency/occupancy reduced then less nurses would still provide agreed nurse:patient ratios.

UNSCHEDULED CARE DIVISION					
Ward name	**DAY Average fill rate - registered nurses / midwives (%)**	**DAY Average fill rate - care staff (%)**	**NIGHT Average fill rate - registered nurses / midwives (%)**	**NIGHT Average fill rate - care staff (%)**	**Exception Report Comments with assurance provided by Associate Directors of Nursing**
A1	94.1%	98.9%	96.7%	96.7%	AMU currently has 9 WTE Band 5 vacancies and the stand alone advert continues. International recruitment to commence in November 15. Practice educator interviews in October. The matron completes a staffing review daily at 2.15pm and staff are moved within the Division to make areas safe.
A2	96.7%	98.1%	113.7%	147.2%	

A3	94.1%	112.2%	91.4%	134.2%	Matron completes a staffing review daily at 2.15pm and staff is moved within the Division to make areas safe. 1:1 risk assessments completed as required and put out to NHSP to support.
A7	77.3%	99.6%	97.8%	100.0%	
A8	90.6%	105.7%	97.8%	111.7%	A3 continues to have an increased requirement to support one to one care of confused and wandersome patients. This has resulted in carers being booked over the current establishment.
B12	92.3%	123.6%	100.0%	127.4%	Daily ward meetings with matron to assess area re acuity and safety –support given where required. On one occasion qualified at night reduced to 2 due to greater trust pressures. Risk assessed by first and second on call support given by NNP.
B14	88.2%	96.2%	83.3%	121.7%	
B18	84.9%	93.3%	90.0%	100.7%	All falls that occurred this month resulted in no physical injury to the patient. We have been more pro-active with falls management. A list is behind the nursing station for at a glance information on who is on a falls alarm, for all the the mdt to see, also added to safety brief, No hospital acquired pressure ulcers for the month of September.
C21	98.9%	100.0%	100.0%	85.0%	
C22	96.4%	84.5%	100.0%	100.0%	extra staffing has been requested for patients requiring 1:1. observation risk assessment completed for the unit
CCU	93.5%	65.9%	96.3%	-	

WOMEN'S & CHILDREN'S SUPPORT SERVICES					
Ward name	**DAY Average fill rate - registered nurses / midwives (%)**	**DAY Average fill rate - care staff (%)**	**NIGHT Average fill rate - registered nurses / midwives (%)**	**NIGHT Average fill rate - care staff (%)**	**Exception Report Comments with assurance provided by Associate Directors of Nursing**
B11	96.4%	95.5%	97.5%	-	Appointed 2 new band 5 staff nurses commenced this month.
Neonatal Unit	83.9%	92.2%	96.9%	97.4%	External funding for a further ANNP has been secured and recruitment process is underway.
C20	117.2%	93.1%	96.8%	-	Extra staffing has been required for escalation. Regularly escalated to +6
C23	98.9%	91.7%	117.1%	100.2%	Additional RN (not Midwife) on nights to provide extra support. This is currently under review as part of the Maternity Staffing review.

4.0 Assurance provided from the Divisional Associate Directors of Nursing:

Scheduled Care -

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

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

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

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

Unscheduled Care – The Division has continued to experience high sickness levels in September 2015. Vacancies are being recruited into and this has reduced pressure somewhat. All areas were safely staffed but there are some deficits across the Division.
These were minimised by close observation and monitoring by the Matrons every day, with daily scrutiny by the Associate Director of Nursing ongoing monitoring of complaints/PALS and DATIX reports. All issues were escalated appropriately and registered nurses or carers were moved from other areas. These

decisions were made based on the best use of staff at the time, taking account of acuity / dependency and skill mix available.

There are some of the larger wards in the division that are requiring more one to one carers on top of their normal establishment to support safe care and support of patients who are confused and wandersome.

The Trust has a rolling recruitment programme which supports the recruitment to vacancies within the division.

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

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

Appendix 1

Please provide the URL to the page on your trust website where your staffing information is available

Ward name	Day				Night				Day		Night	
	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours				
Ward A4	1717.5	1367.5	931.5	1349.5	690	690	345	690	79.6%	144.9%	100.0%	200.0%
Ward A5	1380	1336	1035	952	1035	966	690	701.5	96.8%	92.0%	93.3%	101.7%
Ward A6	1481.5	1160.5	1031	1042	1035	966	690	724.5	78.3%	101.1%	93.3%	105.0%
Ward A9	1380	1234	1380	1288.1	1035	1000.5	690	724.5	89.4%	93.3%	96.7%	105.0%
Ward B19	1035	972.5	678.5	952.5	690	690	690	668.5	94.0%	140.4%	100.0%	96.9%
Ward B4 - Halton	874	836	552	514.5	552	529	322	322	95.7%	93.2%	95.8%	100.0%
Ward 1 - CMTC Treatment Centre	1978	1719.5	1196	932.5	966	874	644	586.5	86.9%	78.0%	90.5%	91.1%
Intensive Care Unit	4830	4036.5	1035	908.5	4830	3973.3	690	632.5	83.6%	87.8%	82.3%	91.7%
Ward A1	2625	2470.5	1500	1483	1890	1827	630	609	94.1%	98.9%	96.7%	96.7%
Ward A2	1380	1334	1035	1015.5	1173	1334	690	1015.5	96.7%	98.1%	113.7%	147.2%
Ward A3 O	1380	1299	1380	1548	1069.5	977.5	690	926	94.1%	112.2%	91.4%	134.2%
Ward A7	1725	1334	1380	1374	1035	1012	690	690	77.3%	99.6%	97.8%	100.0%
Ward A8	1380	1250	1380	1459	1035	1012	690	770.5	90.6%	105.7%	97.8%	111.7%
Ward B12 (Forget-me-not)	1035	955.5	1380	1705.5	690	690	713	908.5	92.3%	123.6%	100.0%	127.4%
Ward B14	1380	1217.5	1035	996	1035	862.5	690	839.5	88.2%	96.2%	83.3%	121.7%
Ward B18	1380	1171	1380	1287.5	1035	931.5	1035	1042.5	84.9%	93.3%	90.0%	100.7%
Ward C21	1035	1023.5	825	825	690	690	690	586.5	98.9%	100.0%	100.0%	85.0%
Ward C22	1069.5	1030.5	1069.5	904	690	690	690	690	96.4%	84.5%	100.0%	100.0%
Coronary Care Unit	1426	1333.5	345	227.5	1069.5	1030	0	0	93.5%	65.9%	96.3%	-
Ward B11	2100	2025	840	802.4	1488	1450.7	0	30	96.4%	95.5%	97.5%	-
Neonatal Unit	1800	1510	450	415	1285.7	1245.4	321.4	313	83.9%	92.2%	96.9%	97.4%
Ward C20	1087.5	1275	870	810	600.8	581.5	0	0	117.2%	93.1%	96.8%	-
Ward C23	1348.5	1333.5	900	825	587.4	688	290	290.7	98.9%	91.7%	117.1%	100.2%
Total	36827.5	33225	23608.5	23617	26206.9	24710.9	12580.4	13761.7				

BOARD OF DIRECTORS

WHH/B/2015/ **201**

SUBJECT:	**HENW Enhanced Monitoring of Postgraduate Trainees in medical specialities**	
DATE OF MEETING:	28th October 2015	
ACTION REQUIRED	**For Discussion**	
AUTHOR(S):	Professor Simon Constable/Dr Richard Briggs/Lesley Kinsey	
EXECUTIVE DIRECTOR:	Simon Constable, Medical Director Choose an item.	
LINK TO STRATEGIC OBJECTIVES:	SO2: To be the employer of choice for healthcare we deliver SO1: Ensure all our patients are safe in our care SO4: To provide sustainable local healthcare services	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO2/2.2 Risk that the Trust does not have the right people with the right skills ie workforce is not competent and cannot deliver as commissioned. SO4/4.3 Failure to manage key contracts appropriately resulting in contract penalties or reduction in service standards; and failure of operational processes to deliver service to agreed contract targets, outputs or standard	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	Choose an item. Choose an item. Choose an item.	
EXECUTIVE SUMMARY (KEY ISSUES):	There has been a thorough review of the medical specialties following evidence of a lack of progression in HENW Trainees due to a poor educational experience and inability to meet the requirements of their curriculum. This has also highlighted deficiencies in clinical and educational supervision of trainees and how they have been allocated and the subsequent level of training required to undertake these roles. It is considered that the current challenges are an educational manifestation of broader operational and cultural issues within the medical specialities. These are being addressed concurrently. It must also be recognised that such issues are not Trust-wide.	
RECOMMENDATION:	***The Board is asked to:*** • Consider the suite of measures proposed to mitigate the risks for trainee numbers and consultant posts/availability in service in the context of wider issues within the Division of Unscheduled Care.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

HENW Enhanced Monitoring of Postgraduate Trainees in Medical Specialities

EXECUTIVE SUMMARY

HENW allocate the numbers and grades of Medical Trainees who rotate through Warrington & Halton within the "Mersey footprint" and following Reviews undertaken by the Training Programme Director for Medicine /HENW Concerns were raised as follows:-

- Loss of Substantive Consultants (Recruitment) and quality of LOCUM Provision (Geriatric Med)
- Consultant Ward Round – NO Consultant input/direct Supervision of Trainees/Trainee time spent providing the "acute take" (AMU)
- Trainee Access to OPD Clinics – (min. 20 per year RCP Curriculum – weekly/timetabled/bleep free
- Trainee learning/development – little opportunity for progression of portfolio for Sub-Specialty/Time is spent providing Service. (Geriatric Med/AMU/Cardiology
- CMT Grades – not included in the "post take ward round" – NO Feedback (Medicine)
- Review of SUPERVSION for Trainees – Educational and Clinical Accreditation – Job Plans/Allocation/training required. (Focus on Medicine)

CONTEXT

Although there is a constant tension between service delivery and training; we are bound by our "Learning and Development Agreement" – LDA – to deliver training when in receipt **and tariff payment** of Trainees to support and complement our Medical Workforce. But this cannot be at the expense of a Trainee who is required to complete their Curricula and undertake their "Annual Review of Competence Progression" – ARCP.

