Warrington and Halton Hospital NHS Foundation Trust
Board of Directors
Agenda

Wednesday 25th June 2014, 1300 - 1700hrs
Trust Conference Room, Warrington Hospital

1300	***W&HHFT/TB/14/094***	***Welcome, Apologies & Declarations of Interest***		Chairman
	W&HHFT/TB/14/095	***Presentation: Improving Outcomes for Patients with Dementia through Enhancing the Healing Environment***	Presentation	Dementia Team
	W&HHFT/TB/14/096	***Minutes of the previous meeting held on 28th May 2014***	Paper	
	W&HHFT/TB/14/097	***Action Plan***	Paper	Chairman
1330	***W&HHFT/TB/14/098***	***Chairman's Report***	Verbal update	Chairman
	W&HHFT/TB/14/099	***Chief Executives Report***	Verbal update	Chief Executive

People

1350	***W&HHFT/TB/14/100***	***i) Workforce and Educational Development Key Performance Indicators*** ***ii) Workforce Transformation***	Paper Paper	Director of Nursing and Organisational Development
1410	***W&HHFT/TB/14/101***	***Nursing - Safer Staffing Levels***	Paper	Director of Nursing and Organisational Development

Quality

1425	***W&HHFT/TB/14/102***	***Patient Story***	Presentation	Matron Cheryl Finney, Trauma & Orthopaedics
1445	***W&HHFT/TB/14/103***	***Quality Dashboard***	Paper	Director of Nursing and Organisational Development
1500	***W&HHFT/TB/14/104***	***Effective Governance to Support Medical Revalidation***	Paper	Medical Director
1515	***10 Minute Break***			

1525	***W&HHFT/TB/14/105***	***Q4 2013/14 monitoring and 2014/15 annual plan review***	Paper	Chief Executive
1535	***W&HHFT/TB/14/106***	***Finance Report to 31 May 2014***	Paper	Director of Finance & Commercial Development
1555	***W&HHFT/TB/14/107***	***Outcome of Business Case Review***	presentation	Director of Finance & Commercial Development
1605	***W&HHFT/TB/14/108***	***Corporate Performance Dashboard and Exception Report***	Paper	Chief Operating Officer
1615	***W&HHFT/TB/14/109***	***The Perfect Week***	Paper	Chief Operating Officer
1635	***W&HHFT/TB/14/110***	***Monitor - Corporate Governance Compliance statements***	Paper	Chief Executive
1645	***W&HHFT/TB/14/111***	***Board Committee Reports:*** ***i. Board Committee Verbal Update*** ***a) Strategic People Committee held on 9 June 2014*** ***b) Finance and Sustainability Committee held on 17th June 2014*** ***ii. Minutes for Noting:*** ***a) Strategic People Committee – 7th April 2014*** ***b) Quality Governance Committee – 13th May 2014*** ***c) Finance and Sustainability Committee – 21st May 2014***		Chair of each Committee Lynne Lobley Carol Withenshaw To note To note To Note
	W&HHFT/TB/14/112	***Any Other Business***		
1700 ends		***Dates of next meeting*** *30th July 2014*		

W&HHFT/TB/14/095

BOARD OF DIRECTORS

Presentation	Improving Outcomes for Patients with Dementia through Enhancing the Healing Environment **Dr Graham Barton** Lead Clinician **Deb Hatton** Matron for Elderly Care **Debra Carberry** Nurse Specialist Older People **Deborah Hammond** Ward Manager (Forget Me Not Unit) **Lee Bushell** Building Surveyor - Estates Capital Projects
Date of Meeting	25th June 2014

W&HHFT/TB/14/097

TRUST BOARD
ACTION PLAN – Current / Outstanding Actions
Meeting: Trust Board 25th June 2014

Meeting date	Minute Reference	Action	Responsibility & Target Dates	Status	
26-02-2014	TB/14/026(i)	The Director of Finance and Commercial Development to report back to the Board within the next financial year, the outcomes of the business case review.	Director of Finance and Commercial Development	Due to the availability the outcomes of the business case review to be carried forward to 25th June 2014.	Presentation: see agenda item TB/14/107
26-02-2014	TB/14/034	The Director of Nursing and Organisational Development to present to the April 2014 Board meeting the Governance Dashboard Report (see TB/14/33)	Director of Nursing and Organisational Development:	Due to further work on the development of the dashboard and its presentation to the Quality Governance Committee prior to Board this matter remains ongoing.	Ongoing

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/098

BOARD OF DIRECTORS

Paper Title	**Chairman's Report**
Date of Meeting	25th June 2014

W&HHFT/TB/14/099

BOARD OF DIRECTORS

Paper Title	**Chief Executive's Report**
Date of Meeting	25th June 2014


People

W&HHFT/TB/14/100(i)

BOARD OF DIRECTORS

Paper Title	Human Resources / Education & Development Key Performance Indicators (KPIs) Report
Date of Meeting	25 June 2014
Director Responsible	Karen Dawber
Author(s)	Mick Curwen
Purpose	This report focuses on the KPIs which are felt to give a good indication to the Board on progress with the main workforce and governance performance areas within Human Resources and Education and Development.

Paper previously considered	**Committee**	**Date**
HR / E&D KPIs Reports	Trust Board meetings	28 May 2014
HR / E&D KPIs Reports	Strategic People Committee	9 June 2014

Relates to which Trust objectives — **Appropriate**

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

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

	Page/Paragraph Reference
Mandatory training rates are largely unchanged but appraisal rates for non-medical staff have increased significantly	**Pages 2 - 4 / Section 2.1 & 2.2**
No change on doctors revalidation	**Page 4/Section 2.3**
Sickness absence – slight reduction in month and stable	**Pages 4 – 5 / Section 2.4**
Turnover showing an upward trend. Vacancy rate stable. Headcount falling.	**Page 5 / Section 2.5 & 2.6**
Temporary staffing expenditure – slight increase of £15k	**Pages 5 & 6 / Section 2.7**
All main Equality and Diversity targets achieved for 2014 and reasonable progress on training target	**Page 6 / Section 2.8**

Recommendation(s)

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

Appendix 1

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

1.0 Introduction

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

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

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

2.0 HR and E&D Trust Workforce Standards KPIs Overview

2.1 Mandatory Training

The target for all mandatory training is 85%.

There has been very little change to the mandatory training rates but there has been a further increase for Fire Safety. The trend in recent months of little change has therefore continued. However, individually, some Divisions/areas are meeting the trust target for some parts of the mandatory training.

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

Division	Fire Safety	Health & Safety	Manual Handling
Scheduled Care	73% (73%) (Amber)	88% (88%) (Green)	60% (61%) (Red)
Unscheduled Care	74% (75%) (Amber)	86% (86%) (Green)	73% (73%) (Amber)
Women's & Children's	78% (77%) (Amber)	89% (89%) (Green)	77% (74%) (Amber)
Estates	87% (75%) (Green)	100% (98%) (Green)	98% (95%) (Green)
Facilities	79% (74%) (Amber)	81% (81%) (Amber)	80% (82%) (Amber)
Corporate Areas	81% (82%) (Amber)	96% (96%) (Green)	88% (90%) (Green)

The only area achieving all of the targets is Estates.

At a Corporate level the arrangements introduced in September 2012 for Corporate Induction continue to work well and an impressive 99% of staff attended corporate induction during May 2014.

2.1.1 Health & Safety (Green)

There has been no change from the previous month and the rate remains at 88% and green. The target for 2014/15 is being achieved.

2.1.2 Fire Safety (Amber)

There has been an increase of 1% from the previous month and the rate is 77% and amber. This is the third month in succession that rates have increased

As previously reported, Dave Wood, Fire Officer has now returned to the trust and commenced 2 June 2014.

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

There has been no change from the previous month and the rate is 74% and amber.

2.1.3.1 Manual Handling Patient Training Only (Red)

There has been no change from the previous month and the rate is 67% and red.

2.1.3.2 Manual Handling Non-Patient Training Only (Green)

There was a slight reduction of 1% and the rate is now 85% but the status is still green and the target is being met.

2.2 Staff Appraisals

The target for completed PDRs is 85%.

Although there was no change in the rate for medical staff, there was a significant increase for non-medical and it is at its highest rate since November 2011.

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

Division	PDR Rate
Scheduled Care	81% (71%) (Amber)
Unscheduled Care	73% (64%) (Amber)
Women's and Children's	74% (75%) (Amber)
Estates	72% (63%) (Amber)
Facilities	84% (73%) (Amber)
Corporate Areas	60% (74%) (Red)

There are no areas achieving the target however, there were marked increases in: Scheduled Care (10%), Unscheduled Care (9%), Estates (9%) and Facilities (11%). Unfortunately the Corporate areas fell by 14%.

2.2.1 Non-Medical Staff (Amber)

For the period up to May 2014 the percentage of non-medical staff having had an appraisal increased significantly by 5% and is 75% and the status is amber.

Divisions have been reminded at the bi-lateral meetings that priority must still be given to appraisal rates despite the financial position and it is pleasing that this has been recognised in improved rates in many areas/departments.

2.2.2 Medical & Dental Staff (Amber)

The combined rate for Consultant staff and Middle Grade doctors, up to May 2014 has

remained the same at 79%. The rate for Consultants increased by 1% to 86% and other M&D fell by 2% to 65%.

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

2.3 Revalidation for Medical and Dental Staff (Green)

The Revalidation Decision Making Group has not met since 6 May 2014 so the rate remains at 81% with 51 doctors having been approved for revalidation by the GMC.

The next Decision Making Group meeting will take place on 3 July 2014.

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 May 2014 showed an improvement in month from the previous month to 3.99%. The cumulative rate for April – May 2014 is 4.12%. In comparison with last year the rates are very similar at 3.98% and 4.15% respectively.

The latest NHS staff sickness absence rates released by the Health and Social Care Informatics Centre show a decrease nationally in the rate from 4.72% to 4.44% based on the position as at the month of January 2014 (not cumulative). The average for all acute trusts nationally was 4.21% and the average for all trusts in the North West was 5.09%. The position of this trust at January 2014 was 4.47%. In comparison with other major acute trusts in the North West the table below gives this benchmark information:

Name of Acute Trust	Sickness Rate as at the month of January 2014
Bolton	5.66%
Central Manchester	5.46%
Wirral	5.31%
Morecambe Bay	5.24%
Royal Liverpool	5.23%
Tameside	5.01%
UHSM	4.84%
Pennine	4.61%
Salford	4.61%
Wigan	4.64%
Stockport	4.50%
Warrington & Halton	**4.47%**
Aintree	4.40%
Blackpool	4.37%
Southport and Ormskirk	4.22%
St Helens & Knowsley *	3.96%
Chester	3.61%

* includes all Mersey Deanery doctors

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 at well over 300 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 so the next available information will not be until July 2014. The rate shown on the dashboard is the position at the end of Q4 for 2013/14 which was 42%. 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 May 2014 increased to 9.14% and for the first time in more than 12 months the status is not green and has changed to amber. Since December 2013 a steady upward trend has been developing. This is probably due to a combined effect of some staff not being replaced due to the financial constraints and staff in post figures falling. However, it should be noted that two of the Clinical Divisions (Scheduled Care and Women's and Children's) and the corporate areas are achieving the target (all under 9%) and it is only Unscheduled Care which is an outlying area at 10.32%.

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

The Trust FE FTE was 3676 and staff in post 3391 FTE. This means the vacancies FTE has reduced slightly to 7.75% and the status is 'green'. The relatively high number of vacancies (285) is mostly due to pressure on some managers to not fill vacancies to contribute to the financial position in the trust and has some bearing on turnover rates as mentioned above.

The headcount of 4155 was a reduction of 16 from the previous month. From a peak of 4201 in January 2014 there have now been reductions in each of the last 4 months. On a positive note, 126 posts have been advertised during April and May 2014 and a minimum of 51 appointments have been made, some of which have yet to commence.

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 May 2014 increased slightly by £15k and was £841k, which represents 6.69% of the pay bill for the month and cumulatively for April – May 2014 the rate is 6.63%. 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 April are as follows:

Nurse Bank and Agency Nursing - £326k (£350k for April)
Agency (exc Medical & Nursing Agency) - £125k (£110k for April)
Medical Locums and Medical Agency - £390k (£366k for March)

Medical locums/agency increased by £24k and Agency by £15k. Nurse Bank /Agency decreased by £24k.

