# Warrington and Halton Hospital NHS Foundation Trust
## Board of Directors
## Agenda

Wednesday 25th March 2015, time 1300 – 1630 hrs
Trust Conference Room, Warrington Hospital

| | | | | |
|---|---|---|---|---|
| ***1300*** ***15mins*** | ***W&HHFT/TB/15/046*** | ***Welcome, Apologies & Declarations of Interest*** | | Chairman |
| | ***W&HHFT/TB/15/047*** | ***Minutes of the previous meeting held on 25th February 2015*** | Paper | |
| | ***W&HHFT/TB/15/048*** | ***Action Plan*** | Paper | |
| ***1310*** ***10mins*** | ***W&HHFT/TB/15/049*** | ***Chairman's Report*** | Verbal | Chairman |
| ***1320*** ***20mins*** | ***W&HHFT/TB/15/050*** | ***Chief Executives Report*** | Verbal | Chief Executive |
| Sustainability | | | | |
| ***1340*** ***10mins*** | ***W&HHFT/TB/15/051*** | ***Verbal Report from the Chair of the Finance and Sustainability Committee*** | Verbal | Terry Atherton, Non-Executive Director |
| ***1350*** ***20mins*** | ***W&HHFT/TB/15/052*** | ***Finance Report – 28th February 2015*** | Paper | Director of Finance & Corporate Development |
| ***1410*** ***20mins*** | ***W&HHFT/TB/15/053*** | ***Corporate Performance Report – 28th February 2015*** | Paper | Chief Operating Officer |
| Quality | | | | |
| ***1430*** ***10mins*** | ***W&HHFT/TB/15/054*** | ***Verbal Report from the Chair of the Quality Governance Committee*** | Verbal | Mike Lynch, Non-Executive Director |
| ***1440*** ***20mins*** | ***W&HHFT/TB/15/055*** | ***Quality Dashboard – 31st January 2015*** | Paper | Director of Nursing and Governance |
| ***1500*** ***10mins*** | ***Break*** | | | |
| ***1510*** ***15mins*** | ***W&HHFT/TB/15/056*** | ***Complaints – Attitude*** | Paper | Director of Nursing and Governance |
| ***1525*** ***15mins*** | ***W&HHFT/TB/15/057*** | ***Morecombe Bay high level action Plan*** | Paper | Director of Nursing and Governance |
| | ***W&HHFT/TB/15/058*** | ***CQC Fundamental Standards – briefing note*** | Paper | Director of Nursing and Governance |
| People | | | | |
| ***1540*** ***10mins*** | ***W&HHFT/TB/15/059*** | ***Verbal Report from the Chair of the Strategic People Committee***<br><br>***a) Strategic People Committee Terms of Reference Review and membership.*** | Verbal | Anita Wainwright, Non-Executive Director |
| ***1550*** ***15mins*** | ***W&HHFT/TB/15/060*** | ***Workforce and Educational Development Key Performance Indicators*** | Paper | Director of HR & OD |

**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.**

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|---|---|---|---|---|
| ***1605*** ***10mins*** | ***W&HHFT/TB/15/061*** | ***Freedom to Speak Up – Francis Recommendations*** | Paper | Director of HR & OD |
| ***1615*** ***10mins*** | ***W&HHFT/TB/15/062*** | ***Ward Staffing Levels*** | Paper | Director of Nursing and Governance |
| | | | | |
| ***1625*** ***5mins*** | ***W&HHFT/TB/15/063*** | ***Other Board Committee Reports:***<br><br>***Minutes for Noting:***<br>***a) Minutes of the Strategic People Committee 8 December 2014***<br>***b) Minutes of the Quality Governance Committee 13th January 2015***<br>***c) Finance and Sustainability Committee held on 17th February 2015*** | Paper | |
| | ***W&HHFT/TB/15/064*** | ***Any Other Business*** | | |
| ***1630*** ***ends*** | | ***Dates of next meeting***<br>*29th April 2015* | | |

***W&HHFT/TB/15/048***

**TRUST BOARD**
**ACTION PLAN – Current / Outstanding Actions**
**Meeting**: Trust Board 26th March 2015

| Meeting date | Minute Reference | Action | Responsibility & Target Dates | Status | |
|---|---|---|---|---|---|
| 28/01/2015 | TB/15/008 | The Director of Nursing and Governance review the reporting of heart failure on the dashboard to see if there was a more appropriate way of showing the position. Any changes would be included in the Quality Dashboards for 2015/16. | The Director of Nursing and Governance<br><br>April 2015 | Currently under review | Action ongoing |
| 28/01/2015 | TB/15/010 | The Director of Nursing and Governance include in the next Complaints report any high level trends or themes that may exist with regard to the complaints made against staff attitude. | The Director of Nursing and Governance<br><br>April 2015 | See agenda item W&HHFT/TB/15/056 | Action Complete |
| 28/01/2015 | TB/15/011 | The Director of Nursing and Governance provide an update on progress on End of Life Care at the June or July 2015 Board meeting | The Director of Nursing and Governance - June/July 2015 | Identified on the Board work plan – anticipated date September/October 2015 | Action ongoing |
| 25/02/2015 | TB/15/034 | The Interim Director of Human Resources and Organisational Development to present to the March Board the Francis Recommendations regarding the Freedom to Speak up Review and what the Trust was doing to address the recommendations. | Interim Director of Human Resources and Organisational Development March 2015 | See agenda item W&HHFT/TB/15/061 | Action Complete |

| | | | | | |
|---|---|---|---|---|---|
| 25/02/2015 | TB/15/038 | The Director of Nursing and Governance to provide in future staffing level reports a narrative so that the Board can be assured that the correct staffing levels were in place across the Trust's clinical areas. | The Director of Nursing and Governance – March 2015 | See agenda item W&HHFT/TB/15/062 | Action Complete |
| 25/02/2015 | TB/15/044 | Trust Secretary to distribute briefing note to the Board on the observations from the CQC inspection. | Trust Secretary | Briefing note attached hereto | Action Complete |

## BOARD OF DIRECTORS

WHH/B/2015/ **049**

| | |
|---|---|
| **SUBJECT:** | **Chairman's Report** |
| **DATE OF MEETING:** | 25th March 2015 |
| **DIRECTOR:** | Chairman |

## BOARD OF DIRECTORS

WHH/B/2015/ **050**

| | |
|---|---|
| **SUBJECT:** | **Chief Executive Report** |
| **DATE OF MEETING:** | 25th March 2015 |
| **EXECUTIVE DIRECTOR:** | Chief Executive |

# BOARD OF DIRECTORS

WHH/B/2015/ **051**

| | |
|---|---|
| **SUBJECT:** | **Verbal Report from the Chair of the Finance and Sustainability Committee** |
| **DATE OF MEETING:** | 25th March 2015 |
| **DIRECTOR:** | Terry Atherton, Non-Executive Director |

# BOARD OF DIRECTORS

WHH/B/2015/ **052**

| | | |
|---|---|---|
| **SUBJECT:** | **Finance Report as at 28th February 2015** | |
| **DATE OF MEETING:** | 25th March 2015 | |
| **ACTION REQUIRED** | **For Decision** | |
| **AUTHOR(S):** | Steve Barrow, Deputy Director of Finance | |
| **EXECUTIVE DIRECTOR:** | Tim Barlow, Director of Finance and Commercial Development | |
| | | |
| **LINK TO STRATEGIC OBJECTIVES:** | SO1: Ensure all our patients are safe in our care<br>SO2: To be the employer of choice for healthcare we deliver<br>SO3: To give our patients the best possible experience | |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | SO4/4.2 Failure to: Maintain a liquidity ratio and capital servicing capacity necessary to deliver a continuity of services risk rating of at least 3 on a quarterly basis; remain a going concern at all times remain solvent; and Comply with section G6 of th<br><br>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<br>SO4/4.3 Failure to manage key contracts appropriately resulting in contract penalties or reduction in service standards; and failure of operational processes to deliver service to agreed contract targets, outputs or standard | |
| | | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | |
| **FOIA EXEMPTIONS APPLIED:** | None | |
| | | |
| **EXECUTIVE SUMMARY** (KEY ISSUES): | For the period ending 28th February 2015 the Trust has recorded an actual deficit of £6,724k and a Continuity of Services Risk Rating 2. The cash balance stands at £7,499k. | |
| **RECOMMENDATION:** | ***The Board is asked to: note the contents of the report.*** | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Finance and Sustainability Committee |
| | **Agenda Ref.** | |
| | **Date of meeting** | 17th March 2015 |
| | **Summary of Outcome** | Approved |

**FINANCE REPORT AS AT 28th FEBRUARY 2015**

## 1. PURPOSE

The purpose of the report is to advise the Board of Directors on the financial position of the Trust as at 28th February 2015 and the forecast outturn as at 31st March 2015.

## 2. EXECUTIVE SUMMARY

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

The original 14/15 plan approved by the Board and submitted to Monitor was based on an in year deficit of £1.5m. Monitor required the Trust to produce a reforecast that was completed and approved by the Board in December that revised the deficit to £5.9m. The year to date performance is based on the original plan and the performance against the reforecast is in Section 8.

**Key financial indicators**

| Indicator | Monthly Plan £m | Monthly Actual £m | Monthly Variance £m | YTD Plan £m | YTD Actual £m | YTD Variance £m |
|---|---|---|---|---|---|---|
| Operating income | 17.7 | 18.3 | 0.7 | 195.4 | 197.4 | 2.0 |
| Operating expenses | (16.9) | (18.2) | (1.4) | (188.1) | (194.9) | (6.8) |
| EBITDA | 0.8 | 0.1 | (0.7) | 7.3 | 2.5 | (4.8) |
| Non-operating income and expenses | (0.9) | (0.9) | 0.0 | (9.4) | (9.3) | 0.1 |
| I&E surplus / (deficit) | (0.1) | (0.9) | (0.8) | (2.1) | (6.7) | (4.6) |
| Cash balance | - | - | - | 8.0 | 7.5 | (0.5) |
| CIP target | 1.9 | 0.8 | (1.1) | 9.5 | 6.1 | (3.4) |
| Capital Expenditure | 1.0 | 0.8 | 0.2 | 8.5 | 4.7 | 3.8 |
| Continuity of Services Risk Rating | 3 | 2 | (1) | 3 | 2 | (1) |

## 3. INCOME AND EXPENSES

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

| Position = Surplus/(Deficit) | February £000 | Year to date £000 |
|---|---|---|
| Plan | (91) | (2,125) |
| Actual | (856) | (6,724) |
| **Variance** | **(765)** | **(4,599)** |

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

| Variance = Favourable/(Adverse) | February £000 | Year to date £000 |
|---|---|---|
| Operating income | 652 | 2,030 |
| Operating expenses | (1,359) | (6,746) |
| Non-operating income and expenses | (58) | 117 |
| **Total** | **(765)** | **(4,599)** |

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

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

**Operating Income**

Year to date operating income is £2,030k above plan due to an over recovery on other operating income (£2,978k) partially offset by an under recovery on NHS clinical income (£941k) and non NHS clinical income (£7k).

**Operating Expenses**

Year to date operating expenses are £6,746k above plan due to over spends on pay (£5,663k), clinical supplies (£1,139k) and non clinical supplies (£538k), partially offset by under spends on drugs (£593k).

**Non Operating Income and Expenses**

Non operating income and expenses is £117k below plan mainly due the underspend against depreciation resulting from the slippage in the capital programme.

## 4. COST IMPROVEMENT PROGRAMME

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

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

For the period to date the planned savings for the identified schemes equate to £9,413k, with actual savings amounting to £6,101k which results in an under achievement of £3,312k. An assessment of the full year forecast has been undertaken and based on the estimated savings the in year and recurrent shortfall is shown in the table below:

| **Narrative** | **In Year £000** | **Recurrent £000** |
|---|---|---|
| Annual Target | 11,931 | 11,931 |
| Forecast Outturn | 7,360 | 9,593 |
| **Over / (Under) Achievement against target** | **(4,571)** | **(2,338)** |

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

**5. CASH FLOW**

The cash balance is £7,499k which is £494k below the planned cash balance of £7,993k, with the monthly movements summarised in the table below.

| **Cash balance movement** | **£000** |
|---|---|
| Opening balance as at 1st February | 5,886 |
| In month deficit | (856) |
| Non cash flows in surplus/(deficit) | 915 |
| Decrease in receivables | 972 |
| Decrease in payables | (256) |
| Capital expenditure | (1,026) |
| Other working capital movements | 1,864 |
| **Closing balance as at 28th February** | **7,499** |

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

The current balance equates to circa 13 days operational cash, which is an improvement on the position reported last month. However the value of trade creditors as at 28th February stands at £7.0m, the majority of which are overdue. Under the continuity of services risk rating the liquidity metric is -11.1 days which results in a score of 2. The calculation of the metric includes all current assets and liabilities excluding inventories, so masks the challenging cash position which is managed through working balances.

The operating performance continues to have an adverse effect on the cash position and creditor payments. This operating position, coupled with the non payment to suppliers during the upgrade of the financial systems, resulted in performance against the non NHS Better Payment Practice Code (BPPC) of 22% in the month (40% year to date). This low level of compliance and performance will continue until there is an improvement in the operating position and the resultant cash position.

A continuation of the current operating performance will mean a severe reduction in the internally funded capital programme or a significant increase in creditors to avoid the Trust running out of money next financial year.

**6. STATEMENT OF FINANCIAL POSITION (APPENDIX F)**

Non current assets have increased by £531k in the month, as the capital spend exceeds the monthly depreciation charge.

Current assets have increased by £1,063k in the month mainly due to the increase in cash, partially offset by a decrease in receivables.

Current liabilities have increased by £2,272k in the month mainly due to the increase in deferred income, accruals and capital payables.

Non current liabilities have increased by £117k in the month.

**7. CAPITAL**

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

The approved programme for the year now stands at £10.3m and to date the Trust has spent £4.7m against the budget of £8.5m, which is mainly due to delays in the commencement of various schemes.

| **Category** | **Annual Budget £m** | **Budget to date £m** | **Actual to date £m** | **Variance to date £m** |
|---|---|---|---|---|
| Estates | 5.9 | 5.6 | 2.1 | 3.5 |
| IM&T | 2.7 | 1.9 | 2.0 | (0.1) |
| Medical Equipment | 1.3 | 0.8 | 0.6 | 0.2 |
| Contingency | 0.4 | 0.2 | 0.0 | 0.2 |
| **Total** | **10.3** | **8.5** | **4.7** | **3.8** |

**8. FORECAST OUTTURN**

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

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

| **Position = Surplus/(Deficit)** | **February £000** | **Year to date £000** |
|---|---|---|
| Plan | (403) | (6,302) |
| Actual | (856) | (6,724) |
| **Variance** | **(453)** | **(422)** |

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

| **Variance = Favourable/(Adverse)** | **February £000** | **Year to date £000** |
|---|---|---|
| Operating income | (364) | (185) |
| Operating expenses | 73 | 105 |
| Non-operating income and expenses | (162) | (342) |
| **Total** | **(453)** | **(422)** |

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

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

The Committee needs to be aware that Warrington CCG do not agree to the forecast activity value included in the Trust forecast outturn of £5.9m.

**10. SUMMARY**

For the period ending 28th February the Trust has recorded a deficit of £6,724k, which is £4,599k worse than the original planned deficit and £422k worse than the revised reforecast. There is limited time left in the financial year but even so it is important the trusts focuses on the financial risks to ensure the deficit is minimized as much as possible to achieve or better the £5.9m reforecast deficit, namely:

- Non compliance with contractual data requirements, quality standards, access targets and CQUIN targets resulting in commissioner levied fines or penalties.
- Failure to deliver the revised income target or remain with revised expenditure forecast.
- Identified cost savings target not fully identified and delivered in in accordance with profile.
- Increase in readmissions resulting in bed blockages and payment to commissioners for exceeding current agreed threshold.
- Failure to manage escalation or partner's inability to provide services to withdraw medically fit patients from the hospital.

- Failure to appropriately reduce bank, agency, locum, overtime and waiting list initiatives.
- Failure to increase clinical efficiency and productivity.

In addition, measures have been introduced that attempt to restrict the amount of money spent on temporary spend and discretionary non pay spend in the remainder of the financial year through tightened approval processes

The cumulative deficit includes the contractual fines or penalties associated with A&E breaches, Mixed Sex Accommodation breaches, MRSA occurrences, discharge summaries (24 hour target only), contract challenges for incomplete or invalid patient data and non achievement of CQUIN targets. The total included within the current deficit is a fine / penalty of £1,068k.

The current deficit does not however include contractual fines or penalties associated with all the potential discharge summaries (7 day target only) and activity query notices (spinal services).

**Tim Barlow**
**Director of Finance & Commercial Development**
**18th March 2015**

Warrington and Halton Hospitals NHS
NHS Foundation Trust

## Finance headlines as at 28th February 2015

| Key Financial Metrics | Month | | | Year to date | | | Forecast | | |
|---|---|---|---|---|---|---|---|---|---|
| | Budget £000 | Actual £000 | Variance £000 | Budget £000 | Actual £000 | Variance £000 | Budget £000 | Actual £000 | Variance £000 |
| Operating Income | 17,645 | 18,297 | 652 | 195,407 | 197,438 | 2,030 | 213,746 | 217,113 | 3,367 |
| Operating Expenditure | -16,880 | -18,239 | -1,359 | -188,119 | -194,866 | -6,746 | -204,977 | -213,282 | -8,305 |
| **EBITDA** | **765** | **58** | **-707** | **7,288** | **2,572** | **-4,716** | **8,769** | **3,831** | **-4,938** |
| Financing Costs | -856 | -914 | -58 | -9,413 | -9,296 | 117 | -10,269 | -9,706 | 563 |
| **Net Surplus / (Deficit)** | **-91** | **-856** | **-765** | **-2,125** | **-6,724** | **-4,599** | **-1,500** | **-5,875** | **-4,375** |
| Continuity of Services Risk Rating | 3 | 2 | -1 | 3 | 2 | -1 | 3 | 2 | -1 |
| Capital Expenditure | 1,000 | 800 | -200 | 8,500 | 4,700 | -3,800 | 10,272 | 7,161 | -3,111 |
| Cash Balance | | | | 7,993 | 7,499 | -494 | 6,731 | 3,102 | -3,629 |
| Cost Savings | 1,813 | 752 | -1,061 | 9,413 | 6,101 | -3,312 | 11,931 | 7,360 | -4,571 |

**Summary Position**

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

The reported position for the period is an actual deficit of £6,724k which is £4,599k worse than the planned deficit of £2,125k and an actual Continuity of Services Risk Rating 2 which is below the planned rating of 3. Year to date income is £2,030k above plan mainly due to overperformance on non elective activity, outpatients, training and education income and other operating income, although this is partially offset by underperformance on elective and other NHS activity. Year to date expenditure is £6,746k above plan due to overspends on pay, clinical supplies and non clinical supplies, althought this is partially offset by an underspend on drugs. Year to date non operating income and expenditure is £117k below plan due to an underspend on depreciation.

Cost savings performance is below plan by £3,312k, as schemes to achieve the annual target have not been identified and there has been slippage against a number of those identified schemes.

**Forecast Outturn**

The reforecast exercise completed in December revised the year end deficit of £5.9m, which represents a worsening of the forecast by £1.9m compared to the £4.0m previously reported and is £4.4m below the original planned deficit of £1.5m. This further deterioration results mainly reflected the operating performance in October and November together with a more robust forecast of the remaining months. This reforecast, together with a reduced capital spend to £7.2m, results in a Continuity of Services Risk Rating 2 and a reduced cash balance as at 31st March of £3.1m.

**Key Variances**

Operating Income - £2,030k above plan (favourable).
Operating Expenditure - £6,746k above plan (adverse).
Non operating income and expenses - £117k below plan (favourable).
Cost savings - £3,312k below plan (adverse)
Cash balances - £494k below plan (adverse).
Capital expenditue - £3,564k below plan due to slippage.

**Key Risks**

Divisions unable to deliver income targets based on agreed activity plans or deliver additional activity and income identified in the budget setting process.
Non compliance with contractual data requirements, quality standards, access targets and CQUIN targets resulting in commissioner levied fines and penalties.
Cost savings target not fully identified and delivered in accordance with profile.
Failure to significantly reduce bank, agency, locum, overtime and waiting list initiative expenditure.
The operating performance of the trust adversely affects the cash position and its ability to pay creditors on a timely basis and a continuation of the operating performance will result in the Trust running out of money.

**Other matters to be brought to the attention of the Board**

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

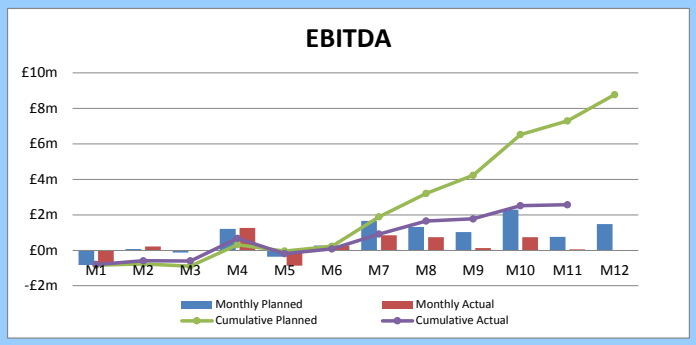
The trust is in discussions with CCGs and NHSE regarding financial responsibility for specialist spinal patients as both parties are unwilling to pay for activity undertaken to date.

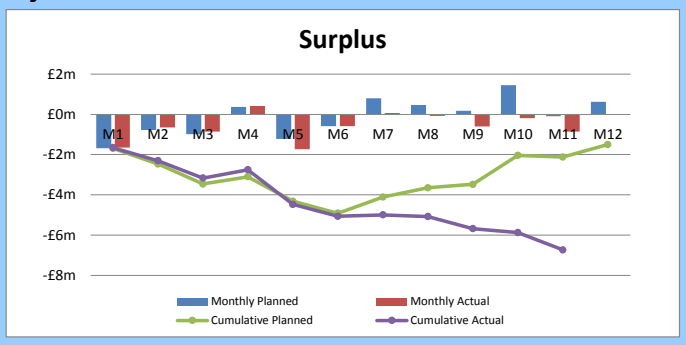
Monitor / NHSE have confirmed that trusts should receive funding equivalent to 14/15 winter monies funding.
Monitor have opened a formal investigation into Trust's compliance with licence due to deteriorating financial position.
15/16 contract discussions with commissioners continue but no contract values have yet been agreed.

# Warrington & Halton Hospitals NHS Foundation Trust

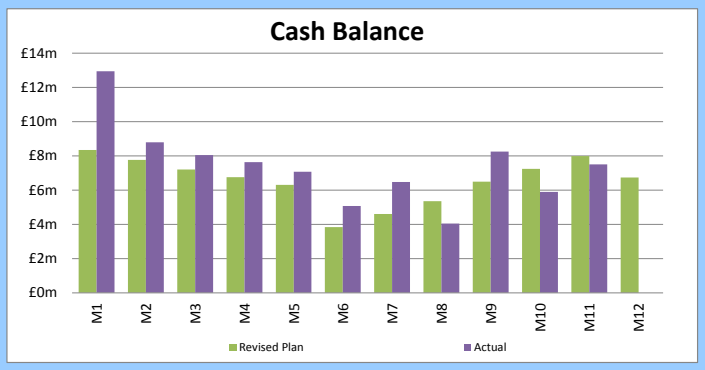
## Finance Dashboard as at 28th February 2015 (Part A)

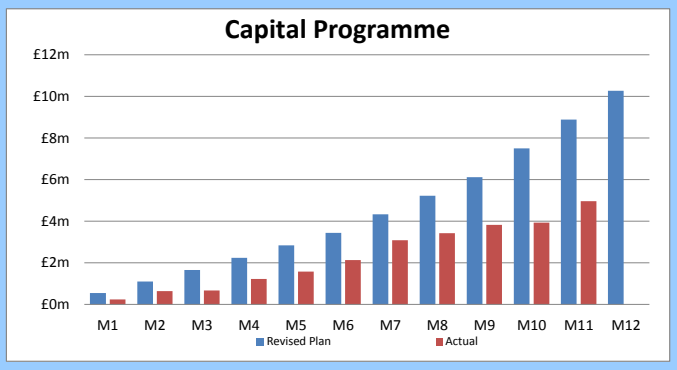
### Profitability



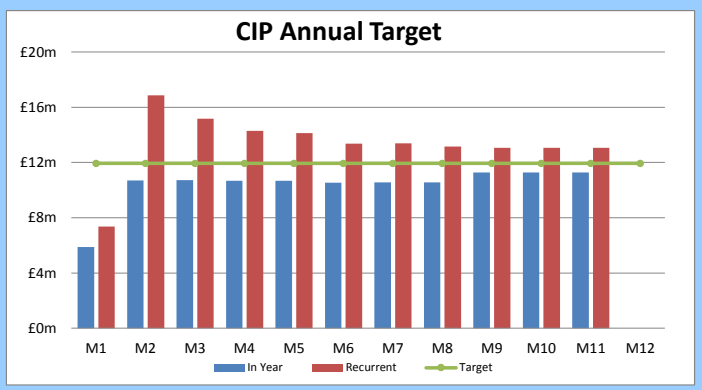



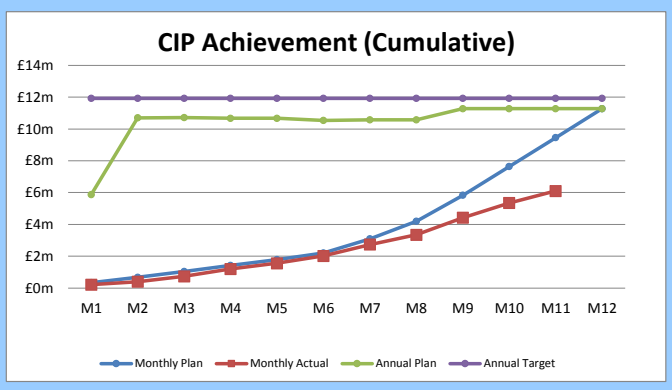

### Cash and Investment




### Cost Improvement Analysis




### Divisional Position (net divisional income and expenditure)

| Division | Annual Budget £000 | Budget in month £000 | Actual in month £000 | Variance in month £000 | Variance in month % | Budget to date £000 | Actual to date £000 | Variance to date £000 | Variance date % |
|---|---|---|---|---|---|---|---|---|---|
| **Clinical** | | | | | | | | | |
| Scheduled Care | 56,367 | 4,710 | 4,532 | 178 | 3.8 | 51,772 | 52,008 | -236 | -0.5 |
| Unscheduled Care | 44,292 | 3,813 | 3,970 | -157 | -4.1 | 40,722 | 41,789 | -1,067 | -2.6 |
| Womens, Children & Support Services | 60,607 | 5,226 | 5,208 | 18 | 0.3 | 55,943 | 55,633 | 310 | 0.6 |
| **Corporate** | | | | | | | | | |
| Operations - Central | 540 | 23 | 45 | -22 | -95.7 | 517 | 465 | 52 | 10.1 |
| Operations - Estates | 7,551 | 695 | 730 | -35 | -5.0 | 6,872 | 6,707 | 165 | 2.4 |
| Operations - Facilities | 8,014 | 661 | 637 | 24 | 3.6 | 7,353 | 7,236 | 117 | 1.6 |
| Commercial Development | 1,170 | 198 | 214 | -16 | -8.1 | 1,122 | 1,059 | 63 | 5.6 |
| Finance | 9,347 | 778 | 746 | 32 | 4.1 | 8,569 | 8,509 | 60 | 0.7 |
| Governance & Workforce | 4,708 | 390 | 306 | 84 | 21.5 | 4,317 | 3,879 | 438 | 10.1 |
| Information Technology | 4,107 | 338 | 493 | -155 | -45.9 | 3,769 | 4,326 | -557 | -14.8 |
| Nursing | 1,895 | 171 | 187 | -16 | -9.4 | 1,735 | 1,746 | -11 | -0.6 |
| Trust Executive | 2,161 | 152 | 171 | -19 | -12.5 | 2,009 | 1,954 | 55 | 2.7 |
| **Total** | **200,759** | **17,155** | **17,239** | **-84** | **-0.5** | **184,700** | **185,311** | **-611** | **-0.3** |

Positive variance = underspend, negative variance = overspend.