The lack of opportunity to learn coupled with the "cultural and behavioural" barriers that exist can diminish their opportunities and prevent them from being successfully recruited to a higher grade post. Furthermore, and as importantly, Senior and Consultant grade posts can ultimately remain unfilled when the Trusts' reputation within the region affect our trainee numbers and our attractiveness as an Organisation.

CURRENT POSITION

This Report highlights the Trainee concerns and issues that need to be addressed within our Organisation as the risks are a loss of reputation coupled with a loss of Trainee numbers in service. This will then exacerbate our Locum appointments and further diminish opportunities for learning. Although the concerns are promptly being addressed and tracked, the Risk Register has highlighted the Actions and Control Measures in place to mitigate the level of Risk.

ACTIONS LISTED WITHIN CIRIS RISK REGISTER

This risk has been jointly monitored by both the Unscheduled Care Division and Medical Education.
*The current risk score for the overall risk is **15.***

MEASURE	TIMESCALES
Weekly SMT Meetings within Unscheduled Care Division	Weekly

Backfill with Locums	Listed as COMPLIANT and FULLY ASSURED as of 28.11.15
International Consultant Recruitment	Listed as COMPLIANT and FULLY ASSURED as of 28.11.15
Changes to Leadership Strategy	Listed as COMPLIANT and FULLY ASSURED as of 13.10.15
Medical Director 'Open Door' Policy	Listed as COMPLIANT and FULLY ASSURED as of 13.10.15
New policy – Consultant Review – patients do not leave acute medicine without having Consultant Review	Update on policy required – listed as PARTIALLY ASSURED
Locum Consultants approached as substantives	Update on action required – listed as PARTIALLY ASSURED
Consultants from outside medicine brought in as Educational Supervisors	LISTED as partially compliant and partially assured as at 13.10.15
Out-patient Clinics Task and Finish Group	1st meeting 20th August – listed as partially assured 13.10.15
Recruitment Drive In Progress	Listed as Partially Compliant 19.10.15

NEXT STEPS

Below are the Suite of Measures to deliver the improvements required:-

The MD/DME and Deputy MD are fully supportive of the Trainee improvements required and have met with Trainees to discuss and support their design of a NEW rota with the Trust doing everything possible to fill the gaps with access to the "top team" on a weekly basis.

The MD led on the "Trainee Forum" and discussed with the Trainees the delivery of a QI – "Quality Improvement Project" to devise a new approach that would enable improved knowledge of OPD Clinic Scheduling and how their rotas could support access.

There is a plan to "GO LIVE" with a NEW AMU/Acute Medicine Take Model from the 19th October which provides 13.5 hours of Consultant Physician presence – 7 Days per week- delivering 5 Consultant Sessions each day at the weekends as opposed to only 2. CCU ward rounds have been mandated to occur daily as from 10th October 2015.

A NEW Consultant Physician appointment with a focus on raising standards and supporting the Medical Specialties, with a view to reforming the way Cardiology and CCU operates.

A thorough Review has taken place to identify who is accredited to **Clinically Supervise** and **Educationally Supervise Trainees** and to allocate Trainees to those who fulfil the **HENW Standards** and have acquired the appropriate Level of Accreditation.

Speciality	Total No of Doctors	Levels of Accreditation	No's of Trainees in Service
MEDCINE	**26**	**7 ES's 12 CS's 7 UNKNOWN 11 Require ES Training for 2016.**	**12 = STs+ 7 = GPST 14 = CT's/FY2/BBT 16 = FY1's**

RECOMMENDATIONS

- ✓ ALL Consultants and SAS Doctors must have attained Clinical Supervisory Level or have NO Supervision of Medical Students or Trainees.
- ✓ ALL Consultants and SAS Doctors must have a Mandatory Section in their Annual Medical Appraisal for Training and Supervision.
- ✓ ALL Consultants and SAS Doctors who undertake the duty of Educational Supervision MUST be accredited to ES Level and this MUST be evidenced in their PA Allocation
- ✓ ALL Newly Appointed Consultants – a Mandatory Requirement that they undertake CS and ES Training in order to support the learning and development of Trainee Doctors.
- ✓ SPA Allocation for the support of Trainees and Medical Students should be scrutinised via the Job Planning process for every Consultant and SAS Doctor. SPA allocation should not be given to those who do not undertake the required duties of a CS/ES.

Our Current Figures for the Medical Workforce who are accredited at **CS Level** are as follows:-

- **CONS = (76) = 56%**
- **SAS = (34) = 77%**
  - ✓ **Clinical Supervision Training "in-house Programme" to be delivered by the DME – 5th Nov 2015**

Our Current Figures for the Medical Workforce who are accredited at **ES Level** are as follows:-

- **CONS = (45) = 33%**
- **SAS - (3) = 7%**
  - ✓ **"Supervision Matters" ES Training Programme to be delivered in-house - Jan-Apr 2016**

As part of the Suite of Measures, we prioritised the Medical Specialties and undertook a review of the Allocation Process for all the Medicine Trainees which has identified a total of **11 Doctors** who require ES Training.

Our overall figures further suggest that we need approx. 50 of the 76 Consultants who are currently only CS Level to attend a Course to achieve ES Level. – This would allow the achievement of a ratio of 2 Trainees to 1 Consultant.

As there is no Funding or Budget allocation within Medical Education to deliver Training Programmes, there remains a tension between their CPD/Study Leave and their Educational roles/CPD Commitment. Medical Education have advised Finance that a "Training Budget" for Medical Education needs to be formally identified and to be highlighted as a Service Pressure. The interim position is to coordinate another ES Training Programme - RCP Accreditation - and that monies from the Trust Central Education Budget provide funding for this Course.

CONCLUSION

The Board is asked to note the Contents of the Report and Discuss the Recommendations.

BOARD OF DIRECTORS

WHH/B/2015/ **202**

SUBJECT:	**Verbal Report from the Chair of the Audit Committee**
DATE OF MEETING:	28th October 2015
DIRECTOR:	Ian Jones, Non-Executive Director

BOARD OF DIRECTORS

WHH/B/2015/ **203**

SUBJECT:	**Verbal Report from the Chair of the Finance and Sustainability Committee**
DATE OF MEETING:	28th October 2015
DIRECTOR:	Terry Atherton, Non-Executive Director

BOARD OF DIRECTORS

FSC/2015/ **204**

SUBJECT:	**Finance Report as at 30th September 2015**	
DATE OF MEETING:	28th October 2015	
ACTION REQUIRED	**For Discussion**	
AUTHOR(S):	Steve Barrow, Deputy Director of Finance	
EXECUTIVE DIRECTOR:	Tim Barlow, Director of Finance and Commercial Development	
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care SO3: To give our patients the best possible experience SO4: To provide sustainable local healthcare services	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework SO4/4.2 Failure to: Maintain a liquidity ratio and capital servicing capacity necessary to deliver a continuity of services risk rating of at least 3 on a quarterly basis; remain a going concern at all times remain solvent; and Comply with section G6 of th SO4/4.3 Failure to manage key contracts appropriately resulting in contract penalties or reduction in service standards; and failure of operational processes to deliver service to agreed contract targets, outputs or standard	
FREEDOM OF INFORMATION STATUS (FOIA):	Whole FOIA Exemption	
FOIA EXEMPTIONS APPLIED:		
EXECUTIVE SUMMARY (KEY ISSUES):	For the period ending 30th September 2015 the Trust has recorded a cumulative deficit of £10,040k, a Financial Sustainability Risk Rating 2 and has a cash balance of £4,153k.	
RECOMMENDATION:	***The Board is asked to note the contents of the report***	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee Not applicable
	Agenda Ref.	
	Date of meeting	21st October 2015
	Summary of Outcome	Noted

FINANCE REPORT AS AT 30th SEPTEMBER 2015

1. PURPOSE

The purpose of the report is to advise the Finance and Sustainability Committee on the financial position of the Trust as at 30th September 2015 and the forecast outturn as at 31st March 2016.

2. EXECUTIVE SUMMARY

Year to date performance against key financial indicators is provided in the table below and further supplemented by the dashboards at **Appendix 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	18.0	18.5	0.5	105.8	108.0	2.2
Operating expenses	(18.4)	(19.0)	(0.6)	(109.4)	(112.6)	(3.2)
EBITDA	(0.4)	(0.5)	(0.1)	(3.6)	(4.6)	(1.0)
Non-operating income and expenses	(0.9)	(1.0)	(0.1)	(5.5)	(5.5)	0.0
I&E surplus / (deficit)	(1.3)	(1.5)	(0.2)	(9.1)	(10.1)	(1.0)
Cash balance	-	-	-	2.0	4.2	2.2
CIP target	0.5	0.9	0.4	2.1	2.2	0.1
Capital Expenditure	0.8	0.6	0.2	3.3	3.7	(0.4)
Financial Sustainability Risk Rating	-	-	-	1	2	1

3. OVERVIEW

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

Position = Surplus/(Deficit)	September £000	Year to date £000
Plan	1,305	(9,069)
Actual	1,522	(10,040)
Variance	**(217)**	**(972)**

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

Variance = Favourable/(Adverse)	September £000	Year to date £000
Operating income	515	2,164
Operating expenses	(610)	(3,166)
Non-operating income and expenses	(122)	31
Total	**(217)**	**(972)**

Cash Position

The operating performance continues to have an adverse effect on the amount of cash available to the Trust but in July cash advances were secured from Warrington CCG (£6m) and Halton CCG (£1.2m) which has allowed the Trust to clear a number of overdue creditors, meet its PDC Dividends obligation and have a cash balance at the 30th September of £4,153k. The Trust needs to manage its working balances in order to maintain a cash balance sufficient to pay creditors and repay both commissioners the cash advances over the remainder of the year.