Total expenditure for the period April – June 2014 is as follows:

Nurse Bank and Agency Nursing - £676k

Agency (exc Medical and Nursing Agency) - £235k
Medical Locums and Medical Agency - £756k

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

Unfortunately the Temporary Staffing Group scheduled for 17 June 2014 was postponed due to the absence of key members of staff. However, work has continued on various initiatives to reduce the temporary staffing spend and these are explained in more detail in the separate paper on the Workforce Transformation Project which also includes an update on Medical Productivity. Where appropriate, this work is being conducted in association with Ernst and Young.

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

2.8 Equality & Diversity

2.8.1 E&D Specialist in place (Green)

The Trust E&D Specialist Adviser originally commenced in June 2012 through a SLA with the Countess of Chester Hospital Trust which ran June 2014. A meeting was held on 20.3.14 with Chester to discuss a possible extension of the SLA and agreement has now been reached and the SLA is in the process of being signed off.

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)

This is only reported bi-annually and the rate for 31 March 2014 was 56%.

Warrington and Halton Hospitals NHS Foundation Trust

Governance & Workforce Division

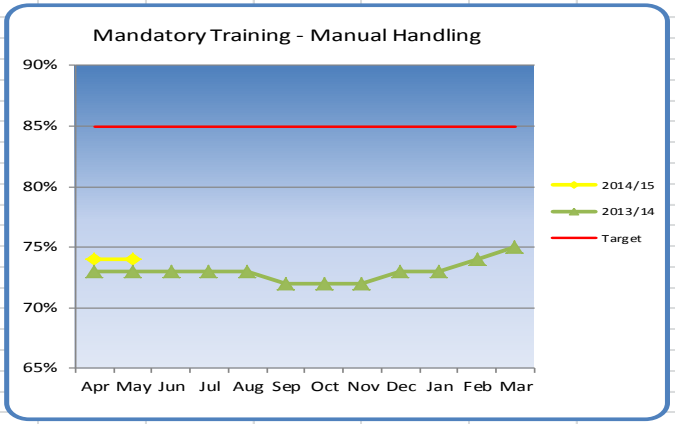
Human Resources / Education & Development Workforce Key Performance Indicators

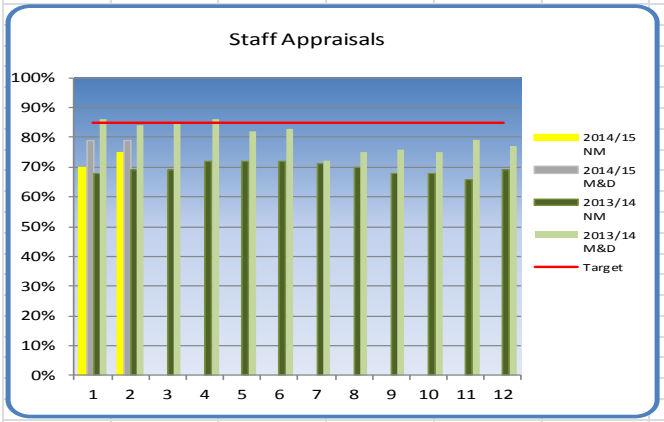
2014/15			Target / Threshold	Frequency	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year to Date	Criteria for RAG Status: Green	Amber	Red
Training & Development	Mandatory Training	Healith & Safety	85% staff trained in last 3 years	Monthly	88%	88%											**88%**	85 - 100%	70 - 84%	< 70%
		Fire Safety	85% staff trained in last 12 months	Monthly	76%	77%											**77%**	85 - 100%	70 - 84%	< 70%
		Manual Handling - Patient	85% staff trained in last 2 years	Monthly	67%	67%											**67%**	85 - 100%	70 - 84%	< 70%
		Manual Handling - Non-Patient			86%	85%											**85%**			
		Manual Handling - Total			74%	74%											**74%**			
	Staff Appraisals	Non Medical	85% staff received appraisal in last 12 months	Monthly	70%	75%											**75%**	85 - 100%	70 - 84%	< 70%
		Medical & Dental - consultants & career grades, (exc Jnr Drs)			79%	79%											**79%**			
	Revalidation for Medical & Dental Staff		85% of eligible M& D Staff revalidated	Monthly	81%	81%											**81%**	85 - 100%	70 - 84%	< 70%
Sickness Absence	Sickness Absence Rates		4%	Monthly	4.18%	3.99%											**4.12%**	3.75%	3.76-4.49%	> 4.50%
	Return to work interviews (wef 2013/14)		85%	Quarterly													**42%**	85 - 100%	70 - 84%	< 70%
Workforce	Turnover (Leavers)		Min 8% or Max 9%	Monthly	9.0%	9.1%											**9.1%**	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											**3676**	6.5 - 10%	5 - 6.4% / 10.1 - 12%	< 5% / > 12%
		Staff in Post WTE (see NB 1 below)			3392	3391											**3391**			
		Staff in Post Headcount (see NB 2 below)			4171	4155											**4155**			
		Vacancies WTE (see NB 1 below)			294	285											**285**			
		Vacancies %			7.97%	7.75%											**7.75%**			
	Flexible Labour Expenditure (% of total paybill)	Bank / Agency / Medical Locums Total	4.5%	Monthly	6.6%	6.7%											**6.6%**	4.5%	4.6 - 5.0%	> 5.0%
	Equality & Diversity	E&D Specialist in place	Achieved	6-monthly													**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	Work in progress	No progress
		Staff have undertaken E&D training	85% staff trained	6-monthly													56%	85 - 100%	70 - 84%	< 70%

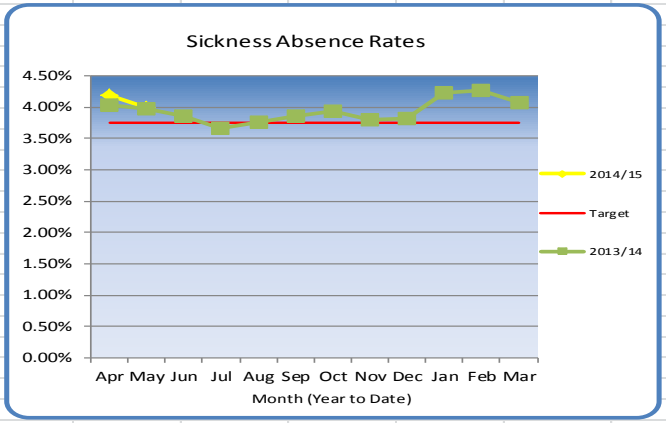
NB 1 Figures from Finance Ledger					**R**	**Red**		**A**	**Amber**		**G**	**Green**								
NB 2 Figures from HR ESR																				

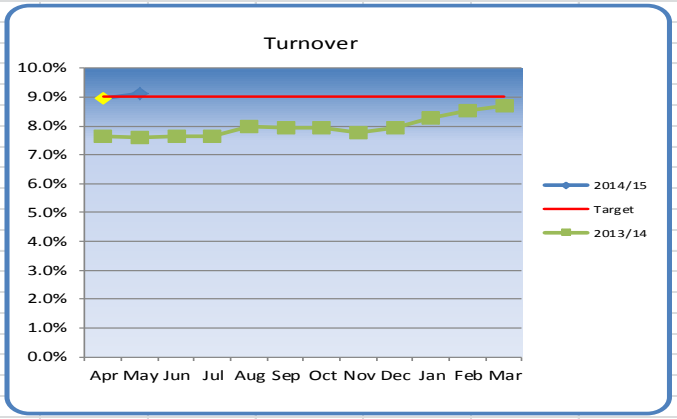

Mandatory Training - Health & Safety
89%
88%
87%
86%
85%
84%
83%
82%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
2013/14
Target

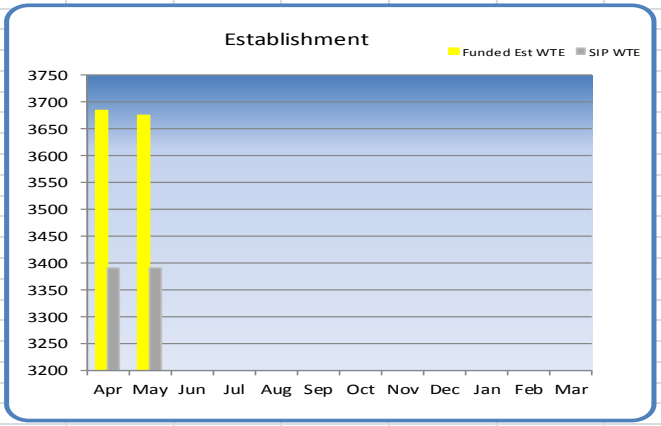

Mandatory Training - Fire Safety
86%
84%
82%
80%
78%
76%
74%
72%
70%
68%
66%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
2013/14
Target

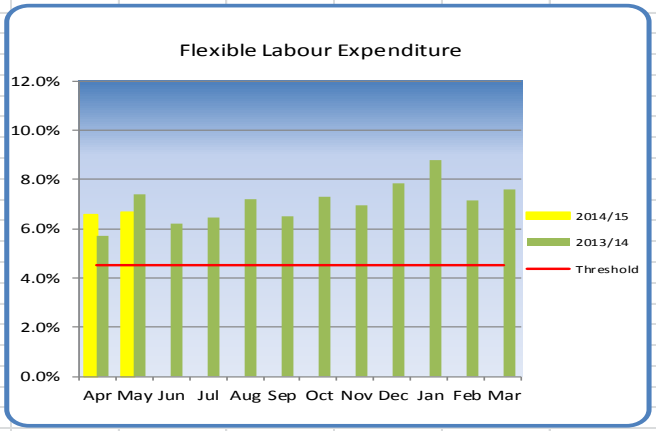

Mandatory Training - Manual Handling
90%
85%
80%
75%
70%
65%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
2013/14
Target


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
4.50%
4.00%
3.50%
3.00%
2.50%
2.00%
1.50%
1.00%
0.50%
0.00%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Month (Year to Date)
2014/15
Target
2013/14


Turnover
10.0%
9.0%
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
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
3750
3700
3650
3600
3550
3500
3450
3400
3350
3300
3250
3200
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar


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

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/100(ii)

BOARD OF DIRECTORS

Paper Title	Workforce Transformation Project – Trust Board Update
Date of Meeting	25th June 2014
Director Responsible	Karen Dawber
Author(s)	Roger Wilson
Purpose	To update the Trust Board on the initial progress made through the Workforce Transformation Project

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

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

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

		Page/Paragraph Reference
•	Administrative and Clerical Staff Review	**Update3. Para I**
•	Medical Productivity	**Update3. Para II**
•	Additional Staffing Spend	**Update3. Para III**
•	Workforce Planning	**Update3. Para IV**

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

The Trust Board is asked to note the content of this report. A further progress report will be presented to the July Board meeting

Workforce Transformation Project

Trust Board Update

June 2014

Introduction

The Workforce Transformation Project effectively commenced on Monday 7th April 2014, there are three core strands to the project: -

I. Administrative and Clerical Staff Review
II. Medical Productivity
III. Additional Staffing Spend

There is a further strand, which is a key-underpinning element and will help to support the future sustainability of the project

IV. Revising and refreshing the Trust approach to workforce planning

Project Updates

Administrative and Clerical Staff Review

The CIP deliverable is currently being refreshed and will be completed by 20th June 2014

The model for delivery and phasing is being reviewed as part of the Outpatient project.

Medical Productivity

The medical productivity project aims to provide the current baseline for consultant job plans from which the trust can develop new policies which increase the consistency, measurability and value for money of planned programmes of work.

All consultant job plans will undergo analysis, following which the Trust's DCC and SPA ratios will be benchmarked against those from similar trusts nationally to identify variation.

All available job plans will be compared to;

- Payroll and divisional budgets
- Outpatient / theatre rotas
- Planned vs actual sessions delivered.

WLI payments approved / made and annual / study leave will also be included in the analysis.

The Trust's job planning policies will then be reviewed and refreshed. It is anticipated that this process will identify a recurrent annual cost saving, with an in-year benefit circa £400k in 14/15.

