Warrington and Halton Hospital NHS Foundation Trust
Board of Directors' meeting held in public.
Agenda

Wednesday 27th January 2016, 1300-1700 hrs.
Conference Room Warrington Hospital

16/015 13.00	**Welcome, Apologies & Declarations of Interest**	Verbal	Chairman
16/016 13.00 for 20 mins	**Patient story**	Patient's family visit	Director of Nursing & Governance
16/017	**Minutes of the previous meeting held on 25th November 2015**	Paper	Chair
16/018	**Action Plan**	Paper	Chair
16/019 13.30 for 10 mins	**Chairman's Report**	Verbal	Chair
16/020 13.40 for 15 mins	**Chief Executive's Report**	Paper	Chief Executive

Sustainability

16/021 13.55 for 10 mins	**Report from the Chair of the Finance and Sustainability Committee including draft minutes from 16/12/15**	Paper	Terry Atherton, on-Executive Director
16/022 14.05 for 20 mins	<u>Finance</u> **Finance Report as at 31 December 2015** **Turnaround checklist**	Paper to follow Paper	Director of Finance and Commercial Development Interim Director of Transformation
16/023 14.25 for 20 mins	**Corporate Performance Report as at 31 December 2015** • **A & E action plan**	Verbal Paper	Chief Operating Officer Chief Operating Officer
16/024 14.45 for 10 mins	**Risk and assurance:** • **Corporate Risk Register** • **Board assurance framework**	 Paper Paper	 Director of Nursing and Governance
14.55 break for 10 mins			
16/025 15.05 for 10 mins	**Monitor quarterly reporting** • **Q3 governance statement**	Verbal update	Director of Finance & Commercial Development
16/026 15.15 for 25 mins	**IM & T Strategy**	Paper	Director of IM & T

Quality

16/027 15.35 for 10 mins	**Report from the Chair of the Quality Committee including approved minutes from 03/11/15**	Paper	Lynne Lobley, Non-Executive Director
16/028 15.45 for 15 mins	**Quality Dashboard as at 31 December 2015**	Paper	Director of Nursing and Governance

16/029 16.00 for 15mins	**Self-assessment using NHS England mortality toolkit**	Paper	Medical Director
16/030 16.15 for 10 mins	**Q3 Infection prevention and control report**	Paper	Medical Director

People

16/031 16.25 for 10 mins	**Report from the Chair of the Strategic People Committee, including draft minutes Strategic People Committee on 07/12/15**	Paper	Anita Wainwright, Non-Executive Director
16/032 16.35 for 10 mins	**Workforce and Educational Development Key Performance Indicators as at 31 December 2015**	Paper	Director of HR & OD
16/033 16.45 for 5 mins	**Monthly Ward Staffing Report as at 31 December 2015**	Paper	Director of Nursing and Governance
16/034 16.50 for 5mins	**Charitable Funds Committee business** **i. Draft minutes from 03/12/15 (draft)** **ii. Terms of Reference** **iii. Approval of the Charitable Funds Annual Report and Accounts 2014-15.**	 Paper Paper Paper	Chair
16/035 17.00	**Any Other Business**	Verbal	Chair

Date of next meeting: Wednesday 24 February 2016

BOARD OF DIRECTORS

16/017

SUBJECT:	Draft minutes from the meeting of the Board held in public on 25 November 2015
DATE OF MEETING:	27 January 2016
DIRECTOR:	Chairman

16/017

Warrington and Halton Hospitals NHS Foundation Trust
Draft Minutes of the Board of Directors meeting held on Wednesday 25th November 2015
Trust Conference Room, Warrington Hospital

Present:

Steve McGuirk	Chairman
Mel Pickup	Chief Executive
Lynne Lobley	Non-Executive Director & Deputy Chair
Terry Atherton	Non-Executive Director
Tim Barlow	Director of Finance and Commercial Development
Mark Brearley	Interim Director of Transformation
Karen Dawber	Director of Nursing and Governance
Simon Constable	Medical Director
Anita Wainwright	Non-Executive Director
Ian Jones	Non-Executive Director
Roger Wilson	Director of Human Resources and Organisational Development
Jason DaCosta	Director of IT
Jan Ross	Acting Chief Operating Officer

In Attendance:

Colin Reid	Trust Secretary

Apologies

Mike Lynch	Non-Executive Director

	W&HHFT/TB/15/212 – Apologies & Declaration of Interest
1	The Chair opened the meeting and welcomed those attending the meeting and those governors attending as observers.
2	Apologies: as above.
3	Declarations of Interest: Lynne Lobley declared an interest in agenda item TB/15/201 - HENW Enhanced Monitoring of Postgraduate Trainees in medical specialities as a lay member of the Mersey Deanery.
4	The Chairman made a number of announcements.
5	The Chairman advised that Mike Lynch had tended his resignation as a non-executive director effective from 30 November 2015. He advised that Mike Lynch was unable to continue in post due to illness which had made him reflect on his personal circumstances. The Chairman asked that it be put on record his thanks and that of the Board for Mike Lynch's help and support whilst a non-executive director on the Board.
6	The Chairman advised that this meeting would be Tim Barlow's last meeting as an executive director of the Trust and would be moving on to another role as Director of Finance with South Manchester. The Chairman asked that it be put on record his thanks and that of the Board for Tim Barlow's work as an executive director on the Board.

7	The Chairman reported that this would be the last formal Board meeting for the Trust Secretary who would be leaving the Trust at the end of December 2015. The Chairman thanked the Trust Secretary for his stewardship of corporate governance and recoded his thanks and that of the Board for his support.
8	The Chairman advised that this would be the last Board meeting at which Jan Ross would be attending as acting Chief Operating Officer and thanked her for her support over the last few months.
	W&HHFT/TB/15/212(i) Device-related pressure ulcer project
9	The Director of Nursing and Governance introduced the task and finish group that had been set up to address the incidences of device related pressure ulcers of patients at the Trust. The Team lead by Rachel Browning Associate Director of Nursing, Scheduled Care/ Head of Midwifery gave their presentation reported that the Group had been set up to reduce the number of pressure ulcers that occur in patients when the skin covering areas break down due to pressure on that area causing an ulcer to develop resulting in pain and discomfort for patients; anxiety for families; increased length of stay; other infections; and ongoing care in the community.
10	Rachel Browning Associate Director of Nursing, Scheduled Care/ Head of Midwifery read out a patient story that related to an elderly patient that had a cast to her leg that had resulted in a pressure ulcers. The Board discussed the patient story and the actions being undertaken by the Trust to address the needs of patients that were susceptible.
11	With regard to the use of the 'Red Cast' as a visual alert the Board supported the approach and asked that it be promoted outside of the Trust as best practice. The Chairman felt that this was a simple process of identification and felt that such innovation should be communicated to improve patient safety and experience.
	W&HHFT/TB/15/213 - Minutes of Meeting
12	The minutes of the meeting held on the 28th October 2015 were approved.
	W&HHFT/TB/15/214 - Action Plan
13	All actions were either ongoing or discharged.
	W&HHFT/TB/15/215 – Chairman's Report
14	The Chairman update the board on the following matters:
15	**Submission to Monitor of the Turnaround Plan 2016/17:** The Chairman reported that the Board had considered the turnaround plan for 2016/17 and would be submitting it to Monitor on 30th November 2015.
16	**Lorenzo go live:** The Chairman congratulated the staff and IT team who had been involved in the go live of the system at the weekend, which he felt that been a huge success. There was recognition that it was still early days for the system, however the Chairman advised that the Trust should not understate the amount of work that had gone into getting the system up and running and the

	commitment of staff.
17	The Chairman asked that at a future Council of Governors meeting there needed to be an update on progress made in delivery of Lorenzo. The trust Secretary advised that given the workload of the Governor Committees it maybe something that should be presented to the Council as a whole in March 2016.
18	**Board Strategy Day:** The Chairman advised that a strategy day had been set for the Board on 16th December 2015, following which additional days would be found for Board/Governors to meet and discuss progress on the Strategic Direction of the Trust. He felt that the workshops maybe held in January and would be dependent on Monitor requirements to submit the Strategic Plan.
19	**Council of Governors:** The Chairman referred to the Council of Governors meeting that is to be held on 25th November. He advised that the meeting Warrington Health Plus would be attending to give a presentation on the Prime Ministers fund it received and the relationship with Trust. The Governors would also be receiving a presentation from Simon Constable on Mortality rates. The Chairman advised that the meeting had been extended to start at 3:30 and finish at 6:30, due to additional Q&As.
20	**Shadowing Staff:** The Chairman reported that, as part of his education of the work of the Trust he had been shadowing staff in their roles, in particular moving from ward to ward to see the work on each and how the staff were coping with the challenges they faced on a daily basis. He advised that he found the staff extremely diligent in their work and the care of patients.
21	**Junior Doctors:** The Chairman reported that action plans were currently being put in place to address the Junior Doctors potential days of action and an update would be reported under any other business.
22	**Car Parking:** The Chairman advised that he and the Chief Executive had met with Halton Borough Council Scrutiny Committee to provide an update on the issues regarding Car Parking. He advised that the meeting had gone well and that the Council were satisfied that actions being taken by the Trust to make amendments to its current procedures, signage and equipment.
	W&HHFT/TB/15/216 - Chief Executive Report
23	**Trust Secretary:** The Chief Executive advised that a substantive position of Trust Secretary had been offered to Angela Wetton following interviews that included herself, the Chairman, Ian Jones and a public Governor David Ellis. She advised that there would be a short delay between the current Trust Secretary leaving on 31 December 2015 and her appointment date which would be some time during March 2016. Arrangement had been made for an interim Trust Secretary to cover the post for that short period.
24	**Director of Community Engagement:** The Chief Executive advised that the Board had been enhanced by the appointment of Patricia McLaren as the Director of Community Engagement. Pat McLaren would be appointed from 1 December 2015 and was time limited as the Trust moves through the turbulent times ahead. Director of Community Engagement would be undertaking the stakeholder and public engagement work that used to be undertaken by Mike Barker.
25	**Consultant appointments:** The Chief Operating Officer reported on the appointment of two consultants which were critical to the Trust. She advised that she was delighted with the

	appointments and with the high calibre of the individuals. The Medical Director supported the comment advising that they were very good appointments and provided an excellent direction of travel.
26	Partnership Events: The Chief Executive reported on two events that had taken place since the last Board meeting. The first was organised with Warrington CCG and was attended by primary and secondary care consultants and GPs. She advised that it was well attended and hoped that this would continue to be developed over time. The second was the launch of 'One Halton' in the development of the Commissioners Strategy for new and enhanced configuration of services across the Halton footprint. The Chief Executive advised that there was positive support for the hospital.
27	The Chairman referred to the development of 'Devo Liverpool' and felt that as that moves forward Halton would be part of it and therefore important that the Trust continue to work and support Halton CCG and the Borough Council going forward.
28	The Board noted the verbal update from the Chief Executive.
	W&HHFT/TB/15/217 – Verbal Report from the Chair of the Strategic People Committee (SPC)
29	Anita Wainwright, Chair of the SPC advised that there had not been a meeting since her last report at the Board meeting in October. She advised that the next meeting of the SPC was 7th December 2015.
	W&HHFT/TB/15/218 – Workforce and Educational Development Key Performance Indicators - 31 October 2015
30	The Director of HR&OD presented the Workforce and Educational Development Key Performance Indicators to 31 October 2015 and highlighted the key indicators and the actions being taken.
31	With regard to Nurse agency Cap the Director of HR&OD reported that the Trust was making good progress in bringing the number in line with the cap; through the introduction of better bank arrangements and the increase in permanent staffing levels. Referring to medical staffing and the use of locums the Medical Director advised that a lot of work was going into appointing permanent staff, and highlighted the appointment of the two consultants reported earlier in the meeting.
32	Lynne Lobley referring to previous discussion on the appointment of locums to fill vacancies asked whether there was a concern with regard to patient safety. The Medical Director advised that there was no compromise to patient safety and reported that there a number of locums employed by the Trust who had been in post for over two years and had the same rights as permanent staff. These individuals followed the same processes and policies directed by the Trust and there was no risk to patients. He did however want to get to the position were all staff were permanent appointments which would support improvement in financial pressures. Lynne Lobley asked whether the dashboard could be expended to include additional reporting on the locum status at the Trust.
33	With regard to understanding why staff were leaving the Trust, the Director of HR&OD advised that exit interviews would be used to understand the reasons. He explained that these would be done at the time that a staff member puts in their resignation so that any matters could be addressed early and may support retention of staff.
34	The Chairman thanked the Director of HR&OD for his report which was noted.

	W&HHFT/TB/15/219 – (i) Six monthly Ward Staffing Report and (ii) Monthly Staffing Report
35	**(i) Six monthly Ward Staffing Report** The Director of Nursing and Governance presented the six month Ward Staffing Report and advised that she had put together the new 6 monthly report to provide the Board with more relevant information whilst a more detailed report would be presented to the SPC in the future. With regard to the recruitment of nursing staff from outside of the UK, the Director of Nursing and Governance reported that the Trust had been working with the NMC and had recruited 14 nurses from Romania. Each had been fully assessed and qualifications had been ratified.
36	Ian Jones referring to recruitment of staff from outside of the UK asked whether appropriate support vehicles were in place once they start work, referring in particular to accommodation and support around their respective wellbeing. The Director of HR&OD advised that the Trust had put in place support vehicles recognising that if they were not in place the Trust may well find that it could not recruit due to reputational issues. In response to other countries the Trust was currently looking to recruit from, the Director of Nursing and Governance advised that the Trust was also looking at recruiting from Spain.
37	The Board noted the work being done to improve bank terms and condition, which would provide a less expensive alternative to using agency nursing and sought an understanding on whether the same could be done for consultants to reduce dependence on high cost locum cover. The Director of HR&OD advised that the there was discussion across the region on whether there could be an agreed rate for visiting consultants. This was still in its infancy at the current time.
38	The Board, having reviewed the Report: 1. Authorised the Strategic People Committee to scrutinise and review the full document and report back its findings to the meeting of the Board on 27th January 2016 2. Devolved the function of scrutiny and assurance for nurse staffing to the Strategic People Committee with monthly update to the Board of Directors 3. Noted that mitigations were in place whilst awaiting full discussion in January 2016
39	**(ii) Monthly Staffing Report** The Director of Nursing and Governance presented the Monthly Ward Staffing Report for October 2015 which was noted and approved the Monthly Ward Staffing Dashboard appended to the Report.
	W&HHFT/TB/15/220 - Verbal Report from the Chair of the Finance and Sustainability Committee
40	Terry Atherton, Chair of the Finance and Sustainability Committee (FSC) provided a verbal report on the activity of the Committee. He reported that the Committee met on 17 November 2015 and had received papers set out in the work plan.
41	Terry Atherton advised that the meeting had a full agenda and received reports on the financial performance of the Trust which was disappointing, particularly as the Trust was currently delivering CIP in line with Plan. With regards to CIP, he advised that with the back loading of savings in the last 5 months of the year there was considerable challenge to deliver. This with the poor performance in activity he advised that there was a risk that the Trust may not deliver the £14.2m deficit. Terry

	Atherton further reported that poor performance in activity would also impact on the cash position and the position with regard to cash was discussed and concerns expressed at the meeting.
42	Terry Atherton advised that the Committee had also received an update on performance in A&E and had received an update on actions being taken internally to support improvement in the 4 hr target. He advised that the Committee had also received reports on Winter Planning, Service Level Reporting, Contact Performance Report and a Commercial Development Report.
43	The Chairman thanked Terry Atherton for his verbal report which was noted.
	W&HHFT/TB/15/221 – Finance Report - 31 October 2015
44	The Director of Finance and Commercial Development presented his final Finance Report for the Trust as at 31 October 2015. He reported that for the period ending 31st October 2015 the Trust had recorded a cumulative deficit of £11.3m, a cash balance of £3.8m and a Financial Sustainability Risk Rating 1 and advised that the cumulative deficit was therefore £1.7m above plan.
45	The Director of Finance and Commercial Development advised that operating performance continued to have an adverse effect on cash availability, however the cash advances in July secured from Warrington CCG (£6m) and Halton CCG (£1.2m) allowed the Trust to clear a number of overdue creditors, meet its PDC Dividends obligation and retain the cash balance. He advised that there was a requirement to manage the 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.
46	The Director of Finance and Commercial Development reported that operating income was £3.3m above plan. He explained that this was due to an over recovery on other operating income and NHS clinical income which was partially offset by an under recovery on non NHS clinical income. However operating expenses year to date was £5.0m above plan due to over spends on pay, drugs, clinical supplies and non-clinical supplies, giving the net cumulative deficit of £11.3m
47	Lynne Lobley asked what the views was of the Executive surrounding the level of maturity in using SLR by the services. The Director of Finance and Commercial Development advised that this was well understood within some services , however he hoped that with the introduction of the CBUs this would escalate maturity within service level management sue to the intention of having smaller services. The Medical Director supported the comments made by the Director of Finance and Commercial Development.
48	With regard to the first instalment of the working capital loan from the Department of Health, the Director of Finance and Commercial Development advised that this was received on the 16th November and advised on the process of drawn down and the requirement to maintain an agreed maximum cash balance.
49	The Chairman thanked the Director of Finance and Commercial Development for his report which was noted.

	W&HHFT/TB/15/222 - Corporate Performance Report - 31 October 2015
50	The Acting Chief Operating Officer presented the Corporate Performance Report – 31 October 2015 and reported that the Trust continued to achieve all targets with the exception of the A&E 4hr target. She reported that a detailed action plan was in place that incorporates all the keys issues raised through the UM report with the main changes to date being to define assessment space in both scheduled and unscheduled care and with the changes to SAU the Trust now had assessment space free at 8am every morning. AMU had also been redefined as assessment space which also ensured additional assessment space. The acting Chief Operating Officer advised that although these actions had been difficult to undertake, they had had an impact on performance and in the long term would ensure that the Trust assess and manage patients in the most appropriate place leading to correct bed allocation and a subsequent reduction in outliers and an overall reduction in Length of stay. The acting Chief Operating Officer advised that it was now important that the trust drive to maintain a sustainability A&E performance at above 90%.
51	Referring to clinician engagement the Acting Chief Operating Officer advised that medical rotas had been changed and this had resulted in some concern, however there was recognition that the changes benefited the Trust through increased flow of patients. The Medical Director advised that there was recognition that the changes although done for turnaround was also the right thing to do.
52	The Chairman thanked the acting Chief Operating Officer for her report which was noted.
	W&HHFT/TB/15/223 - Improving and sustaining cancer performance
53	The acting Chief Operating Officer report on the requirements set out by Monitor, the TDA and NHS England concerning the 62 day cancer standard. She explained that the instruction in the letter required every trust to complete an assurance statement on the eight high priority actions identified by the national Cancer Waiting Times Taskforce. The report presented was to provide the Board with an update on local compliance against eight priorities.
54	The Board reviewed and noted the action plan charts which set out the current status of the eight priority actions and subsequent key work streams in order to deliver them.
	W&HHFT/TB/15/224 - Board Assurance Framework
55	The Director of Nursing and Governance presented on behalf of the Executive Team the Board Assurance Framework and reported that it had been refreshed to take into account of the Trust strategic objectives approved in February 2015. She explained that the Executive had completed a first review of the BAF and recognise that the risk scores would require further review to take account of any impact the implementation of Lorenzo would have on each risk. The Board noted that additional risks had been identified in the People section relating to appropriate permanent Medical staffing and this required further discussion on the size of the risk score which would be undertaken by the Medical Director.
56	The Board ran through each risk and provided comment on the appropriateness or otherwise of the risk, the risk score and the gaps associated with each risk. Comments were expressed regarding what actions were being undertaken to reduce the gaps identified.
57	The Board having reviewed the BAF, confirmed that the BAF: i. covered the Trust's main activities and adequately identified the principal objectives the

	organisation was seeking to achieve; ii. adequately identified the risks to the achievement of those objectives; and iii. provided that adequate assurance systems were in place to ensure the systems of control were effective and efficient in controlling the risks identified.
	W&HHFT/TB/15/225 – Verbal Report from the Chair of the Quality Committee
58	Lynne Lobley, temporary Chair of the Quality Committee reported on the work that had been done to address the content and quality of reporting to the Quality Committee for onward reporting to the Board. She advised that in discussions these had also identified a need to provide a dashboard not only of the quality indicators but also to address how other indicators could also be reported, such as finance, under an umbrella report. Lynne Lobley advised that the team was looking at using a similar model of reporting to that used at Salford Royal.
59	Lynne Lobley reported that the Committee had also reviewed the action plan arising from the CQC inspection and was assured that the actions were deliverable to the satisfaction of the Committee and the CQC. The Committee had also received a report of delivery of CQINS and reviewed the Corporate Risk Register.
60	The Chairman thanked Lynne Lobley for her verbal report on the activity of the Quality Committee which was noted.
	W&HHFT/TB/15/226 – Quality Dashboard - 31st October 2015
61	The Director of Nursing and Governance presented the Quality Dashboard as at 31st October 2015 which was taken as read.
62	The Director of Nursing and Governance advised that the Dashboard looked to be improving month on month with regards the exception reports and advised that the PFD reported at the last meeting would be sent to the Coroner with a covering letter and action plan and advised that the Quality Committee would monitor progress of the action plan.
63	Anita Wainwright asked when the Board would see sight of the new dashboard referred to earlier in the meeting. The Director of Nursing and Governance advised that she hoped to have the first cut of the report to the Quality Committee in January and then to the Board at its meeting on 27th January 2016. It was suggested that each Committee should see sight of the new dashboard given that it brought together all indicators from the QPS framework. The Chairman also felt that given there would be a shift in the way the Board received information that the Governors should also receive training on the new indicators.
64	The Board: 1. noted that the data for a number of indicators can change month on month. This applies to mortality peer review, 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. noted progress and compliance against the key performance indicators; and 3. noted the actions planned to mitigate areas of exception

	W&HHFT/TB/15/227 - Complaints Q2 Report
65	The Director of Nursing and Governance presented the Q2 Complaints Report and explained that the report provided an overview of complaints and other feedback received by the Trust. She advised that the Trust received a total of 99 formal complaints between 1 July and 30 September 2015, which was a small reduction of 6 from Q1. The Director of Nursing and Governance advised that 513 people contacted PALS in Quarter 2; this was also a reduction from the previous quarter of 149 contacts although there had been an increase from the previous year.
66	The Director of Nursing and Governance advised that that certain elements of the complaints process that needed to be addressed, in particular she advised that there was a need to move towards more direct contact with patients and complaints and also to look at the structure and format of letters sent. The Chairman asked whether the move to CBU's would support improved engagement from the lead clinician and therefore greater accountability. The Director of Nursing and Governance advised on the complaint process and how complaints were escalated. The Medical Director explained that it was the intention to front up the most senior people in the CBU and therefore would support greater engagement at that level.
67	Referring to the graphs that provided the total number of complaints against themes, Anita Wainwright noted that the most common complaint was now treatment rather than the poor attitude of staff. The Director of Nursing and Governance advised that there had been a lot of work on supporting staff in terms of their individual approach to patients and visitors and this had resulted in the reduction in complaints in that area. The Director of Nursing and Governance advised that she would look at the reasons for the level of complaints due to treatment to see if there was an underlying issue. Lynne Lobley suggested that the Director of Nursing and Governance look to see if there was another trust that had a good record of dealing with complaints and see if there was any lessons that could be learned.
68	The Board noted the Complaints Q2 Report.
	W&HHFT/TB/15/228 - Other Board Committee Reports
69	The Board having received verbal update from the Chairs of each of the Committees, the Board noted the following Committee minutes: a) Finance and Sustainability Committee held on 21st October 2015 b) Audit Committee on 20 October 2015 c) Quality Committee on 4 August 2015
	W&HHFT/TB/15/229 - Any Other Business
70	The Director of HR&OD reported on the junior doctor's dispute and the day of action that had been called. He advised on the measures being taken by the Trust to ensure that all that all essential services were provided. The board noted the current position and supported the approach taken by the executive.
71	The Chief Executive advised that the Trust was currently in the top three of NHS employers where staff had received the flu vaccination. She advised that to date 77% of staff had received the vaccination against only 57% last year. The Chief Executive hoped that the Trust would top 80% by

	the end of the month. The Board congratulated the Occupational Health team for their hard work in raising awareness and providing the vaccination to the staff.
72	There was no further business for discussion the Chairman closed the meeting. Next Meeting: Wednesday 27th January 2016 in the Trust Conference Room.

BOARD OF DIRECTORS

16/018

SUBJECT:	Board actions from previous meetings
DATE OF MEETING:	27 January 2016
DIRECTOR:	Chairman

16/018

TRUST BOARD
ACTION PLAN – Current / Outstanding Actions as at January 16

Meeting date	Minute Reference	Action	Responsibility & Target Dates	Status
29 July 2015	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	Proposed for March 4 Board time out.

BOARD OF DIRECTORS

16/019

SUBJECT:	**Chairman's Report**
DATE OF MEETING:	27th January 2016
DIRECTOR:	Chairman

BOARD OF DIRECTORS

16/020

SUBJECT:	Chief Executive Report
DATE OF MEETING:	27th January 2016
EXECUTIVE DIRECTOR:	Chief Executive Letter from NHS Improvement re 15-16 outturn and 16-17 planning. Letter from NHS Improvement & CQC re regulatory collaboration. Letter from Monitor re agency frameworks and caps Letter from CEO NHS Improvement. HENW/GMC Enhanced Monitoring Annual Assessment Visit (Medical Director)

Monitor
Making the health sector work for patients

tda Trust Development Authority
Quality. Delivery. Sustainability.

NHS Improvement
(Monitor and the NHS Trust Development Authority)

Melany Pickup
Chief Executive
And
Mark Brearley
Interim Finance Director
Warrington and Halton Hospitals NHS Foundation Trust

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15 January 2016

2015/16 Outturn and 2016/17 Plan including Sustainability and Transformation Fund

As announced in the recent Spending Review, the government has committed to provide an additional £8.4 billion real-terms funding for the NHS by 2020/21. The increase in funding available for 2016/17 totals £3.8 billion in real terms, a £5.4 billion cash increase. It includes a £1.8 billion Sustainability and Transformation Fund (S&T Fund) for the provider sector in 2016/17, to be targeted primarily at providers of emergency care. This is a good settlement for the NHS in times of public spending constraint when the majority of government departments are facing real-terms funding reductions.

However, this settlement is dependent on the NHS provider sector delivering a deficit of not more than £1.8 billion in 2015/16 and breaking even in 2016/17 after application of the fund. To realise this settlement, this letter sets out what your board must urgently do during the remainder of the 2015/16 financial year.

2016/17 Financial framework and planning

On 22 December 2015 we published *Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21.* This sets out the steps to help local organisations deliver a sustainable, transformed health service and improve quality of care, wellbeing and NHS finances. The planning guidance includes details of the operational planning approach for the next financial year and sets out a pragmatic approach to tariff setting and business rules, with the aim of supporting system stability and recovery in 2016/17. The key details of this package, which is favourable for most NHS providers, are set out in Appendix 1.

In addition, the planning guidance introduces the £1.8 billion S&T Fund for 2016/17. The fund is to support providers move to a sustainable financial footing. It will be primarily allocated to providers of emergency care that have been under the greatest financial

pressure, although it will include an element to support providers achieve overall sustainability by driving maximum efficiencies. The fund will be deployed in a way that creates a balanced aggregate financial position in the NHS trust and NHS foundation trust sector in 2016/17. Payments will be made by commissioners, but approved by NHS Improvement. The fund replaces the need for the current scale of direct Department of Health (DH) cash funding for providers. Details of the fund and of eligibility to access it are attached in Appendix 2.

This additional funding is conditional on the NHS provider sector breaking even in 2016/17. To ensure this happens, every NHS trust and NHS foundation trust will have to deliver an agreed financial control total for 2016/17. This will be a core part of the new financial oversight regime that NHS Improvement will put in place.

An impact assessment model has been developed by NHS Improvement that models a range of known factors at an individual provider level. The outcome of this work will be used to allocate emergency care providers with an indicative payment from the S&T Fund and all providers with a control total for 2016/17. The key assumptions and the detail for your trust are attached in Appendix 3.

The offer of payment to your trust from the S&T Fund, explained in Appendix 3 and to be made by your lead commissioner, is for a limited period only. Please confirm by **8 February 2016** that your trust accepts this offer and in doing so agrees to the conditions. It is then our expectation that the operational plans you submit in February and April will be consistent with, or better than, the control total outlined.

The NHS settlement for 2016/17 relies on tight financial management of the capital budget. We will need to work very closely with providers to develop a capital framework which enables them to operate within the resource available. Providers should develop their capital plans for 8 February 2016, distinguishing essential expenditure from strategic investments. This should prepare providers for restrictions to both access to external finance and deployment of existing cash reserves to ensure the NHS does not exceed its capital budget. Providers that have agreed local capital to revenue transfers for 2015/16 will not be disadvantaged by these agreements in 2016/17.

2015/16 Outturn

As you will be aware, the scale of what we need to do in the future depends on how well we end this financial year. Collective urgent action is required now to ensure we contain the aggregate provider deficit position to within a £1.8 billion control total in 2015/16.

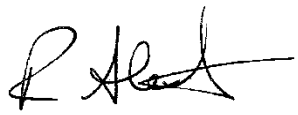
To limit the scale of the financial distress that will be carried forward into 2016/17, we would like your continued commitment to take the actions necessary to improve your current year financial position, while ensuring that safe care is delivered. We also ask you to review your plan for the remainder of 2015/16, focusing particularly on the areas

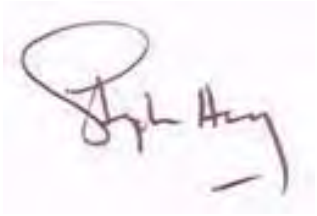
listed in Appendix 4, with the aim of improving your financial position in quarter 4 (Q4; January to March) 2015/16. These areas include both operational efficiencies and technical or one-off measures that we will need to deploy to deliver the £1.8 billion control total.

In addition, we will be meeting a number of challenged providers this month to agree a set of actions, including headcount reduction, additional to the current plan, with the clear intention of improving the financial position of those individual providers.

We cannot over emphasise that the 2016/17 Spending Review settlement that we have outlined above depends on every NHS organisation delivering the best possible financial outturn for 2015/16.

Many thanks for your continued support.





Bob Alexander
Deputy Chief Executive
NHS TDA

Stephen Hay
Deputy Chief Executive
Monitor

Copy to:

Jim Mackey, Chief Executive NHS Improvement
Elizabeth O'Mahony, Director of Finance, NHS TDA
Jason Dorsett, Director of Finance, Reporting and Risk, Monitor

Key details of the 2016/17 financial framework for providers

We recognise that the planning documents include a large amount of technical information. Given this, we would like to draw your attention to the key details of the favourable financial framework we have secured for 2016/17 with the aim of delivering maximum stability and financial recovery.

Proposals in relation to the national tariff (soon to be subject to consultation):

- A delay in the introduction of HRG4+ to provide a year of pricing stability combined with no changes to specialised top-ups.
- A cost uplift of 3.1%, reflecting a stepped change in the cost of employers' pension contributions.
- Additional funding to cover the aggregate increased cost of CNST contributions. In addition to the general cost uplift, the majority of the increase in CNST contributions will be targeted at particular HRG chapters.
- An efficiency factor of 2%, which results in a net prices uplift of 1.1%.
- An increase in the marginal rate for emergency admissions to 70% for all providers.
- No application of a specialised services marginal rate in 2016/17. A consultation on the marginal rate will form part of the engagement on the implementation of HRG4+ in 2017/18. We will also move to centralised procurement of devices with set national reference prices.

Other system management changes:

- Commissioners are required to plan to spend 1% of their allocations non-recurrently, consistent with previous years. For provider funds to insulate the health economy from financial risks, the 1% non-recurrent expenditure should be uncommitted at the start of the year.
- The introduction of a commissioner sparsity adjustment for remote areas. The financial impact of this is added to the target allocation of the relevant CCGs. This results in an adjustment for six CCGs in relation to eight hospital sites. The adjustments to target allocations total £31 million.
- The requirement for commissioners and councils to agree a joint plan to deliver the requirements of the Better Care Fund (BTF) in 2016/17. Further, BCF funding should explicitly support reductions in unplanned admissions and hospital delayed transfers of care.

Sustainability and transformation funding

1. The Spending Review settlement confirms a recurrent £5.4 billion cash increase to the NHS England Mandate in 2016/17. This will be deployed as follows:

    - £3.6 billion to flow recurrently into commissioning allocations and related budgets

    - £1.8 billion to be passed through commissioners to fund a Sustainability and Transformation Fund (S&T Fund) which will be provisionally allocated to individual providers this month with the intention of eliminating the NHS provider deficit position in 2016/17 (linked in part to emergency services).

2. The S&T Fund for 2016/17 replaces the need for the current scale of direct Department of Health (DH) cash funding. The fund will be used to support providers move to a sustainable financial footing and will be deployed in a way that creates a balanced aggregate financial position in the NHS trust and foundation trust sector in 2016/17. As such, the 2016/17 S&T Fund will have two elements:

    - a 'general element' which will be distributed to all providers of emergency care and be linked to the setting of agreed control totals

    - a 'targeted element' to support trusts drive efficiencies and go further faster; this will be targeted at leveraging greater than 1:1 benefits from providers.

3. Details on how to access the targeted element of the fund will be made available later in the planning process.

The remainder of this appendix will consider the general element of the fund.

General element of the S&T Fund

4. To be eligible to access the general element of the fund, providers must provide emergency services and formally meet all the conditions in Table 1 below:

Table 1: S&T Fund conditions and measurement

Objective	Conditions/measurement
Deliver agreed control total Provider deficit reduction/ surplus increase	Q1: Agreement of milestone-based recovery plan (OR surplus increase) with NHS Improvement AND agreed **control total for 2016/17**. Agreement to capital control total. Plans to include milestones for Carter implementation (including reporting and sharing data in line with the national timetable) and compliance with the NHS Improvement agency controls guidance. Q2 to Q4: Delivery of plan milestones AND **capital and revenue control totals.**
Access standards	Q1: Agreeing with NHS England and NHS Improvement a credible plan for maintaining agreed performance trajectories for delivery of core standards for patients, including the four-hour A&E standard, the 18-week referral to treatment standard and, for appropriate providers, the ambulance access standards. Q2 to Q4: Delivery of agreed performance trajectories.
Transformation	Q1 to Q3: Local Sustainability and Transformation Plans (STPs) – to work with commissioners and develop an integrated five-year plan in line with the national STP timetable. Q4: STP agreed with NHS England and NHS Improvement. Providers will also have the option to volunteer to join an accelerated 2016/17 transformation cohort.

5. As a condition of the overall fund being approved, the NHS has to demonstrate tangible progress towards a credible plan for achieving seven-day services for patients across the country by 2020. Recipients of funding will be expected to continue to make progress towards achieving seven-day services in 2016/17.

6. S&T funding will be made available to providers as income, which will be paid by a lead commissioner and replace the need for the current scale of DH cash support. The S&T Fund allocated to CCG(s) will be ring-fenced as pass-through payments to the relevant provider in addition to normal contractual payments.

7. This funding will be provisionally allocated at the start of the planning process to ensure providers have the maximum amount of time to prepare a credible plan in sufficient detail to meet their control total and achieve the maximum amount of financial benefit in year.

8. Release of funding will be subject to a quarterly review process in arrears. This review process will cover delivery against the S&T Fund only. Arrangements are being agreed for providers who require working capital prior to the release of funds, but are likely to involve interest-bearing working capital facilities provided by DH. Plans should be prepared on this basis until further guidance is provided.

9. Access to funding will be through a formal agreement between NHS Improvement and trust boards in advance of any funds being paid. This agreement will be embedded in a high quality board-approved plan that is fully compliant with the criteria outlined above.

10. In addition, those providers eligible for S&T funding that meet the conditions of the fund will not face a ‘double jeopardy’ scenario whereby they incur contract penalties as well as losing access to funding; a single penalty will be imposed.

11. Providers that are in deficit and that require cash support after receipt of the funding and after local efficiencies will have access to DH interim support loans, as at present via interest bearing loans.

Individual provider detail
2016/17 Sustainability and Transformation Fund

The 2016/17 financial plan for each provider will be contingent upon its 2015/16 year-end financial position. For the purpose of the provider impact assessment, the Month 6, 2015/16 forecast has been used as the baseline adjusted for the assumed effect of agency controls and other recurrent measures in Q4 2015/16. Any further deterioration in this position will require the relevant provider to deliver higher efficiency levels to achieve the 2016/17 control total.

We have also taken into account other national funding flows in setting the control total such as the impact of changes to the tariff, education and training, CQUIN, CNST, etc.

Both the setting of the baselines and the control totals, and the measurement of performance versus control totals, will exclude gains on disposals of assets.

The general element of the fund will be distributed to providers in proportion to the cost of emergency services as reported in the 2014/15 reference costs.

S&T funding and 2016/17 control total	
General element – S&T Fund Subject to provider eligibility and conditions	£8.0m
Targeted element – S&T Fund Subject to provider eligibility and conditions	To be confirmed
2016/17 Control total	£4.4m deficit

This exercise has been undertaken to set control totals for 2016/17 and considers a range of incremental common factors only. Rather than debate the method by which the numbers above have been calculated, provider boards should now consider if, with the proposed tariff/business rule changes and access to the S&T Fund, their control total is achievable in 2016/17.

Financial improvement in Q4 2015/16

All providers are requested to consider the following opportunities and to report on them in their Month 9 outturn estimates submitted to either Monitor or the NHS TDA. A simple memorandum schedule detailing how much has been attributed to each of the items below should be submitted.

Description	**Detail**
Local capital to revenue transfers	Delivery of maximum amount of safe deferral or reduction in capital expenditure to be supported by capital-to-revenue transfers as agreed with either the NHS TDA or Monitor and the Department of Health.
Accurate monthly capital forecasting	To assist with the national capital position, ensure accurate capital forecasting including identification of any underspend.
Accurate provision reporting	To assist with the national position, ensure provisions are carefully reviewed at Month 9 and, where possible, accurately estimated for the full year.
Workforce	No non-medical agency cover for short-term sickness (<3 days), implementing acting down/cross-cover arrangements to ensure patient safety.
Agency staffing	Full compliance with the policy, including completing the weekly reporting. Review self-certification in weekly reports to identify opportunities for improvement. Focus on reducing number of shifts above rate caps and remaining within nursing agency ceiling.
Reviewing in-year priorities	Reviewing priorities in all areas: revenue maximisation, cost control, efficiency and investments
Balance sheet review: prudence	Remove prudence from estimates of: • accrual; • deferred income; • injury cost recovery (formerly RTA) debtor • partially completed spells

Description	Detail
Bad debt provisions	Remove prudence in bad debt provisions, including ensuring impairments to receivables are line with IFRS and are based on incurred losses and not general estimates or future expected loss events.
VAT changes	Review latest COS guidance to ensure maximum reclaim of VAT including latest position on IT spend.
Annual leave	To the maximum extent allowed under NHS contracts, manage the carry forward of annual leave. Ensure that this does not lead to the use of additional agency staff to cover leave periods. Ensure data used for calculations from HR systems are robust.
Asset valuations	Revalue operational assets at the modern equivalent asset value using the alternative site method where advantageous.
Asset lives review	Review all equipment and buildings asset lives given that less capital will be available for replacement in future. The resulting adjustment will reduce depreciation charges while creating a one-off impairment. Providers will be held to account by NHS Improvement for their financial performance before accounting for impairments.

NHS Improvement
(Monitor and the NHS Trust Development Authority)

Wellington House
133-155 Waterloo Road
London
SE1 8UG

020 3747 0000

15 January 2016

Letter to: CEOs Trusts and Foundation Trusts
Finance Directors Trusts and Foundation Trusts
Medical Directors Trusts and Foundation Trusts
Directors of Nursing Trusts and Foundation Trusts

Dear Colleague,

We are all aware that the NHS, and providers specifically, have been under great pressure as we seek to improve quality outcomes for patients within the financial resources available. However, the size of this year's provider sector deficit makes it clear that, collectively, we need to focus more on financial rigour as one of the routes to excellent quality.

We recognise that both our organisations – NHS Improvement and the CQC – have an important role in enabling every trust to deliver that balance. We also recognise that how we do our work, the signals we send and how we work together, are an important influence on whether you can deliver that balance or not.

We have therefore been discussing between ourselves, and with senior provider colleagues, what more we can do to help and support you and we wanted to share the early outcomes of that work. 'Early outcomes' because, at this point, this is a strategic statement of intent and we want you to tell us what we have to do differently to secure the right finance/quality balance that we all need.

Success is delivering the right quality outcomes within the resources available

We want to start off by being clear that, from our perspective, quality and financial objectives cannot trump one another. We know that, in the past, there was a perception that delivering financial targets was more important than delivering the right quality outcomes; and that, more recently, improving quality was more important than staying in financial surplus.

We want to clearly and unequivocally state, with the full support of our other arms' length body colleagues, that your task as provider leaders is to deliver the right quality outcomes within the resources available.

That is how we will both measure success and that is how the NHS Improvement regulatory framework and the CQC inspection regime will be framed going forward. Some changes will be needed to make this happen in exactly the way we now want.

We will involve you in how we make those changes – for example through the consultations that we will shortly be launching on the CQC's future strategy and a single new NHS Improvement regulatory framework for providers.

CQC and NHS Improvement working together on a single national framework

We recognise that it is particularly important that you get a single clear, consistent message from both of us on this issue. There has been a perception in the past that our organisations have had greater focuses on different sides of the quality/finance balance, potentially creating unhelpful mixed messages.

So, we will jointly design the approach the CQC will use to assess trusts' use of resources. We are also looking at how the CQC can use the financial data NHS Improvement holds and use the expertise of NHS Improvement staff in reaching its judgements on use of resources. Similarly, as NHS Improvement develops its view of the role of quality in the new, single, provider regulatory framework, we will do this jointly with the CQC and NHS England. We will also be sharing revised National Quality Board staffing guidance and a new metric looking at care hours per patient day that we will both use in looking at how trusts manage staffing resources.

In practical terms, we want regulators and commissioners to rely on each other's work, rather than duplicating effort, and we want to create a single unified framework with a single way of measuring success that we all use. We want this to bring greater clarity and consistency and reduce the regulatory burden, as you have asked for.

NHS Improvement and CQC working together on turnarounds

One of NHS Improvement's early priorities will be to work with organisations with large deficits to help them return to surplus. There is an incorrect assumption that this can only be done at the expense of quality. So we will, again, be working together closely so that we can all be sure that, even in the trusts facing some of the biggest financial challenges, it is possible to balance finance and quality.

We hope this gives you a clear statement of our joint intent – success is delivering the right quality outcomes within the resources available – and how we want to translate that intent into the way we work in future. Please provide us with any comments you have on this letter and tell us what more we can do – our email addresses are below. It would help if you used "JOINT NHSI/CQC LETTER" as the subject of any email you send us.

Jim Mackey
Chief Executive
NHS Improvement
Jim.Mackey@monitor.gov.uk

Professor Sir Mike Richards
Chief Inspector of Hospitals
Care Quality Commission
Mike.Richards@cqc.org.uk

Monitor
Making the health sector work for patients

tda Trust Development Authority
Quality. Delivery. Sustainability.

To: NHS foundation trust and NHS trust Chief Executive Officers
Cc: NHS foundation trust and NHS trust Nurse Directors and Finance Directors

15 January 2016

Dear Colleague

New framework arrangements to tackle agency costs and support staff back into substantive and bank roles

It is eight weeks since Monitor and TDA introduced price caps for agency staff, to complement the other agency rules. The price caps are having a positive effect, and a large majority of trusts report that the price caps are helpful. We hear examples across the country of trusts using the price caps to take a stronger stance with agencies, to negotiate lower rates and secure a better deal for themselves, their staff and patients.

However, we all have much more to do to reduce spending further and ensure that workers move back in large numbers to substantive and bank roles. Trusts have asked for further support at national level to address the challenges they face, and I am writing to inform you of the measures we are now taking to strengthen our collective approach.

First, **we will reduce the price caps on 1 February**, as previously proposed. This will significantly reduce maximum rates for doctors and nurses and help you to achieve further savings. This will, of course, present a significant challenge to the sector and trusts will need to work together and hold their nerve in discussions with agencies.

We will also require all agency procurement – for doctors, nurses and all other staff groups – to be via approved frameworks. These frameworks will embed agency worker pay rates in line with standard NHS terms and conditions.

Many trusts have told us of certain agencies refusing to support the agency rules, reinforced by the fact that maximum rates on some existing frameworks exceed the price caps.

Monitor and TDA, working with the framework operators, are taking action to change this. This strengthened approach, which will initially operate in parallel with the price caps, entails a number of elements:

1. We will extend the requirement that trusts procure only through approved frameworks to doctors and other staff, as well as nurses. This will take effect from 1 April 2016. We will only approve frameworks that commit to the further steps below.

2. Framework suppliers will have to renegotiate with agencies or retender to ensure that all their prices are at or below the rates set by NHS Improvement. This process will take several months to conclude (beyond 1 April). In the meantime, all approved framework owners must strongly support the price caps.

3. At the appropriate point, we will change the way the price caps are expressed so that NHS Improvement defines the amount that the *worker* receives – at a level equivalent to standard NHS terms and conditions.

4. Frameworks will embed a requirement that agencies conform to the pay rates set by NHS Improvement. Agencies will bid to be on-framework on the basis of their agency fee, which will then be fixed, and in compliance with our terms.

5. We also intend to take steps to eliminate the practice of agency workers using personal services companies to avoid taxes.

Trusts and staff should take steps to prepare early for these changes, including reflecting on contractual conditions such as timescales associated with transfer fees. Workers will have to move to supportive agencies or back to substantive and bank roles.

We will issue further guidance to providers and framework operators later this month.

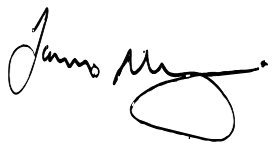
Compliance

It is fundamental that all trusts fully comply with these agency rules and have in place the necessary processes and governance. I would reiterate that overrides can only be made where essential - for patient safety reasons - and that all trusts are expected to work with their commissioners to agree plans for services in the event of staffing issues.

I have asked our regional teams to ensure that every trust in England is taking a complete grip on agency costs, from board level down. **We have also made it a core condition of the Sustainability and Transformation Fund that trusts are compliant with all the agency rules** to receive funding

Thank you for your continued efforts: we have come a long way already, but there is much further to go. We will continue to do everything we can to support you.

Yours sincerely,



Jim Mackey
Chief Executive, NHS Improvement

Monitor
Making the health sector work for patients

tda Trust Development Authority
Quality. Delivery. Sustainability.

To: NHS foundation trust and NHS trust Chief Executive Officers

7 January 2016

Dear colleagues

The peak winter period is always very pressured and, whilst it is clearly not over yet, I wanted to write to thank you for your, and your teams', efforts to prepare for the Christmas period and wish you a Happy New Year.

Overall, our systems managed very well and performance on most of the key metrics was better than last year. A few systems continue to struggle so we are working with organisations in those areas now to address this.

This is clearly a big year for the NHS. We need to get on top of the money, start delivering key constitutional standards and take the opportunity to develop ambitious system-wide plans in the spring. We will be writing separately about the transformation fund and delivery of this year's control totals. We are also working very closely with CQC colleagues to ensure our respective approaches are completely aligned.

I wish you all the best for 2016 and look forward to working with you to deliver the improvements we all want for the NHS and its patients.

All the best

Jim Mackey

Chief Executive - NHS Improvement

BOARD OF DIRECTORS

16/021

SUBJECT:	Report from the Chair of the Finance and Sustainability Committee including draft minutes of the meeting on 16/12/12
DATE OF MEETING:	27 January 2016
DIRECTOR:	Terry Atherton, Non-Executive Director - Chair

FSC/15/

FINANCE AND SUSTAINABILITY COMMITTEE

Minutes of Meeting of the Committee held on 16th December 2015

Present

Terry Atherton	Chair
Anita Wainwright	Non-Executive Director
Mel Pickup	Chief Executive
Mark Brearley	Interim Director of Finance and Commercial Development
Jason DaCosta	Director of IT
Mark Brearley	Interim Director of Transformation
Simon Constable	Medical Director
Karen Dawber	Director of Nursing
Sharon Gilligan	Chief Operating Officer
Steve McGuirk	Trust Chairman

In attendance

Colin Reid	Trust Secretary (items 123 – 124)
Jennie Taylor	Executive Support (items 124 – end)
Ian Jones	Non-Executive Director
Lynne Lobley	Non-Executive Director
Jan Ross	Deputy Chief Operating Officer

Apologies:

Roger Wilson	Director of Human Resources and Organisational Development
Steve Barrow	Deputy Director of Finance
Pat McLaren	Director of Community Engagement

	Apologies and Declarations of Interest – FSC/15/123
1	Apologies: As above
2	Declarations: None
3	The Chair reported that this would be Colin Reid's last meeting and thanked him of behalf of the Committee and himself for his work and support.
4	The Chair welcomed the Chief Operating Officer to her first FSC meeting.
5	The Chair reminded the Committee that this Meeting had been added to the schedule in view of the current financial & corporate performance positions of the Foundation Trust on a restricted Agenda basis ahead of today`s Strategy Day
	Minutes of meeting & Actions – FSC/15/124
6	The minutes of meeting of 17th November 2015 were approved.
	Matters arising

8	The Chair referred to the action that had been carried forward from the October Committee relating to WLIs and asked the Chief Operating Officer for an update on progress. The Chief Operating Officer reported that she was reviewing WLIs across the divisions, with the Medical Director in order to ascertain the perceived need for them. She explained that WLIs were used by all NHS trusts and not all were inappropriately scheduled; explaining that in most cases WLIs were needed due to medical vacancies. The Medical Director, supported the comment of the Chief Operating Officer and explained that WLI where used elsewhere and may be described differently to support different care and also featured within primary care settings. The Chief Operating Officer reported that in a large number of cases WLIs were effective and profitable and advised that she would bring a paper to the next FSC that set out a summary from each division of what WLIs had taken place in the current financial year and the reason behind the decision. She would also report on governance controls that may need to be tightened up, referred to in the action from the October meeting.
9	Steve McGuirk commented on the perception externally of their use within the Trust, in particular by the CCG. He explained that in conversations with the Chair and Chief Executive of Warrington CCG, there was a perceived view that they were being undertaken inappropriately which inflated the costs to the CCG and asked that the paper also include some benchmarking data that would dispel the myth that it was only the Trust that was undertaking WLIs. He explained that he would like to be in the position of sharing a paper with the Commissioners to dispel their perception. The Committee discussed the content of the paper and in particular how the information would be shared with Warrington CCG. The Committee agreed that the paper would first be reviewed by the Committee before being shared with the CCG to see if the content was appropriate. Action: FSC/15/124: the Chief Operating Officer to provide a paper to the January meeting that sets out a summary from each division of what WLIs had taken place in the current financial year and the reason behind the decision. The report would also include what governance controls had been put in place and benchmarking information from other trusts within the North West.
	Corporate Performance Report as at 30th November 2015 FSC/15/125
10	Deputy Chief Operating Officer explained that it has been difficult obtaining accurate information since Lorenzo was introduced although the team in Informatics are working on this. The target of 95% is not being achieved but we are seeking to achieve between 90 and 95%. One key indicator is the number of medical outliers and we have seen an improvement in this, the intention is to remain below 10 as moving to 20 would result in a negative impact on patient care.
11	Deputy Chief Operating Officer reported that early discharge equals better flow and there has been an improvement in use of the discharge lounge however only 18% of patients leave the Trust in the morning.
12	The Chief Operating Officer reported there is an RTT problem with erroneous data due to Lorenzo. The national deadline for submission is 18th December and work is taking to place to achieve this. She will circulate to the Committee an update with final corporate detail as soon as this is available.

13	Deputy Chief Operating Officer reported that yesterday was the start of the winter challenge, staff are working hard, demand is high and patients are ill. Other trusts in the area are suffering the same although she was pleased to report that the A&E staff did seem in control of the situation.
14	The Chairman reported that he was visiting various wards yesterday and realised how full the wards were with elderly, ill patients though he was pleased report the positive attitude of the staff impressed him.
15	The Chair enquired about funding for STAR ward as it looking like only 5 beds will be funded.
16	The Director of Nursing and Governance explained that 24 beds have been opened without funding in place although Chris White does have ideas around spell and excess to address this.
17	The Chief Executive advised that it was specifically asked at the Bilateral meeting if activity was being recorded sufficiently robustly to enable differentiation between CCG Intermediate Care funded activity and normal PBR. It had been confirmed by the Associate Divisional Director, Unscheduled this was the case so the Chief Executive was surprised to hear from the Director of Nursing and Governance she believed this was not. It was agreed the Chief Operating Officer will investigate further.
18	Anita Wainwright commented that if we can only go back 2 months to reclaim any wrongly coded STAR funding this was disappointing. The Chief Executive advised that the amount of funding for STAR beds has been budgeted and there is a mechanism in place for recording the use.
	Financial Position as at 30th November 2015 - FSC/15/126
19	The Interim Director of Finance advised that the report for month 8 is based estimated income based on the first 21 days of November, until the Lorenzo 'go-live' and known activity changes. The Trust has been unable at this stage to fully assess the income, as we are currently unable to report information for the last nine days in November. He also apologised that the Report did not sufficiently draw out the key variances and the 'in-month' movements, which would have aided the reader in understanding the changes in November. The Year to date deficit stands at £12.6m, therefore we need have a run rate per month of no worse than £400k deficit per month, in order to achieve the Forecast Deficit of £14.2M. The Interim Director of Finance advised that this is still achievable, but will be very challenging.
20	The in month position is adverse with variance of -£875k from Plan. This variance is attributed to the 'in-month' loss of contract income against plan .Outpatients shows a £452k adverse variance, this is caused by the loss of significant activity in month but investigation on-going as to whether this is affected by the backlog of data for entry. Elective care has an adverse variance of £428k from the monthly plan, with the main area of variance being Trauma & Orthopaedic activity.
21	Non-Elective care income was £180k favourable in November and the pay and non-pay variance has moved to a lower monthly adverse 'run rate' and this therefore reducing.
22	Interim Director of Finance reported that meetings with him, Chief Executive, Chief Operating

	Officer and Heads of Divisions had taken place to explain what action needs to be taken to influence the income and expenditure position in the remainder of the year and to provide a re-forecast which is expected within a week and monthly thereafter.
23	The Interim Director of Finance advised that at the meeting with Monitor re 15/16 figures they want to know and understand the impact of actual deficit on liquidity and the earliest indication if the forecast deficit cannot be met.
24	He advised the Income lost in November is recoverable but needs to be addressed and not affect patient care. Ian Jones asked if elective income had been as expected would expenditure have increased.
25	Interim Director of Finance explained that expenditure would not have increased significantly, core costs are included but significant non-pay costs show reduction.
26	Interim Director of Finance reported that agency expenditure is the 2nd highest monthly cost but this is due to Lorenzo, but unfortunately as the report outlined cumulative figures this could not be seen from the report. Steve Barrow had circulated a more detailed breakdown which the Committee should have received.
27	Medical Director advised that data review due to Lorenzo will be more accurate in future months. Director of IT explained that a dip in performance was planned around Lorenzo go live and the CCG has been flexible in allowing us to catch up.
28	Lynne Lobley enquired if we are clear where our capacity is. Interim Director of Finance confirmed this is the case and job plans have been aligned and challenges were to be made to ensure the full utilisation of available sessions.
29	Interim Director of Finance advised that a paper will be submitted to JLNC on 23rd December showing that job plans will be on the new Allocate system which will allow us to be clear about the best use of available sessions. Divisions have been asked to evaluate locum usage and this has already identified some more effective usage of their time.
26	Medical Director explained that Allocate will enable best usage of clinicians' time but it will not be immediate, there is a challenge that he has to manage and could therefore have more significance 2016/17. This is the best opportunity to get improvement and plenty of time will be spent on this.
30	The Chief Executive advised that the committee that we are slightly ahead of the game compared to other trusts in looking at Job Plan utilisation, where there may be a disparity in WLI rates, study leave etc and as we have already started reviewing and challenging, in line with our agreed Job Planning Policy. She advised that there is likely to be some unrest with clinical staff.
31	Anita Wainwright enquired if the expected strike action affected elective activity and whether capping costs on agency staff had caused further disruption.
32	Director of Nursing and Governance responded that this is the third week on the Agency Cap return and some agencies are not co-operative on the capped rates. She has met with NHSP and AHP agencies are being more cooperative.

33	Medical Director explained that substantive recruitment is being enhanced by some other organisations but not by us.
34	Director of Nursing and Governance requested clarity on clinical activity around A&E attendance as last year there were 2 x CDUs open which will have had an effect on figures.
35	The Chair summed up and picked out four issues, as follows: • Assumptions around reinvestment of fines and penalties etc. by commissioners could be vulnerable. • A paper produced by Lynne Simpson around elements of pay would be on January F&SC agenda • An I&E deficit of £17.5m loss at year end, would take us to minimum cash requirement of retained cash specified by Monitor • Discussions at our regular Monitor meetings and we must remain mindful of our commitment to them.
	Monitor Regulatory Activity – CIP Assurance Report (i) FSC/15/127
36	Interim Director of Finance advised that the CIP Summary Paper shows we had estimated savings of £4.3m and this had achieved the target for the end of November. Some schemes are however ahead or behind plan. He reported: • Additional schemes identified for December • Other schemes identified for January onwards • A number of locum positions have been converted to substantive positions • £6m needed to achieve last four months and it was imperative that the additional schemes were driven forward at pace.
	Date and time of next meeting *2pm on 20th January in Trust Conference Room*

Action List

Finance and Sustainability Committee

Paper Reference	Action	Responsibility & Target Dates	

BOARD OF DIRECTORS

16/022

SUBJECT:	Finance report – turnaround checklist
DATE OF MEETING:	27th January 2016
DIRECTOR:	Director of Transformation

Gaining grip and control - key areas to consider (short term only)

In general, the turnaround follows the following phases (which very often overlap):

Overview

This document focuses on the first phase of the turnaround process, i.e. establishing immediate control over the organisation and focuses mainly on cash and treasury, short-term stabilisation and identification of "low hanging fruit" in terms of income acceleration and cost reductions. Once the turnaround team has a grip over the day to day running of the organisation. Once the trust is stabilised and a short-term viability is established, the management can focus on understanding Trust's baseline position and causes of the underlying deficit. This will then provide a platform for a stabilisation plan and long term turnaround strategy.

How to use this document

The document is guide and a generic checklist of actions that a restructuring director or newly appointed chief executive may need to take when trying to establish an immediate control over a distressed trust. The document is by no means exhaustive and I would expect the document to expand it time. Also depending on the type of issues, size and level of distress, not every area may be relevant. The document may be used as a discussion document when agreeing with the CRO / board what actions should / will be taken.

1. Gain immediate control over the organisation and run rate reduction

2. Understand Trust's baseline and causes of the underlying deficit

3. Undertake longer term planning and turnaround (2-year recovery plan and 5 year strategy)

There are 13 key focus areas that should be reviewed as part of the immediate grip phase

The initial focus of any turnaround is always on cash, cash management and immediate stabilisation.