Operating Income

Year to date operating income is £2,164k above plan due to an over recovery on other operating income (£2,101k) and NHS clinical income (£121k), partially offset by an under recovery on non NHS clinical income (£58k).

Operating Expenses

Year to date operating expenses are £3,166k above plan due to over spends on pay (£2,071k), drugs (£292k), clinical supplies (£421k) and non clinical supplies (£382k).

4. COST IMPROVEMENT PROGRAMME

The Trust has an annual savings target of £10,300k (including £0.6m balance from 14/15 and an additional £0.2m included in the revised forecast deficit 15/16) and to date the planned value of the schemes equates to £10,818k. However the value of schemes underpinned by detailed plans (evidenced by PIDs) is shown in the table below.

Narrative	In Year £000	Recurrent £000
Annual Target	10,300	10,100
Value of schemes identified	10,818	7,199
Over / (Under) Achievement against target	**518**	**(2,901)**

For the period to date the planned savings target is £2,131k, with actual savings amounting to £2,204k which results in an over achievement of £73k. The identified cost savings programme and the unidentified balance is materially weighted towards the second half of the year, so it is vital that in the first half of the year the planned savings are identified as it will become more difficult to identify and achieve any shortfalls as the year progresses.

5. CAPITAL

The annual capital programme approved by the Board and submitted to Monitor was £20.3m, with £10.0m included for the current year cost of the Estates Strategy proposal. The funding of the programme was a combination of internally generated depreciation (£6.8m) and a planned capital loan (£13.5m) from the Department of Health.

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

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

The position below reflects the revision to the capital programme and to date the Trust has spent £3.7m against the budget of £3.3m, which is due to the fact that a number of schemes have started earlier than planned.

Category	**Annual Budget £m**	**Budget to date £m**	**Actual to date £m**	**Variance to date £m**
Estates	5.2	1.1	1.1	0
IM&T	3.5	1.5	1.9	(0.4)
Medical Equipment	2.2	0.7	0.7	0
Total	**10.9**	**3.3**	**3.7**	**(0.4)**

6. CASH FLOW

The cash balance is £4,153k which is £2,150k above the planned cash balance of £2,003k, with the monthly movements summarised in the table below.

Cash balance movement	**£000**
Opening balance as at 1st September	6,608
In month deficit	(1,522)
Non cash flows in surplus/(deficit)	1,027
Decrease in trade receivables (debtors)	1,591
Decrease in trade payables (creditors)	(3,111)
Capital expenditure	(570)
PDC Dividend payment	(2,181)
Other working capital movements	2,311
Closing balance as at 30th September	**4,153**

The current balance equates to circa 7 days operational cash but as at 30th September the value of trade payables stands at £7.6m, although this is partially covered by the value of trade receivables which stands at £4.7m. Under the financial sustainability risk rating the liquidity metric is -27.0 days which results in a score of 1.

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

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

Cash balance movement	**October £000**	**November £000**	**December £000**
Opening balance	4,153	2,021	2,079
In month deficit	(451)	(420)	(686)
CCG Advance / (Repayment)	(2,200)	(2,200)	(2,200)
Non cash flows in surplus/(deficit)	996	995	994
Movement in receivables (debtors)	(900)	375	450
Movement in payables (creditors)	(442)	(768)	(2,700)
Capital expenditure	(1,099)	(949)	(1,016)
PDC Dividends	0	0	0
Drawdown of loans	0	1,200	3,300
Other working capital movements	1,964	1,825	1,949
Closing balance	**2,021**	**2,079**	**2,170**

The operating performance continues to have an adverse effect on the cash position and creditor payments, with performance against the non NHS Better Payment Practice Code (BPPC) at 26% in the month (25% year to date). This low level of compliance and performance will continue until there is an improvement in the operating position and the resultant cash position.

7. STATEMENT OF FINANCIAL POSITION

Non current assets have decreased by £85k in the month, as the capex spend is lower than the depreciation charge.

Current assets have decreased by £4,404k in the month mainly due to the decrease in receivables, accrued income and cash.

Current liabilities have decreased by £2,985k in the month mainly due to the decrease in payables and the PDC creditor, partially offset by an increase in accruals.

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

8. LOAN APPLICATION

The Trust has secured an interim revolving working capital facility of £11.6m. In addition, Monitor has applied to the Department of Health (via the Independent Trust Financing Facility) for a revenue loan (£14.2m) and capital loan (£4.1m). The application will be submitted to the Department of Health week commencing 26th October although Monitor are unable to provide a date of approval.

The Trust has submitted all relevant documents to Monitor (cash flow forecast, direct debate mandates, boards resolutions) and once approved the first drawn down will be on Monday 16th November (it is typically the Monday preceding the 18th of the month).

The Board approved the suite of financial documents that supported the loan facilities at the meeting held 3rd July 2015 and authorized the Director of Finance or Chief Executive to execute the financial documents on behalf of the Trust. No further action is required by the Board unless there is an increase in the amount of the loan or there are significant changes to the terms and conditions.

9. RISK AND FORECAST OUTTURN

For the period ending 30th September the Trust has recorded a deficit of £10,040k, which is £972k worse than the planned deficit of £9,069k.

The Trust has submitted a revised deficit of £14.2m which is in line with the deficit included in the letter from Monitor dated 3rd August 2015, which is an improvement of £0.8m from the original plan. This increase is heavily predicated on the achievement of an increased cost savings target which now stands at £10.3m, an increase of £0.2m.

The position remains extremely challenging, so it is important the trust focuses on the financial risks to ensure the deficit is reduced to at least £14.2m, namely:

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

Tim Barlow
Director of Finance & Commercial Development
22nd October 2015

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Financial headlines as at 30th September 2015

Key Financial Metrics	Month			Year to date		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income	17,980	18,495	515	105,842	108,006	2,164
Operating Expenditure	-18,371	-18,981	-610	-109,427	-112,593	-3,166
EBITDA	**-391**	**-486**	**-95**	**-3,585**	**-4,587**	**-1,002**
Financing Costs	-914	-1,036	-122	-5,484	-5,453	31
Net Surplus / (Deficit)	**-1,305**	**-1,522**	**-217**	**-9,069**	**-10,040**	**-972**
Continuity of Services Risk Rating				1	2	1
Capital Expenditure	753	570	-183	3,316	3,719	403
Cost Savings	467	906	439	2,131	2,204	73
Cash Balance				2,003	4,153	2,150

Summary Position

The in month position is an actual deficit of £1,522k which is £217k worse than the planned deficit of £1,305k.

The year to date position is an actual deficit of £10,040k which is £972k worse than the planned deficit of £9,069k.

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

Year to date income is £2,164k above plan mainly due to an over recovery on other operating income, partially offset by an under recovery on NHS and non NHS clinical income. Year to date expenditure is £3,166k above plan due to overspends on pay, drugs, clinical supplies and non clinical supplies. Year to date non operating income and expenditure is £31k below plan mainly due to an underspend on depreciation.

Key Variances on year to date position

Operating Income	
NHS Clinical Income	£121k above plan.
Non NHS Clinical income	£58k below plan.
Other Operating Income	£2,101k above plan.
Total	**£2,164k above plan**
Operating Expenditure	
Pay	£2,071k above plan.
Drugs	£292k above plan.
Clinical Supplies	£421k above plan.
Non Clinical Supplies	£382k above plan.
Total	**£3,166k above plan.**
Non operating income and expenses	
Profit on sale of fixed assets	£38k above plan.
Net Interest	£6k above plan.
Depreciation	£117k below plan.
PDC Dividends	£118k above plan.
Total	**£31k below plan.**
Capital expenditure	£403k above plan.
Cost Savings	£73k above plan.
Cash balance	£2,150k above plan.

Other matters to be brought to the attention of the Board

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

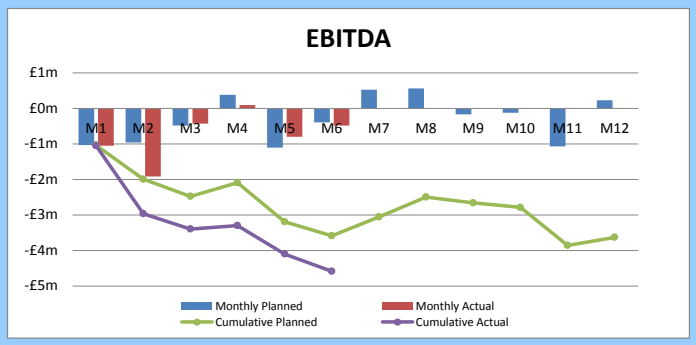
On the 12th August the Trust was placed in breach of it's licence with Monitor and therefore agreed to a number of Enforcement Undertakings which have resulted in the Trust forecasting a revised 15/16 deficit of £14.2m.

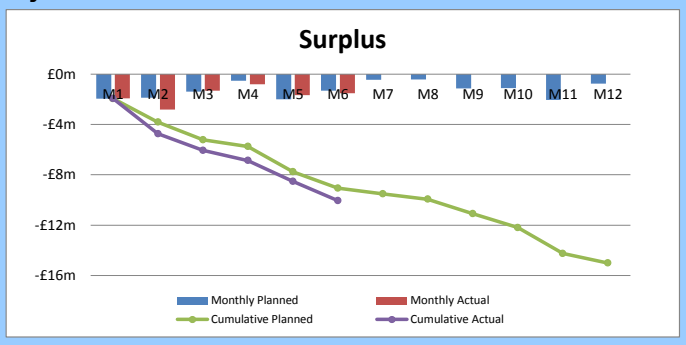
As part of the Enforcement Undertakings the Trust is required to submit an initial 16/17 financial plan by 30th November that with all actions that are reasonably possible, seeks to minimise the deficit and in addition to seek to move to a breakeven position.