The medical productivity project steering group includes the trust and divisional medical directors, who will collectively review the baseline, develop and recommend the guidelines to be put in place for the future.

Collation and analysis of job plans and other relevant information is under way and due to be completed and presented to the steering group by July 4. A more accurate account of the savings opportunity will be delivered at this point.

Additional Staffing Spend

In June Team Brief, it was announced that with effect from 1st July 2014, revised rates for Waiting List Initiative sessions would be put in place. Following JLNC on 12th June this will now not take place and the savings generated from this must now be found by alternative means. A task and finish group will be set up to formulate a plan to deliver these savings.

May 2014 saw an overall increase in temporary staffing spend of £15k. However, during this period, nursing fell by almost £24,000 (7%). An increased spend in medical locums and other additional agency costs, resulted in an overall rise on April's figures.

Rolling adverts for Staff Nurses in Unscheduled Care have been live since mid May with the first batch of candidates interviewed on 17th June. A similar exercise will be undertaken for Staff Nurses in Scheduled Care following direction from the Division.

Various work is on-going to streamline and expedite current recruitment processes. This includes use of e-systems in the DBS (Disclosure and Barring Service) and authority to recruit processes.

Discussions with NHSP have commenced to design a training programme to allow qualified nurses from a care home environment to gain the skills required to work on acute wards.

International recruitment now underway for Consultant Radiologists with an initial batch of CV's with the division for review.

Workforce Planning

Underpinning elements I to III above, is the need to refocus and refresh the approach to Workforce Planning in the Trust.

The Trust is on track to complete the workforce planning template for Health Education England will require the Trust to complete a document by July 2014.

Due to operational pressures, the full session planned for 29th May 2014 was stood down and an abridged session with Unscheduled Care took place instead.

A further session with Unscheduled Care colleagues took place on 11th June 2014, it should be noted at this juncture that as part of the development of the Dementia Care Service, a clear and structured approach to workforce planning is being undertaken.

For Scheduled Care the session was held on 2nd June 2014 and a range of actions have arisen and are being worked on with the Division. Furthermore, it was agreed at the meeting that Roger Wilson would attend the Scheduled Care Ward Manager's Away Day on 27th June 2014.

For Women, Children & Support Services the session was held on 19th June 2014 and a range of actions have arisen and are being worked on with the Division.

Follow up sessions have been arranged for the end of September with each of the Divisions and networked activity between the Divisions will take place over the coming months.

Health Education England attended all of the above sessions and are sharing the learning from other Trusts with us, as part of a growing relationship with the Trust.

Summary and Recommendations

The Trust Board is asked to :

- Note the content of this report and the progress being made

- Decide if further progress reports should be presented to the Trust Board meeting or are agreeable to the monitoring of this Programme of work to be reported through the new PMO reporting arrangements

Roger Wilson
17th June 2014

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/101

BOARD OF DIRECTORS

Paper Title:	Publication of Staffing Data and Exception Report May 2014
Date of Meeting	25th June 2014
Director Responsible	Director of Nursing and Organisational Development
Author(s)	Deputy Director of Nursing
Purpose	The purpose of this paper is to provide an overview of the monitoring and management of nursing and midwifery staffing during May 2014. In addition it provides information as to the occurrence of harm related to VTE, falls, hospital acquired pressure ulcers and catheter associated urinary tract infections. It must be noted that the data related to harm is subject to change following final approval: it is the Quality Dashboard that the Board must use for this assurance. Additionally, due to reporting mechanisms currently in place, the sickness and absence data reported here relates to April 2014.

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

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

The Board is asked to note the content of the "Publication of Staffing Data and Exception Report May 2014"

Publication of Staffing Data and Exception Report May 2014

Introduction

In May 2014 the Board received a briefing paper in relation to its commitments regarding its collective responsibility for managing nursing, midwifery and healthcare assistant staffing capacity and capability. This briefing paper also outlined process for publishing and displaying staffing data as described in Hard Truths the government response to the Mid Staffordshire NHS Foundation Trust Public Inquiry and the National Quality Board (NQB) guidance issued in November 2013.

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

The Government made a number of commitments in Hard Truths: The Journey to Putting Patients First to make this information more publically available and the briefing paper outlined the process for meeting these milestones, which will in phase one focus on all inpatient areas; including acute, community, mental health, maternity and learning disability.

The briefing paper described our commitment to publish staffing data from April and, at the latest, by the end of June 2014.

Publication of Staffing Data - recommendations and actions

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

The Trust is also required to provide information about the nurses, midwives and care staff deployed for each shift compared to what has been planned and this is to be displayed at ward level. Again this action has been implemented, in that all areas have been involved in the production of the How Are We Doing? boards and the rollout began this month.

The Trust is also required to produce a Board report containing details of planned and actual staffing on a shift by shift basis at ward level for the previous month. This report is to be presented to the Board every month, and must also be published on the Trust's website, The Trust will expected to link or upload the report to the webpage on NHS Choices. The attached report has been developed to comply with this recommendation and has as required been published on the Trust website.

The report provides information on our staffing levels - looking at the staff hours assigned to each ward and how many hours were worked in that month.

We are committed to ensuring that levels of nursing staff, which include registered nurses, midwives and unregistered health care assistants (HCA's), match the acuity and dependency needs of patients

within clinical ward areas in the trust. This includes an appropriate level and skill mix of nursing staff to provide safe and effective care. These staffing levels are viewed along with reported outcome measures, 'registered nurse to patient ratios' and the number of staff per shift required to provide safe and effective patient care.

Real time management of staffing levels to mitigate risk

In the event of shortfalls of staff or unexpected increases in patient acuity and dependency requirements, the agreed staffing levels are reviewed and RAG rated (Red/Amber/Green) with escalation actions specified at each level. Please note that the term 'ward' includes critical care areas, and accident and emergency department for ease of understanding.

- **Green status:** the ward is to determined to have safe levels and would not require escalation as these constitute the levels expected through the agreed ward establishment.
- **Amber status:** the ward is determined to be at a minimum safe level. The matron will be alerted, but no further escalation may always be required. Staff will prioritise their work and adjust their workload through the shift accordingly, with a continual review of any changes to the acuity and dependence.
- **Red status:** the ward is determined to be at an unsafe level. The matron will be alerted. Mitigating actions will be taken, and documented, which may include the movement of staff from another ward and utilisation of supernumerary staff within the numbers or reducing the number of patients on the ward to match the staff availability. In exceptional circumstances activity would be reduced through reduction in the number of beds. This addresses the risk and reduces the shift to an amber rating. Red shifts are escalated via our matrons to the associate directors of nursing and actions are monitored for effectiveness.

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

The report also includes a sample of the in-depth exception reporting carried out within the Divisions, this month ITU have provided this report attached at Appendix 2.

Recommendation

The Board are asked to note this report

Appendices

Appendix 1

Safer Staffing Exception Report

Staffing Exception Report May 2014.pdf

Staffing Levels - May 2014

Warrington and Halton Hospitals NHS
NHS Foundation Trust

The columns in bold contain the figures that are submitted to the DoH via the Unify portal