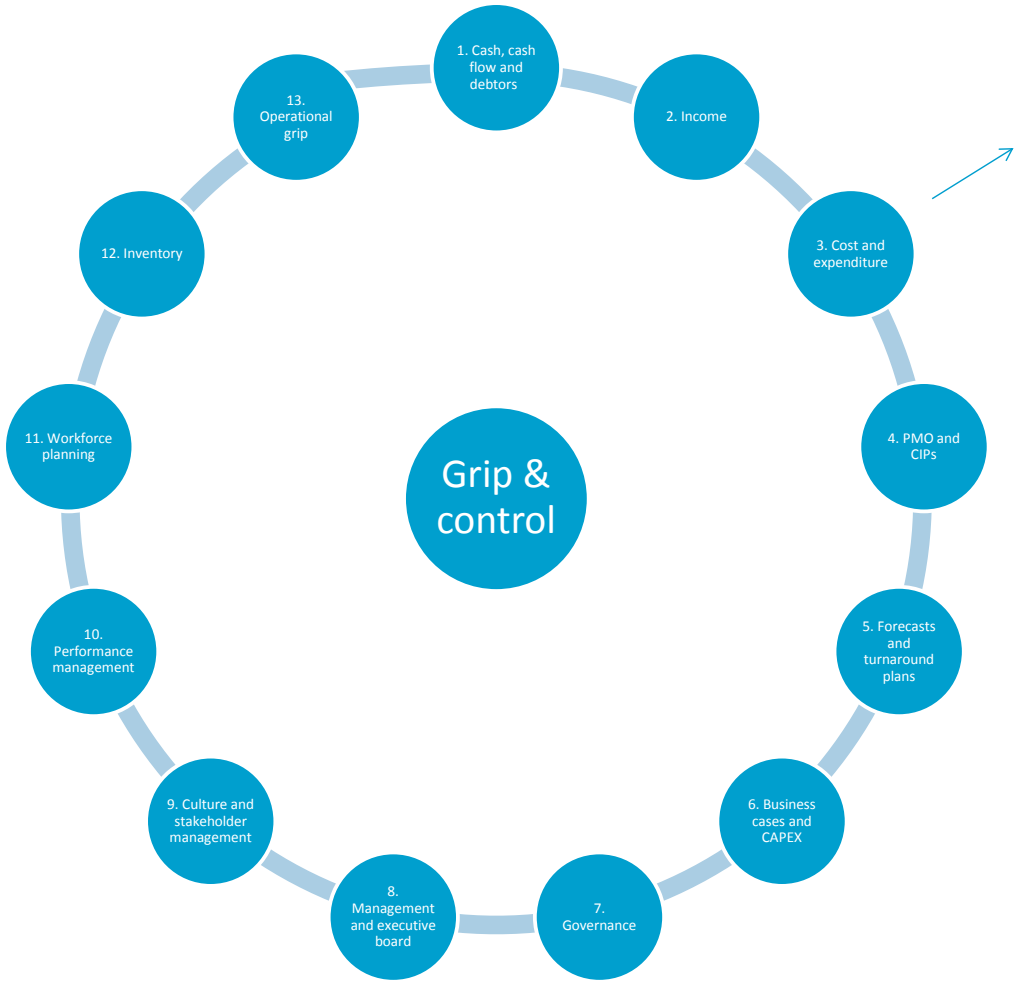
This document sets out in detail 148 actions any turnaround director should consider when trying to gain an initial grip over the organisation.

The actions are split into 13 areas which are closely interlinked.

The implementation timings and specific focus on these areas will differ depending on the actual level of distress and liquidity.

Please note that focus on CIPs alone usually does not constitute a turnaround.

It is also assumed that any turnaround will take into account impact on quality and therefore all decisions are subject to a quality review.



This area is further split as follows:
- finance;
- procurement;
- contracting;
- estates; and
- other.

Glossary of terms

PO	purchase order
VSM	very senior manager
CIP	cost improvement programme
CQUIN	commissioning for quality and innovation (payment)
RTT	referral to treatment
KPI	key performance indicator
SFI	standing financial instruction
NHS SBS	NHS Shared Business Services
NHS BSA	NHS Business Service Authority
VAT	value added tax
PMO	programme management office
DoF	director of finance
NHSE	NHS England
HR	human resources

Gaining grip and control - key areas to consider (short term only)

Action	Area	Comments (Exec Lead)	Comments (Description)
1.0	***Cash, cash flow and debtors***		
1.1	Establish 13 week cash flow process	MB	Actioned
1.2	Ensure that there are tight procedures around payment approvals	MB	Actioned (£5,000 authorisation level suspended).
1.3	Ensure that no payments are made to non-essential purchasers	MB	Actioned (only approved invoices paid).
1.4	Consider approaching commissioners to advance funding to temporarily improve cash flow (we have seen commissioners advancing payments over 10 rather 12 months to assist with immediate cash flow problems)	MB	Actioned (main commissioners pay on 1st month and cash advance secured in first half of the year).
1.5	Establish weekly cash committee with operational, financial and procurement representatives present	MB	Actioned (cash reviewed weekly by senior finance team and reviewed monthly by Finance & Sustainability Committee).
1.6	Consider stretching creditors beyond current creditors days	MB	Actioned (BPPC performance is 26% as at 30th November).
1.7	Review and assess existing debtors ledger and focus on "easy wins" to target for immediate collection	MB	Actioned (aged debt reviewed weekly by finance team).
1.8	Develop strategy for each debtor – assess risk, ability to net-off if provider to provider debtors / creditors where the trust is in a positive net-off position. Ensure that utilise assistance linked to recovery of income from overseas patients (Cost Recovery Support Team and Overseas Healthcare Team).	MB	Actioned
1.9	Consider process change within the collections team to optimise cash management etc.	MB	Actioned (see actions 1.1 to 1.8)
1.10	Review and recover all private patient non-payments	MB	Actioned (outstanding debt refered to external debt recovery team).
1.11	If possible, discuss further support with commissioners – bring forward date when income received (from 15th to 1st) (in addition to action 1.4)	MB	Actioned (see action 1.4).
1.12	Immediately assess estates position, if there are any external landlords consider renegotiation of terms to pay in arrears rather than in advance	MB	Not applicable (Trust does not occupy other premises).
1.13	Assess what assets can be sold	MB	Actioned (all equipment assets surplus to requirements are sold).
1.14	Reduce the number of payment runs to ensure that there is a greater control over outflows	MB	Restricting creditor payment will prove as effective and stops need for urgent payment requests.
1.15	Implement cash focussed KPIs and a reporting dashboard	MB	Actioned (aged debt reviewed regulary, management of working balances, creditor payments delayed)
1.16	Ensure that invoices are issued as soon as possible rather in batches	MB	Actioned
1.17	Establish pro-active debt collection - cold call all key debtors before due date to ensure that payments are received	MB	Actioned (all commissioners pay on agreed dates)
1.18	Develop payment plans for key and large creditors where possible to ensure smoother profile and cash conservation	MB	Actioned
2.0	***Income***		
2.1	Create commercial board to oversee income opportunities (this should include estates value maximisation opportunities - please link this to a review of estates strategy - 3.21)	MB	Actioned (commercial developmet group established to explore opportunities)
2.2	Undertake a full coding review (establish working group aimed at improvement of the depth of coding - assuming that there is not a block contract)	MB	Actioned (Trust has employed a Clinical Coding manager to work with clinicans to improve depth of coding).
2.3	Ensure that any changes in coding are clearly communicated to and recorded with the commissioners to ensure that income is received.	MB	Actioned (Trust has employed a Clinical Coding manager to work with clinicans to improve depth of coding).
2.4	Review income contracts with commissioners to highlight any opportunities to maximise income and to reduce penalties.	MB	Actioned (continued dialogue with commissioners about reduction in penalties and reinvestment plans)
2.5	Review progress on CQUINs, RTT, activity etc. and assess the likelihood / size of penalties for non-delivery or underperformance	MB	Actioned (reviewed and monitored monthly)
2.6	Optimise car parking income (if possible)	MB	Actioned
2.7	Ensure fully recovery of any income from 3rd parties (use of facilities, estates, joint appointments, consultants working outside trust, junior doctor training etc.)	MB	Actioned (the Trust reviews the register of services provided on an annual basis to ensure that all services are recharged, a service specification is in place and that services are costed appropriately. In addition, any new services identified in year are added to the register and cahrged accordingly).
2.8	Run refresher meetings with consultants and junior doctors to ensure contracts are understood and to ensure that key staff understand what levers to pull to ensure increased revenue	MB	Actioned (Trust has employed a Clinical Coding manager to work with clinicans to improve depth of coding). I think this is more to do with clinicians understanding how contracting and PBR works rather than just the depth of coding - could we not run some master
2.9	Consider estate rationalisation where possible (rent/sell where possible)	MB	Actioned (currently producing Phase 1 FBC).
2.10	Review any tenant and licence agreements to see if there is any possibility to further maximise income from estates	MB	Actioned (the Trust reviews the register of services provided on an annual basis to ensure that all services are recharged, a service specification is in place and that services are costed appropriately. In addition, any new services identified in year are added to the register and cahrged accordingly).
3.0	***Cost and expenditure***		
	Finance related controls		
3.1	Review the approach used by the trust to improving quality and reducing costs across the organisation. Consider alternatives such as lean etc.	MB	Actioned (PMO team expanded in terms of numbers and expertise). Members of AQUA, working on a number of schemes to improve
3.2	Complete a full budget review - identify budget reduction opportunities and target overspend areas, create plans to bring them back in line with the initial budget	MB	In progress (meetings have been held with all divisions that seek to reduce overspends and maximise underspends. An additional CIP was allocated to all clinical and corporate divisions and those divisions underspent was mandated to achieve a great underspend rather than ensure a balanced budget).
3.3	Identify the full value of the creditor ledger including unapproved invoices	MB	Actioned
3.4	Review PO system; strengthen or improve if required. Going forward any non-PO purchases should be reported by exception	MB	Actioned (currently 81% of expenditure is via PO). Expenditure via Non-PO reviewed monthly by procurement
3.5	Reset budget holders if required	MB	Meetings have been held with all divisions that seek to reduce overspends and maximise underspends. In addition, the £5,000 approval limit has been removed to ensure increased financial rigour.
3.6	Bring all existing orders on the system by creating POs (mainly agency staff, long term call off contracts etc.)	MB	Actioned (see action 3.4).
3.7	Reset SFIs and delegation authorities if required	MB	Actioned (£5,000 authorisation level suspended).
3.8	Impose stringent controls over expenditure – overspends may need to be linked to disciplinary action	MB	In progress (meetings have been held with all divisions that seek to reduce overspends and maximise underspends. An additional CIP was allocated to all clinical and corporate divisions and those divisions underspent was mandated to achieve a great underspend rather than ensure a balanced budget). In addition, the £5,000 approval limit has been removed to ensure increased financial rigour.

Gaining grip and control - key areas to consider (short term only)

Action	Area	Comments (Exec Lead)	Comments (Description)
3.9	Establish controls over central and corporate expenditure	MB	**In progress (meetings have been held with all divisions that seek to reduce overspends and maximise underspends. An additional CIP was allocated to all clinical and corporate divisions and those divisions underspent was mandated to achieve a great underspend rather than ensure a balanced budget). In addition, the £5,000 approval limit has been removed to ensure increased financial rigour.**
3.10	Review all telephony and large IT contracts - renegotiate where possible	MB	Actioned 2/3 years ago but can consider. Telephone contract in the process of being renewed at reducted tariffs
3.11	Undertake a user review for IT and telephony - cancel all unused mobiles, telephone lines, dongles etc.	MB	Actioned 2/3 years ago but can consider.
3.12	Review, reduce and control all "discretionary" spend such as travel expenses, subscriptions, training, clothing, hospitality, bed hire, office equipment etc.	MB	Actioned. The Trust is compiling a list of actions necessary that improve the financial position of the Trust. The review and control of discretionary spend is one of the actions. Travel restricted to 2nd class travel and fixed journey times, journal subcriptions have been reviewed, office equipment already restricted via the procurement team
3.13	Identify priory suppliers and confirm that cash is available for priority suppliers	MB	Actioned (working capital loan agreed to maintain liquidity)
3.14	Review all VSM pay costs - consider action (where applicable) on retire & return staff and ensure that the trust complies with guidance on "off payroll" workers and daily rates	MB	**Under review.**
3.15	No invoices to be paid unless matched with PO	MB	Actioned where possible (eg utilities, rates). 81% of invoices matched to PO and reviewed on a monthly basis
3.16	Review scope for savings from making use, or increased use, of NHS SBS (where applicable)	MB	Under continual review (the Trust has a service contract based on the number of invoices raised and received. The Trust has reduced the volume of transactions and therefore the cost by invoice consolidation and continually reviews those suppliers that this can apply to).
3.17	Review scope for savings from making use, or increased use, of NHS Professionals (where applicable)	MB	Actioned. The Trust utilises NHSP as first choice supplier for all temporary nursing requirements. In addition working collaborativey with Monitor to pilot tools to reduce agency expenditure and move staff from agency to NHSP
3.18	Review if trust can utilise NHS BSA to determine potential saving opportunities on 3rd party non-pay spend via NHS Supply Chain (where applicable).	MB	Under continual review. Price tracking regularly undetaken by procurement comparing NHS SC prices with other 3rd party distributors to secure best value
3.19	Where applicable, test saving opportunities via use of NHS Core list.	MB	Under continual review. NHS Core Lists tested and changes made where savings have been identified. See 3.18
3.2	Ensure that Medical Capital Equipment Asset register, medical equipment maintenance schedule and capital medical equipment procurement plans are in place.	MB	Actioned
3.21	Review saving opportunities via use of Crown Commercial Services where applicable.	MB	Under continual review. CCS framework and savings opportunties reviewed as and when needs are identified. In additon to CCS, HealthTrust Europe, ESPO, NHS SC and NHS SBS procurement frameworks are ulitilised where best value can be demonstrated
3.22	VAT position has been reviewed and all recovery opportunities maximised	MB	Under continual review. In addition to VAT reviews, STAFFflow via Liaison is in place and a number of Managed Service Contracts are in place that maximise VAT recovery
	Procurement related controls		
3.23	Review procurement, understand what contracts are due to expire/when to assess ability to renegotiate contracts or put contracts for tender	MB	Under continual review. A contract database is in place and annual plans for delivery of CIP are produced that incorporate the renewal of contracts
3.24	(Re)set targets for procurement for contract renegotiations	MB	Annual procurment CIP target set that are inclusive of contract renegotiations. All monitored and reported monthly.
3.25	Procurement - remove rolling, value based purchase orders	MB	Under continual review. 90% of goods are procured via pre-determined catalogues that removes the need for rolling, value based purchase orders. Where call-off orders are in place these are regularly monitored
	Contracting related controls		
3.26	Understand supplier discounts and penalties for early / late payments - set out plans to recover / avoid	MB	Under continual review. Top 10% of suppliers (by value) have been approached to negotiate terms re early payment discounts for implementation where financially beneficial
3.27	Ensure that all key contracts (including agency staff) are procured via appropriate frameworks. Any off framework arrangements should not be permitted, except in exceptional circumstances.	MB	Actioned. Crown Commercial Service and HealthTrust Europe frameworks utilised for all clinical agency staff. All monitored via NHSP and Liaison (STAFFflow) via MI and regular meetings
3.28	Review or create list of all key contracts and external suppliers – including start dates, breaks etc.	MB	Partially actioned (data requirements collated by Head of Procurement that capture all information to ascetain whether individuals exceed the £220 per day for 6 months limit)
3.29	Look into cost reduction via consolidation of supplier base and invoices	MB	Under continual review. A number of suppliers' invoices are processed via monthly consolidated invoices and Pharmacy Invoices are dealth with via pre-payment to reduce the volume of invoices and associated costs via SBS. Invoice volumes are measured on a monthly basis
3.30	Ensure that the rules around professional fees over £50k are adhered to	MB	Under Review.
	Estates related controls		
3.31	Specifically review and benchmark overall running costs for facilities and estates. Put in place cost reduction plans if above average (see utility and other contract review points)	SG	Full review of ERIC data currently underway (Lord Carter data pack suggets opportunities for productivity improvements in cleaning, linen & laundry and waste and cost efficiency improvements in linen & laundry, energy and water & sewerage).
3.32	Undertake a review of estates strategy and confirm if action points, cost reductions etc. have been undertaken. If not implement "low hanging fruit" decisions immediately	SG	In this context it is assumed that the Estate Strategy refers to the optimal use of all buildngs, and the disposal of those that are not required. This is part of the overall Estate Strategy, which is currently at FBC production stage. See action 3.31 in relation to Lord Cater data pack.
3.33	Ensure that estates have been rationalised - vacate all unused buildings, switch to rent on daily basis, room rather than floor rent etc. where possible	SG	As part of the overall estate strategy all appropriate buildings have been reviewed to determine utilisation. SLA's for all non-Trust occupnats have been reviewed.
3.34	Ensure that all lights and heat is turned off in unused buildings (ensure that comply with insurance requirements)	SG	Heating and lighting is reduced in occupied areas to ensure no degradation of fabic occurs, or that health and safety issues are not introduced. The Trust has alos implemented a wide reaching eneregy efficiency scheme, including the use of combined heat and power units, low energy lighting, and other energy saving devices.
3.35	Review all utility contracts to ensure that represents best value	SG	Under continual review, Trust is currently under contraact with Crown Commercial Services. See action 3.31 in relation to Lord Carter data pack).
3.36	Waste disposal is managed and monitored	SG	Under continual review (Lord Carter data pack suggests that there is limited opportunity for cost efficiency savings in waste management).

Gaining grip and control - key areas to consider (short term only)

Action	Area	Comments (Exec Lead)	Comments (Description)
	Other controls		
3.37	Undertake clinical and non-clinical cost benchmarking	MB	**The Trust partakes in sharing benchmarking information in most specialty areas. In addition, all divisions are encouraged to access the Better Care/Better Value indicators to compare performance with all Trusts nationally. LOS improvement workstream established based on BCBV to look at reducing LOS in key areas**
3.38	Undertake drug formulary review and medicines management review	MB	This forms part of one of the 2015/16 CIP schemes and will continue to feature in 2016/17.
3.39	Ensure that all overtime and enhanced payments are subject to prior approval and are monitored and minimised where possible	MB	Actioned (all requests for overtime and WLIs are subject to Executive Director approval) - Can we check this because I do not think this is robust
4.0	***PMO and CIPs***		
4.1	Review the existing PMO structure: is it fit for purpose and is there board support and staff buy-in?	MP	Actioned - PMO structure in place with governace arrangements that include executive and NED oversight and QIA review and approval by Executive Director of Nursing and Medical Director. Dashboards in place to provide ease and accurate reporting. Staff side in attendance at sub committee (chaired by CEO) and weekly meetings with staff side and HRD
4.2	If the answer to 4.1 is no, start working on improvement and strengthening of the PMO office	MP	Not applicable
4.3	Review existing CIPs for quality, deliverability and progress	MP	Actioned
4.4	Reset CIP targets for each division / directorate - ensure that these new targets have been prepared by each directorate to ensure buy-in	MP	Actioned (additional CIP targets set during year).
4.5	Review CIP quality approach – maturity level grading (idea, documentation, financial verification, quality approval, DoF CIP executive lead sign off to go live as a scheme)	MP	Actioned robust governance process in place and have been improved and strengthened over the last 18months
4.6	Undertake series of workshops with the workforce (ensure good crosssection of staff such as clinician, estates, finance, procurement etc) to generate ideas and buy-in	MP	Workshops have previously been held in the Trust and this proved to be a useful exercise in 'brain storming' to generate ideas. It is proposed to repeat this exercise in February 2016 and workshops will be multi-disciplinary. Relaunch of Trust values and staff engagement plan will link into this
4.7	Ensure that staff receives training to use tools and templates	MP	All senior staff have received training in preparation of project documentation and ongoing refresher training will be provided as necessary by the Programme Management Office.
4.8	Establish CIP budget holders in each division / specialty to ensure that each area is accountable	MB	Actioned (CIP targets set at divisional level and under auspices of DGM / Head of Department)
5.0	***Forecasts. reporting and turnaround plans***		
5.1	Prepare financial baseline	MB	Actioned
5.2	Assess underlying run rate vs outturn positions	MB	Actioned
5.3	Increase finance team bandwidth / review capabilities / align to divisions etc.	MB	Actioned (Finance division restructure under way).
5.4	Reduce the number of budget holders and reset objectives	MB	Individual letters written by CEO to all general managers and Senior nurses stipulating expectations in relation to budgetary control and achievement of CIPS All Execs have objectives as above and additionally all Exec leads for CIP schemes made fully aware of their responsibilities to deliver.
5.5	Develop turnaround plan (recovery plan)	MB	Actioned (in accordance with the Enforcement Undertakings signed by the Trust on 10.08.15 and Monitor on 12.08.15).
5.6	Develop clinical service sustainability review and strategic plan	MB	Three main target areas for clinical sustainability being addressed, Out patients, Trauma and Orthopaedics and Stroke care. Efficiency, productivity and cost reduction plans agreed. Joint clinical Stategy being developed between St Helens and KNowsley Trust lead by respective medical directors
5.7	Develop structure of daily, weekly and monthly operational performance review	MB	Turnaround plan reviewed weekly by executives. Daily by PMO, Monthly bilateral reviews with Executive team and Divisional teams.
5.8	Develop automated key performance reports and KPI dashboards	RW/MB	HR have implemented. Trust currently developing Balanced Scorecard.
6.0	***Business cases / Capital expenditure***		
6.1	Review live business cases and assess what can be deferred or stopped	MB	**Under continual review.**
6.2	Review planned capital expenditure what can be deferred or stopped	MB	Actioned (the Capital Planning Group meet monthly and review actual spend and planned spend for the remainder of the year. All capital expenditure is risk rated and only schemes that are deemed high risk are approved. A number of schemes have already been stopped or deferred)
6.3	Ensure that all business cases and capex is procured via appropriate framework	MB	Actioned (all revenue and capital expenditure is subject to either the Trust SFIs or EU procurement regulations and the most appropriate procurement route is adopted which may be via approved framework or the most suitable tendering route).
7.0	***Governance***		
7.1	Create turnaround board or steering committee	MB	Actioned - Finance and performance committee is the committee of the board that deals with finance and performance issues, the committee is chaired by a Non exec and meets on a monthly basis (at least 10 meetings per year)
7.2	Ensure that the committee meets on a regular basis and feeds back to the board and to overall staff communications	MB	Actioned following monthly meeting a verbal update is given to the board meeting with the confirmed minutes following a month in areas. Monthly team brief is then utilised as the vehicle to inform wider staff groups
7.3	Review effectiveness of current management structures - are they effective	MB	Actioned (move to CBUs 1st April 2016).
7.4	Consider utilisation of non-executive directors for certain roles (if the skill set fits) to increase Trust's capacity	MP	A non-Executive Director (with a background of finance) is now a member of the Innovation Cost Improvement Committee which is held on a monthly basis. This provides additional challenge and scrutiny of the CIP Programme.
7.5	Create a plan to gain and maintain "grip" - including controls and processes. Ensure that the plan has key milestones and assigned responsibilities.	MP	The CIP programme is monitored through a system called PM3 which produces regular reports and RAG rating status of individual projects. These are submitted on a monthly basis to the Programme Board and Innovation Cost Improvement Committee.
8.0	***Management and executive board***		
8.1	Review necessity for various management meetings and committees etc. to free up management time		Trust Board 'time out' arranged for 15.01.16 to progress these items.
8.2	Ensure that there is a greater challenge during board and other key meetings		

Gaining grip and control - key areas to consider (short term only)

Action	Area	Comments (Exec Lead)	Comments (Description)
8.3	Establish list of ongoing and planned projects and determine what can be cancelled or delayed to free up people's time		
8.4	Establish list of budget holders and determine level of buy-in so far (link with the SFIs reset)		
8.5	Turnaround board to approve all new projects across the trust (reduce distractions, focus on critical path)		
9.0	***Culture and communications with internal and external stakeholders***		
9.1	Review existing workforce communications plan and improve and change to reflect the key changes in culture and approach	RW	New improvement culture commenced September 2015
9.2	Establish regular contact and communications with the staff to ensure staff understanding and engagement (maybe establish employee forum)	RW	Actioned (via staff groups already established)
9.3	Establish regular workshops to gather cost saving ideas and drop in session to communicate changes	MP	A 'Bright Ideas' initiative was launched 2 years ago to encourage staff to suggest cost saving ideas. This has continued with regular updates, feedback and reminders using the Trust's Intranet and internal communications.
9.4	Ensure that the management and the board embraced the "culture of cuts" and of continuous improvements throughout the trust.	MP	An update on the Trust financial position and progress against CIP schemes is routinely delivered by the Chief Executive in the monthly Team Briefs for all staff.
9.5	Establish regular contact with the trustees and ensure that they understand the key developments and changes	MB	Actioned (via Governors Council)
9.6	Establish regular contact with external stakeholders such as commissioners, other acute trusts, NHSE, Monitor etc.	MB	Actioned (via groups, committees already established)
10.0	***Performance management***		
10.1	Reset executive team objectives - ensure that these are geared towards grip and stabilisation		Trust Board 'time out' arranged for 15.01.16 to progress this item.
10.2	Reset staff objectives and establish process to appraise within three months of year end. Ensure trust objectives are cascaded appropriately into personal objectives	RW	Trust wide PDR apparaisal system in place
10.3	Where possible, identify non-performing individuals across the trust and ensure that they enrol on performance improvement programmes to improve skills (co-ordinate with HR)	RW	Performance Improvement and Incremental Pay Progression Policies support this process.
10.4	Create internal special measures / recovery plans for loss making specialties/directorates	MP	Ten Specialties have been targeted for cost improvement and specific objectives agreed with clinical teams. In addition to this, the SLR process has identified the top 10 loss making HRG codes which have similarly been prioritised for action.
10.5	Ensure that service line management is fully implemented throughout the organisation - this will require clear management structures and strong performance management buy-in.	MB	**In progress. Service Line Reporting is well established within the Trust and divisions are provided with quarterly reports showing profit/loss by specialty and by HRG code. This will be further developed in to Service Line Management culture from April 2016 onwards following a major management restructuring and the development of 9 Clinical Business Units.**
11.0	***Workforce planning***		
11.1	Establish vacancy control board	RW	Actioned
11.2	Assess recruitment process and establish processes to maintain quality but accelerate on boarding	RW	Actioned
11.3	Implement weekly head count tracker (temporary and substantive)	RW	Actioned (monitored on a monthly not weekly basis).
11.4	Assess number of interims, termination dates and daily rates	RW	Actioned
11.5	Consider apprentices to be hired for administration, band 1 and band 2 posts under the Agenda for Change	RW	Actioned
11.6	New recruitment to be considered on short hours e.g. 30 not 37.5	RW	Actioned
11.7	Ward staffing levels v guidance (including uplift)	KD	All nurse staffing levels reviewed on a 6 monthly basis in line with all national guidance. Our uplift is currently LESS than the recommended 23% at 20%
11.8	Impose greater controls over bank and agency – self imposed cap on agency spend	RW	Actioned (Trust is applying the capped rates subject to patient safety needs)
11.9	Impose greater controls over locum spend	RW	Actioned (Nurse Agency Spend Task and Finish Group meets fortnightly to review)
11.1	Review unfunded posts – check if some funds could be recovered	RW	Unfunded posts are reviewed as part of the budget setting process prior to the start of a new financial year. This ensures close scrutiny and, if posts are to be funded on a substantive bases, divisions have to provide a supporting business case.
11.11	Consider a direct engagement model for medical and medical support staff hired through locum and agency	RW	Actioned (Trust uses Liaison Staff Flow model).
11.12	Consider rostering options and opportunities	RW	Actioned (Trust uses e-rostering system for nursing and is reviewing consultant job plans).
11.13	Review costs associated with RTT - do the penalty savings outweight the additional spend (if applicable)	MB	The Trust has historically achieved all 18 week RTT targets and has therefore not been subject to financial penalties. This has been monitored very closely during the last two months (whilst the Trust has procured a new PAS system) to ensure ongoing compliance.
11.14	Review on-call run rate	SG	Both the Estates and Medical Engineering on-call groups are currently being reviewed.
		RW	On call reviewed 2 years ago but no negotiated agreement could be reached.
11.15	Review contract rates ensure that all aligned by band / post etc.	RW	Actioned (all rates should be in line with appropriate banding)
11.16	Review any regular overspends on locum and agency staff - impose caps where possible	RW	**The expenditure on locum and agency staff is subject to ongoing review because it is a key priority CIP scheme for 2015/16. The target date for completion is 31.3.16.**
11.17	Review and compare job plans for consultants, specialist nurses - improve if and where possible	RW	**All Consultant job plans are being reviewed to ensure a consistency of approach with the Trust's Consultant Job Planning Policy. Target date for completion is 31.1.16. All revised job plans will be uploaded to Allocate (which is a software programme recently procured by the Trust to monitor clinical activity). This will then form a key CIP scheme for 2016/17.**
11.18	Ensure that e-rostering is in use for nurses and benefits realised	KD	Actioned Allocate e roster in place but is not being fully utilised, additional IT support required, agreed in October to revisit maximum benefits from february onwards. Team established to work on this
11.19	Ensure that clear systems are in use for junior doctors, consultants etc.	RW	If this relates to booking arrangements, we already have systems in place.
11.2	Monitor absence and sickness on individual, service line and trust level	RW	Actioned
11.21	Ensure that rigorous illness policy and procedure is in place to minimise absence at work.	RW	Actioned
11.22	Ensure that sickness is regularly reviewed at the board level.	RW	Actioned
12.0	***Inventory***		

Gaining grip and control - key areas to consider (short term only)

Action	Area	Comments (Exec Lead)	Comments (Description)
12.1	Establish current inventory levels and stock ordering system	MP	Actioned (Materials Management service in place on certain wards / departments with regular stock review and stock taking udertaken) Trust's JAC Pharmacy System records stock procured by the hospital and issued to cost centres. This produces a monthly balance report that shows changes in stockholding to allow further analysis. This information is shared with Finance. Pharmacy provides a top-up service which includes monitoring of stock levels to ensure stockholding is kept to a minimum.
12.2	Review stock and reset stock targets by category / area (if required)	MP	Wards have a list of stock medicines with agreed maximum stock levels. Stock medicines and maximum stock levels are reviewed both on an ad hoc basis and as part of a full review General stock - regular stock takes and reviews underken on those ward that receive a materials management services 'Small Changes / Big Differences' initiative in the process of being implemented
12.3	Consider collection of excess drugs from wards and return to the pharmacy (if possible and applicable)	MP	Medicine return (removal of medication no longer required) is performed as part of the weekly ward top-up service. Returns are checked and returned to stock if appropriate.
12.4	If possible, establish automated stock cabinets to improve stock control	MP	Automated stock cabinets are in use in Theatres for sundries/supplies items. Option to purchase automated stock cabinets for other areas for medication stocks is under review.
12.5	Ensure that drug costs are benchmarked against peers	MP	The Trust uses DEFINE to benchmark with other Trusts. Pharmacy procures medicines via the regional procurement contract wherever such contracts exist and consequently drug savings are maximised. The Chief Pharmacist attends a Regional Pharmacy forum where information is shared.
12.6	Off contract spend controls and reports are in place and monitored	MP	This is monitored and reported monthly. 'Off contract' expenditure is kept to a minimum and where the Trust has to buy off-contract, the difference in cost is claimed back.
12.7	Wastage and overspend are monitored and reported	MP	The cost of expired stock and the expenditure on medicines is monitored and reported monthly. Medicine wastage is reviewed at the Trust's Audit Committee, Medicine expenditure is report to Drug and Therapeutics Committee.
12.8	Where possible, procurement function is fully integrated into the process and incentivised to reduce costs	SB	Actioned. Annual procurement CIP target set, annual plans established and monthly monitoring agains progress undertaken
13.0	***Operational grip (including estates)***		
13.1	Ensure that uncoded spells have been minimised or eliminated - ensure that clinicians are included in the process and proper and regular training is in place.	SG	Actioned (Trust has employed a Clinical Coding manager to work with clinicans to improve depth of coding).
13.2	Review and if required enhance capacity planning for each key areas such as outpatients, wards, day cases, A&E, community areas etc.	SG	**All specialties have completed a Business Plan for 2016/17 and a key component of this is a comprehensive demand and capacity review across all points of delivery eg. OP, theatre lists etc. Draft Business Plans have been submitted at this stage and will need to be reviewed and finalised by 28.2.16.**
13.3	Ensure that capacity planning is fully implemented across the trust, down to sub-specialty level	SG	**See 13.2 above**
13.4	Ensure that utilisation data is collected and compared to plan and peers - the data to be made available throughout the trust (board, clinicians, service lines etc.). Ensure that the data creates basis for utilisation improvement initiatives.	SG	**The Trust partakes in sharing benchmarking information in most specialty areas. In addition, all divisions are encouraged to access the Better Care/Better Value indicators to compare performance with all Trusts nationally.**
13.5	Ensure that key management information is shared with the clinicians to ensure that they understand performance and targets.	SG	Clinical Leads routinely attend divisional / exec team BiLateral meetings which are held monthly. This includes a full review of all financial and performance targets.
13.6	Review outpatient procedure to ensure that as efficient as possible and any downtime is minimised	SG	The Trust adheres strictly to a 6 week notice for annual leave booking for consultant medical staff. Any clinic capacity not being used is allocated to other Specialties during the normal Monday to Friday working week to avoid paying premium costs during evenings and weekends.
13.7	Review theatre utilisation against peers and targets, share within the trust (where appropriate) and build into personal performance targets	SG	A priority CIP scheme for 2015/16 has been to improve theatre utilisation across both hospital sites in the Trust. Performance against this scheme is a key objective for the appropriate AGM.
13.8	Monitor bed utilisation, compare to peers and targets	SG	Similarly, bed utilisation is a priority CIP scheme and we have benchmarked our performance against other Trusts using the Better Care/Better Value indicators. This has highlighted potential gains in T&O, Cardiology, General Medicine and schemes to reduce beds are being progressed accordingly.
13.9	Length of stay performance is actively reviewed and managed	SG	This is routinely undertaken by the Patient Flow Manager using Point Prevalence studies as appropriate to highlight problem areas. In turn, this prompts routine discussions with Health Economy partners on delayed transfers of care.
13.10	Ensure that clear discharge policies are in place, with clearly defined responsible individuals to ensure that patients are discharged at the earliest opportunity where appropriate	SG	**Clear discharge policies are in place and the Trust has access to a fully functioning Discharge Lounge to ensure that vacant beds can be utilised as early as possible in the working day. In addition, Matrons are tasked with responsibility for ensuring that each ward is able to create at least one empty bed by 10am each day. This is subject to daily monitoring and reporting. This action was recommended during the most recent ECIST visit.**
13.11	Ensure that staff levels are matched to patient demand patterns to avoid waits and avoidable admissions	KD/SG	Nurse staffing levels in the Trust are routinely measured and monitored using the Telford model. Medical staff job plans are reviewed on an annual basis to ensure a good balance between demand and capacity to meet the needs of the organisation.

BOARD OF DIRECTORS

16/023

SUBJECT:	**Briefing Paper and Living Well Action Plan**	
DATE OF MEETING:	27 January 2016	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Jan Ross Deputy Chief Operating Officer	
EXECUTIVE DIRECTOR:	Sharon Gilligan, COO	
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):	The Purpose of this briefing paper is to give the Board an update on current performance against the four hour standard and associated Action plan (Living well Action Plan). It is important to note that within the Trust there are two separate working documents that sit below it to ensure key actions are addressed within a timely manner.	
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.

Briefing Paper : Living well Action Plan

January 2016

Jan Ross Deputy Chief Operating Officer

Overview

The Purpose of this briefing paper is to give the Board an update on current performance against the four hour standard and associated Action plan (Living well Action Plan). It is important to note that within the Trust there are two separate working documents that sit below it to ensure key actions are addressed within a timely manner. The Accident and Emergency Department (AED) task force plan and the Acute Medical unit (AMU) task force both meet weekly and track and monitor the working plans.

Background

The Trust has struggled to consistently deliver performance against the 95% standard for the past eighteen months despite a reduction in attendances. There have been several in-depth reports which have all given recommendations for improvement. The Living well Action Plan has been jointly written with the CCG and pulls together all previous Action plans and recommendations from the various reports, it was written following a joint event where the UM report was discussed in detail with the CCG the Trust and the Local Authority.

With the support of the AED team and an interim manager we have set about the necessary key actions identified in the living well action plan, with the overall aim of enabling sustainable delivery of the four hour standard. Both the, Accident and Emergency Department and the Acute Medical Unit meet weekly as a task force to ensure the key actions are happening within the agreed time frame, and issues are logged and escalated as appropriate. The Deputy Chief Operating Officer meets weekly with the Chief Operating Officer to feedback on progress; to date in turn the Chief Operating Officer updates the Executive team weekly.

Progress to Date

The main changes to date have been the move to define assessment space in both scheduled and unscheduled care. The Surgical Assessment Unit (SAU) was moved the first week in October to an area where patients cannot be bedded overnight therefore enabling us to have assessment space free at 8am every morning. The GP Assessment Unit GPAU was also redefined as assessment space with the capacity for ten trollies and this was opened on the 4th November, we managed to keep this functioning for two months until week commencing 4th January when we have seen an increase in ambulance attendances as well as an increase in admissions and required to use the assessment space as escalation beds. On average we have since the 4th January had 37 extra escalation beds open to manage demand. The Acute Medical Unit assessment space has been re allocated back to assessment space as of the 20th January.

Throughout the same two week period (4th January- 20th January) we have also seen an increase in medical outliers we have had 20 -30 medical outliers within the scheduled care bed base in January last year the outlier number was between 3-40. All patients receive a daily medical review and this is tracked through the bed meeting to ensure safe effective care. This week we have managed to considerably reduce to 14 outliers and again the plan is to move back to the target of less than 10, which we consistently achieved prior to Christmas.

We have seen some improvements in aspects of patient flow throughout the hospital bringing the teams together both geographically as well as in the bed meetings. The bed meetings have been restructured and the information required at those meetings clearly defined to ensure accurate information is provided to enable prompt and appropriate decision making. We are now in the process of clearly defining roles and responsibilities as well as looking at our on call process. We run a "perfect 7" from the 4th of January however as this was an extremely busy week for us and our partner agencies the impact was not as great as expected, although it did ensure that everyone was focused on flow and patient safety. We also tested the Full Capacity Protocol as we enacted it for the longest period to date. We are now in the process of reviewing the impact and will make any changes required to the policy through Emergency preparedness meeting.

We plan to run a MADE event in February to have a whole system approach to patient flow. The main purpose of a MADE event is to challenge whether patients in every bed on a ward need to be in hospital. Review relevant inpatients to assess opportunities for more rapid or even same-day discharge, based on examining how far individuals are from being "medically fit for discharge" and how this is being applied, constructive challenge of any 'unhelpful rules', and flexibility on the part of community services. We hope it will highlight local myths or misunderstandings about services and what could be managed in the community and overall improve communication and understanding between all parts of the system

Within the Accident and Emergency Department the key priority is Triage and initial assessment. Although we do deliver the Monitor targets on Median time to initial Assessment and mean time to treatment, it is apparent that we stream the majority of patients through our major's space and therefore potentially cause longer queues than necessary. To resolve this issue we are introducing a different way of working with an assessment hub from the 1st February which will be Senior Nurse Lead with Medical Support, the team will run this for one month then review and revise as necessary.

The majority of the breaches of the four hour standard occur during the Night, the consultant team have therefore agreed to work several night shifts throughout the month of January as part of a diagnosis process, and the detail will be feedback through the weekly taskforce and actions agreed.

Current Performance

As can be seen by the chart below (Appendix 1) The Trust has not achieved the target of 95%, November and December have seen a deterioration in that sustained performance and January is also proving difficult, It must be noted that the other quality indicators within the report do

demonstrate that we are meeting Monitors targets for assessment and treatment. The attached action plan demonstrates the key actions being taken to support improvement in performance.

The implementation of Lorenzo has given the operational teams additional pressures and the teams are attempting to get back to business as usual. Some management changes have been made to support the stabilisation phase, the process of discharge from AED is currently being reviewed as it continues to cause some delays in removing patients from the system and is therefore contributing to breaches.

Summary and Next Steps

There remains a lot of work to be completed within the Accident and Emergency department. A focus on triage and senior clinical decision making is the next key priority. As well as ensuring the majority of patients are seen within 60 minutes.

The Trust is also planning to run a MADE event in February to try and support flow and gain the support of the wider health economy in establishing issues and areas for support.

The key actions are taking place to sustainably address ongoing failure to achieve the four hour standard, however as reported in the December update we have had a difficult December and January. The plan is to get back on track with our action plan and drive forward with the changes required. A further update on the action plan will be brought back in six months' time.

Appendix 1

#	Metric	Target trajectory	Jul-15	Aug-15	Sep-15	Qtr2	Oct-15	Nov-15	Dec-15	Qtr3	Jan-16	Feb-16	Mar-16
1	A&E 4 hour wait target (including walk-in activity from Widnes from August)	95% by end of Sept 2015	93.96%	93.17%	91.69%	92.92%	90.74%	88.09%	85.03%	88.02%			
2a	Median time to initial assessment in AED	Q2 <70mins Q3 <65mins Q4 <60mins	13.0	14.0	13.0	14.0	12.0	13.0	16.0	14.3			
2b	95th percentile time to initial assessment in AED	Q2 <120mins Q3 <110mins Q4 <100mins	63.0	65.0	69.0	66.0	63.0	70.0	85.0	72.4			
3	Median time to treatment in AED	Q2 <200mins Q3 <190mins Q4 <180mins	70.0	66.0	73.0	70.0	76.0	88.0	77.0	79.8			
4	Medical outliers on last day of the month / quarter	<10 patients by end of Sept 2015	0	18	12		26	13					
5	% discharges taking place before midday (average for month / quarter)	Q2 20% Q3 28% Q4 35%	16.92%	16.19%	16.19%	16.45%	18.41%	17.00%	18.51%	17.95%			
6a	NHS attributable DToC (patients)	Q2 15 patients Q3 10 patients Q4 5 patients	9	10	22		18	23	14				
6b	NHS attributable DToC (days)	Q2 45 days Q3 30 days Q4 15 days	295	261	332		532	292	552				
6c	External partner attributable DToC (patients)	Q2 50 patients Q3 40 patients Q4 30 patients	4	9	6		2	4	1				
6d	External partner attributable DToC (days)	Q2 150 days Q3 120 days Q4 90 days	123	176	145		58	32	53				
7	% of patients in hospital for 21 days who receive an MDT case note review	Q2 40% Q3 60% Q4 80%			95.14%		91.61%	85.79%	69.23%				

IMPROVING NON ELECTIVE CARE IN WARRINGTON

Theme	**Achievement of AED Quality Standards**
Outcome statement	**If it can't be managed in 4 hours - it shouldn't be managed here**

DO NOW	Within 30 Days
Do SOON	Completed within 60 days
DO LATER	Timescale to be defined

Clinical Leads / Owners

Doctor	Nurse	AHP	Manager	Exec Sponsor

Support required

What evidence will there be that actions have been done ?

	What will you do ?	Qualiatative Indicators	Quantitative Indicators	Risks to delivery	Responsible person	Timescale for completion	Ease of Delivery - NOW/SOON/LATER	Comments
Goal	**People receive a quality service when requiring AED services through use of consistent A&E processes**							
Objective 1	To improve triage system and processes to segment care pathways appropriately	Median time to initial assessment in AED Q2 <70mins Q3 <65mins Q4 <60mins	Achievment of A&E Quality Standards Redesigning of Triage, Minors, Walk in major pateints, ambulatory care and majors area to improve effeciency and flow.	Waiting for beds for pateints requiring admission. Processes within ED are not robust enough.	Dr Anna Vondy / Sue Talbot Crosby / Catherine McWhinney	1st February 2016 - initial trial		Reviewed weekly in AED Taskforce Group and monitored via the AED workplan
Objective 2	To define AED flow - with a critical path of A&E process to achieve care within a maximum of 4 hours (national standard achievement)	Median time to treatment in AED Q2 <200mins Q3 <190mins Q4 <180mins	Trajectory towards achievment of 4 hour target - and then consistent achievment againt national target	Culture & Behaviours across the system / commitment to 95% standard	Clinical Lead / Matron	01/04/2016		
Objective 3	Early warning and escalation processes are in place when 4 hour perfomance is challenging	Escalation plan/Dashboard triger appropriate Response- live database/information which feeds data from Lorenzo and can easily be is cascaded	Escalation process is agreed with appropriate triggers and escalation responses when required	Capacity of other services to respond timely. Trust escalation and system wide escalation plan to be reviewed.	Dr Roy Bhati / Emma Blackwell / Jan Ross	internal escalation 1/2/16		Escalation triggers are being written both internally and externally to ensure a whole system response this element has no time scale at present meetings are set up
Action 1	Nominated senior nurse co-ordinates the activity and workload of the AED	Doctor Controller and Nurse Controller on every shift. Identified by different colour uniform.	Identified Lead Nurse as part of rota and available for every shift	Funding for uniforms	Sue Talbot Crosby	01/02/2016		Awaiting Uniforms
Action 2	Triage within 15 minutes of presentation to A&E service Triage process will consider needs of 0-18 years, adult and 75+/frail age groups		80% of patients will be Triaged within 15 minutes of arival	Culture & Behaviours / Flow throughout the rest of the hospital / Appropriate staffing	Sue Talbot Crosby	31/12/2015		Triage HUB implemented 1st February 2016, Consultant led but senior nurse delivered. HUB will receive 1) all ambulance patients and 2) walk in patients will self stream, using the screems in the waiting room.
Action 3	Triage can activate required diagnostic services	Diagnosis can be made quickly and decisions therefore made in a timely manner.	80% of diagnostics are completed withing 2 hours of request.	Demand Training of staff including IRMER training Governance approval	Sue Talbot Crosby Neil Holland	31/12/2015		Discussions taking place between relevant managers to ensure Goverance and training are in place
Actions 4	Time from arrival to definitive treatment from a decision making clinician within 120 minutes	Median time to treatment in AED Q2 <200mins Q3 <190mins Q4 <180mins	95% of patients seen with agreed timeframe	Medical Rota / Nurse staffing	Deputy Medical Director / Matron	31/03/2016		
Action 5	AEC pathways are in place for people who meet the criteria	Increase zero Length of Stay	The CCG have agreed to fund the Trust to join the Ambulatory Network	Staffing Resources	Sue Talbot Crosby /Dr Anne Robinson	01/04/2016		This Piece of work commences in April background work has already started pathways have been identified and written
Action 6	Breach analysis focusing on out of hours	reduction in breaches therefore patient experience	Reduction in number of breaches particulary out of hours	Staffing resorce	Sue TC	01/02/2016		AED Consultants have agreed a rota

BOARD OF DIRECTORS

16/024

SUBJECT:	**Risk and assurance**	
DATE OF MEETING:	27th January 2016	
ACTION REQUIRED	**Note the report**	
AUTHOR(S):	Millie Bradshaw	
EXECUTIVE DIRECTOR SPONSOR:	Karen Dawber, Director of Nursing and Governance	
LINK TO STRATEGIC OBJECTIVES:	All	
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.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	They are 26 risks within the Part 1 RR. The risks have been escalated up through the Governance processes of Divisional Integrated Governance Groups and sub-committees to the Quality Committee. Discussion took place at the Quality Committee to review Estates and Infection Control Part 1 risks.	
RECOMMENDATION:		
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

Part 1 Risk Register

EXECUTIVE SUMMARY

The primary purpose of the Risk Management System is to help staff to; -

- improve the quality of care and treatment;
- protect patients, staff and visitors from harm;
- Eliminate or reduce unnecessary costs.

PROCESS

- Source of the Risk (financial, incident, external review, national guidance) as examples
- Control measures in place to try and manage the Risk. If these do not work as the Risk continues then an…
- Evaluation to assess if the Controls are effective or not…
- Action Plan is set up which includes a number of…
- Actions points to clearly identify the steps in the Action Plan to mitigate the risk

CLASSIFICATION OF RISK AND PROCESS

EXTREME (15-25): In all cases, where the risk of personal injury or damage is imminent, immediate remedial action must be taken. The risk is applied to the Part 1 Risk Register on CIRIS. The risk will be reviewed at the Safety and Risk sub-Committee on a monthly basis.

An appropriate Lead is identified for each risk to ensure regular assessment of the risk and the development and implementation of action plans.

It is accepted that, in some cases, required actions will have resource implications and that this could take considerable time to achieve. It is recognised that it is neither realistic, nor practicable; to eliminate all risks and the emphasis will be upon managing and controlling significant risks.
The risks of 15-25 result in the Board of Directors deciding where resources are to be allocated and which risks are to be considered acceptable.

NB. Where it is not possible to treat the risk at the prescribed level, the risk is communicated up through the management structure which includes Bilateral meetings.

REVIEW OF THE RISK REGISTER

The Risk Registers are reviewed monthly at DIGG'S and at the Safety and Risk and the Patient Safety Committees. Any amendments and/or recommendations requested by either Sub Committee are carried out by the relevant Lead.

The Risk Register is reviewed at the Quality Committee monthly and any amendments and/or recommendations are given to the Associate Director of Governance, who is responsible for contacting by email and phone the relevant lead to ensure these amendments are made.

ACTIONS TO ENSURE RISK REGISTERS ARE KEPT UP TO DATE

A monthly Governance dashboard is sent to the Leads and Governance Managers to remind them to update their Risk Register entries, check their Control measures are in place and actions plans reviewed and updated. The Dashboards also form part of the Bilateral review meetings

NEXT STEPS

From April 2016 the RR will form part of the Board Dashboard.

RECOMMENDATIONS

The Board are asked to receive, review, note and comment on the escalation of the Risks within the January 2016 submission which includes:

- Part 1 Risk Register (overview)
- Individual risks with Controls, Evaluations, Action Plan and action points

CONCLUSION

The Board to be assured that all risks and being reviewed and monitored in accordance to the Risk Management Strategy.

Part 1 Risk register (To be read in conjunction with accompanying report) 26 Items

Risk ID	Risk Title	Division / Department	Source of the Risk	Date Identified	Initial Risk Score	Managerial Lead	Date of Last Review	Impact Rating	Residual Risk Score	Date for Review	Target Date for Completion	Strategic Aim Risk Score
Group Name: Corporate Nursing												
000074	Risk of failure to deliver on the zero tolerance (MRSA Bacteraemia) threshold 2015/2016	Infection Control	Incident	07/05/2015	Extreme risk 16	McKay, Lesley; Matron - Infection Control; INFCON	05/01/2016	4 - Major	Extreme risk 16	02/02/2016	31/03/2016	4
					Extreme risk 16		05/01/2016	4 - Major	Extreme risk 16		31/03/2016	4
000549	Risk due to limited time/human resource of Antimicrobial Pharmacist	Infection Control	External Review	03/12/2013	High risk 12	McKay, Lesley; Matron - Infection Control; INFCON	05/01/2016	4 - Major	Extreme risk 16	02/02/2016	31/03/2016	4
001045	Lack of an adequately resourced surveillance system	Infection Control	Risk Assessment	05/03/2015	Extreme risk 16	McKay, Lesley; Matron - Infection Control; INFCON	05/01/2016	4 - Major	Extreme risk 16	02/02/2016	31/03/2016	6
Group Name: Estates												
000134	External Fire Audit has identified a risk due to Inadequate Emergency (Escape) Lighting within Phase 2 at Halton site (Phase 1 completed)	Estates	Risk Assessment	31/01/2009	Extreme risk 16	Patterson, Ron; Capital Projects Manager; EST	02/11/2015	4 - Major	Extreme risk 16	31/01/2016	29/02/2016	4
000170	External Fire Audit has identified a Risk due to Inadequate Emergency (Escape) Lighting - Warrington Appleton Wing	Estates	Risk Assessment	31/01/2009	Extreme risk 16	Patterson, Ron; Capital Projects Manager; EST	02/11/2015	4 - Major	Extreme risk 16	31/01/2016	31/07/2016	4
001296	Risk of reputational damage following introduction of automatic number plate recognition car park management system.	Estates	Complaint	09/07/2015	Extreme risk 20	Cresswell, George; Associate Director of Estates; EST	02/11/2015	4 - Major	Extreme risk 16	31/01/2016	31/12/2015	8

Risk ID	Risk Title	Division / Department	Source of the Risk	Date Identified	Initial Risk Score	Managerial Lead	Date of Last Review	Impact Rating	Residual Risk Score	Date for Review	Target Date for Completion	Strategic Aim Risk Score
001066	Risk of proliferation of water-borne pathogens within hot and cold water distribution pipe	Estates	Risk Assessment	25/03/2015	Extreme risk 15	Wardley, Darren; Operational Estates Manager - Estates; EST	02/11/2015	5 - Catastrophic	Extreme risk 15	31/01/2016	31/03/2016	10
Group Name: Finance, Supplies and Information												
001052	Breach of Licence Conditions	Finance & Supplies Department	Committee Review	13/03/2015	Extreme risk 20	Barrow, Steve; Deputy Director of Finance; FIN	18/01/2016	4 - Major	Extreme risk 20	28/01/2016	31/03/2016	12
Group Name: HR												
000269	Risk of expenditure on temporary staffing significantly exceeding budget and affecting the future viability of the trust with reports to Monitor	Human Resources and Organisational Development	Committee Review	01/04/2012	Extreme risk 20	Wilson, Roger; Director of Human Resources & OD; WHH	30/12/2015	4 - Major	Extreme risk 16	03/02/2016	31/03/2016	8
Group Name: Scheduled Care												
001559	Potential financial risk to the Division due to Charnel Ventilation failing in theatre 1. Leading to potential fine if RTT not met.	Scheduled Care Division	Committee Review	13/10/2015	High risk 12	Rigby, Mark; Theatres Manager - Warrington; W-TH	12/01/2016	5 - Catastrophic	Extreme risk 15	09/02/2016	29/02/2016	6
Group Name: Trust Wide												
001075	Risk to the trust financially and reputationally if the clinical teams do not have support to access data and complete returns on AQ clinical measures	Warrington and Halton Hospitals NHS Foundation Trust	Audit	14/04/2015	Extreme risk 16	Ramakrishnan, Subramaniam; Consultant; GASTRO	16/12/2015	4 - Major	Extreme risk 16	20/01/2016	04/04/2016	4
001549	Summary Hospital-level Mortality Indicator (SHMI): higher than expected	Warrington and Halton Hospitals NHS Foundation Trust	External Review	19/10/2015	Extreme risk 16	Constable, Simon; Medical Director; EXMD	19/10/2015	4 - Major	Extreme risk 16	30/01/2016	31/03/2016	8
Group Name: Unscheduled Care												

Risk ID	Risk Title	Division / Department	Source of the Risk	Date Identified	Initial Risk Score	Managerial Lead	Date of Last Review	Impact Rating	Residual Risk Score	Date for Review	Target Date for Completion	Strategic Aim Risk Score
000898	Potential risk to Trust reputation and financial impact of not meeting AED 4 hour Targets	Accident & Emergency Department	Committee Review	28/11/2014	Extreme risk 20	Franklin, Sue; Divisional Head of Nursing - Unscheduled Care; UCD	22/12/2015	4 - Major	Extreme risk 20	24/02/2016	30/12/2015	8
001464	Loss of Registrars as training posts	Unscheduled Care Division	External Review	21/09/2015	Extreme risk 20	Constable, Simon; Medical Director; EXMD	08/01/2016	4 - Major	Extreme risk 20	20/01/2016	29/02/2016	8
000165	Potential risk to patient safety, performance & targets due bed capacity and patient flow through AED	Accident & Emergency Department	Risk Assessment	15/10/2012	Extreme risk 16	Franklin, Sue; Divisional Head of Nursing - Unscheduled Care; UCD	22/12/2015	4 - Major	Extreme risk 16	24/02/2016	30/12/2015	9
000542	Lack of physical capacity of GPAMU to review patients	Acute Medicine	Risk Assessment	15/10/2013	Extreme risk 16	Forrest, Dawn; Divisional Manager - Unscheduled Care; UCD	23/12/2015	4 - Major	Extreme risk 16	26/01/2016	30/11/2015	4
000967	Staffing vacancies within Cardiology impacting on capturing patient data/ financial implications	Cardiology	Risk Assessment	02/02/2015	Extreme risk 15	Seddon, Helen; Assistant General Manager – Cardiology & Respiratory; UCD	23/12/2015	3 - Moderate	Extreme risk 15	23/02/2016	30/11/2015	6
Group Name: WCCSS												
000900	Non-compliance with the requirement to provide full SACT data and with the requirement to have electronic chemotherapy prescriptions. Risk increased.	Pharmacy	External Review	02/12/2014	Extreme risk 15	Matthew, Diane; Chief Pharmacist - Pharmacy; WCSS	08/12/2015	4 - Major	Extreme risk 20	09/02/2016	31/03/2016	3
000089	Insufficient staffing establishment to meet minimum service requirements affecting key objectives and patient safety Linked to 000347 and 000724	Pharmacy	Risk Assessment	31/01/2011	Extreme risk 16	Matthew, Diane; Chief Pharmacist - Pharmacy; WCSS	08/12/2015	4 - Major	Extreme risk 16	09/02/2016	30/03/2016	8

Risk ID	Risk Title	Division / Department	Source of the Risk	Date Identified	Initial Risk Score	Managerial Lead	Date of Last Review	Impact Rating	Residual Risk Score	Date for Review	Target Date for Completion	Strategic Aim Risk Score
000695	CT Unit Environment (Warringt on): Lack of space, lack of privacy & dignity.	Radiology	Risk Assessment	07/05/2014	Extreme risk 16	Holland, Neil; Assistant Divisional General Manager - Radiology; RAD	08/12/2015	4 - Major	Extreme risk 16	09/02/2016	31/03/2016	8
000772	Risk of NNU having to close due to staffing shortages. increased risk of infection. Increased risk of infants being transferred out within the network	Child Health	Risk Assessment	19/09/2014	Extreme risk 20	Scott, Jane; Matron - Child Health; SCBU & NNU	08/12/2015	4 - Major	Extreme risk 16	12/01/2016	31/01/2016	8
001204	Inability to implement Shared Care until DAWN system has been installed. Failure to implement can result in the CCG not commissioning us.	Rheumatology	Risk Assessment	15/06/2015	Extreme risk 16	Warbrick, Kate; Divisional Manager - Scheduled Care; SCD	08/12/2015	4 - Major	Extreme risk 16	09/02/2016	31/03/2016	8
001209	Risk of harm to patients because demand exceeds current medical and nursing staffing capacity. Replaces risk ID : 000728 which has been retired.	Rheumatology	Risk Assessment	15/06/2015	Extreme risk 16	Warbrick, Kate; Divisional Manager - Scheduled Care; SCD	08/12/2015	4 - Major	Extreme risk 16	09/02/2016	31/03/2016	8
001250	Poor compliance with NHS Cancer Screen Programme Quality Assurance (QA) Colposcopy services recommendations from 2010 & 2013 assessment reports	Women's Health	External Review	19/06/2015	Extreme risk 16	Warbrick, Kate; Divisional Manager - Scheduled Care; SCD	11/01/2016	4 - Major	Extreme risk 16	29/02/2016	29/02/2016	6
001094	Risk of improvement notice/services being de-commissioned if Trust is unable to procure and install an electronic chemotherapy software system	Women's, Children's and Support Services Division	External Review	09/05/2015	Extreme risk 15	Warbrick, Kate; Divisional Manager - Scheduled Care; SCD	10/12/2015	5 - Catastrophic	Extreme risk 15	09/02/2016	31/03/2016	5

16/024ii

BOARD ASSURANCE FRAMEWORK

2015/16

January 2016

Commentary

The Board last reviewed the assurance framework at the November '15 meeting. As at that date there were 13 significant risks recognised against the four corporate objectives. Each risk was scored against the (likelihood x impact) matrix at the rear of this document.

The table below illustrates that the totality of risk faced by the Trust has increased during the past two months, with a larger number of risks scoring more highly. Each of the four objectives now has a risk scoring 20 threatening its achievement. This reflects the increasing pressure to which the Trust is subject over the past two months.

	Number of risks	
Risk score	November 2015	January 16
20-25	2	4
15-16	3	3
12	4	3
Upto and including 10	4	3 (removed)

In this version of the assurance framework, any risks with a current score upto and including 10 have been removed to enable the Board's focus to be particularly on higher scoring risks. Higher scoring risks pose greater threats than the Board's risk appetite provides for and further mitigation to reduce each risk is in progress.