Warrington & Halton Hospitals NHS Foundation Trust

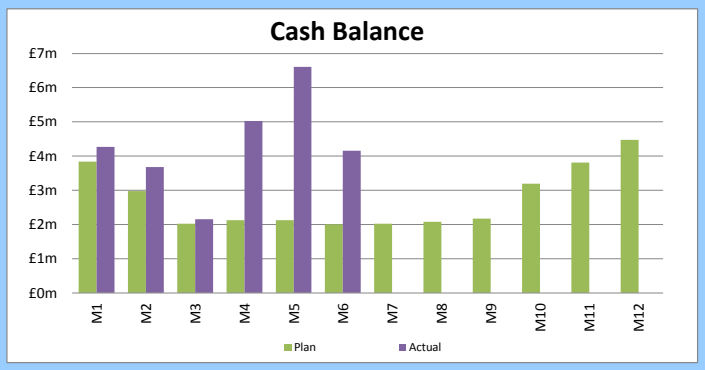
Finance Dashboard as at 30th September 2015 (Part A)

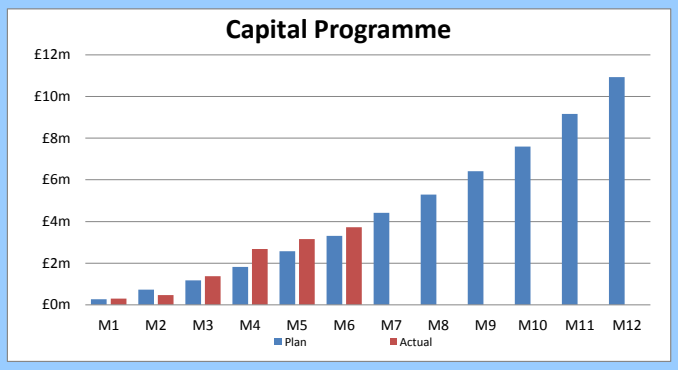
Profitability



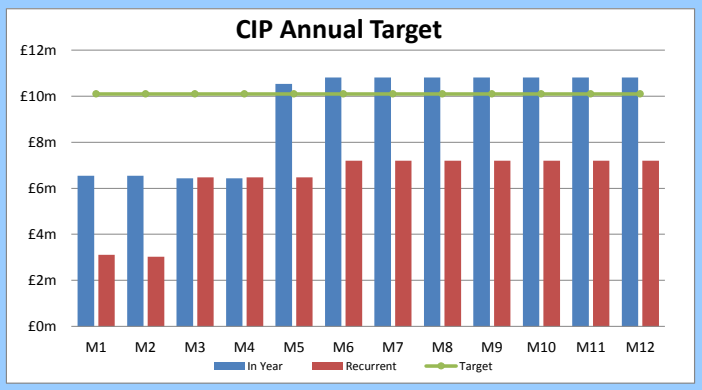


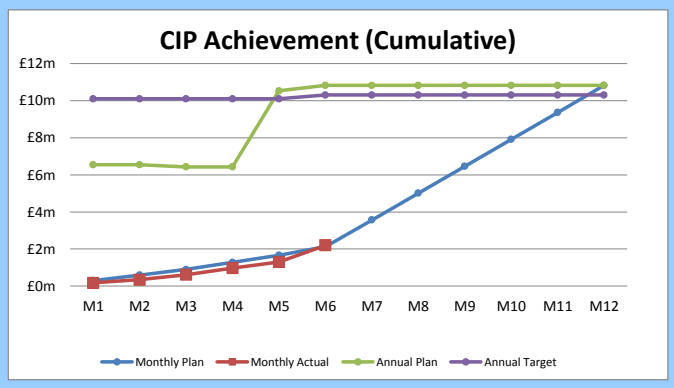
Cash and Investment





Cost Improvement Analysis





Divisional Position (net divisional income and expenditure)

Division	Annual Budget £000	Budget in month £000	Actual in month £000	Variance in month £000	Variance in month %	Budget to date £000	Actual to date £000	Variance to date £000	Variance date %
Clinical									
Scheduled Care	56,355	4,802	4,772	30	0.6	28,643	28,888	-245	-0.9
Unscheduled Care	45,238	3,946	4,189	-243	-6.1	23,404	24,553	-1,149	-4.9
Womens Children & Support Services	58,301	5,078	5,072	7	0.1	30,608	30,574	34	0.1
Corporate									
Operations - Central	489	41	40	0	0.8	245	174	71	28.9
Operations - Estates	7,440	554	568	-13	-2.4	3,516	3,538	-22	-0.6
Operations - Facilities	7,847	653	661	-8	-1.2	3,928	3,776	152	3.9
Finance	12,940	1,107	1,086	21	1.9	6,482	6,355	128	2.0
HR & OD	4,140	346	357	-12	-3.4	2,058	1,954	104	5.1
Information Technology	4,009	338	403	-65	-19.2	2,041	1,974	67	3.3
Nursing & Governance	2,931	247	246	0	0.2	1,443	1,410	33	2.3
Research & Development	37	2	4	-1	-43.3	17	19	-2	-10.4
Strategy, Partnerships & Comms	621	54	60	-6	-11.3	328	334	-6	-1.9
Trust Executive	2,091	163	199	-35	-21.7	1,113	1,192	-79	-7.1
Total	**202,440**	**17,331**	**17,656**	**-325**	**-1.9**	**103,827**	**104,741**	**-914**	**-0.9**

Positive variance = underspend, negative variance = overspend.

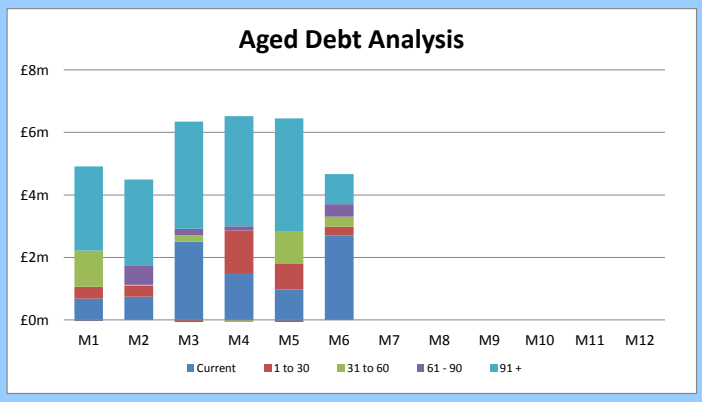
Financial Sustainability Risk Rating

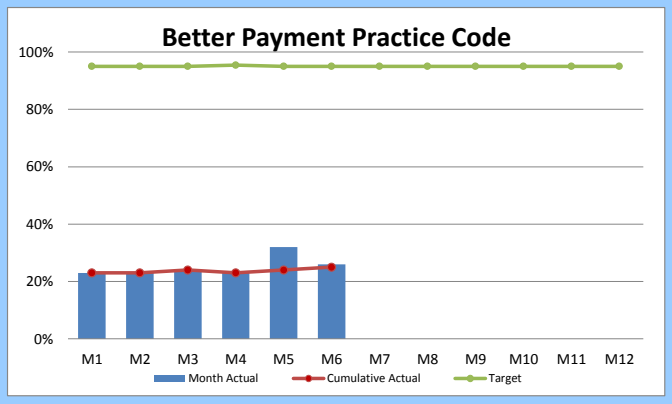
Financial Sustainability Risk Rating	Actual Metric	Actual Rating
Liquidity Ratio (days)	-2.1	1
Capital Servicing Capacity (times)	-27.0	1
Income & Expenditure Margin (%)	-9.3%	1
Income & Expenditure Margin as a % of plan (%)	-0.8%	3
Overall Risk Rating		**2**

Warrington & Halton Hospitals NHS Foundation Trust

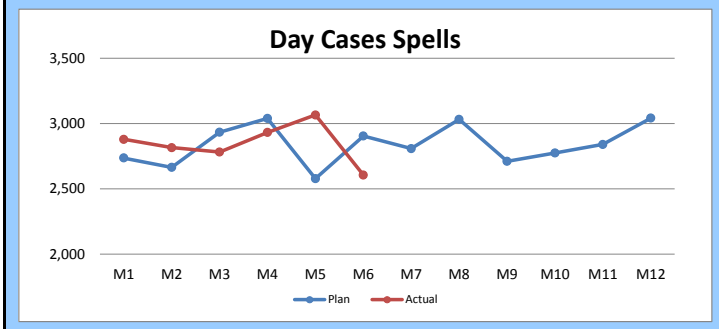
Finance Dashboard as at 30th September 2015 (Part B)