									Day					Night												
									Registered midwives/nurses			Care Staff		Registered midwives/nurses			Care Staff									
Division	Ward	Non-escalation Beds	Budgeted Registered staff	Vacancies including maternity leave	Posts appointed to but not yet started	Budgeted Unregistered staff	Vacancies including maternity leave	Sickness & Absence (April 14)	Agreed nurse to patient ratios	**Total monthly planned staff hours**	**Total monthly actual staff hours**	**Total monthly planned staff hours**	**Total monthly actual staff hours**	Agreed nurse to patient ratios	**Total monthly planned staff hours**	**Total monthly actual staff hours**	**Total monthly planned staff hours**	**Total monthly actual staff hours**	Number of hours where staffing fell below agreed levels	Length of a shift in hours	Number of shifts where staffing fell below agreed levels	**Falls***	**hospital acquired pressure ulcer***	**catheter associated UTI's***	**New VTE's***	Rag rating	Associate Director of Nursing/Matrons Assurance Statement to exceptions
Scheduled Care	W-A4 - Ward A4	28	17.80	0.00	0.00	14.70	0.00	5.60	1:7	1426.0	1391.5	1069.5	1040.5	1:9	1069.5	722.0	713.0	712.5	722.0	11.5	62.8	3	0	0	0	AMBER	The ward has been escalated by 12 - 14 beds and this is reflected in the nursing establishment. The plan is that during June this will be rectified. The ward is assessed on a shift by shift basis by the Ward Manager and staffing levels were altered accordingly using temporarily redeployed staff where possible.
	W-A5 - Ward A5	28	21.10	4.60	1.00	14.60	0.00	9.00	1:7	1782.1	1758.0	1069.5	1058.0	1:9	1069.5	1035.0	713.0	701.5	243.5	11.5	21.2	1	0	0	0	AMBER	This ward is permanently escalated by 6 beds.
	W-A6 - Ward A6	28	18.60	0.60	0.00	13.60	1.40	3.17	1:7	1426.0	1408.5	1069.5	1023.0	1:9	1069.5	1023.5	713.0	713.0	243.5	11.5	21.2	7	1	0	0	AMBER	There 2 staff on long-term sick leave whose absence is being dealt with through Trust policy. Staffing is assessed by the Ward Manager and Matron and acuity and dependency taken into account.
	W-A9 - Ward A9	28	17.80	2.00	0.00	15.50	0.00	3.78	1:7	1426.0	1379.5	1426.0	1426.0	1:9	1069.5	1069.5	713.0	713.0	46.5	11.5	4.0	6	0	0	0	AMBER	The ward has been escalated by 4 beds 50% of the time during May. The ward is assessed on a shift by shift basis by the Ward Manager and staffing levels were altered accordingly using temporarily redeployed staff where possible.
	W-B19 - Ward B19	18	14.30	2.00	0.00	13.90	3.30	4.21	1:6	1069.5	1046.5	713.0	701.5	1:6	713.0	713.0	713.0	713.0	41.0	11.5	3.6	3	0	0	1	AMBER	The ward has been escalated by 4 beds during May. The ward is assessed on a shift by shift basis by the Ward Manager and staffing levels were altered accordingly using temporarily redeployed staff where possible.
	W-B4-H - Ward B4 - Halton	27	12.20	0.36	0.00	6.00	0.00	9.40	1:9	874.0	749.5	552.0	402.5	13.5 :1	552.0	540.5	322.0	322.0	274.5	11.5	23.9	0	0	0	0	AMBER	The staffing levels alter according to activity and flexes up and down accordingly. Staff are moved regularly to support the wards at Warrington, but only when is is safe to do so.
	W-CM1-H - Ward 1 - CMTC Treatment Centre	30	26.60	1.40	0.00	14.00	0.00	5.15	1:5.5	1978.0	1913.0	1196.0	1151.0	10 : 1	966.0	931.5	644.0	621.0	167.5	11.5	14.6	0	0	0	0	AMBER	The staff levels alter according to activity and flexes up and down accordingly. Staff are moved regularly to support the wards at Warrington, but only when is is safe to do so. At the CMTC there is also a forward wait which is staffed as the day ward is not mixed sex , requiring 3 RNs to staff the 2nd floor.
	W-ICU - Intensive Care Unit	18	76.74	5.43	2.00	11.52	1.00	5.42	1:1 Level 3 1:2 Level 2	4991.0	4726.5	1069.5	989.0	1:1 Level 3 1:2 Level 2	4991.0	4680.5	713.0	632.5	736.0	11.5	0.0	0	2	0	0	AMBER	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) Monthly planned hours worked out on 31 day month 14 Q nurses required per shift but if dependency/occupancy reduced then less nurses would still provide agreed nurse:patient ratios
Total		205	205.14	16.39	3.00	103.82	5.70	45.73											2474.5		151.3	20	3	0	1		
Unscheduled Care	AED	0	59.17	1.00	1.00	13.02	0.00	3.42		4464.0	4250.3	1162.5	815.0		3205.1	3294.8	896.5	738.4	629.6	12.5		2	0	0	0	AMBER	The staffing in AED is pooled, and during the month of May an additional area, CDU2 was opened and not all shifts could be filled, staff were utilised from other areas.
	W-A1A - Ward A1 Asst	29	41.40	8.50	6.00	22.10	1.20	4.75	5.5	2325.0	2140.0	1550.0	1252.5	0.0	1953.0	1732.5	651.0	640.5	713.5	12.5	12.5	2	0	0	0	AMBER	This area accommodates DVT where during the month there we 30 hours short. The ward is assessed on a shift by shift basis by the Ward Manager and staffing levels were altered accordingly using temporarily redeployed staff where possible.
	W-A2A - Ward A2 Admission	28	18.83	1.07	0.00	12.88	1.96	4.21	5.6	1426.0	1506.5	1069.5	1023.5	0.0	1069.5	1069.5	713.0	839.5	-161.0	11.5	-14.0	5	0	0	1	GREEN	During part of this month, A2 Ward was relocated to Daresbury Ward, which as a single room unit required an increase in staffing from establishment.
	W-A3OPAL - Ward A3 Opal	34	18.83	1.28	0.00	15.46	0.17	10.38	8.5:1	1426.0	1263.5	1426.0	1339.5	0.0	1069.5	978.5	713.0	680.0	373.0	11.5	32.4	15	2	0	0	AMBER	There was short term sickness in month of May, and the wards were supported from other areas. The sickness was managed through Trust policy. Staffing level being monitored.
	W-A7 - Ward A7	33	18.80	-0.08	2.23	15.46	4.28	3.33	8.3:1	1426.0	1491.3	1426.0	1191.0	0.0	1069.5	1104.0	713.0	839.5	8.7	11.5	0.8	3	2	0	0	GREEN	During this month there were additional staff to support the Perfect Week initiative, and an number of 1:1 shifts required for both days and nights.
	W-A8 - Ward A8	34	18.80	1.30	0.00	15.50	1.70	7.34	8.5:1	1484.0	1452.0	1759.5	1360.0	0.0	1069.5	1023.5	1046.5	955.0	569.0	11.5	49.4	2	1	0	0	AMBER	Ward A8 had short term sickness, being monitored through Trust policy. The ward is assessed on a shift by shift basis by the Ward Manager and staffing levels were altered accordingly using temporarily redeployed staff where possible.
	W-B12 - Ward B12 (Forget-me-not)	21	13.68	0.52	0.00	15.46	4.85	1.69	7.0:1	1069.5	1247.0	1426.0	1318.8	0.0	713.0	851.0	713.0	747.5	-242.8	11.5	-21.1	12	2	0	0	GREEN	Ward situated on A2 for part of month with 24- 28 beds depending on escalation and variable staff demand as a result
	W-B14 - Ward B14	24	18.80	-1.60	0.00	12.90	2.20	5.20	6.0:1	1426.0	1381.5	1069.5	1058.0	0.0	1069.5	1035.0	713.0	655.5	148.0	11.5	0.0	2	0	0	0	AMBER	This was due to short term sickness, shifts that went unfilled were assessed on a daily basis by the ward manager and matron. Staffing level being monitored.
	W-B18 - Ward B18	24	18.84	2.95	0.00	18.02	8.02	5.28	6.0:1	1426.0	1095.5	1426.0	1120.5	0.0	1069.5	1046.0	1069.5	770.0	959.0	11.5	81.3	3	0	1	0	AMBER	B18 had significant increase in establishment in April to accommodate flexibility in use of cohort beds. Currently recruiting into these post. The establishment is such that the ward staffing numbers will be above that which is required and staff will act as a 'pool' for other ward in the Division.
	W-C21 - Ward C21	24	13.68	-0.90	0.00	11.30	1.15	5.19	8.0:1	1069.5	1058.0	816.5	798.5	0.1	713.0	713.0	839.5	805.0	64.0	11.5	5.6	3	0	0	0	GREEN	No exception
	W-C22 - Ward C22	21	13.68	0.55	1.00	12.88	1.80	6.52	7.0:1	1069.5	897.0	1069.5	997.5	0.1	713.0	713.0	713.0	713.0	244.5	11.5	21.3	2	0	0	0	AMBER	This was due to long term sickness, shifts that went unfilled were assessed on a daily basis by the ward manager and matron. Staffing level being monitored.
	W-CCU - Coronary Care Unit	8	21.17	0.88	0.00	2.61	2.84	0.67	2.0:1	1426.0	1345.5	356.5	218.5	0.0	1069.5	1069.5	0.0	0.0	218.5	11.5	19.0	1	0	0	0	AMBER	Unregistered nursing staff were moved from this area to support other areas (for example A3)
Total		280	275.68	15.47	10.23	167.59	30.17	57.98											3524.1		187.1	52	7	1	1		
WCSS	W-B11B/W-B11C - Ward B11	24	29.50	7.10	3.00	9.20	1.80	5.19	1:1 level3 1:2 Level2	2100.0	1680.0	840.0	790.0	0.0	1488.2	1276.0	0.0	0.0	84.0	7.5 day 10.63 night		0	0	0	0	AMBER	NB Paeds operates a rota system to cover the whole unit. Staff work flexibly to cover all areas. The rota reflects annualised hours and summer and winter staffing level.
	W-NHDU/W-NITU/W-NSC - Neonatal Unit	18	24.38	1.00	0.00	6.52	0.00	4.13	7.5:18	1092.0	1092.0	798.0	798.0	7.5:18	942.8	942.8	240.0	240.0	0.0	7.5 day 10.63 night		0	0	0	0	GREEN	Staffing monitored in accordance with occupancy.
	W-C20 - Ward C20	12	12.63	0.60	0.00	5.00	0.00	3.53	1:4	1232.5	1231.0	675.0	675.0	1:6	581.3	581.3	0.0	0.0	1.5	7.5 day 10.63 night		0	0	0	0	GREEN	Staffing monitored in accordance with occupancy.
	W-C23 - Ward C23	22	97.92	2.40	0.60	18.93	0.00	unable to calculate at pooled staff	1:7.33	1348.5	1282.0	899.0	891.5	1:11	581.3	581.3	290.6	290.6	74.0	7.5 day 10.63 night		0	0	0	0	AMBER	The staffing budget for C23 is pooled. Staffing levels are monitored in accordance with acuity and dependency.
Total		76	164.43	11.10	3.60	39.65	1.80	12.85											159.5		0.0	0	0	0	0		
Grand Total		561	645.25	42.96	16.83	311.06	37.67	116.56											6158.1		338.4						

harms is subject to change following investigation through gove

Appendix 2

Warrington and Halton Hospitals NHS
NHS Foundation Trust

ICU Staffing Establishment May 2014

Introduction

The Intensive Care Unit (ICU) provides a combined, general intensive care and high dependency (HDU) service which can be flexibly utilised depending on patient occupancy and dependency. The ICU has 20 bed spaces and is currently funded for 18. The standard ratio of capacity for staffing and finance purposes is 8 ICU beds and 10 HDU beds.

The following table outlines the current possible combinations of bed occupancy in relation to patient dependency for 13 nurses plus a mandatory supernumerary Shift Co-ordinator:

Nurses	Combination of Patients					
14	*11 ICU 4 ICU	10 ICU 6 HDU	9 ICU 8 HDU	8 ICU 10 HDU	7 ICU *12 HDU	6 ICU *14 HDU

*These combinations may be limited by the amount of equipment available, primarily ventilators and infusion pumps.

As illustrated above, the determining factor of occupancy is not defined by simply 18 beds open, but is influenced by patient dependency in relation to the number of nursing staff. If there is a larger ratio of ICU patients then it is clear that as few as 15 beds may be occupied in total, or conversely up to 20 beds occupied if the majority are HDU patients. The latter would have to take into consideration the general use of the isolation cubicles, equipment available and the loss of flexibility within the unit.

Critical Care Network Requirements

A national document, Core Standards for Intensive Care Units, was published in 2013 as a joint collaboration between key critical care organisations. The standards for nurse staffing are detailed below with an indication of our level of compliance:

Standard	Additional rationale / consideration	Compliance
Level 3 patients (level guided by ICS levels of care) require a registered nurse/patient ratio of a minimum 1:1 to deliver	A greater ratio than 1:1 may be required to safely meet the needs of some critically ill patients, such as unstable patients requiring various simultaneous nursing activities and complex therapies used in	**NHSP (own staff) used to achieve this as necessary to backfill sickness absence and maternity leave.**

Standard	Additional rationale / consideration	Compliance
direct care	supporting multiple organ failure. Enhanced Level 3 patient status takes in to account severity of illness and the related nursing demands.	**Mainly compliant but occasions where unable to achieve.**
Level 2 patients (level guided by ICS levels of care) require a registered nurse/ patient ratio of a minimum 1:2 to deliver direct care	The 1:2 ratios may need to be increased to 1:1 to safely meet the needs of critically ill patients, such as those who are confused/delirious requiring close monitoring and/or those being nursed in single rooms.	**NHSP (own staff) used to achieve this as necessary to backfill sickness absence and maternity leave. Mainly compliant but occasions where unable to achieve.**

Standard	Additional rationale / consideration	Compliance
Each designated Critical Care Unit will have a identified Lead Nurse who is formally recognised with overall responsibility for the nursing elements of the service e.g. Band 8a Matron	This person must be an experienced critical care nurse with detailed knowledge and skills to undertake the operational management and strategic development of the service. This person will have: • undertaken leadership/management training • be in possession of a post registration award in Critical Care Nursing • be in possession or working towards post graduate study in relevant area This person will be supported by a tier of Band 7 sisters/charge nurses who will collectively manage human resources, health & safety, equipment management, research, audit, infection prevention & control, quality improvement and staff development.	**Compliant.**
There will be a supernumerary clinical coordinator (sister/ charge nurse bands 6/7) on duty 24/7 in critical care units	The responsibilities of the clinical coordinators include: • Providing clinical nursing leadership, supervision and support to teams to optimise safe standards of patient care on each shift • Coordinate and supervise nurse staffing • Continuity of patient care	**Supernumerary Band 7 Co-ordinator on every shift.**

Standard	Additional rationale / consideration	Compliance
	• Facilitate admissions and discharges to ensure efficient and effective patient flow • Communicate with the multidisciplinary team and liaise with other departments to ensure efficient, effective, safe care is delivered in a timely manner • Be visible and accessible to staff, patients and relatives • Ensure effective use of human and non-human resources • Education and training All Clinical coordinators must be in possession of a post registration award in Critical Care Nursing and be a graduate or working towards a degree.	
Units with greater than 10 beds will require additional supernumerary (this person is not rostered to deliver direct patient care to a specific patient) registered nursing staff over and above the clinical coordinator to enable the delivery of safe care. The number of additional staff per shift will be incremental depending on the size and layout of the unit (e.g. multiple single rooms). Consideration needs also be given during events such as infection outbreaks	The role of additional supernumerary registered nursing staff is to support the clinical coordinator. This will include assistance with admissions, transfers, supporting and supervising nursing staff, arranging staff sickness cover and relief in single rooms. The number of additional supernumerary registered nursing staff will be built around multiples of critical care beds and geographical layout of units and as a minimum will require: **11 – 20 beds** = 1 additional supernumerary registered nurse **21 – 30 beds** = 2 additional supernumerary registered nurses **31 – 40 beds** = 3 additional supernumerary registered nurses	**Not achievable within establishment 24/7. Achieved if occupancy / dependency within the unit is under capacity.**

Standard	Additional rationale / consideration	Compliance
Each Critical Care Unit will have a dedicated Clinical Nurse Educator responsible for coordinating the education, training and CPD framework for critical care nursing staff and pre-registration student allocation	The role will be supernumerary and additional Clinical Nurse Educators will be required for larger units, i.e. 1 WTE per circa 75 staff. Consideration needs to be given to local need such as rapid staff turn-over, large numbers of junior staff. The Clinical Nurse Educator will be in possession of a post registration award in Critical Care Nursing and appropriate post graduate certificate in education or equivalent.	**Supernumerary Practice Development Facilitator in post to support 78 Registered Nurses but shared (0.4 wte) with Trust training Dept.**
All nursing staff appointed to Critical Care will be allocated a period of supernumerary practice	This period is to allow adequate time for registered nurses to develop basic skills and competencies to safely care for a critically ill patient. All registered nurses commencing in critical care should be commenced on Step 1 of the National Competency Framework. The supernumerary period for newly qualified nurses should be a minimum of 6 weeks; this time frame may need to be extended depending on the individual. The length of supernumerary period for staff with previous experience will depend on the type and length of previous experience and how recently this was obtained. All newly registered nursing staff should be allocated a preceptor. Newly appointed staff that have completed preceptorship should be allocated a mentor.	**6 weeks supernumerary period for all new starters. Preceptorship and mentorship programme in place. National Competency Framework implemented May 2014. Established in-house competency teaching programme in place.**
A minimum of 50% of registered nursing staff will be in possession of a post registration award in Critical Care Nursing	Nurse education programmes should follow the National Standards for Critical Care Nurse Education (2012) and include both academic and clinical competence assessment.	**Currently at 43%. Plan in place to achieve > 50% by year end. Included in Scheduled Care Risk Register.**
Units should not utilise greater than 20% of registered nurses from bank/agency on any one shift when they are NOT their own staff	All registered nursing staff supplied by bank/agency should be able to demonstrate using documented evidence that they are competent to work in a critical care environment. All agency/bank staff are to be provided with unit orientation.	**NHSP usage all own staff. No Agency usage.**

Standard	Additional rationale / consideration	Compliance
Where direct care is augmented using non-registered support staff, appropriate training and competence assessment is required	All non-registered staff should have a defined period of induction, training for their role which includes competency assessment and personal development plan. All staff reporting to a registered nurse should work collaboratively to provide / support the provision of high quality compassionate care and support within clearly defined professional boundaries that comply with agreed employer's ways of working. Where Assistant Practitioner roles are introduced they should be in line with the National Education and Competence Framework for Assistant Critical Care Practitioners (DH, 2008).	**Not Applicable.**

Current establishment

The following table represents our current establishment and the figures that were discussed at a Telford staffing review in 2012.