The table below summarises the position as at January 2016:

BAF risk #	Moniker	Risk owner	Initial score	Nov 15 score	January 15 score
Objective 1:To ensure that all care is rated amongst the top quartile in the NW for patient safety, clinical outcomes and patient experience.					
1.1	CQC compliance for quality	DoN&G	25	15	15
1.2	Health and safety	DoN&G	15	10	10 & removed
1.3	National and local mandatory, operational targets	COO	16	12	20
1.4	Business continuity	COO	20	5	5 & removed
Objective 2: To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work together to care for our patients.					
2.1	Engage staff; adopt new working, new systems.	DoIT	16	8	16
2.2	Nurse staffing	DoN&G	25	20	20
2.3	Medical staffing	MD	25	12	12
2.4	Engaging and involving workforce	DoHR&OD	20	10	8 & removed
2.5	Right people, right skills in workforce	DoHR&OD	25	15	15
Objective 3: To deliver well-managed, value for money, sustainable services.					
3.1	Developing Estates OBC to FBC	DoF	16	12	12
3.2	Monitor undertakings: corporate governance and financial management	CEO / DoF	20	15	25
3.3	Clinical and business information systems	DoIT	16	12	12
Objective 4: To work with our partners to consolidate and develop sustainable, high quality care as part of a thriving health economy.					
4.1	Length of stay; delayed transfers; bed shortages.	DoN&G	25	20	20

In the schedules below the Executive sets out the main controls, assurances and gaps in control over each of the current risks remaining with a score of at least 12. They are set out as risks against each of four the corporate objectives.

The Board is invited to review the controls and assurances set out over the risks and to determine what further action may be required.

Quality

Strategic Objective 1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience

Ref	Principal Risk (failure = key risk)	Initial Risk Score LxI	Control systems	Residual Risk Score LxI	Assurance	Gaps in Assurance/Controls
1.1 DoN&G	i. **Failure to comply with the CQC regulations for service providers and managers (Health and Social Care Act 2008/14) – Currently rated *Requires Improvement* following comprehensive inspection January 2015** ii. **Failure to have effective risk management systems in place** iii. **Failure to engage with patients, public and staff to provide the best possible patient experience**	5x5 (25)	Executive Directors responsibility for CQC Outcomes, with identified operational leads reporting via Board Committee	3x5 (15)	Quality Committee assurance that accountabilities and processes have been discharged with a focus upon understanding reductions of harm. Matrons Round – *back to basics.* Safety Thermometer results. Quality Report and external audit limited scope assurance report. CQC Action Plan tracked in Quality Committee.	The committees are still in the first 6 months of operation and processes and reporting is still evolving following a very comprehensive review of the structures. CBU structure to be implemented from April 15. Assessment Centre will identify CBU leadership talent. *'We are WHH'* values and behaviours to be launched. *Operation Springboard* CBU launch.
			Implementation of the national CQUIN for the NHS Safety Thermometer Implementation of AQ indicators		Quality strategy to monitor and progress reporting against Safety Clinical Effectiveness and Patient Experience Strategy	Not yet fully compliant with all areas of AQ National CQUINs for Sepsis and AKI difficult to fully implement
			Accountability through governance structures including bi-lateral review at divisional level.		Targets for reducing harm have been achieved eg avoidable pressure ulcers, UTIs, VTE, medication errors and 'never events'. NHSLA standard ratings were level 2 (2012) for general standards; and level 3 (2013) for Maternity.	Need to be able to look at different ways of monitoring effectives with a more outcome focus Remain areas of non-compliance or less than would be expected
			Trust policies and procedures including completion of CQC Assurance Templates by leads and service managers		Effective operation of Assurance Committees. Outcomes from work of Assurance Committees are reported to Board e.g. exceptions and assurances through minutes.	Currently very reliant on process and assurance is often gained from measuring the process not the out come
			Quality Strategy approved by the Board in November 2014.		DAWES Audits, MIAA audits. Internal audit report actions tracked on Sirus. NED walkabouts with Execs. Benchmarking Complaints and Patient Feedback quarterly report HED data	Most indicators and reported audits concentrate on ward and nursing areas, need to expand to greater coverage Nursing Strategy to be launched April 16.

Ref	Principal Risk (failure = key risk)	Initial Risk Score LxI	Control systems	Residual Risk Score LxI	Assurance	Gaps in Assurance/Controls
					Quarterly review of quality indicators and priorities.	W & C / Midwifery Strategy to be launched April 16. Patient Experience Strategy draft Jan 16. Midwifery Strategy draft as at Dec 15. Complaint / patient experience data is very complaint-focussed and reactive; need to move to a more proactive way of both engaging with stakeholders and reporting feedback. Gaps in Patient Experience team; review due in 2016. New strategy less than 1 year old.
			Quarterly meetings with CQC to monitor on going actions Monthly clinical quality meetings with the CCG		CQC unannounced inspection report March 2013 from visit held in January 2013 Care Quality Commission rating Requires Improvement from inspection January 2015, published July 2015 Action plans in place for compliance with CQC recommendations Action plans in place to address QSG Concerns Participation in regional and Cheshire and Mersey wide initiatives: Aqua; mortality collaborative etc. External assurance requests when additional assurance is required examples in last 12 months from : • RCOG • Other NHSF • Specialist Trusts	Rating will require RI and actions will stand until a point when CQC re inspects Time to release clinicians to participate. Clinical leader development programme to be implemented (Top Leaders / Aspirant Directors). Actions still on going to some external reviews, these are tracked on the external review tracker
			Risk Management strategy approved on an annual basis by trust board		Quarterly risk management reports Development work commenced with Stanford Risk Authority (USA) to develop new ways of integrated risk, claims and incident management	Risk management processes are still based on NHSLA standards and are reliant on process and procedures. Work with Stanford is experimental to the UK and will be reliant on a cultural shift on how we manage incidents.

Ref	Principal Risk (failure = key risk)	Initial Risk Score LxI	Control systems	Residual Risk Score LxI	Assurance	Gaps in Assurance/Controls
1.3 **COO**	**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**	4 x 4 (16)	Operating Framework reviewed annually, and annual plan is prepared to demonstrate ability to deliver targets effectively.	5 x 4 (20)	Board involved in the Annual Planning process and subsequent reports to monitor progress of delivery against this plan.	30 GP vacancies across Warrington with no walk in centre or UCC to divert patients away from AED
			Effective operation of Governance structure.		Effective operation of Assurance Committees. Outcomes from work of Assurance Committees are reported to Board. Full capacity protocol ensured safe care week 2 January 16. System resilience groups (in Warrington & in Halton). Monthly KPI performance meetings.	Reduction in investment in Warrington LA has resulted in changes to criteria for care support resulting in service users having to be at the extreme of need to access support potentially resulting in a worsening in their health and independence resulting in more AED visits. Gaps in consultant and nursing leadership will be addressed by CBU structure, with triumvirate leadership, going live April 16. Fortnightly Taskforce meeting meets without Exec leadership. CBUs will need a refreshed performance management framework. We require assurance that Lorenzo is resilient; data quality acceptable; benefits realised; users adopting functionality; 16-17 budgets robust. '*MADE*' week (ESIT's tool to identify blocks around the health economy) scheduled week before half term Feb 16. Evidence that real time current and cumulative performance data being used to support and inform decision making. Reorganising resources to strengthen clinical leadership across 7 days and nights.
			Performance management system (eg Bi Laterals, diagnostic meetings each month)		Assurance that Performance management systems is operating effectively as designed.	Review of Intermediate care underway due to a evidenced base shortage of capacity causing delays in complex discharge
			Engagement with staff		Board confirmation that all appropriate staff are effectively engaged.	Domiciliary care contracts not resolved caused a shortfall in supply to help maintain services users independence at home

Ref	Principal Risk (failure = key risk)	Initial Risk Score LxI	Control systems	Residual Risk Score LxI	Assurance	Gaps in Assurance/Controls
			Awareness raising programme undertaken in relation to targets.		Confirmation that Awareness raising programme has been delivered in full.	A&E delivery of national target
			Corporate Performance and Quality Dashboard Reports to Board on a monthly basis, including infection control reports.		Internal Audit provide a range of independent assurances through the audit plan Other assurances from independent organisations eg data assurance. Management assurances around the accuracy of information provided.	New dashboard being modelled but not implemented. IG Toolkit self-assessment March 16. Internal audit data quality audit 2016.
			Executive and Non-Executive ward and services visits (Walkabouts)		Programme and results have been designed and reviewed effectively and outcomes feed into Trust programme.	
					Internal self-assessment prior to the external review.	Well-led review due 2016. Internal self-assessment prior to the external review.
			Monitor trends that are relevant to triggering a governance concern.		Results of monitoring.	
			Annual Governance Statement		Independent assurance that the annual governance statement is reliable and robust	The whole health and social care system must collectively find governance and sustainability solutions – some of which we can influence but not control.
			Whole System Management meeting [Overall health system risk that has impact on the Trust] • Lobby for non-recurrent financial support		Warrington wide response to emergency demand Aligning entre pathway under Trusts control Greater Control of Urgent Care Centre's (Halton) and provision of GPAU.	Reponses from external stakeholders / providers is too slow and lacks sophistication. Actions to be undertaken by the Trust to address gaps include: 1) New whole system dashboard 2) Senior leader escalation meetings 3) Measurable metrics to be available weekly across health system for complex delays in discharge 4) IC service review 5) Newly reformed Transformational change board to capture issues and actions 6) CCG led ED recovery weekly meeting

People

Strategic Objective 2: To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work together to care for our patients.

Ref	Risk (failure = key risk)	Risk Score LxI	Control systems	Residual Score LxI	Assurance	Gaps in Controls/Assurance
2.1 **DoIT**	**Failure to engage staff to adopt and change new ways of working when implementing the new systems**	4x4 (16)	Appropriate engagement structure in place, including reporting changes through the Strategic People Committee and Council of Governors and Members Joint working with Staff Side/JLNC	4 x 4 (16)	Signoff of a business change strategy for each project and PID. *Go live* plan executed successfully. No increase in crude mortality since *go* live (December 15: 81 inpatient deaths; in December 2014 we had 133).	Awaiting confirmation that fully featured implementation achieved eg production of contract data sets. Operational Leads for Lorenzo to be designated and in post in medium term. Business change team stood down post *go live.*
			Staff engagement events planned as part of the project.		Monitoring through IMT Programme Board and into Board from F&S.	
			Business Change and key stakeholder time included in project.		Effective operation of Assurance Committees. Outcomes from work of Assurance Committees are reported to Board eg exceptions and assurances through minutes including staff survey results, monthly KPIs, patient feedback. Divisional temperature checks through bilaterals.	
			Alignment of project to wider trust initiatives to promote the driver for change.		Compliance with standards; quality and performance reports are identifying deteriorating performance; FSC acquiring and scrutinising assurance that systems are designed well and operating effectively.	
			Time for training built into the project plans.			
			Benefits realisation plan.		Additional resource seconded in from NHSE until 2017.	Sufficient resources to execute all the engagement and training during *go live* but being withdrawn post *go live.* IM&T strategy is draft; it seeks investment in people for benefits realisation; recognition of clinical leaders through

Ref	Risk (failure = key risk)	Risk Score LxI	Control systems	Residual Score LxI	Assurance	Gaps in Controls/Assurance
						assessment centre for CBUs; revenue funding for nursing (Lorenzo) leadership (currently funded by capital); clinical champions; eg CCIO; Deputy CCIO).
2.2 **DoN&G**	**Failure to have the required nurse staffing ratios and numbers to provide a high standard of care due to a lack of resources (financial, workforce, planning)**	5x5 (25)	Director of nursing is the named executive to ensure that ward staffing is reported on a monthly basis and reviewed on a 6 monthly basis	4x5 (20)	Monthly reports are produced based on hours worked and expected levels Nursing staffing levels reviewed based on a recognised acuity tool with an agreed up lift of 20% Ward staffing levels displayed outside all wards Daily ward staffing meetings E Roster MIAA reports DAWES Reports SOS Executive ward to board walkabouts	Agreed staffing levels are in place for all ward areas but only established wards are substantively recruited to this can cause an over reliance on temporary staffing or reductions of staffing levels to cover Nationally a 23-24% uplift is recommended, there is concern that the 20% uplift is not adequate to allow for all training, holidays and sickness Reporting methodologies are based over a month and on hours worked, this does not allow for the day to day fluctuations in staffing numbers to be noticed Poor implementation of Allocate E roster has resulted in site / senior managers not getting full functionality from system
			Implementation of national and local guidance relating to staffing levels and methodologies		Reports to board are based on the recommendations of Hard Truths (NQB) and NICE guidance	Recent correspondence from the CNO / DOH has led to some confusion on the efficacy of NICE guidance and mandated staffing levels
			Viewed as an attractive place to work, as a provider of integrated care.		Staff survey; Friends & Family test. Exit interviews are sought for all nursing posts in hard to recruit areas (eg unscheduled); findings reported to NMAC or Workforce Committee. Joining the Cheshire & Merseyside Maternity Women's & Children's Network. Temporary Staffing Group monitors flexible workforce.	(More questions could be added to FFT to gain insight). *Great place to work* campaign to be launched. No online directory of services – due April 16. New staff handbook *About the Trust* being created. New *Media & Engagement Strategy* being created – due March 16.

Ref	Risk (failure = key risk)	Risk Score LxI	Control systems	Residual Score LxI	Assurance	Gaps in Controls/Assurance
					Red flags on monthly staffing report to Board.	Monthly temperature of pulse survey would provide assurance. More joint appointments to be made. Research profile to be enhanced. More organisation development activity. Data for analysing staffing is not available electronically – has to be manually collated.
			Nurse staffing levels scrutinised at Board and People committee		Monthly challenge and discussions Triangulated with incidence of Harm and any staff concerns raised	The acuity measurements of patients is manual collated on a 6 monthly basis, an additional module to the allocate E roster to enable live collection of data aprox £25k PA
2.3 MD	**Failure to have the required medical staffing to provide a high standard of care due to a lack of resources (financial, workforce, planning)**	5 x 5 (25)	The Medical Director, supported by the Divisional Chiefs of Service and Director of Postgraduate Medical Education, is the named executive to ensure that medical staff are deployed appropriately to match demand. Vacancies in substantive posts are filled with locum doctors and additional cover is sought with doctors working additional shifts flexibly. We follow national or local guidance, where published, as to suggested ratios of doctors to patients (eg. RCP ward rounds) and skill mix is determined by HENW.	4 x 3 (12)	Speciality rotas are published weekly/monthly. Increased emphasis on whole-Trust medical staffing, especially out-of-hours to combine resource for acute care, evidenced by rotas. Complaints report and summary data. DATIX incident reports. Feedback from consultants and trainees and third parties such as Ward Managers and Acute Care Team; minutes from JLNC and Junior Doctor Forums. Review of skill mix on a regular basis at Divisional and speciality level to ensure that vacancies in substantive posts can be filled with substantive Trust appointments or other longer term alternatives sought, such a specialist nurses, Physician Associates or consultants from another speciality. Collaboration with Alder Hey.	Nationally poor recruitment climate for consultants in certain specialities (e.g. acute medicine, emergency medicine and medical specialities). Local reputation and inability to attract consultants as a result of operational pressures. Fixed HENW allocation with short-notice gaps in trainees deployed. Ongoing industrial action by BMA. • Re-energised medical leadership. • Revitalised recruitment strategy. • Reform of rotas and working practices, including electronic tools. • Seeking multi-professional workforce (e.g pharmacists, PAs). No partnership Board for collaborative working with St H & K.

Ref	Risk (failure = key risk)	Risk Score LxI	Control systems	Residual Score LxI	Assurance	Gaps in Controls/Assurance
					Readiness assessment centre in March 16 will further strengthen clinical leadership. Planned development programme for 8 triplets of triumvirate leaders. Greater productivity from consultant body as clinical audit and governance work undertaken outside contracted hours for direct clinical care.	Lack of integration between Warrington & Halton CCGs. Little appetite for transformational change amongst Warrington & Halton CCGs. Few joint clinical appointments. Few benefits from membership of the Academic Health Science Network. Opportunities to be more outward facing in the health economy. Not a provider of community services. Reputation management programme required. A formal mapping process to collate business intelligence of all educational institutions training clinicians and AHPs within 30 miles could help prioritise a engagement programme to increase our share of recruits.
2.5 **DoHR& OD**	**Risk that the Trust does not have the right people with the right skills ie workforce is not competent and cannot deliver as commissioned.**	5x5 (25)	Control systems in place to support risk: • Education Governance • NMAC • National WFP • Medical Education Committee • OD Strategy • People Strategy • Talent Management • Recruit & Selection Policies and Procedures • ICC and Workforce Transformation	3x5 (15)	• Strategic People Committee • Board Workforce KPI reports • Educational Governance Reports to SPC • Workforce analysis & Workforce Plans • External Medical Education and Nurse Education reviews • Compliance with CQC & NHSLA Standards and Audits • Staff Survey • Staff engagement & wellbeing reviews • Staff FFT • NHS top 100 employers • HRD &DNS role to split in increase capacity • HR Business Partners in post • Clinical leadership being strengthened (CBUs) • 100 apprentices across the Trust • Sickness absence performance best amongst NW Trusts	Require the development of robust workforce plans linked to capacity and demand and activity profile of the changing strategic direction of the Trust Need to strengthen the links between business planning and workforce through the FSC and SPC. Requirement to reduce agency staffing and increase substantive staff recruitment. More opportunity to build: *Employer brand* *Deep employee engagement* *Mandatory training performance* *Talent management programme* *Attraction and retention strategies* *Review of L & D capacity* *Positive press relationships* *Social media profile*

Ref	Risk (failure = key risk)	Risk Score LxI	Control systems	Residual Score LxI	Assurance	Gaps in Controls/Assurance
					• Flexible working policies. KPIs: locum spend; pay performance; Band 5 nurse churn.	*Joint appointments* *Link to and programmes with Chester Uni*

Sustainability

Strategic Objective 3: To deliver well managed, value for money, sustainable services.

Ref	Risk (failure = key risk)	Risk Score LxI	Control systems	Residual Score LxI	Assurance	Action Plan Gaps in Control/ assurance
3.1 **DOF**	**Failure to move Estates Development from OBC to FBC for Phase 1 project 1 and 2 and then through to project 5, thus not delivering new estate and financial savings**	4 x 4 (16)	• Finance and Sustainability Committee to take forward • Monthly estates Project Board and appropriate sub Groups • Regular updates to the Executive Directors and HMB • Programmed slots with Board for updates	3 x 4 (12)	• Board approved 'OBC' that describes the Trust objectives and approach, regular Board updates to follow • Regular reports to the FSC evidencing actions and approach support the delivery of the strategy and its expected outcomes. • Monthly meetings of the Project Board to agree and oversee the implementation of the work plans. • Annual 6 facet survey by *NIFE Services*. • Data evidencing utilisation of existing estate.	Work with partners and stakeholders needs to be accelerated and detail enhanced. Route to funding needs to be agreed and Monitor process confirmed and worked towards Halton estate under-utilised. Kitchen, mortuary and other elements of estate require urgent improvement / replacement and monies to fund are not assured. Capital Plan 16-17 yet to determine capital rationing for estate.
3.2 **CEO & DoF**	**Failure to deliver the requirements of the Monitor undertakings with regards to Corporate Governance and Financial Management and move out of Licence Breach or into Special Measures – including:** **Failure to deliver £14.2m deficit**	4 x 5 (20)	▪ Monthly detailed report to the Board ▪ Monthly financial analysis with CoS risk rating assessment current and forecast ▪ Reporting compliance with CIP Metrics ▪ Detailed discussion and papers to the ICIC and FSC ▪ Executive Meeting Monthly Review, with Bi-laterals and HMB	5 x 5 (15)	• Financial and Sustainability Committee reviews all relevant financial and strategic reports on a monthly basis • Audit Committee reporting to the Board • Internal audit reports • Monitor reporting and monthly performance meetings • Monthly Board reporting	• Risk to delivery of CIP through either internal targets being missed or because of external agencies • Commissioner affordability of CIP and forecast plans • Budget overspends through Winter pressures or substantially increased demand • Pay costs escalate • GP referrals change in patterns • Business development strategy to repatriate activity

Ref	Risk (failure = key risk)	Risk Score LxI	Control systems	Residual Score LxI	Assurance	Action Plan Gaps in Control/ assurance
	Lack of a 3-5 year strategic plan that returns Trust to breakeven **Underachievement of CIP** **Under delivery of profitable services** **Risks outside Trusts control without immediate mitigations** **Winter Pressures CCG Contracts**		▪ Divisional management and governance accountability structures ▪ Standing financial instructions and scheme of delegations ▪ Legal contracts agreed with CCG, regular contract meetings.		• Year-end contract agreements and external audit opinion. • PMO is staffed with 3.6WTE; led by experienced appointee. • Expenditure variances to budget are small.	• CCG relationships • Joint appointments and collaboration with near neighbours • Service line reporting of CBU performance • 16-17 CIP scheme is draft, not RAG rated. • Development programme for operational managers. • Short term gaps amongst Business Change Managers. • Shared (back office) business services & pathology services offer opportunities for collaboration. • Warrington site hotter than optimal; Halton colder. • DoF does not attend monthly sustainability meeting.
3.3 **DoIT**	**i. Failure to develop a fit for purpose clinical and business information systems to support delivery of high quality patient care**	4 x 4 (16)	New 16/17 Overarching Strategy and implementation plan with approved financial investment options	(3 x 4) (12)	Board approval and subsequent monitoring of delivery of strategy via updates to Board with an assurance focus upon the twin national challenge of providing information to our patients by 2015 and moving to paperless by 2018. Programme board established to monitor progress reporting into FSC. Capital programme in place to deliver the strategy. External funding being sourced to secure addition investment. Additional resources secured and new structure being put in place aligned to delivery programme.	To refresh the Trust's IMT Strategy and development robust annual work and financial plans to support implementation and delivery. IM&T Strategy due for consideration at Jan 16 Board. Capital Plan 16-17 yet to determine capital rationing for IM&T.
			Governance Structure; IM&T Programme Board Data Quality and Management Steering Group		Medical Records Strategy Group reports and minutes. Internal audit review and reports and management action plans	Increase the establishment of Project, Training and Change IMT Team to develop and support implementation of the Trusts Strategic IMT Strategy

Ref	Risk (failure = key risk)	Risk Score LxI	Control systems	Residual Score LxI	Assurance	Action Plan Gaps in Control/ assurance
	ii. Failure to realise benefits from IMT investments as projects complete and the solution moves into business as usual mode **iii. Lack of access to medical records and key patient health information due to inability to support critical information assets and systems 24*7 as dependency increases**		Information Governance and Corporate Records Group. OPD User Group. Diagnostic Users Group Benchmarking Review Group Finance and Sustainability Committee.		IT systems project implementation progress reports to Board through committee structure (new Finance and Sustainability Committee) On Exec Team agenda frequently. Exec leads is a CEO direct report. All IM&T risks tracked on Sirus.	Operational Leads for Lorenzo are not formalised and funded from revenue long term.
			Continual benefits monitoring through IMT Programme Board and ICIC into the F&S		IMT Programme Board approved 'Business Change strategy' that describes the project objectives and approach. Passed through to Board via F&S if required. Quarterly reports to the FSC evidencing actions and approach support the delivery of the benefits and expected project outcomes.	Review the IMT Structure to ensure it remains fit for purpose to support BAU and 24*7 working. Need to satisfy ourselves that benefits realisation from Lorenzo implementation yielding to plan.
			IT on call developed and reviewed every quarter through the IG group IT SOPs continually reviewed as part of MIAA annual cycle Business continuity plans updated and tested in line with new operational SOPs		IG group review the IT Helpdesk and out of hours quarterly and report to F&S through on call and helpdesk call statistics.	Viability of 24*7 IT Helpdesk and desktop/system support reviewed every 6 months.

Sustainability

Strategic Objective 4: To work with our partners to consolidate and develop sustainable, high quality care as part of a thriving health economy for the future.

Ref	Risk (failure = key risk)	Risk Score LxI	Control systems	Residual Score LxI	Assurance	Action Plan Gaps in Control/ Gaps in Assurance
4.1 **DoN&G**	**Failure to work collaboratively with partners to reduce the patient length of stay and delayed transfers of care leading to shortage of acute beds and increased risk of harm to patients with a longer length of stay**	5x5 (25)	Daily bed meetings, policies and procedures Work with divisions at the Bilateral meetings	4x5 (20)	Integrated working and joint protocols Review of policies and protocols Work to develop integrated working including frail elderly pathways 21 day and above MDT review of all patients	Need to strengthen the debate and discussion at committee level to provide assurance Frail elderly needs additional investment
			Weekly point prevalence and statutory delays		Bed availability and reducing statutory delays	Manual data collection open to interpretation and validity questioned, Lorenzo go live will provide electronic solution
			Partnership working with other providers and commissioners – System Resilience Group, Health and wellbeing group etc		Evidence of joint working and joint developments to work collaboratively Review of discharge team and move to one team Early opportunities to work with provider colleagues to develop an integrated intermediate care system	Concerns regarding effectiveness of the SRG Different employers and T&C's Discussions still embryonic, working group in place

Glossary of Terms

Term	Definition
Assurance	Confidence, based on sufficient evidence, that internal controls are in place and are operating effectively, and that objectives are being achieved.
Assurance Framework	A structure within which a board of directors identifies the principal risks to the Trust meeting its principal objectives, and through which they map out both the key controls to manage them and how they have gained sufficient assurance about the effectiveness of those controls
Control Systems	These are actions that are intended to manage risk by reducing its impact, its likelihood of occurrence, or both and should be genuine, practicable and realistic
Gaps in Assurance	Failure to gain sufficient evidence that policies, procedures, practices or structures on which reliance is placed are operating effectively
Gaps in Controls	Failure to put in place sufficiently effective policies, procedures, practices or structures to manage risks and achieve objectives
Residual Risk Score	The likelihood and impact of the risk occurring after the controls are in place
Principal Risks	The risks which threatens the achievement of the strategic objectives
Initial Risk Score	The likelihood and impact of the risk occurring.
Strategic Objectives	Strategic objectives set by the Board of Directors

Likelihood and Impact Assessment

Likelihood and Impact Assessment

LIKELIHOOD (L)	IMPACT (I)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Almost Certain (5)	Low (5)	Significant (10)	High (15)	High (20)	High (25)
Likely (4)	Low (4)	Significant (8)	Significant (12)	High (16)	High (20)
Possible (3)	Low (3)	Low (6)	Significant (9)	High (12)	High (15)
Unlikely (2)	Very Low (2)	Low (4)	Significant (6)	Significant (8)	Significant (10)
Rare (1)	Very Low (1)	Very Low (2)	Low (3)	Low (4)	Low (5)

Likelihood score (L)	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Impact/Consequence score (I)	1	2	3	4	5
	Negligible Impact	Minor Impact	Moderate Impact	Major Impact	Catastrophic Impact

BOARD OF DIRECTORS

16/026

SUBJECT:	**IM&T Strategy 2016-2020**	
DATE OF MEETING:	27th January 2016	
ACTION REQUIRED	**For Discussion**	
AUTHOR(S):	IM & T	
EXECUTIVE DIRECTOR SPONSOR:	Jason DaCosta, Director of IM&T	
LINK TO STRATEGIC OBJECTIVES:	Relates to and supports the achievement of all strategic objectives as one of the Trust's essential enabling strategies.	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	The IM & T strategy and the control systems described within it are key elements of the Trust's system of internal control by which objectives are met.	
FREEDOM OF INFORMATION STATUS (FOIA):	Will be published in full.	
FOIA EXEMPTIONS APPLIED:	-	
EXECUTIVE SUMMARY (KEY ISSUES):	Achievement of the digital strategy is essential for trust sustainability, compliance with CCG initiatives and achievement of legislative duties. This strategy sets out an affordable programme of work, building on the previous IMT strategies and outlines through a series of pledges the activities that have to be undertaken to transition the trust from a implementation phase into a benefits led business as usual model.	
RECOMMENDATION:	That the Board discuss the strategy and form a consensus as to the prioritisation of revenue and capital budgets to fund it.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Information Technology

From PCs and Paper to Electronic Records

IT Strategy 2016-2020

V0.5

DRAFT

Amendment History

Version	Date	Amendment History
V0.1	Nov 2015	Created
V0.2	Dec 2015	P. Sherry – Updated, shared with Executive Team
V0.3	Jan 2016	Updated Shared with IMT staff
V0.4	Jan 2016	Updated, Shared with HMB
V0.5	Jan 2016	Formatting and feedback incorporated

Contents

1. Introduction

Continual change is required from the acute sector to tackle continuing and increasing challenges. NHS foundation trusts (FTs) are providing the widest ever range of services to patients in order to protect their health and wellbeing.

However Monitor, the health regulator, has warned trusts of the continuing need to improve how they operate - including making radical changes to how care is delivered - if they are to actively manage the intense pressure they are under from an increased demand for care and a worst in a generation financial position.

Monitor's analysis of Trusts' performance between April 2015 and June 2015 shows that England's 151 FTs (the majority of NHS providers) missed a number of national waiting times targets, including in A&E, for routine operations and some cancer treatments. Trusts also struggled to deal with an increase in demand for diagnostic tests, partly due to staff shortages and ineffectively organised services.

For the second successive financial year, the sector has recorded a deficit (-£445m) in the first quarter. Trusts have cited higher than expected pay costs, including over-reliance on expensive agency staff - as being the primary cause of this deficit.

Dr David Bennett, Chief Executive at Monitor, has said:

'Trusts are working hard to provide patients with quality care. However, today's figures reiterate that the sector is under massive pressure and must change to counter it. The NHS simply can no longer afford operationally and financially to operate in the way it has been and must act now to deliver the substantial efficiency gains required to ensure patients get the services they need.'

Within Warrington we recognise that radical and lasting change is required. As part of this change we have made a commitment that, by 2018, there would be "fully interoperable electronic health records so that patient's records are paperless".

This move is supported by a Government commitment in Personalised Health and Care 2020 that 'all patient and care records will be digital, interoperable and real-time by 2020'.

Radically new care delivery models supported by new payment arrangements which are value and outcome based are driving the need for change to meet the pressures in performance both financially and organisationally. This requires information to flow more effectively across health and care to support the delivery of direct patient care. In recent years the patient demographic is evolving rapidly. Providers of health and social care are facing a population with ever more complex needs. These needs often cross multiple boundaries of the existing care model. Experience has shown that the interfaces between the services required is an area of risk. Where information does not effectively flow between services there is at best the risk of duplication leading to waste. At worse patients may be 'lost' in the system which will likely lead to higher admission rates to secondary care, as well as poorer outcomes.

In addition, the Trust has a new duty to share information for care introduced by the Health and Social Care (Safety and Quality) Act 2015. As part of this, patient's record arrangements for integrated care working have to work effectively.

This strategy builds on the investment from 2014 to 2016 to achieve the ambition of being paper-free at the point of care to promote integration.

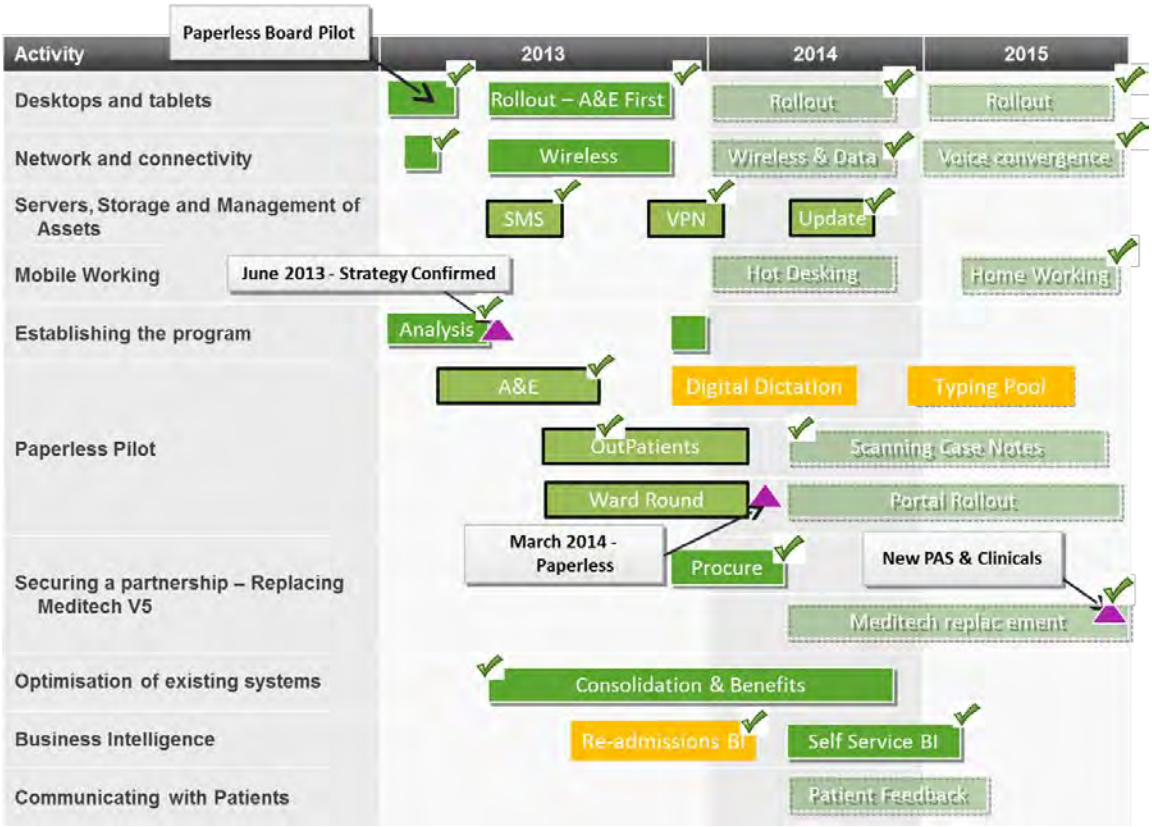
2. Current position

In May 2013, as part of the 2013-16 IMT Strategy, Warrington and Halton NHS Foundation Trust embarked on a 3 tier approach to the programme of work to set out the starting point for the tools, systems and culture we need to deliver. This created a clear portfolio of work outlining a return on investment which everyone understands, has contributed toward, and is committed to delivering.

The 2013-2016 strategy contributed to enhancing the Trust Transformation programme by establishing 3 work streams in the following way.

Connecting people with information as we move from PCs to Tablets	Move to paperless by implementing an EPR to replacing paper with electronic notes to support quality care	Consolidate down and optimise our current systems with new ways of working and investing benefits to reduce our costs

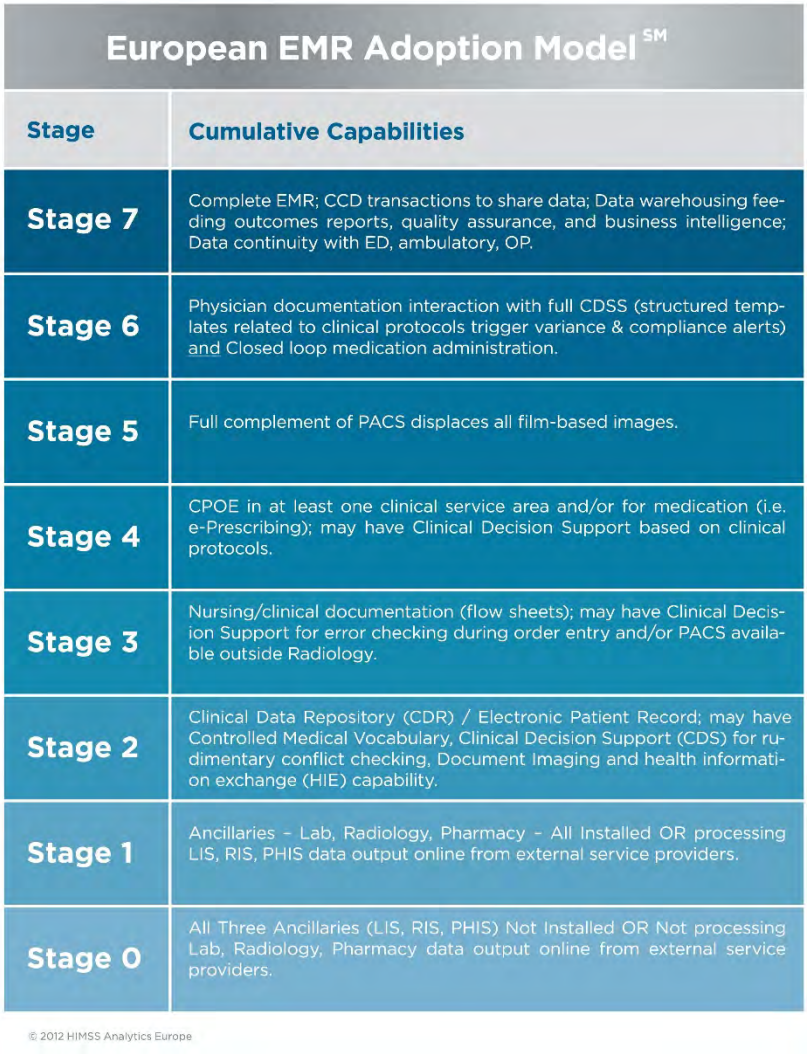
Successful delivery of this programme has created the right culture for change and the trust now has the essential systems and infrastructure to reduce our overall operating budget as part of the trust 5 year plan.



A new index will rate NHS providers' technological maturity and will eventually be part of the statutory regulatory regime.

Based on the European HiMSS EMR (Health Information Management Systems Society Electronic Medical Record) adoption model, a UK digital maturity index is set to be published later in 2016.

When assessing our investment over the last 3 years against the European HIMSS model the trust benchmarks at stage 3.



European EMR Adoption Model SM	
Stage	**Cumulative Capabilities**
Stage 7	Complete EMR; CCD transactions to share data; Data warehousing feeding outcomes reports, quality assurance, and business intelligence; Data continuity with ED, ambulatory, OP.
Stage 6	Physician documentation interaction with full CDSS (structured templates related to clinical protocols trigger variance & compliance alerts) and Closed loop medication administration.
Stage 5	Full complement of PACS displaces all film-based images.
Stage 4	CPOE in at least one clinical service area and/or for medication (i.e. e-Prescribing); may have Clinical Decision Support based on clinical protocols.
Stage 3	Nursing/clinical documentation (flow sheets); may have Clinical Decision Support for error checking during order entry and/or PACS available outside Radiology.
Stage 2	Clinical Data Repository (CDR) / Electronic Patient Record; may have Controlled Medical Vocabulary, Clinical Decision Support (CDS) for rudimentary conflict checking, Document Imaging and health information exchange (HIE) capability.
Stage 1	Ancillaries – Lab, Radiology, Pharmacy – All Installed OR processing LIS, RIS, PHIS data output online from external service providers.
Stage 0	All Three Ancillaries (LIS, RIS, PHIS) Not Installed OR Not processing Lab, Radiology, Pharmacy data output online from external service providers.

This strategy will enable the trust to build on this position and realistically achieve a successful transition through stage 4, 5 and 6. Reaching further stages will be a result of focus, clear direction and a steadfast commitment from leadership. Stage 6 organisations have established clear improvement goals.

Completion of the ambition to become paperless and move between maturity levels is challenging, requires commitment and takes time and investment. Activities undertaken include procuring the necessary software and hardware technologies from the market, finding a way to pay for it, ensuring that the systems can hold and transfer data to our legally-defined standards and effecting the business change and training to embrace and using the technologies and move away from managing clinical workflows with paper and whiteboards.

Most projects have delivered and to maximise our collective chances of achieving the 2020 ambition, we need to continue on this journey now, building on the plans or in some cases, starting work for the first time on new initiatives.

In this strategy we set out:

- A set of initial work streams that will complete outstanding work into 16/17 and beyond.

- Additional products required for our patients and staff including expected timescales and essential funding requirements.

- The steps for developing the right skills and structure for our Informatics service with a crystal-clear picture of how we support the move from paper and fixed PC's toward paperless and mobility enabling progress through the HiMMS stages of maturity.

- How we can optimise our investment to secure a return on the investment.

3. The drivers for change

There are 3 main drivers for change

1 The increasing demand of our patients to sustainably meet their care needs.
2 The move by the commissioning bodies to care in the community models and the need to access patient records across the Local Health Economy.
3 The demand from the DoH and Monitor to complete the rollout of the electronic Patient Record to achieve paper-free records

Sustainably meeting our patient's needs.

Our response to this demand is our vision for every patient to be able to the following (and more) -

1 register directly from GP demographics accessed through the NHS Spine
2 order prescriptions electronically
3 access apps and digital tools to mobile our staff away from desks
4 communicate with their health care professionals online or via video link rather than via a time consuming face to face consultation and view and take control of their full health record through a single online portal.

Access to patient records across the Local Health Economy

The current model of delivery of healthcare has remained broadly static over recent years whilst the pattern of demand and need has changed around us. It is widely accepted that the growing health and social care needs of the increasing number of elderly frail patients with complex requirements can no longer be met by continuing to work in traditional silos. In addition changing medical technology is now allowing much of what once required hospital care to be delivered much closer to the patient.

For our patients with long term conditions such as diabetes or asthma; devices, skin sensors or clothes which monitor health will be able to upload directly into patients' records through this platform.

For the first time in the Trust, all health care professionals have direct access to the summary care record which will also be extended by March 2016 to include information on whether a patient has a learning disability or dementia.

This strategy allows us to continue planning immediately on an economic model looking at the investment required to maximise the benefits of our technology. There will be a need for more investment in this space.

Complete the rollout of the electronic Patient Record to achieve paper-free records

By April 2016 Health services must produce a delivery plan to demonstrate how they will increase their use of digital services and become paper-free at the point of care.

Furthermore, current Health Secretary Jeremy Hunt recently noted that data sharing and transparency are not the only ways technology will underpin NHS reform in what he calls 'Patient Power 2.0' where the NHS encourage patients to use developing technologies to work in partnership with health care professionals to manage their own health.

Properly funded and well implemented healthcare IT is an inevitable force for good. Underachievement of our pathways results in large 7 figure sums of inefficiency and potential fines.

As an example - cancer physicians state that between 10 per cent and 15 per cent of appointments are cancelled because they cannot access diagnostic results in real time.

The evidence for digital helping to keep patients safer is clear cut.

Further examples include over Christmas 2015 an additional 44 adhoc clinics and pull and prep 142 additional sets of records that we did not know about some of which were not available for clinic. Electronic systems remove the need for pulling and prepping clinics.

We are at this stage of having selected and implemented the Phase 1 technological solutions. This strategy allows us to continue planning immediately on an economic model looking at the investment required to maximise the benefits of our technology. There will be a need for more investment in this space.

We have learnt that a lot of investment – capital, time, staff hours – will be needed to bring in the changes, and that a lot of disinvestment – of 'traditional' ways of doing things – will be required to generate the promised savings. This change will undoubtedly produce challenges, both from service users and service providers. Clarity of visions and leadership as well as effective communication will be required.

3. Principles for change

Clinical Engagement

It should be no surprise to see this at the top of the list. Change that is clinically led and clearly seen as for the benefit of patients is far more likely to be successful than change that is driven externally. Suffice it to say that clinicians are the end users of digital health platforms and adoption starts and end in their hands. Our most successful projects have involve working with clinicians on major IT initiatives and being engaged from day one makes a mission defining difference. Their feedback is invaluable and their ability to champion a solution across their peer network cannot be overlooked.

Patient Engagement

Enhancing patients' abilities to be proactive in their care will redefine how we deliver our services and enhance the clinician patient relationship in novel and meaningful ways. This is again critical for sustainability and will enhance our benefit return.

Product Localisation

Configuring systems to match our needs is of the utmost importance to invest time learning about end users at a system by system level preferably through frontline observations and stakeholders engagements. This way a solution can be localised and better benefit its users. We will need more resources to support application development.

Tangible Benefits

In too many cases claims are made about benefits which simply are not tangible. We will want to see intangible benefits related to user experience and service quality which leads to tangible cash releasing benefits. Such an approach demonstrates the holistic thought process of a solution provider.

Support

Poor support or data quality costs the trust money and reputation. Investing in system support coupled with continuous learning for our staff is critical to success. Moving from paper to electronic patient record is likely to requir**e the need for 24/7 ePR support**.

In addition, a network of 'Expert Users' needs to established to ensure that the clincians have access to support in their local areas. This requires a new role to be established and included in the appropriate job descriptions.

4. The Future State

We are going to continue to take the Trusts I.T. and Information service from being good to being great. That means great in the eyes of our current and potential clinical users.

Most organisations invest in 5 areas – Service Desk, Infrastructure (Networks and PC devices), Applications, Business Intelligence and Innovation & Change.

We will address these 5 areas and will contribute to the Trust Transformation programme by continuing to invest in 3 work streams linked to our QPS framework set out in the 2013 – 2015 strategy:

1.1

Connecting people with information as we move from PCs to Tablets	Move to paperless by implementing an EPR to replacing paper with electronic notes to support quality care	Consolidate down and optimise our current systems with new ways of working and investing benefits to reduce our costs

4.1 Connecting people

4.1.1 User devices

The trust needs mobile technology infrastructure shared across sites and with local providers to lower costs and increase efficiency for our staff.

Our strategy for a mixed economy for hardware includes fixed desktops, whilst also incorporating Workstations On Wheels (WOW's) for ward areas, handheld PCs/tablets for mobile working and smartphones.

Whilst, for some tasks, the fixed PC remains of value, we will continue work towards freeing staff from their desks, with the eventual goal to be a mobile device for each member of staff, appropriate to the range of tasks to be performed.

The positive experiences of laptops and mobile devices continue to improve. The benefits of these devices include; mobility, flexibility and improving data capture so we can recover the costs of our activity. In relation to tablets, these are not being used extensively in clinical areas, with concerns expressed over security, maturity and battery life. Contrasting experiences of WOW's were reported with the devices used mainly for their mobility and to enable the use of computers at the bedside.

As the mobile applications start to proliferate out we will see the shift from WOW's and PCs to mobile devices. The appropriate device required by an individual staff member will likely vary according to their role.

Pledge

We will continue to centrally fund and purchase PC and Tablet infrastructure to ensure standardisation and value for money.

We will build on the success of the maternity and midwifery tablet rollout by equipping all our consultants with their own tablet so providing access to the medical record and patient information both on and off site. This will enable new flexible ways of working such as virtual ward rounds which will speed up discharge times and allowing consultants with information to support their patients remotely at all times.

4.1.2 Network, Video and VoIP.

Security is paramount: through our logs and in our news we see a steady increase of the recorded incidents of attempts at unauthorised access. At the same time we need to switch gears as software starts being provided as a service outside our firewalls. In addition contractors, patients and families needing connectivity is becoming normal and expected.

We have to meet these two challenges without losing security. Identity is at the core of security. We need to know who is connecting and how we can improve their experience without losing security. Investing in Open Radius Servers will create an environment for NHS staff, contractors, patients and families to roam and connect through NHS WiFi.

Pledge

We will continue to build from strong foundations, putting security first but extending the infrastructure beyond the walls of just our staff and our buildings by investing in Open Radius Servers, firewalls and increasing the speed and ease of connectivity.

4.1.3 Patient WiFi

Current position

In 2014 the trust implemented a new WiFi, providing mobility to its staff for the first time. We need to extend the current networks that exist as requests for Wi-Fi access are increasing for non-trust devices which the above don't really account for on mass scale rollout.

The main requests fall into the following groups

1: Trust Staff – Personal Device – Internet Access Only (plus trust email)

This would likely accommodate most of the requests we get as a lot of staff just want to use their device for internet and email. No involvement from the Network team would be needed for people to connect.

This could have an impact on our 10Mbps separate internet connection from BT which is also used for remote access

2: Other NHS Staff - NHS Device – Internet/N3 and Trust Resources

This is the most difficult to accommodate. We need to provide access to the internet via N3 whilst also filtering for security and misuse. Authentication methods can be difficult as no trust desktop account.

3: Guest Access – Any Device – Internet Only

We will explore third party provision but using our infrastructure. We can provide patient access similar to Hotels, guests would be prompted to register on a portal page, which is a legal requirement. Access would be via separate internet connection with some basic filtering for security. Bandwidth limitations would also be implemented. Further research needed with third parties to gather more information.

Pledge

We will fund patient access to our WiFi and increase internet connection speed from 10Mpbs

4.1.4 Server infrastructure

Medical informatics is the largest growth area in the industry. Led by the paperless agenda, genome analysis and the need for Business Intelligence at the patient level, performance is improving by harnessing the processing of the data through open stack software like VMWare to make medical information available to support patient decision making. Shortage of storage and server hardware will hamper this. Continual investment is essential to ensure we maintain high performance, high availability of our infrastructure.

The number of systems we have to support has grown from XXX in 2010 to XXX in 2015.

At the same time we will explore options to move services off site and out into the cloud. Services such as NHS Mail 2 offer the opportunity to move the risk around arability and storage away from the trust.

Pledge

We will move away where possible from trust hosted services, with the start of this being the hosting of Lorenzo by CSC and then quickly following will be the migration to NHS Mail 2.

Continual annual investment in server and storage will have to continue to meet the growing demand on local hosting to prevent compromising our current systems.

Outsourcing these services may be acceptable when our local circumstances are stable. However if the environment is constantly subject to change then we risk become static, a slave to external agencies and unable to respond rapidly. We thus become stagnant; we therefore have no plans to outsource at the moment.

4.2 Improving Quality

In many ways the path for our journey through the maturity level is set for us.

Achievement of Stage 4 on the maturity model requires us to deliver electronic prescribing. Lorenzo IPPMA (Inpatient Prescribing and Patient Medication Administration is already on our roadmap for 2016.

The Trust is already 'film free' (via PACS) so Stage 5 is addressed.

Implementation of a clinically focussed document management and retrieval system for legacy paper case notes and for paper based information that is not easily captured digitally leads the Trust to Stage 6 and good data warehousing and Business Intelligence for stage 7.

Achievement of level 7 is within reach over the next 2 years, placing us at the forefront of maturity across the UK and throughout wider Europe.

This journey, started by the implementation of Lorenzo, requires the Trust to make the most of our commercial commitment moving forward to to complete Phase 2 of the ePR rollout.

5.2.1 Electronic Prescribing

Current systems for prescribing and administration of medicines in UK hospitals are based on a model established over 40 years ago. Since then medications used have grown in number and complexity, with a resulting potential for greater risk to patients.

Electronic prescribing (e-Prescribing) systems, where the supply, ordering, and patient administration of medicines is supported by electronic systems, offer the opportunity to address such problems, as well as to support a robust audit trail and enable potential innovations in the medicines use process. Most notably it enables a step change in patient safety around medicines prescribing and administration – one of the areas currently high on the Trust's Risk Register.

A growing number of hospitals in the UK have introduced e-Prescribing systems, and the earliest adopters have had e-Prescribing successfully in use for over a decade.

A major motivation to implementing Lorenzo is to access an integrated ePrescribing module as part of the electronic clinical record. Lorenzo's IPPMA module will be available as part of our commercial commitment to complete the phase 2 rollout of additional Lorenzo functionality. Current information is that Lorenzo IPPMA will be likely included as part of the HSCIC RPA (Revised Product Agreement) and will therefore not involve the Trust in additional software licence costs.

To achieve successful rollout e-Prescribing (IPPMA) must be understood in the context of the whole medicines use process, not as just about prescribing or exclusively of relevance to prescribers. Nurses use e-Prescribing systems to administer medicines, and pharmacists to review orders and manage the supply of medicines. Beyond these central stakeholders – doctors, nurses and pharmacists – are many other healthcare

professionals who are potential users of e-Prescribing if and when they need to review a patient's medication.

Introducing e-Prescribing systems improve the safety of medicines use and reduce the current and unacceptable levels of adverse drug events (ADEs). There are, however, other motivations. At the organisation level these may include generating new management data on medicines use, establishing and maintaining formularies, and the opportunity to redesign aspects of the medicines use process and establish new practices.

Pledge

We will build a strong and committed multi-disciplinary team to lead an ePrescribing project. Doctors, nurses and pharmacists must work together with other healthcare professionals and managers to prepare the ePrescribing implementation. The project will require the active support of senior managers and senior clinical leaders, who must be briefed to ensure that they understand the challenges of ePrescribing, the changes it will bring and the benefits.

5.2.2 Document management and structured forms

A strategic end–to end digital case note solution, e-enabling currently mainly paper-centric processes and facilitating service re-design will enable the Trust to digitise, securely manage and store existing physical case notes from both offsite and onsite storage (Bulk and On-demand scanning).

The solution will enable the digitisation of newly received or generated paper (Day forward) in line with statutory regulatory compliance whilst enabling any user to quickly locate the case note and contained records.

A separate investment case will review the benefits of a digital case note solution across the Trust including the implementation and optimisation of technology, process design and change management services, support for scanning operations including external bureau services (offsite scanning) and business transformation consultancy to assist the Trust realise the identified benefits.

Pledge

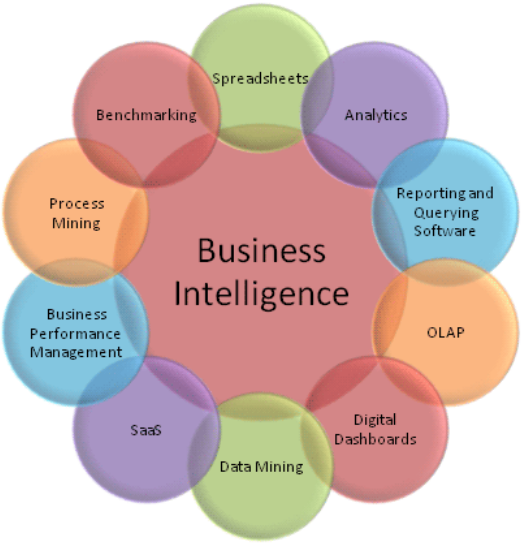
We will build on the EDRMS proof of concept completed in 2014 to the benefit to the trust and work with senior clinicians throughout 2016/17 to approve and adopt the change.

5.2.3 Data warehouse and Business Intelligence.

Business intelligence (BI) is used to suport better decision making process and making more informed strategies.

BI is a challenging issue for all industries. The healthcare sector is no different. In fact, there is an added burden of analysing patient's sensitive data which is governed by strict privacy rules apart from the general financial information.

We will therefore continue to invest in our Information Governance structures and monitory training programme whilst using information in the following ways:



Accurate data guarantees benefits in the form of:

- Reduction in administrative costs as repeat and manual processes to calculate wait times and pathway targets can be removed
- Boost in reimbursement rates as we are paid for the work we do
- Betterment of efficiency process as we benchmark ourselves against the best
- Improving patient's satisfaction as clinical decisions are taken sooner

There are basically three types of data which is of interest to healthcare - financial, clinical and operational. Within this data, a number of other parts of data comes into play. It is here that the task of BI self-service tools comes into play to consolidate this information into one version of the truth. They help in proper analysis of health data by clinical and operational management which in turn helps in making strategic decisions.

Attainment of self service BI will put the trust maturity at level 7.

Pledge

Whilst aiming for level 7 maturity we will invest in self-service BI tools along with additional 2 Information staff who can also create applications to provide analytics and intellect to the new clinical units.

5.2.4 Data Warehouse

Data warehousing is a methodological approach for organising and managing our data to provide a single trustworthy, consistent, integrated data foundation from our many applications and systems.

Importance

Effective and resilient data warehousing is must for any organisation. It will be impossible for Clinical Business Units of any size to make intelligent decisions without good information and data. It enables the competitive advantage. Data warehousing is essentially tells about our patients and provides the relationships and it is foundation for Business Intelligence (BI).

Data Warehouse Design

Building a data warehouse requires addressing the following technical and non-technical issues.

- Determine the trust and business unit goals and objectives
- Identification of various requirements
- Identify the tool for data warehousing and presentation of the data
- Develop the methods for end user accessing the information, including both reporting and analysis.

Primary Goal

The primary goal of any data warehouse is to integrate data from disparate sources into a centralized store, where that data can be used across the enterprise for decision support.

Pledge

We currently have two data warehouse staff. The size of this team needs to increase to maintain the service and it is proposed to recruit another two members to deal with workload additional Clinical Business Units will demand. These skilled staff can also be used to as a development team to develop our mobile apps to present the data.

5.2.5 Business Intelligence (BI)

Information involves interpreting facts, identifying the relation between them and find the more abstract meaning. Each characteristic, such as customer, store, date could serve as predicate in queries.

Data warehousing emphasizes organizing, standardizing and formatting facts in such a way that we can derive information from them. BI is then concerned about acting on that information.

5.2.6 Integration

The need to integrate the Trust's systems is essential, ensuring good data quality, preventing duplication of processes and supporting electronic, integrated care pathways as the patient moves through the different parts of the trust and the wider economy.

Currently the trust relies on expensive external support for this service so the plan is to recruit and retain an additional member of staff to support and develop system interfaces.

This is a service we can build upon and charge outward to the wider health economy.

5.3 Optimisation and Benefits

Changing to be successful doesn't stop: technology can speed up the rapid transformation , bring about a step change in quality and no more so when organisations utilises the automation power of systems to remove location, introduce standardisation, retain memory and remove unnecessary process steps. Over the last 3 years the trust has shifted quarter of a mile but we need a team to continue the radical change we can achieve who are also flexible to use the additional functionality we can adopt to complete our journey.

Pledge

We will put in place a structure and team who will continually optimise the use of our technology footprint to make the organisations more safe and sustainable.

5.3.1 AED

The improvement in AED are many and over the next 2 years we will be able to -

- Create a mobile app to capture disposal and patient Observation will ensure all patients observations are carried out within 15 minutes of triage and improve the clinical utilisation within the department.
- Capture additional pathways electronically in CDC forms to improve audit.
- Adopt electronic prescribing to remove prescribing on CAS card especially as we start using the medication list out of summary care record into Lorenzo
- Send electronic referral to teams out of ED to save time communicating as will reviewing past medical history on admission pulled from our data warehouse

- Increase the richness of our information, condition of the patient and the treatment they receive, so the recording of comorbidities and associated income reflects the treatment the patient receives.

- Process the estimated date of discharge around length of stay averages correctly on the Wards allowing the AED coordinators to place patients without the need for length bed referral process, reducing the reliance on bed managers.

5.3.2 Inpatient

- Improve clinical noting for the wards, common text configured to save clinical time typing.

- VTE performed by non medical prescriber removing clinicians from pre-op Water low forms

- Introduce risk stratification against patterns and patients.

- Always events built into the ward e-Whiteboard to prompt staff when the patient has not had appropriate assessments and treatment given - e.g. water, pain relief, etc. and understand what they are.

- AKIs and infection control lists in ICE Alerts for fast tracking patients.

All these improvement will save considerable time as reducing adverse events which will in turn likely lead to reduced length of stay, a lower incidence of adverse events, a higher level of patient satisfaction and a reduced level of complaints and litigation.

ICE referrals changes to turn off auto accept allowing electronic triage rather than paper, including ICE to remove ICE and capture better

5.3.4 Outpatients

- Fully automated digitised process.

- Service orders electronic - remove paper, tracking safely etc

5.3.5 Maternity

- Code against free text to intently, assess and evaluate risk and cost benefits of care to reduce claims and improve practice

- Global trigger tool highlighting near misses and areas of good practice

6 Benefits of change

Whilst each project requires formal business case approval, as soon as we automate pathways and process flow the patients of Warrington will see immediate benefits.

Achieving Stage 7 will:

- Highlight pre-existing condition for children, frail and the elderly and build these into all new plans providing an opportunity for secure the correct income for the care we provide;
- Provide immediate access to pre-existing medicine formulary through an electronic selection so we maintain control of our drug expense;
- Prohibit discharges without a discharge letter for all patients, avoiding expense contractual fines;
- Lower the number of tests required by beginning to make information about previous tests available reducing the demand and increasing costs placed on our diagnostic services;
- Offer Patient choice to appointments so we reduce the DNA rates;
- Eliminate multiple patient care plans existing which extends patients stay;
- Require all patients to have structured pre-op and admission notes to cover an patients dependent needs so we can plan the discharge earlier;
- Ensure all complaints and incident reviews have access to an effective medical notes without the need for paper;
- Reduce the amount of estate rebuild costs as part of the estate strategy.

By enacting these pledges, and others over time, we will be able to lower costs for everyone and give back a suggested 1 to 2.4 ratio against any investment and provide clinicians more control over their patients' health care.