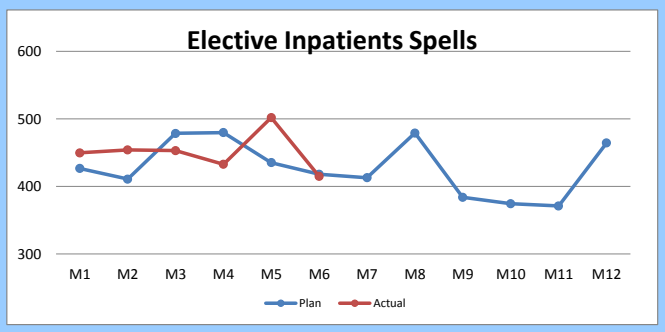
Balance Sheet and Liquidity

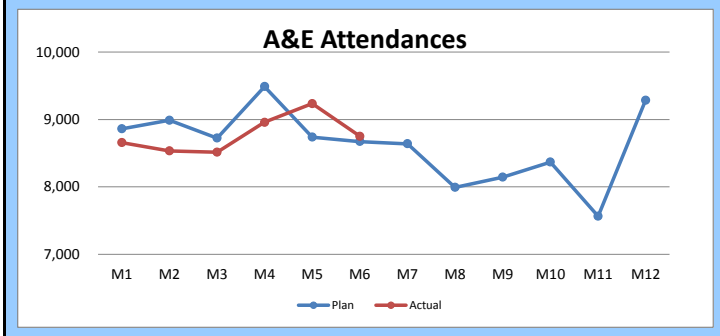


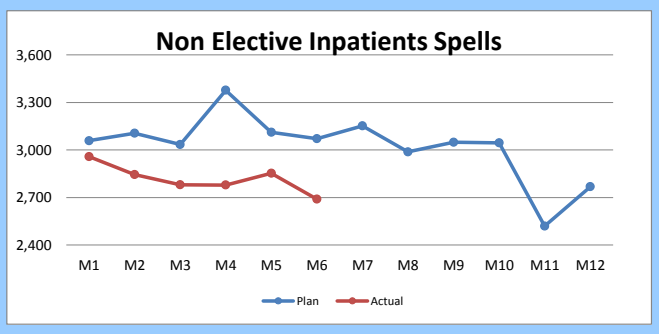


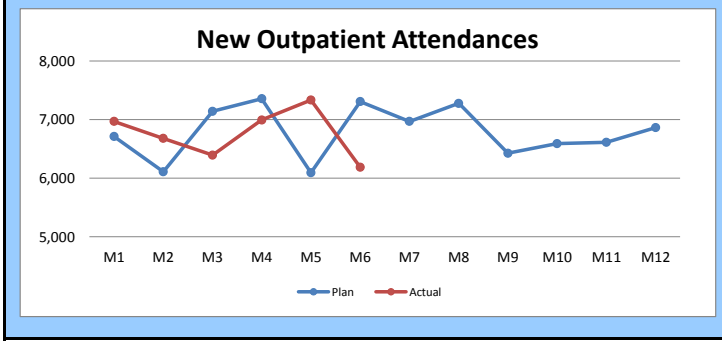
Activity Analysis

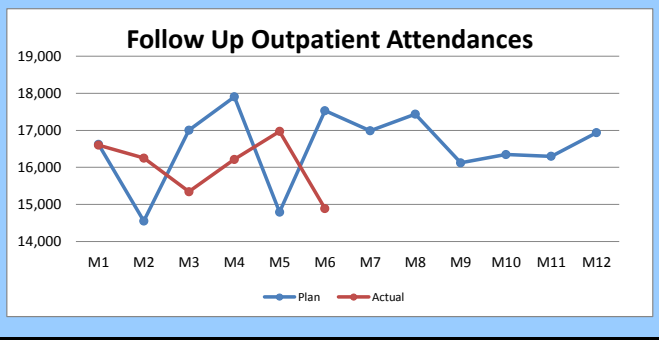












Warrington & Halton Hospitals NHS Foundation Trust **Appendix C**

Income Statement, Activity Summary and Risk Ratings as at 30th September 2015

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	3,157	3,169	12	18,408	18,903	494	37,608	39,281	1,673
Elective Excess Bed Days	20	14	-6	115	83	-32	232	201	-31
Non Elective Spells	4,429	4,259	-170	27,085	25,310	-1,775	54,067	50,210	-3,857
Non Elective Excess Bed Days	279	294	15	1,651	1,597	-54	3,190	3,572	382
Outpatient Attendances	3,153	2,958	-195	17,070	17,116	47	35,068	35,235	167
Accident & Emergency Attendances	878	904	27	5,276	5,627	352	10,171	10,823	652
Other Activity	4,571	5,072	501	27,294	28,383	1,089	55,023	59,121	4,098
Sub total	**16,486**	**16,670**	**183**	**96,900**	**97,021**	**121**	**195,359**	**198,443**	**3,084**
Non Mandatory / Non Protected Income									
Private Patients	9	7	-2	53	72	19	106	104	-2
Other non protected	107	106	-1	642	565	-77	1,284	1,175	-109
Sub total	**116**	**113**	**-3**	**695**	**637**	**-58**	**2,204**	**1,279**	**-111**
Other Operating Income									
Training & Education	588	558	-30	3,528	3,513	-15	7,056	7,080	24
Donations and Grants	0	0	0	0	0	0	0	0	0
Miscellaneous Income	790	1,154	364	4,719	6,835	2,116	9,475	12,737	3,262
Sub total	**1,378**	**1,712**	**334**	**8,247**	**10,348**	**2,101**	**16,532**	**19,817**	**3,285**
Total Operating Income	**17,980**	**18,495**	**515**	**105,842**	**108,006**	**2,164**	**213,281**	**219,539**	**6,258**
Operating Expenses									
Employee Benefit Expenses (Pay)	-13,183	-13,568	-385	-78,418	-80,489	-2,071	-155,274	-160,227	-4,953
Drugs	-1,148	-1,253	-105	-6,913	-7,205	-292	-13,802	-14,619	-817
Clinical Supplies and Services	-1,633	-1,629	4	-9,726	-10,148	-421	-19,530	-20,142	-612
Non Clinical Supplies	-2,407	-2,531	-124	-14,369	-14,751	-382	-28,304	-27,495	809
Total Operating Expenses	**-18,371**	**-18,981**	**-610**	**-109,427**	**-112,593**	**-3,166**	**-216,910**	**-222,483**	**-5,573**
Surplus / (Deficit) from Operations (EBITDA)	**-391**	**-486**	**-95**	**-3,585**	**-4,587**	**-1,002**	**-3,629**	**-2,944**	**685**
Non Operating Income and Expenses									
Profit / (Loss) on disposal of assets	0	-7	-7	0	38	38	0	0	0
Interest Income	3	2	-2	20	12	-8	40	23	-17
Interest Expenses	-4	-4	0	-24	-22	2	-451	-312	139
Depreciation	-569	-565	5	-3,417	-3,300	117	-6,834	-6,734	100
PDC Dividends	-344	-462	-118	-2,063	-2,181	-118	-4,126	-4,233	-107
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	**-914**	**-1,036**	**-122**	**-5,484**	**-5,453**	**31**	**-11,371**	**-11,256**	**115**
Surplus / (Deficit)	**-1,305**	**-1,522**	**-217**	**-9,069**	**-10,040**	**-972**	**-15,000**	**-14,200**	**800**
Activity Summary	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**
	£73k above plan.								
Elective Spells	3,421	3,329	-92	19,604	19,787	182	39,201	40,249	1,048
Elective Excess Bed Days	91	64	-27	532	391	-141	1,068	782	-286
Non Elective Spells	3,071	2,909	-162	18,760	16,907	-1,853	36,284	32,702	-3,582
Non Elective Excess Bed Days	1,327	1,391	64	7,776	7,521	-254	15,020	16,616	1,596
Outpatient Attendances	29,759	28,514	-1,245	167,276	167,229	-47	336,500	344,328	7,828
Accident & Emergency Attendances	8,673	8,661	-12	53,471	52,649	-822	103,464	102,033	-1,431
Financial Sustainability Risk Ratings	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**
Metrics									
Capital Servicing Capacity (Times)				-1.7	-2.1	-0.4	-0.8	-0.6	0.1
Liquidity Ratio (Days)				-16.8	-27.0	-10.3	-11.5	-9.9	1.6
I&E Margin (%)				-0.1	-0.1	0.0	-0.1	-0.1	0.0
I&E Margin as % of plan (%)				0.0	0.0	0.0	0.0	0.0	0.0
Ratings									
Capital Servicing Capacity (Times)				1	1	0.0	1	1	0.0
Liquidity Ratio (Days)				1	1	0.0	2	2	0.0
I&E Margin (%)				1	1	0.0	1	1	0.0
I&E Margin as % of plan (%)				2	3	1.0	2	4	2.0
Financial Sustainability Risk Rating				**1**	**2**	**0**	**2**	**2**	**0**