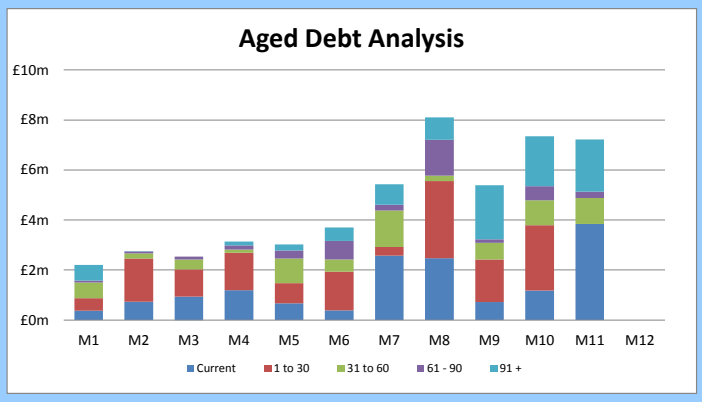
### Continuity of Services Risk Rating

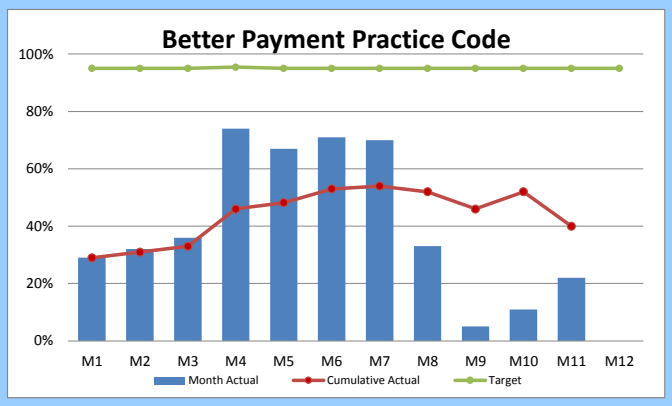
| Continuity of Services Risk Rating | Actual Metric | Actual Rating |
|---|---|---|
| Liquidity Ratio (days) | -11.1 | 2 |
| Capital Servicing Capacity (times) | 0.5 | 1 |
| **Overall Risk Rating** | | **2** |

# Warrington & Halton Hospitals NHS Foundation Trust

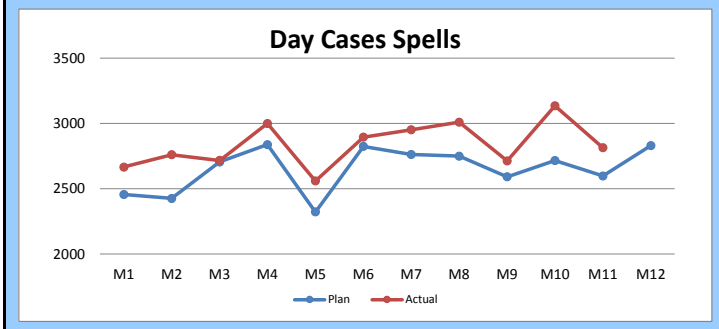
## Finance Dashboard as at 28th February 2015 (Part B)

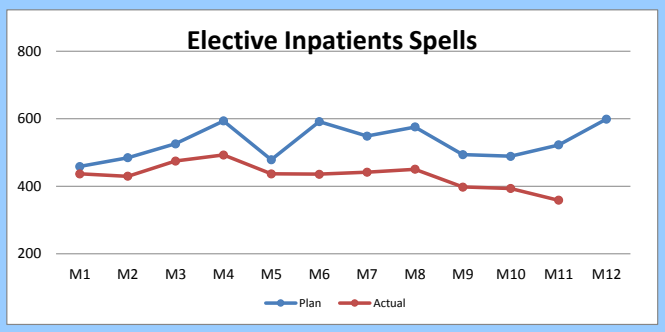
### Balance Sheet and Liquidity

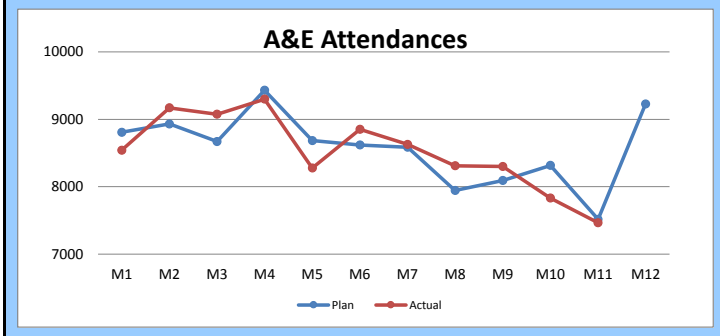


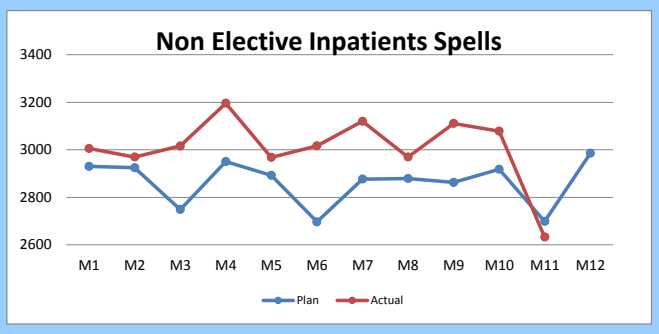



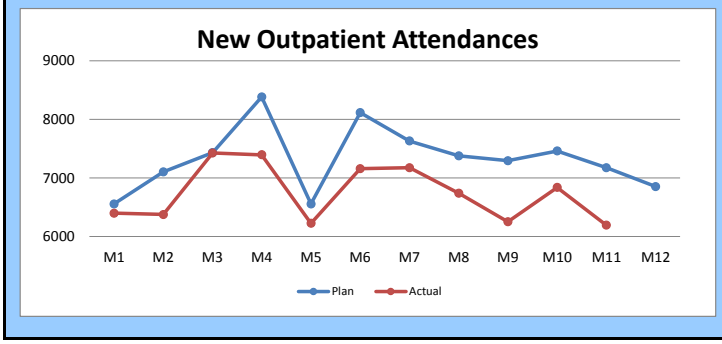

### Activity Analysis

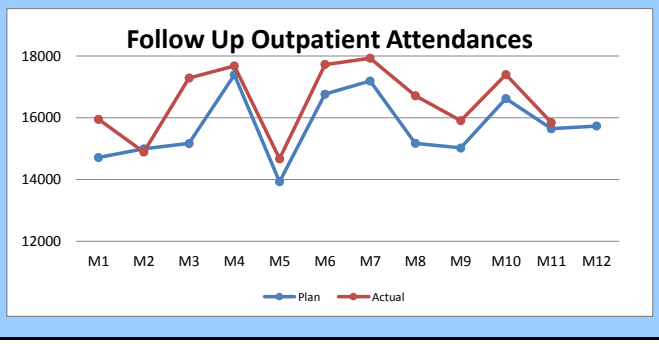


**Warrington & Halton Hospitals NHS Foundation Trust** **Appendix C1**

**Income Statement, Activity Summary and Risk Ratings as at 28th February 2015 (Based on original plan)**

| Income Statement | Month | | | Year to date | | | Forecast | | |
|---|---|---|---|---|---|---|---|---|---|
| | Budget £000 | Actual £000 | Variance £000 | Budget £000 | Actual £000 | Variance £000 | Budget £000 | Actual £000 | Variance £000 |
| **Operating Income** | | | | | | | | | |
| **NHS Activity Income** | | | | | | | | | |
| Elective Spells | 3,402 | 2,815 | -588 | 36,057 | 34,858 | -1,199 | 39,884 | 39,823 | -61 |
| Elective Excess Bed Days | 20 | 21 | 1 | 220 | 209 | -12 | 242 | 264 | 22 |
| Non Elective Spells | 4,072 | 4,207 | 135 | 47,596 | 49,306 | 1,710 | 52,145 | 53,302 | 1,157 |
| Non Elective Excess Bed Days | 293 | 120 | -173 | 3,385 | 2,923 | -462 | 3,701 | 3,456 | -245 |
| Outpatient Attendances | 2,880 | 2,640 | -239 | 30,693 | 30,694 | 1 | 33,480 | 34,018 | 538 |
| Accident & Emergency Attendances | 745 | 722 | -22 | 9,270 | 9,381 | 111 | 10,184 | 10,284 | 100 |
| Other Activity | 4,901 | 5,034 | 134 | 53,512 | 52,422 | -1,090 | 58,103 | 57,082 | -1,021 |
| **Sub total** | **16,311** | **15,559** | **-752** | **180,734** | **179,793** | **-941** | **197,738** | **198,229** | **491** |
| **Non Mandatory / Non Protected Income** | | | | | | | | | |
| Private Patients | 13 | 2 | -11 | 140 | 71 | -69 | 152 | 86 | -66 |
| Other non protected | 107 | 141 | 34 | 1,177 | 1,239 | 62 | 1,284 | 1,397 | 113 |
| **Sub total** | **120** | **142** | **22** | **1,317** | **1,310** | **-7** | **1,436** | **1,483** | **47** |
| **Other Operating Income** | | | | | | | | | |
| Training & Education | 641 | 562 | -79 | 7,055 | 7,209 | 154 | 7,696 | 8,327 | 631 |
| Donations and Grants | 0 | 820 | 820 | 0 | 820 | 820 | 0 | 500 | 500 |
| Miscellaneous Income | 573 | 1,214 | 641 | 6,302 | 8,306 | 2,004 | 6,876 | 8,574 | 1,698 |
| **Sub total** | **1,214** | **2,596** | **1,382** | **13,357** | **16,335** | **2,978** | **14,572** | **17,401** | **2,829** |
| **Total Operating Income** | **17,645** | **18,297** | **652** | **195,407** | **197,438** | **2,030** | **213,746** | **217,113** | **3,367** |
| **Operating Expenses** | | | | | | | | | |
| Employee Benefit Expenses (Pay) | -12,060 | -13,428 | -1,368 | -135,704 | -141,368 | -5,663 | -147,753 | -154,546 | -6,793 |
| Drugs | -1,204 | -1,205 | -1 | -13,038 | -12,445 | 593 | -14,242 | -13,307 | 935 |
| Clinical Supplies and Services | -1,623 | -1,641 | -18 | -17,535 | -18,674 | -1,139 | -19,154 | -20,189 | -1,035 |
| Non Clinical Supplies | -1,993 | -1,966 | 27 | -21,842 | -22,380 | -538 | -23,827 | -25,240 | -1,413 |
| **Total Operating Expenses** | **-16,880** | **-18,239** | **-1,359** | **-188,119** | **-194,866** | **-6,746** | **-204,977** | **-213,282** | **-8,305** |
| **Surplus / (Deficit) from Operations (EBITDA)** | **765** | **58** | **-707** | **7,288** | **2,572** | **-4,716** | **8,769** | **3,831** | **-4,938** |
| **Non Operating Income and Expenses** | | | | | | | | | |
| Interest Income | 3 | 3 | 0 | 37 | 35 | -2 | 40 | 36 | -4 |
| Interest Expenses | 0 | -2 | -2 | 0 | -11 | -11 | 0 | -12 | -12 |
| Depreciation | -524 | -525 | -1 | -5,759 | -5,554 | 205 | -6,283 | -5,770 | 513 |
| PDC Dividends | -336 | -390 | -55 | -3,691 | -3,766 | -76 | -4,026 | -3,960 | 66 |
| Restructuring Costs | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Non Operating Income and Expenses** | **-856** | **-914** | **-58** | **-9,413** | **-9,296** | **117** | **-10,269** | **-9,706** | **563** |
| **Surplus / (Deficit)** | **-91** | **-856** | **-765** | **-2,125** | **-6,724** | **-4,599** | **-1,500** | **-5,875** | **-4,375** |
| **Activity Summary** | **Planned** | **Actual** | **Variance** | **Planned** | **Actual** | **Variance** | **Planned** | **Actual** | **Variance** |
| Elective Spells | 3,120 | 3,172 | 53 | 34,750 | 35,975 | 1,225 | 38,181 | 40,507 | 2,326 |
| Elective Excess Bed Days | 81 | 92 | 11 | 912 | 915 | 3 | 1,003 | 1,153 | 150 |
| Non Elective Spells | 2,697 | 2,633 | -64 | 31,362 | 33,086 | 1,724 | 34,367 | 36,436 | 2,069 |
| Non Elective Excess Bed Days | 1,295 | 495 | -800 | 14,960 | 12,964 | -1,996 | 16,354 | 15,405 | -949 |
| Outpatient Attendances | 26,449 | 27,016 | 566 | 294,934 | 310,363 | 15,429 | 320,888 | 343,820 | 22,932 |
| Accident & Emergency Attendances | 7,516 | 7,464 | -52 | 93,588 | 93,741 | 153 | 102,814 | 103,215 | 401 |
| **Continuity of Services Risk Ratings** | **Planned Metric** | **Actual Metric** | **Variance Metric** | **Planned Metric** | **Actual Metric** | **Variance Metric** | **Planned Metric** | **Actual Metric** | **Variance Metric** |
| Liquidity Ratio - Metric (Days) | -1.0 | -1.4 | -0.3 | -9.2 | -11.1 | -1.9 | -9.0 | -13.0 | -4.0 |
| Liquidity Ratio - Rating | 3 | 3 | 0 | 2 | 2 | 0 | 2 | 2 | 0 |
| Capital Servicing Capacity - Metric (Times) | 2.3 | -1.9 | -4.2 | 2.0 | 0.5 | -1.5 | 2.2 | 0.8 | -1.3 |
| Capital Servicing Capacity - Rating | 3 | 1 | -2 | 3 | 1 | -2 | 3 | 1 | -2 |
| **Continuity of Services Risk Rating** | **3** | **2** | **0** | **3** | **2** | **0** | **3** | **2** | **0** |

**Warrington & Halton Hospitals NHS Foundation Trust** **Appendix B2**

**Income Statement, Activity Summary and Risk Ratings as at 28th February 2015 (Based on reforecast)**

| Income Statement | Month | | | Year to date | | | Forecast | | |
|---|---|---|---|---|---|---|---|---|---|
| | Forecast £000 | Actual £000 | Variance £000 | Forecast £000 | Actual £000 | Variance £000 | Forecast £000 | Actual £000 | Variance £000 |
| **Operating Income** | | | | | | | | | |
| **NHS Activity Income** | | | | | | | | | |
| Elective Spells | 3,385 | 2,815 | -570 | 36,011 | 34,858 | -1,153 | 39,823 | 39,823 | 0 |
| Elective Excess Bed Days | 23 | 21 | -2 | 230 | 209 | -21 | 264 | 264 | 0 |
| Non Elective Spells | 4,167 | 4,207 | 40 | 48,679 | 49,306 | 627 | 53,302 | 53,302 | 0 |
| Non Elective Excess Bed Days | 268 | 120 | -148 | 3,150 | 2,923 | -227 | 3,456 | 3,456 | 0 |
| Outpatient Attendances | 2,917 | 2,640 | -277 | 31,189 | 30,694 | -495 | 34,018 | 34,018 | 0 |
| Accident & Emergency Attendances | 753 | 722 | -31 | 9,361 | 9,381 | 20 | 10,284 | 10,284 | 0 |
| Other Activity | 5,052 | 5,034 | -18 | 51,715 | 52,422 | 707 | 57,082 | 57,082 | 0 |
| **Sub total** | **16,565** | **15,559** | **-1,006** | **180,335** | **179,793** | **-542** | **198,229** | **198,229** | **0** |
| **Non Mandatory / Non Protected Income** | | | | | | | | | |
| Private Patients | 7 | 2 | -6 | 78 | 71 | -7 | 86 | 86 | 0 |
| Other non protected | 117 | 141 | 24 | 1,280 | 1,239 | -41 | 1,397 | 1,397 | 0 |
| **Sub total** | **124** | **142** | **18** | **1,358** | **1,310** | **-48** | **1,483** | **1,483** | **0** |
| **Other Operating Income** | | | | | | | | | |
| Training & Education | 747 | 562 | -185 | 7,580 | 7,209 | -371 | 8,327 | 8,327 | 0 |
| Donations and Grants | 500 | 820 | 320 | 500 | 820 | 320 | 500 | 500 | 0 |
| Miscellaneous Income | 725 | 1,214 | 489 | 7,850 | 8,306 | 456 | 8,574 | 8,574 | 0 |
| **Sub total** | **1,972** | **2,596** | **624** | **15,930** | **16,335** | **405** | **17,401** | **17,401** | **0** |
| **Total Operating Income** | **18,661** | **18,297** | **-364** | **197,623** | **197,438** | **-185** | **217,113** | **217,113** | **0** |
| **Operating Expenses** | | | | | | | | | |
| Employee Benefit Expenses (Pay) | -13,159 | -13,428 | -269 | -141,489 | -141,368 | 121 | -154,546 | -154,546 | 0 |
| Drugs | -1,212 | -1,205 | 7 | -12,199 | -12,445 | -246 | -13,307 | -13,307 | 0 |
| Clinical Supplies and Services | -1,704 | -1,641 | 63 | -18,453 | -18,674 | -221 | -20,189 | -20,189 | 0 |
| Non Clinical Supplies | -2,237 | -1,966 | 271 | -22,830 | -22,380 | 450 | -25,240 | -25,240 | 0 |
| **Total Operating Expenses** | **-18,312** | **-18,239** | **73** | **-194,971** | **-194,866** | **105** | **-213,282** | **-213,282** | **0** |
| **Surplus / (Deficit) from Operations (EBITDA)** | **349** | **58** | **-291** | **2,652** | **2,572** | **-80** | **3,831** | **3,831** | **0** |
| **Non Operating Income and Expenses** | | | | | | | | | |
| Interest Income | 3 | 3 | 0 | 34 | 35 | 1 | 36 | 36 | 0 |
| Interest Expenses | -2 | -2 | 0 | -11 | -11 | 0 | -12 | -12 | 0 |
| Depreciation | -428 | -525 | -97 | -5,341 | -5,554 | -213 | -5,770 | -5,770 | 0 |
| PDC Dividends | -325 | -390 | -65 | -3,636 | -3,766 | -130 | -3,960 | -3,960 | 0 |
| Restructuring Costs | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Non Operating Income and Expenses** | **-752** | **-914** | **-162** | **-8,954** | **-9,296** | **-342** | **-9,706** | **-9,706** | **0** |
| **Surplus / (Deficit)** | **-403** | **-856** | **-453** | **-6,302** | **-6,724** | **-422** | **-5,875** | **-5,875** | **0** |

| Activity Summary | Planned | Actual | Variance | Planned | Actual | Variance | Planned | Actual | Variance |
|---|---|---|---|---|---|---|---|---|---|
| Elective Spells | 3,443 | 3,172 | -271 | 36,630 | 35,975 | -655 | 40,507 | 40,507 | 0 |
| Elective Excess Bed Days | 100 | 92 | -8 | 1,005 | 915 | -90 | 1,153 | 1,153 | 0 |
| Non Elective Spells | 2,848 | 2,633 | -216 | 33,276 | 33,086 | -190 | 36,436 | 36,436 | 0 |
| Non Elective Excess Bed Days | 1,195 | 495 | -700 | 14,041 | 12,964 | -1,077 | 15,405 | 15,405 | 0 |
| Outpatient Attendances | 29,482 | 27,016 | -2,466 | 315,227 | 310,363 | -4,864 | 343,820 | 343,820 | 0 |
| Accident & Emergency Attendances | 7,557 | 7,464 | -93 | 93,951 | 93,741 | -210 | 103,215 | 103,215 | 0 |

| Continuity of Services Risk Ratings | Planned Metric | Actual Metric | Variance Metric | Planned Metric | Actual Metric | Variance Metric | Planned Metric | Actual Metric | Variance Metric |
|---|---|---|---|---|---|---|---|---|---|
| Liquidity Ratio - Metric (Days) | 1.4 | -1.4 | -2.8 | -12.4 | -11.1 | 1.3 | -13.0 | -13.0 | 0.0 |
| Liquidity Ratio - Rating | 4 | 3 | -1 | 2 | 2 | 0 | 2 | 2 | 0 |
| Capital Servicing Capacity - Metric (Times) | -0.5 | -1.9 | -1.5 | 0.6 | 0.5 | -0.1 | 0.8 | 0.8 | 0.0 |
| Capital Servicing Capacity - Rating | 1 | 1 | 0 | 1 | 1 | 0 | 1 | 1 | 0 |
| **Continuity of Services Risk Rating** | **3** | **2** | **0** | **2** | **2** | **0** | **2** | **2** | **0** |