We are already committed to realising £22m of cash releasing savings from phase 1 and phase 2 of Lorenzo and the EDRMS business case identifies over £8m of cash releasing savings over the next 10 years.

Pledge

We currently have two data business change members with the skills to develop and deliver on this massive investment. We will continue with investment in our people and the skills they require.

7 Staffing Structure

The Trust is made up of a complex group of teams and the department struggles to meet all needs of all teams and departments. Introducing 9 new Clinical Business Units will bring more demand from the technology and information systems and services. Investment in our people is therefore critical to ensure we maintain business as usual whilst driving forward improvements within the trust. Investment is required in 3 key areas -

1. The scale of IMT led cultural change required - bringing about an information driven decision making organisation across the Clinical Business Units and therefore the trust - is considerable. Currently the data quality contained within our current systems has to improve and our investment within our Information and Data Warehouse team has to increase as demand rises.

2. Just one part-time programmer can transform our slow, manual paper processes and create a fully automated eSVL process. To optimise our investment and building on this success necessitates a dedicated motivated set of individuals to design, create, drive and reinforce new mobile and e-enabled processes through development of applications.

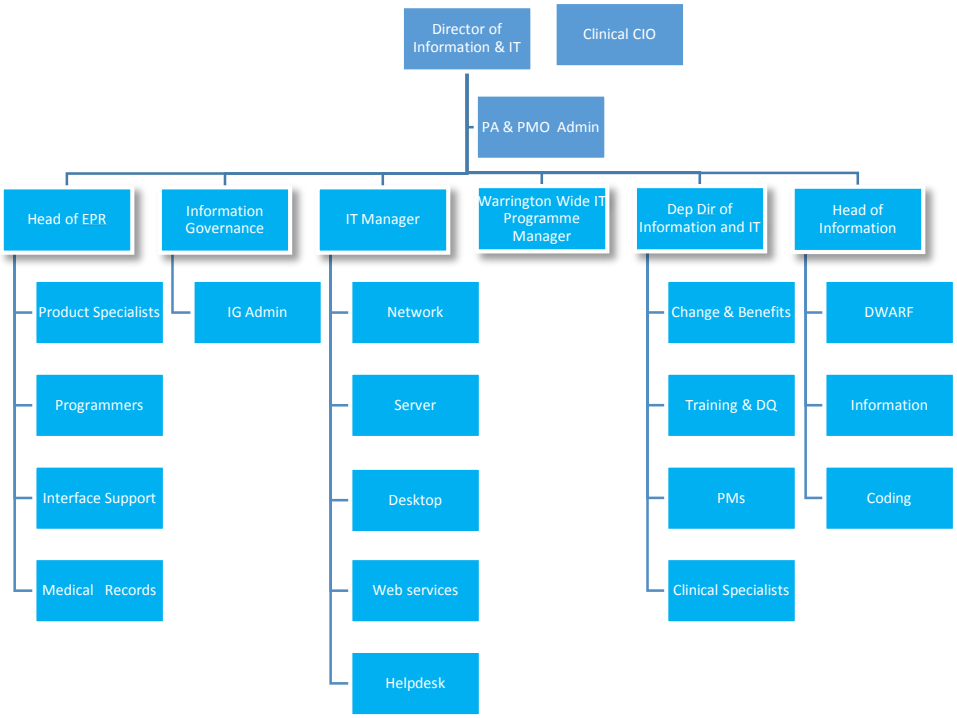
3. As we now operate with new modern fit for purpose systems, these continue to be improved and new functionality made available. An ePR Manager is required to lead the product specialist team as we continue to utilise the extensive system management capabilities to meet the need for testing and continual optimisation of new functionality to keep the trust safe the trust and benefiting from new ways of working.

4. 24/7 ePR support will be required as the patient record moves from paper to electronic. If a clinician or nurse is struggling to access vital patient information such as drug allergies for care plans they need access to immediate help and advice. An change to the traditional support arrangement is now essential, with a multi-layer approach of super users offering local first line support to end users, backed up by second line helpdesk support and third line supplier support. The options for delivery either through shift work or delivered by a 3rd party organisation will be explored throughout 2016.

5. Integration is key to delivering the electronic patient record and the wider electronic interaction with the health economy. It is expected for the trust to send GP letters electronically, along with other clinical documentation and to adopt the use of the NHS Number from the NHS Spine. The Trust currently do not have the skills to provide this critical role in house and expand the connectivity of systems across the 250 separate databases we currently operate. It is proposed that we recruit a Integration Manager to oversee the topology and management of this essential function.

Obviously these new roles place increasing burden on the financial pressures of the Trust. It is therefore proposed these costs are met through the current IMT allocation or through allocation of funds to appropriate project business cases.

It is proposed we recruit an additional data warehouse manager, two programmers to build apps to move the data nearer the end user and patient so exploiting our mobility investment and a Head of EPR to manage the continual system upgrades alongside managing the safe transition from paper to paperless with EDRMS. In addition we need to appoint an Integration Manager and provide the resources to support a 24/7 ePR support service. The role of the Chief Clinical Information Officer (CCIO) and Deputy CCIO will continue to be funded through allocation to appropriate project funds.



8 Cost

	16/17	17/18	18/19	19/20
Infrastructure				
PC/Desktop Refresh	240	240	240	240
Network	320	320	320	320
Server	200	200	200	200
	760	**760**	**760**	**760**
Systems				
Lorenzo Phase 2	178	178	178	178
IPPMA	1052			
EDRMS	416	1155	1155	1155
Theatres	700			
Integration	86	86	86	86
	2,432	**1,419**	**1,419**	**1,419**
Staffing				
Head of ePR	56	56	56	56
Programmers	70	70	70	70
Data Warehouse	40	40	40	40
Integration Manager	60	60	60	60
24*7 support & SuperUsers	140	140	140	140
	366	**366**	**366**	**366**
TOTAL	**3,558**	**2,545**	**2,545**	**2,545**

Costs are in 000's and subject to VAT.

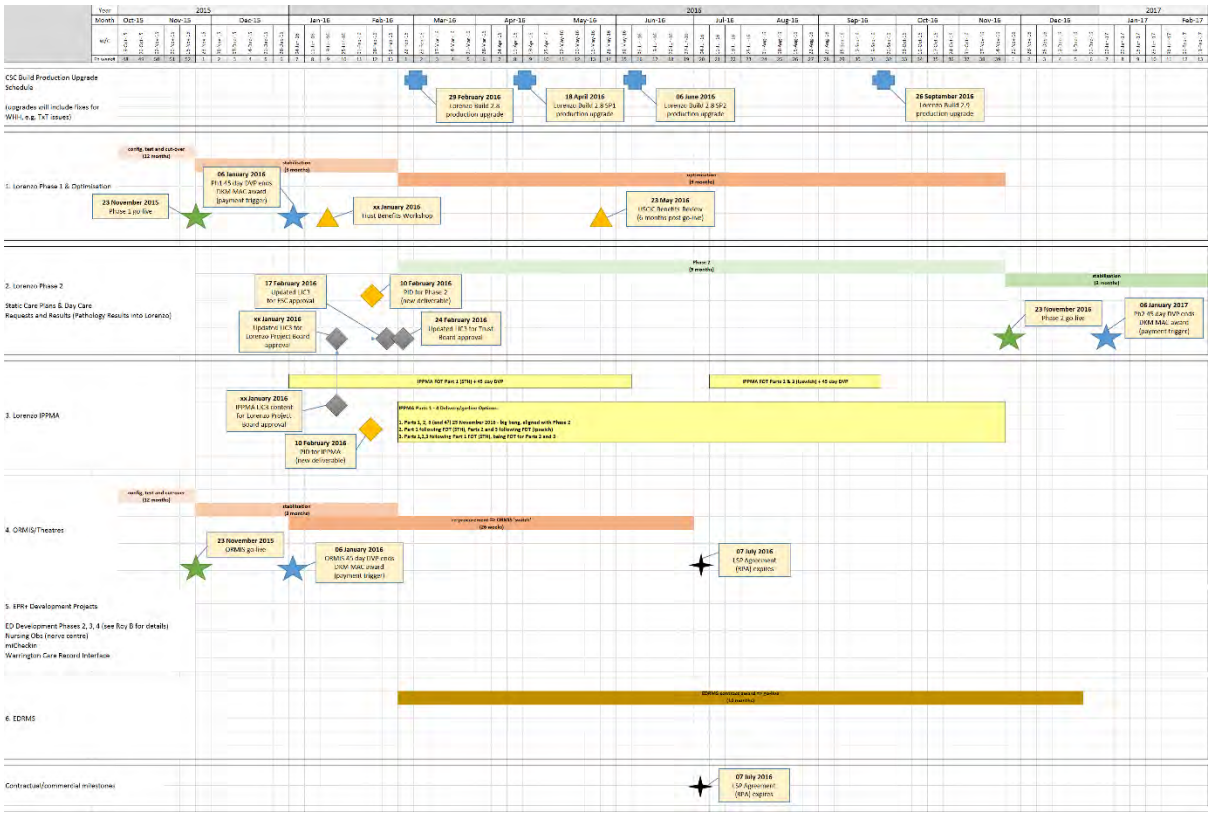
All of these costs can be met in the following ways -

The staffing costs are met through the saving against previous Meditech licence fees, resulting in a return of £544,000 to the trust.

The infrastructure and System costs are built into the 10 year capital programme.

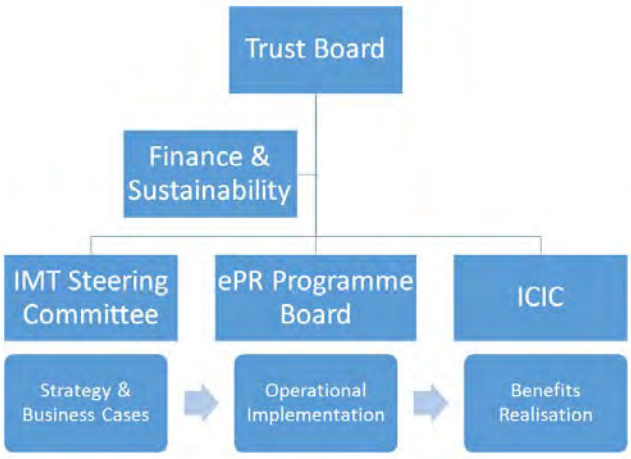
9 How will progress be monitored

9.1 Plan



9.2 Governance

Current governance arrangements will continue, with the IMT Steering Committee driving through strategic initiatives, the Lorenzo Programme Board (renamed Programme Board) monitoring implementation and the ICIC leading on the benefits.



10 Conclusion

Achievement of the digital strategy is essential for trust sustainability, compliance with CCG initiatives and achievement of legislative duties. This strategy sets out an affordable programme of work, building on the previous IMT strategies and outlines through a series of pledges the activities that have to be undertaken to transition the trust from a implementation phase into a benefits led business as usual model.

BOARD OF DIRECTORS

16/027

SUBJECT:	Report from the Chair of the Quality Committee including approved minutes of the meeting on 3/11/15
DATE OF MEETING:	27 January 2016
DIRECTOR:	Lynne Lobley, Non-Executive Director - Chair

Warrington and Halton Hospitals NHS
NHS Foundation Trust

QUALITY COMMITTEE

Minutes of the Meeting held on Tuesday 3rd November 2015
Trust Conference Room, Warrington Hospital

Present:

Lynne Lobley	Non-Executive Director – Chair
Steve McGuirk	Chairman
Diane Matthew	Chief Pharmacist
Denise Gill	Representing Director of IT
Tim Barlow	Finance Director
Simon Constable	Medical Director
Jan Ross	Deputy Chief Operating Officer
Claire Blackman	Interim Associate Director of Nursing WCSS
Karen Dawber	Director of Nursing
Kate Warbrick	Associate Director of Operations, Scheduled Care
Belinda Tench	Representing Associate Director of Operations, Unscheduled Care
Millie Bradshaw	Associate Director of Governance and Risk
Mel Hudson	Head of Midwifery
Claire Pratt	Representing Deputy Director of Nursing
Anne Robinson	Associate Medical Director, Quality Improvement
Dawn Chalmers	Deputy Chief Nurse, Warrington CCG
Jennifer Owen	Deputy Chief Nurse, Halton CCG

In Attendance:

Jennie Taylor	Executive Assistant (minutes)

	WHHFT/GC/15/122 - Apologies for Absence and Introductions	Responsibility and Target date
1	Apologies received from: Mike Lynch, Non-Executive Director (Chair) Terry Atherton, Non-Executive Director Dawn Forrest, Associate Director of Operations, Unscheduled Care Jason DaCosta, Director of IT John Wharton Rachael Browning, Associate Director of Nursing, Scheduled Care Roger Wilson, HR Director Paula Chattington, Consultant Mel Pickup, Chief Executive Jan Snoddon, Chief Nurse, Halton CCG Carol Millington, Acting Head of Therapies	
	WHHFT/GC/15/123 - Declarations of Interest	
2	There were no declarations of interest made in relation to the agenda items for the Quality Committee meeting.	
	WHHFT/GC/15/124 – Minutes of the previous meeting held on 4th August 2015	**Members**
3	The minutes of the meeting held on 4th August were accepted as a true record of the meeting with the following amendment. Apologies had been made by Dawn Chalmers but not recorded.	

	WHHFT/GC/15/125 - Action Plan	
4	Work Programme and Reporting Structures Action complete.	
5	CQUIN Quarterly Report Action complete.	
6	Quality Dashboard Action complete.	
7	Corporate Risk Register Discussions still ongoing with NHSLA. Remain on Action plan	
8	Mobile Communication Policy Policy is to be revised. Action complete.	
	WHHFT/QGC/15/126 – Workshop Summary from 8th September	
9	The recommendations were: • Design and implement an integrated dashboard for all quality, people and sustainability indicators, showing the inter-dependencies. A good example of this is the Salford data tool. • Populate Quality Report based on the output from DARZI Committees for the Quality Committee in October. • Consider the responsibility for monitoring sub speciality metrics reporting to the DIGG as a possible divisional model. • Review the role of the DIGG to both align outputs with the Darzi Committees.	
10	Karen Dawber, Director of Nursing explained that we have requested a copy of the Salford Dashboard and a mock version is being produced. It was agreed to populate the Quality Report for the December meeting.	**Hannah Gray/ Ros Harvey**
11	Karen Dawber, Director of Nursing explained that Governance is covered at DIGG and is also discussed at Quality Bi-lateral meetings to ensure appropriate monitoring and assurance. An 'Away Day' has been organised for 24th November. Lynne Lobley, Non-Executive Director/Chair explained that she was happy with the explanations given and was assured that Quality and Governance are being monitored divisionally.	
12	Karen Dawber explained that there is a comprehensive action plan and we need to track these however it will form part of the 'Away Day'. Simon Constable, Medical Director explained there is a piece of work being undertaken around membership of Committees, Sub-Committees and how information is disseminated around the layers of the Trust.	
	WHHFT/QGC/15/127 –CQC Report Action Plan	
13	Karen Dawber, Director of Nursing explained that since the report was published in July and the action plan completed in August this is the first formal quarterly review at Quality Committee. Karen Dawber advised that she, Simon Constable and Millie Bradshaw had met with the CQC the week before to go through the progress, the feedback from CQC was positive.	

14	For assurance it was agreed to review each Action individually: **Appointment of a stand-alone HR Director**.	
15	Action Complete **Appointment of a senior corporate person to oversee (Associate Director of Midwifery)**	
16	Action Complete, Melanie Hudson has a strategic role and midwifery strengthened as a result. **Ensure medicine stocks in the outpatient department are recorded and checked.**	
17	Restarting monthly outpatients audits and to investigate other areas, now compliant with CQC requirement. **Take action to ensure that waiting times for outpatient clinics are improved, reduce patient waiting times and DNA rates.**	
18	Jan Ross, Deputy Chief Operating Officer explained that there is now an interim manager in outpatients who is reviewing the whole pathway. She explained how this will link with Lorenzo. She also explained that letters are being reviewed with relation to patient information and agreed to produce KPI's to measure progress being made. It was agreed that the OPD improvements will be monitored via a dashboard to the Finance and Sustainability Committee in December as part of the report on performance.	**Deputy Chief Operating Officer December 2015**
19	Lynne Lobley, Non-Executive Director/Chair asked if clinic availability has an effect on the Trust being hospital of choice. Simon Constable, Medical Director responded that our directory of services requires a formal review to ensure accuracy. Patient experience was raised and Following a discussion it was agreed that Mel Hudson would produce some patient feedback from Outpatients and Claire Pratt would look at using volunteers to obtain feedback.	
20	Jan Ross, Deputy Chief Operating Officer opened discussion around text message reminder service as this is not an area that is routinely used. She will be meeting the provider shortly. Concerns have been raised regarding Information Governance and making information available to a 3rd party. This will be added to the agenda of next Information Governance meeting as confidentiality might be an issue. Item to be on January Quality Committee agenda for update.	**Deputy Chief Operating Officer to update January 2016**
21	**Continue to embed and promote the care of low risk women in line with NICE guidelines.** Karen Dawber, Director of Nursing explained that we know we are compliant with the NICE guidance. Mel Hudson advised that an audit has taken place and feels there is still some work to be done in ensuring that all staff are confident with low risk care. Karen Dawber asked if there is any evidence that we are going against NICE guidance to which Mel Hudson responded that there is some evidence some low risk women may be being monitored unnecessarily. Simon Constable, Medical Director explained the action as a continuous improvement and this is a process that has been delivered and is continuing to be sustained. He explained that risk stratification of women in pregnancy/labour by definition is a continuous improvement. It was agreed that Mel Hudson would add commentary to the action.	**Head of Midwifery December 2015**

	Continue to improve staff engagement.	
22	Claire Blackman, Acting Associate Director of Nursing, WC&SS explained that the staff temperature check is not as good as hoped but engagement and confidence is showing a marginal improvement on the last check.	
23	Midwives only have been "temperature checked" so far but next round is to include medical staff. It was agreed to carry out Temperature Check baseline with medical staff and to take the results to the Strategic People Committee.	
	Develop a strategy for the expansion of outpatient services to meet patient demand and preferences.	
24	This item is ongoing and will be monitored via Finance and Sustainability Committee.	
	Ensure there is a clear vision and strategy for both midwifery and gynaecology services that is clearly communicated with staff.	
25	Mel Hudson, Associate Director of Nursing explained strategy is in draft form and is to be reviewed at divisional level before the bi-lateral meeting. It is hoped to be presented in draft at the December meeting.	**Head of Midwifery December 2015**
	Review the admission process for the GP Acute Medical Unit to ensure patients are appropriately referred to the service.	
26	Jan Ross, Deputy Chief Operating Officer explained that this is happening and in approximately six weeks on commencement of Lorenzo we will have live ADT that will allow real time tracking and monitoring. Due to the length of stay of patients and lack of fit for purpose medical rota the plan is that this will be resolved. Karen Dawber, Director of Nursing enquired if this will be available as a dashboard. Jan Ross responded that Lorenzo will pick this up and evidence will be provided from weekly action meeting. Metrics for GPAMU are covered at Bi-Lateral meetings.	
	To improve compliance with the Department of Health target to treat 95% of patients within four hours.	
27	Jan Ross, Deputy Chief Operating Officer explained that work is progressing. Steve McGuirk, Chairman commented that the regulator were impressed with the amount of work and progress made.	
	Ensure that nursing and midwifery staffing levels and skill mix are appropriate particularly in medical care services and maternity.	
28	Karen Dawber, Director of Nursing explained that this is on-going with additional staff in maternity and a large piece of work around nurse staffing. The action although problematic has been closed as part of this action plan is monitored via Strategic People Committee. Simon Constable, Medical Director commented that staffing levels as at yesterday where escalation showed challenges in staffing. Karen Dawber, Director of Nursing responded that there are times when there is not the right number of staff on duty, this is compounded by the unfunded beds. She continued that core bed base with the right patients is staffed and that a six monthly staffing review is due at the Board meeting this month. Acuity and dependency are fluctuating although trends are being monitored and data collected. Lynne Lobley, Non-Executive Director/Chair recommended adding a commentary showing progress made as part of the staffing report	

	Review accommodation at ward level to ensure that patients at end of their lives can be nursed in appropriate rooms that afford privacy for patient and families.	
29	Karen Dawber, Director of Nursing explained that the End of Life Steering Group has been reinvigorated with a piece of work being done to look at preferred place of death and side ward availability. Infection Control have audited side wards and have identified a shortfall in the number.	
	Ensure all staff in the department have time to take their allocated breaks	
30	Belinda Tench, Matron, explained that they are all getting breaks but not necessarily their full allocation, this action is on-going.	
	Ensure smooth transition of leadership within the palliative care team.	
31	This action is complete with the appointment of a new consultant and matron.	
	Increase seven day working for all disciplines across the medical directorate.	
32	Simon Constable, Medical Director advised we have been benchmarked against the Keogh requirements although there is some clarity required around the definition of seven days. We need to put some things in place immediately around consultant care in Unscheduled Care and specifically In-Reach/AMU rota. We are writing to the CCG to look at plans going forward.	
	The increase in referral rates year on year presented a challenge for the service and the provider should ensure that the specialised palliative care team has the appropriate staffing levels and skill mix to meet the demands on the service.	
33	This action is on-going with work progressing via End of Life Steering Group.	
	Ensure staff complete the Malnutrition Universal Screening Tool (MUST) for all patients who require one.	
34	Millie Bradshaw, Associate Director of Governance and Risk explained that in line with the risk assessment this is monitored via dashboard. Lynne Lobley, Non-Executive Director/Chair recommended adding commentary to Quality Dashboard. Karen Dawber, Director of Nursing advised this is included. She explained that MUST scores have improved over the year.	
	Ensure that medical staffing is sufficient to provide appropriate and timely treatment and review of patients including out of hours.	
35	Simon Constable, Medical Director advised that this action in on-going (see paragraph 32).	
	Ensure that medical staffing is appropriate at all times including medical trainees, long term locums, middle-grade doctors and consultants.	
36	Simon Constable, Medical Director advised that this action is on-going (see paragraph 32).	

	Improve local leadership in maternity services to ensure a cohesive approach to care delivery between medical and nursing staff.	
37	Midwifery consultant appointed together with new obstetrician with interest in low risk care. Action complete.	
	Improve the way risks are communicated to nursing staff within the medical directorate.	
38	Belinda Tench, Matron, confirmed that safety briefings take place every day and progress has been made. Action complete.	
	Increase the visibility of executive staff and the board in the service.	
39	Karen Dawber, Director of Nursing confirmed this action is complete.	
	Review its access to specialist medical advice over 24 hours in line with national guidance for end of life care (in relation to Palliative Care)	
40	Karen Dawber, Director of Nursing advised this action is on-going.	
	Demand and capacity in the medical division	
41	Jan Ross, Deputy Chief Operating Officer explained that DTOC and outliers are reported in performance report. Capacity and Demand Review and Frail Elderly Review has made a difference. Karen Dawber advised bed reconfiguration has taken place. Action is on-going.	
	Development of a business case to look to appoint a further consultant Paediatrician	
42	Simon Constable, Medical Director advised that he is engaged in communication with Halton CCG around a community paediatrician and scope for further appointment. Action has been paused for six months.	
	Development of an ANNP post to augment the rota in the Children's Division.	
43	Karen Dawber, Director of Nursing confirmed action is complete.	
	Development of business case for a neonatal enhanced practitioner	
44	It was agreed Karen Dawber, Director of Nursing to review this action by 30th November 2015 as this may not be required.	**Director of Nursing December 2015**
	Implement and evaluate the pilot for Physician Associate.	
45	It was agreed that this action to be merged with medical staffing action.	
	Implement and monitor the temporary nurse staffing efficiency programme which has been developed.	
46	It was agreed that this action is monitored via the Strategic People Committee.	
	Increase accident reporting in the OPD relating to availability of medical records.	
47	Karen Dawber, Director of Nursing asked if there is something more we can do to increase reporting. Millie Bradshaw, Associate Director of Governance and Risk agreed to undertake some task/finish or drop in sessions.	**Associate Director of Governance and Risk December 2015**

	Provide robust monitoring and assurance as a result of the new Performance Improvement Policy and to ensure the Incremental Pay Progression Policy provides initial stock of position on minimum level of performance.	
48	Karen Dawber, Director of Nursing advised that this action is in progress via Strategic People Committee with Director of HR as lead director.	
	To ensure a full review of the usage of STAB bay to include the monitoring of ITU occupancy, delayed discharge which is presented to the Board.	
49	Kate Warbrick, Associate Director of Operations confirmed action is complete as monitoring is in place and as the Network requested clarity and options to be produced these are now covered in the monthly meeting. The area is now called theatre recovery and the terminology is to be really clearly communicated. Karen Dawber, Director of Nursing has asked for a report to the Bi-lateral meeting that links up the network ITU report.	**Associate Director of Operations – Scheduled Care December 2015**
	To ensure appropriate arrangements are in place to ensure medication stocks in the outpatient department are monitored via the Medicines Safety Group.	
50	This action covered previously, agreed to merge action.	
	To ensure Board has direct oversight of vacancies and enhanced workforce planning.	
51	Karen Dawber confirmed this action is complete with the revised dashboard to Board.	
	To ensure case note availability and completeness are ready for patient appointments.	
52	Jan Ross, Deputy Chief Operating Officer confirmed this action is covered by the outpatient plan but once Lorenzo EPR is in place all will be resolved in part and fully once EDRMS is rolled out.	
	To ensure full participation and representation with the Cheshire and Merseyside review of maternity, paediatrics and neonatal services and provide quarterly reports on the strategic developments to the Quality Committee.	
53	Karen Dawber, Director of Nursing confirmed this action is complete and Melanie Hudson is our representative.	
	To ensure the RMO at Halton site and to measure for monitoring improvement to included staff perception, patient transfer, patient feedback on a monthly basis.	
54	Simon Constable, Medical Director confirmed this action to be completed soon and he will update via Patient Safety Committee.	**Medical Director December 2015**
	To identify a 2nd candidate to be sent on secondment to do the ANNP course in 2016.	
55	Claire Blackman Acting Associate Director of Nursing advised that funding is in place and will be advertised in next two weeks.	
	To plan and implement change and enforcement to senior medical roles to develop a skill set of senior medical leaders.	
56	Simon Constable, Medical Director confirmed this action is complete with key posts now identified and appointed to.	

57	**To provide actions from the participation in Monitor to the national pilot to reduce temporary staffing.** Simon Constable, Medical Director confirmed this action is complete.	
58	**To review of job plans for medical teams in Children's Services as there were insufficient medical staff out of hours in the critical care services.** Simon Constable, Medical Director advised that this action is paused awaiting Cheshire and Mersey Review.	
59	**WHHFT Operational Action Plan requested by Commissioners as part of the QSG Assurance Meetings.** Millie Bradshaw, Associate Director of Governance and Risk confirmed this action is complete.	
60	Karen Dawber, Director of Nursing asked the Committee if we are happy that everything following the CQC visit is covered. Simon Constable, Medical Director asked if we can group actions together into areas to reduce the number of actions. Discussion took place around whether to include names of responsible lead to be added as providing assurance.	
61	It was agreed that this actions be grouped together into categories and Associate Director of Governance to complete. It was agreed to review on a quarterly basis and Director of Nursing to update Board of today's meeting.	**Director of Nursing December 2015 (complete)**
	WHHFT/QGC/15/127 – Governance Report	
62	Millie Bradshaw, Associate Director of Governance and Risk reviewed her report. Highlights included: • 154,620 patient contacts this quarter • Top non clinical incidents remain as physical assault to staff, although numbers are small • 3 new SUIs were reported in quarter 2 • 16 Completed SUIs with learning and improvement described • Top complaint relates to treatment • 33 new clinical claims received in Quarter 2 • Coroners inquests – 14 reports requested out of 246 deaths in this quarter • Learning and improvement from divisional governance reports listed and included • External agency visits shown in detail on page 44 including any actions required.	
63	Lynne Lobley, Non-Executive Director/Chair queried the graph on page 3, Millie Bradshaw, Associate Director of Governance and Risk agreed to add an explanation re validated and non-validated numbers.	**Director of Governance and Risk December 2015**
64	Lynne Lobley, Non-Executive Director/Chair asked for details of the issue around patient transfers from CMTC (page 9). Kate Warbrick, Associate Director of Operations, Scheduled Care explained this is monitored continuously to ensure that patients are not admitted via A&E by default and activity is reported monthly through DIGG.	

65	Steve McGuirk, Chairman explained that for the greater public good it is important to see the trends in graphs. Millie Bradshaw agreed to change this to show all levels separately and to scale.	**Director of Governance and Risk December 2015**
66	Simon Constable, Medical Director queried table 4, page 5 and asked that if a really serious incident is reported but doesn't make top 5 would it be thoroughly investigated. Diane Matthew, Chief Pharmacist confirmed that this would be examined in depth at Medicines Management meeting.	
67	Tim Barlow, Finance Director commented that as an organisation that likes to improve then this report shows excellent learning and development.	
68	Millie Bradshaw, Associate Director of Governance and Risk explained that incident data is compared against other trusts and we are in the top quartile of reporters and that the level of harm is below average.	
69	Lynne Lobley, Non-Executive Director/Chair agreed that this was a very helpful report.	
70	Deputy Chief Nurse, Halton CCG asked who monitors the learning. Millie Bradshaw, Associate Director of Governance and Risk explained that we know where work has been undertaken in divisions although a link is not always available.	
71	Karen Dawber, Director of Nursing updated the Committee about Stanford project and explained STEIS reporting has been enhanced to provide much more detail following the Stanford workshop.	
	WHHFT/QGC/15/129 - LSMS Report	
72	Jan Ross, Deputy Chief Operating Officer presented the report as Executive Director responsible for Security.	
73	Karen Dawber, Director of Nursing queried the level of security cover at night as there are usually only two security officers on duty and are regularly called to deal with drink/drug incidents. Jan Ross agreed but commented that some areas do not make geographical sense and agreed to continue undertaking work around the estate.	
74	The Committee thanked Phil Sloan, LSMS for his comprehensive report.	
	WHHFT/QGC/15/130 – Quality Dashboard	
75	Karen Dawber, Director of Nursing explained that MUST score is a result of poor surveillance with a being staff member down although now back in post.	
76	SHMI and HSMR – Simon Constable, Medical Director has undertaken work with Hannah Gray and is reported at Clinical Effectiveness and the minutes are supplied to this Committee.	**Medical Director to update December 2015**
77	Mortality Review Group – Anne Robinson Associate Medical Director workstreams that can be linked including coding, improving work, mortality peer review/7 day review. Other organisations are also being visited.	

78	Simon Constable, Medical Director described all the areas to be considered that would provide improvement of preventable deaths. Steve McGuirk, Chairman advised that there is a simple political statement that weekend admission meant poorer patient outcome. Simon Constable advised the data is not to be dismissed and there are things we can do from a clinical point of view.	
80	Karen Dawber, Director of Nursing explained that HSMR last year was under 100 and is now 109. Anne Robinson, Associate Medical Director explained she had discussed this with Aintree who have been running improvement work since they were an outlier. Simon Constable complimented the team that they are doing all the right things and visiting externally to gain better understanding.	
	WHHFT/QGC/15/132 – RCOG Letter	
81	Millie Bradshaw, Associate Director of Governance and Risk explained this letter is for information only providing assurance on work done in maternity.	
82	It was agreed this document to be considered for positive marketing.	
	WHHFT/QGC/133 – CQUIN Quarterly Report	
83	There are four national CQUIN goals which focus on Acute Kidney Injury Dementia care Sepsis Urgent Emergency Care.	
84	**Acute Kidney Injury** - Anne Robinson Associate Medical Director explained that page 9 of the report gives a clear overview, she is confident that goals are being achieved and definitely making progress.	
85	**Sepsis –** Anne Robinson, Associate Medical Director explained that this is very difficult to collect and is being collected retrospectively and not at source. There is some confusion nationally and we have recently been advised the correct way to report and this is not how we have done it so far and it is labour intensive. Lorenzo will help with data collection.	
86	**Dementia** – Biannual report completed and submitted to Patient Experience Sub Committee.	
87	**Urgent Emergency Care –** Work taken place over Q1 and Q2 so that by the end of Q2 we will provide a report on the current provision identifying gaps in pathway provision.	
88	Simon Constable, Medical Director explained that this is where Lorenzo will come into its own for live feedback.	
	WHHFT/QGC/134 – SBAR	
89	Karen Dawber, Director of Nursing advised that the Coroner has issued the organisation with a Prevention of Future Deaths (PFD) relating to falls in the hospital. All actions have been agreed and this will be reported back to the Coroner.	

	A 'deep dive' has been undertaken into falls, figures are showing as quite static although by identifying the dates when falls are high we could produce some activity to reduce them. Falls continue to be in the top 5 of incidents reported although the latest report from the National Learning and Reporting System (NLRS) shows the Trust patient accident is below peer group.	
	WHHFT/QGC/135 – Part 1 Corporate Risk Register	
90 91	Lynne Lobley, Non-Executive Director/Chair requested focussing on new risks. Millie Bradshaw, Associate Director of Governance updated the Committee and advised that all risks were discussed at Patient Safety. Psychiatric room in A&E is now non complaint with NICE Guidelines but thought to be relatively easy to resolve.	
	WHHFT/QGC/136 – Serious Incident Update	
92	This item was discussed earlier during the Governance Report.	
	WHHFT/QGC/137 – Infection Control (verbal update)	
93	Simon Constable, Medical Director advised that Infection Control is covered in the dashboard, there have been 4 cases of pseudomonas in Neo Natal Unit that has been monitored as an outbreak. This has been notified to PHE.	
	WHHFT/QGC/138 – Medicines Management (verbal update)	
94	Diane Matthew, Chief Pharmacist to supply brief report to accompany minutes.	
	Policies/Guidelines for Consultation/Approval	
	Revised Major Incident Plan (for ratification)	
95 96	Tim Barlow, Director of Finance requested pages are numbered for clarity. Plan ratified by Quality Committee.	
	HIGH LEVEL BRIEFING AND MINUTES FROM REPORTING COMMITTEE CHAIRS	
	WHHFT/QCG/15/139 – Information Governance and Corporate Records and SIRO report	
97	The HLBP from 14th September 2015 was noted by the Committee.	
	WHHFT/QCG/15/140 – Health and Safety Sub Committee	
98	The action notes of meeting dated 10th September 2015 were noted by the Committee.	
	WHHFT/QCG/15/141 – Strategic People Committee	
99	The minutes of the meeting dated 10th August 2015 were noted by the Committee.	

	WHHFT/QCG/15/142 – Clinical Effectiveness Sub Committee	
100	The notes of the meeting held on 17th September 2015 were noted by the Committee.	
	WHHFT/QCG/15/143 - Event Planning Group	
101	The HLBP of 26th October 2015 was noted by the Committee.	
	WHHFT/QCG/15/144 – Patient Safety Sub Committee	
102	The minutes of the meeting held on 24th September were noted by the Committee.	
	WHHFT/QCG/15/145 – Patient Experience Committee	
103	The Minutes of the meeting held on 29th September were noted by the Committee.	
	WHHFT/QCG/15/146 - Infection Control Sub Committee	
104	The HLBP dated 20th October 2015 and action notes of meeting 15th September were noted by the Committee.	
	W&HHFT/QGC/15/147 – any other business **Internal Quality Summit**	
105 106	Karen Dawber, Director of Nursing is proposing an in-house quality summit, for areas that may cause concern and sought member's thoughts. A summit may be called in an areas is triggering on quality issues It was agreed all were in favour and the Terms of Reference agreed.	
	Date and time of next meeting: **1st December at HALTON**	

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

BOARD OF DIRECTORS 16/028

SUBJECT:	**QUALITY DASHBOARD (2015/2016) JANUARY 2016**
DATE OF MEETING:	27th January 2016
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. The KPI titles in red text denote data which has been affected by the switch from Meditech to Lorenzo. The leads and information department are working on these issues.	
RECOMMENDATION:	***The Board is asked to:*** 1. Note that the data for a number of indicators can change month on month. This applies to mortality peer review, 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 4. Note the change in incident figures	
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

Patient Safety

1. VTE

There are problems with extracting data from the new Lorenzo system as the relevant reports are not yet available. The data in Appendix 1 is raw data whereby the cohort has not been applied and the 17.75% relates only to VTE Assessment Forms and does not include VTE assessments from e-forms or the whiteboard.

VTE Root Cause Analysis (RCA)

- There is a significant delay in completion of VTE RCA due to the number of steps in the process, access to case notes and cancellation of the November Thrombosis Committee (at which these are reviewed). There are therefore a high, and increasing number of outstanding RCAs.
- A report has been submitted to Patient Safety Sub Committee to bring the VTE RCA approach into line with other Trust RCA processes in order to reduce the time from identification to completion of the RCA.

IT solutions, supported by the Clinical Governance Department are being implemented to help mitigate this delay. RCAs due to be reviewed at the cancelled November meeting will be reviewed virtually by the Thrombosis Committee members.

2. HCAI

Clostridium difficile – 0 hospital apportioned Clostridium difficile cases were reported in December. YTD the Trust has reported 22 hospital apportioned cases of Clostridium difficile. This includes the 9 cases removed from contractual sanctions. A review panel meeting to discuss the cases from Q3 will be held on 11th February 2016.

MRSA bacteraemia – A nil return was submitted for November.

Clinical Effectiveness

3. **SHMI** (Summary Hospital-level Mortality Indicator)

The Trust continues to compare well with local peers regarding crude death rates; this is 2.3% for 2015/2016 (as at 22/11/15). Data reports are being developed to capture the death rate data from Lorenzo for the period since 'go live'. Actual numbers of deaths continue to be closely monitored using Lorenzo and bereavement office data and there is a significant reduction in deaths in December 2015 and January 2016 compared to the same months in the previous year. The Mortality Review Group (MRG) is monitoring progress against the revised Reducing Avoidable Mortality action plan. The Trust Board will receive the next Mortality Overview Report at the January 2016 Trust Board meeting.

4. *SEPSIS

Due to a data error, an inaccurate 61.29% was reported in the December 2015 Quality Dashboard. This figure is in fact 18%. Issues have been identified relating to both the capture and extraction of this data in Lorenzo. The actions required will need to be completed for the UNIFY submission deadline of the end of January.

5. *Acute Kidney Injury CQUIN

October 2015 and November 2015 performance is included on the dashboard; November data has however not yet been validated and December data is not yet available, current performance against Q3 baseline is 35%.

6. AQ Measures

Heart Failure

The cumulative appropriate care score to include September, is 82.89%; below the target of 84.1% for the end of Q2 CQUIN. The CQUIN payment is based on cumulative data at the end of each quarter therefore we have not achieved this measure, with a possible penalty of £21,888 at the end of Q2.

The non-compliance issues relate to the following:-

- HF Specialist review <72 hours of HF documentation (1 out of 13 not compliant)
- Written Discharge Instructions Given and Discussed (6 out of 27 not compliant)

Pneumonia

- Initial Antibiotic Selection for CAP in Immunocompetent Patients 28/20 (96.6%)

- Initial Antibiotic Received Within 6 Hours of Arrival 31/34 (91.2%)
- Adult Smoking Cessation Advice/Counselling 6/9 (66.7%)
- CURB-65 score 28/31 (90.3%)

Meeting with the Clinical Commissioning Group (CCG) agreed the following:

- The CCG would not expect a routine report on Hip and Knee replacement.
- Hip fracture and COPD should continue
- ARLD should continue although it was acknowledged there are some issues with the information being collected and if it is in line with clinical guidelines
- Sepsis AQ will stop - agreed that collection of 2 sets of data was futile as data was already being collected for a National CQUIN.
- Diabetes - the CCG agreed that the collection of this data took up a great deal of time and energy for no useful gain. Suggestion that it is replaced with regular audit/report/monitoring of e.g. patients presenting with hypoglycaemia, DKA.

Patient Experience

7. Dementia CQUIN

On the 21st of November 2015 the Trust went live with a new PAS system, Lorenzo. The figures have been taken from the old PAS system, Meditech, and are based on activity up to the 21st of November. Data from part two recorded in the December Quality Dashboard has reduced from 80% to 72.7%. Adding the information recorded on Lorenzo reduces the performance for Part 1 to 31.38% and Part 2 to 42.11%. Our CCGs have accepted that we are experiencing issues with validating some data from Lorenzo and have agreed not to invoke any penalties for under performance on either part 1 or 2. Historic performance has always been above the threshold and manual sampling also shows compliance. This is a data quality issue which will be rectified as Lorenzo embeds.

8. 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. September fell to 88%, October is at 94% and November at 96%. Compliance for quarter 1 is 90%, rising to 93% for quarter 2 and just under 95% for quarter 3.

9. 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 we failed to achieve 95% for falls and waterlow in December we did achieve the threshold for Q3. Although not yet meeting the target for MUST, the data shows increasing compliance from 85% for quarter 1, 86% for quarter 2, and 88% for quarter 3.

10. Friends and Family

A low return of 3.74% was recorded for A&E in December and the mitigating circumstances related to the implementation of Lorenzo and high activity across the Trust resulting in the full capacity protocol being enacted.

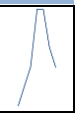
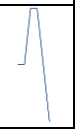
Jan-16

Quality Dashboard 2015/16

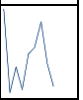
Warrington and Halton Hospitals NHS
NHS Foundation Trust

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
Safety																					
INCIDENTS	MODERATE, MAJOR OR CATASTROPHIC HARM: APPROVED	TBC	QC	10	6	9	25	10	10	20	40	20	2	4	26					91	changes monthly
	MODERATE, MAJOR OR CATASTROPHIC HARM: UNDER REVIEW	N/A		13	0	4	17	3	10	7	20	4	3	6	13					50	changes monthly
	SERIOUS UNTOWARD INCIDENTS (SUIs) Level 2	N/A		3	1	2	6	3	1	1	5	2	1	0	3					14	
HEALTHCARE ACQUIRED INFECTIONS	MRSA	0= green, 1-5=amber, >5 red	QC, QI	0	0	0	0	0	1	1	2	0	0	0	0					2	
	CLOSTRIDIUM DIFFICILE (due to lapses in care)	<=27 per year	QC, QI	0	1	3	4	1	0	3	4	0	0	0	0					8	
	CLOSTRIDIUM DIFFICILE (no lapse in care)	None set	N/A	3	4	1	8	0	0	1	1	0	0	0	0					9	
	CLOSTRIDIUM DIFFICILE (under review)	None set	N/A	0	0	0	0	0	0	0	0	3	2	0	5					5	
NEVER EVENTS		0	QC	0	1	0	1	0	0	0	0	0	0	0	0					1	
VTE	% OF PATIENTS RISK ASSESSED	>=95%	QC	97.52%	96.21%	96.01%		95.33%	95.77%	94.02%		95.04%	65.63%	17.75%*							
	% OF ELIGBLE PATIENTS HAVING PROPHYLAXIS (SAFETY THERMOMETER)	100%	QC	100.00%	100%	99.82%		100%	100%	99.82%		99.65%	100%	99.47%							
	NUMBER OF PATIENTS WHO DEVELOPED A HOSPITAL ACQUIRED VTE (APPROVED)	TBC	QC	3	0	0	3	0	1	0	1	0								4	
	NUMBER OF PATIENTS WHO DEVELOPED A HOSPITAL ACQUIRED VTE (UNDER REVIEW)	N/A	N/A	4	6	7	17	1	2	0	3	2								22	
HARM FREE CARE	% OF PATIENTS FREE FROM HARM (SAFETY THERMOMETER)	TBC	OH	97.70%	92.60%	98.34%		95.51%	97.33%	98.52%		96.81%	94.04%	96.26%							
	% OF PATIENTS FREE FROM HARM (MEDICINES SAFETY THERMOMETER)	TBC	QI	100%	97.5%	98.1%		100%	100%	98.5%		100%	92.60%	No Audit							

Target or Indicator		Target	IC	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD	Trend
Effectiveness																					
MORTALITY	HSMR (12 MONTH ROLLING)	<=100 = G, As expected = A, Higher than expected = R	QI, IP, QC	104	105	106		109	109	107		106									
	SHMI (12 MONTH ROLLING)	<=100 = G, As expected = A, Higher than expected = R	QI, IP, QC	114	114	115		115	114	113											
	TOTAL DEATHS IN HOSPITAL	None set	reporting only	92	80	107	279	87	81	77	245	88	93	83						788	
	MORTALITY PEER REVIEW (NB figures change as reviews are conducted)	Q1 - 45% Q2 – 55% Q3 – 75% Q4 – 95%	IP, SU2S	78%	81%	64%	74%	77%	73%	76%	75%	77%	60%	NYP						73%	
	REGULATION 28 - PREVENTION OF FUTURE DEATHS REPORT	None set	Reporting only	0	0	0	0	0	0	1	1	0	0	0						1	
CARDIAC ARRESTS	Annual: <75 = G, 75 – 85 = A, >85 = Red	see left	QC	4	2	11	17	10	5	6	21	4	9	6	19					57	
ADVANCING QUALITY	ACUTE MYOCARDIAL INFARCTION	>=95%	QI, C	93.18%	94.94%	96.83%		97.16%	97.14%	97.01%		97.31%								97.31%	
	HIP AND KNEE	>=95%	QI	98.51%	99.22%	98.97%		98.85%	99.01%	99.22%		99.33%								99.33%	
	HEART FAILURE	>=84.1%	QI, C	72.22%	73.17%	75.44%		78.85%	81.15%	82.89%										82.89%	
	PNEUMONIA	>=78.1%	QI, C	80.00%	78.83%	78.65%		78.00%	77.82%	77.94%										77.94%	
APPROPRIATE DISCHARGE PLANNING FOR PATIENTS WITH AKI		25% Q3	C	Absence of AKI Calculator in current system resulted in CCG agreeing for baseline to be set at Q2				Achieved 20.7% for Q2 established 25% as a baseline for Q3			20.70%	31%	38%*								
SEPSIS SCREENING OF ALL ELIGIBLE PATIENTS ADMITTED TO EMERGENCY AREAS		40% for Q3	C	Quarter one data for establishing baseline				26%	40%	28%	31.3%	18%*	26%		Q3 TO DATE 22%						
SEPSIS SCREENING: ANTIBIOTICS GIVEN WITHIN AN APPROPRIATE TIMESCALE		20% for Q3	C	Quarter 1: establishing indicator detail				25%	23.1%	0%	15.4%	22.22%	27.27%		Q3 TO DATE 25%						
Patient Experience																					
FALLS	ALL FALLS (APPROVED)	913	IP (5% reduction)	82	89	80	251	75	73	85	233	95	74	43	212					696	
	FALLS PER 1000 BED DAYS	<=5.6	IP (national benchmark)	4.97	6.22	5.03		4.97	4.53	4.84		5.02	4.60	2.65						4.76	
	MODERATE, MAJOR AND CATASTROPHIC HARM FALLS (APPROVED)	<=13	IP (10% reduction)	2	2	2	6	1	0	2	3	2	0	0	2					11	
	MODERATE, MAJOR AND CATASTROPHIC HARM FALLS (UNDER REVIEW)	N/A		1	0	1	2	0	0	2	2	1	0	1	2					6	
	MODERATE HARM FALLS (APPROVED)	<=12	SU2S (10% reduction)	2	2	2	6	1	0	2	3	2	0	0	2					11	
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	0	0	0	0					3	
	GRADE 3 AND 4 HOSPITAL ACQUIRED (UNAVOIDABLE)	N/A		1	1	0	2	0	0	0	0	1	0	1	2					4	
	GRADE 3 AND 4 HOSPITAL ACQUIRED (UNDER REVIEW)	N/A		0	0	0	0	0	0	0	0	0	0	0	0					0	
	GRADE 2 HOSPITAL ACQUIRED, AVOIDABLE AND UNAVOIDABLE (APPROVED)	<=63	QI (5% reduction)	15	8	6	29	8	6	4	18	10	2	1	13					60	
	GRADE 2 HOSPITAL ACQUIRED, AVOIDABLE AND UNAVOIDABLE (APPROVED)	<=59	10% reduction internal stretch target	15	8	6	29	8	6	4	18	10	2	1	13					60	
	GRADE 2 HOSPITAL ACQUIRED, AVOIDABLE AND UNAVOIDABLE (UNDER REVIEW)	N/A		0	0	0	0	2	0	1	3	3	9	5	17					20	
TRANSFERS	OUT OF HOURS TRANSFERS	TBC	BK	1	0	1	2	0	0	DC		DC	DC	DC							
	NON-ESSENTIAL WARD TRANSFERS	TBC	QI	DC	DC	DC		DC	DC	DC		DC	DC	DC							
ALWAYS EVENTS		100%	QI	89%	90%	92%	90%	96%	96%	88%	93%	94%	96%	96%	94.58%					93%	
DEMENTIA	DEMENTIA ASSESSMENT % (PART 1)	>=90%	C	96.85%	97.62%	95.53%		96.80%	94.86%	94.36%		92.18%	81.3%*	26.15%							
	DEMENTIA ASSESSMENT % (PART 2)	>=90%	C	100%	100%	100%		100%	95.12%	100%		85.71%	72.7%*	27 REQUIRE ASSESSMENT EXCEPTION REPORT							
	DEMENTIA ASSESSMENT % (PART 3)	>=90%	C	100%	100%	100%		100%	100%	100%		100%	100%								
	DEMENTIA - STAFF TRAINING	Q3 = 50%	C	Compliance established at 27.02% end Q1 plus additional 15% for Q2			27.02%				42%	44.50%	46.50%	49.64%	49.64%*					49.6%	
CARE INDICATORS RISK ASSESSMENTS	FALLS	>=95%	IP	82%	92%	93%	93%	97%	97%	93%	96%	96%	99%	92%	96%						
	WATERLOW (PRESSURE ULCERS)	>=95%	IP	77%	93%	92%	91%	96%	95%	92%	94%	96%	96.3%	93%	95%						
	MUST (MALNUTRITION)	>=95%	IP	78%	85%	89%	85%	91%	80%	87%	86%	90%	88%	85%	88%						
	DIABETIC FOOT	Q1 - 61% Q2 – 71% Q3 – 81% Q4 – 91%	C	QR	QR	77.60%	77.60%	72.00%	81.40%		76.80%				95%					77.2%	
MIXED SEX OCCURENCES		0	QC	6	0	1	7	0	0	0	0	0	3	0	3					10	
FRIENDS AND FAMILY (PATIENTS' VIEWS)	STAR RATING	N/A	Reporting only	4.61	4.66	4.70		4.66	4.65	4.72		4.71	4.70	4.73							
	% RECOMMENDING TRUST: INPATIENTS	>=95%	IP, QI, QC	97%	96%	97%		98%	98%	96%		97%	96%	96%							
	% RECOMMENDING TRUST: A&E	>=87%	IP, QI, QC	83%	83%	83%		88%	87%	90%		85%	86%	85%							
	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%		12.52%	8.51%	3.55%							
	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%		20.95%	22.84%	4.19%							
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%		14.95%	11.8%	3.74%							
	RESPONSE RATE: INPATIENTS	Contract target to be agreed	IP, QI, QC	30.30%	33.80%	31.44%		31.96%	6.13%	63.10%		35.09%	30%	31.45%							
COMPLAINTS AND CONCERNS	NUMBER OF COMPLAINTS RECEIVED	2014/2015 received 478 (No threshold set)	IP	49	23	31	103	24	35	37	96	45	32	25	102					301	
	% OF COMPLAINTS RESOLVED WITHIN THE AGREED TIMESCALE	>=94%	IP, QC	100%	97.50%	97.56%	98.08%	97.67%	100%	100%	98.90%	96.15%	97.87%	100%	98.4%					98.13%	
	NUMBER OF CONCERNS RECEIVED	NOT SET	IP	10	8	26	44	39	19	6	64	4	5	9	18					126	
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				Training has commenced	Training has commenced	Training has commenced							
REDUCING AVOIDABLE EMERGENCY ADMISSIONS TO HOSPITAL		TBC	C	4 pathways identified, awaiting CCG agreement				Adult and paediatric conditions identified, report shared with CCG				Audit underway & completed		Results to be presented to CCG							

BOARD OF DIRECTORS

Item 16/029

SUBJECT:	**Mortality Overview Report** Q3 2015/2016	
DATE OF MEETING:	27th January 2016	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Hannah Gray, Clinical Effectiveness Manager Simon Constable, Medical Director	
EXECUTIVE DIRECTOR:	Simon Constable, Medical Director	
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care Choose an item. Choose an item.	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework SO3/3.3 Failure to provide staff, public and regulators with assurances post Francis and Keogh review 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 overviews trust mortality data and provides local and national context. It also outlines the actions in place to ensure robust oversight and monitoring, through a comprehensive mortality peer review process, as well as improvement plans to reduce trust mortality rates and the trust mortality ratio figures.	
RECOMMENDATION:	***The Board is asked to:*** *note the contents of the report and discuss and approve the recommended options*	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

Mortality Overview Report: Q3 2015/2016

EXECUTIVE SUMMARY

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

CONTEXT

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

MORTALITY DATA

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

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

a) Trust Crude Mortality

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

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

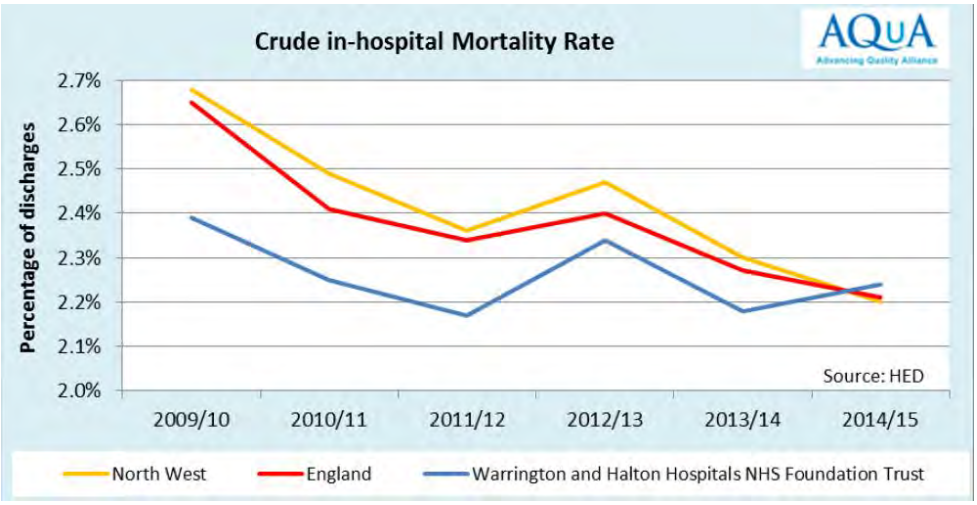


Chart 2: WHHNHSFT, England average and North West Acute Trusts (latest available national data).

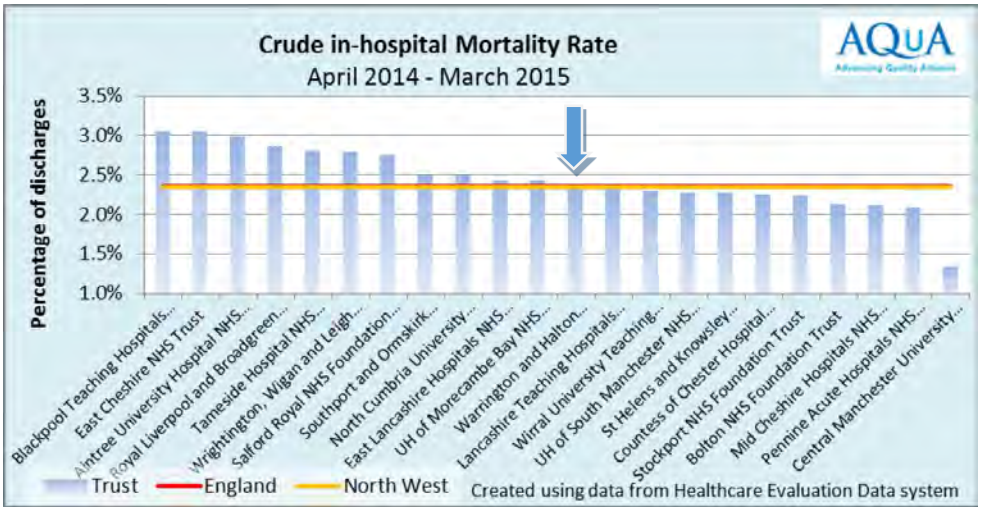


Chart 3: Crude Mortality Rates for WHHNHSFT and local peers (HSMR patients only), November 2014 – October 2015 (latest data available). NB: Q3 2015/2016 = October only

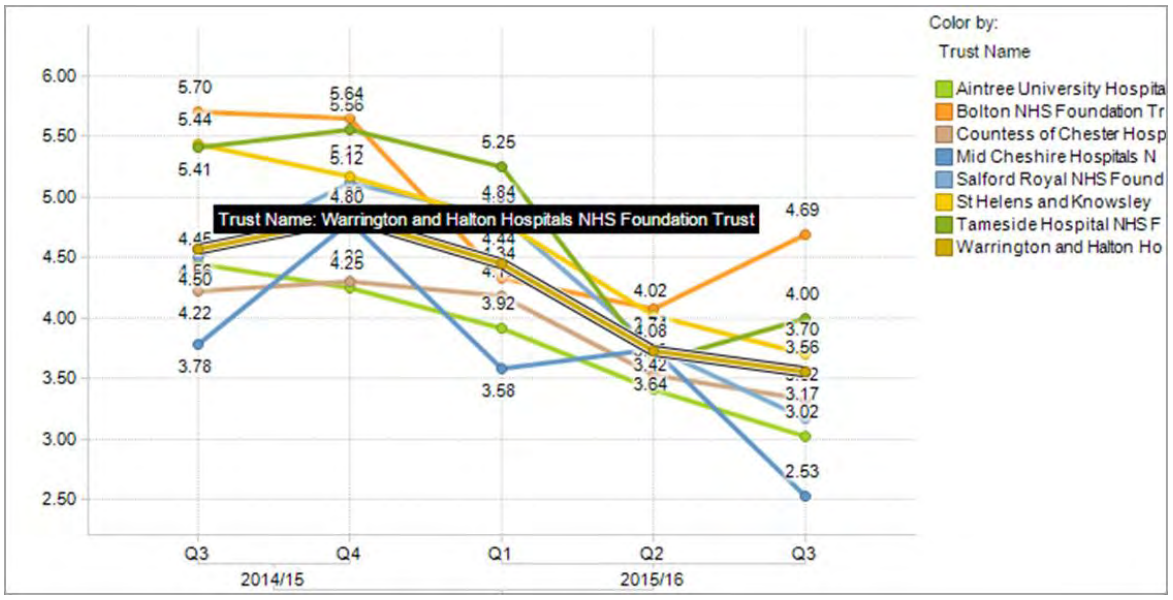
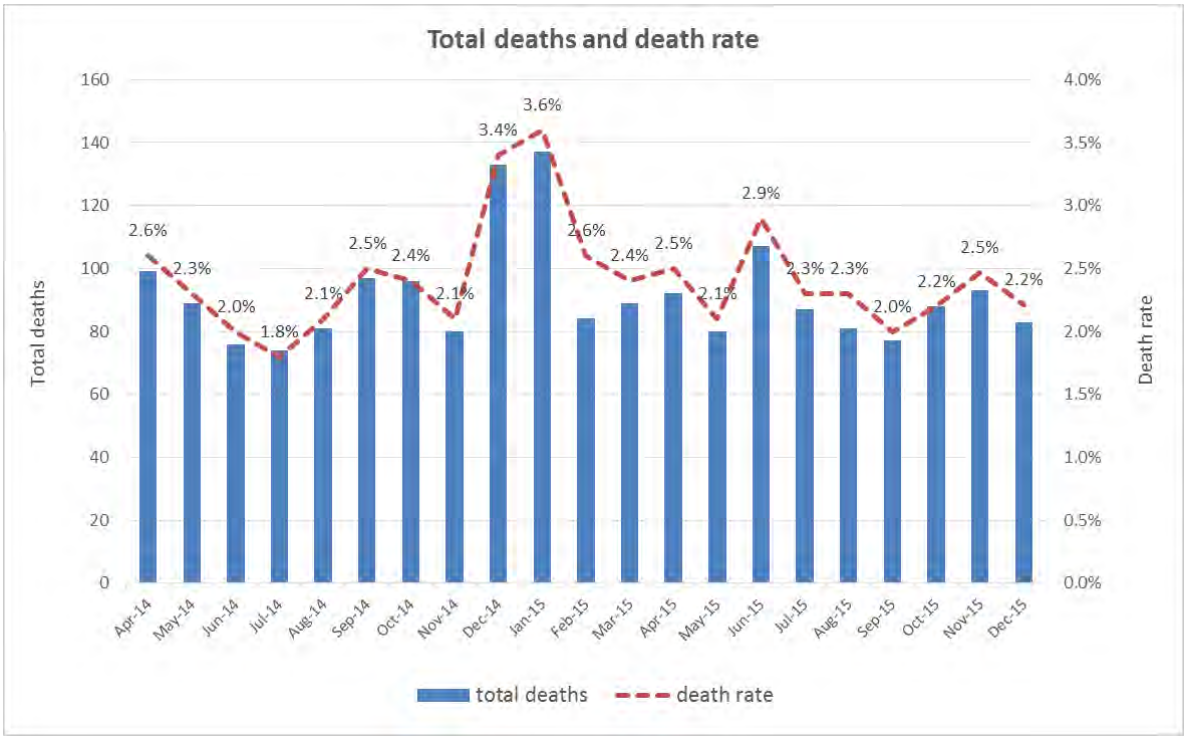


Chart 4: WHHNHSFT total deaths and death rate (deaths as a % of all discharges) per month.