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

Cash Flow Statement as at 30th September 2015

	Actual April £000's	Actual May £000's	Actual June £000's	Actual July £000's	Actual August £000's	Actual September £000's	Forecast October £000's	Forecast November £000's	Forecast December £000's	Forecast January £000's	Forecast February £000's	Forecast March £000's	Annual Position March £000's
Surplus/(deficit) after tax	**(1,936)**	**(2,811)**	**(1,313)**	**(798)**	**(1,660)**	**(1,522)**	**(451)**	**(420)**	**(686)**	**(805)**	**(1,287)**	**(511)**	**(14,200)**
Non-cash flows in operating surplus/(deficit)													
Finance (income)/charges	1	1	3	2	2	2	68	68	67	68	68	61	411
Depreciation and amortisation	543	548	536	548	561	565	2,204	572	572	572	572	573	6,734
(Gain)/loss on disposal of property plant and equipment					(45)	7						38	0
PDC dividend expense	344	344	344	344	344	462	342	342	342	342	342	341	4,233
Other increases/(decreases) to reconcile to profit/(loss) from operations	(9)	(4)	8	(9)	(10)	(17)	14	13	13	26	27	224	276
Non-cash flows in operating surplus/(deficit), Total	**879**	**889**	**891**	**885**	**852**	**1,019**	**996**	**995**	**994**	**1,008**	**1,009**	**1,237**	**11,654**
Operating Cash flows before movements in working capital	**(1,057)**	**(1,922)**	**(422)**	**87**	**(808)**	**(503)**	**545**	**575**	**308**	**203**	**(278)**	**726**	**(2,546)**
Increase/(Decrease) in working capital													
(Increase)/decrease in inventories	392	(147)	(132)	(93)	232	(433)						181	0
(Increase)/decrease in NHS Trade Receivables	1,832	526	(1,082)	(675)	136	1,707	(650)	250	250	250	250	(1,493)	1,300
(Increase)/decrease in Non NHS Trade Receivables	303	12	(658)	(280)	16	(116)	(250)	125	200	200	200	1,048	800
(Increase)/decrease in other related party receivables	(266)	292	(277)	(256)	548	194						(235)	(0)
(Increase)/decrease in other receivables	412	(63)	66	19	(3)	(22)						(409)	0
(Increase)/decrease in accrued income	(390)	(1,518)	523	405	(469)	1,232	(464)	(703)	0	(72)	867	588	0
(Increase)/decrease in prepayments	(1,302)	(960)	1,692	(51)	50	(577)	250	350	350	350	350	297	800
Increase/(decrease) in **Deferred Income** (Govt. Grants)	255	2,912	254	5,769	1,002	665						(10,857)	0
Increase/(decrease) in Current provisions	(71)	1	6	8	7	3	(20)	(20)	(20)	(20)	(20)	(92)	(240)
Increase/(decrease) in Trade Creditors	(1,475)	(80)	474	(439)	1,776	(3,111)	(442)	(768)	(3,200)	(2,374)	(3,701)	10,357	(2,984)
Increase/(decrease) in Other Creditors	(160)	73	(33)	(156)	9	79						188	(0)
Increase/(decrease) in accruals	1,402	659	(1,289)	(328)	(482)	1,346						(1,308)	(0)
Increase/(decrease) in other **Financial liabilities (borrowings)**	£73k above plan.	3	695	(49)	4	4						(722)	0
Increase/(decrease) in **Other liabilities** (VAT, Social Security and Other Taxes)	75	11	(47)	51	(133)	92						(50)	(0)
Increase/(decrease) in **Other liabilities** (charitable assets)													
Increase/(Decrease) in working capital, Total	**1,069**	**1,721**	**192**	**3,924**	**2,694**	**1,064**	**(1,576)**	**(766)**	**(2,420)**	**(1,666)**	**(2,054)**	**(2,507)**	**(323)**
Increase/(decrease) in Non-current provisions	58	12	(66)	(17)	12	12						(12)	(0)
Net cash inflow/(outflow) from operating activities	**70**	**(188)**	**(296)**	**3,994**	**1,899**	**573**	**(1,031)**	**(191)**	**(2,112)**	**(1,463)**	**(2,332)**	**(1,793)**	**(2,869)**
Net cash inflow/(outflow() from investing activities													
Property - new land, buildings or dwellings	(70)	(90)	(18)	(326)	(122)	(23)	(225)	(225)	(225)	(225)	(225)	(226)	**(2,000)**
Property - maintenance expenditure	(150)	(58)	(56)	(28)	(160)	(33)	(335)	(192)	(224)	(275)	(654)	(756)	**(2,921)**
Plant and equipment - Information Technology	(58)	4	(718)	(530)	(80)	(490)	(309)	(294)	(235)	(250)	(216)	(304)	**(3,480)**
Plant and equipment - Other	(23)	(13)	(114)	(431)	(108)	(24)	(230)	(238)	(332)	(320)	(327)	(379)	**(2,539)**
Proceeds on disposal of property, plant and equipment					78							(78)	0
Increase/(decrease) in Capital Creditors		(252)	(300)	181	80	(263)						554	(0)
Net cash inflow/(outflow() from investing activities, Total	**(301)**	**(409)**	**(1,206)**	**(1,134)**	**(312)**	**(833)**	**(1,099)**	**(949)**	**(1,016)**	**(1,070)**	**(1,422)**	**(1,189)**	**(10,940)**
Net cash inflow/(outflow) before financing	**(231)**	**(597)**	**(1,502)**	**2,860**	**1,586**	**(260)**	**(2,130)**	**(1,140)**	**(3,128)**	**(2,533)**	**(3,754)**	**(2,982)**	**(13,810)**
Net cash inflow/(outflow) from financing activities													
PDC Dividends paid						(2,181)						(2,052)	(4,233)
Interest (paid) on non-commercial loans									(78)	(78)	(78)	(78)	(312)
Interest element of finance lease rental payments - *other*	(2)	(3)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	41	0
Interest received on cash and cash equivalents	3	2	1	2	3	2	2	2	1	2	2	1	23
Drawdown of non-commercial loans	0	0	0					1,200	3,300	3,635	4,450	5,718	18,303
(Increase)/decrease in non-current receivables	(8)	0	(11)	5	0	(12)						13	(11)
Net cash inflow/(outflow) from financing activities, Total	**(7)**	**(1)**	**(14)**	**3**	**(1)**	**(2,195)**	**(2)**	**1,198**	**3,219**	**3,555**	**4,370**	**3,643**	**13,770**
Net increase/(decrease) in cash	**(238)**	**(598)**	**(1,517)**	**2,864**	**1,586**	**(2,455)**	**(2,132)**	**58**	**91**	**1,022**	**616**	**661**	**(40)**
Opening cash	**4,511**	**4,273**	**3,675**	**2,159**	**5,022**	**6,608**	**4,153**	**2,021**	**2,080**	**2,171**	**3,193**	**3,810**	**4,511**
Effect of exchange rates													
Closing cash	**4,273**	**3,675**	**2,159**	**5,022**	**6,608**	**4,153**	**2,021**	**2,080**	**2,171**	**3,193**	**3,810**	**4,471**	**4,471**

Forecast cash position as per **Original Monitor plan**	3,838	2,979	2,028	2,131	2,122	2,003	2,021	2,080	2,171	3,193	3,810	4,471
Actual cash position	4,273	3,675	2,159	5,022	6,608	4,153	2,021	2,080	2,171	3,193	3,810	4,471
Variance	**435**	**696**	**131**	**2,891**	**4,486**	**2,150**	**0**	**0**	**0**	**0**	**0**	**0**

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

Statement of Position as at 30th September 2015

Narrative	Audited position as at 31/03/15 £000	Actual Position as at 31/08/15 £000	Actual Position as at 30/09/15 £000	Monthly Movement £000	Forecast Position as at 31/03/16 £000
ASSETS					
Non Current Assets					
Intangible Assets	567	1,200	1,178	-22	865
Property Plant & Equipment	143,355	143,102	143,081	-21	146,360
Other Receivables	1,336	1,269	1,215	-53	1,336
Impairment of receivables for bad & doubtful debts	-253	-240	-228	12	-253
Total Non Current Assets	**145,005**	**145,331**	**145,245**	**-85**	**148,308**
Current Assets					
Inventories	3,312	3,059	3,492	433	3,312
NHS Trade Receivables	5,627	4,891	3,184	-1,707	4,326
Non NHS Trade Receivables	1,364	1,380	1,496	116	564
Other Related party receivables	585	544	350	-194	585
Other Receivables	1,865	1,462	1,537	75	1,864
Impairment of receivables for bad & doubtful debts	-321	-314	-330	-17	-321
Accrued Income	882	2,332	1,100	-1,232	882
Prepayments	2,498	3,068	3,645	577	1,698
Cash held in GBS Accounts	4,486	6,589	4,134	-2,455	4,446
Cash held in commercial accounts	0	0	0	0	0
Cash in hand	25	19	19	0	25
Total Current Assets	**20,323**	**23,030**	**18,627**	**-4,404**	**17,381**
Total Assets	**165,328**	**168,361**	**163,872**	**-4,489**	**165,689**
LIABILITIES					
Current Liabilities					
NHS Trade Payables	-2,351	-2,533	-776	1,757	-6,484
Non NHS Trade Payables	-8,134	-8,208	-6,853	1,354	-301
Other Payables	-1,856	-1,589	-1,667	-79	-1,853
Other Liabilities (VAT, Social Security and Other Taxes)	-2,667	-2,624	-2,717	-92	-2,667
Capital Payables	-1,599	-779	-516	263	-1,599
Accruals	-5,765	-5,727	-7,073	-1,346	-5,765
Interest payable on non commercial int bearing borrowings	0	0	0	0	0
PDC Dividend creditor	-76	-1,795	0	1,795	-76
Deferred Income	-974	-11,166	-11,831	-665	-974
Provisions	-335	-284	-287	-3	-295
Loans non commercial	0	0	0	0	0
Borrowings	-185	-332	-332	0	-185
				0	
Total Current Liabilities	**-23,942**	**-35,037**	**-32,053**	**2,985**	**-20,199**
Net Current Assets (Liabilities)	**-3,619**	**-12,007**	**-13,426**	**-1,419**	**-2,818**
Non Current Liabilities					
Loans non commercial	0	0	0	0	-18,303
Provisions	-1,395	-1,394	-1,407	-12	-1,395
Borrowings	-703	-1,159	-1,164	-4	-703
Total Non Current Liabilities	**-2,098**	**-2,554**	**-2,570**	**-17**	**-20,401**
£73k above plan.					
TOTAL ASSETS EMPLOYED	**139,288**	**130,770**	**129,249**	**-1,521**	**125,089**
TAXPAYERS AND OTHERS EQUITY					
Taxpayers Equity					
Public Dividend Capital	90,242	90,242	90,242	0	90,242
Retained Earnings prior year	3,970	3,969	3,969	0	3,970
Retained Earnings current year	0	-8,518	-10,039	-1,521	-14,200
Sub total	**94,212**	**85,693**	**84,172**	**-1,521**	**80,012**
Other Reserves					
Revaluation Reserve	45,077	45,077	45,077	0	45,077
Sub total	**45,077**	**45,077**	**45,077**	**0**	**45,077**
TOTAL TAXPAYERS AND OTHERS EQUITY	**139,289**	**130,770**	**129,249**	**-1,521**	**125,089**