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

**Cash Flow Statement as at 28th February 2015**

| | Actual April £000's | Actual May £000's | Actual June £000's | Actual July £000's | Actual August £000's | Actual September £000's | Actual October £000's | Actual November £000's | Actual December £000's | Actual January £000's | Actual February £000's | Forecast March £000's | Annual Position March £000's |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Surplus/(deficit) after tax** | **(1,655)** | **(647)** | **(858)** | **414** | **(1,726)** | **(587)** | **72** | **(81)** | **(607)** | **(195)** | **(856)** | **851** | **(5,875)** |
| **Non-cash flows in operating surplus/(deficit)** | | | | | | | | | | | | | |
| Depreciation and amortisation | 523 | 525 | 523 | 523 | 524 | 524 | 438 | 476 | 429 | 545 | 525 | 215 | 5,770 |
| Impairment losses/(reversals) | | | | | | | | | | | | | 0 |
| (Gain)/loss on disposal of property plant and equipment | | | | | | | | | | | | | 0 |
| PDC dividend expense | 336 | 335 | 336 | 335 | 336 | 336 | 336 | 336 | 302 | 391 | 390 | 191 | 3,960 |
| Other increases/(decreases) to reconcile to profit/(loss) from operations | (16) | 9 | (3) | (19) | 6 | (16) | 40 | (85) | 62 | (32) | 0 | (36) | (89) |
| **Non-cash flows in operating surplus/(deficit), Total** | **843** | **869** | **856** | **839** | **866** | **844** | **814** | **727** | **793** | **904** | **915** | **370** | **9,641** |
| **Operating Cash flows before movements in working capital** | **(812)** | **222** | **(2)** | **1,253** | **(860)** | **257** | **886** | **646** | **186** | **709** | **59** | **1,221** | **3,766** |
| **Increase/(Decrease) in working capital** | | | | | | | | | | | | | |
| (Increase)/decrease in inventories | (36) | (93) | 68 | 52 | 141 | (254) | (68) | (32) | (108) | 147 | (377) | 338 | (222) |
| (Increase)/decrease in NHS Trade Receivables | 775 | (332) | 869 | (991) | 504 | (618) | (346) | (3,643) | (445) | 1,107 | 1,183 | 156 | (1,782) |
| (Increase)/decrease in Non NHS Trade Receivables | 154 | (430) | (121) | 203 | (257) | (47) | 248 | (446) | 471 | (403) | (89) | 521 | (195) |
| (Increase)/decrease in other related party receivables | (235) | (75) | 181 | (237) | 206 | (11) | (161) | (36) | 185 | 11 | (111) | (85) | (367) |
| (Increase)/decrease in other receivables | (1) | 303 | 144 | (102) | 137 | (20) | (35) | 467 | (353) | (137) | (11) | 501 | 892 |
| (Increase)/decrease in accrued income | 261 | 417 | (231) | (542) | (220) | 364 | (647) | (175) | (668) | 841 | 28 | 299 | (274) |
| (Increase)/decrease in prepayments | (1,833) | 507 | (386) | (165) | 872 | (291) | 253 | 9 | 463 | (364) | (74) | 1,425 | 416 |
| Increase/(decrease) in Deferred Income (excl. Govt Grants.) | (243) | 612 | (14) | 18 | 344 | 64 | 1,359 | 1,325 | 1,883 | (2,988) | 799 | (1,694) | 1,466 |
| Increase/(decrease) in Current provisions | 5 | (11) | 12 | 7 | 8 | 8 | 0 | (47) | 10 | (72) | 4 | 106 | 30 |
| Increase/(decrease) in Trade Creditors | 2,508 | (3,205) | (351) | (1,190) | (1,086) | 1,182 | 2,944 | (1,175) | 1,939 | (1,816) | (61) | (2,304) | (2,616) |
| Increase/(decrease) in Other Creditors | 167 | (407) | 61 | (27) | 85 | 95 | (63) | (93) | 20 | 355 | (195) | 820 | 818 |
| Increase/(decrease) in accruals (adj for dep'n acrrue to budget) | (189) | (568) | (645) | 1,702 | 7 | (448) | (2,162) | 1,672 | 476 | 846 | 682 | (1,444) | (71) |
| Increase/(decrease) in other Financial liabilities | | | | | | | | | 734 | 2 | 70 | (66) | 741 |
| Increase/(decrease) in Other liabilities (VAT, Social Security and Other Taxes) | (4) | 94 | (120) | 64 | (62) | 15 | 35 | 2 | 30 | (64) | 73 | (38) | 25 |
| **Increase/(Decrease) in working capital, Total** | **1,329** | **(3,188)** | **(533)** | **(1,208)** | **679** | **38** | **1,359** | **(2,171)** | **4,636** | **(2,534)** | **1,921** | **(1,465)** | **(1,137)** |
| Increase/(decrease) in Non-current provisions | (27) | 13 | 14 | (27) | 16 | 15 | (177) | 20 | 41 | 54 | 114 | (255) | (200) |
| **Net cash inflow/(outflow) from operating activities** | **490** | **(2,953)** | **(521)** | **18** | **(165)** | **310** | **2,068** | **(1,505)** | **4,863** | **(1,771)** | **2,094** | **(499)** | **2,429** |
| **Net cash inflow/(outflow() from investing activities** | | | | | | | | | | | | | |
| Property - new land, buildings or dwellings | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (258) | (117) | (76) | (39) | **(490)** |
| Property - maintenance expenditure | (158) | (115) | (35) | (207) | (241) | (132) | (444) | (143) | (6) | (223) | (739) | (191) | **(2,634)** |
| Plant and equipment - Information Technology | (39) | (165) | (23) | (283) | (92) | (245) | (322) | (150) | (814) | 138 | (76) | (1,081) | **(3,152)** |
| Plant and equipment - Other | (45) | (119) | 27 | (61) | (23) | (179) | (194) | (37) | (56) | 85 | (135) | (148) | **(885)** |
| Increase/(decrease) in Capital Creditors | (171) | (865) | (171) | 124 | (58) | 315 | 271 | (201) | 80 | (469) | 574 | (309) | (880) |
| **Net cash inflow/(outflow() from investing activities, Total** | **(413)** | **(1,264)** | **(202)** | **(427)** | **(414)** | **(241)** | **(689)** | **(531)** | **(1,054)** | **(586)** | **(452)** | **(1,768)** | **(8,041)** |
| **Net cash inflow/(outflow) before financing** | **77** | **(4,217)** | **(723)** | **(409)** | **(579)** | **69** | **1,379** | **(2,036)** | **3,809** | **(2,357)** | **1,642** | **(2,267)** | **(5,613)** |
| **Net cash inflow/(outflow) from financing activities** | | | | | | | | | | | | | |
| Public Dividend Capital received | 0 | | | | | | | | | | | | 0 |
| PDC Dividends paid | 0 | | | | | (2,065) | | | | | | (1,895) | (3,960) |
| Interest (paid) on non-commercial loans | 0 | | | | | | | (5) | (1) | (2) | (2) | (2) | (12) |
| Interest received on cash and cash equivalents | 4 | 2 | 6 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 0 | 36 |
| Drawdown of non-commercial loans | | | | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Repayment of non-commercial loans | 0 | | | | | | | | | | | | 0 |
| (Increase)/decrease in non-current receivables | (84) | 65 | (38) | (4) | 9 | (2) | 24 | (398) | 399 | (13) | (29) | (233) | (305) |
| **Net cash inflow/(outflow) from financing activities, Total** | **(80)** | **67** | **(32)** | **(1)** | **12** | **(2,064)** | **27** | **(400)** | **401** | **(12)** | **(28)** | **(2,130)** | **(4,241)** |
| **Net increase/(decrease) in cash** | **(3)** | **(4,150)** | **(755)** | **(410)** | **(568)** | **(1,994)** | **1,406** | **(2,436)** | **4,210** | **(2,370)** | **1,613** | **(4,397)** | **(9,854)** |
| **Opening cash** | **12,956** | **12,953** | **8,803** | **8,048** | **7,638** | **7,070** | **5,076** | **6,482** | **4,046** | **8,256** | **5,886** | **7,499** | **12,956** |
| **Closing cash** | **12,953** | **8,803** | **8,048** | **7,638** | **7,070** | **5,076** | **6,482** | **4,046** | **8,256** | **5,886** | **7,499** | **3,102** | **3,102** |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Forecast cash position as per Original Monitor plan | 8,342 | 7,772 | 7,202 | 6,751 | 6,301 | 3,839 | 4,597 | 5,356 | 6,489 | 7,241 | 7,993 | 6,731 |
| Actual cash position | 12,953 | 8,803 | 8,048 | 7,638 | 7,070 | 5,076 | 6,482 | 4,046 | 8,256 | 5,886 | 7,499 | 3,102 |
| Variance | 4,611 | 1,031 | 846 | 887 | 769 | 1,237 | 1,885 | -1,310 | 1,767 | -1,355 | -494 | -3,629 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Forecast cash position as per Re-Forecast Monitor plan | 8,342 | 7,772 | 7,202 | 6,751 | 6,301 | 3,839 | 4,597 | 5,356 | 4,995 | 5,125 | 4,304 | 3,102 |
| Actual cash position | 12,953 | 8,803 | 8,048 | 7,638 | 7,070 | 5,076 | 6,482 | 4,046 | 8,256 | 5,886 | 7,499 | 3,102 |
| Variance | 4,611 | 1,031 | 846 | 887 | 769 | 1,237 | 1,885 | -1,310 | 3,261 | 761 | 3,195 | 0 |

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

**Statement of Position as at 28th February 2015**

| Narrative | Audited position as at 31.3.14 £000 | Actual Position as at 31.01.15 £000 | Actual Position as at 28.02.15 £000 | Monthly Movement £000 | Forecast Position as at 31.3.15 £000 |
|---|---|---|---|---|---|
| **ASSETS** | | | | | |
| **Non Current Assets** | | | | | |
| Intangible Assets | 316 | 546 | 573 | 26 | 523 |
| Property Plant & Equipment | 132,588 | 132,005 | 132,480 | 475 | 133,771 |
| Other Receivables | 1,233 | 1,332 | 1,369 | 36 | 1,808 |
| Impairment of receivables for bad & doubtful debts | -195 | -252 | -259 | -7 | -465 |
| **Total Non Current Assets** | **133,942** | **133,631** | **134,162** | **531** | **135,637** |
| **Current Assets** | | | | | |
| Inventories | 2,769 | 2,952 | 3,329 | 377 | 2,991 |
| NHS Trade Receivables | 3,052 | 6,172 | 4,990 | -1,183 | 4,834 |
| Non NHS Trade Receivables | 573 | 1,200 | 1,289 | 89 | 768 |
| Other Related party receivables | 200 | 371 | 482 | 111 | 567 |
| Other Receivables | 1,960 | 1,558 | 1,569 | 11 | 1,068 |
| Impairment of receivables for bad & doubtful debts | -355 | -362 | -362 | 1 | -217 |
| Accrued Income | 884 | 1,485 | 1,457 | -28 | 1,158 |
| Prepayments | 1,727 | 2,662 | 2,736 | 74 | 1,311 |
| Cash held in GBS Accounts | 12,937 | 5,867 | 7,479 | 1,612 | 3,082 |
| Cash held in commercial accounts | 0 | | | 0 | 0 |
| Cash in hand | 19 | 20 | 20 | 0 | 20 |
| **Total Current Assets** | **23,766** | **21,924** | **22,987** | **1,063** | **15,582** |
| **Total Assets** | **157,708** | **155,555** | **157,149** | **1,594** | **151,219** |
| **LIABILITIES** | | | | | |
| **Current Liabilities** | | | | | |
| NHS Trade Payables | -1,513 | -1,791 | -1,412 | 378 | -1,535 |
| Non NHS Trade Payables | -5,728 | -5,200 | -5,517 | -317 | -3,831 |
| Other Payables | -1,755 | -1,948 | -1,753 | 195 | -2,573 |
| Other Liabilities (VAT, Social Security and Other Taxes) | -2,678 | -2,668 | -2,741 | -73 | -2,702 |
| Capital Payables | -1,386 | -241 | -815 | -574 | -630 |
| Accruals | -5,986 | -6,643 | -7,325 | -682 | -5,916 |
| Interest payable on non commercial int bearing borrowings | 0 | 0 | 0 | 0 | 0 |
| PDC Dividend creditor | -49 | -1,360 | -1,750 | -390 | 0 |
| Deferred Income | -1,353 | -3,714 | -4,513 | -799 | -2,078 |
| Provisions | -282 | -202 | -206 | -4 | -264 |
| Loans non commercial | 0 | | | 0 | 0 |
| Borrowings | 0 | -162 | -169 | -7 | -154 |
| **Total Current Liabilities** | **-20,730** | **-23,929** | **-26,201** | **-2,272** | **-19,683** |
| **Net Current Assets ( Liabilities )** | **3,036** | **-2,005** | **-3,214** | **-1,208** | **-4,101** |
| **Non Current Liabilities** | | | | | |
| Loans non commercial | | | | 0 | 0 |
| Provisions | -1,510 | -1,452 | -1,565 | -114 | -1,357 |
| Borrowings | 0 | -574 | -638 | -64 | -587 |
| **Total Non Current Liabilities** | **-1,510** | **-2,026** | **-2,203** | **-177** | **-1,944** |
| **TOTAL ASSETS EMPLOYED** | **135,468** | **129,600** | **128,746** | **-855** | **129,592** |
| **TAXPAYERS AND OTHERS EQUITY** | | | | | |
| **Taxpayers Equity** | | | | | |
| Public Dividend Capital | 90,063 | 90,063 | 90,063 | 0 | 90,063 |
| Retained Earnings prior year | 12,446 | 9,597 | 9,597 | 0 | 9,597 |
| Retained Earnings current year | -2,849 | -5,868 | -6,723 | -855 | -5,876 |
| **Sub total** | **99,660** | **93,792** | **92,937** | **-855** | **93,784** |
| **Other Reserves** | | | | | |
| Revaluation Reserve | 35,808 | 35,808 | 35,808 | 0 | 35,808 |
| **Sub total** | **35,808** | **35,808** | **35,808** | **0** | **35,808** |
| **TOTAL TAXPAYERS AND OTHERS EQUITY** | **135,468** | **129,600** | **128,746** | **-855** | **129,592** |

# BOARD OF DIRECTORS

WHH/B/2015/ **053**

| | | |
|---|---|---|
| **SUBJECT:** | **CORPORATE PERFORMANCE REPORT** | |
| **DATE OF MEETING:** | 25th March 2015 | |
| **ACTION REQUIRED** | **For Discussion** | |
| **AUTHOR(S):** | Simon Wright | |
| **EXECUTIVE DIRECTOR:** | Simon Wright, Chief Operating Officer and Deputy Chief Executive | |
| | | |
| **LINK TO STRATEGIC OBJECTIVES:** | All | |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework | |
| | | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | |
| **FOIA EXEMPTIONS APPLIED:** | None | |
| | | |
| **EXECUTIVE SUMMARY** (KEY ISSUES): | This corporate report updates the Board on the progress of the Trust in relation to activity, performance and workforce targets to 28th February 2015.<br><br>In overall terms, based on the performance in month 11, the Trust has an Amber/Green rating, as highlighted in Appendix 1. | |
| **RECOMMENDATION:** | ***The Board is asked to:***<br><br>note the current status of the performance indicators and the actions being undertaken to address the 4hr performance target in A&E | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Finance and Sustainability Committee |
| | **Agenda Ref.** | FSC/15/26 |
| | **Date of meeting** | 17 March 2015 |
| | **Summary of Outcome** | Noted |

# NATIONAL KEY PERFORMANCE INDICATORS

## ACCIDENT AND EMERGENCY DEPARTMENT

The trust performance remains unacceptably low and the following additional actions have been taken to make the necessary improvements

- a new Substantive AED manager has been appointed and starts in June;
- approval has been given to fund 30 intermediate care beds in Daresbury for 6 months commencing this month with a phased roll out;
- additional medical emergency admissions (25 beds worth per week) are being co-located on a new medical ward by switching a surgical ward into a medical one and establishing the available beds known as escalation recurrently;
- the Perfect Week will re-run from March 30-April 15;
- Wards A1 and A2 will merge during the perfect week to create a larger ambulatory unit to better manage internal short stay flow;
- command and control systems are to be introduced into AED to ensure internal approaches have not slipped during the period of congestion resulting from DTOC delays;
- The Chief Operating Officer, Medical Director and Director of Nursing and Governance are establishing an internal steering group to oversee the pathway and operational changes necessary to restore normal operational management of emergency demand; and
- discussions are underway with commissioners on assurance that demand controls , nursing home admission avoidance and readmission reductions for 2015/16 will avoid over performance in emergency admissions.

## CLOSTRIDIUM DIFFICILE & MRSA

These areas are dealt with within the Quality Dashboard

## RECOMMENDATIONS

The Board is asked to note the current status of the performance indicators and the actions being undertaken to address the 4hr performance target in A&E

**APPENDIX 1**

**Feb-15**

# Monitor Governance Risk Rating - 2014/15

Warrington and Halton Hospitals NHS
NHS Foundation Trust

All targets are QUARTERLY

| Target or Indicator | | Target | Weighting | Apr | May | Jun | QTR-1 | Jul | Aug | Sep | QTR-2 | Oct | Nov | Dec | QTR-3 | Jan | Feb | Mar | QTR-4 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Referral to treatment waiting time | Admitted patients | 90% | 1.0 | 92.61% | 93.21% | 93.58% | 93.14% | 90.70% | 90.34% | 92.04% | 91.04% | 92.07% | 92.73% | 92.99% | 92.60% | 92.93% | 92.18% | | |
| | Non-admitted patients | 95% | 1.0 | 98.03% | 97.63% | 98.54% | 98.07% | 97.79% | 97.72% | 98.14% | 97.89% | 97.62% | 96.99% | 97.51% | 97.38% | 96.99% | 97.27% | | |
| | Incomplete Pathways | 92% | 1.0 | 94.55% | 94.56% | 94.94% | 94.68% | 94.88% | 95.29% | 94.94% | 95.03% | 94.50% | 94.33% | 93.96% | 94.27% | 93.49% | 93.87% | | |
| A&E Clinical Quality | A&E Maximum waiting time of 4 hrs from arrival to admission/transfer/discharge | >=95% | 1.0 | 94.54% | 92.66% | 95.01% | 93.97% | 91.74% | 93.54% | 93.26% | 92.74% | 93.00% | 91.23% | 83.75% | 89.67% | 84.08% | 80.13% | | |
| All Cancers:62-day wait for First treatment | From urgent GP referral - **post** local breach re-allocation (CCG) | 85% | 1.0 | 90.00% | 82.14% | 85.07% | 85.45% | 86.81% | 82.16% | 88.50% | 85.19% | 86.67% | 90.69% | 80.00% | 86.38% | 87.10% | 85.19% | | |
| | From NHS Cancer Screening Service referral - **post** local breach re-allocation | 90% | 1.0 | 100.00% | 100.00% | 98.00% | 99.33% | 100.00% | 98.00% | 99.00% | 99.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | | |
| | From urgent GP referral - **pre** local breach re-allocation (Open Exeter - Monitor) | 85% | | 90.00% | 88.46% | 85.07% | 87.91% | 86.52% | 80.26% | 85.71% | 85.45% | 90.30% | 93.00% | 83.00% | 89.10% | 89.20% | 87.00% | | |
| | From NHS Cancer Screening Service referral - **pre** local breach re-allocation | 90% | | 100.00% | 100.00% | 98.00% | 99.33% | 100.00% | 98.00% | 100.00% | 99.00% | 100.00% | 98.00% | 100.00% | 99.00% | 100.00% | 100.00% | | |
| All Cancers:31-day wait for second or subsequent treatment | Surgery | >94% | 1.0 (Failure for any of the 3 = failure against the overall target) | 96.00% | 98.00% | 97.00% | 97.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | | |
| | Anti Cancer Drug Treatments | >98% | | 100.00% | 100.00% | 98.00% | 99.33% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | | |
| | Radiotherapy (not performed at this Trust) | >94% | | | | | | | | | | | | | | | | | |
| All Cancers: 31-Day Wait From Diagnosis To First Treatment | | >96% | 1.0 | 96.00% | 96.00% | 98.00% | 96.67% | 98.00% | 99.00% | 100.00% | 99.00% | 98.00% | 98.00% | 97.00% | 97.70% | 98.00% | 100.00% | | |
| Cancer: Two Week Wait From Referral To Date First Seen | Urgent Referrals (Cancer Suspected) | >93% | 1.0 (Failure for either = failure against the overall target) | 93.10% | 92.90% | 93.05% | 93.00% | 93.80% | 92.70% | 93.80% | 93.50% | 93.50% | 95.20% | 94.70% | 94.80% | 94.80% | 94.80% | | |
| | Symptomatic Breast Patients (Cancer Not Initially Suspected) | >93% | | 93.05% | 93.00% | 93.10% | 93.05% | 93.75% | 91.90% | 93.90% | 93.30% | 92.99% | 94.20% | 94.20% | 93.10% | 93.50% | 92.90% | | |
| Clostridium Difficile - Hospital acquired **(CUMULATIVE)** | Due to lapses in care | 26 (for the Yr) | 1.0 ** | 1 | 3 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 5 | 5 | | |
| | Total (including: due to lapses in care, not due to lapses in care, and cases under review) | | | 2 | 5 | 7 | 7 | 8 | 15 | 16 | 16 | 19 | 20 | 23 | 23 | 24 | 26 | | |
| | Under Review | | | 1 | 2 | 3 | 3 | 4 | 11 | 12 | 12 | 15 | 16 | 19 | 19 | 20 | 22 | | |
| Failure to comply with requirements regarding access to healthcare for people with a learning disability | | N/A | 1.0 | No | No | No | No | No | No | No | No | No | No | No | No | No | No | | |

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

## APPENDIX 1

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

**Additional Notes:**

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

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

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

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

# BOARD OF DIRECTORS

WHH/B/2015/ **054**

| | |
|---|---|
| **SUBJECT:** | **Verbal Report from the Chair of the Quality [Governance] Committee** |
| **DATE OF MEETING:** | 25th March 2015 |
| **DIRECTOR:** | Mike Lynch, Non-Executive Director |

# BOARD OF DIRECTORS

WHH/B/2015/ **055**

| | |
|---|---|
| **SUBJECT:** | **QUALITY DASHBOARD (2014/2015) MARCH 2015** |
| **DATE OF MEETING:** | 25th March 2015 |
| **ACTION REQUIRED** | **For Assurance** |
| **AUTHOR(S):** | Ros Harvey (Corporate Nursing Programmes Manager)<br>Hannah Gray (Clinical Effectiveness Manager) |
| **EXECUTIVE DIRECTOR:** | Karen Dawber, Director of Nursing and Governance |
| | |
| **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<br>SO1/1.3 Failure to achieve infection control targets in accordance with the Risk Assessment Framework |
| | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full |
| **FOIA EXEMPTIONS APPLIED:** | None |
| | |
| **EXECUTIVE SUMMARY** (KEY ISSUES): | The Quality Dashboard provides a monthly update on KPIs for 2014/2015 from the:-<br>• CQUINs – National (Local CQUINs will be monitored by the CQUIN monitoring group and reported by exception if required).<br>• Quality Contract<br>• Quality Account - Improvement Priorities<br>• Quality Account – Quality Indicators<br>• Sign up to Safety – national patient safety topics<br>• Open and Honest<br><br>Exception reports are included for non-compliant indicators including SHMI, HCAI, MUST Care Indicator, Pressure Ulcer CQUIN, AQ Heart Failure& Pneumonia, Friends and Family, |

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

## 1. Key Performance Indicators

| | Threshold | IC | A | M | J | Q1 | J | A | S | Q2 | O | N | D | Q3 | J | F | M | Q4 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Intelligent Monitoring** | | | | | | | | | | | | | | | | | | | |
| Banding March 14 = 5 | Not set | | | | | | 3 | | | | | | 5 | | CQC Inspection | | | | |
| Number of elevated risks March 2014 = 1 | Not set | | | | | | 2 | | | | | | 1 | | CQC Inspection | | | | |
| Number of risks March 2014 = 4 | Not set | | | | | | 5 | | | | | | 3 | | CQC Inspection | | | | |
| **Safety** | | | | | | | | | | | | | | | | | | | |
| **Mortality** | | | | | | | | | | | | | | | | | | | |
| HSMR (12 month rolling) | <=100 = G, As expected = A, Higher than expected = R | QI, IP, QC | 98 | 98 | 98 | | 98 | 98 | 99 | | 101 | 102 | 105 | | | | | | 105 |
| SHMI (12 month rolling) | <=100 = G, As expected = A, Higher than expected = R | QI, IP, QC | 109 | 110 | 110 | | 110 | 112 | 111 | | 112 | 112 | | | | | | | 112 |
| Total deaths in hospital | Not set | | 99 | 89 | 76 | 264 | 74 | 81 | 97 | 252 | 95 | 80 | 133 | 308 | 136 | 84 | | | 1044 |
| Regulation 28 - Prevention of future deaths report | Not set | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | 0 |
| **Incidents resulting in Moderate, Major or Catastrophic harm** | | | | | | | | | | | | | | | | | | | |
| Incidents resulting in moderate, major or catastrophic harm | TBC | QC | 6 | 9 | 6 | 21 | 4 | 5 | 9 | 18 | 6 | 8 | 5 | 19 | 2 | 1 | | | 61 |
| Incidents of moderate, major or catastrophic harm under investigation | N/A | | 1 | 0 | 2 | 3 | 0 | 1 | 2 | 3 | 1 | 1 | 15 | 17 | 14 | 27 | | | 64 |

| | Threshold | IC | A | M | J | Q1 | J | A | S | Q2 | O | N | D | Q3 | J | F | M | Q4 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Falls** | | | | | | | | | | | | | | | | | | | |
| All falls (approved) | Not set | | 91 | 78 | 87 | 256 | 88 | 76 | 79 | 246 | 71 | 68 | 91 | 234 | 69 | 77 | | | 875 |
| Moderate, major and catastrophic harm falls (approved) | <=13 per year | IP | 1 | 3 | 2 | 6 | 1 | 2 | 3 | 6 | 0 | 4 | 0 | 4 | 0 | 0 | | | 16 |
| Moderate, major and catastrophic harm falls (awaiting approval) | N/A | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 2 | 4 | 2 | | | 8 |
| Major and catastrophic harm falls (approved) | <=2 per year | QC | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | 1 |
| **Pressure Ulcers** | | | | | | | | | | | | | | | | | | | |
| Grade 3 and 4 Hospital Acquired (Avoidable) | <=6 per year | IP | 1 | 1 | 0 | 2 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 2 | 0 | 0 | | | 4 |
| Grade 3 and 4 Hospital Acquired (Unavoidable) | <=10 | QC | 0 | 0 | 0 | 0 | 1 | 0 | 2 | 3 | 0 | 0 | 1 | 1 | 0 | 0 | | | 4 |
| Grade 3 and 4 Hospital Acquired (Under review) | N/A | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | | | 1 |
| Grade 2 Hospital Acquired | <=101 per year | IP | 3 | 8 | 2 | 13 | 11 | 3 | 3 | 17 | 9 | 5 | 8 | 22 | 7 | 1 | | | 60 |
| Grade 2 Hospital Acquired – stretch target | <=90 per year | IP | 3 | 8 | 2 | 13 | 11 | 3 | 3 | 17 | 9 | 5 | 8 | 22 | 7 | 1 | | | 60 |

| | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| (20% reduction) | | | | | | | | | | | | | | | | | | |
| | **Threshold** | **IC** | **A** | **M** | **J** | **Q1** | **J** | **A** | **S** | **Q2** | **O** | **N** | **D** | **Q3** | **J** | **F** | **M** | **Q4** | **YTD** |
| Grade 2 Hospital Acquired (under review) | N/A | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | | | 4 |
| % RCA / mini investigation completed | 100% | IP | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | | | 100 |
| % of patients with a pressure ulcer (Community or hospital acquired) (ST) | <=3.99% (November 2014 – March 2015) (median YTD) | C | 4.92 | 3.07 amended | 3.73 | | 3.37 | 5.63 amended | 4.95 | | 4.34 | 5.90 | 4.65 | | 3.60 | 5.20 | | | |
| **Health Care Acquired Infections** | | | | | | | | | | | | | | | | | | | |
| MRSA | 0= green, 1-5=amber, >5 red | QC, IP | 0 | 1 | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | | | 3 |
| Clostridium difficile | <=26 per year | QC, IP | 2 | 3 | 2 | 7 | 1 | 7 | 1 | 9 | 3 | 1 | 3 | 7 | 1 | 2 | | | 26 |
| MSSA | Not set | | 1 | 0 | 1 | 2 | 1 | 0 | 0 | 1 | 1 | 1 | 2 | 4 | 2 | 2 | | | 11 |
| **Out of hours transfers** | TBC | BK | 1 | 2 | 5 | 8 | 1 | 5 | 1 | 7 | 3 | 0 | 7 | 10 | 3 | 3 | | | 31 |
| **Never Events** | 0 per year | QC | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | 0 |
| **Number of cardiac arrests in hospital wards, outside A&E, Theatres, CCU and ICU'.** | Annual: <75 = G 75 – 85 = A >85 = Red | QC | 8 | 11 | 7 | 26 | 3 | 13 | 6 | 22 | 5 | 7 | 13 | 25 | 12 | 5 | | | 90 |
| **Medicines Safety Thermometer % harm free (ST)** | TBC | IP | PILOT | PILOT | PILOT | | PILOT | PILOT | 98.3 | | 99.2 | 97.4 | 99.2 | | Quarterly Reporting | Quarterly Reporting | | | |