Source: WHHNHSFT Information Department

Charts 3 and 4 show a rise in deaths and death rate at WHH in June 2015. The death rate for June 2015 is higher than that of other local Acute Trusts, however our rates were lower than most trusts in the preceding three months. To provide assurance, the Clinical Effectiveness Sub Committee requested a review, to take

into consideration factors including mortality review findings, staffing levels and incidents during this period. A report presented at the October 2015 meeting indicates no significant differences during this period.

December 2015 and January 2016 figures (to date) are significantly lower than at the same time in the previous year. **In December 2015 we had 81 inpatient deaths; in December 2014 we had 133. There have been 31 deaths from 1/1/16 to the 10/1/16, in the same period last year, we had 62 deaths.** The death rate for December 2014 was 3.4%, compared with 2.2% in December 2015.

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

Recommendation	Assurance Forum	Deadline	Progress
All deaths in the hospital should be reviewed on an ongoing basis.	Clinical Effectiveness Sub-Committee	Q4 2015/16	A revised system of peer review was launched on 1/10/15. The target for Q1 and Q2, for the % reviewed, was met.

Trust deaths by ward and year

Numbers of deaths and death rates on wards in 2013/2014, 2014/2015 and Q1 and Q2 2015/2016.

		Number of deaths			Death Rate		
Ward	**Lead Speciality**	**2013/14**	**2014/15**	**Q1+2 15/16**	**2013/14**	**2014/15**	**Q1+2 15/16**
A1	Acute Medicine	101	105	46	2.2%	2.3%	2.4%
A2	Acute Medicine	92	88	36	5.1%	5.5%	4.2%
A3	Elderly Medicine	76	103	46	8.3%	13.6%	12.2%
A4	General Surgery	36	10	9	2.9%	0.6%	2.5%
A5	General Surgery	14	38	16	1%	2.4%	1.6%
A6	Colorectal Surgery	25	29	9	1.3%	1.9%	1.1%
A7	Respiratory Medicine	138	133	80	10.4%	13.6%	15.1%
A8	General Medicine/ Neuro-rehab/Elderly	82	96	43	10.4%	13.2%	11.5%
A9	Trauma & Orthopaedics	32	33	8	2.7%	2.6%	1.3%
B11	Paediatrics	1	1	0	0.1%	0.1%	0
B12	Elderly Care/Dementia	56	52	19	11.7%	14%	13.7%
B14	Stroke	67	81	37	10.1%	10.9%	10.8%

B18	General Medicine and infection control cohort ward	44	45	18	8.2%	9.5%	8%
B19	Trauma & Orthopaedics	7	10	4	1.2%	1.9%	1.3%
C20	Gynaecology & Women's Health	3	6	3	0.1%	0.3%	0.3%
C21	Cardiology	36	47	24	3.3%	4.7%	4.5%
C22	Gastroenterology	43	60	30	4.1%	6.3%	5.5%
Coronary Care Unit	Cardiology	33	30	11	8%	6.5%	5.5%
Clinical Decisions Unit	Emergency Medicine	1	2	1	0.02%	0.04%	0.04%
CMTC	Trauma & Orthopaedics	0	1	0	N/A	0.1%	0
Intensive Care Unit	Critical Care Medicine	152	131	66	59.4%	63.6%	58.9%
Labour Ward (including still births)	Obstetrics & Paediatrics	14	9	3	0.67%	0.46%	0.29%
Neonatal Unit	Neonatology	7	4	0	3.02%	1.69%	0
Surgical Assessment Unit	General Surgery	1	3	3	0.05%	0.1%	0.3%
Theatre Recovery	General Surgery	7	11	1	36.8%	45.8%	11.1%
Urgent Care Centre	General Medicine	1	3	0	0.2%	1.3%	0
Halton Intermediate Care Unit	Intermediate Care	1	2	0	1.1%	0.8%	0
Total		**1076**	**1134**	**514**	**2.3%**	**2.5%**	**2.3%**

Source: WHHNHSFT Information Department

Deaths by day of admission

This table shows a weekday / weekend split for crude numbers of deaths (patients who died in hospital or within 30 days of discharge), and SHMI* figures for WHHNHSFT and other local trusts with a higher than expected SHMI for weekday or weekend admissions or both, for the period October 2014 – September 2015 (latest available on HED). The SHMI for all 22 NW acute trusts for this period is 107 for weekend admissions and 101 for weekday admissions. The weekend figure is statistically significantly high. 21 of the 22 Acute Trusts in the NW have a weekend SHMI over 100. Although other trusts have a similar gap between their weekday and weekend SHMI, and we have identified no concerns regarding weekend care in general (as part of any focussed or general mortality review to date), a project group has been set up to review deaths following weekend admissions, and will report to the Mortality Review Group.

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

Trust Name	Weekend Admission	SHMI	Statistically Significant?	Expected number of deaths	Number of patients discharged who died in hospital or within 30 days	Percentage of mortalities occurring in hospital	Percentage of admissions with palliative care coding	Average comorbidity score per spell
RBN - ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	Weekday	98.53	N	1728.4	1703	67.80%	1.17%	3.78
RBN - ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	Weekend	112.72	Y	491.5	554	73.30%	1.25%	3.81
RBT - MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	Weekday	94.46	N	1161.3	1097	66.50%	0.91%	3.31
RBT - MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	Weekend	105.88	N	357	378	64.30%	0.83%	3.19
REM - AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TR	Weekday	98.46	N	1526.5	1503	69.30%	2.92%	4.5
REM - AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TR	Weekend	101.48	N	472	479	71.60%	3.37%	4.64
RJR - COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TI	Weekday	101.43	N	1111.1	1127	70.90%	1.44%	3.03
RJR - COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TI	Weekend	103.56	N	320.6	332	75.60%	1.77%	3.03
RM3 - SALFORD ROYAL NHS FOUNDATION TRUST	Weekday	93.96	N	1429.4	1343	73.90%	2.68%	4.29
RM3 - SALFORD ROYAL NHS FOUNDATION TRUST	Weekend	89.21	N	491	438	74.40%	3.04%	5.05
RMC - BOLTON NHS FOUNDATION TRUST	Weekday	100.49	N	1313.6	1320	72.90%	1.10%	3.06
RMC - BOLTON NHS FOUNDATION TRUST	Weekend	109.41	N	436	477	69.40%	1.27%	3.08
RMP - TAMESIDE HOSPITAL NHS FOUNDATION TRUST	Weekday	109.67	Y	945.5	1037	68.60%	1.62%	3.95
RMP - TAMESIDE HOSPITAL NHS FOUNDATION TRUST	Weekend	118.74	Y	333.5	396	66.40%	1.82%	4.29
RWW - WARRINGTON AND HALTON HOSPITALS NHS FOUND	Weekday	110.73	Y	1078.3	1194	69.90%	1.48%	3.34
RWW - WARRINGTON AND HALTON HOSPITALS NHS FOUND	Weekend	118.69	Y	331.1	393	74.60%	1.59%	3.48

b) SHMI and HSMR

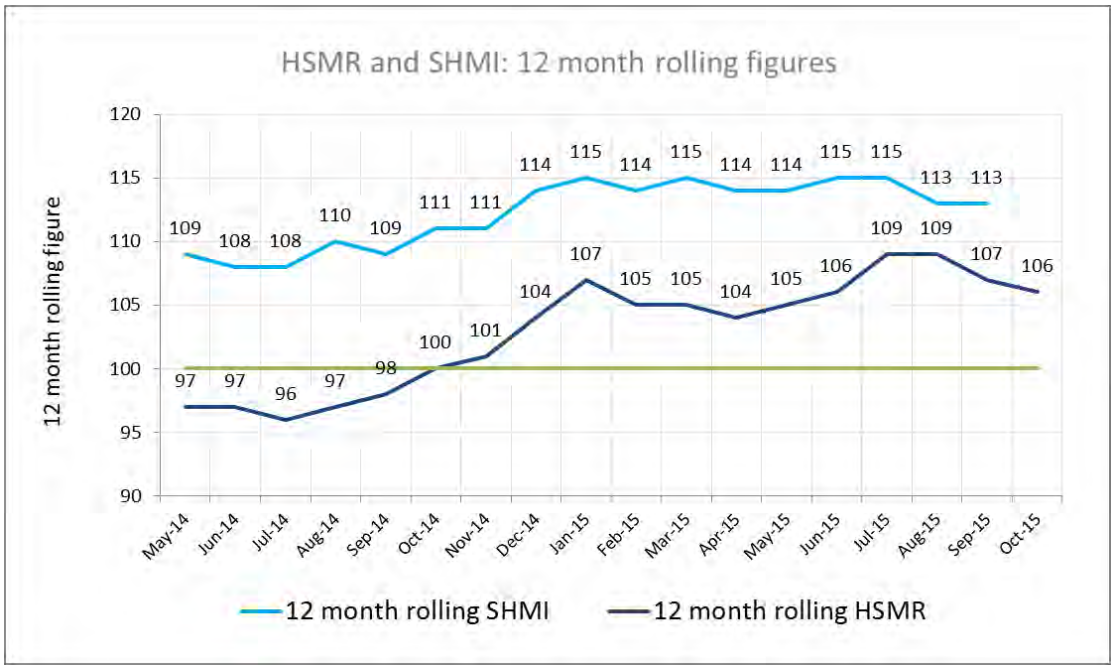
These indicators are produced and published quarterly as an experimental official statistic by the Health and Social Care Information Centre (HSCIC) with the first publication in October 2011. The SHMI is the ratio between the actual number of patients who die at the trust, or within 30 days of being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

	HSMR	SHMI
Numerator	All spells culminating in death at the end of the patient pathway, defined by specific diagnosis codes for the primary diagnosis of the spell: uses 56 diagnosis groups which contribute to approx 80% of in hospital deaths in England*.	Total number of observed deaths (in-hospital and 30 day post discharge deaths)
Denominator	Number of in hospitals admissions where the primary diagnosis at the beginning of the spell i.e. the first or second episode is one of those from the 56 diagnosis groups known to be responsible for around 80% of in hospital mortality. (percentage will vary dependent on the case mix of the hospital)	Total number of patient admissions
Adjustments	• Sex • Age in bands of five up to 90+ • Admission method • Source of admission • History of previous emergency admissions in last 12 months • Month of admission • Socio economic deprivation quintile (using Carstairs) • Primary diagnosis based on the clinical classification system • Diagnosis sub-group • Co-morbidities based on Charlston score • Number of previous emergency admissions	Risk-adjusted, based on age, sex, admission method, co-morbidity

	• Palliative care • Year of discharge	
Exclusions	None	• Specialist, community, mental health and independent sector hospitals. • Stillbirths • Day cases, regular day and night attenders
* HSMR does not exclude 20% of deaths, it looks for the diagnosis groups that account for the majority of deaths, hence the figure of 80% is quite variable dependent on the case mix of the trust.		

Following a significant focus on mortality reduction in the trust, we improved from a previously 'higher than expected' SHMI score, to having an 'as expected' score between October 2013 and December 2014. The latest SHMI figure published on the HSCIC website is 'higher than expected', as is the latest figure available on the HED system, for the 12 months ending September 2015. We monitor mortality ratios on a monthly basis using the HED system and have reported internally a 'higher than expected' score in the rolling 12 month periods ending January 2015 (115) - September 2015 (113). The latest HSMR is 106, for November 2014 – October 2015, this is 'as expected'.

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



c) Documentation and coding

Signs and symptom codes

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

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

The CCS groups that R codes map to have relatively low mortality rates and, therefore, low numbers of expected deaths. If a trust has a high level of R coding then it is more likely to have a higher level of deaths with an R code as the primary diagnosis (first and second episode). Charts 6 and 7 show that our use of R codes is higher than the NW average and the England average, although reducing in 2015/2016.

Chart 6: Non-elective Finished Consultant Episodes with an R code as the primary diagnosis

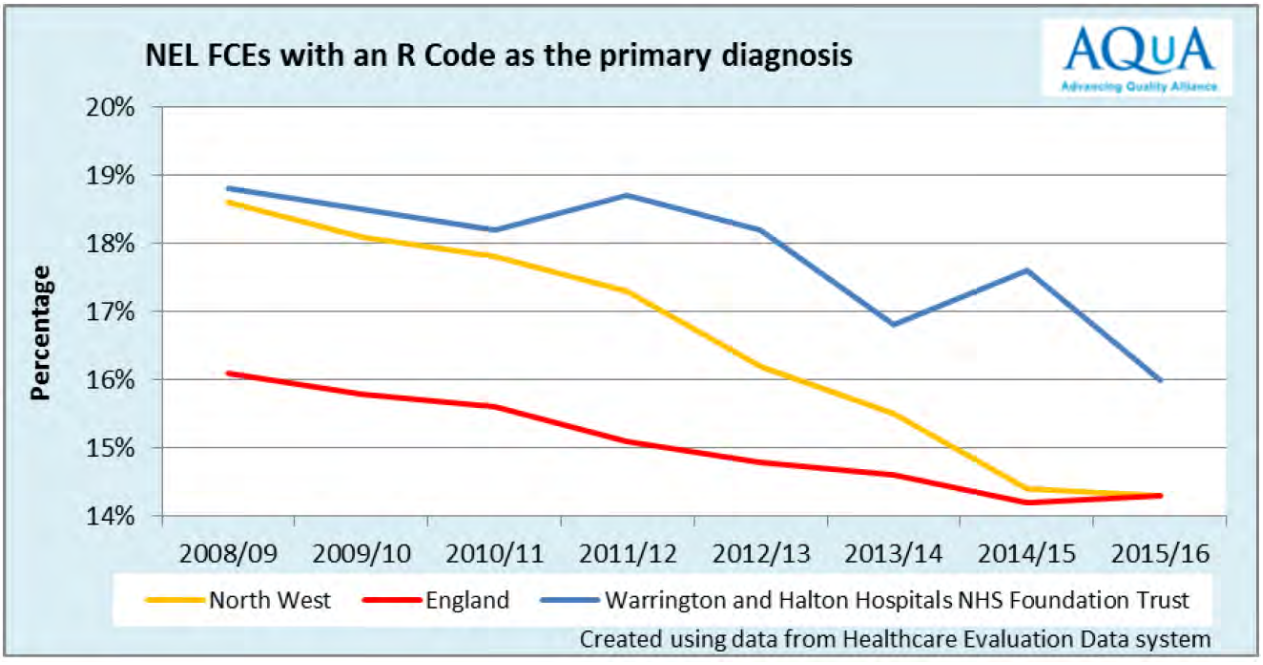
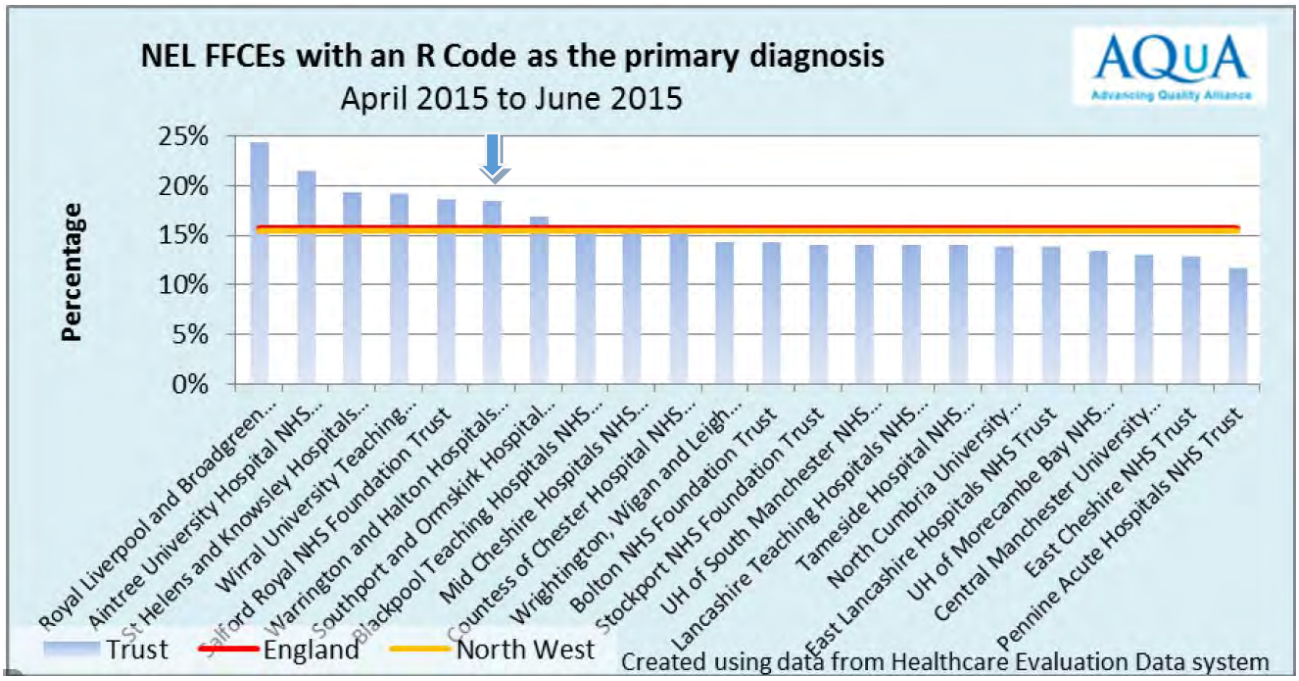


Chart 7: Non-elective finished consultant episodes with an R code as the primary diagnosis (NW Acutes).



Quality of documentation and coding

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

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

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

Chart 8: WHHNHSFT and local peers' average diagnosis coding depth.

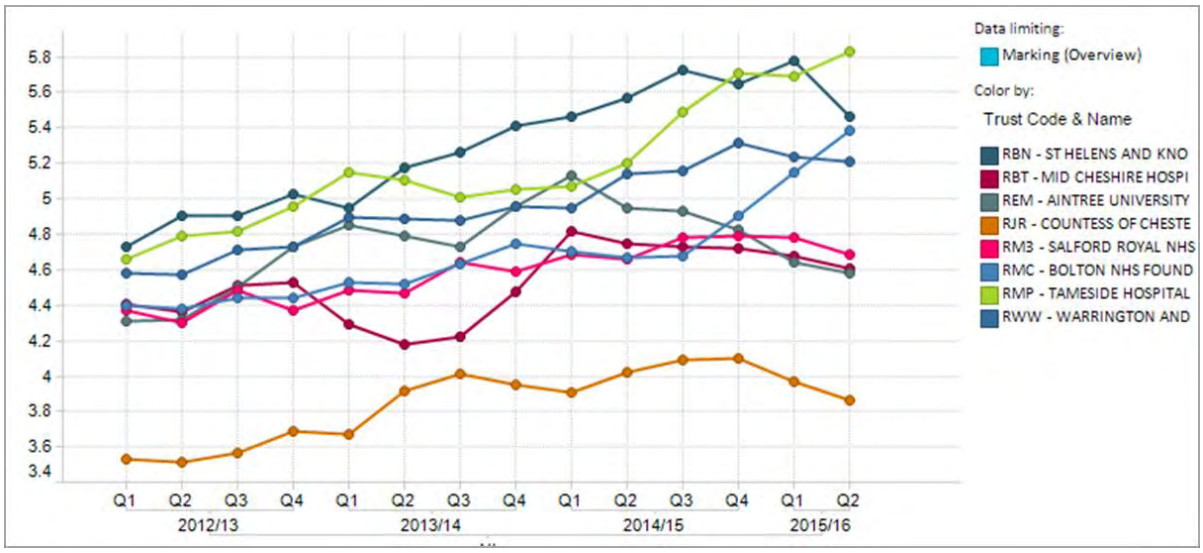
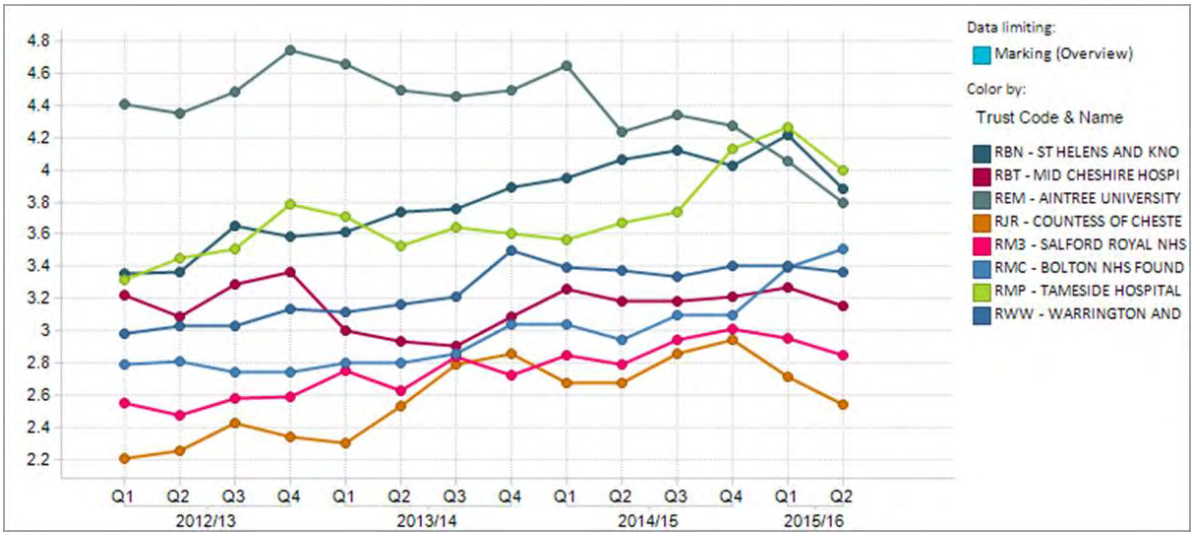


Chart 9: WHHNHSFT and local peers' average total comorbidities



d) Specialist Palliative Care

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

Chart 10: NW Acutes' Specialist Palliative Care service rates

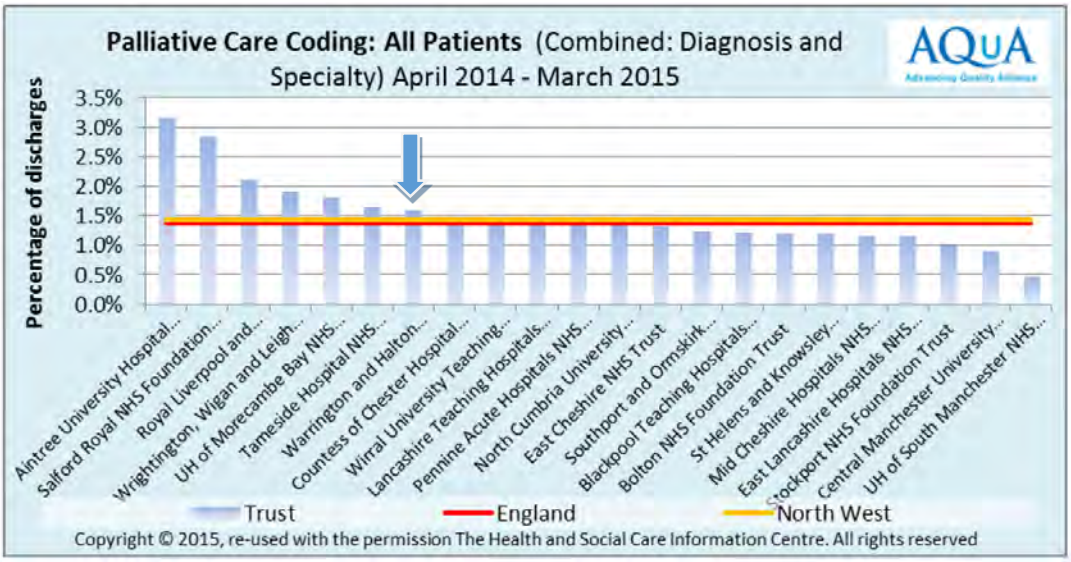
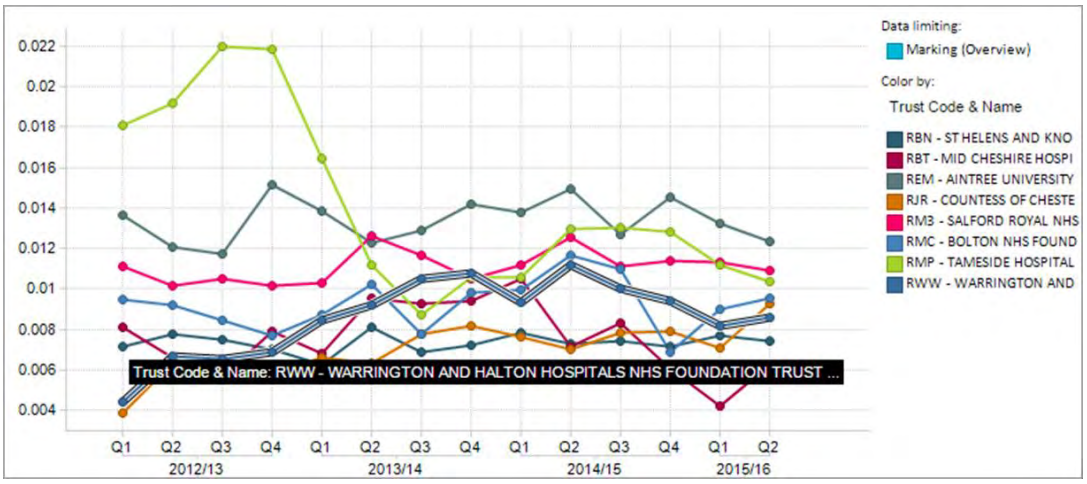


Chart 11: Local trusts' Specialist Palliative Care service provision rates April 2012 – September 2015



e) CQC monitoring

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

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

ICNARC monitor the performance of Intensive Care Units across England. The latest quarterly ICNARC data, for Q3 2015, reveals an 'as expected' standardised mortality rate of 102. In the area of patient safety, indicators continue to be positive with low rates of early (premature) discharges, out of hours discharges and unit acquired infections especially bloodstream infections.

ACTIONS

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

External Assurance:

AQuA's Reducing Mortality Lead has been invited to attend the NW Mortality Review Network, created by WHH. This will enable us to benefit from AQuA's expertise and external assurance regarding the efficacy of our approaches.

We have met key contacts at Aintree University Hospitals NHS FT who have imparted valuable experiences of their reducing mortality journey, supported by an AQuA 'deep dive' into mortality at their Trust. We have used this to revise our Reducing Mortality Action Plan which is monitored by the Mortality Review Group.

1. Mortality Peer Review

We have made significant progress towards establishing a high quality and effective mortality review process which is both trust-wide and standardised in a way that is helpful. This will also be capable of being individualised to meet the specific needs of any given speciality. Since 1st October 2015, deaths are peer reviewed through a straightforward process which is escalated to the Mortality Review Group (MRG) as necessary and where learning and improvement is the underlying rationale. Such a process need not necessarily be cumbersome or disproportionately time-consuming. Arguably something can be learned from every patient and every death – the nature of that learning may be clinical/technical. Equally it could be about documentation, adherence to policy and best practice or indeed issues of care and compassion. This key element of clinical governance has important implications for quality of care, death certification and clinical coding and will form the basis for key improvement work which incorporates the care of the

acutely unwell patient as well as end-of-life care (and thus the other elements of this action plan detailed below). The MRG is now an effective multidisciplinary group, with a strong medical and CCG presence, chaired by Dr Phil Cantrell, in her role as Associate Medical Director: Quality Governance, within the new Medical Cabinet. We have also developed a NW mortality review network to enable the share and spread of good practice in this area.

NHS England distributed a Mortality Governance Guide to all Medical Directors in December 2015; we are pleased to report that have already implemented the vast majority of their recommendations and will use the guide to support the development of activity still in progress.

2. Focussed Reviews

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

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

3. Care Pathways and Care Bundles

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

The Emergency Laparotomy Pathway and the Acute Kidney Injury Pathway have been developed by the Acute Care Group, were recently ratified and are ready to implement.

The trust is working on the new Sepsis NCEPOD, Sepsis CQUIN and Sepsis AQ measures. The Sepsis guidance has been approved by the Acute Care Group ready for implementation, and the paediatric sepsis pathway is being developed. The trust 'Sepsis Month' campaign started in January 2016, raising awareness of how to identify and treat sepsis.

4. Management of the Deteriorating Patient

The Acute Care Team were finalists in both the HSJ Awards and the North West Coast Research and Innovation Awards in 2015.

The Acute Care Group are primarily focussed on the following areas of development:

- The Emergency Laparotomy Pathway and the Acute Kidney Injury Pathway have been recently ratified and are ready to implement.
- Implementation of NICE Guidance for Critical Care Rehabilitation and for IV Fluids.

The Group terms of reference are being amended to reflect the structure of the Clinical Business Unit, to begin in April 2016.

5. Staffing

Like many trusts, we are working toward a number of workforce priorities to drive forward quality of care provision 7 days a week. The acute medical pathway is crucial. Consultant Physician presence for at 13.5 hours a day 7 days a week has been mandated and rostered since 1st November 2015 as a key initiative for quality. Access to senior decision-makers is especially relevant given the apparent difference in outcomes associated with a weekend admission. This model has already improved the number of patients being reviewed by a consultant within 14 hours of admission (and RCP standard) from 38% in September 2015 to 75% in December 2015. Further improvements are being sought. We are also working on incremental improvements on 7 day cover with key medical specialities such as cardiology and gastroenterology as well as the amount and level of routine management support to clinical staff out of hours. In line with national drivers, we are seeking to review where 7 day working would most benefit our patients and provide seamless care from assessment, admission and discharge.

6. End of Life Care

November has seen the revised Individual Plan of Care and support for patient at end-of-life (IPOC) being introduced to the wards. This is supported by the entire team including Gwen Waller the Palliative Care Matron. There has been some rearrangement within the team to replace her vacated post. A Clinical Educator has joined the team from January to support the wards in their use of not only our IPOC but also the other TRANSFORM tools such as the AMBER care bundle with a view to this becoming self-supporting in the wards. The team have submitted data for both the hydration at end of life regional audit and

organisational data for the regional bereavement support audit. When the results of these and the national audit are available in 2016 they will no doubt influence the education provision the team provide. A review of use of single rooms at end of life has shown that a third of patient in our care are in single rooms. The team is not yet at full strength but continue to provide 7 day support to the wards along with outpatient reviews in clinic. The team are continuing the link nurse programme and those link nurses attending the study day in November were provided with the opportunity to improve their communication skills. The use of the 5 priorities of care for end of life continues with use of the Individual Plan of Care, we aim to improve the utilisation of this and also provide assurance on trust compliance with the NICE guidelines on End of Life Care published in December over the coming months.

7. Documentation and coding

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

The Trust has an above average use of 'signs and symptom' codes, the detail of which is provided on pages 9 and 10 of this report. The DIGG lead for Unscheduled Care is aware of this issue and is working with colleagues to address this. A review into a sample of cases is underway and will identify any issues regarding patients' care and any areas for improvement.

NEXT STEPS

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

RECOMMENDATIONS

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

CONCLUSION

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

Acknowledgements:

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

References:

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

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

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

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

Appendix 1: AQuA Mortality Report November 2015 – please see following pages

NHS

AQuA

Advancing Quality Alliance

Quarterly Mortality Report

Report No. 10

November 2015

Edition prepared for:

Warrington and Halton Hospitals NHS Foundation Trust

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Contents

INTRODUCTION

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

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

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

This report is set out in four sections:

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

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

This report has been prepared following the publication of the SHMI for the period April 2014 to March 2015; Appendix B details the metadata for the information contained within this report.

SECTION 1 – The North West

1.1 Crude Mortality Rate

The North West has the third lowest crude in-hospital mortality rate in England with a rate that is similar to the overall rate for England – see chart 1. The rates for both England and the North West had been reducing over the past few years and now stand at around 2.3% – see chart 2.

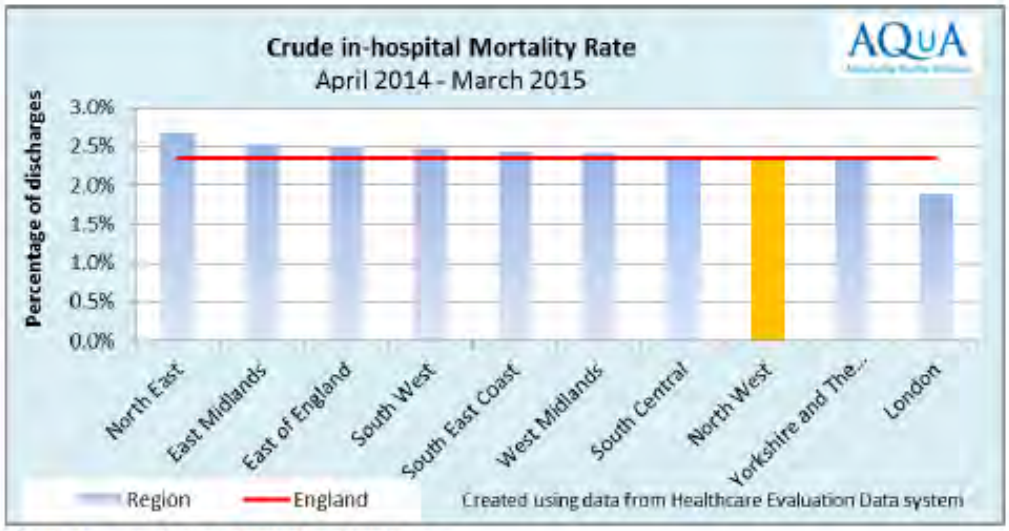


Chart 1 – crude in-hospital mortality rate

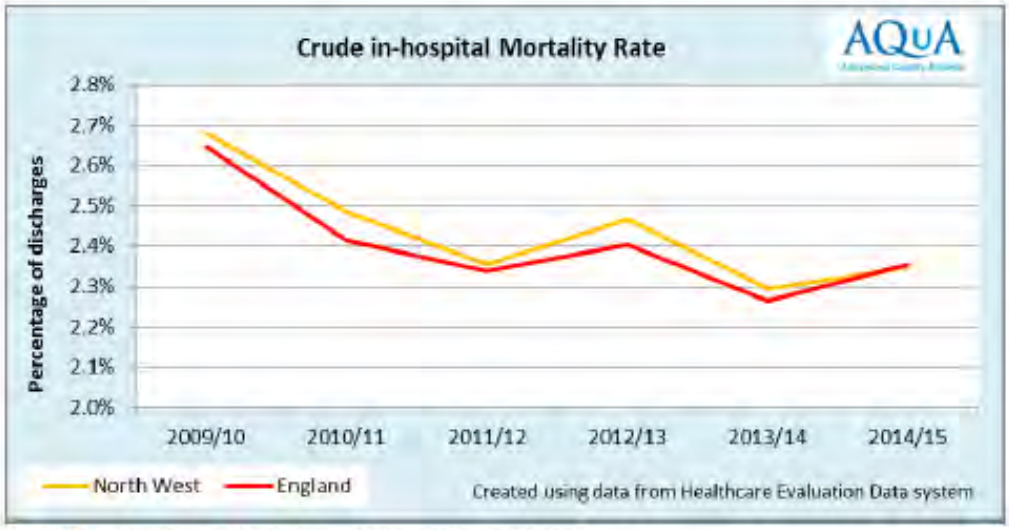


Chart 2 – crude in-hospital mortality rate time-series

Across the former SHAs, crude mortality rates for non-elective [NEL] activity are between five and twelve times higher than for elective [EL] activity; the crude NEL mortality rate for England being 2.7% and the crude EL mortality rate for England being 0.4% (seven times higher) – see chart 3. For deaths occurring within 30 days of discharge, there is a five-fold difference between those following a non-elective admission and those following an elective admission [1.1% and 0.2%, respectively] with less regional variation (three and a half to six and a half fold difference). When reviewing the underlying causes of high(er) mortality rates, it would, therefore, be beneficial to explore pathways relating to emergency care.

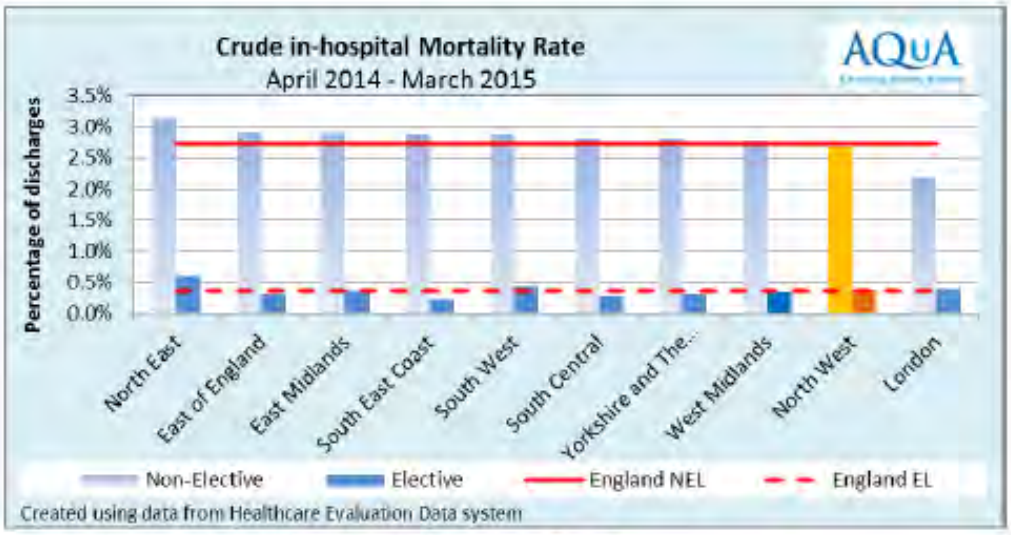


Chart 3 – crude in-hospital mortality rate, NEL & EL split

1.2 SHMI

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

Although the North West has a crude mortality rate that is very similar to the England rate, it has the second highest SHMI [1.03] – see chart 4a. In essence, this means that, given our demographic make-up, the case-mix that we treat and the other illnesses that our patients have, it is to be expected that our crude rate would be lower than it is.

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

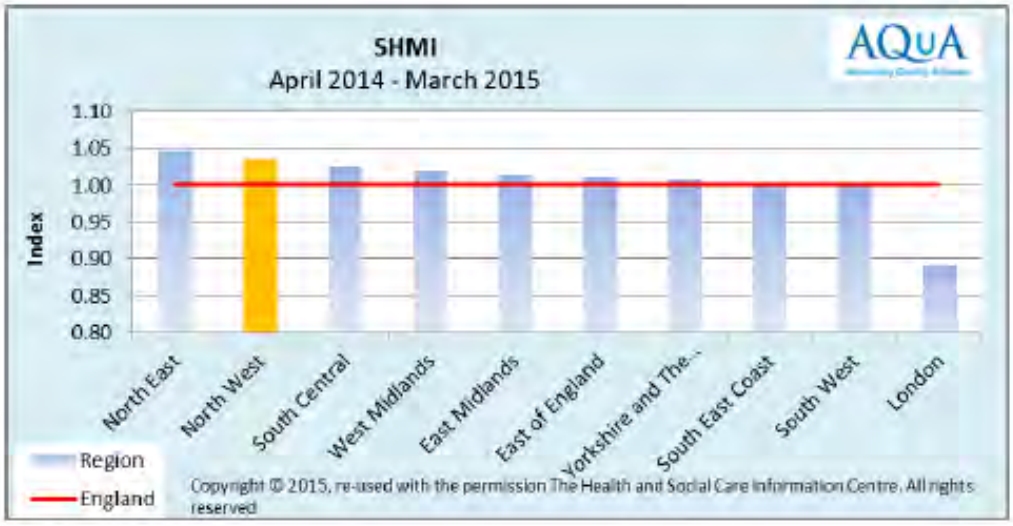


Chart 4a – latest SHMI

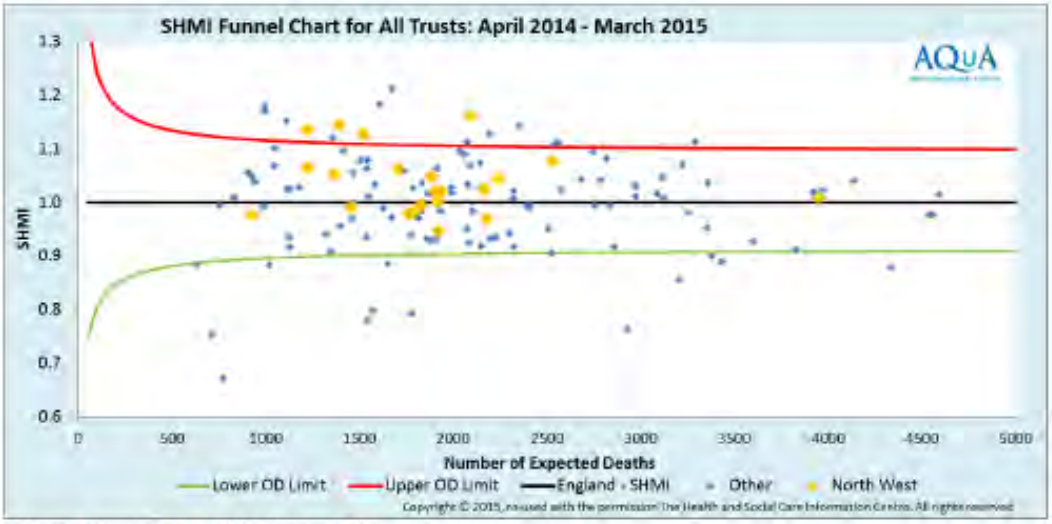


Chart 4b – latest SHMI Funnel Plot

The SHMI for the North West had been worsening since the indicator was first published for the period April 2010 to March 2011 until the period October 2011 to September 2012 - see chart 5. Small improvements have then been observed in each of the subsequent six releases of SHMI with a 'levelling off' in the next five releases up to Jan 2014 to December 2014. The latest SHMI release has seen an improvement in the North West SHMI but it is necessary to wait and see if this is a sustained improvement.

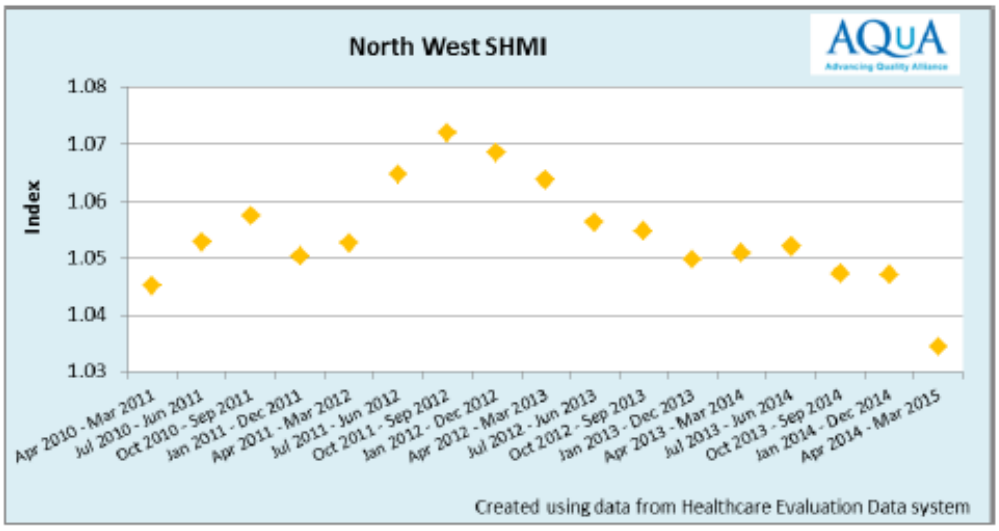


Chart 5 – NW SHMI time-series

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

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

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

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

Following this was a 'third phase' with a return to reducing Observed and Expected values [second pair of green arrows]. The Observed number of deaths was falling faster than the Expected number of deaths and, consequently, our SHMI continued its downward trend.

We now appear to be entering a 'fourth phase' with increases in both the number Observed and Expected deaths. The latest release has seen the increase in Expected deaths occuring at a faster rate than for Obsevred deaths which has consequently seen a reduction in the North West SHMI.

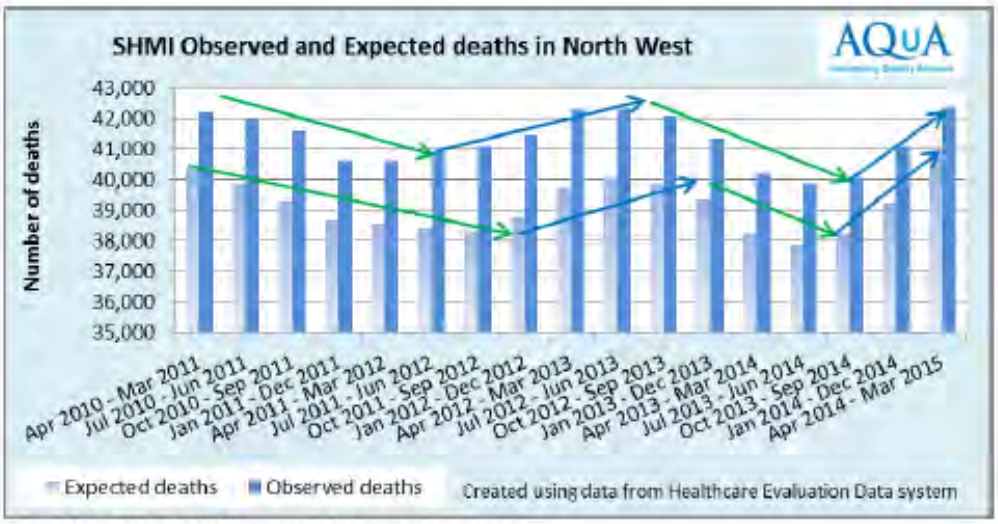


Chart 6 – NW SHMI Observed & Expected deaths

1.3 SHMI – proportion of deaths that occur in-hospital

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

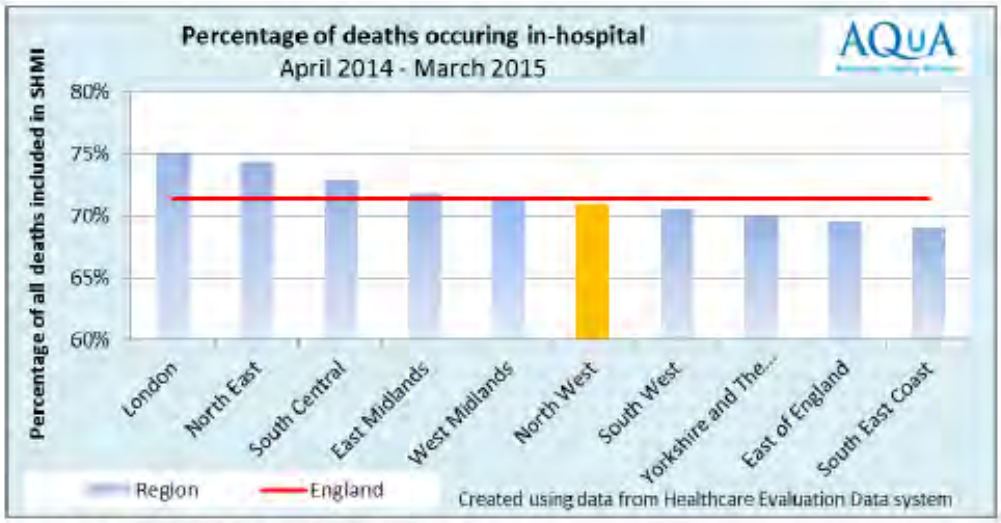


Chart 7 – Percentage of deaths occurring in-hospital

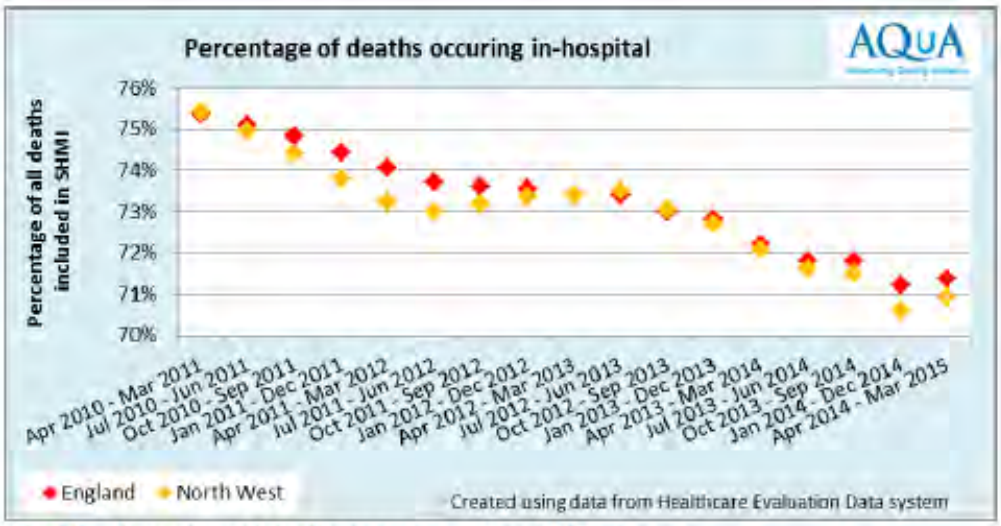


Chart 8 – Percentage of deaths occurring in-hospital time-series

SECTION 2 – Trusts in the North West

2.1 Crude Mortality Rate

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

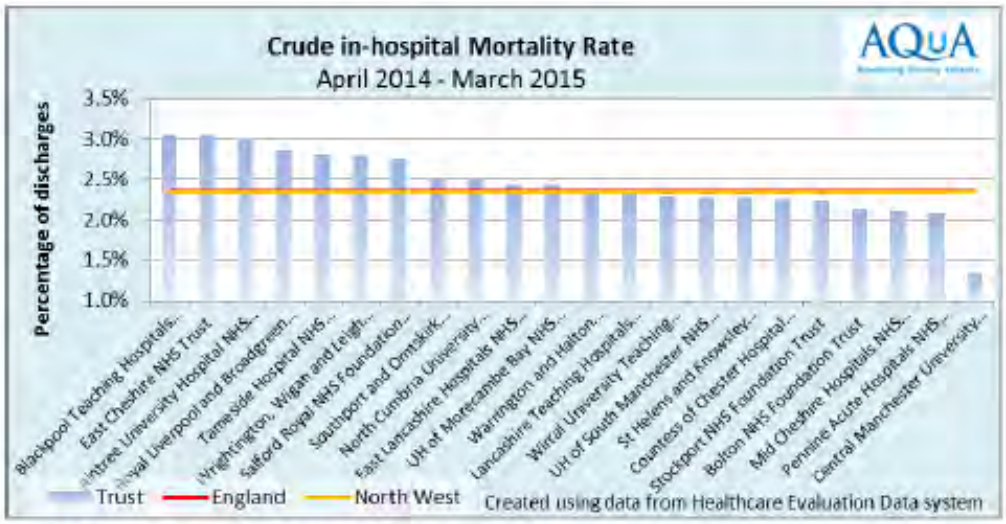


Chart 9 – crude in-hospital mortality rate by trust

There is a similar degree of variance for in-hospital deaths for non-elective admissions – from 1.5% to 3.6% - see chart 10. Although crude rates are a useful starting point in understanding the situation regarding a trust's mortality, direct comparisons between trusts should be treated with caution due to potential differences in case-mix and the age-profile of the patients treated. Case-mix variables may be subtle or as fundamental as either not providing a relatively low-risk service [e.g. paediatrics] or of providing a relatively high-risk service [e.g. sub-regional trauma centre] (both examples having the effect of increasing the crude rate). These are, of course, some of the very differences that standardised rates adjust for.

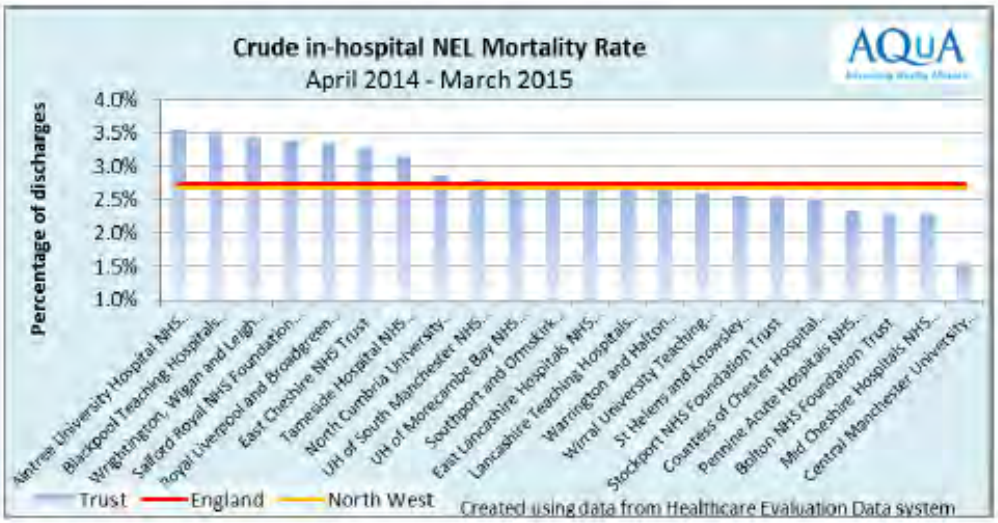


Chart 10 – crude in-hospital NEL mortality rate by trust

2.2 SHMI

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

A list of Trust codes and names can be found in Appendix C.

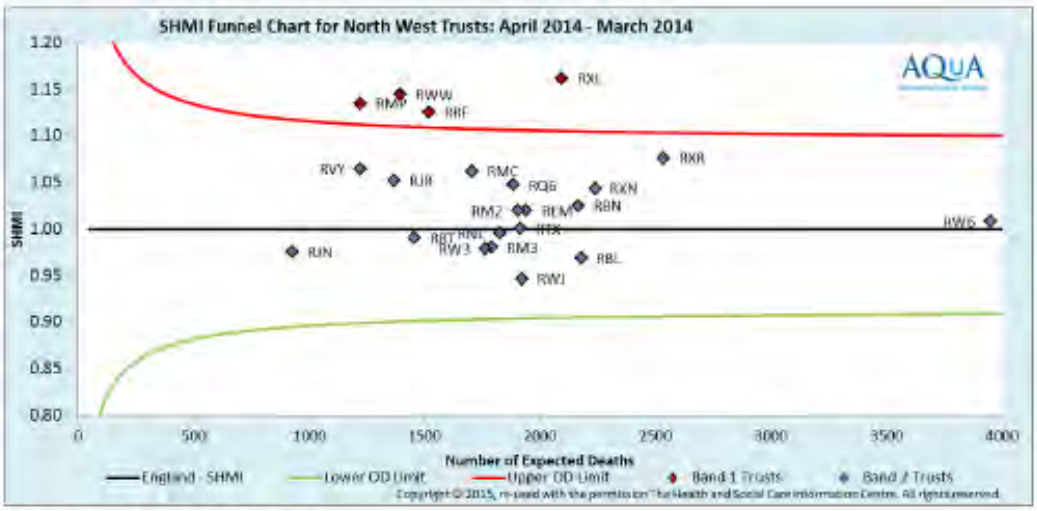


Chart 11 – latest SHMI by trust

2.3 Palliative Care coding

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

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

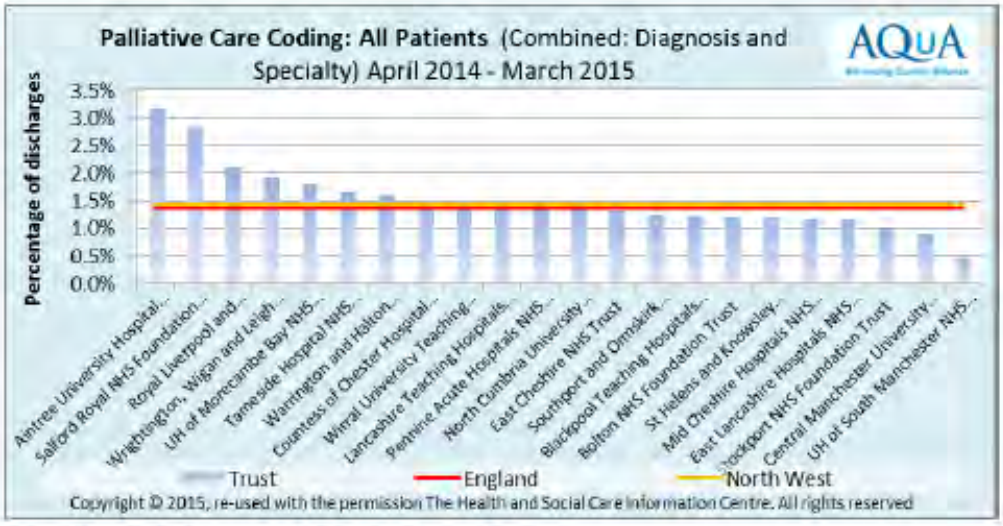


Chart 12 – Palliative Care coding by trust, all patients

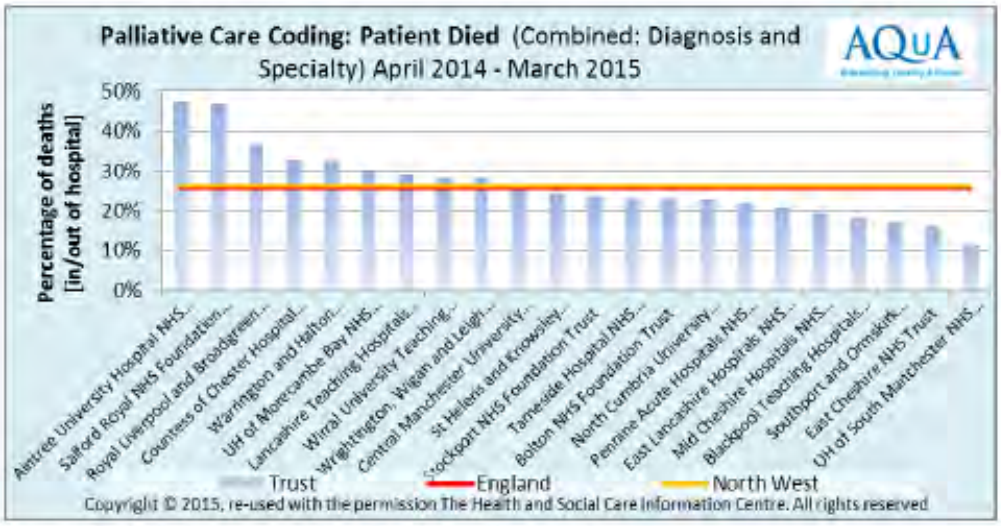


Chart 13 – Palliative Care coding by trust, patient died

2.4 Signs and Symptoms coding

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

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

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

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

Chart 14 shows the general use of R Codes – there is a two-fold difference between the trust with the highest usage of R codes in the primary diagnosis [20%] (all episodes of a Spell where the first episode was non-elective) and the trust with the lowest [11%].