BOARD OF DIRECTORS

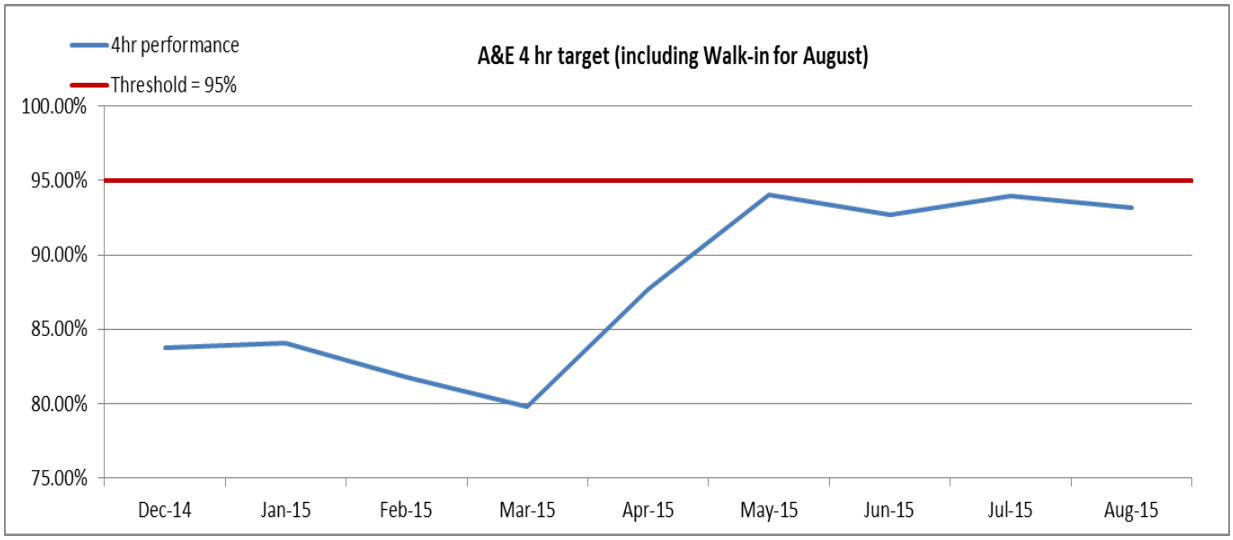
WHH/B/2015/ **205**

SUBJECT:	**CORPORATE PERFORMANCE REPORT**	
DATE OF MEETING:	28th October 2015	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Jan Ross Deputy Chief Operating Officer	
EXECUTIVE DIRECTOR:		
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework Choose an item. Choose an item. Choose an item. Choose an item.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	Choose an item. Choose an item. Choose an item.	
EXECUTIVE SUMMARY (KEY ISSUES):	This corporate report updates the Board on the progress of the Trust in relation to activity, performance and workforce targets to 30th of September 2015.	
RECOMMENDATION:	***The Board is asked to: note content***	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item. Or type here if not on list:
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

NATIONAL KEY PERFORMANCE INDICATORS

ACCIDENT AND EMERGENCY DEPARTMENT

The chart below shows the marked improvement in AED performance. The Trust is consistently delivering around 93% including Urgent Care centre activity. Whilst it is recognised that this is not over the target of 95% it is a sustained improvement following a lot of initiatives lead by the division. Further work is now ongoing with interim support looking specifically at the culture within the department as well as the process for patients requiring Acute Medical beds (AMU function). The aim of this work is to improve flow and ensure patients receive care within the right environment, therefore reducing LOS.



CLOSTRIDIUM DIFFICILE

During Q2 the Trust reported 17 cases of *Clostridium difficile*, 5 of which are initially hospital apportioned (appendix 1).

The Trust is currently on trajectory with 9 cases against the mid-year trajectory of 13 cases. A meeting is scheduled with the CCG in November to assess the 5 cases from Q2 for lapses in care.

MRSA

During Q2, 3 cases of MRSA bacteraemia have been reported, 2 of which are hospital acquired. The 2 hospital acquired cases occurred on the same ward and are linked (different antibiotic sensitivity patterns). The post infection reviews have identified:-

- Case 1 – likely contaminant
- Case 2- wound or IV device associated

The Ward has been given additional infection control training, is undergoing a Quality in Care review and is receiving additional support to correct areas identified for care improvement.

NEXT STEPS

There is an overall action plan in development for improved performance particularly against the four hour standard, it is recognised the four hour performance is a Trust wide issue and therefore lots of different work and actions are required to continue to improve including:

- Further work clinical pathways – Frailty, Ambulatory care
- Diagnostics
- Early discharges use of discharge lounge
- DTOC's
- Focus on Early assessment (Senior decision making)
- Leadership – Culture & Staff engagement
- Further work with the flow and discharge team
- Continue breach analysis – Actions
- LOS (over 21 day LOS review)

RECOMMENDATIONS

Included in the report is an explanation of the key metrics as recommended from the previous report.

CONCLUSION

The Board is asked to acknowledge the report.

APPENDIX 1

Sep-15

Monitor Access Targets & Outcomes - 2015/16

Warrington and Halton Hospitals NHS
NHS Foundation Trust

A&E figure includes walk-in activity from Aug 15

All targets are QUARTERLY

Target or Indicator		Threshold	Weighting	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4
Referral to treatment waiting time	Admitted patients	90%	N/A	92.55%	93.48%	93.14%	93.05%	92.05%	93.01%	92.74%	92.57%								
	Non-admitted patients	95%	N/A	97.53%	97.18%	98.13%	97.64%	97.71%	97.52%	97.51%	97.58%								
	Incomplete Pathways	92%	1.0	93.38%	94.30%	93.84%	93.87%	93.10%	93.49%	93.08%	93.23%								
A&E Clinical Quality	A&E Maximum waiting time of 4 hrs from arrival to admission/transfer/discharge	>=95%	1.0	87.75%	94.05%	92.68%	91.13%	93.96%	93.17%	91.69%	92.92%								
All Cancers:62-day wait for First treatment	From urgent GP referral - **post** local breach re-allocation (CCG)	85%	1.0 (Failure for either = failure against the overall target)	88.10%	86.40%	83.80%	86.10%	86.00%	85.00%	85.00%	85.33%								
	From NHS Cancer Screening Service referral - **post** local breach re-allocation	90%		100.00%	100.00%	87.50%	93.80%	100.00%	100.00%	100.00%	100.00%								
	From urgent GP referral - **pre** local breach re-allocation (Open Exeter - Monitor)	85%		88.10%	86.00%	81.00%	85.25%	85.90%	85.00%	85.00%	85.35%								
	From NHS Cancer Screening Service referral - **pre** local breach re-allocation	90%		100.00%	100.00%	87.50%	93.80%	100.00%	100.00%	100.00%	100.00%								
All Cancers:31-day wait for second or subsequent treatment	Surgery	>94%	1.0 (Failure for any of the 3 = failure against the overall target)	100.00%	100.00%	96.00%	98.67%	100.00%	100.00%	100.00%	100.00%								
	Anti Cancer Drug Treatments	>98%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%								
	Radiotherapy (not performed at this Trust)	>94%																	
All Cancers: 31-Day Wait From Diagnosis To First Treatment		>96%	1.0	100.00%	100.00%	96.00%	100.00%	100.00%	100.00%	100.00%	100.00%								
Cancer: Two Week Wait From Referral To Date First Seen	Urgent Referrals (Cancer Suspected)	>93%	1.0 (Failure for either = failure against the overall target)	93.70%	93.80%	92.00%	93.00%	95.20%	93.30%	93.03%	93.70%								
	Symptomatic Breast Patients (Cancer Not Initially Suspected)	>93%		92.80%	98.30%	89.70%	93.20%	93.30%	96.60%	95.20%	93.30%								
Clostridium Difficile - Hospital acquired **(CUMULATIVE)**	Due to lapses in care	27 (for the Yr)	1.0 **	0	1	4	4	4	4	4	4								
	Not due to lapses in care			3	7	8	8	8	8	8	8								
	Total (including: due to lapses in care, not due to lapses in care, and cases under review)			3	8	12	12	13	13	17	17								
	Under Review			0	0	0	0	1	1	5	5								
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								

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

APPENDIX 1

people with a learning disability

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

We are in breach to a number of regulated activities as a result of the CQC Inspection in January 2015 and the subsequent report to which the Trust reviewed and agreed.

An action plan is in place that is being monitored at Trust, Commissioner, NHS England (North West) and Monitor level.

Until such time that the CQC revisit the Trust and re-inspect our services and provide a subsequent report to say that we are now compliant with the Regulations (or not) the red/amber rating is this section will remain in

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

18 Weeks Referral to Treatment

Performance is measured on an aggregate (rather than specialty) basis and NHS foundation trusts are required to meet the threshold on a monthly basis.

Consequently, any failure in one month is considered to be a quarterly failure for the purposes of the Risk Assessment Framework.

Failure in any month of a quarter following two quarters' failure of the same measure represents a third successive quarter failure and should be reported via the exception reporting process.

Failure against any threshold will score 1.0, but the overall impact will be capped at 2.0

**** Clostridium Difficile**

Monitor's annual de minimis limit for cases of C-Diff is set at 12. However, Monitor may consider scoring cases of <12 if Public Health England indicates multiple outbreaks

Monitor will assess NHS foundation trusts for breaches of the C. difficile objective against their objective at each quarter using a cumulative year-to-date trajectory.

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

Assessed at: 25% of the annual centrally-set objective at quarter 1; 50% at quarter 2; 75% at quarter 3; and 100% at quarter 4 (all rounded to the nearest whole number, with any ending in 0.5 rounded up).

AED Monthly Monitor Metrics Return - Guidance

#	Metric	Description
1	A&E 4hr Wait Time Target	This is the % of patients who have been seen in Under 4hrs. It excludes Planned Follow-up patients and from August 2015 it includes the Walk-in (UCC) activty as agreed by Simon Wright with Monitor
2a	Median Time to Initial Assessment in AED	Measures the Median time from the patients Arrival Time to the Earliest time between a. Initial Assessment Time or b. Clinician First Seen Time. This is because sometimes patients are seen by Doctors straight away and therefore do not have an initial assessment time recorded separately. Again it excludes Planned Follow-Up attendances and from August 2015 it includes the Walk-in (UCC) activty as agreed by Simon Wright with Monitor
2b	95th Percentile Time to Initial Assessment in AED	Same as above but this time measures the 95th Percentile rather than the Median time
3	Meditan Time to Treatment in AED	Measures the Median time from the patients Arrival Time to the Clinician First Seen Time (or Treatment Time). Also Excludes Planned follow-up patients and includes the UCC data from August.
4	Medical Outliers on the Last Day of the Month/Quarter	Total Medical Outliers on the last day of each month, figure taken from the Bed Database that is populated from Daily Beds Report supplied by patient flow team.
5	% Discharges taking place before Midday (Average for Month/Quarter)	Works out the % of discharges taking place between 00:00hrs and 11:59am compared to the total Discharges that take place. If a patient is transferred onto the Discharge Lounge between 00:00hrs and 11:59am than they are included in the discharge before midday total - as per Simon Wright request.
6a	NHS Attributable DToC (Patients)	Number of patients who have been deemed to be a Delayed Discharge on the last Thursday of each month and the delay is attributable to the NHS - figure taken from Monthly Delayed Discharge return.
6b	NHS Attributable DToC (Days)	Total of Delayed Days for the patients who were classed as a delay at any point in the month and the delay is attributable to the NHS. Again figure taken from Monthly Delayed Discharge return.
6c	External Partner Attributable DToC (Patients)	Number of patients who have been deemed to be a Delayed Discharge on the last Thursday of each month and the delay is attributable to an External Partner (eg Social Services) - figure taken from Monthly Delayed Discharge return.
6d	External Partner Attributable DToC (Days)	Total of Delayed Days for the patients who were classed as a delay at any point in the month and the delay is attributable to an External Partner (eg Social Services). Again figure taken from Monthly Delayed Discharge return.
7	% of patients in hospital for 21 days who receive an MDT case note review	Number of patients who received an MDT case note review at Day 21 as a percentage of the patients who were still admitted on day 21.