| | Threshold | IC | A | M | J | Q1 | J | A | S | Q2 | O | N | D | Q3 | J | F | M | Q4 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **VTE** | | | | | | | | | | | | | | | | | | | |
| % of patients risk assessed | >=95% | QC | 95.55 | 95.92 | 95.61 | | 95.33 | 95.30 | 95.31 | | 95.64 | 95.91 | 95.47 | | 95.27 | 93.71 | | | |
| % of eligible patients having prophylaxis (ST) | 100% | QC | 92 | 99.8 | 93 | | 100 | 99.6 | 100 | | 100 | 100 | 100 | | 99.83 | 100 | | | |
| Number of patients who developed a HA VTE | Baseline TBC | QC | 7 | 8 | 5 | 20 | 12 | 4 | 3 | 19 | 6 | 4 | 1 | 11 | | | | | **50** |
| Number of patients who developed a HA VTE (under review) | | | 0 | 0 | 1 | 1 | 1 | 5 | 4 | 10 | 8 | 2 | 4 | 14 | | | | | **25** |
| **% free from harm (ST)** | | OH | 97.3 | 99.2 | 97.8 | | 98 | 96.4 | 98 | | 97.4 | 96.5 | 98 | | 97.2 | 96.6 | | | |
| **Catheter Acquired Urinary Tract Infections** | | | | | | | | | | | | | | | | | | | |
| CA – UTI: Number of catheterised patients who developed a UTI (ST) | <=3 per month <=36 annual | IP | 4 | 2 | 2 | 8 | 2 | 4 | 5 | 11 | 0 | 5 | 1 | 6 | 2 | 2 | | | 29 |
| CA – UTI % of catheterised patients who developed a UTI (ST) | <=0.6% each month | IP | 0.76 | 0.38 | 0.39 | | 0.40 | 0.89 | 0.99 | | 0 | 0.92 | 0.19 | | 0.34 | 0.40 | | | |
| **Dementia** | | | | | | | | | | | | | | | | | | | |
| Dementia Assessment % (Part 1) | >=90% | C | 94.55 | 95.69 | 95.43* | | 94.26 | 96.59 | 92.45 | | 92.70 | 96.61 | 96.29 | | 96.93 | 94.81 | | | |
| Dementia Assessment % (Part | >=90% | C | 100 | 100 | 100* | | 100 | 100 | 91.89 | | 100 | 100 | 97.22 | | 96.77 | 100 | | | |

| 2) | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Threshold** | **IC** | **A** | **M** | **J** | **Q1** | **J** | **A** | **S** | **Q2** | **O** | **N** | **D** | **Q3** | **J** | **F** | **M** | **Q4** | **YTD** |
| Dementia Assessment % (Part 3) | >=90% | C | 100 | 100 | 100* | | 100 | 100 | 100 | | 100 | 100 | 100 | | 100 | 100 | | | |
| **Care Indicators** | | | | | | | | | | | | | | | | | | | |
| Falls - risk assessment % compliance | >=95% | IP | 100 | 95 | 95 | 96.6 | 98.8 | 98.9 | 98 | 98.7 | 99 | 98 | 99 | 97 | 90 | 100 | | | |
| Waterlow - risk assessment % compliance | >=95% | IP | 98 | 92.7 | 88.3 | 93 | 95.6 | 93.3 | 83 | 90.6 | 96 | 98 | 100 | 95 | 91 | 100 | | | |
| MUST - risk assessment measures | >=95% | IP | 57.2 | 59.4 | 60 | 58.9 | 81.6 | 71.1 | 75 | 75.9 | 83 | 83 | 94 | 77 | 60 | 81.8 | | | |
| **Effectiveness** | | | | | | | | | | | | | | | | | | | |
| **Advancing Quality % compliance** (cumulative scores) | | | | | | | | | | | | | | | | | | | |
| Acute MI | >=95% | IP, C | 100 | 98.4 | 98.9 | | 98.4 | 98.8 | 99 | | 98.37 | 97.90 | | | | | | | 97.90 |
| Hip and Knee | >=95% | IP, C | 95.2 | 96.5 | 95 | | 96.4 | 96.7 | 96.9 | | 97.23 | 97.57 | | | | | | | 97.57 |
| Heart failure | >=90.2% | IP, C | 100 | 90.9 | 87.9 | | 83.1 | 84.3 | 83.7 | | 84.31 | 81.42 | | | | | | | 81.42 |
| Pneumonia | >=73.9% | IP, C | 68.6 | 72.8 | 74.4 | | 75.1 | 76.1 | 75.2 | | 74.66 | 73.36 | | | | | | | 73.36 |
| Stroke | >=60.4% | IP, C | 69.7 | 61.4 | 57 | | 58.3 | 60 | 60.7 | | 61.76 | 61.30 | | | | | | | 61.30 |
| COPD (data not yet released) | >=50% | IP, C | | | | | | PILOT | PILOT | | | | | | | | | | |
| **Patient Reported Outcome Measures** (PROMS) | | | | | | | | | | | | | | | | | | | |
| Hip replacement (Average health gain) | 0.44 (latest England average Mar 2014) | IP,QC | | Still provisional data | | | | | | | | | | | | | 0.41 | | 0.41 |
| Knee replacement (Average health gain) | 0.32 (latest England average Mar 2014) | IP,QC | | Still provisional data | | | | | | | | | | | | | 0.34 | | 0.34 |
| Groin surgery (Average health gain) | 0.085 (latest England average Mar | IP,QC | | Still provisional data | | | | | | | | | | | | | 0.065 | | 0.065 |

| | 2014) | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Threshold** | **IC** | **A** | **M** | **J** | **Q1** | **J** | **A** | **S** | **Q2** | **O** | **N** | **D** | **Q3** | **J** | **F** | **M** | **Q4** | **YTD** |
| **Patient Experience** | | | | | | | | | | | | | | | | | | | |
| **Always events** (Q1&2 implementation, Q3 data collection) | TBC | IP | | | | | | | | | 84% | 100% | 100% | | 100% | 100% | | | |
| **Mixed sex occurrences** | 0 | QC | 6 | 3 | 0 | 9 | 0 | 0 | 0 | 0 | 0 | 0 | 5 | 5 | 3 | 6 | | | 23 |
| **Friends and family (F&F) test (patients' views)** | | | | | | | | | | | | | | | | | | | |
| F&F Test. **Star rating** | TBC | | 4.54 | 4.5 | 4.58 | | 4.53 | 4.6 | 4.58 | | 4.6 | 4.61 | 4.59 | | 4.59 | 4.55 | | | |
| F&F Test Inpatients **Net promoter changed to % recommending Trust – November 2014.** | >=94% (National average changes each month including independent) | OH | 76 | 74 | 81 | | 76 | 77 | 94 | | 95 | 97 | 96 | | 96 | | | | |
| F&F Test A&E **Net promoter changed to % recommending Trust – November 2014.** | >=86% (National average changes each month) | OH | 42 | 35 | 41 | | 40 | 45 | 82 | | 85 | 87 | 84 | | 87 | | | | |
| F&F response rate (A&E) | Q1 – >=15% Q4 - >=20% | C | 23.08 | 18.52 | 20.79 | 20.75 | 19.55 | 17.58 | 14.51 | 17.26 | 13.57 | 17.86 | 16.48 | 15.93 | 19.74 | 19.16% | | | 19.42% |
| F&F response rate (inpatients) | Q1 – >=25% Q4 - >=30% March 2015 achieve >=40% | C | 27.32 | 26.83 | 34.62 | 29.55 | 32.20 | 30.02 | 26.39 | 29.55 | 32.85 | 30.99 | 28.44 | 30.77 | 26.69 | 33.04 | | | 29.59 |
| **Friends and family test (staff views)** | | | | | | | | | | | | | | | | | | | |
| **Staff friends and family question (needing care)** (Extremely likely and likely responses from F&F quarterly staff survey) | TBC Q3 Staff survey results. Last year = 65 | C | | | | 70.9 | | | | 72 | | | | STAFF SURVEY 61 | | | | | |

| | Threshold | IC | A | M | J | Q1 | J | A | S | Q2 | O | N | D | Q3 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Staff F&F place to work** (as above) | Q3 Staff survey results. Last year = 60 | | | | | 66.8 | | | | 67 | | | | STAFF SURVEY 59 | | | | | |
| **Complaints and concerns** | | | | | | | | | | | | | | | | | | | |
| Number of concerns received | Not set | IP | 0 | 9 | 6 | 15 | 16 | 10 | 6 | 32 | 6 | 4 | 2 | 12 | 0 | 4 | | | 63 |
| Number of complaints received **Please see note below.** | 2013/2014 received 422 (No threshold set) | IP | 31 | 39 | 38 | 108 | 52 | 30 | 32 | 114 | 50 | 34 | 37 | 121 | 44 | 59 | | | 446 |
| % of complaints resolved within the agreed timescale | >=94% | IP | 94.44 | 95.24 | 100 | 96.51 | 96.88 | 100 | 97.5 | 98.23 | 97.92 | 100 | 100 | 99.1 | 100 | 100 | | | 98.17 |

**ST = Safety Thermometer. This is a survey carried out on one day a month on all wards. The survey provides a point prevalence figure e.g. of the number of inpatients who have a hospital acquired pressure ulcer on that day. The figure is NOT the total number of incidents in the month.**

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

**Inclusion criteria key**: Improvement priority (IP), National Quality related CQUINs (C), Local quality related CQUINs by exception*(CE), Quality Account indicators (QI), CQC Intelligent Monitoring quality related 'Elevated risks' and 'risks'(CQC), National Patient Safety Priorities (related to Sign up to Safety campaign) (SS), Contract KPIs (Quality section only) not considered at other forums (QC), Directive from Sir Bruce Keogh (BK), Open and Honest (OH)

# 2. Exception reporting

## SHMI (Summary Hospital-level Mortality Indicator)

The quarterly re-base of SHMI data has again been performed and our revised figures have risen further. Since April 2014, for three 12 month periods, our SHMI is now deemed to be 'higher than expected'; at 112 for September 2013 - August 2014 and 112 for November 2013 – October 2014 and December 2013 – November 2014. The HSMR has risen to 105, which is still 'as expected'. The Trust's crude death rates remain comparable with other Trusts. In August 2014 the trust made a commitment to review the care of all patients who die in our hospitals. Whilst much effort has been focussed on this process, 100% of deaths are not yet being reviewed. The Medical Director is committed to continuing the Trust's journey towards full compliance and has convened a high level group which has met to determine the future direction; ensuring engagement and learning and improvement across the organisation. In addition to this, we will continue to focus on improvement work around the deteriorating patient, critical care access and end of life care. A review into all deaths between 1/12/14 and 6/1/15 was undertaken by a small group of senior consultants and nurses; the reviewers will meet to discuss findings and integrate actions with the improvement work described. Work is also progressing around the accurate recording of patients' details including their admission source and comorbidities.

## Care Indicators

High Quality Care was a local CQUIN for 2013/2014. The care indicators audit was a process which was developed as part of this CQUIN to audit compliance with risk assessments for Falls, Waterlow and MUST Risk Assessments. The Trust identified this as an important aspect of quality of care and thus agreed to continue monitoring as a Quality Indicator for the Quality Accounts in 2014/2015. The results (random sample) indicate improvement to 100% compliance with both Waterlow and Falls, however compliance with MUST although improved at 81.8% still remains an issue. The trust is moving from sampling patients to roll out across all wards. The Patient Safety Champion will be formulating a recovery plan to ensure that all the wards participate in the self-assessment and that completion of MUST risk assessments improve to achieve the required 95% compliance.

## Clostridium Difficile

2 hospital apportioned case of Clostridium difficile were reported in February. The total number of hospital apportioned cases is 26 YTD against the threshold of 26 cases. A meeting has been requested with the Lead nurse at the CCG to discuss the case review process.
The Clostridium difficile objective for 2015/2016 has been published and the Trust threshold for the next financial year will be 27 cases.

## Advancing Quality – Heart failure and Pneumonia

The nursing and medical teams continue to work toward patients with Heart Failure receiving the treatment they require and in the vast majority of patients this is the case. We are working on looking at the fails which are in the main due to patients who were admitted and discharged with a diagnosis of Heart Failure within 24 hours. We are looking to develop a document similar to that used in the pneumonia work stream in support of this. Importantly, it must be noted that concerns were raised at the last AQ meeting that there may be issues with accuracy of recording heart failure patients who may not eventually have heart failure (it would be unusual only to be admitted for 24 hours with this condition). Our most recent data reflects two patients where we did not provide discharge instructions. One of these patients was subsequently found not to have heart failure. Meetings have taken place with AQuA to assist us in resolving these issues. With regards to the slight dip in compliance with Pneumonia there are no significant additional issues to report.

## Falls

Our improvement priority for 2014/2015 established a 10% reduction for falls resulting in moderate - catastrophic harm which equates to <=13 falls. The trust can report that whilst we have performed well in reducing the overall number of falls we are disappointed to report that we have failed to achieve the threshold for falls resulting in moderate - catastrophic harm. (As of February we have 16 falls of this severity and 8 awaiting approval). During 2014/2015 the trust has also identified falls as a Sign up to Safety goal. Sign up to Safety aims to deliver harm free care for every patient, every time, everywhere. It champions openness and honesty and supports everyone to improve the safety of patients. This is something that our trust has been working towards over the last few years. Our driver document articulates the trusts strategy for a 30% reduction in moderate falls by 2017. The trust did agree a 10% reduction in falls where moderate harm occurs by March 2015 for stage one of Sign up to Safety but as with the improvement priority we have failed to reach this threshold. As such we will have to concentrate efforts and ensure that we address this shortfall in stage two for 2015/2016. Falls management will also be a priority for the Falls Group and the new Patient Experience Committee. A decision is still required in relation to reduction in moderate – catastrophic falls remaining as an improvement priority for 2015/2016.

## Mixed Sex Occurrences

There were a total of six patients in ICU who were reported as unjustified breaches in February. The total number of breach days was 10 the total financial penalty is £2,500. A root cause analysis has been completed for the breaches.

## Friends and Family

The Q4 response rate for A&E is 20% and for inpatients is 30% with an additional CQUIN measure of achieving 40% response rate for inpatients for March 2015. At the end of February 2015 compliance with all three measures was at risk so a recovery plan has been implemented which includes daily monitoring in addition to regular e-mails highlighting compliance to all departments. Current compliance for Q4 is A&E January to date 18/03/15 = 19.42%; Inpatients January to date 18/03/15 = 33.07% and Inpatients – March only = 48.91%. Recovery work will continue to ensure this compliance is improved.

## 4. KPI Updates and clarification

### Pressure ulcer (Community or hospital acquired) (ST)

This indicator is in place to monitor progress with the national CQUIN - The number of patients recorded as having a category 2-4 pressure ulcer (old or new) as measured using the NHS Safety Thermometer on the day of each monthly survey / Total number of patients surveyed on the day.
The Trust median baseline for October to March 2014 was established at 3.99%. We have agreed improvement value of <=3.99% with commissioners. The Trust is required to show improvement in the period November 2014 to March 2015. The Trust has been over the target of 3.99% with the exception of January with a rate of 3.60%. The main issue is old PU (known as community). Analysis of "old to new" shows that the rate has increased due to the number of old PU's Work being undertaken to identify the patients who are admitted from care homes and directly from home and we will then identify themes e.g. location of PU and long term conditions to share with care homes and GP's. Commissioners have agreed that a report outlining community vs hospital acquired will address any concerns and enable us to achieve.

### CQC: Intelligent Monitoring

**The 'elevated risk' is:**
Whistleblowing (18-7-13 – 29-9-14)

**The 'risks' are:**
Composite indicator: In-hospital mortality - Cardiological conditions and procedures (01-May-13 to 30-Apr-14)
Composite indicator: In-hospital mortality - Haematological conditions (01-May-13 to 30-Apr-14)
NHS Staff Survey - KF10. The proportion of staff receiving health and safety training in last 12 months (01-Sep-13 to 31-Dec-13)

# BOARD OF DIRECTORS

WHH/B/2015/ **056**

| | | |
|---|---|---|
| **SUBJECT:** | **Board requested assurance report of complaints about staff attitude – September 2014 to February 2015** | |
| **DATE OF MEETING:** | 25th March 2015 | |
| **ACTION REQUIRED** | **For Assurance** | |
| **AUTHOR(S):** | Michele Lord, Patient Experience Matron | |
| **EXECUTIVE DIRECTOR:** | Karen Dawber, Director of Nursing and Governance | |
| | | |
| **LINK TO STRATEGIC OBJECTIVES:** | SO1: Ensure all our patients are safe in our care<br>SO2: To be the employer of choice for healthcare we deliver<br>SO3: To give our patients the best possible experience | |
| **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.<br>SO2/2.2 Risk that the Trust does not have the right people with the right skills ie workforce is not competent and cannot deliver as commissioned. | |
| | | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | |
| **FOIA EXEMPTIONS APPLIED:** | None | |
| | | |
| **EXECUTIVE SUMMARY** (KEY ISSUES): | This report provides an overview of complaints made about staff attitudes over a six month period.<br>• The Trust received a total of 63 formal complaints between 1 September 2014 and 28 February 2015 about the attitude of staff.<br>• Of these 63 complaints, 43 were part of a larger complaint about other aspects of care.<br>• Most complaints are about nursing staff, with 23 about qualified nurses, 2 about midwives and 5 about care assistants; a total of 30 complaints.<br>• 26 complaints were about medical staff. | |
| **RECOMMENDATION:** | ***The Board is asked to:***<br>• Note the numbers of complaints made about staff attitude.<br>• Note examples of types of concerns raised and actions taken. | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Not Applicable |
| | **Agenda Ref.** | |
| | **Date of meeting** | |
| | **Summary of Outcome** | Choose an item. |

# Complaints Report

## Complaints about attitude

### Introduction

The Health & Social Care Information Centre compiles an annual report detailing complaints made to all NHS hospital and community services. The source of the data for this report is the KO41a, a report completed by healthcare providers annually. The report for 2013 – 2014 says that of a total of 114,788 written complaints reported through the KO41a, 13,269 were about staff attitude, an increase of 966 (8%) on the previous year.

A complaint about the attitude of staff may well be risk assessed as low harm, but it is very important to track and theme these type of complaints as they can indicate personal problems of individuals that might need supportive or disciplinary action as well as larger issues within teams and services that can erode trust between the patient and health care professionals.

While we understand that a number of factors can affect the communication and attitude of staff and the perception of patients and their families/carers to communication and attitude, we must ensure that we are able to respond any complaint in an equitable manner.

The aim of this report is to provide assurance to the board that we are able to generate meaningful information to managerial and clinical leads that can be used to reflect on complaints about attitude. This may help to identify people and teams where there is a need for intervention to remedy the source of complaints, or to recognise factors that can lead to an increase in complaints and act on these. The time span chosen is 1 September 2014 to 28 February 2015.

Since April 2015 we have the ability to drill down into the subjects of complaints and attitude is a discreet subject, not as it was formally, a category within communication. A range of staff groups can be identified in reports. The period of time reviewed in this report is 1 September 2014 to 28 February 2015. The total number of formal complaints logged for this period is 255. Please note that if any of these are withdrawn they are attributed to concerns and will be subtracted from the final number of formal complaints for the year.

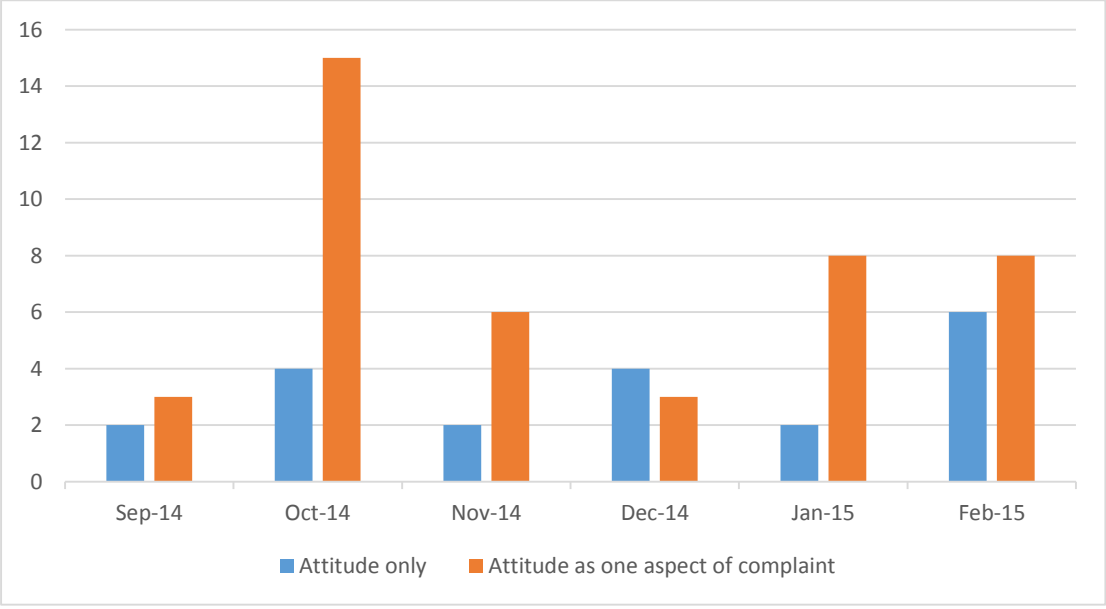
Complaints about attitude are either received in isolation or as part of wider complaints about treatment and care. Staff can find complaints about attitude quite difficult to respond to, since they often refer to incidents between the patient/complainant and the member of staff in the course of care or treatment, and there may be no witness to the interaction. Often the complainant did not raise the issue at the time and time has passed since the incident, making it difficult for staff to recall specific details of their interaction with the patient or complainant.

Example:
A complainant was told by a patient in her mother's bay that two carers had treated her mother very badly and she had raised concerns at the time, but felt that the issues had not been addressed by the matron. She made a formal complaint after her mother's death and felt that the two carers should not have still been working with patients. She also complained about the doctor's attitude. She felt he was curt and insensitive in describing the seriousness of her mother's condition within her hearing and causing a lot of distress and anxiety.

Outcome/Actions:
These aspects of the complaint were partly upheld.
The matron apologised that she had not provided feedback to the complainant after she initially raised concerns. She discussed the concerns about the carers with the ward manager and all the nursing staff on ward A5. The care assistants named in the complaint met with the matron who identified the appropriate standards for behaviour and attitude and asked them to reflect on their care of the patient. The matron would assured the complainant that this was not their intention and they regretted any distress that may have occurred because of their actions or behaviour. The matron has arranged for the nursing assistants to attend a specialised training programme to improve their core care competencies which included emphasis on compassion in care. The care training package will offer support and advice to staff in order for them to deal with empathy with some of the more challenging situations.

The consultant apologised if his communication had caused any distress. He had reflected on this incident and responded that he would be more mindful of his bedside conduct in the future.

**Graph 1: Number of complaints citing attitude by month**




Graph 1 indicates that generally attitude is more often one aspect of complaints about a range of issues. Of 63 complaints that included concerns about staff attitude for the

six month period, only 20 were specific complaints about staff, while 43 cited attitude as one of several concerns. The 20 complaints only about staff attitude account for 7.8% of the total number of complaints received during the period, Attitude as one aspect of the complaint accounts for 16.8% of the total.

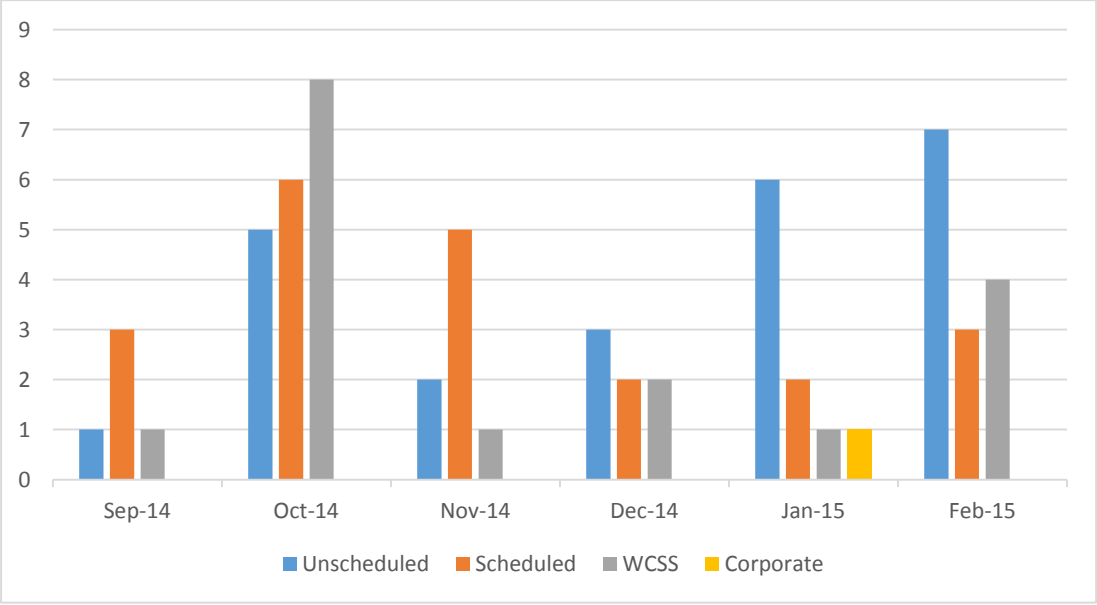
In order to provide some context on the issue of complaints about attitude it is important to look at other acute Trusts and their reporting of the same information.