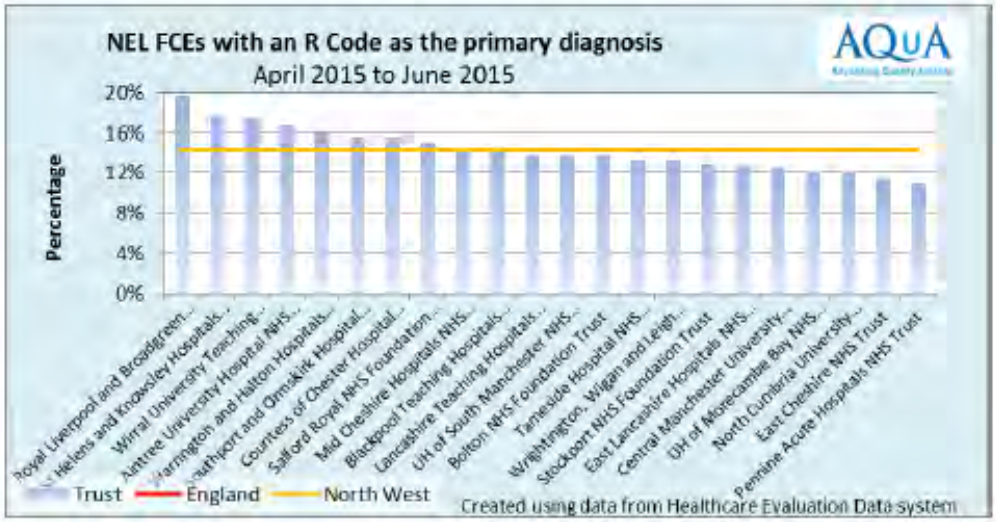


Chart 14 – Signs & Symptoms coding by trust, NEL, all episodes, all patients

Chart 15 shows the use of R Codes in the first episode – here, there is a two-fold difference between the trust with the highest usage of R codes in the primary diagnosis [24%] and the trust with the lowest [12%].

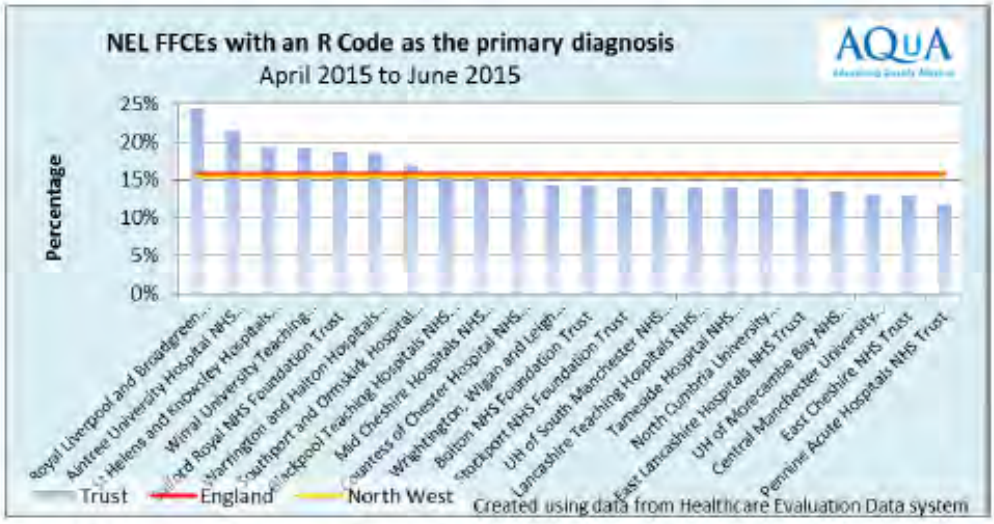


Chart 15 – Signs & Symptoms coding by trust, NEL, first episode, all patients

The number of expected deaths for a trust is calculated on all discharges so, whilst the data shown in Chart 16 has no greater effect on the SHMI than the data shown in Chart 16 [indeed, the patients reported in chart 16 will also have been reported in charts 14 & 15] higher levels of patients who died and had an R Code as their primary diagnosis in the last episode of their care might warrant further investigation. In this area, a much greater variance between trusts is observed [from 0.0% to 2.3%].

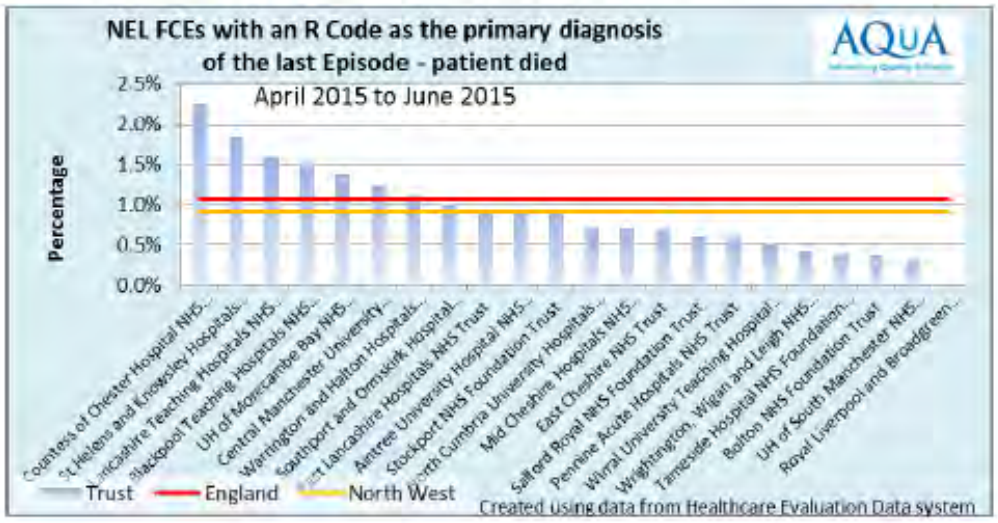


Chart 16 – Signs & Symptoms coding by trust, NEL, patient died

2.5 Co-morbidity

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

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

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

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

For non-elective episodes, there is a fair range of average Charlson values per episode* between trusts in the North West [from 2.4 to 4.7] – see chart 17. This may be a reflection of the relative health of the population that each trust serves but it could also reflect more comprehensive coding processes.

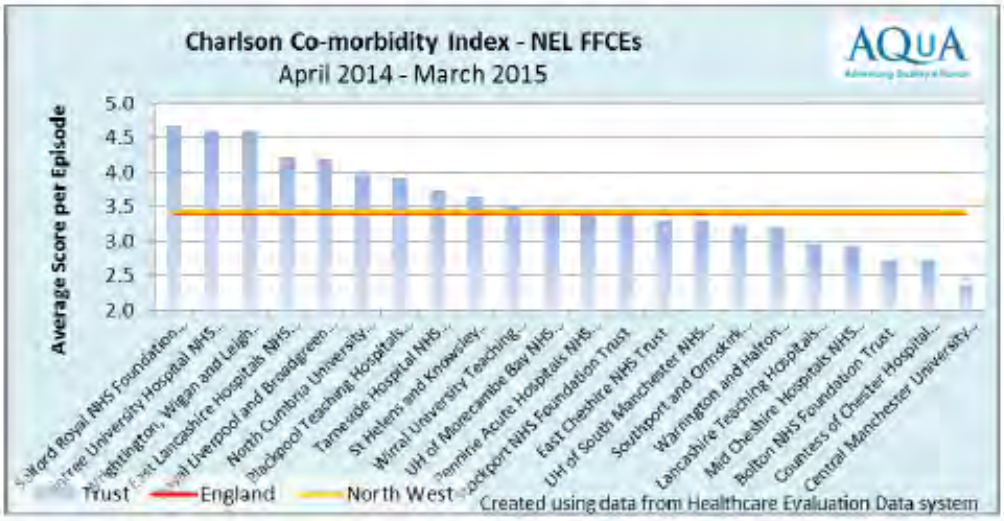


Chart 17 – Co-morbidity score by trust, NEL

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

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

SECTION 3 – Your Trust

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

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

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

3.1 Crude Mortality Rate

Fin. Year	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Trust	2.39%	2.25%	2.17%	2.34%	2.18%	2.37%
North West	2.68%	2.49%	2.36%	2.47%	2.30%	2.35%
England	2.65%	2.41%	2.34%	2.40%	2.27%	2.35%

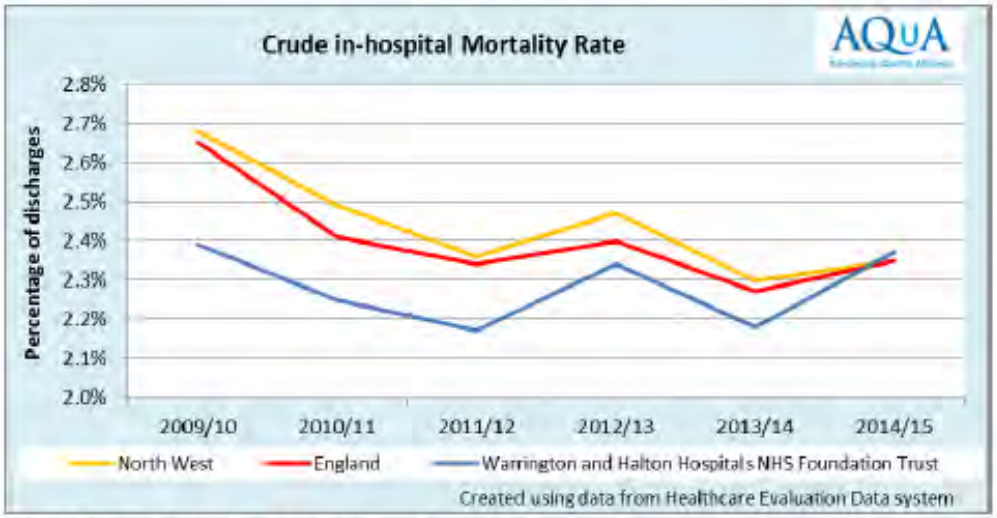


Chart 18 – trust crude in-hospital mortality rate time-series

3.2 SHMI

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

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

Period	Apr 14 - Mar 15
Trust	1.14
North West	1.03

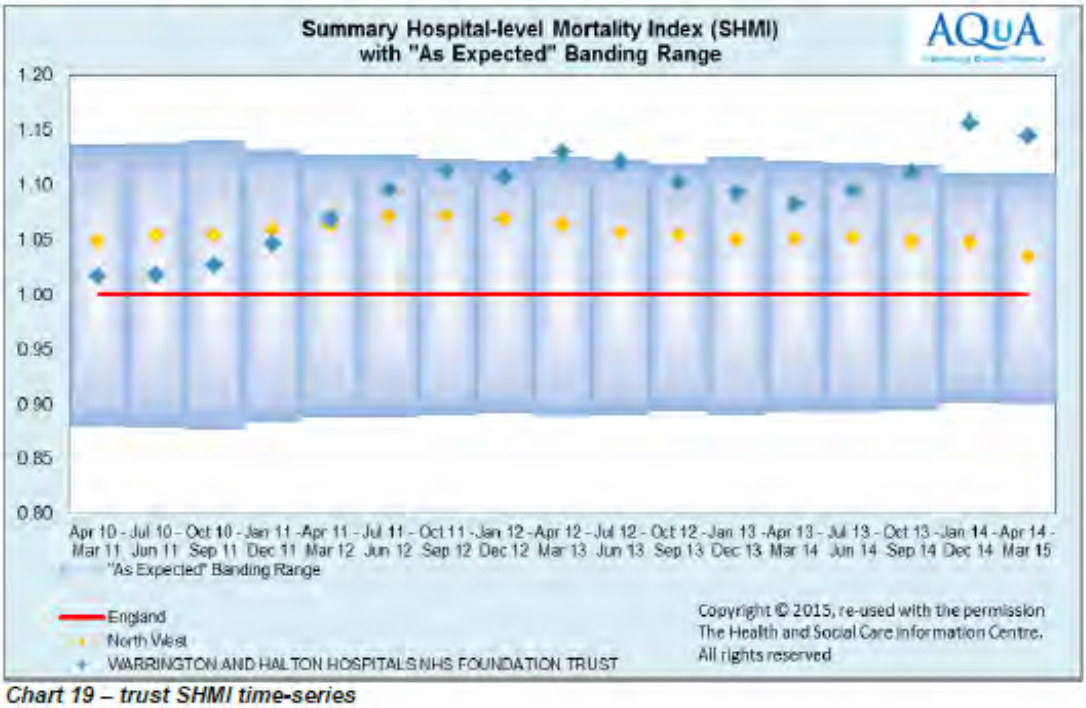


Chart 19 – trust SHMI time-series

3.3 Palliative Care Coding

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

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

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

Period	Apr 14 - Mar 15
Trust	1.5%
North West	1.43%
England	1.38%

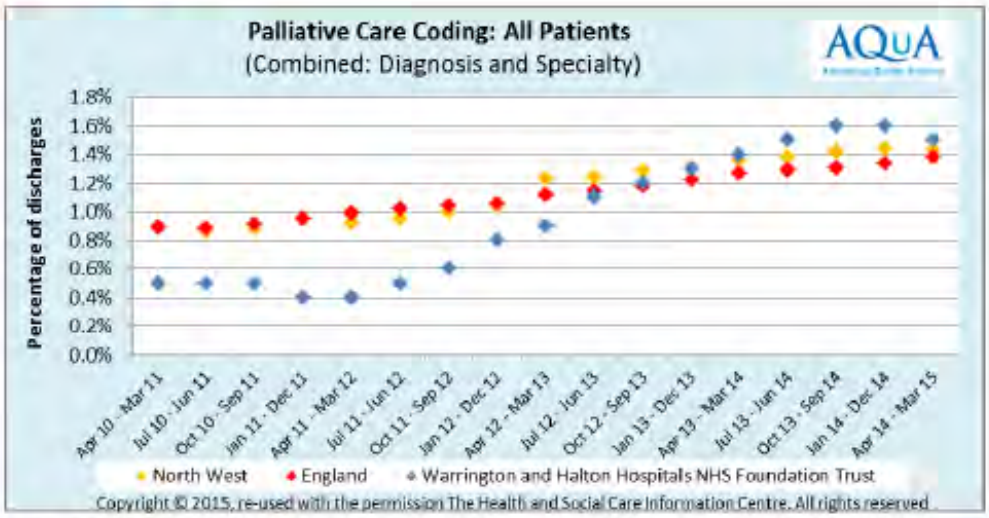


Chart 20 – trust Palliative Care coding time-series, all patients

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

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

Period	Apr 14 - Mar 15
Trust	32.6%
North West	26.3%
England	25.7%

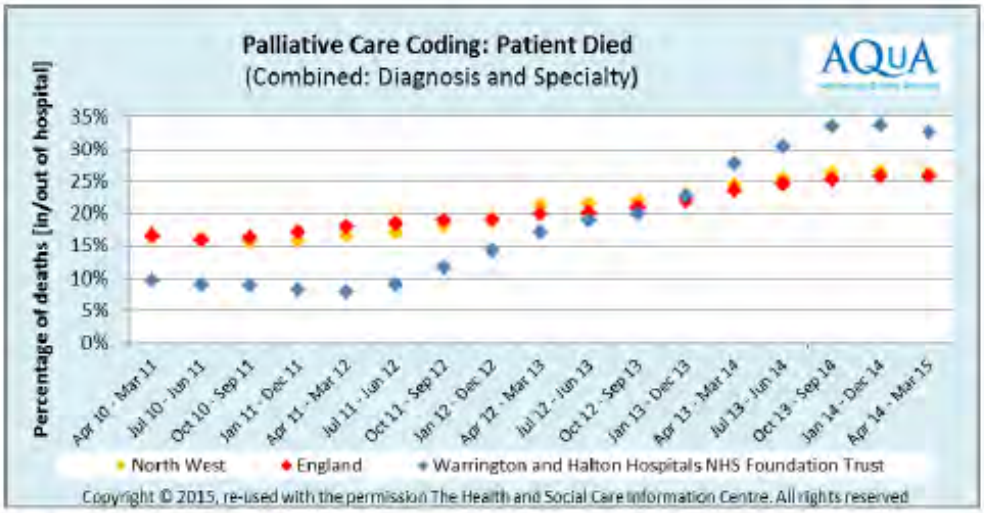


Chart 21 – trust Palliative Care coding time-series, patients died

3.4 Signs and Symptoms coding

All non-elective FCEs.

Fin. Year	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Trust	18.8%	18.5%	18.2%	18.7%	18.2%	16.8%	17.6%	16.0%
North West	18.6%	18.1%	17.8%	17.3%	16.2%	15.5%	14.4%	14.3%
England	16.1%	15.8%	15.6%	15.1%	14.8%	14.6%	14.2%	14.3%

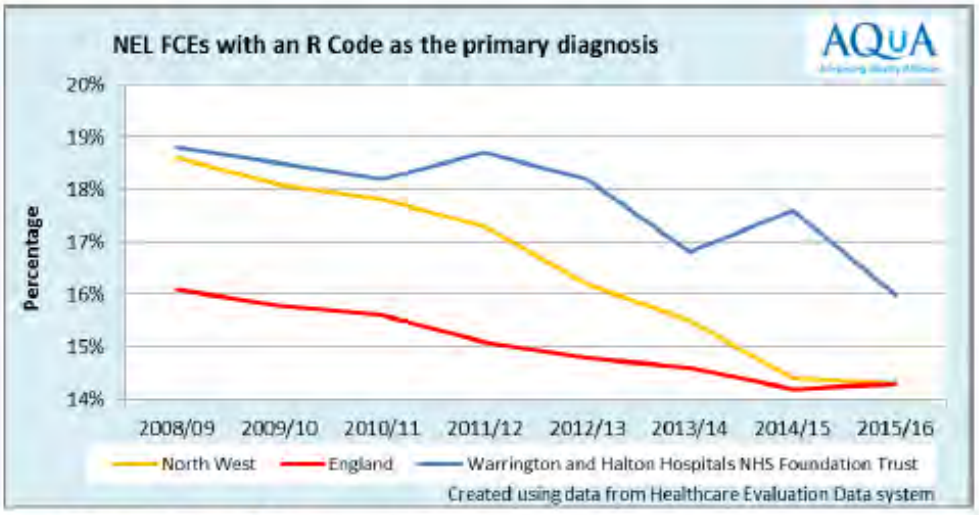


Chart 22 – trust Signs & Symptoms coding time-series, NEL, all patients

First Episode of the non-elective Spell.

Fin. Year	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Trust	20.1%	19.8%	19.6%	20.4%	20.0%	18.6%	19.7%	18.5%
North West	19.4%	19.1%	18.8%	18.4%	17.4%	17.0%	15.9%	15.5%
England	17.0%	16.5%	16.5%	16.0%	15.9%	16.0%	15.6%	15.7%

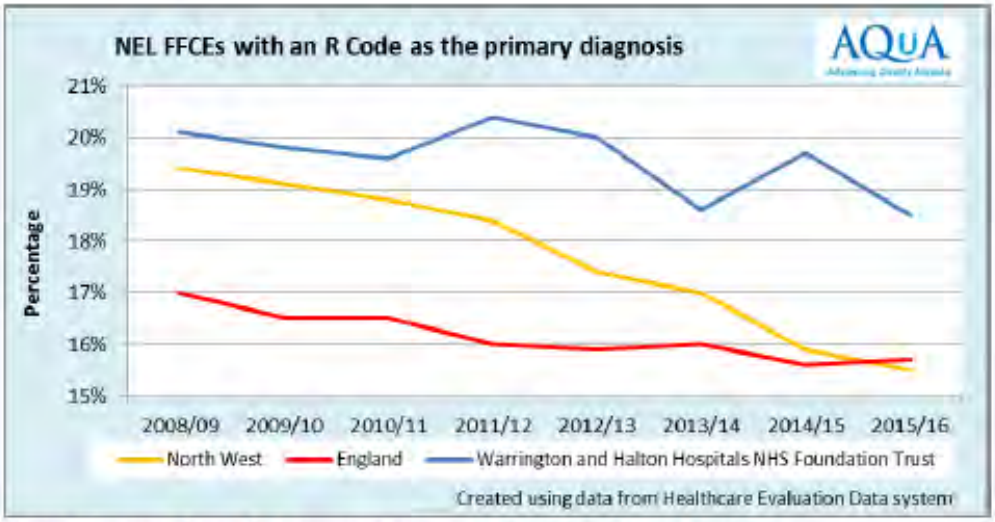


Chart 23 – trust Signs & Symptoms coding time-series, NEL, all patients

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

Fin. Year	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Trust	3.1%	2.8%	2.9%	2.5%	2.6%	2.9%	1.4%	1.1%
North West	4.7%	3.3%	2.6%	2.2%	1.8%	1.3%	1.1%	0.9%
England	4.1%	3.4%	2.8%	2.3%	2.1%	2.1%	1.7%	1.1%

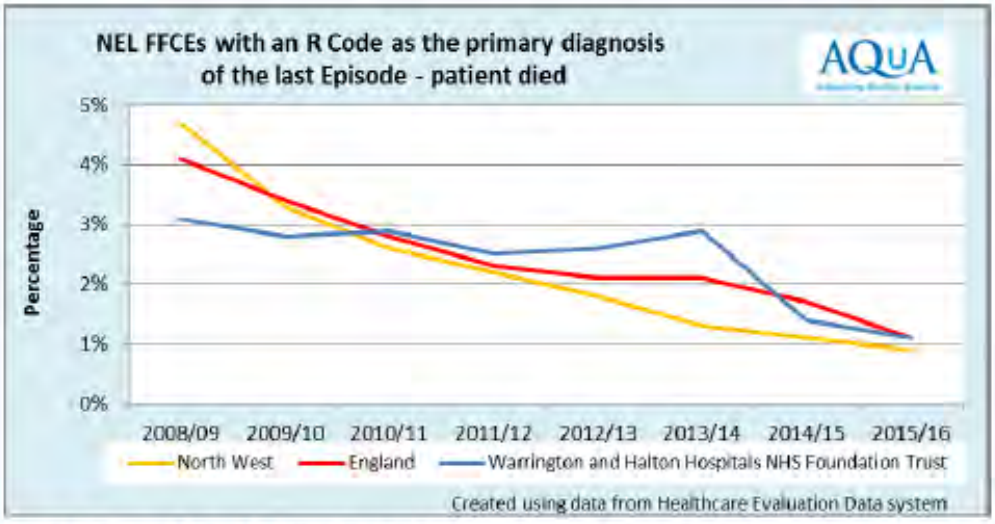


Chart 24 – trust Signs & Symptoms coding time-series, NEL, patient died

3.5 Co-morbidity

Fin. Year	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Trust	2.3	2.6	2.8	2.8	2.9	3.1	3.1	3.3
North West	2.3	2.5	2.7	2.8	3.0	3.2	3.4	3.6
England	2.1	2.4	2.6	2.8	3.0	3.1	3.3	3.5

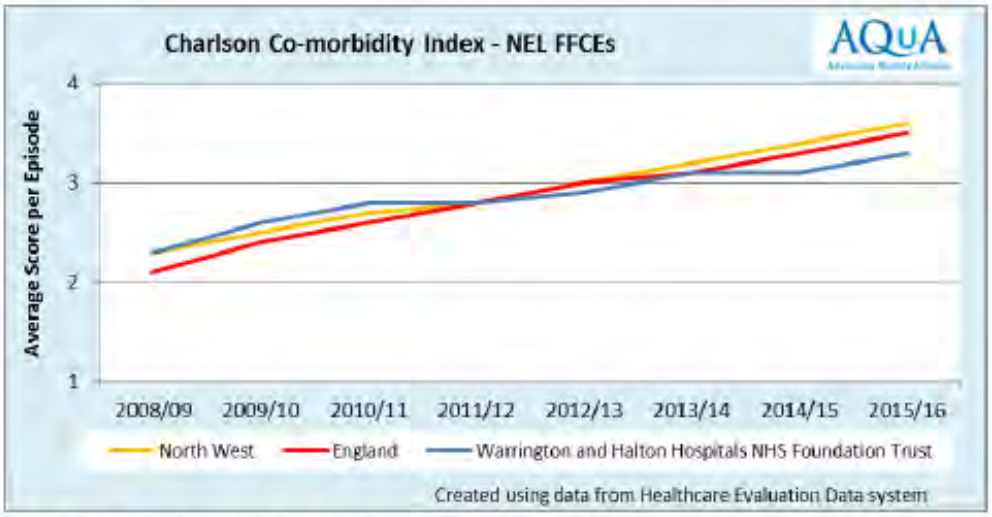


Chart 25 – Charlson Co-Morbidity Index time-series, NEL

SECTION 4 – Quarterly Focus

In this section we examine the seasonal variation of mortality indicators. SHMI uses 12 months' activity [36 months for the statistical model], so all months of the year and, therefore, all seasons are equally represented. This guards against any seasonal bias yet some geographical areas or trusts may be affected by a 'severe' winter more than others.

As the statistical model has all months equally represented, it is flawed to represent SHMI as isolated months. However, it is necessary to do this in order to explore the relative impact on different trusts or regions. It is also useful to isolate months and plot the SHMI alongside the crude mortality rate. **The SHMI values shown below are, therefore, solely illustrative for the purpose of supporting the discussion in this report and should not be reproduced.**

The first point to examine is whether we see 'seasonality' in SHMI. Chart 26 shows the monthly SHMI, alongside the 95% confidence intervals and the monthly crude mortality rate. We can see that the statistically significant higher SHMI in the winter months is simply a bi-product of the rise in crude mortality rate at this time.

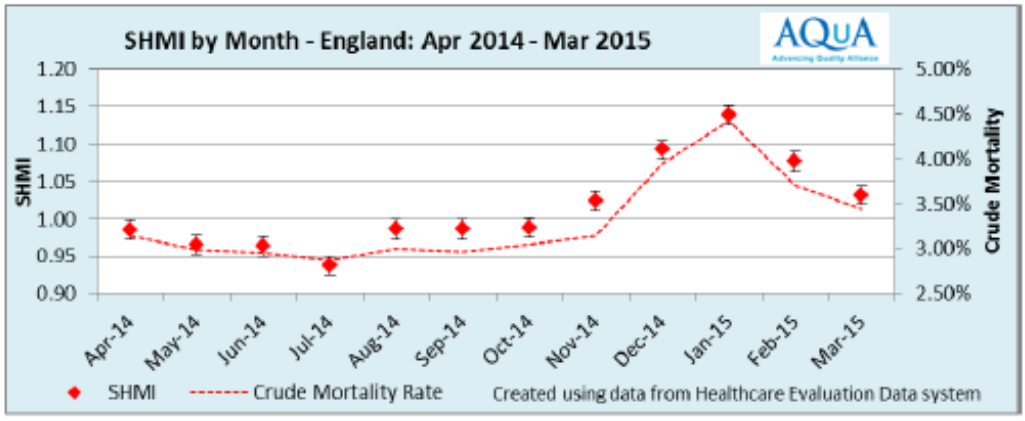


Chart 26 – England monthly SHMI & Crude Mortality Rate: Apr 2014 – Mar 2015

Examining the crude mortality separated into four age bands (0-17 years, 18 – 64 years, 65 – 74 years and 75+ years) shows that the seasonal effect is greatest for the over 75 year old patients – see Chart 27. For this season, subsequent analysis focuses on this age-group.

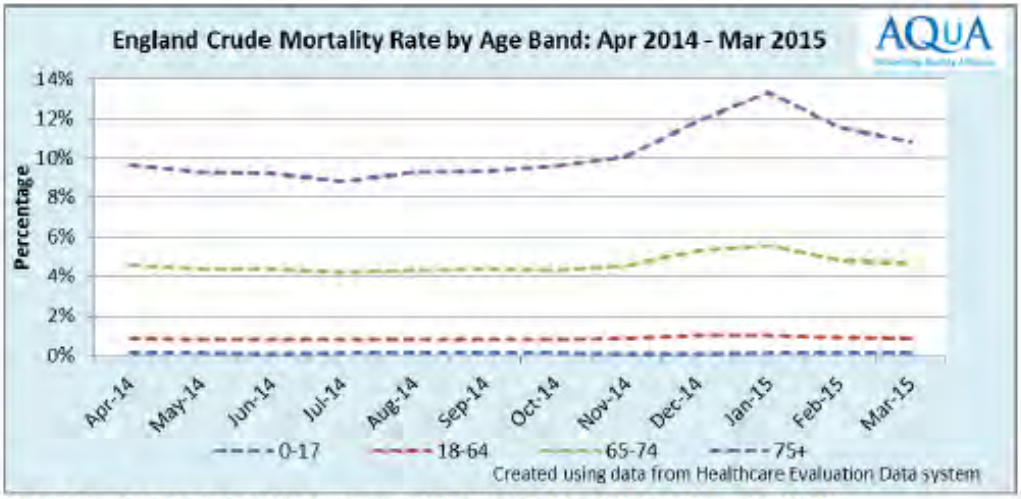


Chart 27 – England monthly crude mortality by age band: Apr 2014 – Mar 2015

The monthly SHMI and crude mortality rate for the over 75 year old patients is shown below.

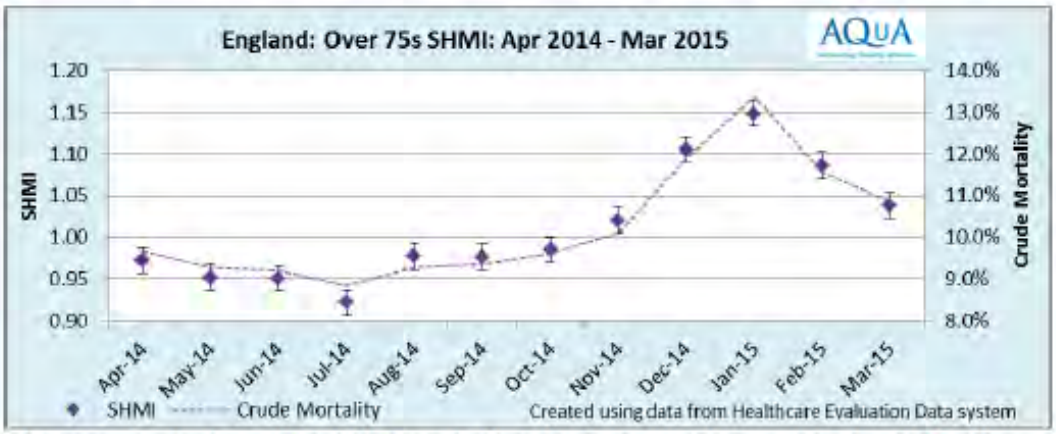


Chart 28 – England monthly SHMI & Crude Mortality Rate over 75 year olds: Apr 2014 – Mar 2015

Looking at several of the old SHAs, we see that the same seasonal patterns for SHMI and the crude rate are experienced by each SHA – see Charts 29 and 30.

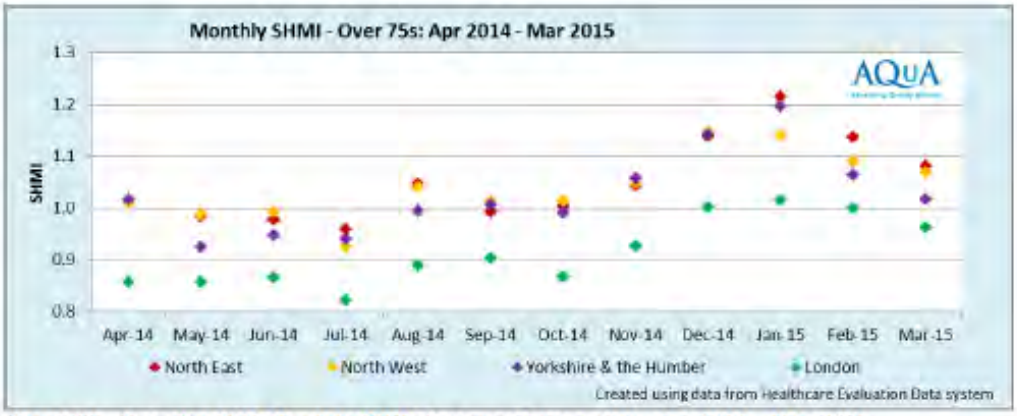


Chart 29 – Selected SHA Monthly SHMI for over 75 year olds: Apr 2014 – Mar 2015

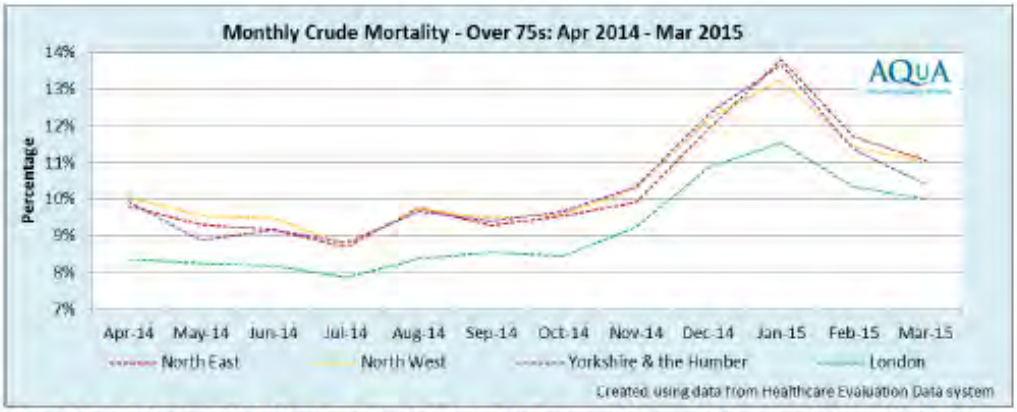


Chart 30 – Selected SHA Monthly Crude Mortality for over 75 year olds: Apr 2014 – Mar 2015

Over the last three full financial years we see that this pattern is repeated, with each SHA having a similar pattern of rising and falling crude mortality rates for over 75 year olds in line with the seasons.

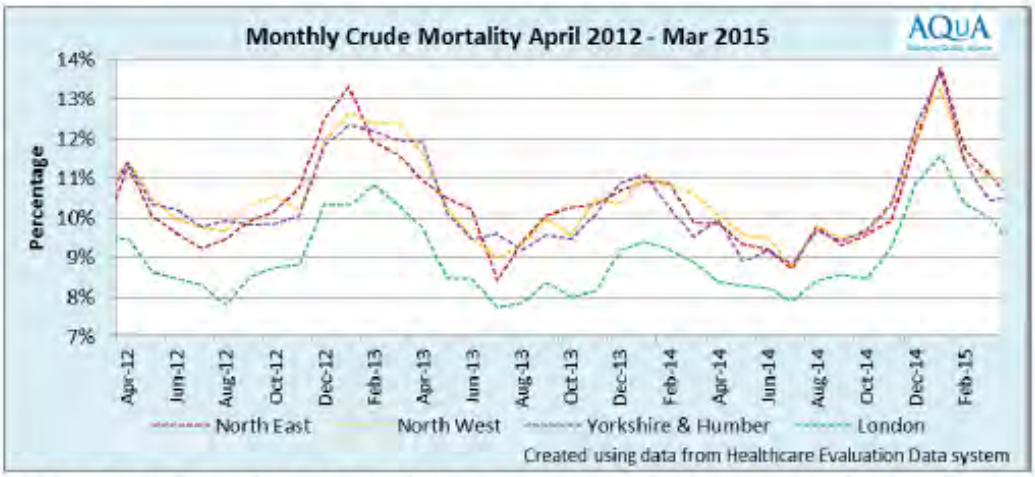


Chart 31 – Selected SHA Monthly Crude Mortality for over 75 year olds: Apr 2012 – Mar 2015

To understand what contributes to the elevated SHMI and crude mortality in the over 75 year olds during winter we considered the reason for admission. Analysis shows that both the highest activity (for both discharges and observed deaths) is the Pneumonia CCS group. However, evaluation of the monthly SHMI for this group did not sufficiently demonstrate the 'seasonal' effect seen above. Looking at other CCS groups with fewer deaths will not demonstrate this effect therefore examining diagnostic groups does not provide more insight.

Although at a trust level, there is rarely any statistically significant difference by month, it can be helpful for trusts to understand the 'seasonal' effect on their own SHMI for the over 75 year old patients in their care and how they compare to the North West and England. This is shown in Chart 32 below.

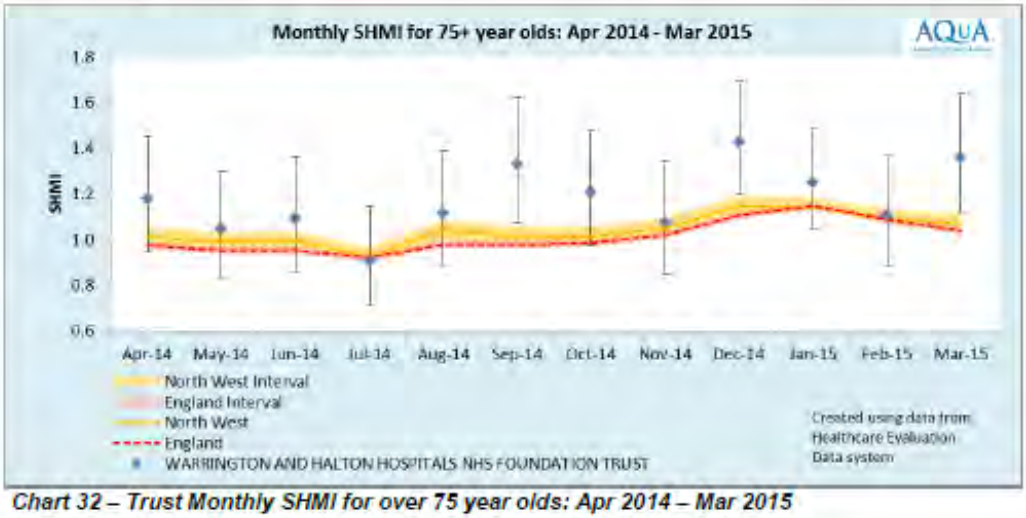


Chart 32 – Trust Monthly SHMI for over 75 year olds: Apr 2014 – Mar 2015

Appendix A: Differences between HSMR, RAMI and SHMI

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

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

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

Appendix B: Metadata

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

Resource type	Title	Description	Coverage	Numerator	Denominator	Date	Source
Mortality	Chart 6	Observed and Expected deaths	22 Trusts in North West	N/A	N/A	October 2009 – March 2015	HED (Note: Data for last two periods uses HSCIC data)
Mortality	Chart 7	% Deaths occurring in-hospital	137 SHMI Trusts	Discharge Method = 4	Discharge Method = 4 plus deaths from the HES-ONS linked mortality data file	Latest published SHMI (12 month period)	HED
Mortality	Chart 8	% Deaths occurring in-hospital	137 SHMI Trusts (22 in North West)	Discharge Method = 4	Discharge Method = 4 plus deaths from the HES-ONS linked mortality data file	October 2009 – March 2015	HED
Clinical Coding	Chart 12 & 20	Palliative Care coding	22 Trusts in North West	Patients with ICD10 Code Z515 in any position of any episode or Specialty Code 315 in any episode	All discharges	Latest published SHMI (12 month period)	HSCIC
Clinical Coding	Chart 13 & 21	Palliative Care coding	22 Trusts in North West	Patients with ICD10 Code Z515 in any position of any episode or Specialty Code 315 in any episode (where Discharge Method = 4)	Discharge Method = 4 plus deaths from the HES-ONS linked mortality data file	Latest published SHMI (12 month period)	HSCIC
Clinical Coding	Charts 14 & 22	Signs & Symptoms coding	22 Trusts in North West	ICD10 "R" code in primary diagnosis of any episode. Admission Method = 21 – 28, 31, 32, 81 – 89, 98.	Number of episodes	Latest FY for which data has been published	HED

Resource type	Title	Description	Coverage	Numerator	Denominator	Date	Source
Clinical Coding	Charts 15 & 23	Signs & Symptoms coding	22 Trusts in North West	ICD10 "R" code in primary diagnosis of the first episode. Admission Method = 21 – 28, 31, 32, 81 – 89, 98	Number of first episodes [i.e. Spells]	Latest FY for which data has been published	HED
Clinical Coding	Charts 16 & 24	Signs & Symptoms coding	22 Trusts in North West	ICD10 "R" code in primary diagnosis of last episode. Admission Method = 21 – 28, 31, 32, 81 – 89, 98 (where Discharge Method = 4)	Number of last episodes [i.e. Spells] Discharge Method = 4	Latest FY for which data has been published	HED
Clinical Coding	Chart 17 & 25	Charlson Co-morbidity Index	22 Trusts in North West	Total co-morbidity score for all relevant codes[1] in Diag02 – Diag20 for the first episode[2]	Number of first episodes [i.e. Spells]	Latest published SHMI (12 month period)	HED
Seasonal Mortality	Chart 26	Monthly SHMI & Crude Mortality	137 SHMI Trusts (22 in North West)	SHMI: Observed deaths Crude Mortality: Observed deaths	SHMI: Expected Deaths Crude Mortality: Total Discharges	Latest published SHMI (12 month period)	HED
Seasonal Mortality	Chart 27	Monthly Crude Mortality by Age Band	137 SHMI Trusts (22 in North West)	Observed deaths	Total Discharges	Latest published SHMI (12 month period)	HED
Seasonal Mortality	Chart 28	Monthly SHMI & Crude Mortality for over 75s	137 SHMI Trusts (22 in North West)	SHMI: Observed deaths for over 75s Crude Mortality: Observed deaths for over 75s	SHMI: Expected Deaths for over 75s Crude Mortality: Total Discharges for over 75s	Latest published SHMI (12 month period)	HED

Resource type	Title	Description	Coverage	Numerator	Denominator	Date	Source
Seasonal Mortality	Chart 29	Monthly SHMI for over 75s	North West, North East, London and Yorkshire & the Humber SHAs	Observed deaths for patients aged 75 or over	Expected deaths for patients aged 75 or over	Latest published SHMI (12 month period)	HED
Seasonal Mortality	Chart 30	Monthly Crude Mortality for over 75s	North West, North East, London and Yorkshire & the Humber SHAs	Observed deaths for patients aged 75 or over	Total discharges for patients aged 75 or over	Latest published SHMI (12 month period)	HED
Seasonal Mortality	Chart 31	Monthly Crude Mortality for over 75s	North West, North East, London and Yorkshire & the Humber SHAs	Observed deaths for patients aged 75 or over	Total discharges for patients aged 75 or over	April 2012 – March 2015	HED
Seasonal Mortality	Chart 32	Monthly Crude Mortality for over 75s	137 SHMI Trusts (22 in North West)	Observed deaths for patients aged 75 or over	Expected deaths for patients aged 75 or over	Latest published SHMI (12 month period)	HED

[1] See Appendix D.1 of SHMI Methodology

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

Appendix C: Trust Codes and Names

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

Medical Directorate
6th Floor, Skipton House
80 London Road
SE1 6LH

TO:
Medical Directors of Acute, Mental Health and Community Trusts

17th December 2015

Dear colleagues,

Re: Self-assessment on Avoidable Mortality

All around the world individuals, institutions and healthcare systems are grappling with the distinction between excess and avoidable mortality. In England this came in to sharp relief during the 2013 review into the 14 hospitals with the highest mortality. The debate continues, but we have started to make some progress.

Following the review into those hospitals Professor Nick Black from the London School of Hygiene and Tropical Medicine and Professor Lord Ara Darzi were asked to examine the relationship between excess and avoidable mortality using established case note review methodology. They determined that about 4% of deaths in our hospitals were potentially avoidable and that there was no obvious relationship with excess deaths over and above the average. Given the experience gleaned through this process we are seeking to establish a standardised methodology for reviewing deaths in our hospitals with the aim of identifying themes for improvement both nationally and within organisations. We are currently procuring a training programme for retrospective case record review and will engage the Academy of Medical Royal Colleges to help guide the process to ensure clinical relevance.

In addition, we are pleased to say that the Government remains committed to reforming the process of death certification, subject to consultation, with the intention of introducing Medical Examiners to improve the accuracy of local reporting and thereby support measures to reduce avoidable deaths. This was an accepted recommendation of the Francis Inquiry. The process has worked particularly well in Sheffield, University Hospital Birmingham and Heart of England amongst others.

Many Trusts already take this very seriously and have sophisticated governance processes in place, but to encourage all Trust boards to focus on this difficult issue, the NHS Mandate includes an intention to publish avoidable mortality by Trust. The exact form this will take has yet to be determined and will be considered carefully.

To start the process we are asking Trusts to conduct a self-assessment of their

avoidable mortality using a simple tool that we have developed which accompanies this letter. **Please return this self-assessment to england.rcrr@nhs.net by the 31st of January**. Please note that due to the differences in the evidence base between acute and other services, there are different sections of the tool for different service types. Please complete only the relevant section.

At the same time we are sharing a Mortality Governance Guide developed by Monitor and the Trust Development Authority to help support Trust Boards to take a common and systematic approach to the issue of potentially avoidable mortality and to link this to quality improvement work.

Evidence from CQC inspections suggests that useful areas for Trusts to focus on are their early warning and escalation systems for patients who are deteriorating and the application of the sepsis bundle particularly in acute medical settings.

Should you have any queries, please contact the team at england.rcrr@nhs.net.

Yours sincerely,

Dr Mike Durkin
Director of Patient Safety,
NHS England and NHS Improvement

Professor Sir Bruce Keogh
National Medical Director,
NHS England

Mortality Governance Guide

This document seeks to provide some basic guidance around mortality governance and how a focus on clinical care should be the Board's highest priority. This will also help prepare trusts for a programme of work underway in NHS England's Patient Safety Domain, around standardising retrospective case record review (RCRR) for in-hospital deaths. Whilst this guidance is largely applicable to acute trusts, there is clearly a need for similar processes in Community and Mental Health services and Ambulance Trusts in order to allow the Board to gain assurance on the quality of patient care. This is especially the case as the system moves towards greater integration of care delivery.

General Principles

While most hospitals undertake some form of mortality review, there is wide variation in terms of methodology, scope, data analysis, and contribution to learning. By establishing a consistent process of reviewing care through a structured analysis of patient records, we aim to improve the quality of care by helping hospitals to learn from problems that contribute to avoidable patient death and harm. NHS England has commissioned HQIP to manage procurement of development of a standardised methodology and training roll out to all NHS trusts in England. A supplier will be in place by January 2016, with a pilot expected to start in Q1 2016/17.

Whilst those that die will account for 3% or less of those admitted to an acute hospital, concentrating attention on the factors that cause those deaths will also impact positively on all patients, reducing complications, length of stay and readmission rates. This is through the mechanism of improving pathways of care, reducing variability of care delivery through the use of care bundles, and early recognition and escalation of care of the deteriorating patient. Retrospective case record review will identify examples where these processes can be improved and this information needs to be constantly fed back to clinicians. Furthermore, it will be possible to gain an understanding of the care delivered to those whose death is expected and inevitable. In many organisations this group of patients does not receive optimal care, often because the diagnosis (i.e. this person is dying) is not made or the necessary expertise is in short supply.

In time it will be possible to raise awareness amongst clinicians and managers of the need to promote best practice and behaviours, reduce variability, and make the focus on mortality everyone's business. It should become the subject of formal and informal conversations, from the Board room to the coffee room. Therefore, attention to the issues discussed in this document is relevant for all NHS providers, not just those for whom there are judged to be concerns around mortality.

Governance Processes

Mortality governance should be a top priority for trust Boards. Executive and Non-Executive Directors should have the capability and capacity to understand the issues affecting mortality and to provide appropriate challenge. It is recommended that Trusts have in place the following or similar processes in support of mortality governance, which will also help prepare for roll out of the national RCRR programme.

1) All trusts should have a mortality surveillance group (MSG), with multidisciplinary and multi-professional membership

The primary role of the MSG is to provide assurance to the Trust Board on patient mortality. Mortality indicator statistics do not in themselves constitute evidence regarding the standard of care delivered. Therefore, assurance must be based on review of care received by those who die as well as understanding the statistics. This group should review data on patient deaths, including results and learning generated by local mortality review, and consider strategies to improve care and reduce avoidable mortality. This should be chaired by a Board level clinician (i.e. the Medical Director or Director of Nursing). Serious consideration should be given to external membership from the local clinical commissioning group or NHS England area team and also a local service user/member of the public (e.g. a member of the local Healthwatch group). Attached at Appendix 1 is an example of Terms of Reference for an acute trust mortality surveillance group. Terms of reference for other types of provider would be broadly similar although the use of benchmark data would be different.

In addition to contextual information about quality of care the MSG should also receive statistical information about all deaths in the Trust and should track those in the highest risk groups. In most Acute Hospitals the largest numbers of deaths are in those patients admitted as acute medical emergencies with the diagnoses of sepsis, pneumonia, stroke, myocardial infarction, and heart failure. Other important diagnoses are Acute Kidney Injury and fractured neck of femur. The hospital information department or a commercial provider should be able to provide regular reports of overall crude mortality and numbers of deaths by diagnostic groups. Further detailed information on for example, deaths by ward, at weekends, Bank Holidays can be reviewed on a regular basis.

National audits providing information on mortality at Trust level, such as ICNARC, TARN, the National Bowel Cancer audit, and other aspects of care including stroke (SSNAP) and myocardial infarction (MINAP) should also be used to identify areas where care may need to be improved.

It may be useful to understand the source of referral for patients who die within 24-36 hours of admission. A significant proportion of these are people who are inevitably at the end of their lives and admission to an acute or community provider may not be in their best interest. Many will be referred from nursing homes or their own homes despite the presence of an appropriate care plan. This is easily achieved by tracking admissions by postcode. Undertaking this type of audit may provide rich information for engaging with commissioners and other LHE partners. It will also provide valuable insights into how these patients are managed in the acute trust, whether decisions, interventions and care are appropriate for this group of patients bearing in mind the recommendations of the review "One Chance to get it Right".

If there are concerns about a cluster of cases or a distinct diagnostic group (for example fractured neck of femur) as identified by an elevated mortality rate, adverse audit report, complaints, Deanery feedback or information arising from a Morbidity and Mortality meeting then a process as described in the section "Response to a mortality alert" (below) should be followed.

2) Mortality reporting to the trust Board

Mortality reporting must be provided regularly in order that Executives remain aware and Non Executives can provide appropriate challenge. This should be at the public section of the meeting with the data suitably anonymised. We would expect the Non Executives to satisfy themselves that appropriate governance processes are in place, that the Trust is providing safe care and that systems exist to detect and reduce the level of avoidable deaths. The type of questions we expect to be asked of the Executives are:

- *What process exists for review of all deaths?*
- *How many people died in the Trust last month?*
- *What are the 3 biggest causes of death in the Trust and the current mortality rates for these?*
- *What is the Trust's current overall crude mortality rate, HSMR and SHMI?*
- *How does the Mortality Surveillance Group (MSG) function, what information does it consider, who are its members and chair?*
- *How will the MSG maintain oversight of avoidable mortality and identify outliers?*
- *Are there any specialities, sub-specialties, diagnostic codes or times of the week for which the data suggest elevated mortality levels? What further analysis and actions are you taking?*
- *How will the MSG keep the Board informed about the work it does?*
- *What steps is the Trust taking to implement the advice from the Academy of Medical Royal Colleges regarding daily senior review and 7 day working in the Hospital?*
- *Is support from Critical Care outreach available 24/7?*

3) In order to understand the standard of care being delivered to those who die there needs to be a high level assessment of all deaths

This is quite achievable if the responsibility is distributed amongst all consultants in those specialties with large numbers of deaths (e.g. acute medicine). It is the responsibility of all registered medical practitioners to understand the outcomes of their clinical practice so this should form a core element of SPA time. In specialties with fewer deaths (e.g. orthopaedics), case note review can be undertaken by a nominated individual. For those patients on a supportive care pathway where death should be judged unavoidable, assessment is still necessary in order to provide assurance of appropriateness and standard of care delivered.

The national RCRR methodology will include a standard review proforma and two-staged review process. Until rolled out, local mortality review templates (ideally electronic) may be used for this initial assessment of all deaths and include: demographic details, mode of admission, initial clinical assessment, ongoing management including investigations and interventions, issues around infection and venous thromboembolism (VTE), nutrition and hydration, recognition of deterioration, use of critical care services, end of life care and appropriateness of cardiorespiratory resuscitation (DNAR) assessment. This is not an exhaustive or exclusive list. In order to improve clinician engagement it is worth considering, in collaboration with the clinical teams, developing bespoke templates for different groups of patients e.g. acute medicine, acute abdomen, stroke, fractured neck of femur, end of life care as these patients will have different needs and their care should be informed by the relevant guidance from NICE, royal college or specialist association.

Standards from these guidance documents should be embedded into these review templates along with generic Trust standards for care. Please note: the national methodology will also include scope for local, specialist adaption to the review form.

If there is a desire to understand the level of avoidable mortality then deaths can be categorised using a stratification tool such as the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) categorisation (see "Process for responding to a mortality alert" below). This is largely a subjective judgement which will also be supported by the national methodology, based on the PRISM studies.

If there are found to be concerns about the standard of care then the case must be reviewed in-depth by a multidisciplinary team. This should be at a regular departmental morbidity and mortality meeting with representation from senior and junior doctors and nurses, and other AHPs as appropriate for that specialty. These meetings should have equivalent priority, administrative support and governance as other MDT meetings that exist to decide care in for example all cancer disciplines. The outputs from these meetings need to be recorded, especially conclusions about outstanding care and suboptimal care, both of which should be captured and sent on to provide data for the **MSG.**

Furthermore it might also be prudent to undertake a case note review as described in a selection of high risk diagnostic groups (typically for most acute trusts pneumonia, heart failure, sepsis, stroke, AKI, #neck of femur) at least annually in order to provide ongoing assurance. Redesign of the pathway of care for the group of patients concerned should be considered making use of care bundles and including advice from NICE, Royal Colleges and other professional groups on current best practice.

Given the known association between staffing levels (doctors and nurses) and clinical outcomes including mortality rates the MSG should pay particular attention to these issues at all times when reviewing a service or circumstance where concerns have been raised.

4) Process for responding to a mortality alert

It is not the purpose of this document to provide detailed advice on this as there other publications which cover this ("Dying to Know" published by Association of Public Health Observatories October 2010).

In summary if there are concerns about mortality in any particular patient group then it is necessary to undertake an in depth case note review. It is important to identify the correct cohort of patients. This may be obvious depending upon the source of the concern (e.g. CQC alert or elevated SMR for a particular diagnostic group) or may require further investigation (e.g. global high weekend mortality). Once this has been established then a review of the case notes for a reasonable consecutive sample of the patients who died (say 30 – 40) by a relevant multidisciplinary group should be undertaken in order to establish whether the clinical care those patients received was appropriate or not. The review group should decide the criteria to be used for judging the standard of care much in the same way as the high level template described above although in this situation more detail may be required. This group will need adequate time and administrative support. There should be a lead person identified who will be responsible for the review and writing up the result.

The care should be categorised. The standardised RCRR methodology will include direction on categorisation, but in the interim, a useful approach is to employ the Confidential Enquiry into Stillbirths in Infancy (CESDI) mortality classification bandings. Deaths are classified according to CESDI as follows:

- Grade 0- Unavoidable Death, No Suboptimal Care,
- Grade 1- Unavoidable Death, Suboptimal care, but different management would not have made a difference to the outcome.
- Grade 2- Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death)
- Grade 3- Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death).

Alternatively, the NCEPOD grading of care can be used:

- 1 = Good practice: A standard that you would accept from yourself, your trainees and your institution.
- 2 = Room for improvement: Aspects of clinical care that could have been better.
- 3 = Room for improvement: Aspects of organisational care that could have been better.
- 4 = Room for improvement: Aspects of both clinical and organisational care that could have been better.
- 5 = Less than satisfactory: Several aspects of clinical and/or organisational care that were well below that you would accept from yourself, your trainees and your institution.

In this way it is straightforward to determine if there is a problem. Assessment of coding should be part of the case note review but the primary focus should be to provide assurance on the quality of care. It is entirely possible that good care was provided to all patients and that all the deaths in the "alert" were unavoidable but experience in several Trusts shows 10-15% of cases will have elements of sub-optimal care. In any event following this approach will provide assurance to the Board that there is a formal process in place underpinned by sound documentary evidence.

5) Coding

Accurate clinical coding is essential in order that the correct information is collected in terms of activity and outcomes. This is necessary for a host of reasons not least that this constitutes the raw data upon which decisions are made about the Trust's income. Clinicians need to be educated about how coders extract information from the hospital notes and how the way they record clinical findings and opinions support or hinder that process. Meetings and educational events between clinicians and coders can help build mutual understanding between these groups.

6) Feedback to the frontline

Clinicians need to be kept informed of the outcomes of their work if they are to learn and improve. It is essential that there is a mechanism for the outputs of the mortality governance process to be fed back to clinical staff as well as plans for improvement, lessons learnt and pathway redesign.

Dashboards depicting outcomes at individual / team / ward / department level can be used for these processes and are best devised in conjunction with the individuals

concerned. Other vehicles such as safety lesson of the week email alerts, cascading through governance groups using this data as part of appraisals should be considered.

Appendix 1

Example Terms of Reference for an Acute Hospital Mortality Surveillance Group

MEMBERSHIP

Chairman – Medical Director

Information Department Representation

Director of Nursing or Deputy

Senior Nurse

Doctor-Anaesthetist

Doctor-Acute Physician

Doctor – Care of the Elderly

Doctor – Respiratory /Cardiology

Doctor – Accident & Emergency

Doctor – General Surgery

Governance Representation

Junior Doctor Representation

QUORUM

Four members plus the Chairman (one nurse, two doctors and a governance representative).

FREQUENCY OF MEETINGS

The Committee will meet monthly.

Operational functions:

To work towards the elimination of all avoidable in-hospital mortality.

1. To review on a monthly basis, the benchmarked mortality rates of the Trust.
2. To consider the mortality data in conjunction with other qualitative clinical data and identify areas for future investigation. To facilitate the increased use of Clinical databases, run by various bodies including professional societies in the fuller assessment of in-hospital mortality.
3. To investigate any alerts received from the Care Quality Commission (CQC) or identified by the Mortality monitoring information systems e.g. Dr Foster, HED, etc.

4. To develop data collection systems to ensure the Trust's mortality data is timely robust and in line with national and international best practice.
5. To ensure mortality information linked to consultant appraisals is accurate, contextual and engenders a culture of clinical excellence.
6. To develop an annual mortality clinical coding improvement plan and receive regular reports on its implementation.
7. To assign clinical leads to address raised mortality in particular clinical areas by the deployment of strong evidence based interventions such as care bundles. The MC will receive regular reports on implementation and the measurable impact of these interventions on hospital mortality.
8. To work with established groups to ensure each junior doctor intake receives the latest guidelines on care protocol implementation and clinical coding best practice.
9. To review and monitor compliance with other Hospital policies including DNAR and Death Certification Policy.
10. To monitor and consider the information from the electronic review of all in hospital deaths.

Strategic functions:

1. To act as the strategic hospital mortality overview group with senior leadership and support to ensure the alignment of the hospital departments for the purpose of reducing all avoidable deaths.
2. Strategic oversight of extant mortality review committee(s).
3. To produce a Mortality Reduction Strategy that aligns hospital systems such as audit, information services, training and clinical directorates. This strategy will be reviewed on an annual basis by the Medical Director
4. Sign off of action plans and methodologies that are designed to reduce morbidity and mortality across the trust.
5. Sign off of all regulatory mortality responses.
6. To report on Mortality performance to the Board.