Band	Current WTE	Telford WTE
7	**6.84***	**7.95**
6	**11.36***	**10.54**
5	**58.54**	**56.67**
Qualified Total	**76.74**	**75.16**
2 (Support Carers)	**12.52**	**12.86**
2 (Ward clerk)	**1.0**	**1.0**
3 (House keeper)	**1.0**	**1.0**

*Please note that these figures do not include a supernumerary Band 7 1.0wte Practice Development Facilitator and 0.4wte non-clinical Band 6 governance post.

The minimum staffing requirements are: Day shifts 14 qualified + 3 Carers

Night Shifts 14 qualified + 2 Carers

The Critical Care Network use the following calculation for establishment requirements:

7 wte qualified nurses per ICU bed

5.7 wte qualified nurses per 2 HDU beds

Based on occupancy of 8 ICU beds and 10 HDU beds, this equates to 84.5wte qualified nurses. Our current establishment is 76.74wte.

However, average unit occupancy for 2013-2014 was 80% (see table below) which enabled the staff to be utilised flexibly and to also provide support to non-critical care areas during periods of reduced patient occupancy / dependency.

Critical Care Occupancy 2013-2014:

MONTH	SITE	BED DAYS	OCCUPIED	UTILISED %
April	WARRINGTON	530	490	92
May	WARRINGTON	558	462	83
June	WARRINGTON	540	435	81
July	WARRINGTON	558	410	73
August	WARRINGTON	558	481	86
September	WARRINGTON	540	337	62
October	WARRINGTON	558	413	74
November	WARRINGTON	540	453	84
December	WARRINGTON	558	437	78
January	WARRINGTON	558	453	81
February	WARRINGTON	504	399	79
March	WARRINGTON	558	463	83
TOTAL	**WARRINGTON**	6560	5233	80

Staffing Incidents

There have not been any reported nurse staffing incidents on ICU since February 2013.

Additional considerations

- E-rostering has been implemented on ICU since March 2014

- Sickness absence is closely monitored and proactively managed within the unit. We currently have the following number of staff being formally monitored:
    - 4 staff on 2nd letters of concern
    - 3 staff on 1st letters of concern
    - 2 staff with Stage One thresholds
    - 14 staff on the 6 month monitoring phase following a Stage One threshold
- During periods of reduced occupancy / patient dependency ICU staff regularly support general wards
- We consistently run at higher than average rates of maternity leave
- Pay budget underspent year end 2013-2014. Band 7 Management Team are financially aware and don't automatically fill shifts with NHSP to optimum staffing level during periods of reduced occupancy / patient dependency

Challenges ahead 2014-2015

- Impending extended leave for Interim Matron – plan in place to appoint Interim Ward Manager who will be supported by a Divisional Matron. The remaining ICU Band 7s will maintain their current areas of responsibility and receive management time to ensure effective team leadership
- 2 staff currently on maternity leave with a further 3 to commence by the end of July 2014 – Band 5 secondment opportunities currently being advertised to backfill, however there are potential implications for skill-mix as we would be replacing experienced staff with new starters
- Recruitment currently in progress for Acting Band 6 (to cover current Acting Band 7) and permanent Band 5s

N. Crosby, **Interim ICU Matron**

May 2014


Quality

W&HHFT/TB/14/102

BOARD OF DIRECTORS

Presentation	**Patient Story** **Matron Cheryl Finney, Trauma & Orthopaedics**
Date of Meeting	25th June 2014

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Title: **Patient Story - BJ**

Presented by: **Matron Cheryl Finney, Trauma & Orthopaedics**

Date: **25 June 2014**

I arrived at Warrington Hospital at 10.30 at Thursday night 24th April following an accident which left me with an injured leg. I was seen in A&E and the doctors decided to keep me in overnight and to go to theatre on Friday. I arrived on A9 at 03.30am.

The staff settled me in and gave me pain killers and I did get some sleep, but it had been a long day. The doctor came to see me the next day and told me that they would not be able to do the surgery today. I asked if I needed to stay in or could I go home and come back in, the doctor said we could plan for Monday. I was happy with this and said there is no point me taking up a bed if I could be at home. I went home and was told to contact the ward on Monday morning and speak to the trauma nurse.

This is where my problem began, I rang the ward on Monday 28th April after being fasted overnight and was told there was no bed and the trauma nurse was on annual leave. I was told to contact the ward again on Tuesday morning, which I accepted.

I received a phone call at 09.30 that there would be a bed later today and to remain NBM. I received a phone call from the hospital that the bed had now gone and I was not to come in. I asked when the bed would be available but was told I would need to ring in the morning to see if bed available. I was getting angry now because I was in pain and needed to have surgery. I am a business man and am due to go on a trip to France on 11th May which has been arranged for some time, will this mean I can't go! Why had the bed gone when I was due to arrive later that day?

I rang Wednesday morning and spoke to the Trauma nurse, who did not have a bed but was working on it. I apologise that I was very abrupt on the phone but I was frustrated at the delay. I received a phone call and was asked to come in for 11.00. I arrived on the ward and the trauma nurse spoke to me, there was no empty bed but one was coming up. I then waited an hour and half outside the ward on an uncomfortable chair and felt very uneasy and in the way as trollies came by.

Eventually, I was shown to my bed and was happy with the nursing care and the operation and medical care. The Matron came to speak with me and asked me to share my story, as the hospital is looking at ways to improve the patient experience. I was happy to raise my issues and if I had known that it would have taken 6 days to get to theatre, then I would not have gone home on the Friday.

I felt in limbo and had to keep being NBM. I would have thought that the communication could be better, I felt I was always chasing a bed and why did the hospital not plan for the bed better as they know about me. I was very lucky that I am not self- employed because if I was I would have had lost earnings. I do have private insurance and if I had have known this was how long it was going to be, I might have considered looking at private healthcare.

I would like to finish by saying my issues were regarding the process of getting a bed and that I was happy with my care and treatment once in a bed.

W&HHFT/TB/14/103

BOARD OF DIRECTORS

Paper Title:	Quality Dashboard June 2014
Date of Meeting	25 June 2014
Director Responsible	Karen Dawber (Director of Nursing and Organisational Development)
Author(s)	Ros Harvey (Corporate Nursing and Governance Support Manager) Hannah Gray (Clinical Effectiveness Manager)
Purpose	To monitor performance against the KPIs within the Trust's Improving Quality: Patient Safety, Experience and Clinical Effectiveness Strategy (IQ Strategy)

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**
	Executive Team	Prior to Trust Board meeting

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

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).		
	The Quality Dashboard is currently under review in relation to CQUIN, contractual and improvement priority measures. These issues will be finalised by July 2014.	Page/Paragraph Reference
○	This report contains exception reports for MRSA & C.diff; mixed sex occurrences, pressure ulcers and information on incidents resulting in major and catastrophic harm.	3
○	VTE, Dementia and Discharge Summaries relate to the early extraction of data (19th June 2014) and are therefore provisional until final submission to UNIFY on the **30th June 2014**.	
○	VTE Risk Assessment data for April has been revised to show submission figure to UNIFY.	

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

The Board is asked to:

- Note progress and compliance against key performance indicators in the Improving Quality Strategy
- Approve actions planned to mitigate areas of exception

1. Key Performance Indicators

Patient Safety	Target / threshold	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
		Figures are totals or % for the month / quarter (except where stated)																
HSMR (rolling 12 months, latest data available)	See Appendix 1	2013/14 data													98			98
SHMI (rolling 12 months, latest data available)	See Appendix 1	2013/14 data												105				105
Total deaths in hospital	None set	98	88															186
Regulation 28 - Prevention of future deaths report	TBC	0	0															0
Incidents resulting in Major or Catastrophic harm	TBC	0	0															0
Incidents of major or catastrophic harm under investigation	N/A	4	4															8
Falls (moderate, major and catastrophic harm)	<=13 per year	0	0															0
Falls (moderate, major and catastrophic harm) awaiting approval	N/A	1	2															3
Pressure Ulcers – Grade 3 and 4 Hospital Acquired (Avoidable)	<=6 per year	1	1															2
Pressure Ulcers – Grade 3 and 4 Hospital Acquired (Unavoidable)	N/A	0	0															0
Pressure Ulcers – Grade 3 and 4 Hospital Acquired (Not yet determined)	N/A	0	0															0
Pressure Ulcers – Grade 2 Hospital Acquired	<=101 per year	3	8															11
Pressure Ulcers – Grade 2 Hospital Acquired (under review)	N/A	0	3															3
MRSA	0 =Green, 1-5 =Amber, >5 =Red	0	1															1
C difficile	<=26 per year	2	3															5
Never Events	0 per year	0	0															0
VTE – % of patients risk assessed	>=95% of patients	95.55	93.51															
VTE – % harm free (Safety Thermometer (ST))	TBC	98.86	99.62															
Medication Errors – Omitted doses (Quarterly audit)	KPI inclusion under review due to development of Medicines dashboard																	
Medication Errors – Insulin related errors																		
CA – UTI: Number of catheterised patients who developed a UTI (ST)	<=32 per year	4	2															6
CA – UTI % of catheterised patients who developed a UTI (ST)	TBC	0.76	0.38															
Dementia Assessment (Part 1)	>=90% of patients	94.55	95.69															
Dementia Assessment (Part 2)	>=90% of patients	97.44	100															
Dementia Assessment (Part 3)	>=90% of patients	100	100															

NB YTD results for VTE, Discharge Summaries to GPs & Dementia includes March data.

Effectiveness		2013/14	2014/15		J	F	M	Q4	YTD
Advancing Quality	Acute MI	**>=91.46%**	>=95%	2013/2014 data	97.84	97.97			97.97
	Hip and knee	**>=92.23%**	>=95%		96.23	96.52			96.52
	Heart failure	**>=86.85%**	>=90.2%		87.35	87.50			87.50
	Pneumonia	**>=75.23%**	>=73.9%		72.95	72.25			72.25
	Stroke	**>=62.57%**	>=60.4%		55.48	55.82			55.82

Discharge summaries to GPs within 24 hours	95% of patients	92.30	92.17											92.04

Patient Experience														
Complaints (number received)	None set	32	45											77
Concerns (number received)	None set	2	1											3
Complaints (% resolved within the agreed timescale)	>=94%	94.44	95.24											94.74
Mixed sex occurrences (clinical unjustified)	0	6	3											9
Friends and Family Test (Trust score, out of maximum 5)	TBC	4.54	4.5											
Friends and Family Test – NET PROMOTER (total)	>=70	59	56											
Friends and Family Test – NET PROMOTER (A&E)	None set	43	36											

2. Exception reporting

Mixed Sex Occurrences

DSSA Breach & Sanction Reporting: There was one breach in CCU on 6 May 2014 and there were two breaches in ICU/HDU on 22 May 2014. Root Cause Analysis reports have been completed and sent to commissioners.