St Helens and Knowsley NHS Foundation Trust reported 323 formal complaints received 2013/14, with 48 of these about staff attitude (14.8% of the total). No further breakdown of the data is available.

Chelsea and Westminster NHS Foundation Trust reported a total of 356 formal complaints in 2013/14. There were 64 complaints where the primary concern related to attitude of staff (17.9% of total) and 34 where attitude was part of a wider complaint (9.5%). Of the 98 complaints about attitude, 39 were about medical staff and 26 about nursing staff.

Central Manchester University Hospitals NHS Foundation Trust reported a total of 1084 formal complaints in 2013/14. There were 164 reported complaints about staff attitude (15.1% of total). Of these, the majority of complaints were nursing staff (44%), followed by medical staff (34%) then administrative staff (18%).

**Graph 2: Complaints about attitude by division/by month**



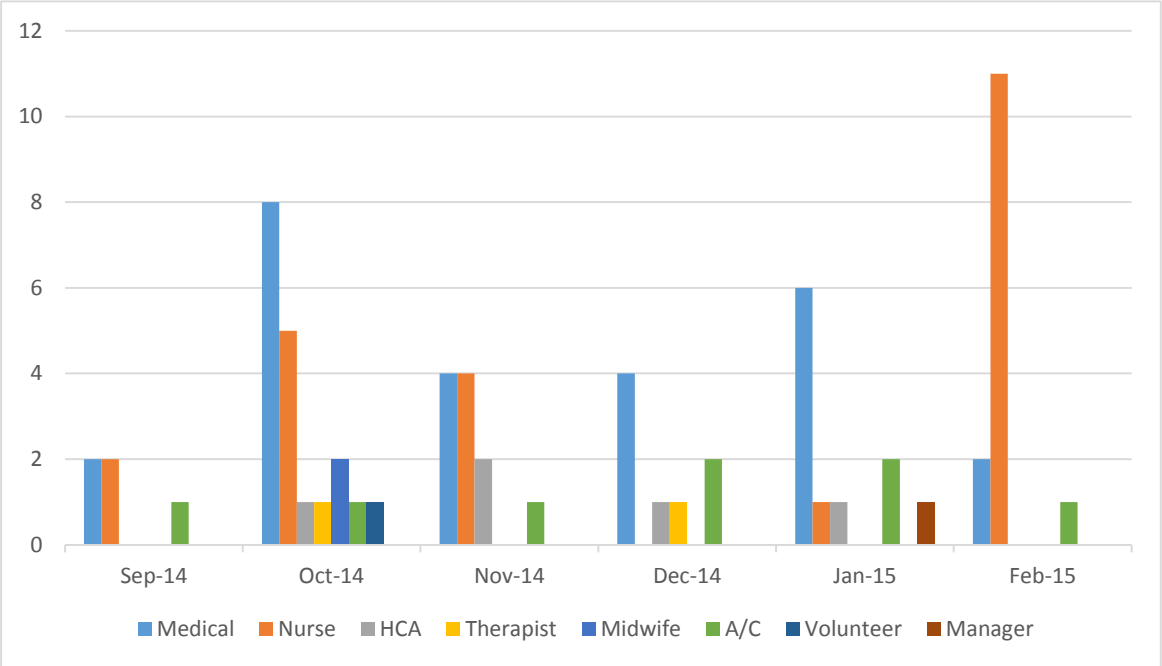

Between September 2014 and February 2015 Unscheduled Care Division received a total of 24 formal complaints about attitude, with 13 of these about staff in Accident and Emergency. Scheduled Care Division had 21 complaints, with 11 of these about clinic appointments (5 each in surgical and orthopaedic clinics and 1 in ophthalmology). WCSS had 17 complaints about, or including attitude, including 4 for maternity services, 3 for gynaecology, 4 for paediatrics (including AED) and 5 for OPD.

Corporate services had 1 attitude complaint about a member of the bereavement office staff.

Example:
A patient complained that her consultant had been dismissive and combative during her consultation. She felt that the consultant's tone and insensitive communication significantly heightened rather than alleviated her emotional state and because of this, she was not able to calmly reflect on any of the information that was shared.

Outcome/Actions:
This complaint was upheld.
The consultant reflected on the complaint and reviewed the medical records and apologised about her attitude if it appeared uncaring. In order to learn and develop her skills the consultant booked onto an advanced communications skills course in November 2014. She assured the patient that she was always looking to improve and learn from contacts and experiences with patients and was very apologetic that the patient had a poor experience.

**Graph 3: Complaints against specific staff groups.**




Please note that people may raise concerns about the attitude of more than one member of staff in a formal complaint.

**Table 1: Breakdown of total complaints about attitude by staff group.**

| Staff group | Number of complaints about attitude |
|---|---|
| Medical | 26 |
| Nursing | 23 |
| Care Assistants | 5 |
| Therapies | 2 |

| Staff group | Number of complaints about attitude |
|---|---|
| Midwife | 2 |
| Administrative | 8 |
| Volunteer | 1 |
| Manager | 1 |

Example:
Complainant felt that she was spoken to in an inconsiderate and disgraceful manner when she arrived at the wrong place.

Outcome/Actions:
This aspect of the complaint was upheld.
Patient had mistakenly attended Warrington Hospital instead of Halton, so there was slight delay in her being seen. Her concerns about the receptionist's attitude were discussed with the member of staff, who offered her apologies for causing the patient additional distress. She reflected on her behaviour and the feedback and was asked to complete the care and compassion workbook, a copy of this was enclosed with the response. She assured her manager that she would ensure that there was no repetition of this poor attitude toward patients.

**Conclusion**

Complaints about attitude are difficult for managers because complainant's perceptions of a situation can be coloured by anxiety, pain, fear and distress. In addition, a complainant may not put a situation in context, i.e. they were angry and abusive to staff, a critical situation meant there was no time for explanations or the information or message being delivered is unpalatable. At the same time, we cannot encourage a culture where patient's complaints about attitude are dismissed out of hand. We must acknowledge other people's points of view and treat their concerns with seriousness and respect.

Example:
Patient's daughter was not happy with the treatment her mother received by a particular member of nursing staff. She felt he was very aggressive and rude to her mother and other patients had also complained about him.

Outcome/Actions:
Following an initial investigation, the member of staff was immediately spoken to and action was taken in accordance with the Trust's disciplinary procedures. The matron also shared the complaint letter with the ward team and made it very clear that such behaviour will not be tolerated. The nurse involved apologised that his behaviour and actions have caused distress and anxiety. He reflected on this incident and assured the matron that there will be no repetition of this unprofessional behaviour. He was taken off night duty indefinitely to enable monitoring of his work performance, behaviour and attitude.

**Recommendations**

Some staff deal very well with complaints about attitude, providing responses that acknowledge the complainant's viewpoint and provide actions taken (see examples). Below are some actions that could improve this across the board.

- Where there is a complaint about a member of staff's attitude, the manager or clinical lead for that person should be the one to respond. Complainants are not likely to be impressed by a response from the person they had a problem with. This also means that the manager can speak about the individual's usual performance and instigate disciplinary processes if these are indicated, either because this is one of several issues, or because of the seriousness of the incident. The manager is also in a position to monitor future performance and identify appropriate development activities.
- In addition to apologising, there should be some evidence that the individual has reflected, learned, improved etc. Though apologies are important, it is also important to demonstrate that action was taken. Complainants often only want to ensure that what happened to them will not happen to someone else.
- If the member of staff is very insistent that there was no inappropriate behaviour or attitude on their part, this needs to be clearly stated and not confuse the issue by then identifying actions or training to be taken.
- Interview any witnesses and include their accounts in the investigation and response.
- Managers must note any repeated complaints about attitude and review actions to be taken to prevent future problems.

Example:
The complainant did not like the attitude of the consultant caring for her dying mother. She was particularly upset that he said that "it was not looking good" in her mother's hearing, causing acute distress and contributing to deterioration in her breathing.

Outcome/Actions:
The consultant felt that he was usually courteous to patients and relatives and treated them with the greatest empathy and respect. He felt that when discussing such difficult issues as end of life care and prognosis, discussions with relatives and patients can be distressing and doctors have to endeavour to convey the severity of illness with honesty and compassion. The consultant assured the complainant that he would be more mindful of his bedside conduct in the future and apologised for the effect his remark had on your mother and yourself.

# BOARD OF DIRECTORS

WHH/B/2015/ **057**

| | |
|---|---|
| **SUBJECT:** | **Review of Morecambe Bay High Level Inquiry** |
| **DATE OF MEETING:** | 25th March 2015 |
| **ACTION REQUIRED** | **For Discussion** |
| **AUTHOR(S):** | Millie Bradshaw, Associate Director of Governance |
| **EXECUTIVE DIRECTOR:** | 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): | The Report details a distressing chain of events that began with serious failures of clinical care in the maternity unit at Furness General Hospital, part of what became the University Hospitals of Morecambe Bay NHS Foundation Trust. The result was avoidable harm to mothers and babies, including tragic and unnecessary deaths. What followed was a pattern of failure to recognise the nature and severity of the problem, with, in some cases, denial that any problem existed, and a series of missed opportunities to intervene that involved almost every level of the NHS. Had any of those opportunities been taken, the sequence of failures of care and unnecessary deaths could have been broken. As it is, they were still occurring after 2012, eight years after the initial warning event, and over four years after the dysfunctional nature of the unit should have become obvious.<br><br>The Report includes detailed and damning criticisms of the maternity unit, Morecambe Bay NHS Foundation Trust and the regulatory and supervisory system. |
| **RECOMMENDATION:** | ***The Board is asked to:***<br>**1.** Note that the Morecambe Bay High Level Inquiry is being reviewed by the Trust<br>**2.** Note that progress would be reviewed by the Quality Committee to provide assurance to the Board of |

| | | |
|---|---|---|
| | Directors that actions have been undertaken to address the 17 recommendations that relate to trusts. | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Not Applicable |
| | Agenda item | |
| | **Date of meeting** | |
| | **Summary of Outcome** | Choose an item. |

**EXECUTIVE SUMMARY**

The Morecambe Bay Investigation was established by the Secretary of State for Health to examine concerns raised by the occurrence of serious incidents in maternity services provided by what became the University Hospitals of Morecambe Bay NHS Foundation Trust (the Trust), including the deaths of mothers and babies.

Relatives of those harmed, and others, expressed concern over the incidents themselves and why they happened, and over the responses to them by the Trust and by the wider National Health Service (NHS), including regulatory and other bodies.

The independent investigation of these events, covered the period from 1 January 2004 to 30 June 2013.

The origin of the problems lay in the seriously dysfunctional nature of the maternity service at Furness General Hospital (FGH). Clinical competence was substandard, with deficient skills and knowledge; working relationships were extremely poor, particularly between different staff groups, such as obstetricians, paediatricians and midwives. There was a growing move amongst midwives to pursue normal childbirth 'at any cost'; there were failures of risk assessment and care planning that resulted in inappropriate and unsafe care; and the response to adverse incidents was grossly deficient, with repeated failure to investigate properly and learn lessons.

The Investigation Team reviewed cases, including all the maternal deaths and deaths of babies in the period under investigation, using a validated method, and found 20 instances of significant or major failures of care at FGH, associated with three maternal deaths and the deaths of 16 babies at or shortly after birth. Different clinical care in these cases would have been expected to prevent the outcome in one maternal death and the deaths of 11 babies. This was almost four times the frequency of such failures of care at the Royal Lancaster Infirmary.

The Report showed that the problems did not develop overnight, and the first sign of their presence occurred in 2004, when a baby died from the effects of shortage of oxygen, due to a mismanaged labour. The investigation in 2004 was rudimentary, over-protective of staff and failed to identify underlying problems.

**ASSESSMENT**

The Report makes 44 Recommendations to which the Warrington and Halton Hospitals NHS Foundation Trust will review in accordance with its Policy for the Management of National Guidance, to which High Level Inquiries is included.

Out of the 44 Recommendations, the initial assessment shows that 17 are applicable to all NHS trusts. As a result Leads within the Trust have been identified to review and address those recommendations.

The remaining 27 Recommendations are for external organisations examples being the Department of Health, NHS England and Care Quality Commission to take forward and develop national standards and or policies.

**RECOMMENDATION:**

1. To note that the Morecambe Bay High Level Inquiry is being reviewed in the Trust
2. To Note that progress would be reviewed by the Quality Committee to provide assurance to the Board of Directors that actions have been undertaken to address the 17 recommendations that relate to trusts.

**CONCLUSION:** The Trust has systems in place to review and respond to the High Level Enquiry. The Trust will effectively monitor progress in order to provide assurance to the Board that what happened at Morecambe could not occur at Warrington and Halton Hospitals NHS Foundation Trust.

# BOARD OF DIRECTORS

WHH/B/2015/ **058**

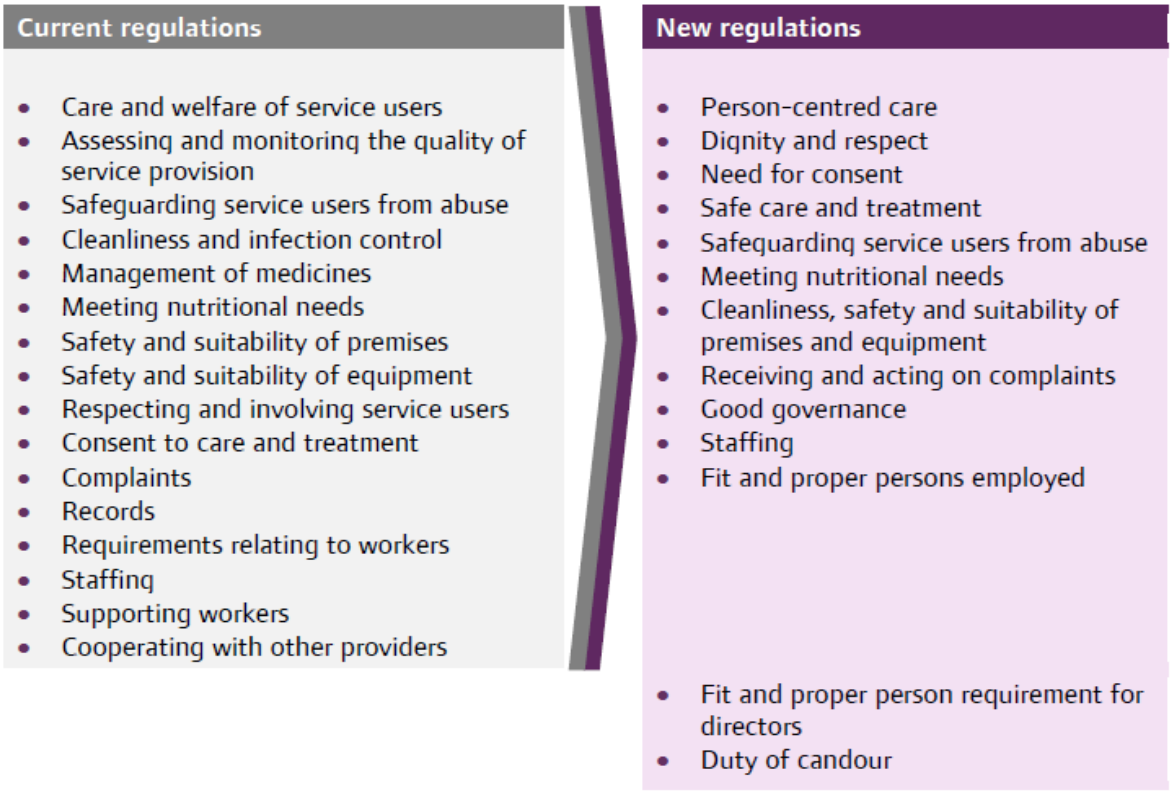
| | | |
|---|---|---|
| **SUBJECT:** | **New Care Quality Commission Fundamental Standards** | |
| **DATE OF MEETING:** | 25th March 2015 | |
| **ACTION REQUIRED** | **For Assurance** | |
| **AUTHOR(S):** | Millie Bradshaw | |
| **EXECUTIVE DIRECTOR:** | Karen Dawber, Director of Nursing and Governance | |
| | | |
| **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): | There are 11 new Care Quality Commission regulations that set out the fundamental standards of quality and safety. These replace the current 16 regulations as from 1st April 2015. The new regulations provide clear statements of the standards below which care should never fall. | |
| **RECOMMENDATION:** | ***The Board is asked to:***<br>**1.** For the Board to receive and note the information<br>**2.** To be informed that the CQC Operational Procedure to the revised changes will be submitted to the Quality Committee in April for review and Approval | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Not Applicable |
| | Agenda item | |
| | **Date of meeting** | |
| | **Summary of Outcome** | Choose an item. |

**EXECUTIVE SUMMARY**

There are 11 new Care Quality Commission regulations that set out the fundamental standards of quality and safety. These replace the current 16 regulations as from 1st April 2015. The new regulations provide clear statements of the standards below which care should never fall.

A comparison of the previous and the new regulations is shown in Figure 1.

**Figure 1**




**ASSESSMENT**

The new regulations are more focused than the previous ones which will enable the CQC to pinpoint more clearly the standards below which care must not fall, and take appropriate enforcement action.

There are also two brand new regulations: a duty of candour, and a fit and proper person requirement for directors to which a Paper was provided for the latter to the Board in September 2014 to inform them to the changes.

The Trust captures all the evidence within CIRIS Integrated Governance system. The Trust is working closely with (3E, CIRIS) to identify any systematic changes required to the operational management for the local quarterly Assessments, which are underpinned by supporting Evidence.

**RECOMMENDATION:**

**3.** For the Board to receive and note the information

**4.** To be informed that the CQC Operational Procedure to the revised changes will be submitted to the Quality Committee in April for review and Approval

**CONCLUSION:** The recent CQC Inspection led to even greater understanding of the requirements to demonstrate compliance with their Standards. Work is ongoing throughout the Trust to ensure work that was undertaken for the Inspection continues to be embedded in all areas.

## Person-centred care

Regulation 9 specifies that the care and treatment of service users must be appropriate, meet their needs and reflect their preferences. To meet this standard provider organisations must

- Carry out an assessment of the care and treatment needs of then service user in the context of their preferences, involving the service user or their representative as appropriate;
- Aim to meet the service users' preferences while ensuring that their needs are met;
- Ensure that the service user understands their options for care and treatment and has the opportunity to discuss the risks and benefits of those options with a healthcare professional;
- Ensure that the service user or their representative is involved in decisions relating to their care and/or treatment to the maximum extent;
- Provide appropriate opportunities for people or their representatives to manage their care or treatment;
- Involve people using services in decisions relating about the way in which the service is delivered in so far as it relates to their care or treatment;
- Provide relevant persons with the information they would reasonably need to participate in decisions on their care and treatment;
- Make reasonable adjustments to enable the service user to receive their care or treatment;
- Where meeting a service user's nutritional and hydration needs, have regard to the service user's well-being.

The CQC cannot prosecute providers for breach of the regulation or any of its parts, but the CQC may decide to take regulatory action.

The CQC's guidance, http://www.cqc.org.uk/content/regulations-service-providers-and-managers, gives more detail on what providers might do to meet the standard. The underlying principles for providers are that they must do what is practicable and reasonable in each instance to comply with the standard. Clearly a culture that promotes involving people in their treatment will be as important as having the right systems and processes in place. However boards will want to assure themselves that what is reasonable and practicable in delivering patient-centred treatment is being achieved.

## Dignity and respect

Regulation 10 stipulates that patients and service users must be treated with dignity and respect.
To comply with the regulation provider organisations must:

- Ensuring the privacy of the patient or service user;
- Support the autonomy, independence and involvement in the community of the patient or service user;
- Give due regard to any relevant protected characteristics (as defined in section 149(7) of the Equality Act 2010) of the patient or service user. The protected characteristics are age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation.

A component of the regulation is that boards must take account of the section of the CQC's guidance beginning on page 34 of the following: http://www.cqc.org.uk/content/regulations-service-providers-and-managers. The CQC cannot prosecute providers for breach of the regulation or any of its parts, but the CQC may decide to take regulatory action.

The dignity and respect regulation applies to both facilities and to the way in which individuals are treated. The requirement for separate sleeping and bathroom facilities for each sex is not subject to a reasonableness test, although other aspects of the privacy dimension of the regulation are subject to the provider organisation making all reasonable efforts: to hold discussions in private spacers and to respect the privacy preferences of the patient/service user, for example.

The CQC's guidance appears to acknowledge that autonomy brings with it different and sometimes additional risks. In recognising the need to support independence as safely as possible the guidance ostensibly recognises that while risks associated with supporting independence can be identified and controlled they cannot be completely eliminated. The logic of the acknowledgment is that in enforcing the regulation the CQC will accept that from time to time controls will not deliver the desired outcome and adverse incidents will occur.

To comply with the provisions on protected characteristics provider organisations will need to ensure that they do not discriminate unlawfully either directly or indirectly. It is likely that NHS provider boards will already have sources of assurance available to them in this respect.

## Need for consent

To comply with regulation 11 provider organisations must ensure that they obtain the consent lawfully and that the person who obtains the consent has the necessary knowledge and understanding of the care and/or treatment for which they are seeking consent. A component of the regulation is that boards must take account of the section of the CQC's guidance beginning on page 37 of the following: http://www.cqc.org.uk/content/regulations-service-providers-and-managers.

The CQC can bring a criminal prosecution for a breach of this regulation or a breach of part of the regulation. To bring prosecution it is not necessary for the CQC to first take other regulatory action or issue a warning notice. It is a defence to this offence that the provider organisation took all reasonable steps to comply and acted with all due diligence.

Provider organisations already have well functioning systems in place to ensure that consent is obtained, but given the consequences of any system failure boards will probably wish to check the health of their systems and assurances on them.

## Safe care and treatment

Regulation 12 sets out what provider organisations must do to deliver safe treatment. This includes:

- Assessment and control of the risks to the health and safety of patients or service users;
- Ensuring staff have the qualifications, competence, skills and experience to provide safe care and treatment;
- Ensuring premises are fit for purpose and safe for use;
- Ensuring equipment is safe for such use and is used safely;
- Ensuring equipment or medicines are available in sufficient quantities to ensure safe treatment;
- Ensuring medicines are managed properly and safely;
- Ensuring effective infection control including health care associated infections;

- Ensuring that shared responsibility for care or treatment and transfer to other providers is dealt with safely and effectively.

A component of the regulation is that provider organisations must have regard to nationally recognised guidance and the section of the CQC's guidance beginning on page 41 of the following: http://www.cqc.org.uk/content/regulations-service-providers-and-managers. In effect the requirement is that provider organisations should follow such guidance. The CQC guidance contains further detail on how to comply with the regulation. Effective systems of risk management operated with diligence and rigour go to the heart of complying with the regulation.

The CQC can bring a criminal prosecution for a breach of this regulation or a breach of part of the regulation if the breach results in avoidable harm to the patient or service user or if a person using the service is exposed to significant risk of harm. The regulations themselves make no mention of 'exposed to significant risk of harm' and the guidance does not define it further, however the implication is that the CQC will consider prosecutions for 'near miss' situations if the fact that significant harm did not occur was fortuitous rather than because of the operation of a last line of defence.

Oversight of robust, effective risk management and assurance systems to ensure patient safety goes to the heart of a boards work. Nevertheless boards may wish to review the operation and effectiveness of their risk management systems in the light of the new criminal offence.

## Safeguarding service users from abuse and improper treatment

The expectation set out in regulation 13 is that provider organisations have a 'zero tolerance approach' to abuse, unlawful discrimination and unlawful restraint. Abuse is defined in the regulation as: any behaviour towards a service user that is an offence under the Sexual Offences Act 2003; ill-treatment whether of a physical or psychological nature, including degrading treatment; theft, misuse or misappropriation of money or property and neglect.

Restraint is defined in the guidance as when someone: 'uses, or threatens to use, force to secure the doing of an act which the service user resists, or restricts the service user's liberty of movement, whether or not the service user resists, including by use of physical, mechanical or chemical means. An offence is committed where such restraint is unnecessary or disproportionate restraint, or where a person is unlawfully deprived of liberty.

A component of the regulation is that boards must take account of the section of the CQC's guidance beginning on page 48 of the following: http://www.cqc.org.uk/content/regulations-service-providers-and-managers.

The CQC can go straight to prosecution if a failure to meet the sections of the regulation dealing with abuse, discrimination or unlawful restraint results in avoidable harm or significant risk of harm. Once again it is a defence that the provider organisation took all reasonable steps to comply and acted with all due diligence, so boards will wish to be assured that this is the case.

## Meeting nutritional and hydration needs

To comply with regulation 14 provider organisations must make sure that people using their services have enough to eat to meet their nutrition needs and enough to drink to meet their hydration needs. Provider organisations

must ensure that people using their services have their nutritional needs assessed and that food is provided to meet those needs. This will include prescribed nutritional supplements and/or parenteral nutrition. Provider organisations must take account of preferences and religious and cultural backgrounds when providing food and drink and must provide the support necessary to enable people to eat and drink.

A component of the regulation is that boards must take account of the section of the CQC's guidance beginning on page 54 of the following: http://www.cqc.org.uk/content/regulations-service-providers-and-managers. The CQC can go straight to prosecution if a failure to meet the regulation results in avoidable harm or significant risk of harm. It is a defence that the provider organisation took all reasonable steps to comply and acted with all due diligence, so once again, boards will wish to be assured that this is the case.

## Premises and equipment

To comply with regulation 15 provider organisations must ensure that premises are clean, fit purpose, well maintained and accessible. They must also ensure that equipment is clean, suitable, properly maintained, stored securely and used properly. It should be noted that legal responsibility remains with the registered provider organisation even where they delegate responsibility through contracts or legal agreements to a third party, independent suppliers, professionals, supply chains or contractors. Where the service user or patient owns the equipment needed to deliver their care and treatment, or the provider does not provide it, the provider must still make every effort to make sure that it is clean, safe and suitable for use.