ACCOUNTABILITY

The MSG would be formally accountable the Trust Board

BOARD OF DIRECTORS

Item 16/030

SUBJECT:	**Infection Prevention and Control**	
DATE OF MEETING:	27 January 2016	
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 up to and including quarter 3 (Q3) 2015/16 and highlights the Trust's progress against infection prevention and control key performance indicators.	
RECOMMENDATION:	***The Board is asked to: note the paper and progress made.***	
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 3 (Q3) 2015/16 and highlights the Trust's progress against infection prevention and control key performance indicators year to date (YTD).

The Trust has reported 22 hospital apportioned cases of Clostridium difficile against the annual threshold of 27 cases. YTD 17 cases have been submitted to Warrington Clinical Commissioning Group and 9 removed from cases counted for contractual sanctions purposes.

Nil returns were submitted for MRSA bacteraemia in Q3. YTD 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 infection. 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.

Monitor assesses 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 5 cases from Q2 resulted in the removal of 1 case from contractual sanctions. Learning from the cases with lapses in care has been shared across the Divisions via the integrated governance groups.

During Q3 the Trust reported 12 cases of *Clostridium difficile*, 5 of which are initially hospital apportioned (appendix 1). A meeting is scheduled with the CCG in February 2016 to assess these cases for lapses in care.

The Trust is currently on trajectory to meet the annual threshold and progress continues against the recovery plan as detailed in appendix 2. The Trust's rate per 100,000 bed days (information within the recovery plan) compares favourably (lowest rate with the exception of tertiary care centres) with other Trusts in Cheshire and Merseyside.

Antimicrobial Prescribing

Antibiotic prescribing point prevalence audits are conducted quarterly which demonstrate on average 90% compliance (not including stop/review dates) with the Antibiotic Formulary.

In addition to these audits, ward rounds are conducted once per week by the Consultant Microbiologist and Antibiotics Pharmacist. Data collated from ward rounds conducted in the financial year 2014 – 2015 is included at appendix 3.

The findings indicate a number of opportunities for improvement and suggest greater gains can be made if additional resources (Antibiotics Pharmacist time) were available to support additional ward rounds. Additional Consultant Microbiologist capacity is also being reviewed to enhance antimicrobial stewardship.

A key benefit of the antibiotic ward round data is the £9K avoided spend by stopping/changing antibiotic treatment. Only drug costs have been estimated in the summary. Other savings in terms of improving quality of care, decreasing length of stay, and reduced morbidity/mortality are not encompassed. Another benefit is identifying more patients who could be discharged and receive antibiotic treatment in the community.

Recent publications highlight the requirement to strengthen antimicrobial stewardship:-

- The Code of practice for the Health and Social Care Act on prevention of HCAIs now has a criterion for antibiotic stewardship

- NICE guidance (NG015) Effective antimicrobial stewardship: has been reviewed. The Trust is compliant with some but not all areas of the NICE recommendations and the Trust has been rated partially compliant/assured and the associated risk level varied

A meeting has taken place with the Chief Pharmacist and the Infection Prevention & Control Team to re-request the additional resources required to strengthen antimicrobial stewardship in the Trust.

BACTERAEMIAS

MRSA bacteraemia

Nil returns were submitted during Q3.

MSSA bacteraemia

In Q3, the Trust reported 9 cases of MSSA bacteraemia, only 1 of which was hospital apportioned and is currently being investigated.

E. coli bacteraemias

In Q3, a total of 32 cases of E. coli bacteraemia were reported making a total of 115 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 Q3 a total of 4 wards were monitored for reported problems with diarrhoea and vomiting amongst patients. Causative organisms were not identified. The Microbiology laboratory is conducting a trial on in house rapid testing for gastroenteritis viruses. This will provide more timely results to inform decision making on reopening facilities.

Pseudomonas aeruginosa - Neonatal Unit

The Pseudomonas aeruginosa incident in the neonatal unit has been concluded. A number of actions are required by Estates to improve water outlets and these have been added to the local divisional action plan.

VRE – Ward B19

In October an issue was identified with Vancomycin-resistant enterococcus (VRE) transmission on Ward B19. Following identification of VRE from a clinical site of the index case, contact screening was undertaken and a further 4 patients were identified with VRE colonisation (4 cases E. faecalis; 1 case E. faecium).

Additional testing of the isolates showed that the isolates shared similar profiles but were not identical. Therefore this was concluded as a cluster of cases not an outbreak.

A number of actions were taken including:-

- Ward closure (as advised by Public Health England)
- STEIS notification
- Enhanced environmental hygiene and equipment cleaning (chlorine)
- Segregation of toilet facilities from non-affected patients
- Augmented hand hygiene (washing followed by alcohol-based hand rub)
- Antibiotic review for colonized patients

The ward was re-opened following 6 days closure.

SURVEILLANCE SYSTEMS

The Infection Prevention & Control Team is using a locally developed surveillance system. Whilst this has some useful features it does not provide robust assurance that all risks are identified. The Team is reviewing systems in other organisations as part of product evaluation. In addition, work is planned to identify if developments can be made using existing IT systems e.g. Lorenzo and the Trust's Laboratory computer.

INFECTION PREVENTION & CONTROL TRAINING

Attendance at infection control training was previously highlighted as a concern (low compliance). The Infection Prevention and Control Team have supported the Divisions by providing additional department specific training and compliance figures have significantly improved (76% clinical staff and 88% for non-clinical staff). The additional sessions will continue to drive further improvements in training attendance.

Additional scrutiny has been put in place at the Infection Control Sub-Committee meeting and Matrons will continue reporting training figures until they are above 85%.

NEXT STEPS

Further work is required to:-

- Progress actions detailed in the Clostridium difficile recovery action plan
- Promote Antimicrobial Stewardship
- Support staff training in Infection Control
- Review infection control surveillance systems
- Support work around invasive device management/bacteraemia reduction

RECOMMENDATIONS

The Board is asked to note the contents of the report and the work required as listed in next steps.

CONCLUSION

The Infection Prevention & Control Team implemented a targeted recovery plan in response to the unexpected rise in Clostridium difficile case in Q1 resulting in the position being recovered by the end of Q3.

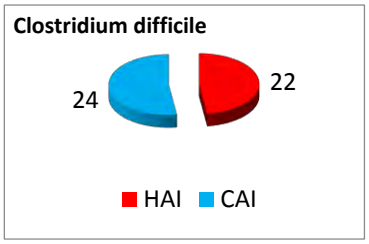
Swift action was taken into address the VRE and Pseudomonas incidents and both were concluded promptly.

Lesley McKay
Associate Director of Nursing for Infection Prevention & Control
January 2016

Appendix 1 - HCAI Surveillance data April –December 2015

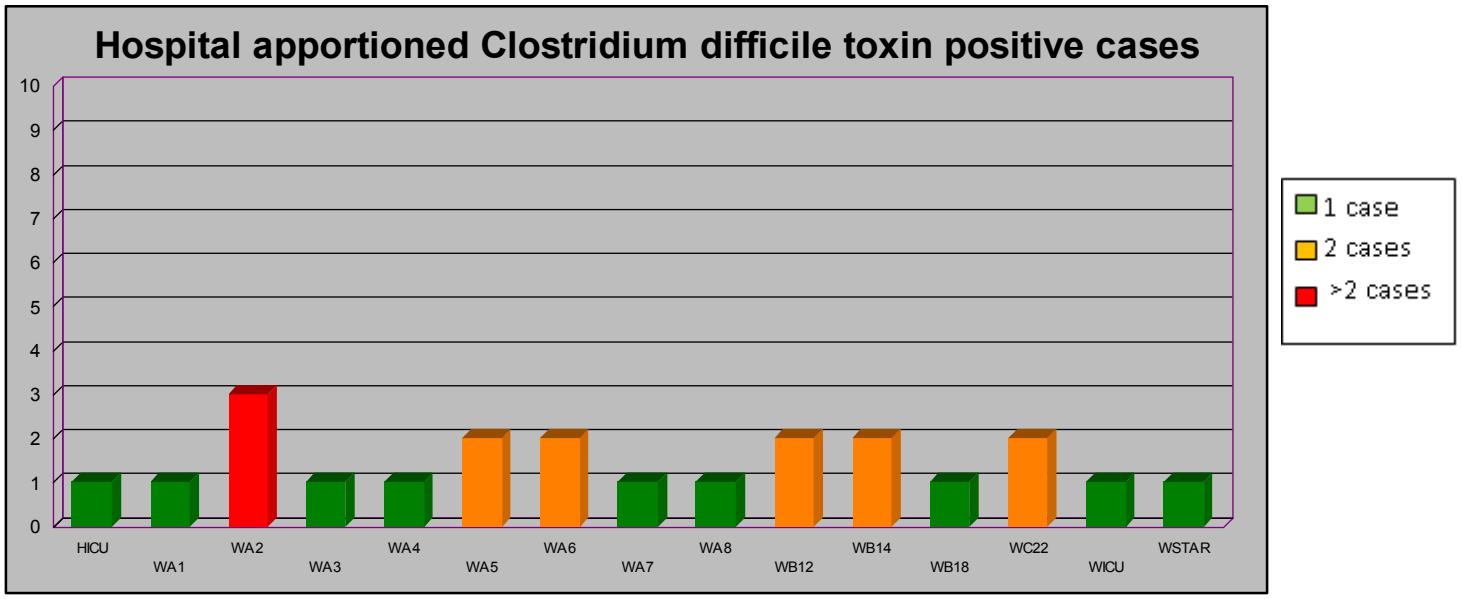
CLOSTRIDIUM DIFFICILE

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
HAI	**3**	**5**	**4**	**1**	**0**	**4**	**3**	**2**	**0**	**22**
CAI	1	3	1	3	3	6	3	1	3	24
Total	4	8	5	4	3	10	6	3	3	46



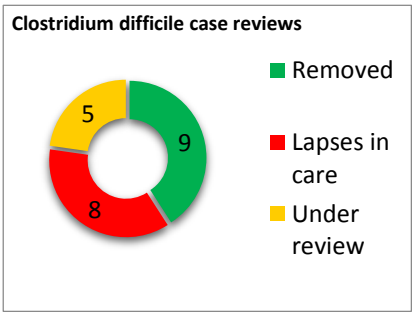
*** 1 Community apportioned Clostridium difficile case reported in May due to Pseudomembranous colitis identified by CT scan**

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



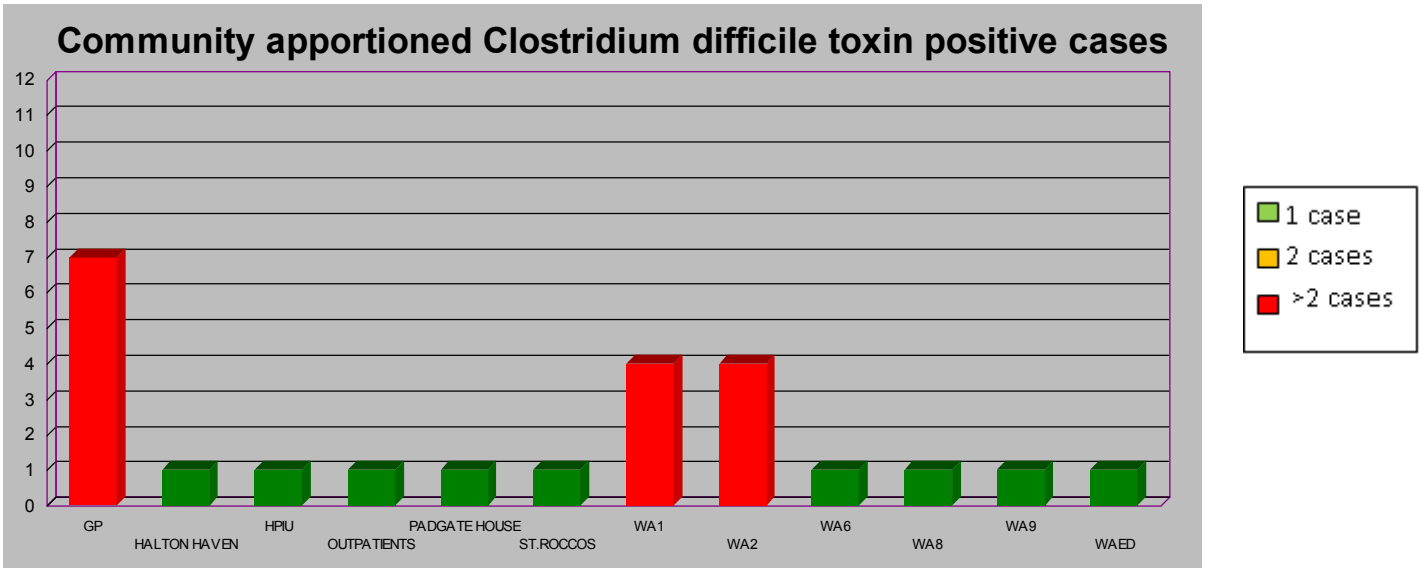
9 hospital apportioned case (April – September 2015) have been removed from cases counted for contractual sanctions

2015/16	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total HAI C. difficile	3	5	4	1	0	4	3	2	0	22
Cases under Review	0	0	0	0	0	0	3	2	0	5
Not due to lapse in care	3	4	1	0	0	1				9
Due to lapses in care	0	1	3	1	0	3				**8**

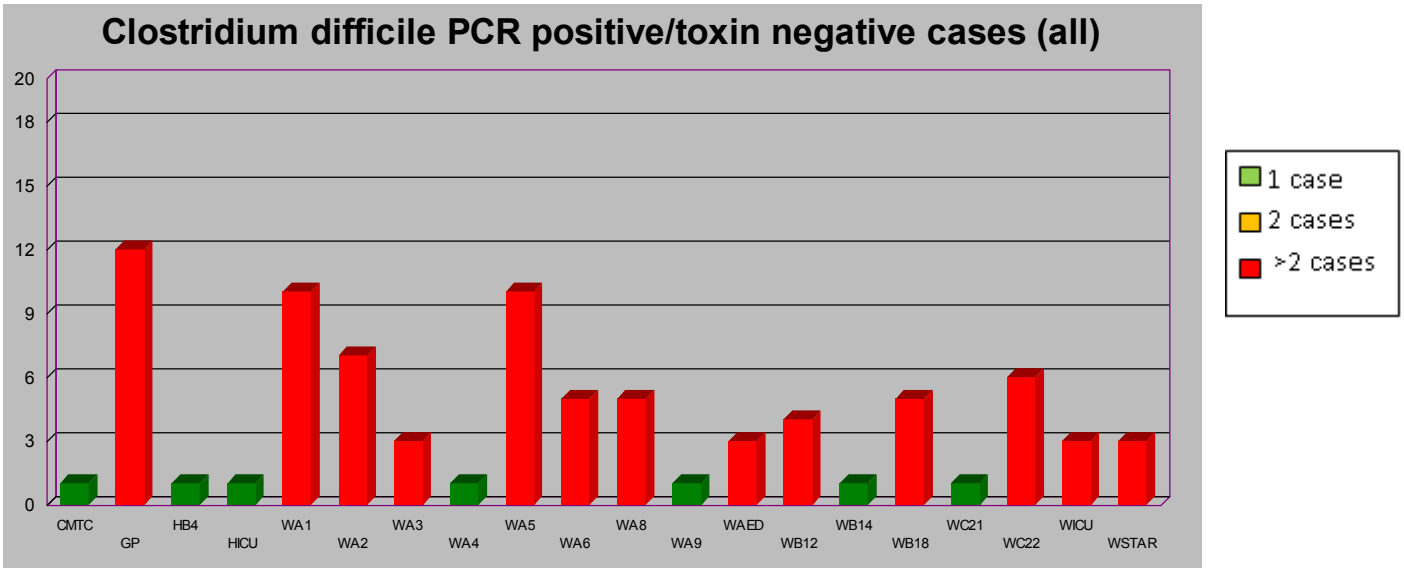


Community apportioned Clostridium difficile *toxin positive* cases by location when detected

*1 case reported due to PMC identified by CT scan



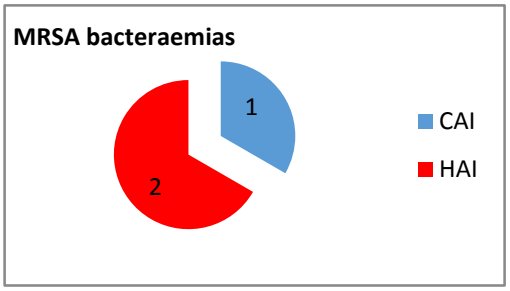
Clostridium *difficile PCR positive/toxin negative* cases by location when detected (Local surveillance)



BACTERAEMIAS

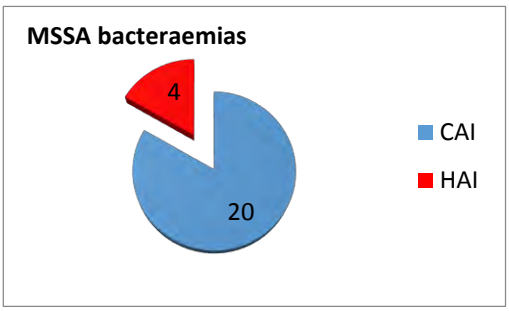
MRSA bacteraemia

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
Oct	17
Nov	7
Dec	8
Total	**115**

Appendix 2 - Clostridium difficile recovery plan

Clostridium difficile Infection

Recovery Action Plan

2015 – 2016

Updates
26/06/2015 10/09/2015 04/12/2015
09/07/2015 07/10/2015 07/01/2016
04/08/2015 05/11/2015

Situation

The annual threshold for Clostridium difficile cases for this financial year has been set at 27 cases. Year to date (7th January 2016) the Trust has reported 22 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 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 9 of the cases from quarters 1 - 2 have been removed from cases that count towards contractual sanctions.

Additional comments **-** Due dates for actions have been deferred in a couple of the monthly action plan reviews and formally revised in December 2015 to reflect more realistic target dates.

Updates
26/06/2015 10/09/2015 04/12/2015
09/07/2015 07/10/2015 07/01/2016
04/08/2015 05/11/2015

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	03/16		1		
Review staffing level in Medical Microbiology	SC	HMB	03/16		2	Added to risk register	
Assess requirement to limit use of Co-amoxiclav	ZQ	AMSG	01/16		1		
Highlight use of Trust formulary to guide prescribing	RC	ADC	12/15	11/15	2	Participation in EAAD	
Review and introduce antibiotic prescribing competency assessments	SC	CMM	03/16		2		
Roll out guidance on use of PPI medication (awaiting Pan Mersey guidance)	SC	GC/ARob	03/17		2		
Appoint medical champions to promote prudent prescribing	SC	DMD	12/15	Already in place	2	AMSG membership	

Environmental hygiene/equipment							
Action required	***Lead***	***Supported by***	***Due date***	***Completion date***	***Priority***	***Evidence***	***RAG***

Updates
26/06/2015 10/09/2015 04/12/2015
09/07/2015 07/10/2015 07/01/2016
04/08/2015 05/11/2015

Develop a deep cleaning programme based on priority	LMcK	Facilities	03/16		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 – Nursing priorities	
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	03/16		2		
Review condition of all commodes and replace if required	Matrons	Ward staff	03/16		1		
Trust wide mattress audit scheduled for July 2015	JH	External company	12/15	10/2015	1	Audit findings report	
Trust wide pillow audit	Matrons	HK	03/16		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	03/16		2		

Updates
26/06/2015 10/09/2015 04/12/2015
09/07/2015 07/10/2015 07/01/2016
04/08/2015 05/11/2015

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	03/16		2		
Review isolation door notices/signage	LMcK	IPCNs	03/16		2		
Ensure actions taken when unable to isolate symptomatic patients are documented	Matrons	Ward staff	03/16		2		
Review use of Daresbury Unit with en-suite facilities	LMcK	ADN	03/16		2		
Carryout Trust wide inpatient isolation audit	LMcK	Matrons	03/16		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	03/16		2		

Updates
26/06/2015 10/09/2015 04/12/2015
09/07/2015 07/10/2015 07/01/2016
04/08/2015 05/11/2015

Hand hygiene and use of personal protective equipment							
Action required	***Lead***	***Supported by***	***Due date***	***Completion date***	***Priority***	***Evidence***	***RAG***
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	05/16	To be determined	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	In progress with UV light box	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	OPD Manager	03/16		2		

Case review and shared learning

Updates
26/06/2015 10/09/2015 04/12/2015
09/07/2015 07/10/2015 07/01/2016
04/08/2015 05/11/2015

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	03/16		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	03/16		2		
Consultant level infection control engagement	SC	DMDs	06/15	10/06/15	1	DIPC letter	

Priority 1 – Urgent action within 3 months Priority 2 – Medium term action within 6 – 12 months

Updates
26/06/2015 10/09/2015 04/12/2015
09/07/2015 07/10/2015 07/01/2016
04/08/2015 05/11/2015

RAG Legend	
Action not commenced	
Action in progress	
Action completed	

Personnel		
ADNs	Associate Directors of Nursing	Rachael Browning, Sue Franklin. Claire Blackman
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

Updates
26/06/2015 10/09/2015 04/12/2015
09/07/2015 07/10/2015 07/01/2016
04/08/2015 05/11/2015

DWM	Data Warehouse Manager IT	
GC	Gastroenterology Consultant	
HMB	Hospital Management Board	
JH	Joshua Hennighan	Medical Devices Coordinator
IPCNs	Infection Prevention and Control Nurses	Lesley McKay; Karen Smith; Andrew Sargent; Glynn Marriott
IPCT	Infection Prevention and Control Team	Dr Thamara Nawimana, Dr Zaman Qazzafi, Rachael Cameron, Lesley McKay, Karen Smith, Andrew Sargent, Glynn Marriott
RC	Rachael Cameron	Antibiotics Pharmacist
SC	Dr Simon Constable	Executive Medical Director/DIPC
ZQ	Dr Zaman Qazzafi	Consultant Medical Microbiologist

Updates
26/06/2015 10/09/2015 04/12/2015
09/07/2015 07/10/2015 07/01/2016
04/08/2015 05/11/2015

Appendix 1 – Cheshire and Merseyside comparative data

Public Health England

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

***C. difficile* : Trust Apportioned Cases**

	Counts				Rates per 100,000 Bed Days			
Acute Trust Name	Oct to Dec 2014	Jan to Mar 2015	Apr to Jun 2015	Jul to Sep 2015	Oct to Dec 2014	Jan to Mar 2015	Apr to Jun 2015	Jul to Sep 2015
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	13	16	10	15	21.8	27.2	17.2	26.9
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	0	0	0	2	0.0	0.0	0.0	15.6
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	7	19	6	9	14.7	39.6	12.9	20.0
EAST CHESHIRE NHS TRUST	6	2	7	10	20.4	6.5	23.7	35.5
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	1	0	0	3	8.7	0.0	0.0	26.5
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0	0	0	0.0	0.0	0.0	0.0
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	5	9	17	7	10.5	18.8	35.7	15.0
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	18	8	8	8	26.4	11.6	11.7	12.3
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	8	6	12	10	21.6	16.3	33.4	27.1
ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	7	10	13	12	11.7	16.9	22.4	20.6
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	0	0	1	0	0.0	0.0	28.9	0.0
THE WALTON CENTRE NHS FOUNDATION TRUST	5	4	4	0	41.6	32.0	31.2	0.0
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	7	8	12	5	15.3	16.9	25.6	10.5
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	4	10	11	11	6.7	16.5	18.3	18.9
Cheshire and Merseyside	81	92	101	92	16.0	17.6	20.2	18.8

Updates
26/06/2015 10/09/2015 04/12/2015
09/07/2015 07/10/2015 07/01/2016
04/08/2015 05/11/2015

Appendix 3

Joint Consultant Microbiologist and Pharmacist Ward Rounds – Overall Summary
1st April 2014 – 31st March 2015

A joint Consultant Microbiologist and Antimicrobial Pharmacist ward round has been carried out once per week since 2011. There is also a second weekly ward round with a clinical pharmacist and microbiologist. The aims of these ward rounds are to ensure patients are receiving optimum antimicrobial therapy and to promote Antimicrobial Stewardship throughout the trust.

Number of Patients Reviewed (total)

Time period	Number of patients reviewed	Number of antimicrobials reviewed
April 2013 – March 2014	592	770
April 2014 – March 2015	420	579

420 patients were reviewed on the ward rounds between April 2014 and March 2015, and a total of 579 antimicrobials were reviewed. This is a decrease of 25% in the number of antibiotics reviewed as compared to the same time period in 2013-2014.

Summary of Ward Round Interventions

The table below (table 1) summarises the outcome of the antibiotic reviews.

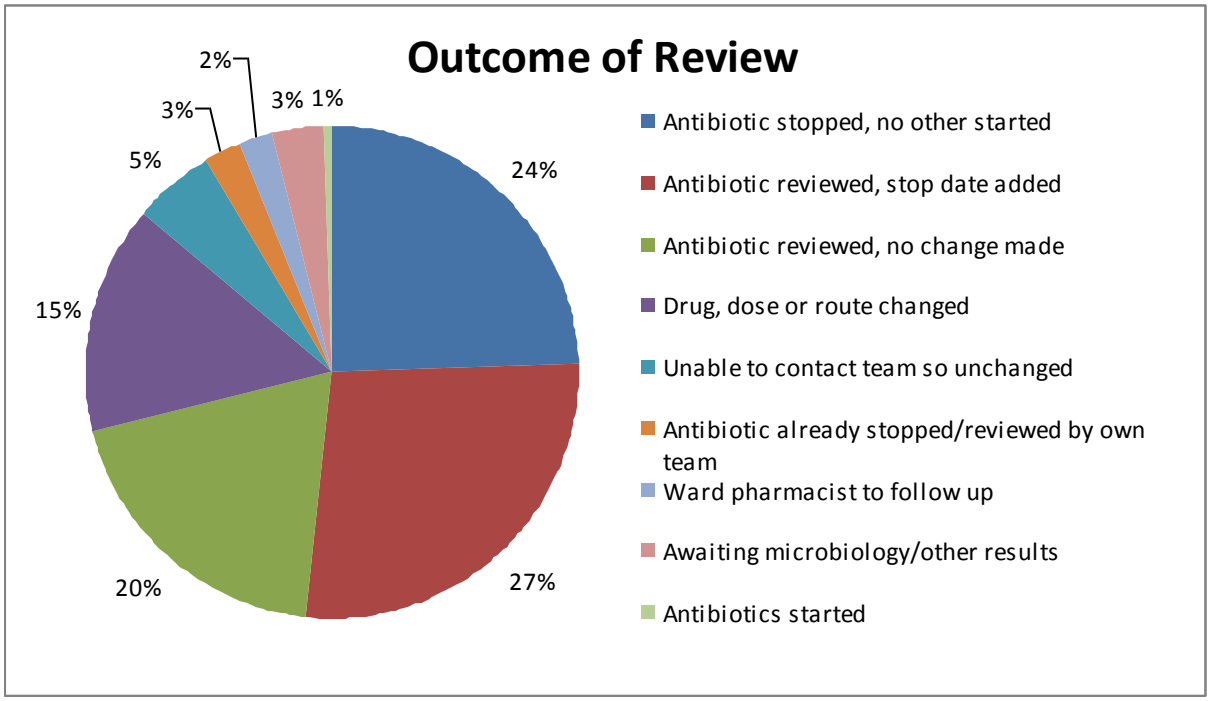
141 (24%) of the antibiotics which were reviewed on the ward round were stopped.

87 (15%) of the antibiotics were changed – either to a different antibiotic or the dose was changed or the route of administration (e.g. intravenous to oral) was changed.

Overall 39% of patients either had their antibiotic stopped or were on a different antibiotic once they had been reviewed on the ward round.

Table 1- Outcome of Antibiotic Review

Outcome of review	**Number of interventions**
Antibiotic stopped, no others started	141 (24%)
Antibiotic reviewed, stop date added	157 (27%)
Drug, dose or route changed	87 (15%)
Unable to contact team so unchanged	30 (5%)
Antibiotic reviewed, no change made	113 (19%)
Awaiting microbiology/other results	18 (3%)
Antibiotic already stopped/reviewed by own team	15 (2%)
Ward pharmacist to follow up	13 (2%)
Not on antibiotics before review - started antibiotics	4
OPAT referral advised	1



Antibiotics stopped

141 (24%) of the antibiotics which were reviewed on the ward round were stopped. This was only done if the team with clinical responsibility for the patient could be contacted. In 30 patients (9%) the team with clinical responsibility for the patient could not be contacted on the ward round so no changes were made at the time of the ward rounds.

Benefits of the ward round

The ward rounds are beneficial in that patients are exposed to fewer days of antibiotic treatment or changed to more appropriate antibiotic treatment. This improves patient safety as it reduces the risks associated with antibiotic treatment.

Cost savings have been made by stopping unnecessary antibiotics, changing antibiotics to more appropriate treatment and adding stop dates to courses of antibiotics. If an assumption is made that antibiotics are either stopped, switched from intravenous antimicrobials to oral antimicrobials or a review date is added which shortens the duration of treatment by 48 hours then there is an estimated cost saving of £8900 per annum (based on contract prices). This does not include potential cost savings from changing patients to more appropriate treatment where there may have been a risk of treatment failure leading to increased length of stay and morbidity. In reality the financial impact is difficult to quantify as some patients may have been changed to more expensive antibiotics.

Nursing time is also saved by the appropriate stopping of antibiotics, particularly intravenous antibiotics.

Rachel Cameron
Antibiotics Pharmacist
June 2015 (Updated December 2015)

BOARD OF DIRECTORS

16/031

SUBJECT:	Report from the Chair of the Strategic People Committee including draft minutes of the meeting on 7/12/15
DATE OF MEETING:	27 January 2016
DIRECTOR:	Anita Wainwright, Non-Executive Director - Chair

STRATEGIC PEOPLE COMMITTEE MEETING

Draft Minutes of the meeting held on
Monday 7 December 2015, 1000hrs
Trust Conference Room, Warrington Hospital

Present:

Anita Wainwright	Non-Executive Director (Chair)
Lynne Lobley	Non-Executive Director
Karen Dawber	Director of Nursing and Governance
Pat McClaren	Director Community Engagement
Mick Curwen	Associate Director of Human Resources
Nick Jenkins	Deputy Medical Director
George Cresswell	Associate Director Estates and Facilities
Steve Barrow	Deputy Director of Finance
Candice Ryan	Head of Workforce Strategy and Engagement
Clare Blackman	Associate Director of Nursing WCSS
Mike Grogan	Staff Side

In attendance:

Dr Richard Briggs	Associate Medical Director, Academic Affairs
Shelley Walker	Therapy Manager
Sharon Harper	Education Governance Officer
Deborah Erskine-Smith	HR Business Partner, Unscheduled Care
Janet Oxley	Executive Secretary (taking minutes)

Apologies:

Mel Pickup	Chief Executive
Roger Wilson	Director of Human Resources and Organisational Development
Jason DaCosta	Director of IT
Sharon Gilligan	Chief Operating Officer
Wendy Johnson	Associate Director of Education and Development
Kate Warbrick	Associate Divisional Director, Scheduled Care
Dawn Forrest	Associate Divisional Director, Unscheduled Care
Rachael Browning	Head of Midwifery
Sue Franklin	Associate Director of Nursing, Unscheduled Care
Carl Roberts	Head of Employment Services
Carol Millington	Head of Therapies

	The Chair opened the Strategic People Committee meeting and introductions were made.
	WHHFT/SPC/15/88 – Medical Education update Dr Richard Briggs, Associate Medical Director, Academic Affairs was welcomed to the meeting and presented an overview of the current state in Medical Education. For ease of reference the full detailed presentation is embedded below.

	Medical Education for Strategic People Com Dr Briggs explained in detail the following areas: medical training, Warrington and Halton Medical Training, Doctors in Training, Training Supervision by HENW (Health Education North West), Survey Indicators, Indicators by Specialty, Positive/Negative Outliers, GMC Results and Themes, Comparative Results by Specialty/Indicators, the HENW agenda, GMC Trainer Standards Compliance by June 2016, the GMC Submission June 2016, LEPs Responsibilities, Challenges, Strengths and Areas Causing Stress. Dr Briggs and his team are working on feedback, taking note on the trends and themes year on year; working on making changes especially around medicine which had gone into special measures previously. Preparations are being made for the HENW visit in January 2016 and it is important that the Trust shows to be compliant in order to get the extra trainees required. Dr Briggs explained about Allocate where all the doctors' job plans are reviewed and their responsibilities reflected in their job plans. The team aim to keep up the standard of in-house training and to provide more simulation training. The Chair thanked Dr Briggs for his comprehensive overview and noted the challenges facing the Trust in January and June 2016. Lynne Lobley, Non-Executive Director noted that Patient Safety and Early Warning Systems were key areas to keep track on. The Chair suggested that there be a follow up after the HENW visit in January and an update back to the Strategic People Committee in April 2016. A declaration of interest was noted by the Non-Executive Directors.
	WHHFT/SPC/15/89 Attendance The attendance record was noted.
1	**WHHFT/SPC/15/90 – Declarations of Interest - in Agenda Items** Declarations of Interest - in Agenda items: Non-Executive Director declaration of interest noted in item 88 above.
2	**WHHFT/SPC/15/91 – Minutes of the previous meeting** The minutes of the meeting held on the 12th October 2015 were approved, subject to amendments to attendance list and date.
3	**WHHFT/SPC/15/92 – Action Plan** Update on previous actions: Item: 050/66/077/92 Resus training, Halton: All areas are on amber and on track, dashboard to be produced to provide assurance and evidence as part of the people measures. **Update**: Percentage well up at Halton and CMTC. 62% Day Care Centre and all other areas up to 80%. ***Action: SPC/15/92: Division to keep tracking and provide and update in February.***

Item: 046/066/077
International Recruitment: two Matrons going out to Romania for recruiting approximately 20 nurses. Trust working with NHSP, running well and ensuring integration into wards. Support and development package in place for the nurses taking into consideration: flights, accommodation, food/bed packs and social aspects.

Nursing and training sessions: exploring different ways of training, 'growing your own' – a short paper on what other Trusts are doing – Countess of Chester, Walton, Bolton & Lancashire linking this to the work around retention and temporary staffing.

Update: The Director of Nursing and Governance updated on the work that is in place looking at the elements of the role of the associate nurse, the involvement of the HEE (Health Education England) and the pilot site for the Associate Nurse. Working closely with University of Chester; looking at different levels of entry, taking on Riverside nurses at school leaver age 16-17 and these nurses undertaking work experience on wards; working towards having something that is branded amalgamating with the local colleges.

Lynne Lobley, Non-Executive Director stated that it is important to do things differently. The Director of Nursing and Governance explained that the Trust is looking at the skills escalator and secondment opportunities. Discussions around all these areas would be a main topic of discussion at the Nursing Strategy Away Day. The main aim is to 'grow your own' and to work towards developing a Warrington and Halton School of Nurses working in partnership with the University of Chester.

The Deputy Medical Director informed on the current work around Physician Associates which is about to hit the North West. HENW are about to start training for PA's approximately 150 in total with 10 trained through Warrington and Halton. There is national expansion to the U.S. for which four PA's will commence in Warrington at the beginning of January 2016. There is still work to do around addressing the challenges as previously mentioned by Dr Briggs.

Lynne Lobley, Non-Executive Director asked for the current position around the LWEC work and asked for an update around this at a future Strategic People Committee meeting.

Action: SPC/15/92: Director of Nursing & Governance to provide an outline summary of the above factors and an update on the LWEC work

WHHFT/SPC/15/93 – Director of Human Resources & Organisation Development Verbal Update

The Associate Director of Human Resources updated on the following:

- Industrial action – stood down and currently suspended, working through the agreement and the action could be activated again in January. With assurance to the Committee all data had been collected, Senior Managers and Senior Medical Staff had met in preparation for the action. There were some cancellations of patient appointments with some reinstated. Not as many cancellations as other Trusts. Associate General Managers had met putting processes in place to minimise the effect/impact and mindful of the Trust's position. Good communication and relationship with BMA throughout.

- CBU Consultation – launched on 30th November 2015, well attended by all staff affected and at Executive level with a presentation on the processes and timescales and all information placed on the hub. There are Focus Groups set up for Nursing/Medical/Management which have now commenced and any comments being fed

into the consultation process. The Consultation will finish in late December and will lead into Aspiration Interviews in January there will be Readiness Assessment Centres undertaken and conducting assessments in February. The whole process will be in place by 1 April 2016.

- Operational Plan – any key issues that may have been missed if not in the dashboard or the QPS People Measures to be raised with the Director of Human Resources and Organisational Development.

- 16/17 People Strategy – Candice Ryan, Head of Workforce Strategy and Engagement delivered a presentation on the People Strategy which is embedded below for ease of reference.

  A complete and final strategy will come back to the Strategic People Committee in February and to Trust Board in March 2016. It is essential that the Committee is updated in February and to be ready for the CBU feedback also to Trust Board in March 2016.

  Lynne Lobley, Non-Executive Director felt that the 5 Strand Options had to be re-visited and to ensure that Patient Care is implemented into the headline.

  The Chair noted that it was a good piece of work and moving forward at pace.

People Strategy3.ppt

- HR & OD Governance update – an Operational People Committee meeting took place on 12 November 2015. It was apparent from this meeting that Education and HR must build on a closer working relationship in order to form unity. An Away Day has been organised for the 6 January 2016 whereby both teams can work together and develop going forward.

  The Director of Human Resources and Organisational Development to discuss the HR and OD Governance further with the Chair in more detail; to look at the function centrally and assurance scrutiny and so feeding up to Trust Board.

  The Associate Director of Estates and Facilities asked if the CBU Consultation would include Corporate areas and it was noted that it was not that advanced at this stage but would in turn eventually lead to the inclusion. The supporting function needs to align initially to the Clinical Areas in the Consultation.

- The Associate Director of Human Resources updated on the current position of the capped rates for agency staff and the Monitor requirements put in place in November to commence implementing. This covers nursing/medical staff/agenda for change staff and is to compare existing rates against cap rates. There are a number of LSA's in place and some are above cap rates but in compliance with LSA's but in breach with Monitor requirements and this is to be looked into although agencies are not keen to re-negotiate.

  The Nursing information has been extracted for the weekly return quite easily through the NHSP database but the medical side are struggling to pull out the weekly information required to be submitted.

  The Director of Nursing informed that the overseas recruitment is going well and they

	have 14 Romanian nurses commencing although the Spanish nurse recruitment had fell through. The Trust will return to Romania to expand on recruitment there. The Trust has agreed enhanced rates with NHSP at this stage and the NHSP rates fit within the price cap but this will change from February as they point out that they are a bank system. Further discussion took place on the need for HR/Procurement/Finance input into this and to ensure that the Trust is recording that it is doing this exercise. The Associate Director of Human Resources informed that HR use Staff-flow to support with the provision of information and to explore if they can actually provide a weekly report and to put pressure on them to obtain this information. The Director of Human Resources and Organisational Development to update on all the factors above and feed into Trust Board.
	WHHFT/SPC/15/94 – HR KPI dashboard for assurance The HR KPI dashboard was noted and Lynne Lobley, Non-Executive Director asked about what is being done about the PDR's showing in red and that the assurance around this is not easily indicated. The Associate Director of Human Resources explained that the Performance Improvement Policy is now in place and that the focus had been on Lorenzo training in recent weeks, which had affected the PDR/training figures, so there needs to be a push and a plan in place to ensure the figures get back on track. The Deputy Medical Director asked that the HR Business Partners make sure that improvements are made in the divisions and that this is being done and a pro-active HR intervention be put back into the business. The HR Business Partner, Unscheduled advised that they definitely see this as their role and that in A&E regular meetings have been set up and they are looking at Finance/Policies/HR with the AGM in that area. It is about Leaders and Managers taking responsibility for their areas and that real scrutiny takes place at monthly Bi-lateral meetings in order to provide this assurance. Lynne Lobley, Non-Executive Director advised that there was a role for everyone in this – managers/clinical leaders to have this high in their list of priorities and it is a cultural thing. The Head of Workforce Strategy & Engagement explained that there is a big piece of work currently being undertaken around PDR's especially on the documentation/paperwork itself.
	WHHFT/SPC/15/95 – QPS People Measures The summary on QPS People Measures was noted and the Associate Director of Human Resources informed that the performance against measures will also form part of the Readiness Assessment for the CBU Leadership roles. It was also noted that the Revalidation of Nursing Staff had commenced and will be in place by 1 April 2016.

	WHHFT/SPC/15/96 – HR Retention and Turnover (i) Retention and Turnover Discussion Paper; (ii) Retention and Turnover Analysis (iii) Exit Interview Analysis;(iv) Revised Exit Interview Process/On-boarding report The Committee agreed to roll over this item and to combine the above papers into a summary paper highlighting specifically on the themes that need to be focussed on for full discussion at the 1 February 2016 meeting. ***Action: Summary paper for discussion at February 2016 SPC meeting.***
	WHHFT/SPC/15/97– Education & Training update The Education & Training update report was noted and Sharon Harper, Education Governance Officer highlighted the Quality Improvement Champions update and its current position. There will be 30 in total, 2 being in cohort; 15 in June 2016 and 15 in September 2016. It is open to all Trust Staff and they are keen for Medics in Cohort.
	WHHFT/SPC/15/98 – Birthrate Plus Report The Interim Associate Director of Nursing, Scheduled, WCSS explained the background to the Birthrate Plus Assessment. The Department of Health in England has endorsed the use of the Birthrate Plus as a definitive workforce planning tool for Midwifery Services and is the only recognised tool available for calculating midwifery staffing levels. Data had been collected from April to June 2015 and validated by the Birthrate Plus team to ensure the data quality was correct. Midwifery establishments and ratios have now been calculated and recommended following the assessment. Upon receipt of the report the Executive Team agreed an immediate uplift to the maternity staffing levels to one band 5, 6 and 7 Midwife and three band 3 Midwifery Assistants. The Director of Nursing and Governance advised that they were looking at implementing 12 hour shifts, looking at establishments and are confident that the 6 extra staff will work and to justify this to Monitor. They are working on reaching a ratio of 1:28 (births to one wte midwife) and we are currently at 1:29 - an improvement compared to the 2006 Birthrate Plus assessment which reported a ratio of 1:33. A final report to be submitted to the Strategic People Committee in February 2016. ***Action: Final Birthrate Plus report at February 2016 SPC meeting.***
	WHHFT/SPC/15/99 – Policies for ratification There were no policies for ratification.
	WHHFT/SPC/15/100 – Any Other Business
	The Director of Nursing and Governance advised that the Nurse Staffing report will be submitted to the Strategic People Committee in February 2016. ***Action: Nurse Staffing report at February 2016 SPC meeting.*** The Head of Workforce Strategy and Engagement informed of a recent event she attended around Freedom to Speak Up Guardian event. It is up to our Trust to have its structure in place and how to take this forward. The Speak Out Safely campaign set up at this Trust is a mechanism for raising issues and is part of the national structure. This will be raised as an operational discussion and the Director of Human Resources and Organisational Development to put this forward to Trust Board.

	Mike Grogan, Staff side asked that Lynn Mannion his staff side colleague represent him in his absence from the Strategic People Committee meetings and this was agreed. The Associate Director of Human Resources informed of further papers for information loaded into the SPC Information Folder on the pdrive, specifically the NHSLA Compliance – Employment Checks Audit Report which provides significant assurance and that it had gained a 100% scoring on the audit. With no further items reported the Chair thanked members and closed the meeting.
	Date and time of next meeting Monday 1st February 2016 at 1000hrs in the Trust Conference Room.

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

BOARD OF DIRECTORS

16/032

SUBJECT:	Human Resources / Education & Development Key Performance Indicators (KPIs) Report	
DATE OF MEETING:	27 January 2016	
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):	• An increase in-month for sickness rate and cumulative rate. Marginal deterioration in RTW rates and still low • Turnover rate has been maintained but both the stability and vacancy rates have increased the latter of which is largely due to additional Winter pressure posts. Headcount has increased. • More staff are commencing the trust than leavers • Increase in temporary staffing expenditure over budget to over £5m. Various initiatives in place including successful international recruitment to Romania • Recruitment times have reduced again and are achieving the target • Increase in employee cases	
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

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Trust Board Update

HR Performance Management Update

At the Strategic People Committee meeting held on 7 December 2015 there was a focus on PDR and Mandatory Training compliance rates within the Clinical Divisions. Therefore, this report concentrates on the other workforce issues contained in the dashboard and the narrative which follows.

1. Position as at 31 December 2015

Please see the dashboard on the next page for the trust wide position.

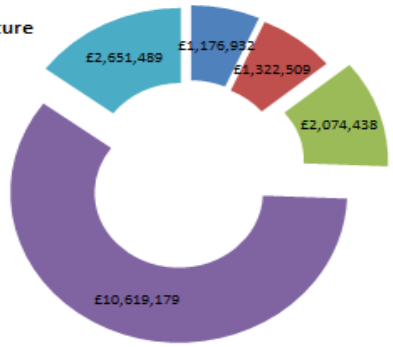
Warrington and Halton Hosptials

Period: 2015 12 | Export PDF | Print | Return Home | Exit

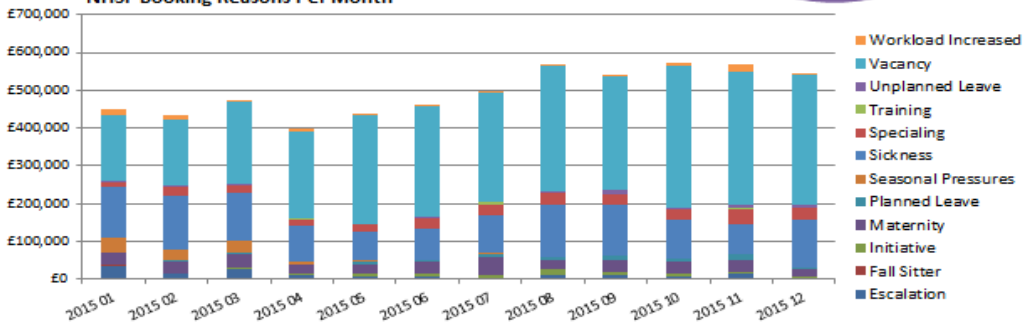
Expenditure

YTD Budget £	£117,040,646
YTD Contracted £	£104,420,687
YTD Non-Contracted £	£17,844,548
YTD Variance £	£5,224,592
Flex Labour Reliance %	14.6%
Overpayment Balance	£63,209

YTD Non Contracted Expenditure

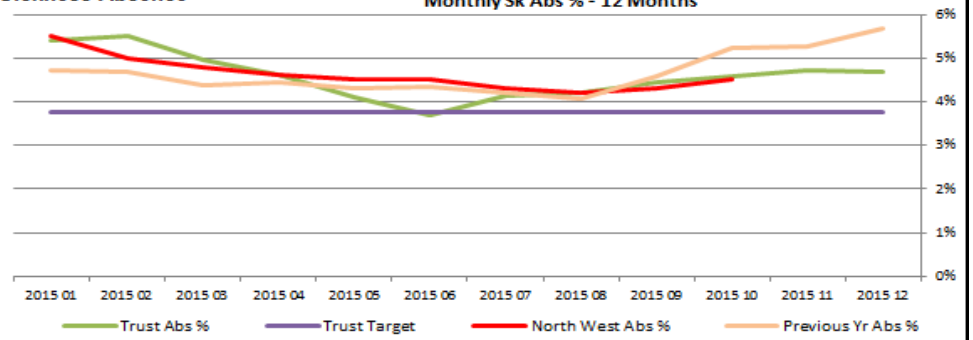


NHSP Booking Reasons Per Month

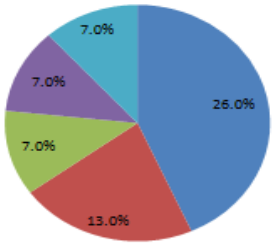


Sickness Absence

Monthly Sk Abs % - 12 Months

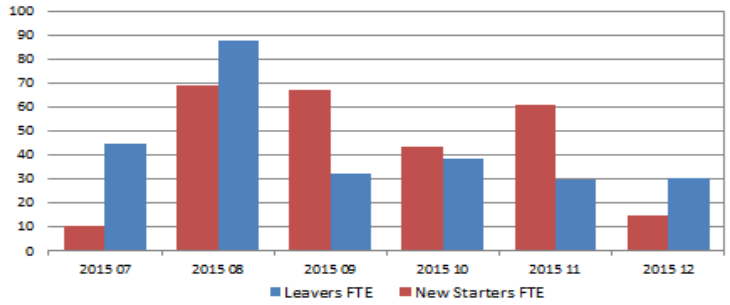


Top 5 Abs Reasons in 12 Months

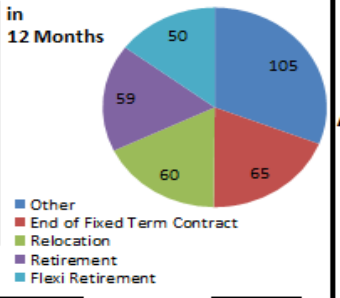


Monthly RTW %	48%	Cumulative RTW %	50%
Monthly Sk Abs %	4.7%	Trust Target	3.75%
YTD Sk Abs %	4.4%		
Long Term Sick %	2.8%	Short Term Sick %	1.9%
Calendar Days Lost	5712	No of Episodes	644
Est Monthly Cost	£360,798	Est Cumulative Cost	£4,188,517

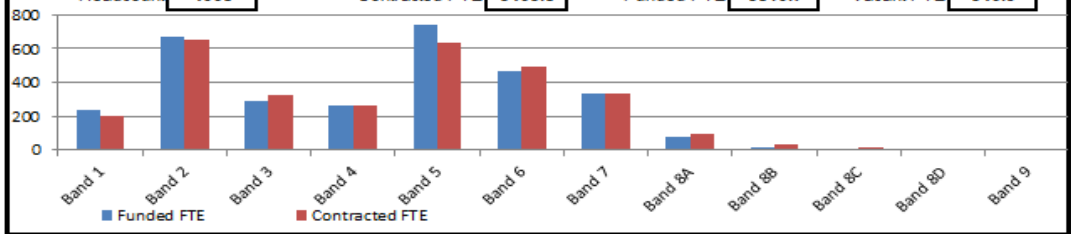
Workforce Profile



Top 5 Reasons for Leavers in 12 Months



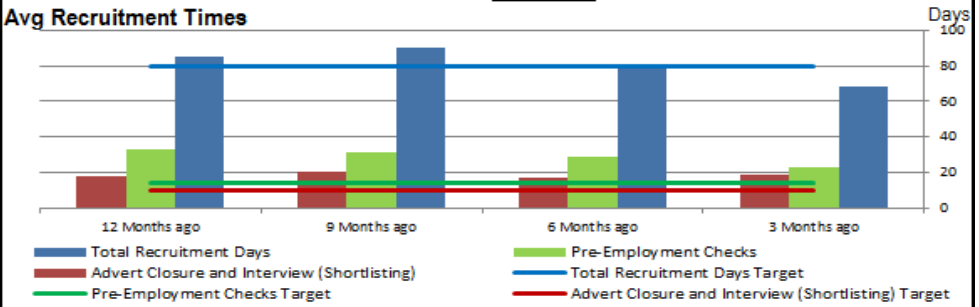
Annual Leave (Hrs)	643,147 : 703,610	Current Mat Leave FTE	59.9	Stability	15.2%
Headcount	4068	Contracted FTE	3463.8	Funded FTE	3810.7	Vacant FTE	346.9



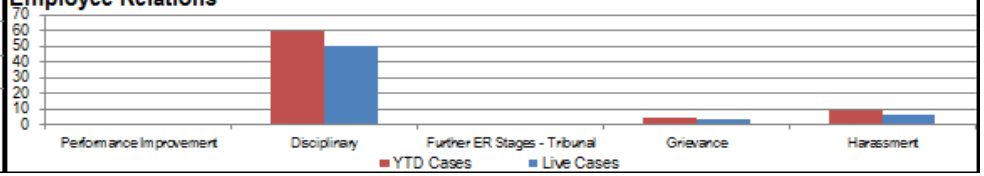
Recruitment

Overall Vacancy % & FTE	9.1%	Turnover	10.9%
Avg Monthly New Starters FTE	42.9		
Avg Monthly Leavers FTE	37.9		

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

Overpayment Balance: Outstanding balance of overpayments the Trust is attempting to recover

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

Headcount: Number of employees

Contracted FTE: Total employed FTE

Funded FTE: Total FTE available

Vacant FTE: Difference between Funded and Contracted FTE

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

Advert Closure and Interview (Shortlisting): Average calendar days between advert closing and interview. Target = 10 Days

Pre- Employment Checks: Average calendar days between successful candidates ID checks being completed and agreeing the start date (excluding notice period). Target = 14 Days

Total Recruitment Days: Average total number of calendar days taken to recruit from Advert to Start Date (includes notice period). Target = 80 Days

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) remains significantly higher than we would want at 14.6%. The reasons for this can be seen throughout the Dashboard, Turnover, Vacancy Rate, Sickness and Stability.

This month has seen a further deterioration of over £1.2m to £5,224,592 with agency expenditure of £10,619,179 largely accounting for the total non-contracted labour spend of £17,844,548. Clearly the amount spent on non-contracted labour does not represent best value for money and continues to be 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. At each bi-weekly meeting the Matrons/Ward Managers are held to account of expenditure and plans to reduce this. A representative from Monitor has also attended some of these meetings

- International nurse recruitment in conjunction with NHSP. A visit to Romania at end of November 2015 has resulted in 14 nurses being appointed and there is a meeting planned for 22.1.16 with NHSP to obtain more details of when they will commence and the support that they will require. Due to the success in Romania, a further visit is planned and will be discussed at the same meeting.

- Working directly in conjunction with Monitor which has resulted in an extensive Action Plan which is reviewed regularly with Monitor

- Roll out of the Allocate system for job planning has commenced from 1 January 2016 which saw job plans loaded onto the system for all consultants. Some analysis of comparing job plans to the trust job planning policy has also commenced to try and identify other opportunities for increased productivity

- Nationally there has been a cap set on agency rates, the first phase of which came into effect from 23 November 2015 with full implementation expected from 1 April 2016. The trust is complying with the submission of data to Monitor for all staff groups.

- Our framework provider: HealthTrust Europe (HTE) has met with the Head of Procurement in Cheshire and Merseyside with a view to the development of a C&M Strategy for the management of agencies (and which agencies to use) to meet the price caps. This would give greater purchasing power to maintain and even push down rates.

- Various initiatives with NHSP aimed at attracting agency workers to work through NHSP have been implemented. These include increasing NHSP rates to attract agency nurses, auto-enrolment of new trust starters onto NHSP, allowing multi-post holders who leave the trust but want to continue working work with NHSP the opportunity to do so automatically, changing the cascade arrangement to giver agencies offering lower rates the opportunity to fill some shifts etc

- We have met with a number of recruitment agencies who seem optimistic that they can source both consultant and middle grade doctors for various vacancies we have in the trust

With regards to NHSP spend in December, expenditure was slightly less than November but is still above £530k. The reason recorded for expenditure for vacancies reduced again but sickness increased and they both remained the main reasons.

Sickness Absence

November saw an increase in sickness absence from 4.5% to 4.7% and affected the cumulative rate for April – December which rose to 4.4% against the trust target of 3.75%. Over the last 3/4 months the trust rate has virtually matched the North West average percentage. Long term sickness absence now equates to 2.8% and short term, 1.9%. The number of episodes of sickness absence increased to 644 compared with 631 in November.

There was a slight deterioration with the RTW rate at 48% (51% for November) for December and 50% 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 are reminded on a monthly basis in writing 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 remains the same at 26%. More work has been completed to improve the recording of whether stress is work related or not. Our initial analysis would suggest that 92% of stress is not work related stress. 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 13% (1% increase) of the sickness absence in the last 12 months although many staff do regularly access the Staff Physiotherapy service in a timely manner and report good outcomes rather than wait for referrals from their GP. At the last Staff Engagement and Wellbeing Group, the Staff Physiotherapy service produced an audit of their service which showed that this was well used by staff and was effective in getting staff back to work quicker.

Workforce Profile

Unfortunately December was not a good month for the number of new starters compared with leavers. More than twice as many staff (30) left the trust, compared with just under 15 starters. This was also reflected with qualified nurse vacancies at band 5 which increased by 10.97 wte to 92.64 wte in December 2015. However, the overall trend over the last 12 months shows that the monthly average position remains positive with more starters (42.9 wte) than leavers (37.9 wte).

The 'Top 5 Reasons for Leaving' are largely not preventable. It has previously been commented about those which are recorded as 'other' but retirement, flexi-retirement and relocation are genuine reasons for staff leaving. Those on fixed term contracts are for a specific reason but perhaps need reviewing as there might be more opportunities to retain some of these staff.

The trust has made some improvements to induction arrangements from January 2016 and more will follow from April 2016. There are imminent plans to introduce changes to the Exit Interview process and to introduce on-boarding.

The ratio of annual leave taken compared with the proportion expected remains at 'amber' but the gap has increased. The concern would be that a higher proportion would need to be taken in Q4 which might be a contributory factor to increased agency spend later in the year.

The headcount has increased by 8 to 4068. Although the number of vacancies has increased significantly to 346.9 this is largely due to an increase of c55 wte qualified and unqualified nursing staff for Winter pressures.

The number of staff on maternity leave has fallen by 3 wte to 59.9 wte but will still be a factor contributing to staffing shortages in some areas.

The stability rate has deteriorated to 15.2% from 13.6% which is of some concern as this indicates that more staff are leaving within their first 12 months of being in post. The on boarding initiative mentioned above should assist with understanding the reasons for this.

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

Recruitment

Labour turnover has been maintained at 10.9% but there has been an increase in the vacancy rate to 9.1% which is largely due to the additional staff for Winter pressures mentioned above.

The average time taken to recruit has fallen again to under 70 days (previously 80 days) and achieves the target of under 80 days. This reflects the hard work done by the Employment Services Team and the new measures introduced to streamline recruitment processes and encourage managers to advertise vacancies and shortlist much quicker. There has been a slight improvement in the time taken for undertaking employments checks which is now just over 20 days.

In respect of Employee Relations, the greatest amount of activity relates to disciplinary cases (60 year to date) and this already surpasses the total for 2015/16. These are largely concentrated within Unscheduled Care and WCSS. The number of dignity at work cases is also beginning to rise with 10 cases in total. In December were no new exclusions/suspensions.

2. Recommendations

That the Board notes the contents of the report and the action being taken to improve the workforce performance indicators.

Roger Wilson
Director of Human Resources and Organisational Development
20 January 2016

BOARD OF DIRECTORS 16/033

SUBJECT:	**Monthly Staffing Exceptions Report**	
DATE OF MEETING:	27 January 2016	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Grace Delaney-Segar (Patient Quality and Safety Champion) Divisional Matrons from unscheduled, scheduled and Woman's children's and support services Associate Divisional Nurses from unscheduled, scheduled and Woman's Children's and Support Serves	
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 December 2015 and is for information only	
RECOMMENDATION:	***The Board is asked to:*** 1. Note the contents of this report in relation to safe staffing	
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 December 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**
SAU	100.0%	61.3%	-	-	SAU has moved off the main ward and is now a standalone unit. The unit is closed overnight. There is still 1.44 assistant practitioner vacancy and a 0.76 Band 2 vacancy.
A5	103.0%	86.9%	97.8%	98.3%	No specific issues with A5, however, due to staffing difficulties on A6 the ward has increased its bed base and on occasions requires additional staff to support this.
A6	84.2%	98.4%	96.7%	100.0%	A6 is now funded for 32 beds however it is not yet fully established. There are 6.2 WTE vacancies for qualified staff and 2 RN on maternity leave (1 is returning imminently). There are 2.33 qualified nurses due to start in post in March 2016. Recruitment continues via the rolling programme.