Incidents: major and catastrophic harm – Improvement Priority 2013/2014

In December 2013 the trust reported 7 incidents (all finally approved) resulting in major (4), and catastrophic harm (3) for the period 2012/2013. The improvement priority threshold for 2013/2014 was therefore confirmed at 6 incidents. In the Quality Report we reported that as "at the 31st March 2014 the trust is performing well, with 6 confirmed incidents of this severity, however, there are a further 11 incidents of this severity under investigation at this time". As of the 12th June 2014 there are 9 finally approved incidents of this severity. There are 5 still under review.

C difficile & MRSA

6 cases of Clostridium difficile were reported in April 2014. 3 of the cases were hospital apportioned and are currently being investigated as level 1 incidents. Total hospital apportioned cases is 5 YTD.

The Trust reported one hospital acquired MRSA bacteraemia in May 2014. This breaches the threshold of zero cases. A post infection review is in progress.

Pressure Ulcers

We have recently introduced the Ward and Department Assessment Scheme (WDAS); this includes an assessment of the area's approach to the prevention and management of pressure ulcers. Root cause analyses continue to be conducted for all hospital acquired pressure ulcers, and the wards produce a 'We caused a pressure ulcer' document to share learning amongst staff. The Trust's pressure relieving equipment is currently being reviewed to ensure it remains suitable. The new Patient Quality and Safety Champion is alerted to all hospital acquired pressure ulcers of this grade via datix and goes straight to the ward to review pressure ulcer care from admission, to ongoing management.

3. Key Performance Indicators: detail (all KPIs are reported in the quarterly report, but not the monthly report)

	KPI detail	Rationale for inclusion	Data Circulation	Data Assurance
Patient Safety				
HSMR	Hospital Standard Mortality Rate calculated by HED (rolling 12 months to the end of the period). RAG rating ranges are: R: in 'higher than expected' category, A: >100 but 'within expected range', G: <=100.	• Contract target • QIPSS • AQUA Reducing Mortality Collaborative (RMC)	• Commissioners •	Accessed via HED
SHMI	Standard Hospital Mortality Index calculated by HED (rolling 12 months to the end of the period) RAG rating ranges are: R: in 'higher than expected' category, A: >100 but 'within expected range', G: <=100.	• QIPSS • AQUA RMC	• Commissioners	Accessed via HED
Falls (moderate, major and catastrophic harm)	Falls which result in moderate, major or catastrophic harm to the patient (Datix finally approved incidents only)	• Contract target • QIPSS	• Commissioners • Falls Prevention Group	Adherence to Trust Policy for the Reporting and Management of Incidents and Investigations. Falls data adheres to NRLS (National Reporting and Learning System) submission criteria. Amendments to process made following advice from PWC
Pressure Ulcers (grade 3&4 hospital acquired)	Number of hospital acquired grade 3 and 4 pressure ulcers (including patients who are admitted with a pressure ulcer (grade 1 – 2) which deteriorates after 72 hrs from admission)	• Contract target • QIPSS	• Commissioners • Pressure Ulcer Link Nurses	Mersey Internal Audit Agency report 2012: 'Significant Assurance'
Pressure Ulcers (grade 2 hospital acquired)	Number of hospital acquired grade 2 pressure ulcers (including patients who are admitted with a pressure ulcer (grade 1) which deteriorates after 72 hrs from admission)	• Contract target • QIPSS	• Commissioners • Pressure Ulcer Link Nurses	Mersey Internal Audit Agency report 2012: 'Significant Assurance'
MRSA	Number of cases of hospital acquired MRSA	• Contract target • Quality Improvement and Patient Safety Strategy 2012 – 2015 (QIPSS)	• Commissioners • Infection Control Sub Committee (ICC)	Process audited annually by PWC on behalf of Monitor.
Clostridium difficile	Number of cases of hospital acquired C difficile	• Contract target • QIPSS	• Commissioners • ICC	Data from Trust MOLIS laboratory system and Public Health England's HCAI national database is cross referenced for accuracy.
Never events	Never Events as determined by The Department of Health criteria	• Contract target • QIPSS	• Commissioners • Clinical Governance sub Committee	Adherence to Trust Policy for the Reporting and Management of Incidents and Investigations.
VTE: % of patients risk assessed	% of inpatients who are assessed for risk of developing VTE	• Contract target • QIPSS	• Commissioners	Supplied by Information Dept. Protocol approved by the Clinical Governance Committee applying the SHA criterion. Performance monitored by Associate Director of Strategy and Business Development

	KPI detail	Rationale for inclusion	Data Circulation	Data Assurance
VTE % harm free (Safety Thermometer)	% of patients who have not developed a VTE since admission to the Trust. Measured by monthly NHS Safety Thermometer point prevalence survey	• CQUIN • QIPSS	• Commissioners	Adherence to National NHS Safety Thermometer data capture and reporting procedures
Medication Errors: omitted doses	Results of a quarterly snapshot audit of the patients' current prescription chart for 8 randomly selected patients on each ward across the Trust. Only wards with 8 auditable patients for all quarters are included when measuring the reduction so that there is a consistency in patient numbers and therefore changes in numbers of omissions can be identified. For the purposes of the audit, 'omissions' = all omitted medicine doses with no documented reason or where the medication was unavailable on more than 2 occasions	• QIPSS	• Medicines Safety Committee	Consider Mersey Internal Audit Agency Review
Medication Errors: insulin related.	Number of medication errors associated with insulin. (Data source = datix incident management system)	• QIPSS	• Medicines Safety Committee	Consider Mersey Internal Audit Agency Review
Catheters and UTIs: Total (Safety Thermometer)	Number of catheterised patients who have developed a UTI since admission to the Trust. Measured by monthly NHS Safety Thermometer point prevalence survey	• QIPSS	• Patient Safety and Experience Action Group	Adherence to National NHS Safety Thermometer data capture and reporting process
Catheters and UTIs: % (Safety Thermometer)	% of catheterised patients who developed a UTI since admission to the Trust. Measured by monthly NHS Safety Thermometer point prevalence survey	• CQUIN • QIPSS	• Commissioners	Adherence to National NHS Safety Thermometer data capture and reporting process
Dementia Assessment (CQUIN)	% compliance with Dementia Assessment Part 1 as per CQUIN.	• CQUIN	• WHH Contract and Performance Group	TBC
Incidents resulting in Major or Catastrophic Harm	Incidents which result in major or catastrophic harm to the patient (Datix finally approved incidents only)	• Improvement Priority 2013/14 Quality Account)	• Commissioners	Adherence to Trust Policy for the Reporting and Management of Incidents and Investigations.
Discharge Summaries to GPs	% of patients having a Discharge Summary sent within 24 hours (including TTO). Contract threshold 95% (penalty applies <90%)	• Contract target • QIPSS	• Commissioners	Supplied by Information Dept. Process agreed with commissioners in accordance with the contract. Independent feedback provided by GPs through the Contract Quality meetings. Compliance audits completed through the Associate Director of Nursing.
Clinical Nursing Indicators	Compliance with a range of nursing indicators relating to ward documentation and processes	• QIPSS	• NMAC • PSEAG	Audit completed by Clinical Research and Audit Nurse.
Effectiveness				
3 Clinical conditions	Focus on 3 key clinical conditions (1 per division) resulting in high patient numbers of admissions, implement best practice care bundles & production of clinical guidelines linked to evidence based pathways that support care and recovery.	• QIPSS • AQUA RMC	• TBC	See KPI detail

	KPI detail	Rationale for inclusion	Data Circulation	Data Assurance
	R,A,G rating indicates level of compliance with agreed action plan targets			
Advancing Quality	Compliance with 4 AQ regional targets for patients with: AMI, heart failure, hip and knee replacement and those who have had a stroke	• CQUIN • QIPSS	• Commissioners	Process agreed with Associate Director of Strategy and Business Development and agreed with commissioners in accordance with the contract.
Critical Care Bundles, numbers of VAP and BSI	All relate to Intensive Care Unit only: Compliance with a range of critical care bundles for a sample of patients. Occurrence of Ventilator acquired pneumonia. Occurrence of line associated blood stream infections.	• QIPSS	• Acute Care Group	Mersey Internal Audit Agency has audited this KPI in 2012 and made recommendations which are being implemented
Readmissions	Emergency readmission for the same primary diagnosis group within 30 days of discharge following an elective spell (18+ only) PBR RULES	• Contract target	• Commissioners	TBC
End of Life Care	Prior to April 2013 report: Compliance with End of life care action plan (incorporating best practice as defined in 'Route to success in end of life care for acute hospitals') Starting April 2013 report: Specialist Palliative care referral rates	• QIPSS • AQUA RMC	• End of Life Care Group	See KPI detail
Clinical Nursing Indicators: MEWS recorded	Compliance with a range of nursing indicators relating to ward documentation and processes: audit of MEWS being recorded	• QIPSS	• NMAC	Audit completed by Clinical Research and Audit Nurse.
Clinical Nursing Indicators: MEWS action (including use of SBAR)	Compliance with a range of nursing indicators relating to ward documentation and processes: audit of appropriate action being taken following identification of MEWS, including the use of SBAR	• QIPSS	• NMAC	Audit completed by Clinical Research and Audit Nurse.
Patient Experience				
Patient Survey	Inpatient Survey responses to 5 CQUIN related questions plus 1 other	• QIPSS	• Commissioners	Survey managed by Quality Health
Staff Survey	Staff Survey result for single question: Would you recommend this hospital to friends and relatives?	• QIPSS	• Commissioners	Survey managed by Quality Health
MSO (unjustified breeches)	Number of clinically unjustified mixed sex breaches	• Commissioning target • QIPSS	• Commissioners	Adherence to Department of Health MSO criteria for reporting Developed data capture systems relevant to each area. Datix completed. Quality Improvement Matron informed by wards and triangulates data with Datix and Extramed systems
Complaints received	Number of complaints received each month	• Related to commissioning target • QIPSS	• PSEAG	
Complaints resolved within	% of complaints closed in the month, which were resolved	• Commissioning target	• Commissioners	Process agreed with Associate Director of

	KPI detail	Rationale for inclusion	Data Circulation	Data Assurance
the agreed time	within the agreed timescales	• QIPSS		Strategy and Business Development and agreed with commissioners in accordance with the contract.

Key:
ICSC: Infection Control Sub Committee
QIPSS: Quality Improvement and Patient Safety Strategy 2012 – 2015
PSEAG: Patient Safety and Experience Action Group
WHH: Warrington and Halton Hospitals NHS Foundation Trust

W&HHFT/TB/14/104

BOARD OF DIRECTORS

Paper Title	**Effective Governance to Support Medical Revalidation**
Date of Meeting	25th June 2014
Director Responsible	Dr Paul Hughes, Medical Director
Author(s)	Dr Paul Hughes, Medical Director
Purpose	To update the Board on the effective Governance processes in place in the Trust which provides support to Medical Revalidation

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**
	Board	26th March 2014

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

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

	Page/Paragraph Reference
• See table setting out progress to date on the implementation of the recommendations. • Monitoring the frequency and quality of Medical Appraisals in our Organisation	Page 1

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

1. The Board is asked to recognise the importance attached to medical revalidation by the GMC, CQC, Monitor and TDA
2. The Board is asked to note the robust structures and processes supporting appraisal and revalidation in the Trust
3. The Board is asked to support ongoing improvements to the appraisal and revalidation process
4. The Board is asked to consider the need for a monthly appraisal and revalidation dashboard to provide ongoing assurance.

Effective Governance to Support Medical Revalidation

Introduction

NHS England require an annual report to be submitted to Board providing assurance on the structures and processes supporting effective appraisal and revalidation-this will form part of an Annual Organisational Audit on the process supporting an annual statement of compliance commencing this year.

In addition the Chair has received a letter dated 5th June from the General Medical Council, Care Quality Commission, Monitor and the NHS Trust Development Authority drawing attention to the statutory responsibilities which the Trust has to ensure all our doctors keep up to date and that they remain fit to practise.