A component of the regulation is that boards must take account of the section of the CQC's guidance beginning on page 59 of the following: http://www.cqc.org.uk/content/regulations-service-providers-and-managers. The CQC cannot prosecute under this regulation but it can take regulatory action. However where a breach of this regulation results in unsafe care or treatment regulation 12 in respect of safe care and treatment, against which criminal charges can be brought, will apply. Boards will therefore wish to confirm assurances in respect of premises and equipment.

## Receiving and acting on complaints

To comply with regulation 16 providers must have an effective and accessible system for identifying, receiving, handling and responding to complaints made by anyone. All complaints must be investigated thoroughly and, where failures have been identified, any necessary action must be taken. The regulation does not define what a complaint is, so it is important that provider organisations have their own robust and justifiable definition so that they can demonstrate compliance. However the guidance states that complaints may be made either orally or in writing, suggesting a broad definition of complaints along the lines of: any expression of dissatisfaction.

The CQC cannot prosecute in regard to this element of the regulation, but it can take regulatory action. However regulation 20 on the duty of candour also applies to the complaints procedure and prosecutions can be brought under regulation 20. A component of the regulation is that boards must take account of the section of the CQC's guidance beginning on page 64 of the following: http://www.cqc.org.uk/content/regulations-service-providers-and-managers.

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When requested to do so, providers must provide CQC with a summary of complaints, responses and other related correspondence or information within 28 days of the request being made. Failure to comply with this element of the regulation is an offence and the CQC can move straight to prosecution without a warning notice being issued.

Provider organisations already have complaints procedures in place, however complaints systems in the NHS have been under increasing scrutiny of late and it is important that NHS providers check that their complaints processes are up to date and functioning well.

It is also important that providers can demonstrate that they are learning from complaints at all levels of the organisation, from trends in feedback and complaints, and can cite examples of where complaints have led to service change and improvement.

## Good governance

To meet regulation 17 provider organisations must ensure that the systems and processes that underpin good governance are in place and operate well. This will include systems of risk management, assurance and checks on assurance. One of the key he outcomes should be an enhanced ability to assess, monitor and drive improvement in the quality, safety and experience of the services provided. The regulation places a duty on provider organisations continually to evaluate and seek to improve their governance and auditing practice.

Provider organisations are required under the regulation to maintain accurate, complete and detailed records for each person to whom they provide a service and records relating the employment of staff and the overall management of the regulated activity. Provider organisations are required under the regulation to seek and act on feedback from patients/service users, those acting on their behalf, staff and other stakeholders to enable them to evaluate their services and drive improvement. A component of the regulation is that boards must take account of the section of the CQC's guidance beginning on page 68 of the following: http://www.cqc.org.uk/content/regulations-service-providers-and-managers. Failure to comply with this element of the regulation is not an offence, but the CQC may take regulatory action.

When requested, provider organisations must give to the CQC a written report setting out how they assess, monitor, and where necessary improve the quality and safety of their services within 28 days of the request being made. Failure to comply with this element of the legislation is an offence and the CQC can move straight to prosecution without first issuing a warning notice.

Sound corporate governance underpinned by robust systems and processes is part and parcel of the work of provider organisations' boards and is subject to periodic review in accordance with the provisions of the foundation trust Code of Governance. Those boards that have not yet commissioned an external review of their governance arrangements may wish to consider whether it would be timely to do so in the light of the regulations.

## Staffing

To meet regulation 18 provider organisations must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced staff are available to meet the needs of patients/service users at all times as well as to meet the other regulatory requirements. Provider organisations must ensure that their staff receive the support, training,

professional development, supervision and appraisals necessary for them to carry out their duties effectively and so that they continue to meet the professional standards necessary to practise.
A component of the regulation is that boards must take account of the section of the CQC's guidance beginning on page 75 of the following: http://www.cqc.org.uk/content/regulations-service-providers-and-managers.

The CQC cannot prosecute for a breach of this regulation but it may take regulatory action. Provider organisations will need to be cognisant and take account of any recommended guidelines on staffing levels including NICE guidelines where available and need to take account of the views of their staff in determining staffing. There is currently no legal requirement to follow guidelines such as those produced by NICE, but organisations that choose not to follow the guidelines should have followed a rigorous process in deciding otherwise and should have a body of evidence available to them to assure themselves on the decision.

## Fit and proper persons employed

To comply with regulation 19 provider organisations must ensure that persons employed to carry on a regulated activity must:

(a) be of good character;
(b) have the qualifications, competence, skills and experience which are necessary for the work to be performed by them; and
(c) be able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the work for which they are employed.

'Regulated activity' means activities set out in Schedule 1, Regulated Activities, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. It is a matter for the provider organisation to decide whether a person is of good character but they must take account of all available information to confirm that the person is of good character, and have regard to the matters outlined in Schedule 4, Part 2 of the regulations:

- Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence, and
- Whether the person has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

The CQC will expect that processes followed to assess good character take account of honesty, trust, reliability and respect. In common with directors, employees must be able to provide information in accordance with Schedule 3 of the regulations: http://www.legislation.gov.uk/ukdsi/2014/9780111117613/schedule/3. If a provider organisation considers that an applicant is suitable, despite them having information about anything set out in Schedule 3, their reasons for reaching that decision should be recorded for future reference.

There is a requirement that provider organisations review the fitness of their staff on a regular basis and take appropriate action where necessary including ensuring that staff found to be unfit no longer carry out the regulated activity. Appraisals are likely to be a suitable vehicle for such reviews. Provider organisations will need to ensure that they have effective and fair procedures in place to deal with concerns about a person's fitness, but where there is the possibility of imminent risk organisations should be able to respond immediately.

Where a qualification is not required by law it is for provider organisations to decide what qualifications are necessary for a role. In either case provider organisations must take steps to ensure that appointed staff hold the necessary qualifications and remain fit and qualified to practise.

A component of the regulation is that boards must take account of the section of the CQC's guidance beginning on page 79 of the following: http://www.cqc.org.uk/content/regulations-service-providers-and-managers.

The CQC cannot bring a prosecution for a breach of any element of this regulation unless it also constitutes a breach of one of the other prosecutable regulations. It can however take regulatory action.

## Duty of candour

Regulation 20 makes it a statutory requirement that health service bodies to act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.

**'Regulated activity'** means activities set out in Schedule 1, Regulated Activities, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In this context a 'relevant person' is the patient or service user. In the event of the patient or service user's death, or if they under 16, or over 16, but lack capacity in relation to the matter the relevant person can be someone lawfully acting on their behalf'

As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body must:

(a) notify the relevant person that the incident has occurred in accordance with the paragraph below and;
(b) provide reasonable support to the relevant person in relation to the incident, including when giving such notification.

The notification must:

(a) be given in person by one or more representatives of the health service body;
(b) provide an account, which to the best of the health service body's knowledge is true, of all the facts the health service body knows about the incident as at the date of the notification;
(c) advise the relevant person what further enquiries into the incident the health service body believes are appropriate;
(d) include an apology; and
(e) be recorded in a written record which is kept securely by the health service body.

This must be followed by a written notification to the relevant person containing:

(a) the information provided orally as described above;
(b) details of any enquiries to be undertaken;
(c) the results of any further enquiries into the incident; and
(d) an apology.

All correspondence between the parties must be kept by the health service body. If the patient or service user or the person acting on their behalf cannot be contacted in person or declines to speak to the representative of the

health service body the above paragraphs do not apply, but the health service body must keep a written record of attempts to contact or to speak to service user, patient or their lawful representative.

## Further definitions

The regulations provide definitions as follows:

**Notifiable safety incident** means any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition, or severe harm, moderate harm or prolonged psychological harm to the service user.

**Severe harm** means a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage, that is related directly to the incident and not related to the natural course of the service user's illness or underlying condition.

**Moderate harm** means harm that requires a moderate increase in treatment, and significant, but not permanent, harm.

**Moderate increase in treatment** means an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care).

**Prolonged psychological harm** means psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days.

**Apology** means an expression of sorrow or regret in respect of a notifiable safety incident.

Most of the requirements under the duty of candour are clear cut. NHS provider organisations will already have in place arrangements to comply with the contractual duty and these are likely to be adaptable to deal with the statutory duty. Nevertheless boards are likely to wish to be assured that the processes they have put in place are compliant with the statutory duty and are delivering the required outcome.

## The CQC's approach

The CQC has included consideration of the duty in its key lines of enquiry (KLOEs) for inspections and intends to use the regulations to promote and encourage good practice and to acknowledge good practice where it is found. The CQC has committed to working with provider organisations to develop processes by which compliance with the duty can be assessed and to reserve use of prosecution for those cases where there is evidence of deliberate withholding or manipulation of information.

The duty on providers to ensure an open and honest culture across and at all levels within its organisation is not in itself controversial, and indeed parallels the existing contractual duty of candour. However NHS provider boards will need to assure themselves that they comply fully with the spirit of openness implied by the duty. While processes and procedures can be put in place quite quickly alongside measures to deliver compliance, culture change

generally takes place over a much longer timescale and it is often the case that behaviours will change before attitudes.

Please find our consultation response here: http://www.foundationtrustnetwork.org/resource-library/fit-and-proper-persons-and-duty-of-candour/?preview=true.

## Display of CQC ratings on NHS provider organisation premises and websites

Regulation 20A of the Fundamental Standards sets out the requirement to display ratings ('performance assessments') at their physical premises and on their website(s). This will be a legal requirement from 01 April 2015. This Annex summarises CQC's guidance but we strongly recommend you read the full guidance (13 pages) and approach CQC for clarification about how you can meet the display requirements with respect to any logistical or practical challenges for your own trusts' premises and services. CQC's guidance for the display of ratings can be found here.

### Specific requirements placed on healthcare providers

To comply with this duty CQC offers the following guidance for NHS Trusts and Foundation Trusts:

- You must display your ratings at each and every premises where you provide a regulated activity, even if the premises is not registered with the CQC, and in your main place of business. Vehicles and patient's homes are exempt.
- Your ratings must be displayed at all premises no later than 21 calendar days after your inspection report has been published on CQC's website. This applies even if you have submitted a request for a review of ratings.
- There are up to three different types of posters outlined by CQC:
    - The provider poster (with information on the trust rating overall),
    - Premises poster (for information relating to services provided at a specific site)
    - Activity poster (for information relating to specific core services).
- Posters need to include specific information: CQC has made posters for displaying ratings available to download from their website. You may also design your own poster but it must be as readable as the CQC template.
- Which posters need to be displayed? There is a table in the guidance that sets out CQC's expectations for different sectors on how posters should be displayed and at which locations. In brief:
    - the premises poster should be displayed at each site, with the provider poster used if there is no premises level poster (for example, for community or mental health providers) or if a premises level poster is not relevant (for example, an NHS trust head office not in a CQC rated location).
    - You may wish to also display activity posters at the entrances to wards/clinics where core services are delivered.
    - Activity posters should always be displayed alongside either the premises poster or the provider poster.
    - Posters should be printed in colour and at a minimum size of A4 (or larger to ensure visibility).
- Where posters should be displayed: CQC expects hospitals to display ratings posters at the main entrance(s) to each hospital so as many people as possible can see them. Community-based services will need to ensure that the poster(s) are visible to patients when they use services. Mental Health trusts will

need to display poster(s) at the main entrance(s) so as many people as possible are able to see them. If some patients do not use the entrance (for example, they are on a locked ward) you must display the poster so those patients can see it. In premises where several registered providers operate, it is up to each provider to ensure the ratings for the services they provide are displayed.

- Additional information: Providers are encouraged to display additional information (alongside, not instead of, the CQC poster) for patients if considered that it will aid their fuller understanding of the CQC ratings.
- Websites: CQC have developed a 'widget' to help you display your rating online (available here). Wherever possible, it is advised that ratings be placed on a 'context-specific' page. For example, a hospital rating should be included on the main page for that hospital. If your trust does not have premises specific pages, you are still required to display your premises ratings. You must put your ratings on every website that you operate that describes the services you offer and the ratings should be on a page that can be reached via the main navigation.

### NHS Providers' view

From your feedback to date, we recognise that members may find the requirements set out above onerous, or more difficult to implement in some care settings than others. We welcome your on going feedback on the implementation of all of the regulations emanating from the Care Act, and we are in an open dialogue with CQC and others about their implementation. Our consultation responses to date can be found here.

## Conclusions

The regulations are intended to comprise a comprehensive suite of requirements that will help the CQC to regulate provider organisation's compliance with fundamental standards. Breach of regulations 11, 12, 13, 14, 16,17 and 20 can lead to directly to the prosecution of organisations with the possibility of substantial fines being imposed in addition to possible dame to the reputation of the organisation involved. It is not known whether prosecution will be the preferred route for breaches given that other regulatory action will be available to the CQC however all provider boards will wish to assure themselves that they have the necessary processes and procedures in place to comply for patient benefit and to support staff appropriately, as well as given the likely national focus on monitoring compliance with the new standards.

NHS Providers
March 2015

# BOARD OF DIRECTORS

WHH/B/2015/ **059**

| | |
|---|---|
| **SUBJECT:** | **Verbal Report from the Chair of the Strategic People Committee** |
| **DATE OF MEETING:** | 25th March 2015 |
| **DIRECTOR:** | Anita Wainwright, Non-Executive Director |

# BOARD OF DIRECTORS

WHH/B/2015/ **059(a)**

| | |
|---|---|
| **SUBJECT:** | **Strategic People Committee Terms of Reference** |
| **DATE OF MEETING:** | 25th March 2015 |
| **ACTION REQUIRED** | **For Decision** |
| **AUTHOR(S):** | Interim Director of HR&OD/ Trust Secretary |
| **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<br>SO3: To give our patients the best possible experience |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | SO2/2.1 Failure to engage and involve our workforce in the design and delivery of our services.<br>SO2/2.2 Risk that the Trust does not have the right people with the right skills ie workforce is not competent and cannot deliver as commissioned. |
| | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full |
| **FOIA EXEMPTIONS APPLIED:** | None |
| | |
| **EXECUTIVE SUMMARY**<br>(KEY ISSUES): | The Terms of reference of the Strategic People Committee have been reviewed by the Committee and comments made on its purpose and future activity following the Strategic People Committee Development session held on 8 December 2014 and meeting of the Committee held on 9 February 2015.<br><br>The terms of reference follow the structure of other Board Committee terms of reference and has removed the identification of a deputy to attend if the core member could not attend. It is now the responsibility for the Core member to notify the Secretary of the Committee if they are unable to attend and to advise who they have asked to attend in their place. |
| **RECOMMENDATION:** | ***The Board is asked to:***<br>1. Approve the Terms of Reference of the Strategic People Committee;<br>2. Agree the membership of the Committee as set out in the terms of Reference;<br>3. agree that Anita Wainwright Chair the Committee; and |

| | | |
|---|---|---|
| | 4. agree that Lynne Lobley is the nominated non-executive director on the Committee. | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Strategic People Committee |
| | **Agenda Ref.** | |
| | **Date of meeting** | 8 December 2014 and 9 February 2015 |
| | **Summary of Outcome** | Noted |

# STRATEGIC PEOPLE COMMITTEE

## TERMS OF REFERENCE

| | |
|---|---|
| Document Title | Strategic People Committee |
| Document Reference | |
| Author | Trust Secretary |
| Intranet Location | TBC |
| Lead Executive Director | Director of Human Resources and Organisational Development |
| Reporting to | Board of Directors |
| Committee Approval | |
| Board of Directors Approval | [25th March 2015] |
| Review Date | [March 2016] |
| Mandatory/ Statutory Standards or Requirements/related documents | Provider Licence<br>Trust Constitution<br>Board Assurance Framework<br>Health Education England |
| Replaces | SPC terms of Reference May 2013 |
| Issue Date | [March 2015] |

## 1. PURPOSE

The Strategic People Committee (the Committee) is accountable to the Board of Directors (the Board) for providing assurance on all aspects of the Trust's workforce in delivering and monitoring a coherent People strategy to support the Trust's Strategic direction "Creating Tomorrow's Healthcare Today" and to ensure that the Trust meets its workforce aims of: the right team; an exemplary employer; and reward management.

The Committee is accountable to the Board for ensuring that it maintains an oversight of the Trust's People Strategy to provide assurance to the Trust Board on the management of risks relating to the Corporate Workforce objectives; oversee the development of the Trust's policies and procedures framework relating to staffing; staff education and organisational Development needs.

## 2. AUTHORITY

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

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

## 3. REPORTING ARRANGEMENTS

The Committee will have the following reporting responsibilities:

The minutes of the Committee meetings will be formally recorded and circulated to the Board. The Chair of the Committee shall draw to the attention of the Board and Audit Committee any issues that require disclosure to it, or require executive action.

The Chair of the Committee will report to the Board monthly following each meeting providing assurance of the Workforce governance arrangements in place within the Trust and provide an annual report to the be presented to either the April or May Board meeting on its work and performance in the preceding year.

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

## 4. DUTIES & RESPONSIBILITIES

The Committee's responsibilities fall broadly into the following three areas:

**Strategy and Performance**

a) To oversee the development and implementation of the Trust's people strategy that will ensure that our staff are well managed, developed, rewarded and engaged.

b) To ensure that the Trust has a comprehensive and integrated approach to the management of its staff expressed in its associated policies.

c) To ensure that the framework for Education Governance is conducive to achieving the Trust's Strategic Objectives and which would include the objectives of the Trust to be a 'Model Employer'.

d) To ensure that the workforce is engaged with and motivated, taking into consideration staff views and opinions.

e) To receive minutes and regular reports from the identified Sub Committees and Working Groups and monitor the implementation of action plans linked to the achievement of Model Employer and management of associated risks.

f) To produce summaries of prioritised risks for inclusion in the Trust's Corporate Risk Register and Board Assurance Framework and ensure that steps are in place to manage and report on the high risks identified.

g) To approve employment policies and Human Resources strategies – subject to any specific considerations being required by either of the Board Committees (Finance and Sustainability Committee and the Quality Committee).

h) To monitor and develop the Trust's performance against national standards so far as they relate to employment.

i) To review cost improvement schemes and their relationship to staffing and workforce experience.

**Governance & Assurance**

j) To provide assurance to the Board that the development and implementation of the Trust people strategy is in line with the Trust's Strategic objectives and that of a Model Employer.

k) To provide assurance to Board on staffing and staffing levels as part of regular workforce review.

l) To ensure that the Trust has an integrated approach to Equality and Diversity and is compliant with all aspects of good practice and legislation in that area.

m) To ensure that the Trust takes account of legal, governmental frameworks, NHS policy and recognised best practice for the management of Human Resources.

n) To ensure NHSLA and CQC standards are monitored where applicable to the remit of the Committee.

o) To provide an assurance report on key areas of performance in relation to achievement of the objectives relating to Model Employer for consideration by the Board.

p) To monitor the progress against actions to mitigate the workforce/people risks on the corporate risk register and provide assurance to the Board that adequate steps are taken to reduce the risks in line with the Board's risk appetite.

q) To review the controls and assurance against relevant workforce/people risks on the Board Assurance Framework and provide assurance to the Board that risks to the strategic objectives are being managed.

**Overall**

r) To approve any matters that, due to time constraints, could not be approved by the Board within the scope of the Committees areas of responsibility.

## 5. MEMBERSHIP

The Committee membership will be appointed by the Board and will consist of:

| | |
|---|---|
| **Chair:** | - Non-Executive Director |
| **Responsible Executive:** | - Director of Human Resources and Organisational Development |
| **Other Members:** | - Non-Executive Director<br>- Director of Nursing and Governance<br>- Associate Director of Human Resources<br>- Chief Operating Officer<br>- Deputy Director Finance<br>- Medical Director<br>- Head of Medical Staffing<br>- Director of Medical Education and R&D<br>- Associate Director of Operations - Unscheduled care<br>- Associate Director of Operations - scheduled care<br>- Associate Director of Operations –W&C<br>- Associate Director of Education and Development<br>- Head of Allied Health Professionals<br>- Associate Director of Transformation |

| | |
|---|---|
| **In Attendance:** | - Associate Director of Communications<br>- Deputy Director of Nursing<br>- Associate Director of Governance and Risk<br>- Trust Secretary/ Executive Secretary<br>- Co-opted members as appropriate<br>- Equality and Diversity Manager |

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

The Board will appoint one of the Non-Executive Director members of the Committee to be Chair of the Committee. Should the Chair be absent from the meeting the committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.

## 6. ATTENDANCE

**a. Members**

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

**b. Officers**

The chair of each of the committee or groups reporting to the Committee will be expected to attend each meeting of the Committee.

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

## 7. QUORUM

A quorum shall be 3 members and shall include one Non-Executive Director and two Executive Directors, one of which must be the Director of Human Resources and Organisational Development. The Chair of the Trust may be included in the quorum if present at a meeting. In the event that a Non-Executive Director member cannot attend a meeting of the Committee, one of the Non Executives Directors who are not members of the Committee may attend in substitution and be counted in the quorum of the Committee.

All Core members and in their absence, their nominated Deputy shall have one vote. In the event of a tie, the Chairman of the Committee shall have the casting vote.

## 8. FREQUENCY OF MEETINGS

Meetings shall be held bi-monthly. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust. The Chair of the Committee with the agreement of the membership may hold the meetings of the Committee monthly. Quarterly Committee development sessions will be held which will not form part of the formal meetings.

## 9. REPORTING GROUPS

The sub committees/groups listed below are required to submit the following information to the Committee:

a) separate reports to support the working of the Committee and would include addressing areas of concern and lack of progression of action plans including serious untoward incidents and or any external reviews affecting the quality of care;

b) the formally recorded minutes of their meeting; and

c) an Annual Report setting out the progress they have made and future developments.

The following sub committees/groups will report directly to the Committee:

i. The Education sub Committee
ii. Equality and Diversity Committee
iii. Staff Engagement & Wellbeing Sub-Committee
iv. Joint Negotiating Consultative Committee
v. Joint Local Negotiating Committee
vi. Education Governance Committee

## 10. ADMINISTRATIVE ARRANGEMENTS

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

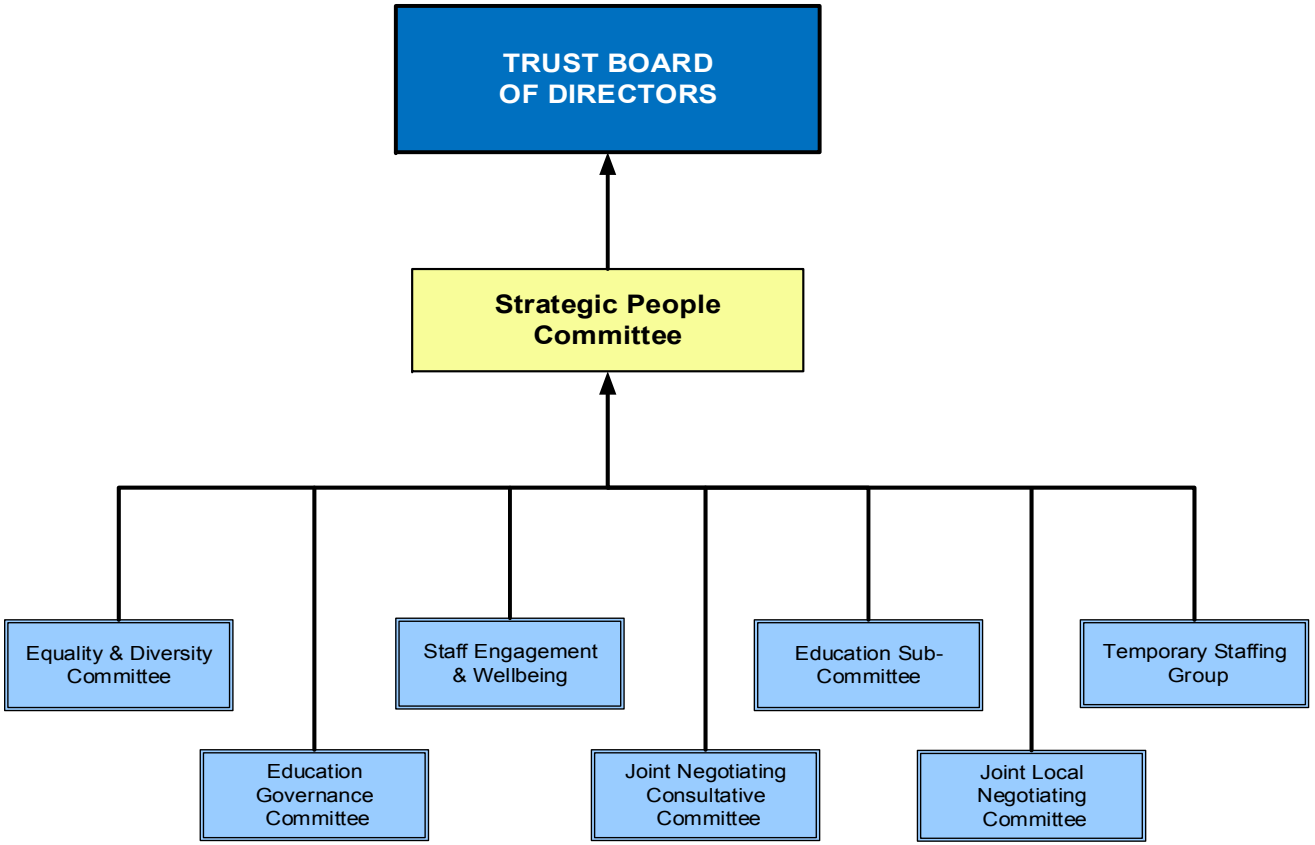
Unless prior agreement is reached with the Chair of the Committee the Agenda and Papers will be sent out within 5 working days before the date of the meeting. No Papers will be tabled at the meeting without prior approval of the Chair.