BOARD OF DIRECTORS

WHH/B/2015/ **2017**

SUBJECT:	**Lorenzo update – Go live**
DATE OF MEETING:	28th October 2015
DIRECTOR:	Jason DaCosta, Director of IM&T

BOARD OF DIRECTORS

WHH/B/2015/ **208**

SUBJECT:	**Governance Statement Quarter 2 15/16**	
DATE OF MEETING:	28th October 2015	
ACTION REQUIRED	**For Decision**	
AUTHOR(S):	Steve Barrow, Deputy Director of Finance	
EXECUTIVE DIRECTOR:	Tim Barlow, Director of Finance and Commercial Development Choose an item.	
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care SO3: To give our patients the best possible experience SO4: To provide sustainable local healthcare services	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.2 Risk of harm through failure to comply with Care Quality Commission National core healthcare standards and maintain registration and failure to achieve minimum requirements for NHSLA Standards within maternity services and wider Trust. SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:		
EXECUTIVE SUMMARY (KEY ISSUES):		
RECOMMENDATION:	***The Board is asked to approve the governance statement for submission to Monitor***	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable Or type here if not on list:
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST

MONITOR GOVERNANCE STATEMENT

QUARTER 2 2015/16 (1st APRIL 2015 – 30th SEPTEMBER 2015)

1. BACKGROUND

In accordance with the Risk Assessment Framework published by Monitor on 27th August 2015, Boards of NHS Foundation Trusts are required to respond to the following statements (see attachment 1).

2. STATEMENTS

2.1 FINANCE STATEMENTS

- The Board anticipates that the Trust will continue to maintain a financial sustainability risk rating of at least 3 over the next 12 months.
- The Board anticipates that the Trust's capital expenditure for the remainder of the financial year will not materially differ from the amended forecast in this financial return.

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 the Risk Assessment Framework page 22 table 3) which have not already been reported (see attachment 3).

3. RECOMMENDATIONS

Finance

The 15/16 Annual Plan submitted to Monitor on 14th May 2015 concluded that the financial sustainability risk rating was a rating of 1 in Quarters 1 to 3 and a rating of 2 in Quarter 4.

The actual continuity of services risk rating for the period ending 30th September 2015 is a rating of 2, which is better than the planned rating.

The finance statement requires the Board to confirm that it anticipates it will "maintain a financial sustainability risk rating of at least 3 over the next 12 months" which therefore runs to Quarter 2 16/17.

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

Governance

In Quarter 2 all targets and indicators were achieved with the exception of A&E Clinical Quality – total time in A&E under 4 hours and is therefore reported as "not met" in the Quarter 2 return.

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
21st October 2015

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Declaration of risks against healthcare targets and indicators for 201516 by Warrington and Halton Hospitals NHS Foundation Trust

Targets and indicators as set out in the Risk Assessment Framework (RAF) - definitions per RAF Appendix A
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)			Annual Plan		Quarter 1				Quarter 2			
	Threshold or target YTD	Scoring Per Risk Assessment Framework	Risk declared	Scoring Per Risk Assessment Framework	Performance	Declaration	Comments / explanations	Scoring Per Risk Assessment Framework	Performance	Declaration	Comments / explanations	Scoring Per Risk Assessment Framework
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	1.0	No	0	93.9%	Achieved		0	93.2%	Achieved		0
A&E Clinical Quality - Total Time in A&E under 4 hours	95%	1.0	Yes	1	91.2%	Not met		1	92.9%	Not met		1
Cancer 62 Day Waits for first treatment (from urgent GP referral) - post local breach re-allocation	85%	1.0	No	0	86.2%	Achieved	Amended by RM from 84% fc	0	85.3%	Achieved		0
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - post local breach re-allocation	90%	1.0	No		100.0%	Achieved			100.0%	Achieved		
Cancer 62 Day Waits for first treatment (from urgent GP referral) - pre local breach re-allocation					85.0%				85.4%			
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - pre local breach re-allocation					100.0%				100.0%			
Cancer 31 day wait for second or subsequent treatment - surgery	94%	1.0	No	0	98.7%	Achieved		0	100.0%	Achieved		0
Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	1.0	No		100.0%	Achieved			100.0%	Achieved		
Cancer 31 day wait for second or subsequent treatment - radiotherapy	94%	1.0	N/A		0.0%	Not relevant			0.0%	Not relevant		
Cancer 31 day wait from diagnosis to first treatment	96%	1.0	No	0	100.0%	Achieved		0	100.0%	Achieved		0
Cancer 2 week (all cancers)	93%	1.0	No	0	93.0%	Achieved		0	93.7%	Achieved		0
Cancer 2 week (breast symptoms)	93%	1.0	No		93.2%	Achieved			93.3%	Achieved		
Care Programme Approach (CPA) follow up within 7 days of discharge	95%	1.0	N/A	0	0.0%	Not relevant		0	0.0%	Not relevant		0
Care Programme Approach (CPA) formal review within 12 months	95%	1.0	N/A		0.0%	Not relevant			0.0%	Not relevant		
Admissions had access to crisis resolution / home treatment teams	95%	1.0	N/A	0	0.0%	Not relevant		0	0.0%	Not relevant		0
Meeting commitment to serve new psychosis cases by early intervention teams OLD measure - use until Q1 2016/17	95%	1.0	N/A	0	0.0%	Not relevant		0	0.0%	Not relevant		0
Ambulance Category A 8 Minute Response Time - Red 1 Calls	75%	1.0	N/A	0	0.0%	Not relevant		0	0.0%	Not relevant		0
Ambulance Category A 8 Minute Response Time - Red 2 Calls	75%	1.0	N/A	0	0.0%	Not relevant		0	0.0%	Not relevant		0
Ambulance Category A 19 Minute Transportation Time	95%	1.0	N/A	0	0.0%	Not relevant		0	0.0%	Not relevant		0
C.Diff due to lapses in care (YTD)	13.5	1.0	No	0	0	Achieved		0	4	Achieved		0
Total C.Diff YTD (including: cases deemed not to be due to lapse in care and cases under review)					12				17			
C.Diff cases under review					11				5			
Minimising MH delayed transfers of care	<=7.5%	1.0	N/A	0	0.0%	Not relevant		0	0.0%	Not relevant		0
Meeting commitment to serve new psychosis cases by early intervention teams NEW measure (from Q3 2015/16)	50%				0.0%	Not relevant			0.0%	Not relevant		
Improving Access to Psychological Therapies - Patients referred within 6 weeks NEW measure (from Q4 2015/16)	75%				0.0%	Not relevant			0.0%	Not relevant		
Improving Access to Psychological Therapies - Patients referred within 18 weeks NEW measure (from Q4 2015/16)	95%				0.0%	Not relevant			0.0%	Not relevant		
Data completeness, MH: identifiers	97%	1.0	N/A	0	0.0%	Not relevant		0	0.0%	Not relevant		0
Data completeness, MH: outcomes	50%	1.0	N/A	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	N/A	Achieved		0	N/A	Achieved		0
Community care - referral to treatment information completeness	50%	1.0	N/A	0	0.0%	Not relevant		0	0.0%	Not relevant		0
Community care - referral information completeness	50%	1.0	N/A		0.0%	Not relevant			0.0%	Not relevant		
Community care - activity information completeness	50%	1.0	N/A		0.0%	Not relevant			0.0%	Not relevant		
Risk of, or actual, failure to deliver Commissioner Requested Services	N/A	Report by Exception	No		No				No			
Date of last CQC inspection	N/A		N/A		26/01/2015				26/01/2015			
CQC compliance action outstanding (as at time of submission)	N/A		No		No				Yes			
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				Yes			
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A		No		No				Yes			
Overall rating from CQC inspection (as at time of submission)	N/A		N/A		Requires improvement				Requires improvement			
CQC recommendation to place trust into Special Measures (as at time of submission)	N/A		N/A		No				No			
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A		No		No				No			
Trust has not complied with the high secure services Directorate (High Secure MH trusts only)	N/A		N/A		N/A				N/A			
Results left to complete:					0				0			
Checks Count:												
Checks left to clear:												
Service Performance Score				1				1				1

0
4
2

Click to go to index

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

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (see notes below)	Board Response
For finance, that: The board anticipates that the trust will continue to maintain a financial sustainability risk rating of at least 3 over the next 12 months.	
The Board anticipates that the trust's capital expenditure for the remainder of the financial year will not materially differ from the amended forecast in this financial return.	
For governance, that: 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, Table 3) which have not already been reported.	
Consolidated subsidiaries: Number of subsidiaries included in the finances of this return. This template should not include the results of your NHS charitable funds.	

Signed on behalf of the board of directors

Signature		Signature	
Name	Mel Pickup	Name	Tim Barlow
Capacity	Chief Executive	Capacity	Director of Finance
Date	30/10/2015	Date	30/10/2015

Responses still to complete: 5

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 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

RISK ASSESSMENT FRAMEWORK (PAGE 22, TABLE 3)

EXAMPLES OF EXCEPTION REPORTS

CONTINUITY OF SERVICES

- 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

- 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

- 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