Background

The Board received the Medical Appraisal and Revalidation Annual Report on 26th March 2014. Further iterations of this report will be adapted to meet the suggested annual report template provided by NHS England and the report will be submitted to Board to coincide with completion of the Annual Organisational Audit thus supporting the completion of the annual statement of compliance.

The letter of the 5th June reinforces the strong belief that the systems to support medical revalidation can provide a powerful lever to improve the quality and safety of medical professional practice. The letter highlights 3 key areas where Board members should focus their attention:

- Monitoring the frequency and quality of medical appraisals in their organisations
- Checking that there are effective systems in place for monitoring of conduct and performance of their doctors
- Confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors

Assessment

1. Monitoring the frequency and quality of Medical Appraisals in our Organisation

Corporate Monitoring and Reporting

As the Trust utilises CRMS – Clinical Resource Management System – this system allows the Appraisal and Revalidation Team the ability to monitor and report on the completion of medical appraisals at any point in time and enables identification of a range of activity:

- Log-in by Appraisee and/or Appraiser
- Medical appraisal meeting date
- Completed appraisals
- Awaiting sign-off
- PDP and summary completion
- Final sign-off
- Feedback completion

Through this web-based tool we are able to monitor and identify at what stage the medical appraisal is progressing to enable a move to final sign-off. Any outstanding Appraisals are identified at the end of every month by running a report from CRMS which enables the team to track completion, but to also monitor, track and identify those who have not completed in their month of birth. For every month following their month of birth; every doctor is sent a numbered "Notification email" advising them that they are required to complete their Appraisal. All outstanding Appraisals are discussed at the Appraisal and Revalidation Group (ARG) where they can be escalated to the Medical Director/Revalidation Officer for further action as required.

Our Audit Report[1] for 2012/13 – when the Medical Appraisal process was in its infancy concluded the following....."*the system tested was found to be robust in its design to manage the medical appraisal process*".

Monitoring and Reporting – Quality of Medical Appraisals

The quality of Medical Appraisals is supported by a robust and generic national template – Medical Appraisal Guide (MAG). This document was mapped into CRMS to provide the structure and content for every medical appraisal and we also added an additional QA tool embedded into CRMS which requires the Appraisee to provide feedback on the process prior to final sign-off. Furthermore, our Trust appointed a senior medical consultant – Dr Mohammed Al-Jafari as the Medical Appraisal Lead who reviews every medical appraisal document within CRMS to ensure the completed appraisal documentation is of a satisfactory standard and to reject the appraisal should there be a failure in delivery of the required documentation.

Furthermore, we also hold bi-annual Appraiser Forums to advise on changes; listen and address any issues and strive to drive quality with also offering their annual Appraisee feedback reports (May 2014) which we hope to further enhance this coming year.

Finally, in accordance with the Trust Medical Appraisal and Revalidation Policy - every doctor is individually responsible for ensuring that they participate in the annual appraisal cycle to meet the requirements of revalidation. They are required to maintain a professional portfolio including feedback from each of their employers (whole practice review) including the independent sector, records of their training, reflective practice and additional documentation as specified by the GMC[2,3].

In essence, we have a robust system in place for provision and access to a doctor's supporting information; a web-based tool which enables monitoring and completion rates; a Medical Appraisal Lead that undertakes a quality assurance role; Appraiser Forums and a Revalidation Review Panel that meets prior to the doctor's Revalidation date to again assure the RO of his decision to recommend or defer.

2. Checking that there are effective systems in place for monitoring of conduct and performance of their doctors

The Trust has a policy in place based upon the Department of Health's Maintaining High Professional standards documentation. When a concern arises about a clinician this policy is

[1] Mersey Internal Audit Agency – MIAA Review of Medical Appraisal Final Report 2012/13
[2] General Medical Council. The *Good Medical Practice* framework for appraisal and revalidation. March 2011. www.gmc-uk.org/static/documents/content/GMC_Revalidation_A4_Guidance_GMP_Framework_04.pdf.
[3] General Medical Council. Supporting information for appraisal and revalidation. March 2012. http://www.gmc-uk.org/Supporting_information100212.pdf_47783371.pdf

followed and should the outcome of any investigation relate to a conduct issue there is a section in the policy which deals with this. The Trust also has a Remediation Policy which can be used in cases when support from the Trust, along with the engagement of the clinician, could result in an individual returning to the required standard of practice for their role.

Conduct cases are monitored in a number of ways. There are:

- Monthly updates on all HR cases are provided to the Strategic People Committee
- Any restrictions or exclusions are reported on a monthly basis to the Board
- The Revalidation Tracker includes all HR related cases, whether formal or informal, and is reviewed regularly by the Medical Director in his meetings with the Head of Medical Employment

All of the above provide the opportunity to establish any trends in the types of cases/for specific individuals/any departmental issues.

The Trust has a system and procedure in place to review incidents, complaints and claims as part of the appraisal and subsequent revalidation process of doctors.
This involves the Governance and Patient Relations departments sending information (performance data, audit information, mandatory training records, incidents and complaints, along with other information) to the Appraisal and Revalidation Officer to upload into CRMS. It is expected that this is reviewed by the Appraiser and Appraisee. Any concerns which come to light during the appraisal process should be highlighted and/or escalated by the appraiser appropriately.

Other procedures are also in place whereby following a patient safety investigation, if it is found that a doctor contributed to or was a root cause to the harm occurring, this information is passed to the Trust Medical Appraisal Lead to review as part of medical management procedures.

The Revalidation Panel Chaired by the Medical Director adds a further quality control process and additional scrutiny involving the Associate Director of Governance, Medical Staffing Manager, Trust Medical Appraisal Lead and the Appraisal and Revalidation Officer further reviewing any known areas of concern in a systematic way for all doctors being considered for revalidation.

3. Confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors

One of the principles of revalidation is that patient feedback should be at the heart of doctors' professional development. The GMC specifies that all doctors should collect colleague and patient feedback[4].

The Trust utilises 360° Clinical which is a web-based Assessment Process of gathering information about a doctor from a variety of colleagues and patients. This Feedback helps promote continuous professional development as well as supporting clinical governance. 360° Feedback for doctors provides information from clinical colleagues, other members of the healthcare team, trainees, managers and patients. The 360° Clinical Assessment System is a collection of online forms to collect data. Users are sent e-mails with links to the website, where they are asked to give information.

[4] General Medical Council. Supporting information for appraisal and revalidation. March 2012. http://www.gmc-uk.org/Supporting_information100212.pdf_47783371.pdf.

When all the information has been collected and collated, a report is generated and uploaded onto CRMS for discussion and review by the Appraiser.

The Trust requirement is for 15 colleague and 20 patient feedback responses at least once per revalidation cycle, normally every five years. A repeat can be requested should development and improvement need to be evidenced for the next appraisal.

Every doctor in the organisation is advised that they are required to complete a 360° report for their revalidation which will take place once within a 5 year cycle and this information is tracked to ensure all doctors have a 360° before that date, with an understanding that the whole process from start to finish can take up to 6 months to complete. New doctors to the Trust, if it is their first consultant post, are asked to complete a 360° in about 3 years. Locums are discussed on an individual basis depending on how long they have worked for the Trust.

Recommendations

5. The Board is asked to recognise the importance attached to medical revalidation by the GMC, CQC, Monitor and TDA
6. The Board is asked to note the robust structures and processes supporting appraisal and revalidation in the Trust
7. The Board is asked to support ongoing improvements to the appraisal and revalidation process
8. The Board is asked to consider the need for a monthly appraisal and revalidation dashboard to provide ongoing assurance.

Dr Paul Hughes
Medical Director

17th June 2014

Sustainability

6 June 2014

Ms Melany Pickup,
Chief Executive
Warrington and Halton Hospitals NHS Foundation Trust
Warrington Hospital
Lovely Lane
Warrington
Cheshire
WA5 1QG

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Making the health sector work for patients

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Dear Mel

Q4 2013/14 monitoring and 2014/15 annual plan review of NHS foundation trusts

I am writing to you in respect of our review of the two year operational plan phase of the 2014/15 annual plan review (APR) as well as the Q4 2013/14 monitoring cycle.

The purpose of Monitor's review of operational plans is to assess whether foundation trusts (FTs) are effectively planning for the future while maintaining and improving quality. This enables Monitor to make a more informed judgement about future risks to the Trust's compliance with its licence conditions.

Under the APR process all FTs are subject to high-level review of two-year operational plans. Following this, and alongside our Q4 monitoring, Monitor determines if a change in regulatory approach is required on a trust by trust basis. This may include specific planning focused actions[1] or Monitor could consider whether to take any regulatory action under the 2012 Act, taking into account as appropriate its published guidance on the licence and enforcement action including its Enforcement Guidance[2] and the Risk Assessment Framework[3].

As set out in our letter dated 16 May 2014[4], at an aggregate level, Monitor's review has highlighted significant concerns about the quality of the sector's planning, particularly that year two of the plans may, on aggregate, be overly optimistic. We ask that you bear this in mind when completing your strategic plan.

In addition, where Monitor has identified specific weakness in individual plans we may ask individual FTs to resubmit their plans as part of the strategic plan submission.

[1] Please see section 2.5 of Monitor's Annual plan review 2014/15 guidance
[2] www.monitor-nhsft.gov.uk/node/2622
[3] www.monitor.gov.uk/raf
[4] APR update letter 16 May 2014

Risk ratings

Monitor has now completed the review of your two-year operational plans[5] and Q4 submissions.

Based on this work, the current and forecast risk ratings are:

	Q4 13/14 (actual)	Q1 14/15 (plan)	Q2 14/15 (plan)	Q3 14/15 (plan)	Q4 14/15 (plan)
Continuity of service risk rating	3	2	2	2	3

Governance risk rating	Green

The governance rating represents Monitor's current view of governance at the Trust. The Trust therefore has a single rating.

These ratings will be published on Monitor's website in June. We would emphasise that the forecast continuity of service risk ratings are the FT's own risk ratings as submitted in the operational plan and as such are never adjusted by Monitor.

The Trust has breached its full year C. difficile objective, also breached at Q3 2013/14, which has triggered consideration for further regulatory action.

Monitor uses the above target (amongst others) as indicators to assess the quality of governance at foundation trusts. A failure by a foundation trust to achieve the targets applicable to it could indicate that the trust is providing health care services in breach of its licence. Accordingly, in such circumstances, Monitor could consider whether to take any regulatory action under the 2012 Act, taking into account as appropriate its published guidance on the licence and enforcement action including its Enforcement Guidance[6] and the Risk Assessment Framework[7].

We expect the Trust to continue to address the issues leading to the target failure and achieve sustainable compliance with the target in 2014/15.

Monitor has decided not to open an investigation to assess whether the Trust could be in breach of its licence at this stage. The Trust's governance risk rating has been reflected as Green. Should any other relevant circumstances arise, Monitor will consider what if any further regulatory action may be appropriate.

[5] Please note that these findings are interim as we consider both the operational and strategic plans part of the same process. As previously communicated in our guidance, final APR findings will be provided to FTs in October 2014 following review of the five-year strategic plan submissions.
[6] www.monitor-nhsft.gov.uk/node/2622
[7] www.monitor.gov.uk/raf

However, we note the following risks from our review of the Trust's operational plan and Q4 submissions:

- The two-year plan quarterly forecast is for a Continuity of service risk rating (CoSRR) of 2, 2, 2, 3 in both 2014/15 and 2015/16; which is the same trajectory that was achieved in 2013/14 and does not deliver a sustainable CoSRR 3;
- We note that there is limited headroom in the plan and we are concerned that the Trust does not appear to be making progress in delivering a sustainable financial position;
- The plan assumes revenue growth of £2.5m per year, which is achieved over the life of the plan via repatriation of market share through the development of specialist centres of excellence in certain specialties and from assuming receipt of winter monies to match costs of delivering the anticipated increase in activity in the two year period. Both revenue items have not yet been secured, although the Trust has plans to secure these;
- The Trust is assuming delivery of upper quartile CIPs compared to other acute foundation trusts in their plans and a higher level of CIP delivery in 2014/15 (5.1%) and 2015/16 (4.7%) than in 2013/14 (3.4%) and 2012/13 (1.5%). Forecast CIP delivery has been assumed to follow the pattern of previous years, with a smaller level of CIP to be delivered in the first half of the financial year followed by a significant stepped increase in forecast CIP delivery in the second half of the financial year; and
- Commissioners are undertaking an end-to-end service review in response to concerns over the clinical and financial sustainability of healthcare services in the mid-Mersey region. However, we understand it is unlikely that this will deliver a final outcome for the Trust to incorporate into its five-year plan submission due on 30 June 2014, which presents some concern over how realistic the plan will be.