					Short term sickness has impacted on staffing levels throughout the month. To ensure safety any gaps on e-roistering are requested on NHSP and escalated to agency if not covered. Staffing remains challenging and we are rigorously managing recruitment. Escalation and medical outliers remain at high levels which is an additional pressure on the nurse staffing particularly at such a challenging time.
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**
A9	86.5%	85.7%	93.5%	100.0%	There has been sustained escalation on the ward for over half of 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 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 staff as NHSP trained has had a very poor fill rate. At time the acuity has been high due to the need to bay tag and special 1:1 patients. These shifts are 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. There has been a reduction in medication errors, but incidents of delayed treatment for intravenous antibiotics and controlled medication.
B19	97.5%	133.9%	100.0%	100.0%	Escalation beds have remained open for most of the month. The ward is over on CSW due to escalation and the NOF unit. The ward has an untrained vacancy, which has been appointed, but not due to start until Sept 2016. Nurse sensitive indicators have shown falls has been an issue due to the nature of high risk patients and some medication errors observed and investigated and is being monitored by the ward manager. There has been 1:1 acuity of patients throughout the month. There have been incidents of delayed treatment of intravenous antibiotics and controlled drugs.

B4	95.7%	93.2%	95.8%	100.0%	B4 have good staffing levels and manage any shortfalls internally. On occasion there is sufficient flex within the staffing to enable staff to move to Warrington to support the wards.
Ward 1 - CMTC	82.5%	60.3%	61.9%	78.6%	CMTC overall have acceptable staffing levels and manage any shortfalls internally. The current vacancies are: 6.6 At the next rolling recruitment day, focus will be on recruiting for CMTC. On occasion there is sufficient flex within the staffing to enable staff to move to Warrington to support the wards.
ICU	83%	71%	82%	79%	18 beds funded but used flexibly depending on dependency of patients 14 Q nurses required per shift but if dependency/occupancy reduced then less nurses would still provide agreed nurse patient ratios. Unit Occupancy for December 2015 was only 66% therefore even though shifts fell short of 14 Q there was adequate nurses to provide standard nurse patient ratios. Currently have a high number of vacancies and maternity leave therefore staffing and capacity reviewed daily to ensure appropriate 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**

AED	94.5%	64.3%	93.3%	82.9%	Please note 3330.08 sicknesses, 12 posts consisting of Band 5, Band 6 & Band 2 appointed but yet to start.
A1	89.8%	99.7%	85.8%	100.0%	International recruitment commenced in November 15, nobody suitable to date. Standalone recruitment advert continues. Practice educator post advertised, no one appointed yet. There have been 2 band 6 secondments appointed to support retention. The Matron completes a staffing review daily at 2.15pm to ensure the ward is safety staffed.
A2	98.1%	91.6%	88.6%	98.4%	There are RN's and CSW's waiting for start dates, all vacancies filled. Band 7 going on secondment for 3 months and there has been an ECF raised to back fill the post. Matron completes a staffing review daily at 2.15pm and the staff are moved within the Division to make areas safe. 1:1 risk assessments completed as required and put out to NHSP to support 1:1's.
A3	96%	72.5%	96.8%	98.9%	HCA's to be increased to 6 carers days and 3 for nights for a trial period until the end of march and to put shifts out to NHSP
A4	99.9%	107.0%	101.6%	114.5%	Ward manager in the numbers. On occasion the 3rd RN is an AP with the ward manager support. Acuity high. Escalated to 34 patients 29.12.15. Several dementia patients & patients requiring 1:1 Care. Staffing establishment under review
A7	95.5%	96.7%	100.0%	100.0%	HCA sickness in month- wards risk assed by matron, ward manager clinical to support shortfall.
A8	77.4%	89.4%	103.3%	85.6%	Escalated to 30 patients 29.12.15. Several patients dementia patients and patients requiring 1:1 Care
B12	95.9%	115.7%	100.0%	142.4%	Ward manager in the numbers on most shifts. Two members of staff on long term sick and other short term sickness.
B14	93.5%	106.0%	75.6%	119.4%	Patients needing 1:1 care during December
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**

B18	82.3%	93.5%	89.2%	89.9%	Shifts not picked up on several occasions for CSW and RN's on NHSP. Large amount of sickness for December for long & short term sickness.
C21	94.6%	81.7%	88.7%	74.2%	Increased sickness in the month of HCA and RN. Ward manager unable to be supervisory and has supported on the ward being clinical. Ward assessed twice daily by matron, support given where required. Acuity closely monitored.
C22	96.4%	84.5%	100.0%	100.0%	
CCU	95.5%	68.4%	98.5%	-	Area risk assessed and CSW moved following assessment to another area.
STAR	93.5%	87.1%	100.0%	100.0%	Staffing Est. currently under review.

WOMEN'S & CHILDREN'S SUPPORT SERVICES					
Ward name	**DAY Average fill rate - registered nurses / midwives (%)**	**DAY Average fill rate - care staff (%)**	**NIGHT Average fill rate - registered nurses / midwives (%)**	**NIGHT Average fill rate - care staff (%)**	**Exception Report Comments with assurance provided by Associate Directors of Nursing**
B11	106.5%	95%	105.9%	-	Normally has no CSW cover at night but have had 62 hours this month. Extra staff due to high demand for HDU
Neonatal Unit	82.9%	41.3%	80.7%	66.5%	The Telford staffing ratio has been updated on professional judgement for the planned hours. The unit has also been experiencing a high sickness rate that is currently under review by the new ward manager. Staffing remains on the risk register.
C20	72.0%	100.0%	100.0%	-	Staffing levels have been on occasion an issue on the ward which is largely related to escalation. The ward is now fully established however, the additional beds and medical outliers prove challenging and

					staffing is supported by movement across the division.
C23	96.5%	77.6%	96.8%	106.0%	Staffing has seen an improvement on the ward, which is largely in relation in improvement of sickness absence. Staffing is monitored as part of the midwifery daily staffing review.

4.0 Assurance provided from the Divisional Associate Directors of Nursing:

Scheduled Care -

Unscheduled Care – The Division has continued to experience high sickness levels in some areas. Vacancies are being recruited into and the division has been a part of the Trust rolling recruitment. The specialist areas have had success too from the rolling recruitment after doing a separate advert to recruit to their posts.

All areas were safely staffed but there are some deficits across the Division. These were minimised by close observation and monitoring by the Matrons every day, with daily scrutiny by the 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.

Recruitment programme with the proactive recruitment of newly qualified student nurses has commenced in the organisation with some success for the division. The division has also been allocated Romanian nurses from the latest overseas recruitment.
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.

5.0 Conclusions

The report shows the variance in staffing against requirements and the actions taken to maintain patient safety when numbers reduce below the planned or beds are escalated.

6.0 Recommendations

Board is asked to note the contents of the report

BOARD OF DIRECTORS

Item 16/034

SUBJECT:	Charitable Funds Committee business i. Draft Minutes of the meeting on 3/12/15 ii. Terms of Reference for the committee iii. Approval by the representatives of the corporate trustee of the Charitable Fund's Annual Report and Accounts 2014-15
DATE OF MEETING:	27 January 16
DIRECTOR:	Lynne Lobley, Non-Executive Director - Chair

Item 16/034i

CHARITABLE FUNDS COMMITTEE MEETING

Minutes of the meeting held on 3 December 2015
Trust Conference Room, Warrington Hospital

Present:

Lynne Lobley	Non-Executive Director – Chair
Ian Jones	Non-Executive Director
Steve Barrow	Deputy Director of Finance
David Ellis	Public Governor
Karen Spencer	Head of Financial Services
Pat McLaren	Director of Community Engagement

In attendance:

Colin Reid	Trust Secretary
Helen Higginson	Charity Fundraising Manager

Apologies:

Karen Dawber	Director of Nursing and Organisational Development
Terry Atherton	Non-Executive Director
Anita Wainwright	Non-Executive Director
Chris Horner	Associate Director of Communications

	WHHFT/CFC/15/32 – Apologies & Declarations of Interest – in agenda items
1	The Chair welcomed all to the meeting. Apologies were noted as above.
2	There were no declarations of interest in the agenda items.
3	The Chair asked that the minutes reflect the Committees thanks to Tim Barlow for his support whilst Director of Finance and Commercial Development. The Committees thanks were also extended to the Mike Barker Deputy Director of Commercial Development.
	WHHFT/CFC/15/33 – Minutes of the meeting held on 8th September 2015
	The minutes of meeting held on 8th September 2015 were approved subject to amendments.
	WHHFT/CFC/15/34 – Action Plan / Update on funding requests from June 2015 meeting.
	The Committee noted that a workshop had been arranged for 3rd February 2016.

The Committee noted the approval by email for the purchase of the Harlequin Financial and fundraising system. The Head of Financial Services advised that the system would be capitalised and therefore the full cost of the system would be spread across the life of the product.

WHHFT/CFC/15/35– Fundraising activities

December Fundraising and awareness update 2015 and Making Waves Campaign – Marketing

The Fundraising Manger provided a presentation on the fundraising activities since the last meeting and the marketing campaign for Making waves, the children's play area project that required fundraising to provide a children's play area located at [ ].

The Committee discussed the presentation and in particular addressed the following:

- **Making Waves** – The Committee noted the requirement to raise circa £85k in order to provide a children's play area located at [ ]. The fundraising activity would progress once a fund request was received from [ ]. The Committee supported this approach to fundraising recognising that contributors were more likely to support a specific cause. The Fundraising Manager would bring a proposal to the Committee on the funding requirement and the scope of work for approval as soon as possible together with a proposal on how the funds would be raised. Ian Jones felt that it was important that the Charity adopt a number of specific fundraising project going forward that would enhance the name of the Charity and the Trust, but suggested that there are undertaken at the same time.
- **Sloppy Slippers** – The Committee noted the need to provide slippers on the wards, particularly for elderly patients. The Slipper had to be of a particular quality and anti-slip. The Director of Community Engagement agreed to look at how this could be provided as a staff indicative.
- **Charitable Funds Newsletter** - The Committee noted that a dedicated newsletter was being considered for publication in the New Year to support the fundraising activity of the Charity.
- **Trust Reputation –** The Committee supported the approach that the Charity should be used to enhance and support the good reputation of the Hospital.
- **Give as You Earn** – The Committee noted that in the current economic climate, give as you earn may not be supported as it would be went the economic climate was buoyant. David Ellis agreed to tie into the staff survey the Governors were undertaking with the Director of HR&OD aspect of give as you earn to see if there was support for this.
- **Charity Shop Window –** Ian Jones noted that at the front of house the Charity was not prominent and did not have a shop window to promote the Charity objectives. The Director of Community Engagement advised that discussions were ongoing regarding the use of the [ ] area and also promotion of the Charity at the atrium. She advised that there were some tough decisions that needed to be made and would include a dialogue with the League of Friends. The Director of Community Engagement agreed to report back to the Committee on future proposals.
- **Grants and Charitable contributions –** the Chair asked that as part of the fundraising activity the Fundraising Manager look at other Charities that contribute to good causes that would assist in raising funds for specific projects.
- **Workshop –** The Committee agreed that the structure of the workshop on 3 February would include a morning session on strategy and the afternoon would include a session with fund holders to explain and the needs and strategic direction of the Charity.

The Chair thanked the Fundraising Manager for her presentation which was noted.

	WHHFT/CFC/15/36 – Financial Report – Q2 The Head of Financial Services presented the financial Report for Quarter 2 and presented the Financial position of funds held, and additional financial information as at 30th September 2015. The Head of Financial Services advised that donations received had dropped off in Q2, reporting that the number of Just Giving donations had increased however the amount of donation had fallen. Ian Jones expressed his disappointment that this had happened. The Fundraising Manager advised that there had been a reduction in July and August but there had been a resurgence in September. The Committee considered how The Committee noted the content of the Financial Report as at 30th September 2015 and to note the restrictions placed on the legacy donations received during the period.
	WHHFT/CFC/15/37 – Annual Report and Accounts 2015
	WHHFT/CFC/15/38 – Verbal update on the funding of Harlequin The Trust Secretary reported on the written approval received from the Committee for the purchase of the approval by Harlequin financial and membership software.
	WHHFT/CFC/15/39 - 1. Charitable Funds Governance arrangements &Continuity of contracts for CF team and 2. Terms of Reference
	WHHFT/CFC/15/40 – Association of NHS Charities The Committee discussed the attendance of committee members at the Association of NHS Charities next meeting in September. It was agreed Helen Higginson, Charity Fundraising Manager would attend on behalf of the Committee.
	WHHFT/CFC/15/41 – Any Other Business The Chair thanked the committee for attending and closed the meeting.
	Date and time of next meeting The next meeting will take place on ….

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

Terms of reference for the Charitable Funds Committee

Charity No 1051858

1. Purpose and Constitution

The Charitable Fund Committee has been formally constituted as a Sub Committee of the Trust Board, as agreed by the Trust Board on the 5th April 2001.

The purpose of the Charitable Fund Committee is to act on behalf of the Trust Board in the administration and financial management of the Trust's Charitable Funds.

2. Terms of Reference

To ensure that the Warrington and Halton Hospitals NHS Foundation Trust Charitable Fund is administered in accordance with the Governing Document lodged with the Charity Commissioners and the Charities Act.

To ensure that the fund is administered in accordance with financial procedures and systems incorporating adequate controls to safeguard assets and compliance with the Trust Corporate Governance procedures as set out in the following documents (and as revised from time to time) the Scheme of Reservation and Delegation, the Standing Financial Instructions and the Standing Orders. These systems and controls are subjected to periodic review by internal and external audit.

To ensure that the Charitable Fund is invested in accordance with the provisions of the Trustee Investment Act 1961 and other relevant legislation.
To agree the Investment and Reserve Policies in relation to the Charitable Funds and periodically review these to ensure these remain appropriate.

To agree a Scheme of Delegation for the Charitable Fund and periodically review.

To appoint where considered necessary investment advisors, qualified within the meaning of the Trustee Investment Act 1961, to provide them with guidance and periodically assess their performance.

To approve the establishment of any new Charitable Fund.

To regularly receive and consider reports from the Director of Finance on the activity of the Fund.

To review the draft Annual Report and Accounts of the fund and to recommend these for approval to the Trust Board.

3. Reporting Procedures

Present the audited annual accounts to the Trust Board for approval.

Minutes of committee meeting to be presented to the Trust Board.

4. Membership

Core Membership of the Committee shall comprise of:

Two Non-Executive Directors
The Director of Finance (Financial Trustee)
Head of Financial Services
Public Governor
Associate Director – Communications

All trustees are able to attend meetings

5. Frequency of meetings

Meetings will be held on a quarterly basis.

6. Quorum

At least one Non-Executive Director and one Executive Director.

7. Approval and Review Date

These Terms of Reference are:

Recommended by Charitable Funds Committee as a result of its consideration at its meeting held on the 3 December 2015.

Signed by the Chairman of Charitable Funds Committee

..... Date: .....

Signed by the Chairman of the Trust Board

..... Date: .....

BOARD OF DIRECTORS Item 16/034iii

SUBJECT:	**Charitable Fund – Trustee's Annual Report and Independently Examined Financial Statements for the Year to 31st March 2015.**	
DATE OF MEETING:	27th January 2016	
ACTION REQUIRED	**For Decision**	
AUTHOR(S):	Karen Spencer – Head of Financial Services	
EXECUTIVE DIRECTOR:	Mark Brearley, Interim Director of Finance and Commercial Development	
LINK TO STRATEGIC OBJECTIVES:	SO3: To give our patients the best possible experience SO4: To provide sustainable local healthcare services	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	To present the Charitable Fund Annual Report and Accounts for approval and signing.	
RECOMMENDATION:	***The Board is asked to:*** Approve the Charitable Fund Annual Report and Accounts for 2013/14	
PREVIOUSLY CONSIDERED BY:	**Committee**	Charitable Funds Committee
	Agenda Ref.	CFC\15\37\1455
	Date of meeting	3rd December 2015
	Summary of Outcome	Recommended for Approval

Charitable Fund – Trustee's Annual Report and Independently Examined Financial Statements for the Year to 31st March 2015

EXECUTIVE SUMMARY

The purpose of this paper is to present the Charitable Fund Annual Report and Accounts for 2014/15 for approval prior to submission on Friday 29th January 2016.

CONTEXT

The Trustee's Annual Report and Independently Examined Financial Statements for the Year to 31st March 2015 have been prepared in accordance with both the Charities Statement of Recommended Practice 2005 (SoRP), and the Charities (Accounts & Reports) Regulations 2008, in addition to the Charities Act 2011.

BACKGROUND

The Trustee's Annual Report and Independently Examined Financial Statements for the Year to 31st March 2015 have been examined by Voisey & Co, and no errors were found.

The document was presented at the Charitable Funds Committee meeting held on 3rd December 2015, during which the Committee provided the recommendation that the Board should approve the Warrington and Halton Hospitals Charitable Fund – Trustee's Annual Report and Independently Examined Financial Statements for the Year to 31st March 2015.

NEXT STEPS

The Charitable Fund Annual Report and Accounts are required to be submitted to the Charity Commission on or before 29th January 2016.

RECOMMENDATIONS

Approval of the Charitable Fund Annual Report and Accounts for 2014/15.

CONCLUSION

The Board is asked to approve the Charitable Fund Annual Report and Accounts for 2014/15.

Warrington and Halton Hospitals NHS Foundation Trust Charitable Fund

Trustee's Annual Report & Independently Examined Financial Statements

For the Year to 31st March 2015

Registered Charity No 1051858

Contents

Reference and administrative details

Address of Charity:	Lovely Lane Warrington Cheshire WA5 1QG Tel: 01925 662835
Registered Charity no:	1051858
Bankers:	Government Banking Service 7th Floor, Southern House Wellesley Grove Croydon CR9 1TR
Independent examiners:	Voisey & Co 8 Winmarleigh Street Warrington Cheshire WA1 1JW

Report of the Trustee for the year ended 31st March 2015

Foreword

Warrington and Halton Hospitals NHS Foundation Trust (the "Corporate Trustee") presents the Charitable Funds Annual Report together with the independently examined financial statements for the year ended 31st March 2015 of Warrington and Halton Hospitals NHS Foundation Trust Charitable Fund ("the Charity"). Under Part 8 section 145 of the Charities Act 2011, the Corporate Trustee has exercised the Charity's exemption from audit. External scrutiny through *independent examination* is permitted and deemed appropriate for the Charity as its gross income is below a statutory threshold.

The Charity's Annual Report and Accounts for the year ended 31st March 2015 have been prepared by the Corporate Trustee in accordance with Part 8 of the Charities Act 2011 and the Charities (Accounts & Reports) Regulations 2008. The Charity's report and accounts include all of the separately established funds for which the Warrington and Halton Hospitals NHS Foundation Trust is sole beneficiary.

Structure, governance and management

Corporate Trustee

The sole corporate trustee of the Charity is the Warrington and Halton Hospitals NHS Foundation Trust. The Charity was established in accordance with paragraph 16c of Schedule 2 of the NHS and Community Care Act 1990.

The Corporate Trustee is managed by its Board of Directors which consists of executive and non-executive directors. It has responsibility for ensuring that the NHS body fulfils its duties in managing the charitable funds. The members of the Board of Directors of the Corporate Trustee who served during the financial year and up to the date of compilation of this Report were as follows.

Name	Title	
Steve McGuirk	Chairman	Commenced 1st April 2015
Allan Massey	Chairman	Resigned 31st March 2015
Lynne Lobley	Non-Executive Director / Deputy Chair(4)	
Clare Briegal	Non-Executive Director / Deputy Chair(2)	Resigned 30th June 2014
Rory Adam	Non-Executive Director / Deputy Chair (3)	Resigned 30th November 2014
Mike Lynch	Non-Executive Director	Commenced 22nd July 2013
Ian Jones	Non-Executive Director	Commenced 1st July 2014
Terry Atherton	Non-Executive Director	Commenced 1st July 2014
Anita Wainwright	Non-Executive Director	Commenced 1st January 2015
Carol Withenshaw	Non-Executive Director	Resigned 31st March 2015
Mark Partington	Interim Director of Transformation (1)	Commenced 1st December 2015
Mel Pickup	Chief Executive	
Mark Brearley	Interim Director of Transformation / Interim Director of Finance and Commercial Development (5)(1)	Commenced 1st July 2015
Tim Barlow	Director of Finance and Commercial Development	Resigned 30th November 2015
Sharon Gilligan	Chief Operating Officer	Commenced 1st December 2015
Simon Wright	Chief Operating Officer / Deputy Chief Executive	Resigned 30th September 2015
Karen Dawber	Director of Nursing and Organisational Development	
Pat McLaren	Director of Community Engagement(1)	Commenced 1st December 2015
Simon Constable	Medical Director	Commenced 1st March 2015
Paul Hughes	Medical Director	Resigned 28th February 2015
Jason DaCosta	Director of Information Technology(1)	
Jan Ross	Acting Chief Operating Officer	Commenced 1st October 2015 Resigned 30th November(6)
Roger Wilson	Director of HR & Organisational Development(1)	Commenced 2nd February 2015

(1) Non-voting Executive Directors.
(2) Deputy Chair from 1st July 2013 – 30th June 2014

(3) Deputy Chair from 1st July 2014 - 30th November 2014
(4) Deputy Chair from 1st December 2014
(5) Interim Director of Transformation from 1st July 2015 Interim Director of Finance and Commercial Development from 1st December 2015.
(6) Relates to time in post as Director.

The Charity is established as an umbrella charity, registered with the Charity Commission (no. 1051858). The umbrella charity covers the existence of a single unrestricted general fund containing 4 (2014: 6) designated funds as at 31st March 2015, and, currently, 7 restricted funds (2014: 4). The Charity was first registered as both Halton General Hospital NHS Trust Charity and Warrington Hospital NHS Trust Charity in April 1996 under the Charities Act 1993, which is now been incorporated into the Charities Act 2011.

In April 2001, supplemental deeds were executed to amalgamate the administration, trustees, objects and powers of the two charities following merger of the two organisations, creating the single body known as North Cheshire Hospitals NHS Trust Charitable Fund. On 1st December 2008, the Trust changed its name to Warrington and Halton Hospitals NHS Foundation Trust, following its transition to Foundation Trust status. The name of the Charity was changed accordingly by way of a supplemental deed and registered with the Charity Commission on 16th March 2010.

Charitable Funds Committee

The Board of Directors (the Board) established a committee on 5th April 2001, known as the Charitable Funds Committee, (the Committee) reporting to the Board, in accordance with standing order 6 for the practice and procedure of the Board of Directors (annex 7 of the Trust's Constitution). The role of the Committee is to oversee the management of the affairs of the Charitable Fund. This is a delegated duty carried out on behalf of the Corporate Trustee. The role is to ensure that the Charity acts within the terms of its declaration of trust and appropriate legislation, and to provide information to the Audit Committee to enable it to provide assurance to the Board that the Charity is properly governed and well managed across its full range of activities.

Aside from any restricted funds held, the Charity holds a single general fund, within which designated funds have been created to acknowledge expressions of wish from donors about the particular department or ward which should ideally benefit from their generosity. The Trustee has an intention to use the income of designated funds in the areas indicated by donors. However the Committee may choose to apply the funds to general purpose in any area of the Trust's hospitals in accordance with the Health Service Act 1977.

Membership of the Committee

The Committee comprises:

- at least two non-executive directors of the Board*;
- the Director of Finance and Commercial Development or his delegated deputy;
- the Director of Nursing;
- Head of Financial Services;
- Deputy Director of Commercial and Corporate Development

- Associate Director of Communications; and
- One public governor

* All non-executive directors of the Trust are members of the Charitable Funds Committee and are entitled to attend and vote at any meeting of the Committee.

During the year under review and up to the date of compilation of this Report, the members of the Charitable Funds Committee were as follows.

Name	Position held	
Steve McGuirk	Chairman	Commenced 1St April 2015
Allan Massey	Chairman	Resigned 31st March 2015
Lynne Lobley (1)	Non-Executive Director (Chair of Charitable Funds Committee)	Commenced 1st July 2014 (as chair)
Mike Lynch (1)	Non-Executive Director	Commenced 22nd July 2013
Ian Jones (1)	Non-Executive Director	Commenced 1st July 2014
Terry Atherton (1)	Non-Executive Director	Commenced 1st July 2014
Anita Wainwright (1)	Non-Executive Director	Commenced 1st January 2015
Clare Briegal	Non-Executive Director (Chair of Charitable Funds Committee)	Resigned 30th June 2014
Rory Adam	Non-Executive Director	Resigned 30th November 2014
David Ellis (1)	Public Governor of Warrington and Halton Hospitals NHS Foundation Trust	
Pat McLaren(1)	Director of Community Engagement	Commenced 1st December 2015
Mark Brearley(1)	Interim Director of Transformation / Interim Director of Finance and Commercial Development	Commenced 1st December 2015
Tim Barlow (1)	Director of Finance and Commercial Development	Resigned 30th November 2015
Karen Spencer (1)	Head of Financial Services	
Chris Horner	Associate Director of Communications	
Mike Barker (1)	Deputy Director of Commercial and Corporate Development	Commenced 1st May 2014 Resigned 31st October 2015
Karen Dawber (1)	Director of Nursing and Organisational Development	

(1) Member of the Charitable Funds Sub Committee for the purposes of approving charitable bids.

The Director of Finance and Commercial Development is responsible for day to day control of the administration of the charitable funds, and, in conjunction with the Chief Executive, approves expenditure on behalf of the Corporate Trustee with an upper limit of £5,000. Expenditure between £5,001 and £24,999 is referred to the Charitable Funds Sub Committee for approval. Requests that are referred to the Sub Committee must be approved by the following members;

- At least two Non-Executive Directors of the Board;
- One from the Director of Nursing or the Director of Finance and Commercial Development or his delegated deputy;

- One from the Head of Financial Services, the Deputy Director of Commercial, Director of Community Engagement and Corporate Development or Public Governor:

Expenditure in excess of £25,000 is referred to the Charitable Funds Committee on a quarterly basis.

Members of the Trust Board and the Charitable Funds Committee are not individual Trustees under Charity Law, but act as agents on behalf of the Corporate Trustee.

Corporate Trustee's appointments

The methods of appointment to the key governance roles within the Board of Directors and Council of Governors of the Corporate Trustee are reported in the Corporate Trustee's Annual Report and Accounts 2014/15 and contained within the Corporate Trustee's Constitution. Copies of these documents can be obtained from the Corporate Trustee's website or from its Communications office, located at Warrington Hospital, Lovely Lane, Warrington, Cheshire WA5 1QG.

All appointments to the Committee are made in accordance with the Committee's approved Terms of Reference.

Trust staff, including executive and non-executive directors, are required to complete the Trust's corporate induction programme, and are encouraged towards continuous professional development through the Trust's on-going performance management arrangements. Directors are able to seek individual professional advice or training at the Trust's expense in the furtherance of their duties.

Governors' knowledge is refreshed through a range of briefing sessions and workshops. The Board of Directors, Committee and governors all have direct access to advice from the Board Secretary who is responsible for ensuring that the Corporate Trustee's procedures are followed and that applicable regulations are complied with.

Administration

The accounting records and day to day financial administration of the funds are dealt with by the Finance Department. Fund raising and promotion of the charity is administered by the Trust's Fundraising team located within the Communications office, both are located at Warrington Hospital, Lovely Lane, Warrington, Cheshire WA5 1QG.

Risk management

The major risks to which the Charity is exposed have been identified and considered. A risk register has been compiled which is reviewed by the Committee on a biannual basis. Income and expenditure is monitored as part of the risk management process, to avoid unforeseen calls on reserves.

Objectives and strategy

The objective of the Charity is to provide for any charitable purpose or purposes relating to the National Health Service wholly or mainly for the services provided by Warrington and Halton Hospitals NHS Foundation Trust.

In its widest context this can mean the provision of medical equipment and training for any hospital employee or group of employees, and the provision of facilities for the direct benefit of our patients. The Corporate Trustee attempts to balance the purchasing of essential equipment for essential services against expenditure which improves the general environment and facilities of the hospitals for its patients. In achieving this balance, the Corporate Trustee always has in mind the wishes of the donors to the Charity.

Public interest benefit

The Corporate Trustee ensures that the *public interest benefit* criteria, as detailed in the Charities Act 2011, are met by critically assessing each funding application from sub-fund holders. Applications for funding can be made by any department within the hospitals, and applications are only restricted by the availability of funds and the quality of the application.

Where possible, funds are used to provide benefit to a wide range of patients, and funds used for staff enablement are allocated to projects that will directly benefit patients. A summary of major purchases made by the Charity during the year under review is contained in the Annual Review of Income and Expenditure Activities [page 9].

Reserve policy

Requirement

In accordance with Charity Commission guidance, the Corporate Trustee acknowledges that there is a requirement to hold reserves. The reserves policy should take into account future commitments from the general unrestricted funds held by the Charity. Assuming that funds have been designated appropriately and will be spent within a reasonable timescale the charity should not rely on the unrestricted designated funds for the absorption of overheads on a continuing basis. Therefore the level of reserves held in the general unrestricted funds of the charity should be sufficient to cover the annual support costs and overheads of the charity.

The charity approves expenditure on a case by case basis taking into account the level of funds available and the Corporate Trustee reserves the right to cancel any past delegation and transfer monies to the general unrestricted funds of the Charity. This may be considered where designated funds have not been spent within a reasonable timescale or where the original purpose of the designation no longer exists. Likewise the Corporate Trustee may choose to designate funds for a particular purpose.

Level of reserves

As at 31st March 2015 following a review of the Charity's reserves policy the Corporate Trustee considers that a minimum reserve of £90,000 (2013/14:£200,000) in the unrestricted general purpose fund should be permanently maintained.

Monitoring

The Director of Finance and Commercial Development will report on the progress of the reserves and make recommendations to the Charitable Funds Committee in order to comply with the policy. The Charitable Funds Committee has authority to vary the minimum level of reserves.

At 31st March 2015 the unrestricted general purpose fund held reserves of £118,360. The difference being due to existing commitments as at the balance sheet date.

Investment policy

Introduction

Where NHS charitable funds have surplus monies not needed to fund immediate charitable activities, Trustees may elect to invest some or this entire surplus in order to generate additional income to fund future activities.

Investment criteria

The investment policy of the Corporate Trustee is to deposit the entire value of the fund with the Government Banking Service in an interest-bearing account. This decision is based upon the intention in the short term to spend the funds, such that long-term investment would not be appropriate.

Interest receivable, interest payable and bank charges

It is the policy of the Corporate Trustee to apportion interest payable and bank charges across all funds, and to credit all funds with the proceeds of the Charity's investments based on the average balance of the funds held.

Annual review of income and expenditure

During 2014/15, the Charity continued to support a wide range of charitable and health-related activities, by purchasing supplementary and complementary equipment or services which may not ordinarily have been provided from NHS sources.

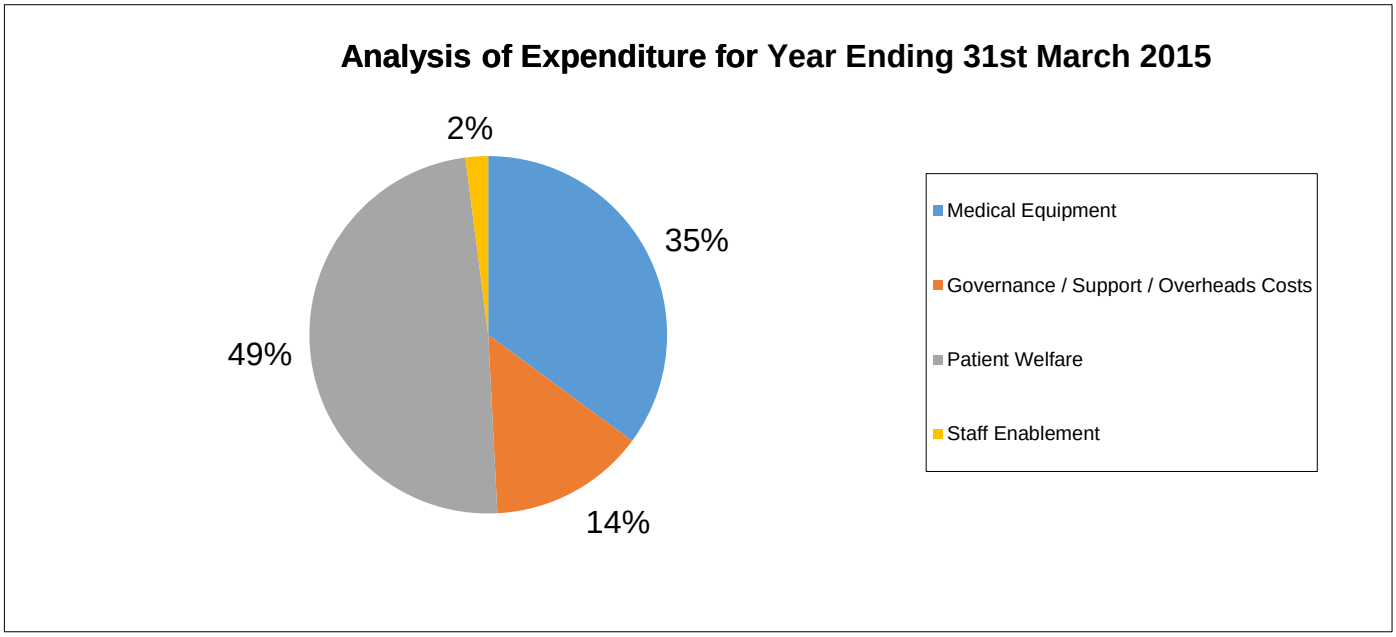
The main source of income received this year by the Charity has been legacy income of £404,340 (2013/14: £92,113). Legacy income where subject to a legal trust is held as restricted funds. The Charity received voluntary donations from members of the public totalling £79,710 (2013/14: £192,873).

The Charity's unrestricted general fund contains a number of designated funds in order to assist the donors in matching their donation with a particular department. All donations are accepted taking into account the donors' intentions and are held in the general fund unless a restriction has been applied; in this case, a separate restricted fund may be created.

This year, the charity's fundraising team spent £1,790 (2013/14: £nil) to generate income of £1,950 (2013/14: nil).

The Corporate Trustee is committed to ensuring that all funds are directed to patient benefit as soon as possible. Expenditure on charitable activities for the year ended 31st March 2015 was £471,150 (2013/14: £258,307).

Total expenditure, which includes overheads and costs of generating income, for the year ended 31st March 2015, was £490,255 (2013/14: £310,361). This is split across the Charity's different categories of expenditure below.



Analysis of significant purchases (exceeding £1,000) made in 2014/2015

• Additional therapists for the new Forget Me Not unit	£90,065
• Fibroscanner machine funded by the Brian Mercer Trust	£89,950
• Upgrade to the Mortuary visitors area	£34,288
• Ultrasound machine, Intensive Care	£26,200
• Transformation of Ward B14 into a TIA assessment area for the "Capture Stroke" service	£25,823
• Improvements to the Trust's Cataract and Glaucoma services	£22,977
• Specialist chairs, hoists and beds for increased patient comfort.	£16,444
• Foetal monitor and wireless transducer system for labour ward	£13,777
• Bed, hoist and slings for clinical training	£10,053
• Video Link for CMTC Theatres funded by the Wishbone Trust	£9,334
• Improvements to patient waiting areas for pre-op assessment at all sites and AMU.	£9,131
• Nanomaxx ultrasound system	£ 8,325
• "Starting Over" Macmillan Delamere Centre cancer patient survivorship course	£7,893
• Improved access to Warrington Hospital for patients and visitors with impaired mobility	£7,013
• Cardiograph machine	£6,825
• Wall mounted thermometers for babies	£2,320
• Warrington Disability Awareness Day 2014	£2,000
• Spirometer	£1,882
• Blood pressure monitors for Ward A9	£1,510
• Vital Signs Monitor and rolling stand	£1,188
Subtotal of expenditure classes over £1,000	**£ 386,998**
Other Charitable purchases (under £1,000)	£ 18,257
Total Charitable purchases	**£405,255**

How your donations make a difference to patients.

New technology to support liver care – Providing the latest equipment for patient care in gastroenterology

The trust launched a new Fibroscan service at the end of June 2015 thanks to the support of the charitable fund. The service is led by gastroenterology consultant Dr Sundaramoorthy Bharathi and Fibroscan is a painless test used for evaluating changes in the liver used in our gastroenterology team. The technique is used to measure hepatic fibrosis in a totally non-invasive and painless manner, with no risks for the patient.

A probe is placed at the skin's surface and using a combination of an elastic wave (generated by a mechanical pulse) and ultrasound technology, a numerical value is recorded. The stiffer the liver, the higher the value. The degree of stiffness of the liver is an indicator of damage, from whatever cause. It allows accurate assessment of liver fibrosis resulting from various problems that cause damage to the liver so that appropriate treatment can be started quickly.

"The charity and The Brian Mercer Trust has enabled us to provide Fibroscan technology for the first time and that really supports gastroenterology services at the trust," explains **Dr Bharathi**, "Fibroscanning helps prevent the need for biopsy in some cases so it provides the best in patient care."

Helping families in difficult times - Creating a new garden of remembrance and other facilities at the hospital mortuary

Losing a loved one is an incredibly difficult time for any family. The team in the hospital mortuary provide a valuable but often unsung service in helping families through that time. They provide a service where families can come in and see their loved ones and help provide support to them. However, the team wanted to improve the facilities for families and relatives so that the environment is as welcoming and friendly as it possibly can be.

The team made a case to the charity to improve the viewing room and facilities in the mortuary and also to create a private garden of remembrance. The idea is that families can have some quiet time, away from the hustle and bustle of the hospital grounds. £34,288 was provided to fund these developments and the new area provides a fantastic facility for families to have some quiet, reflective time together. It also created two dedicated parking spaces for families using the facilities.

"The support from the charity means that we can now provide a much better environment and quiet space with increased privacy," says **Jeff Green**, pathology manager at the hospitals, "The garden has created a tranquil area that provides families and relatives with somewhere they can sit and reflect. That is so important at such a difficult time."

Creating a multi-disciplinary dementia team – Supporting the best care for dementia patients in our Forget Me Not unit

Warrington and Halton Hospitals is proud to have created one of the finest hospital based dementia wards in the NHS with its Forget Me Not unit. As part of the trust's work around providing the very best in dementia care, the elderly care team approached the charitable fund to support a pilot project around staffing a multi-disciplinary dementia care team for six months.

The team consists of specialist nurse, physiotherapist, occupational therapy support and consultant time. They work together to provide the best in dementia care to patients. The fund supported with £90,065 to fund a six month pilot of the new team approach. It has led to a range of patient benefits that have delivered shortened length of stay for dementia patients and integrated care around their needs.

"We've piloted a new approach to dementia care in the Forget Me Not unit that is supporting this group of patients in new ways," says **Dr Graham Barton**, lead elderly care consultant at the hospitals, "We wouldn't have been able to do this without the support of the charity. We've been able to prove the patient benefits so that it is something that will hopefully become routinely funded in the future."

Future plans

The Corporate Trustee does not expect significant changes in the objectives of the Charity in the forthcoming year and is committed to utilising funds to ensure that funds expended are directed to patient benefit as soon as is practicable. During the period under review the Charitable Funds Committee sought spending plans from holders of both restricted and designated income funds with the intention of significantly reducing reserves where suitable projects or programmes can be identified.

At the date of compilation of the financial statements, the following schemes, each involving commitments in excess of £1,000, have been approved.

• A mobile cardiac monitoring unit to monitor the heart rates of patients undergoing physical activity.	£27,103
• 12 Electric recliner chairs that help patients with mobility problems to spend less time in an armchair.	£17,554
• 2 C-Mac video laryngoscope systems which help to enhance laryngeal view in patients with difficult airways.	£17,000
• Improvements across all sites for the comfort of patients and their families.	£10,181
• 47 over bed tables for patient use.	£8,993
• 2 Phototherapy units for the early detection and treatment of jaundice in babies.	£8,029
• Bed side chairs for patients and their families.	£7,107
• Training equipment for theatre staff. To improve quality and overall patient experience.	£6,756
• 2 Infusion pumps to help drug administration.	£6,742
• Gym equipment for the physiotherapy team to enable quicker and better quality recovery for patients.	£5,995
• Licences for all sites to broadcast music to	£5,861
• Wheelchairs.	£5,621
• The creation of a new room for Amputees to make their stay more comfortable.	£5,175
• Phototherapy units and high chairs for the Children's Unit.	£4,410
• Improvements to the quiet room in the Macmillan Delamere Centre.	£2,189
• 6 Tabs falls alarms for vulnerable patients.	£2,126
• Providing patient information across Warrington and Halton.	£2,000
• Potting shed and items for activities for patients.	£1,560

Statement on future strategy

Our strategy for 2015-2016 builds on our work in 2014-2015 and has seen the charity brand begin to be established in a more high profile way with the distribution of collection tins, a strengthened community profile, professional database management, donation tracking and administration functions – along with increased support for teams fundraising.

Our aim now is to increase the amount of active fundraising and thus income to the fund in the future. It is an exciting time for the charity and one where there is a strong belief that foundations have been laid that can be built on over the next 12 months and beyond.

Our outline strategy for 2015-2016 sets the following objectives, with the ultimate objective of significantly increasing income to the charity from community sources:

- Raise the profile of the Warrington and Halton Hospitals' Charity across the local community and across the hospitals' internal communities;
- Be clearer about why the trust is fundraising, and more transparent about how donations are invested for the benefit of patients (including the difference Gift Aid makes);
- Engage supporters and local communities in ways they can fundraise or volunteer for the charity, with an emphasis on fundraising activities which do not require extensive management or investment by the trust;
- Build long-term relationships with supporters through effective donor communications and stewardship;
- Internally, engage all wards and departments in thinking of their area as being part of one charity, with fundraising benefitting all areas equally.

In order to meet the above objectives, priority areas have been identified and were agreed by the Charitable Funds Committee in July 2014.

This outline strategy does consider the current resources of the Charity, in order to set realistic and achievable delivery aims, and as such focuses on a smaller number of areas to make a bigger impact.

Our priority areas are:

1. **Launch of giving campaigns to ask people to fundraise for clearly identified projects**. Projects have been selected to move us towards the aim of identifying clear fundraising campaigns for periods of the year with clear outcomes that allow us to create a strong call for support, and a single focus for community and corporate fundraising across all charity and trust communications.

2015/2016 will see two campaigns: -

- **Making Waves: -** Children's ward outdoor play area. This twelve month campaign will work towards fundraising to provide a new Outdoor play area for the Children's Ward, and will be launched early 2016 to corporates and the public – hopefully linking with one of our local media outlets - we are undertaking external funding bids for elements of the campaign - seeking around £80k in total (dependent on any of the external bids contributing to the fund).

- **Dig Deep for Dementia**: – 2nd phase dementia garden. We have commissioned designs for phase two of the dementia garden – design ideas are currently with the Forget Me Not unit team for discussion.

2. **Increase of 'In Memory' thank you fundraising promotion, and the promotion of Tribute Funds**

The charity already attracts a good level of "In Memory" fundraising with the majority of Just Giving pages being set up in memory of a person who had received care by the trust. However, the charity currently misses an opportunity to increase income to this area, and particularly through utilising the Just Giving in Memory function which enables donors to set up a specific page about their loved one and ask their friends and family to donate. Research into alternative tribute pages is currently underway, bringing a variety of ways in which to engage the in this area.

3. **Increase recognition of our charity 'tree' logo**

We have introduced a number of highly visible charity awareness tools throughout the trust; from our six foot Charity logo - that greets every member of staff and visitor walking through our doors at the Warrington site to providing fundraising information boards throughout the Trust. The charity's internal awareness is definitely growing.

The charity team have also been busy building external awareness by organising community events, recruiting new support for our collection tins and our social media sites have become a lot more active, reaching a variety of supporters.

The creation of a fundraising brochure is currently underway and will be available to all in early spring 2016.

4. Charity volunteer recruitment

One key element as our work grows is to focus on the recruitment of volunteers to assist with events and community growth. The plan is to create a 'volunteers journey' which is to include promotion/recruitment & nurturing of all internal & external volunteers, helping to secure long term support.

Developing the charity function in the trust

During 15/16 the charity has employed, on a fixed term basis, a Charity Fundraising Manager, Helen Higginson.

Helen brings with her many years of fundraising experience and has the commitment to drive the WHH Charity fundraising efforts, establishing a good strategy with a strong forward thinking vision, paramount to our success.

Helen would welcome your fundraising thoughts and ideas so please do not hesitate to make contact at helen.higginson@whh.nhs.uk or call 01925 662666.

Acknowledgement

The Corporate Trustee would like to extend its sincere thanks on behalf of the patients and staff who have felt the impact of this year's donations and legacies, received in person at our Cash Offices, by post or through the Just Giving website. Many of our donors have contributed in times of personal difficulty.

Gratitude is also extended to the Leagues of Friends at the Trust's Warrington and Halton sites. These independent charities operate alongside the Charity, sharing similar objectives, and the Charity occasionally co-purchases items with them.

The Corporate Trustee would also like to acknowledge the increasing fundraising activities of our donors, who have been holding events and undertaking a variety of sponsored feats to generate awareness and funds for the Charity. Their contributions, imagination and enthusiasm are greatly appreciated.

Information regarding the independently examined accounts can be obtained from the Finance Department on 01925 662835.

Approved on behalf of the Corporate Trustee.

PAT MCLAREN ……. Date: 27th January 2016
Director of Community Engagement

Statement of Trustee's responsibilities

The law applicable to charities in England and Wales requires the Trustee to prepare financial statements for each financial year which give a true and fair view of the Charity's financial activities during the year, and of its financial position at the end of the year. In preparing financial statements that give a true and fair view, the Trustee should follow best practice and:

- select suitable accounting policies and then apply them consistently;
- make judgements and estimates that are reasonable and prudent;
- state whether applicable accounting standards and statements of recommended practice have been followed, subject to any departures disclosed and explained in the financial statements;
- prepare the financial statements on the *going concern* basis unless it is inappropriate to presume that the Charity will continue in operation;
- keep proper accounting records, which disclose with reasonable accuracy at any time the financial position of the Charity, and which enables the Trustee to ensure that the financial statements comply with the requirements in the Charities Act 2011, the Charity (Accounts and Reports) Regulations and the provisions of the trust deed; and
- Safeguard the assets of the Charity, therefore taking reasonable steps in the prevention and detection of fraud and other irregularities.

The Corporate Trustee confirms that it has met the responsibilities set out above and complied with the requirements for preparing the accounts. The financial statements set out on pages 19 to 27 attached have been compiled from, and are in accordance with, the financial records maintained by the Corporate Trustee.

Approved by the Corporate Trustee on 27th January 2016 and signed on its behalf by:

STEVE MCGUIRK ……..
Chairman

MARK BREARLEY …….
Interim Director of Finance & Commercial Development

INDEPENDENT EXAMINER'S REPORT TO THE TRUSTEE OF WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST CHARITABLE FUND

I report on the accounts for the year ended 31 March 2015 set out on pages 19 to 27.

Respective responsibilities of trustee and examiner
The charity's trustee is responsible for the preparation of the accounts. The charity's trustee considers that an audit is not required for this year (under Section 144(2) of the Charities Act 2011 (the 2011 Act)) and that an independent examination is needed.

It is my responsibility to:

- examine the accounts under Section 145 of the 2011 Act;
- follow the procedures laid down in the General Directions given by the Charity Commission (under Section 145(5) (b) of the 2011 Act); and
- state whether particular matters have come to my attention.

Basis of the independent examiner's report
My examination was carried out in accordance with the General Directions given by the Charity Commission. An examination includes a review of the accounting records kept by the charity and a comparison of the accounts presented with those records. It also includes consideration of any unusual items or disclosures in the accounts, and seeking explanations from you as trustee concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit, and consequently no opinion is given as to whether the accounts present a 'true and fair view' and the report is limited to those matters set out in the statements below.

Independent examiner's statement
In connection with my examination, no matter has come to my attention:

(1) Which gives me reasonable cause to believe that, in any material respect, the requirements
- to keep accounting records in accordance with Section 130 of the 2011 Act; and
- to prepare accounts which accord with the accounting records and to comply with the accounting requirements of the 2011 Act have not been met; or

(2) to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

Philip Urmston BSc FCA.
Voisey & Co
Chartered Accountants
8 Winmarleigh Street
Warrington
Cheshire
WA1 1JW

28th January 2016

Statement of Financial Activities

	Note	Unrestricted Funds	Restricted Funds	Endowment Funds	2014/15 £'000 Total Funds	2013/14 £'000 Prior Year Total Funds
Incoming resources						
Incoming resources from generated funds						
Voluntary income	2	102	382	0	**484**	285
Activities for generating funds		2	0	0	**2**	6
Investment income	3	1	1	0	**2**	1
Total incoming resources		105	383	0	**488**	292
Resources expended						
Costs of generating funds						
Fundraising: costs of goods sold and other costs		2	0	0	**2**	6
Charitable activities	4	335	136	0	**471**	258
Governance costs	6	12	5	0	**17**	15
Transfers		0	0	0	**0**	31
Total resources expended		349	141	0	**490**	310
Net outgoing resources before transfers		(244)	242	0	(2)	(18)
Gross transfers between funds		(46)	46	0	0	0
Net movement in funds		(290)	288	0	**(2)**	(18)
Reconciliation of funds						
Total funds brought forward		491	141	0	632	650
Total funds carried forward		**201**	**429**	**0**	**630**	**632**

Balance Sheet as at 31st March 2015

	Note	2014/15 £'000	2013/14 £'000
Fixed assets		0	0
Current assets			
Cash at bank and in hand	7	723	667
Debtors	8	53	9
Total current assets		776	676
Current liabilities			
Creditors: amounts falling due within one year	9	146	44
Net current assets		630	632
Total assets less current liabilities		630	632
Net assets		**630**	**632**
The funds of the Charity:			
Restricted income funds	13	429	141
Unrestricted income funds	13	201	491
Total Charity funds		**630**	**632**

The notes on pages 21 to 27 form part of these accounts.

Signed:

Chairman……Date 27th January 2016

Interim Director of Finance
and Commercial Development……Date 27th January 2016

Notes to the accounts

Note 1 Accounting policies

1.1 The financial statements have been prepared under the historical cost convention and in accordance with Accounting and Reporting by Charities: Statement of Recommended Practice (SORP 2005) issued in March 2005, applicable UK Accounting Standards and the Charities Act 2011.

1.2 Funds structure

Restricted funds are to be used in accordance with the specific restrictions imposed by the donor. The Charity held 7 restricted funds at the end of the year under review.

The Charity did not hold any endowments, expendable or otherwise, during the year under review.

Unrestricted funds comprise those funds which the Corporate Trustee is free to use for any purpose in furtherance of the Charity's charitable objects. The Charity has a single unrestricted general fund containing several designated funds. These unrestricted designated funds are created to honour donors' expressions, or are created by the Trustee, at its discretion, to designate monies for specific future purposes. Any funds held within a designated fund can be merged or transferred within the general fund at any time, at the discretion of the Trustee, in accordance with the Health Service Act 1977 and the Charity's dormant funds policy.

1.3 Incoming resources

All incoming resources are recognised once the Charity has entitlement to the resources, it is certain that the resources will be received, and the monetary value of incoming resources can be measured with sufficient reliability.

There were no *gifts in kind* or *intangible income* in the year under review.

1.4 Incoming resources from legacies

Legacies are accounted for as incoming resources either upon receipt, or where the receipt of the legacy is virtually certain. This would require that confirmation has been received from the representatives of the estate(s) that payment of the legacy will be made or property transferred, and that all of the conditions attached to the legacy have been fulfilled.

Material legacies which have been notified, but not recognised as incoming resources in the Statement of Financial Activities, are disclosed in Note 12 to the accounts, with an estimate of the amount receivable.

1.5 Resources expended

All expenditure is accounted for on an accruals basis, and has been classified under the headings that aggregate all costs related to that category. All expenditure is recognised once there is a legal or constructive obligation committing the Charity to the expenditure.

The Charity does not make grants to third parties.

Contractual arrangements are recognised as goods or services are supplied.

1.6 Costs of generating funds

These are costs associated with generating incoming resources, and are recognised as per the Charity's other expenditure.

1.7 Charitable activities

The costs of charitable activities include all costs incurred in the pursuit of the charitable objects of the Charity. These costs comprise the direct costs of charitable purchases, and overhead and support costs as shown in Note 4.

1.8 Governance costs

Governance costs comprise all costs incurred in the governance of the Charity. These costs include fees pertaining to the provision of governance and financial papers to the Charitable Funds Committee, the creation of this Annual Report and Accounts, the audit or independent examination of the accounts, and any associated support costs.

1.9 Fixed asset investments

There were no fixed asset investments as at the Balance Sheet date.

1.10 Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise.

Note 2. Analysis of voluntary income

	Unrestricted Funds £'000	Restricted Funds £'000	**2014/15 Funds £'000**	2013/14 Funds £'000
Donations	50	29	**79**	193
Legacies	52	353	**405**	92
Total	102	382	**484**	285

Note 3. Analysis of investment income

	Unrestricted Funds £'000	Restricted Funds £'000	**2014/15 Funds £'000**	2013/14 Funds £'000
Bank interest	1	1	**2**	1
Total	1	1	**2**	1

Note 4. Analysis of charitable activities

	Unrestricted Funds £'000	Restricted Funds £'000	**2014/15 Funds £'000**	2013/14 Funds £'000
Patient welfare	149	81	**230**	69
Staff enablement	10	0	**10**	34
Medical equipment	125	40	**165**	95
Support costs and overheads	51	15	**66**	60
Total	335	136	**471**	258

Support costs and overheads comprises an apportionment from the Trust's administration charge (Note 5) of £16,000 (2013/14: £18,085); it also includes licences and fees paid to third parties. During the year the Charity employed the services of Plum Marketing to assist in the development and implementation of the Charity's future strategy at a cost of £38,000 (2013/14 £38,000). This fee is included within support costs and overheads.

Note 5. Allocation of administration charge

During the year under review the Charity employed one part-time member of staff to assist with fundraising and the general administration of the charity. An administration charge was also raised to cover the governance, financial and procurement resources of Warrington and Halton Hospitals NHS Foundation Trust. The charge for the year ended 31 March 2015 was £32,000 (2013/14:£32,000).

The costs of administering the Charity have then been split between governance costs (Note 6) and support costs and overheads (Note 4). The element of the administration charge that is attributed to governance costs pertains to the costs associated with the preparation of Committee papers and this Annual Report and Accounts.

During the year under review the Corporate Trustee considered the charity's policy on the allocation of overheads in conjunction with guidance as issued by the Charities Commission. As at 31st March 2015 all shared costs for administration and governance costs but excluding consultancy fees have been apportioned across all funds using a combination of transactional and average balance techniques. Overheads will continue to be apportioned on an annual basis. In the event that a restriction does not permit the allocation of overheads the costs will be met by way of a transfer from the unrestricted funds held by the charity.

Note 6. Governance costs, including costs of independent examination and audit

	Unrestricted Funds £'000	Restricted Funds £'000	**2014/15 Funds £'000**	2013/14 Funds £'000
Independent examination/audit fees	0.5	0.8	**1.3**	1
Administration charge	11.2	4.8	**16**	14
	11.7	5.6	**17.3**	15

Independent examination / audit fees consists of an accrual for the independent examination fee of £1,320 (2013/14: £1,470) for the period of this review.

Note 7. Analysis of cash at bank and in hand

	2014/15 £'000	2013/14 £'000
Bank current account	**723**	667
Total	**723**	667

Note 8. Analysis of debtors

	2014/15 £'000	2013/14 £'000
Prepayments and accrued income	**53**	1
Other debtors	**0**	8
Total	**53**	9

Other debtors represent the balance owed to the Charity by Warrington and Halton Hospitals NHS Foundation Trust. This is because of income received by the Trust on behalf of the Charity at the end of the financial year.

Note 9. Analysis of current liabilities and long term creditors

	2014/15 £'000	2013/14 £'000
Accruals and purchases made on behalf of the Charity	**146**	44
Total	**146**	44

Note 10. Related party transactions

The Charity is a subsidiary of the Trust and is therefore a related party. Warrington and Halton Hospitals NHS Foundation Trust is the sole beneficiary of the Charity. The Charity provides funding to the Trust for approved expenditure made on behalf of the Charity. During the year the Charity made payments to Warrington and Halton Hospitals NHS Foundation Trust totalling £381,266 (2013/14: £245,023) for purchases made by the Trust on behalf of the Charity. At 31st March 2015 the Charity owed Warrington and Halton Hospitals NHS Foundation Trust £127,257 (2013/14:£15,739) for purchases made on behalf of the Charity. The balance was settled after the Balance Sheet date by way of a payment from the Charity to the Trust for its charitable purchases.

At 31st March 2015, Warrington and Halton Hospitals NHS Foundation Trust owed the Charity £nil (2013/14:£7,722) for income due to the Charity which had been paid into the Trust's bank account in the first instance, and which were held there at the Balance Sheet date.

All transactions entered into during the year were conducted on an arm's length basis.

During the year, none of the members of the Trust Board or senior Trust staff, or parties related to them, were beneficiaries of the Charity. Neither the Corporate Trustee nor any member of the Trust Board has received honoraria, emoluments or expenses in the year. The Corporate Trustee has not used the funds of the Charity to purchase trustee indemnity insurance.

Board members, and other senior staff, take decisions on both Charity and exchequer matters, but endeavour to keep the interests of each discrete, and do not seek to benefit personally from such decisions. Declarations of personal interest have been made in both capacities and are available to be inspected by the public in the Corporate Information section of the Trust's website.

From 1st April 2013 NHS charitable funds considered to be subsidiaries are to be consolidated within the Trust accounts in accordance with an accounting direction issued by Monitor. For 2014/15 the Trust has opted not to consolidate charitable funds with the main Trust Accounts because they are immaterial. This will continue to be reviewed each year for appropriateness.

Note 11. Post Balance Sheet events

There have been no events since the Balance Sheet date that would indicate that any revision to the accounts is necessary.

Note 12. Legacies

During the period following the Balance Sheet date, the Charity was advised of future legacy income of £46,821.75 (2013/14:£230,308) all of which had been received by the date of compilation of this Annual Report and Accounts.

Note 13. Fund structure and summary of movements

Charitable funds

The Charity has 8 funds. These are the (unrestricted) General Fund, and 7 Restricted Funds. The restriction has arisen due to the legacy donor's stipulation that the monies be spent within a particular Department.

During the year under review the intensive care fund received legacy income for which a restriction was applied. This resulted in a transfer between restricted funds and unrestricted designated funds. The transfer between unrestricted funds and unrestricted designated funds represents additional monies to those originally set aside to pay for the Charity's re-launch in 2013/14. The Charity Development Fund was closed as at 31st March 2015.

It is anticipated that any future transfers between funds will be as a result of the Committee's on-going review of spending plans and reassignment of funds within the general unrestricted fund.

A summary of fund movements is given below.

Fund	Balance as at 1st April 2014	Outgoing resources	Incoming resources	Transfers	Balance as at 31st March 2015
	£	£	£	£	£
General Unrestricted	490,903	(348,617)	104,496	(45,834)	200,948
Ophthalmology	30,925	(26,457)	1,112		5,580
Cancer Patient Support	20,748	(27,355)	20,545		13,938
Heart Unit	37,512	(1,744)	11,604		47,372
Stroke Unit	52,255	(34,389)	1,752		19,618
Breast Screening	0	(918)	35,378		34,460
Halton Hospital Legacy	0	(7,452)	132,625		125,173
Intensive Care	0	(43,322)	180,392	45,834	182,904
Total Funds	**632,343**	**(490,254)**	**487,904**	**-**	**629,993**

Unrestricted general fund: sub-fund balances

A summary of the sub-funds held within the unrestricted general fund is given overleaf.

Fund	Balance as at 1st April 2014	Outgoing resources	Incoming resources	Transfers	Balance as at 31st March 2015
	£	£	£	£	£
General Unrestricted	389,877	(308,082)	55,766	(19,201)	118,360
Charity Development	18,099	(37,300)	-	19,201	-
Children's Unit Appeal	8,547	(2,221)	3,644	-	9,970
Heartbeat Halton Appeal	2,392	(393)	319	-	2,318
Intensive Care	45,834	-	-	(45,834)	-
Neonatal	20,613	(562)	43,515	-	63,566
Ophthalmology Appeal	5,541	(59)	1,252	-	6,734
Unrestricted Fund Total	**490,903**	**(348,617)**	**104,496**	**(45,834)**	**200,948**