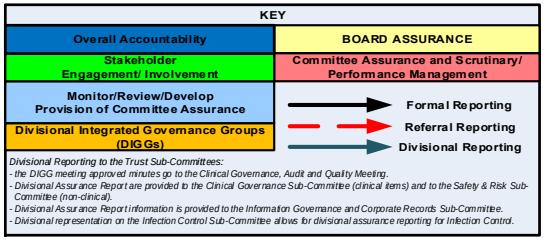
The Committee will undertake a review of its annual work plan prior to the start of the financial year.

## 11. REVIEW / EFFECTIVENESS

The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements. These terms of reference will be reviewed at least annually by the Committee

People


TRUST BOARD OF DIRECTORS
Strategic People Committee
Equality & Diversity Committee
Staff Engagement & Wellbeing
Education Sub-Committee
Temporary Staffing Group
Education Governance Committee
Joint Negotiating Consultative Committee
Joint Local Negotiating Committee


KEY
Overall Accountability
BOARD ASSURANCE
Stakeholder Engagement/ Involvement
Committee Assurance and Scrutinary/ Performance Management
Monitor/Review/Develop Provision of Committee Assurance
Divisional Integrated Governance Groups (DIGGs)
Formal Reporting
Referral Reporting
Divisional Reporting
Divisional Reporting to the Trust Sub-Committees:
- the DIGG meeting approved minutes go to the Clinical Governance, Audit and Quality Meeting.
- Divisional Assurance Report are provided to the Clinical Governance Sub-Committee (clinical items) and to the Safety & Risk Sub-Committee (non-clinical).
- Divisional Assurance Report information is provided to the Information Governance and Corporate Records Sub-Committee.
- Divisional representation on the Infection Control Sub-Committee allows for divisional assurance reporting for Infection Control.

# BOARD OF DIRECTORS

WHH/B/2015/ **060**

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| **SUBJECT:** | Human Resources / Education & Development Key Performance Indicators (KPIs) Report | |
| **DATE OF MEETING:** | 25th March 2015 | |
| **ACTION REQUIRED** | **For Assurance** | |
| **AUTHOR(S):** | Mick Curwen, Associate Director of HR | |
| **EXECUTIVE DIRECTOR:** | Roger Wilson, Interim Director of Human Resources and Organisational Development | |
| | | |
| **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): | a) With the exception of Health and Safety, very little change in Mandatory Training and PDR rates<br>b) No change in the number of doctors revalidated<br>c) Sickness rates continue to rise<br>d) Turnover and Vacancy rates have improved/stabilised. Headcount has increased to its highest rate ever and vacancies continue to be at a low level<br>e) Increase in temporary staffing expenditure to highest monthly level<br>f) High number of medical staff vacancies but some success with consultant appointments<br>g) All main Equality and Diversity targets achieved for 2014 | |
| **RECOMMENDATION:** | ***The Board is asked to:***<br>Note progress on the achievement of the KPIs and the action being taken to try and address shortfalls where appropriate. | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Not Applicable |
| | **Agenda Ref.** | |
| | **Date of meeting** | |
| | **Summary of Outcome** | Not Applicable |

**Appendix 1**

**Human Resources / Education & Development**
**Key Performance Indicators Report March 2015**

## 1.0 Introduction

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

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

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

## 2.0 HR and E&D Trust Workforce Standards KPIs Overview

### 2.1 Mandatory Training

The target for all mandatory training is 85%.

There has been very little change to the mandatory training rates for Manual Handling and Fire but the rate for Health and Safety has dropped significantly and this is explained later. However, individually, some Divisions/areas are meeting the trust target for some parts of the mandatory training.

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

| Division | Fire Safety | Health & Safety | Manual Handling |
|---|---|---|---|
| Scheduled Care | 70% (71%) (Amber) | 21% (92%) (Red) | 63% (64%) (Red) |
| Unscheduled Care | 69% (68%) (Amber) | 26% (88%) (Red) | 55% (57%) (Red) |
| Women's & Children's | 74% (75%) (Amber) | 40% (91%) (Red) | 78% (77%) (Amber) |
| Estates | 90% (77%) (Green) | 74% (100%) (Amber) | 97% (97%) (Green) |
| Facilities | 84% (85%) (Amber) | 48% (81%) (Red) | 85% (85%) (Green) |
| Corporate Areas | 79% (80%) (Amber) | 73% (99%) (Amber) | 77% (77%) (Amber) |

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

At a Corporate level the arrangements introduced in September 2012 for Corporate Induction continue to work well but there was a slight reduction to 97% of staff who attended corporate induction during February 2015.

#### 2.1.1 Health & Safety (Red)

There was a significant reduction of 55% from the previous month and the rate is 36% and red. There have been changes to the content of the Health and Safety course and this must now be completed annually rather than 3 yearly. This is also now consistent with the question

in the Staff Survey which asks whether staff have received Health and Safety training within the last 12 months. The target for 2014/15 is therefore not now being achieved.

### 2.1.2 Fire Safety (Amber)

There has been no change for the previous 4 months and the rate is 74% and amber.

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

There was a slight decrease of 1% from the previous month and the rate is 70% and the status is amber.

### 2.1.3.1 Manual Handling Patient Training Only (Red)

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

### 2.1.3.2 Manual Handling Non-Patient Training Only (Amber)

There was an increase of 1% from the previous month and the rate is 79% and amber.

## 2.2 Staff Appraisals

The target for completed PDRs is 85%.

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

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

| Division | PDR Rate |
|---|---|
| Scheduled Care | 68% (70%) (Red) |
| Unscheduled Care | 65% (64%) (Red) |
| Women's and Children's | 71% (73%) (Amber) |
| Estates | 68% (68%) (Amber) |
| Facilities | 86% (85%) (Green) |
| Corporate Areas | 79% (82%) (Amber) |

Only Facilities are meeting the target and the only area to show an increase was Unscheduled Care but it is still significantly below the target.

### 2.2.1 Non-Medical Staff (Amber)

For the period up to February 2015 the percentage of non-medical staff having had an appraisal reduced by 1% to 71% and the status remains as amber.

### 2.2.2 Medical & Dental Staff (Amber)

The combined rate for Consultant staff and Middle Grade doctors, up to February 2015 remained the same at 84%. The rate for Consultants reduced by 1% to 89% and other M&D stayed the same at 73%.

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

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

### 2.3 Revalidation for Medical and Dental Staff (Green)

The Revalidation Decision Making Group has not formally met since 20 January 2015 so there is no change to the position reported at the previous meeting. Therefore, the total number of doctors revalidated is 108, with 18 doctors deferred. This would make the rate as 86% and the status 'Green'.

The next meeting of the Decision Making Group has been arranged for 31.3.15.

### 2.4 Sickness Absence

#### 2.4.1 Sickness Absence Rates (Amber)

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

Sickness absence for February 2015 remains high at 5.20% which was a slight deterioration from the previous month. Consequently the cumulative rate for April – February 2015 increased to 4.64%.

This is largely explained by the under-reporting within the nursing wards/areas and a genuine increase in staff displaying cold/flu like symptoms.

Other trusts are experiencing similar increases in sickness absence.

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

#### 2.4.2 Return to Work Interviews (RTW) (Red)

The target for this KPI is 85% and is only reported on a quarterly basis. The rate for Q3 was disappointing at 53% which was a reduction of 6% from Q2.

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

### 2.5 Turnover Rate (Amber)

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

The rate for the previous 12 months up to February 2015 showed a slight improvement of 0.22% to 9.92% and the status is amber. For the first time in 4 months the turnover rate is below 10% but it remains high in Unscheduled Care at 11.30% and Scheduled Care at 11.34%. As previously reported, both of these Divisions are undertaking further analysis of leavers by personal interviews to understand in more detail why staff are leaving. Scheduled Care results have already been reported but work is still being undertaken within Unscheduled Care.

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

The Trust FE FTE was 3714 and staff in post 3436 FTE. This means the vacancies FTE has marginally increased to 7.48%, which is one of best months of the year. The status remains as 'green'. The number of vacancies has marginally increased by 1 to 278.

The headcount continues to rise at 4223 and is the highest ever in the trust and was an increase of 18 from the previous month.

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

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

The threshold for this KPI is 4.5% of total pay bill. Total spend in February 2015 increased by a modest amount of £30k and was £1398k, which represents 10.46% of the pay bill for the month and cumulatively for April – February 2015 the rate is 8.02%. Against the agreed threshold for 2014/15 of 4.5% the status, therefore, is 'Red' and was not achieved.

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

**Nurse Bank and Agency Nursing - £461k (£509k for January)**
**Agency (exc Medical & Nursing Agency) - £446k (£432k for January)**
**Medical Locums and Medical Agency - £491k (£427k for January)**

Two areas show an increase as follows: Agency by £14k and Medical Locums /Agency by £64k but Nurse Bank/Agency reduced by £48k. Agency expenditure is largely attributable to the Lorenzo project which showed £387k for February but the project as a whole is underspent on budget.

Total expenditure for the period April – February 2015 is £11.3m broken down as follows:

Nurse Bank and Agency Nursing - £4.6m
Agency (exc Medical and Nursing Agency) - £2.5m
Medical Locums and Medical Agency - £4.2m

NB In order to staff the additional intermediate care beds which were opened earlier this year the trust had to recruit staff predominantly from agencies and some of these staff have continued to be needed to meet additional staffing pressures. The total additional expenditure which is being met externally from Warrington CCG is now £461k which is included in the above amounts. However, the CCG have now indicated that funding for therapy staff can be made permanent and the Therapy Departments are in the process of making appointments on AfC contracts but do not expect to have staff in post until Feb/March 2015.

During February the unprecedented demand on beds continued with many areas escalated. It is planned that from 23.3.15 Daresbury will be re-opened. This has placed an additional demand for staffing and many of these have been agency staff.

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

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

<u>Nurse Bank and Agency Nursing</u>
Elderly and Stroke - £130k (£56k on agency) (£149k in Jan)
A&E - £79k (£117k on agency) (£127k in Jan)
Critical Care - £67k (£57k in Jan)

Acute Medicine – £62k (£38k on agency) (£66k in Jan)
Specialty Medicine - £52k (£41k in Jan)
Surgery - £35k (£34k in Jan)
T&O - £35k (£38k in Jan)
Women's - £28k (£25k in Jan)

Agency
Lorenzo - £387k
Therapies - £60k (£91k in Jan)
PMO – £39k (£31k in Jan)
Pharmacy - £34k (£40k in Jan)

Medical Locums/Agency
Elderly and Stroke - £215k (£192k in Jan)
T&O - £82k (£61k in Jan)
Surgery - £53k (£56k in Jan)
Specialty Medicine - £41k (£39k in Jan)

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

Nursing Recruitment
Rolling adverts are in place in Unscheduled Care for AMU given the high number of vacancies on this unit. In addition, a process is being finalised which will allow some nursing areas to recruit to over establishment. This is 'low risk' given the turnover and sickness and the amount of temporary staffing expenditure being incurred.

International Recruitment
The trust is working with an agency called Globalmedirec to recruit Consultant Radiologists. From the first round of interviews one doctor accepted an offer of employment and commenced on 10.11.14. Further Skype interviews have been held, most recently on 11.2.15 and one of the applicants is to be invited for a formal interview and is awaiting a visa. The trust has also continued to advertise on NHS Jobs and currently has 4 applicants with interviews arranged for 9.4.15.

Unscheduled care have identified a number of consultant posts suitable for international recruitment and a block advert appeared in the BMJ at the end of January and will shortly be repeated. An advert will also appear in the local Indian press later in March. The Division was successful in recruiting two Consultant Gastroenterologists and one Consultant Cardiologist.

Recruitment Process
The trust is working on a number of initiatives to streamline the recruitment process and the first phase has been implemented and publicised in key Divisions. The second phase involves putting in place a revised ECF process using Share Point and it is planned to implement this from 1 April 2015. The trust is also working with 'Stirling Cross' to advertise nursing posts in the Nursing Standard and other media including Twitter and Facebook.

E-Rostering
20 Wards/areas are now live including 18 which are fully live through ESR. 4 more Wards/Areas are planned over the next month to go live. This will then be followed by Theatres and Maternity and the roll out will then be complete.

De Poel
Work is continuing with De Poel on a pilot to focus on Medical Locums and the control over the rates we pay by using their system. Contractual difficulties have delayed the launch of this pilot but these do need resolving before it can commence.

Work is continuing on the Medical Productivity work stream. There has been some slippage with reviewing job plans but the Divisions are trying to recover this position. The trust is working with Allocate and has completed a pilot in both Anaesthetics and A&E. A paper is being produced reviewing the implications and costs but agreement in principle has been obtained.

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

## Unscheduled Care

### Medicine

1 Consultant Interventional Cardiologist

1 Consultant Stroke

1 Consultant Elderly Care/Movement Disorder

1 Consultant Elderly Care/Dementia

1 Consultant Elderly Medicine/Acute (one applicant scheduled for interview 27.4.15)

1 Consultant Orthogeriatric

1 Consultant Respiratory (one applicant scheduled for interview 20.4.15)

1 Consultant AMU

1 LAS Senior ST in Elderly Care

### A&E

4 Specialty Doctors

1 Locum Consultant in Emergency Medicine

## Scheduled Care

1 LAS Foundation Year 1

3 LAS posts in Trauma & Orthopaedics (interviews held on 16.3.15 and one candidate offered post)

1 Core Trainee in Urology

1 Locum Specialty Trainee, ENT

1 Specialty Doctor in Breast Surgery

## Women's and Children's

Radiology

5x Consultant Radiologists

Women's

2 GPST1/2 vacancy

Paediatrics

2 LAS Senior ST

1 LAS Junior ST

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

### 2.8 Equality & Diversity

#### 2.8.1 E&D Specialist in place (Green)

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

#### 2.8.2 Annual Workforce Equality Analysis Report published (Green)

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

#### 2.8.3 Annual Equality Duty Assurance report published (Green)

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

#### 2.8.4 Annual Equality Objectives published (Green)

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

#### 2.8.5 Annual Equality Strategy published (Green)

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

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

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

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

There has been an increase of 1% from Q2 to 64% at Q3.

**Warrington and Halton Hospitals NHS Foundation Trust**

**Governance & Workforce Division**

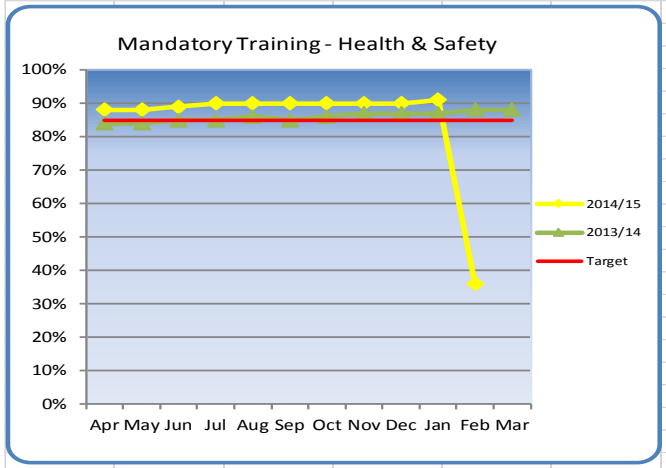
**Human Resources / Education & Development Workforce Key Performance Indicators**

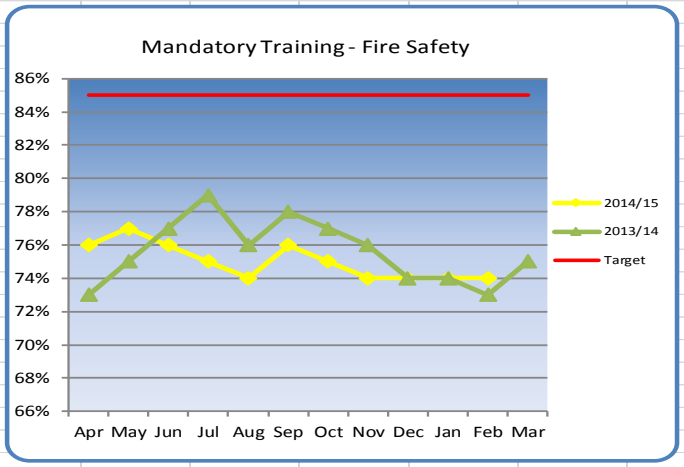
| 2014/15 | | | Target / Threshold | Frequency | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Year to Date | Criteria for RAG Status: Green | Amber | Red |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Training & Development | Mandatory Training | Healthh & Safety | 85% staff trained in last 3 years | Monthly | 88% | 88% | 89% | 90% | 90% | 90% | 90% | 90% | 90% | 91% | 36% | | **36%** | 85 - 100% | 70 - 84% | < 70% |
| | | Fire Safety | 85% staff trained in last 12 months | Monthly | 76% | 77% | 76% | 75% | 74% | 76% | 75% | 74% | 74% | 74% | 74% | | **74%** | 85 - 100% | 70 - 84% | < 70% |
| | | Manual Handling - Patient | 85% staff trained in last 2 years | Monthly | 67% | 67% | 67% | 68% | 65% | 64% | 65% | 67% | 66% | 65% | 64% | | **64%** | 85 - 100% | 70 - 84% | < 70% |
| | | Manual Handling - Non-Patient | | | 86% | 85% | 85% | 83% | 82% | 80% | 76% | 81% | 81% | 78% | 79% | | **79%** | | | |
| | | Manual Handling - Total | | | 74% | 74% | 74% | 74% | 72% | 71% | 69% | 73% | 72% | 71% | 70% | | **70%** | | | |
| | Staff Appraisals | Non Medical | 85% staff received appraisal in last 12 months | Monthly | 70% | 75% | 76% | 75% | 76% | 75% | 73% | 72% | 72% | 72% | 71% | | **71%** | 85 - 100% | 70 - 84% | < 70% |
| | | Medical & Dental - consultants & career grades, (exc Jnr Drs) | | | 79% | 79% | 79% | 83% | 86% | 84% | 85% | 86% | 86% | 84% | 84% | | **84%** | | | |
| | Revalidation for Medical & Dental Staff | | 85% of eligible M& D Staff revalidated | Monthly | 81% | 81% | 82% | 82% | 82% | 82% | 84% | 84% | 85% | 86% | 86% | | **86%** | 85 - 100% | 70 - 84% | < 70% |
| Sickness Absence | Sickness Absence Rates | | 4% | Monthly | 4.18% | 3.99% | 3.98% | 3.94% | 3.70% | 4.31% | 4.90% | 4.82% | 5.35% | 5.15% | 5.20% | | **4.64%** | 3.75% | 3.76-4.49% | > 4.50% |
| | Return to work interviews (wef 2013/14) | | 85% | Quarterly | | | 53% | | | 59% | | | 53% | | | | **53%** | 85 - 100% | 70 - 84% | < 70% |
| Workforce | Turnover (Leavers) | | Min 8% or Max 9% | Monthly | 9.0% | 9.1% | 9.3% | 9.3% | 9.7% | 9.4% | 9.4% | 10.1% | 10.2% | 10.1% | 9.9% | | **9.9%** | 8 - 9% | 5 - 7.9% / 9.1 - 12% | < 5% / > 12% |
| | Establishment / SIP | Funded WTE (see NB 1 below) | Min 6.5% or Max 10% FE / SIP gap | Monthly | 3686 | 3676 | 3682 | 3674 | 3695 | 3700 | 3696 | 3706 | 3717 | 3706 | 3714 | | **3714** | 6.5 - 10% | 5 - 6.4% / 10.1 - 12% | < 5% / > 12% |
| | | Staff in Post WTE (see NB 1 below) | | | 3392 | 3391 | 3371 | 3375 | 3424 | 3382 | 3399 | 3408 | 3409 | 3429 | 3436 | | **3436** | | | |
| | | Staff in Post Headcount (see NB 2 below) | | | 4171 | 4155 | 4134 | 4143 | 4156 | 4152 | 4172 | 4162 | 4182 | 4205 | 4223 | | **4223** | | | |
| | | Vacancies WTE ( see NB 1 below) | | | 294 | 285 | 311 | 299 | 271 | 318 | 297 | 298 | 308 | 277 | 278 | | **278** | | | |
| | | Vacancies % | | | 7.97% | 7.75% | 8.44% | 8.13% | 7.33% | 8.59% | 8.03% | 8.04% | 8.28% | 7.47% | 7.48% | | **7.48%** | | | |
| | Flexible Labour Expenditure (% of total paybill) | Bank / Agency / Medical Locums Total | 4.5% | Monthly | 6.6% | 6.7% | 7.6% | 6.7% | 7.9% | 7.3% | 7.3% | 9.1% | 7.5% | 10.3% | 10.46% | | **8.02%** | 4.5% | 4.6 - 5.0% | > 5.0% |
| | Equality & Diversity | E&D Specialist in place | Achieved | 6-monthly | | | | | | Achieved | | | | | | | **Achieved** | Achieved | Work in progress | No progress |
| | | Annual Workforce Equality Analysis report published | Achieved | Annual | | | | | | | | | | | | | **Achieved** | Achieved | Work in progress | No progress |
| | | Annual Equality Duty Assurance report published | Achieved | Annual | | | | | | | | | | | | | **Achieved** | Achieved | Work in progress | No progress |
| | | Annual Equality Objectives published | Achieved | Annual | | | | | | | | | | | | | **Achieved** | Achieved | Work in progress | No progress |
| | | Annual Equality Strategy published | Achieved | Annual | | | | | | | | | | | | | **Achieved** | Achieved | Work in progress | No progress |
| | | Staff have access to E&D information and resources | Achieved | 6-monthly | | | | | | Achieved | | | | | | | **Achieved** | Achieved | Work in progress | No progress |
| | | Staff have undertaken E&D training | 85% staff trained | 6-monthly | | | 62% | | | 63% | | | 64% | | | | 63% | 85 - 100% | 70 - 84% | < 70% |

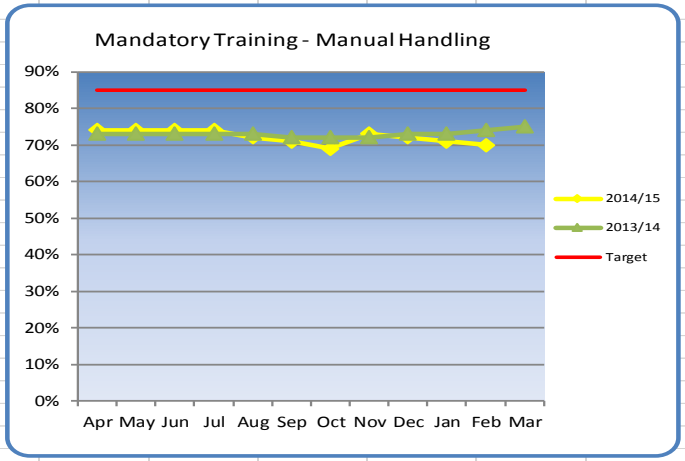
NB 1 Figures from Finance Ledger

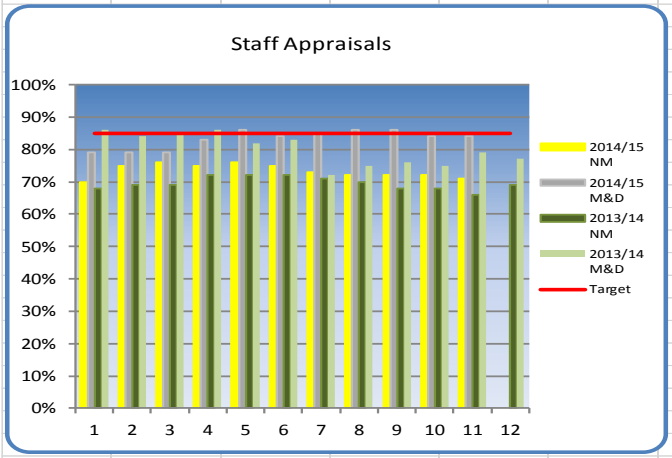
NB 2 Figures from HR ESR

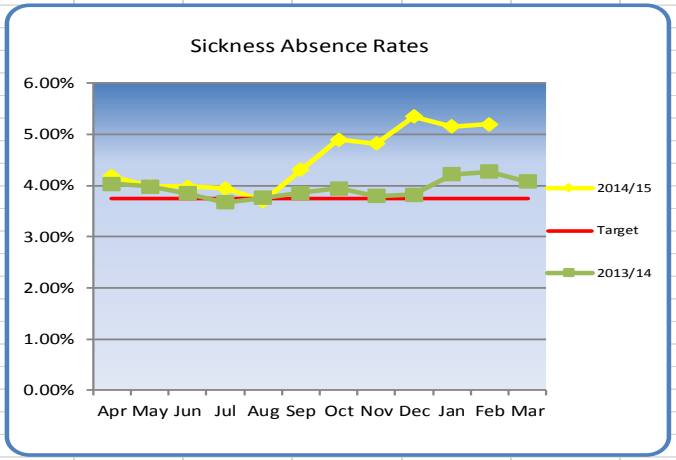
| R | Red | A | Amber | G | Green |
|---|---|---|---|---|---|

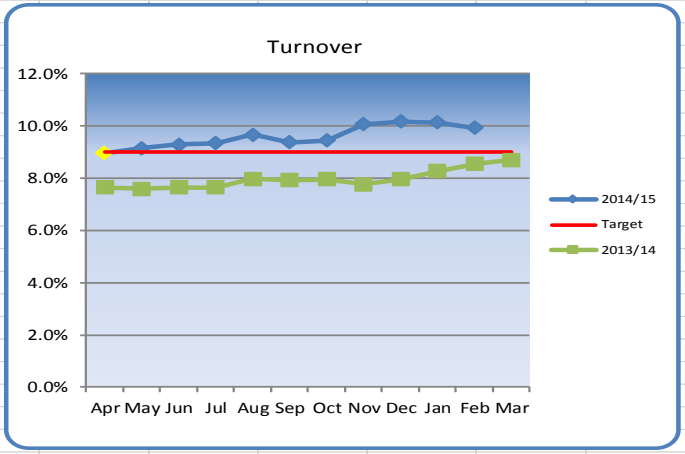

Mandatory Training - Health & Safety
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
2013/14
Target

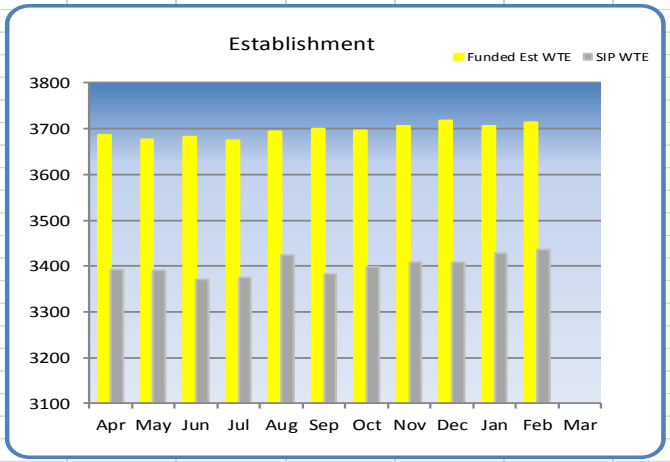

Mandatory Training - Fire Safety
86%
84%
82%
80%
78%
76%
74%
72%
70%
68%
66%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
2013/14
Target

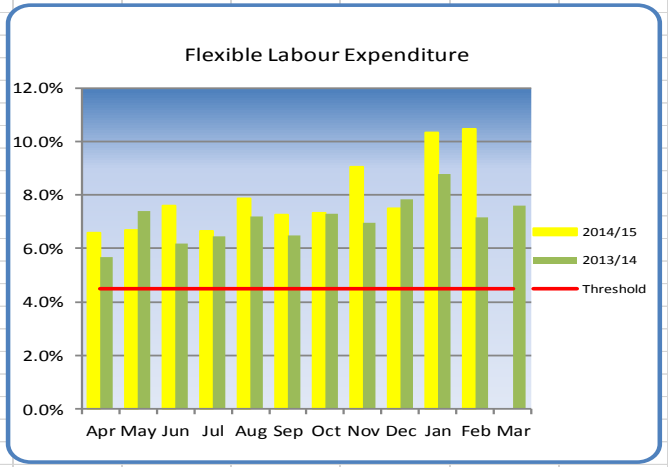

Mandatory Training - Manual Handling
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
2013/14
Target


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


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


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


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


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

# BOARD OF DIRECTORS

WHH/B/2015/ **061**

| | | |
|---|---|---|
| **SUBJECT:** | Sir Robert Francis Freedom to Speak Up Review – Trust Response | |
| **DATE OF MEETING:** | 25th March 2015 | |
| **ACTION REQUIRED** | **For Discussion** | |
| **AUTHOR(S):** | Roger Wilson, Interim Director of HR and OD | |
| **EXECUTIVE DIRECTOR:** | Roger Wilson, Interim Director of HR and OD<br>Choose an item. | |
| | | |
| **LINK TO STRATEGIC OBJECTIVES:** | All | |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | SO2/2.1 Failure to engage and involve our workforce in the design and delivery of our services.<br>SO2/2.2 Risk that the Trust does not have the right people with the right skills ie workforce is not competent and cannot deliver as commissioned.<br>SO3/3.3 Failure to provide staff, public and regulators with assurances post Francis and Keogh review<br>SO1/1.2 Risk of harm through failure to comply with Care Quality Commission National core healthcare standards and maintain registration and failure to achieve minimum requirements for NHSLA Standards within maternity services and wider Trust. | |
| | | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | |
| **FOIA EXEMPTIONS APPLIED:** | None | |
| | | |
| **EXECUTIVE SUMMARY** (KEY ISSUES): | This paper highlights the key recommendations for Trusts following the publication the Sir Robert Francis - Freedom to Speak Up Report | |
| **RECOMMENDATION:** | ***The Board is asked to:***<br>a) Note the recommendations made by Sir Robert Francis in the ***Freedom to Speak Up*** Report and tasks the Director of Human Resources and Organisational Development to lead the organisation response with staff side colleagues and other key stakeholders.<br>b) Delegate authority to the Strategic People Committee to oversee the implementation of these recommendations within the Trust. | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Not Applicable |
| | **Agenda Ref.** | |
| | **Date of meeting** | |
| | **Summary of Outcome** | Not Applicable |

**Freedom to Speak Up – Sir Robert Francis QC Report**

**Warrington and Halton Hospitals NHS Foundation Trust Response**

## 1. Introduction

The Trust already has some firm foundations in place to support staff to raise concerns; we have subscribed to the RCN-led Speaking out Safely Campaign and on our Hub pages, the link to this initiative is very clear. We also have a Whistleblowing Policy.

In the 2014 NHS Staff Survey, our staff say we are worse than average for staff witnessing potentially harmful errors, near misses or incidents in the month prior to them completing their staff survey feedback. This has seen a small increase from 2013 to 2014, i.e. our position has worsened. Our staff put us in the best 205 of Acute Trusts in relation to % of staff reporting errors, near misses or incidents witnessed in the month prior to them completing their staff survey feedback. There has been a 6% improvement on 2013 results. In relation to the Fairness and Effectiveness of incident reporting, again our staff tell us that we are in the Top 20% of Trusts and again there has been a small improvement from 2013. In 2014, a new question for staff was introduced % of staff agreeing that they would feel secure raising concerns about clinical practice, we scored 66% on this, giving us an average rating (the national average for Acute Trusts was 67%), the best score for Acute Trusts nationally was 80%, we have to aim for this and higher.

In summary, we are in a relatively strong position to really build on this element of staff support and clinical safety. We need to build on these strong foundations as we further embed the following recommendations made by Sir Robert Francis QC in the Freedom to Speak Up Report

## 2. Recommendations for Trust Boards

The Freedom to Speak Up Report, contains a number of recommendations for Trust Boards, these are primarily as follows: -

a) assess progress in creating and maintaining a culture of safety and learning, ensuring the culture is free from bullying

b) encourage reflective practice, individually and in teams, as part of everyday practice

c) have a policy and procedure built on good practice

d) talk about and publicly celebrate the raising of concerns

e) ensure staff have formal and informal access to senior leaders. In this area, it also recommends:

f) a person is appointed locally by the chief executive to act as a 'Freedom to speak up guardian'

g) an executive director and non-executive director are nominated as individuals within your organisation who can receive concerns

h) a manager in each department to be nominated to receive concerns
i) Staff have access to advice and support from an external organisation (e.g. a whistleblowing helpline).

**3. Recommendations**

c) That the Trust Board notes the recommendations made by Sir Robert Francis in the Freedom to Speak Up Report and tasks the Director of Human Resources and Organisational Development to lead the organisation response with staff side colleagues and other key stakeholders.

d) That the Trust Board delegates authority to the Strategic People Committee to oversee the implementation of these recommendations within the Trust.

**Roger Wilson**
**Interim Director of HR & OD**
**17th March 2015**

# BOARD OF DIRECTORS

WHH/B/2015/ **062**

| | |
|---|---|
| **SUBJECT:** | **Staffing Exceptions Report** |
| **DATE OF MEETING:** | 25th March 2015 |
| **ACTION REQUIRED** | **For Decision** |
| **AUTHOR(S):** | Alison Lynch (Deputy Director of Nursing Quality and Patient Experience) |
| **EXECUTIVE DIRECTOR:** | Karen Dawber, Director of Nursing and Governance |
| | |
| **LINK TO STRATEGIC OBJECTIVES:** | SO1: Ensure all our patients are safe in our care<br>SO3: To give our patients the best possible experience<br>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<br>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.<br>SO1/1.3 Failure to achieve infection control targets in accordance with the Risk Assessment Framework |
| | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full |
| **FOIA EXEMPTIONS APPLIED:** | None |
| | |
| **EXECUTIVE SUMMARY**<br>(KEY ISSUES): | This report provides an overview of nurse staffing for January 2015. Links to the Safety Thermometer are also included to assist in triangulation of incidents with staffing levels.<br><br>Additional points to note are:<br>• The National Institute for Clinical Excellence have outlined Draft guidance for A&E departments to ensure that there are enough nursing staff available to provide safe care at all times to patients. We are taking part in the national consultation of this guidance.<br>• Additionally, we are using the Safer Nursing Care Tool across the adult inpatient areas within the organisation. After the first set of data collection it will be presented and discussed at Nursing and Midwifery Advisory Council meeting. |

| | | |
|---|---|---|
| **RECOMMENDATION:** | ***The Board is asked to:***<br>1. Note the contents of this report, which describe the progress in the monitoring of complaints and to approve the actions as documented; and<br>2. Approve the staffing exemption Report | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Not Applicable |
| | **Agenda Ref.** | |
| | **Date of meeting** | |
| | **Summary of Outcome** | Choose an item. |

## 1.0 Introduction / Background

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

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

## 2.0 Staffing Report

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

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

## 3.0 Divisional Breakdown

| Ward name | DAY Average fill rate - registered nurses / midwives (%) | DAY Average fill rate - care staff (%) | NIGHT Average fill rate - registered nurses / midwives (%) | NIGHT Average fill rate - care staff (%) | Exception Report Comments with assurance provided by Associate Directors of Nursing |
|---|---|---|---|---|---|
| **SCHEDULED CARE DIVISION** | | | | | |
| **A4** | **97.4%** | **82.9%** | **100%** | **96.4%** | A4 – Continued escalation/bedding down overnight resulting in additional staffing required. Vacancies 0.75wte Band 5, 1.21wte band 2. |
| **A5** | **76%** | **92%** | **86.5%** | **96.4%** | A5 – Escalation of the ward, short term sickness and vacancies currently 2.26wte, 0.6wte band 2 |
| **A6** | **87.2%** | **84.9%** | **99.2%** | **110.7%** | A6 – Vacancies, escalation and sickness all impacting on staffing levels in the month. Current vacancies 3.31wte band 5, 1.0wte band 2. |

| | | | | | |
|---|---|---|---|---|---|
| **A9** | **91.0%** | **88.9%** | **90.5%** | **94.6%** | A9 – Vacancies 3.36wte Band 5, escalation and sickness causing staffing shortfalls on a regular basis |
| **B19** | **94.3%** | **136.2%** | **100%** | **110.7%** | B19 – Managing reasonably well, only 1wte Band 5 vacancy. |
| **B4** | **100%** | **100%** | **100%** | **100%** | |
| **Ward 1 - CMTC** | **99.5%** | **100%** | **95.9%** | **97.8%** | |
| **ICU** | **90.1%** | **66.7%** | **94.1%** | **76.8%** | ICU – Staffing levels have been below the agreed number of 14 due to sickness and maternity leave. ICU beds have been used flexibly depending on the occupancy levels. Occupancy levels for February were 87%. Study leave has been cancelled where possible. Due to challenges in picking up of additional shifts through NHSP and agency we agreed a week's block booking with Pulse to alleviate some of the pressure. |
| **UNSCHEDULED CARE DIVISION** | | | | | |
| **A1** | **89.3%** | **85.8%** | **95.8%** | **92.9%** | A1 – 1:1 required 4 times during the month, careers where moved across the division to cover staffing deficits. 12 shifts out to agency but not covered |
| **A2** | **90%** | **103.6%** | **95.2%** | **110.7%** | A2 – 1:1 carer required 21 times during the month. Sickness on the ward |
| **A3** | **85.4%** | 85.8% | 91.7% | 81.6% | A3- matron aware of short fall, sickness and is confident that care has not been compromised |
| **A7** | **74.9%** | 84.9% | 95.3% | 100% | A7 - matron aware of short fall, sickness and is confident that care has not been compromised |
| **A8** | **99.2%** | **99.5%** | **100%** | **114.6%** | A8 – One band 6 on secondment |

| | | | | | |
|---|---|---|---|---|---|
| **B12** | **100%** | **88.6%** | **160.7%** | **132.1%** | |
| **B14** | **86.6%** | **87.6%** | **84.5%** | **87.7%** | B14 - matron aware of short fall, sickness and is confident that care has not been compromised |
| **B18** | **89.2%** | **92.7%** | **91.7%** | **82.1%** | Daily review (Monday to Friday) of staffing levels for next 24 - 48 hours with Divisional Matron team to assess risk and gain assurance that sub-optimal staffing does not significantly compromise care<br>Opportunity to flex levels depending on cohort bed capacity |
| **C21** | **100%** | **131.2%** | **100%** | **83.9%** | |
| **C22** | **100%** | **83.9%** | **100%** | **100%** | |
| **CCU** | **100%** | **33.3%** | **97.7%** | **NA** | |
| **WOMEN'S & CHILDRENS SUPPORT SERVICES** | | | | | |
| **B11** | **102.9%** | **100%** | **118.8%** | **NA** | |
| **Neonatal Unit** | **102.1%** | **97.4%** | **100.1%** | **100.5%** | |
| **C20** | **92.4%** | **93.3%** | **100%** | **NA** | Long term sickness and maternity - however ward appropriately staffed and beds were shut and not escalated to if no cover was found. |
| **C23** | **91.6%** | **87.7%** | **136.7%** | **96.9%** | |

**4.0 Assurance provided from the Divisional Associate Directors of Nursing:**

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

Number of escalation/medical outliers – February 2015

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

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

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

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

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

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

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

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

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

Appendix 1

Staffing-Levels-2015-02-Feb.pdf

Warrington and Halton Hospitals NHS
NHS Foundation Trust

# Staffing Levels

## Feb-15

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

| | | | | | | | | | Day | | | | | Night | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | Registered midmives/nurses | | | Care Staff | | Registered midmives/nurses | | | Care Staff | | | | | This column will automatically calculate the number of shifts | | | | |
| Division | Ward | Non-escalation Beds | Budgeted Registered staff | Vacancies including maternity leave | Posts appointed to but not yet started | Budgeted Unregistered staff | Vacancies including maternity leave | Sickness & Absence for Jan-15 | Agreed nurse to patient ratios | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Agreed nurse to patient ratios | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Number of hours above or below planned | Length of a shift in hours | Number of shifts above or below planned | Variance | Falls | Hospital acquired pressure ulcers | Catheter associated UTIs | New VTEs | Associate Director of Nursing/Matrons Assurance Statement |
| Scheduled Care | W-A4 - Ward A4 | 28 | 19.38 | 0.00 | 0.00 | 7.70 | 1.00 | 9.35% | 1:7 | 1769.0 | 1723.5 | 667.0 | 553.0 | 1:9 | 783.0 | 783.0 | 319.0 | 307.5 | -171.0 | 11.5 | -14.9 | -4.83% | 1 | 1 | 0 | 0 | |
| | W-A5 - Ward A5 | 28 | 18.03 | 2.76 | 1.00 | 14.60 | 2.81 | 2.87% | 1:7 | 1609.6 | 1222.5 | 966.0 | 897.0 | 1:9 | 966.0 | 835.5 | 644.0 | 621.0 | -609.6 | 11.5 | -53.0 | -14.56% | 1 | 1 | 0 | 0 | |
| | W-A6 - Ward A6 | 28 | 19.57 | 3.66 | 1.00 | 13.62 | 1.00 | 1.85% | 1:7 | 1288.0 | 1123.0 | 1069.5 | 908.5 | 1:9 | 966.0 | 958.0 | 644.0 | 713.0 | -265.0 | 11.5 | -23.0 | -6.68% | 0 | 0 | 0 | 0 | |
| | W-A9 - Ward A9 | 28 | 18.83 | 3.27 | 1.00 | 15.46 | 1.00 | 8.27% | 1:7 | 1288.0 | 1180.0 | 1288.0 | 1144.5 | 1:9 | 966.0 | 874.0 | 644.0 | 609.0 | -378.5 | 11.5 | -32.9 | -9.04% | 1 | 0 | 0 | 0 | The majority of the month A9 has been escalated between 2 - 4 beds and this has been without staff for the escalated area. The ward should have 5 qualified nurses for escalation but this has not occurred. See comments attached to email! |
| | W-B19 - Ward B19 | 18 | 13.68 | 0.00 | 0.00 | 10.30 | 0.00 | 5.49% | 1:6 | 966.0 | 911.0 | 644.0 | 877.0 | 1:6 | 644.0 | 644.0 | 644.0 | 713.0 | 247.0 | 11.5 | 21.5 | 8.52% | 1 | 0 | 0 | 0 | Trial on B19 of #NOF designated unit and majority of month escalation beds. Depending on success of trial then changes to adjust A9 and B19 carers establishment. See comments attached to email! |
| | W-B4-H - Ward B4 - Halton | 27 | 12.20 | 1.00 | 1.00 | 6.00 | 1.00 | 9.73% | 1:9 | 966.0 | 966.0 | 322.0 | 322.0 | 13.5 :1 | 322.0 | 322.0 | 290.0 | 290.0 | 0.0 | 11.5 | 0.0 | 0.00% | 0 | 0 | 0 | 0 | |
| | W-CM1-H - Ward 1 - CMTC Treatment Centre | 30 | 26.60 | 6.38 | 0.00 | 14.00 | 2.50 | 1.79% | 1:5.5 | 1392.5 | 1385.0 | 962.5 | 962.5 | 10 : 1 | 851.0 | 816.5 | 517.5 | 506.0 | -53.5 | 11.5 | -4.7 | -1.44% | 0 | 0 | 0 | 0 | |
| | W-ICU - Intensive Care Unit | 18 | 76.74 | 6.91 | 3.00 | 12.52 | 6.00 | 10.94% | 1:1 Level 3<br>1:2 Level 2 | 4508.0 | 4059.5 | 966.0 | 644.0 | 1:1 Level 3<br>1:2 Level 2 | 4362.6 | 4105.5 | 644.0 | 494.5 | -1177.1 | 11.5 | -102.4 | -11.23% | 0 | 0 | 0 | 0 | 18 beds funded but used flexibly depending on dependency of patients (ie. can be at full capacity at 16 beds if 10 Level 3 and 6 Level 2)<br>14 Q nurses required per shift but if dependency/occupancy reduced then less nurses would still provide agreed nurse:patient ratios.<br>Unit Occupancy for February 2015 was 87% therefore even though shifts fell short of 14 Q there was adequate nurses to provide standard nurse:patient ratios. |
| Total | | 205 | 205.03 | 23.98 | 7.00 | 94.20 | 15.31 | 0.50 | | | | | | | | | | | -2407.7 | | -209.4 | | 4 | 2 | 0 | 0 | |
| Unscheduled Care | AED | | | | | 13.02 | | 11.49% | | 4032.0 | 3824.0 | 1050.0 | 832.0 | | 2984.9 | 2885.9 | 781.8 | 605.2 | -701.7 | 12.5 | -56.1 | -7.93% | 1 | 0 | 0 | 0 | |
| | W-A1A - Ward A1 Asst | 29 | 41.40 | 10.00 | 5.00 | 22.10 | 5.00 | 5.66% | 5.5 | 2450.0 | 2189.0 | 1400.0 | 1198.0 | 0.0 | 1764.0 | 1690.0 | 588.0 | 546.0 | -579.0 | 12.5 | -46.3 | -9.34% | 0 | 0 | 0 | 0 | 4 x 1:1 staff required. CSW moved to A9X1 CSW moved to B18x1. 401 hours of sickness. 12 shifts either cancelled or no fill by bank and agency. |
| | W-A2A - Ward A2 Admission | 28 | 18.83 | 3.00 | 0.00 | 12.90 | 3.00 | 8.40% | 5.6 | 1288.0 | 1159.5 | 966.0 | 1000.5 | 0.0 | 965.9 | 920.0 | 644.0 | 713.0 | -70.9 | 11.5 | -6.2 | -1.83% | 0 | 2 | 0 | 0 | 27 X 1:1 staff required. 126.5 hours of sickness. |
| | W-A3OPAL - Ward A3 Opal | 34 | 18.83 | 1.92 | 1.84 | 15.56 | 1.24 | 2.14% | 8.5:1 | 1288.0 | 1100.0 | 1598.5 | 1371.0 | 0.0 | 966.0 | 885.5 | 1000.5 | 816.5 | -680.0 | 11.5 | -59.1 | -14.01% | 0 | 0 | 0 | 0 | |
| | W-A7 - Ward A7 | 33 | 18.83 | 3.30 | 0.00 | 15.50 | 3.30 | 2.66% | 8.3:1 | 1610.0 | 1205.5 | 1288.0 | 1093.0 | 0.0 | 1249.0 | 1190.0 | 644.0 | 644.0 | -658.5 | 11.5 | -57.3 | -13.74% | 0 | 1 | 0 | 0 | |
| | W-A8 - Ward A8 | 34 | 18.80 | 1.92 | 0.92 | 15.50 | 3.00 | 15.11% | 8.5:1 | 1329.5 | 1319.0 | 1485.0 | 1478.0 | 0.0 | 986.0 | 986.0 | 1046.5 | 1199.0 | 135.0 | 11.5 | 11.7 | 2.79% | 1 | 0 | 0 | 3 | 1 week of 1:1 csw required and 1 band 6 secondment to ucc |
| | W-B12 - Ward B12 (Forget-me-not) | 21 | 13.68 | 2.21 | 0.00 | 15.50 | 2.21 | 2.48% | 7.0:1 | 966.0 | 966.0 | 1570.0 | 1363.0 | 0.0 | 644.0 | 1035.0 | 644.0 | 851.0 | 391.0 | 11.5 | 34.0 | 10.22% | 0 | 0 | 0 | 1 | CSW 1:21 wte 4 patients on unit that require 1:1 nursing for month and 18th to 20th Feb two patients on the unit that required 1:1 nursing at the same timeone patient has fallen twice on the unit and twice on previous ward so |
| | W-B14 - Ward B14 | 24 | 18.80 | 57.00 | 1.00 | 12.90 | 1.00 | 4.98% | 6.0:1 | 1288.0 | 1115.5 | 966.0 | 846.0 | 0.0 | 966.0 | 816.5 | 644.0 | 565.0 | -521.0 | 11.5 | -45.3 | -13.48% | 0 | 0 | 0 | 1 | Patient from whiston is vre positive. Nursed in a double cubicle. |
| | W-B18 - Ward B18 | 24 | 18.84 | 0.41 | 0.00 | 18.02 | 0.42 | 10.60% | 6.0:1 | 1288.0 | 1148.5 | 1288.0 | 1194.5 | 0.0 | 966.0 | 885.5 | 966.0 | 793.5 | -486.0 | 11.5 | -42.3 | -10.78% | 1 | 1 | 0 | 1 | Daily review (Monday to Friday) of staffing levels for next 24 - 48 hours with Divisional Matron team to assess risk and gain assurance that sub-optimal staffing does not significantly compromise care<br>Opportunity to flex levels depending on cohort bed capacity |
| | W-C21 - Ward C21 | 24 | 13.68 | 0.52 | 0.00 | 12.88 | 2.29 | 4.41% | 8.0:1 | 966.0 | 966.0 | 737.5 | 967.5 | 0.1 | 644.0 | 644.0 | 644.0 | 540.5 | 126.5 | 11.5 | 11.0 | 4.23% | 0 | 0 | 0 | 0 | |
| | W-C22 - Ward C22 | 21 | 13.68 | | | 12.88 | | 9.58% | 7.0:1 | 1069.5 | 1069.5 | 1069.0 | 891.0 | 0.1 | 713.0 | 713.0 | 713.0 | 713.0 | -178.0 | 11.5 | -15.5 | -4.99% | 0 | 0 | 0 | 0 | |
| | W-CCU - Coronary Care Unit | 8 | 21.17 | 1.22 | 0.00 | 2.60 | 0.00 | 9.22% | 2.0:1 | 1288.0 | 1288.0 | 311.0 | 103.5 | 0.0 | 966.0 | 943.5 | 0.0 | 11.5 | -218.5 | 11.5 | -19.0 | -8.52% | 0 | 0 | 0 | 0 | |
| Total | | 280 | 216.54 | 81.50 | 8.76 | 169.36 | 21.46 | 0.87 | | | | | | | | | | | -3441.1 | | -290.3 | | 3 | 4 | 0 | 6 | |
| WCSS | W-B11B/W-B11C - Ward B11 | 24 | 29.50 | 4.60 | 2.00 | 9.20 | 1.00 | 5.41 | 1:1 level3<br>1:2 Level2 | 1900.0 | 1956.0 | 760.0 | 760.0 | 0.0 | 1327.0 | 1576.0 | 0.0 | 0.0 | 305.0 | 7.5 day<br>10.63 night | | 7.65% | 0 | 0 | 0 | 0 | HDU patient requiring 1:1 |
| | W-NHDU/W-NITU/W-NSC - Neonatal Unit | 18 | 24.38 | 4.00 | 5.80 | 6.52 | 0.00 | 2.59 | 7.5:18 | 959.0 | 979.0 | 720.0 | 701.0 | 7.5:18 | 851.0 | 852.0 | 216.0 | 217.0 | 3.0 | | | 0.11% | 0 | 0 | 0 | 0 | ad hoc sickness covered by nurse specialist on call. |
| | W-C20 - Ward C20 | 12 | 12.63 | 1.40 | 1.40 | 5.00 | 2.40 | 8.11 | 1:4 | 990.0 | 915.0 | 780.0 | 727.5 | 1:6 | 542.6 | 543.1 | 0.0 | 106.6 | -20.5 | | | -0.89% | 0 | 0 | 0 | 0 | |
| | W-C23 - Ward C23 | 22 | 97.92 | 2.50 | 2.50 | 18.93 | 11.60 | | 1:7.33 | 1218.0 | 1116.2 | 812.0 | 712.5 | 1:11 | 560.0 | 765.5 | 280.0 | 271.3 | -4.5 | | | -0.16% | 0 | 0 | 0 | 0 | |
| Total | | 76 | 164.43 | 12.50 | 11.70 | 39.65 | 15.00 | 16.11 | | | | | | | | | | | 283.0 | | 0.0 | | 0 | 0 | 0 | 0 | |
| Grand Total | | 561 | 586.00 | 117.98 | 27.46 | 303.21 | 51.77 | 17.48 | | | | | | | | | | | -5565.8 | | -499.7 | | 7 | 6 | 0 | 6 | |