We are pleased to note the steps already taken by the Trust to improve its financial performance. The Trust has commissioned external support from Ernst & Young (E&Y) in Q3 2013/14 to help it in identifying CIPs and bringing delivery of CIPs forward. The Trust has committed to working with E&Y until at least July 2014.

We expect the Trust to:

- Develop and deliver sufficient schemes to meet its CIP requirement for 2014/15, including bringing forward delivery of schemes should this be appropriate;
- Deliver its plans to repatriate income within the specialties outlined within its operational plan and to develop suitable financial mitigations should the assumed winter monies not be realised;
- Continue to work closely with E&Y to develop additional transformational opportunities to feed into the Trust's 2015/16 CIPs; and
- Continue to work collaboratively with other local providers and commissioners on developing longer-term service reconfiguration plans.

We are not taking formal regulatory action at this time, however the Trust will remain on monthly financial monitoring until such time that it recovers to a sustainable CoSRR 3.

In our review of the Trust's five-year plan, we would like to obtain an understanding from the Trust of what alternative plans exist to address the risks to the clinical and financial

sustainability of the Trust's service should the commissioner-led end-to-end service review be delayed further or should it fail to deliver a suitable solution or the Trust.

Next steps

A report on the FT sector aggregate performance from Q4 2013/14 will shortly be available on our website (in the News, events and publications section) which I hope you will find of interest.

For your information, we will shortly be issuing a press release setting out a summary of the key findings across the FT sector from the Q4 and APR monitoring cycle.

We will also publish on our website, under your entry in the Public Register of NHS foundation trusts, the commentary/summary document of the operational plan excluding any appendices in a similar format to previous years.

Please note that as previously communicated in April's FT bulletin[8] we are not attaching an executive summary of our quarterly review as we have done previously.

If you have any queries relating to the above, please contact me by telephone on 02037470352 or by email (Tania.Openshaw@monitor.gov.uk).

Yours sincerely

Tania Openshaw
Senior Regional Manager

cc: Mr Allan Massey, Chairman
Mr Tim Barlow, Director of Finance and Commercial Development

[8] FT Bulletin April 2014

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/106

BOARD OF DIRECTORS

Paper Title	Finance Report as at 31st May 2014
Date of Meeting	25th June 2014
Director Responsible	Tim Barlow, Director of Finance & Commercial Development
Author(s)	Steve Barrow, Deputy Director of Finance
Purpose	To provide a performance update against the annual financial plan.

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

Relates to which Trust objectives **appropriate**

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

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

Page/Paragraph Reference

- Please refer to Executive Summary.

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

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

Finance Report as at 31st May 2014

1. Purpose

The purpose of the report is to advise the Board of Directors on the financial position of the Trust as at 31st May 2014 and the forecast outturn as at 31st March 2015.

2. Executive Summary

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

Key financial indicators

Indicator	May Plan £m	May Actual £m	May Variance £m	YTD Plan £m	YTD Actual £m	YTD Variance £m
Operating income	17.4	17.3	(0.1)	34.0	33.9	(0.1)
Operating expenses	(17.3)	(17.1)	0.2	(34.8)	(34.5)	0.3
EBITDA	0.1	0.2	0.1	(0.8)	(0.6)	0.2
Non-operating income and expenses	(0.9)	(0.9)	0.0	(1.7)	(1.7)	0.0
I&E surplus / (deficit)	(0.8)	(0.7)	0.1	(2.5)	(2.3)	0.2
Cash balance	-	-	-	7.8	8.8	1.0
CIP target	0.3	0.2	(0.1)	0.7	0.4	(0.3)
Capital Expenditure	0.6	0.4	0.2	1.1	0.7	0.4
Continuity of Services Risk Rating	2	2	0	2	2	0

3. Income and Expenditure (Appendix B)

The reported position for the year to date period is a deficit of £2,303k, which is £170k lower than the planned deficit of £2,473k.

This deficit position is comprised of the following variances:

- operating income is £128k below plan
- operating expenses are £298k favourable to plan.
- non operating income and expenses are on plan.

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

While the in-month result is a significant deficit, it reflects the expected lower levels of activity and income expected in May due to the impact of the bank holidays and associated leave but is still marginally ahead of plan. In addition, the year to date performance reflects the planned profile of the cost improvement savings, the delivery of which is weighted towards later months.

4. Cost Improvement Programme

The Trust had an annual savings target of £11.9m and by the year end schemes had been identified to achieve this target, which are included in the table below.

Narrative	In Year £m	Recurrent £m
Annual Target	11.9	11.9
Value of schemes identified	10.7	16.9
Over / (Under) Achievement against target	**(1.2)**	**5.0**

For the period to date the planned savings for the identified schemes equate to £676k, with actual savings amounting to £403k which results in an under achievement of £273k. The cost savings programme is heavily phased in the second half of the year, so it is vital that in the first half of the year planned savings are identified as it will become more difficult to identify and achieve any shortfalls as the year progresses.

5. Cash Flow (Appendix C)

The cash balance is £13.0m which is £4.6m above the planned cash balance of £8.4m, with the monthly movements summarised in the table below.

Cash balance movement	£m
Opening balance as at 1st May	13.0
Cash related EBITDA	0.9
Increase in receivables	0.5
Decrease in payables	(3.5)
Capital expenditure	(0.4)
Other working capital movements	(1.7)
Closing balance as at 30th May	**8.8**

The planned cash balances detailed in the cashflow were based on a £10.3m forecast year end cash balance but the actual cash balance was £13.0m as a number of commissioners settled outstanding invoices in March.

The cash balance of £8.8m equates to circa 16 days operational cash. Under the continuity of services risk rating the liquidity metric is -2.2 days which scores at a 3, which reflects a reasonably strong liquidity position but the metric includes all current assets and liabilities excluding inventories, so masks the challenging cash position which is managed through working balances.

The operating performance continues to have an adverse effect on the cash position and creditor payments. In order to maintain a reasonable cash balance, payments to creditors must be extended. Therefore performance against the non NHS Better Payment Practice Code (BPPC) is 32% in May (31% year to date).This low level of compliance and performance will continue until there is an improvement in the operating position and the resultant cash position.

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

6. Statement of Financial Position (Appendix D)

Non current assets have decreased in the month by £161k, as capital expenditure is less than depreciation cost.

Current assets have decreased by £4,458k mainly due to the reduction in cash used for

creditor payments.

Current liabilities have decreased by £3,984k in the month mainly due to the reduction in payables.

Non current liabilities have increased by £13k in the month.

7. Capital

The approved capital programme for the year stands at £10.3m and to date the Trust has spent £0.7m against the budget of £1.1m, 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	6.4	0.5	0.3	0.2
IM&T	2.5	0.5	0.2	0.3
Medical Equipment	1.0	0.1	0.2	(0.1)
Contingency	0.4	0.0	0.0	0.0
Total	**10.3**	**1.1**	**0.7**	**0.4**

8. Risk and Forecast

For the period ending 31st May the Trust has recorded a deficit of £2,303k and although this is £170k better than plan, there are still a number of financial risks that need to be avoided or mitigated, namely:

- Non compliance with contractual data requirements, quality standards, access targets and CQUIN targets resulting in fines or penalties.
- Divisions fail to deliver services within available resources.
- Clinical divisions unable to deliver income targets based on agreed activity plans or deliver additional activity and income identified in budget setting process eg spinal or repatriation.
- Cost savings target not fully identified and delivered in in accordance with profile.
- Increase in readmissions resulting in bed blockages and payment to commissioners for exceeding current agreed threshold.
- Failure to manage escalation or partners inability to provide services to withdraw medically fit patients from the hospital.
- Failure to continue to reduce bank, agency, locum, overtime and waiting list initiatives.
- Failure to increase clinical efficiency and productivity.
- Non receipt or reduced level of anticipated winter funding.

Based on the financial position as at 31st May and the processes introduced to increase financial rigor and scrutiny, the Trust is forecasting achievement of the planned deficit, continuity of services risk rating and all other key financial indicators.

Tim Barlow
Director of Finance & Commercial Development
18th June 2014

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Finance Headlines as at 31st May 2014

Key Financial Metrics	Month			Year to date			Forecast		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income	17,442	17,304	-138	33,979	33,851	-128	213,746	213,746	0
Operating Expenditure	-17,370	-17,094	276	-34,740	-34,441	299	-204,977	-204,977	0
EBITDA	72	210	138	-761	-590	171	8,769	8,769	0
Financing Costs	-856	-858	-2	-1,711	-1,712	-1	-10,269	-10,269	0
Net Surplus/(Deficit)	**-784**	**-648**	**136**	**-2,472**	**-2,302**	**170**	**-1,500**	**-1,500**	**0**
Continuity of Services Risk Rating	2	2	0	2	2	0	3	3	0
Capital Expenditure	551	399	-152	1,101	641	-460	10,208	10,208	0
Cash Balance				7,772	8,803	1,031	6,731	6,731	0
Cost Savings	339	196	-143	676	403	-273	11,931	11,931	0

Summary Position

The reported position for the period is a deficit of £2,302k which is £170k lower than the planned deficit of £2,472k. This delivers a Continuity of Services Risk Rating 2 which is in line with plan. Elective activity is 470 spells (£378k) above plan and outpatients are 1,519 attendances (£212k) above plan, although this is offset by A&E attendances, non elective and other activity that are below plan. Pay is £133k below plan, drugs is £264k below plan and non clinical supplies is £11k below plan, although this is partially offset by clinical supplies that is £110k above plan.

Cost savings performance is below plan by £273k, which is a concern as the target is backdated towards the latter part of the financial year.

Forecast Outurn

The Trust is forecasting that the planned deficit of £1.5m will be achieved based on the financial position to date, coupled with the introduction of a revised governance structure that will increase financial rigor and scrutiny.

Key Variances

Operating Income - £128k below plan.
Operating Expenditure - £299k below plan.
Cost savings - £273k below plan
Cash balances - £1,031k above plan but the plan was based on a forecast year end cash balance of £10.3m (actual cash balance as at 31st March was £13.0m).
Capital expenditue - £460k below plan due to slippage but forecasting that all slippage is recovered by year end.

Key Risks

Divisions unable to deliver income targets based on agreed activity plans or deliver additional activity and income identified in the budget setting process.
Cost savings target not fully identified and delivered in accordance with profile.
Failure to significantly reduce bank, agency, locum, overtime and waiting list initiative expenditure.

Other matters to be brought to the attention of the Board

EY continue to work with operational teams to identify and maximise opportunities for cost reduction.
The Finance & Sustainability Committee have approved no changes to Phase 1 (14/15 to 15/16) of the annual plan and approved the proposals for Phase 2 of the annual plan (16/17 to 18/19). The general principle of the activity changes in Phase 2 of the plan were triangulated with Warrington and Halton CCGs.

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

Income Statement, Activity Summary and Risk Ratings as at 31st May 2014

Income Statement	Month			Year to date			Forecast		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income									
NHS Activity Income									
Elective Spells	2,833	3,103	270	5,618	5,996	378	39,884	39,884	0
Elective Excess Bed Days	17	26	9	34	45	12	242	242	0
Non Elective Spells	4,445	4,262	-183	8,918	8,692	-227	52,145	52,145	0
Non Elective Excess Bed Days	322	252	-70	642	558	-84	3,701	3,701	0
Outpatient Attendances	2,832	3,006	174	5,629	5,841	212	36,853	36,853	0
Accident & Emergency Attendances	884	874	-11	1,757	1,715	-41	10,184	10,184	0
Other Activity	4,774	4,452	-322	8,713	8,302	-411	54,729	54,729	0
Sub total	**16,108**	**15,974**	**-134**	**31,311**	**31,150**	**-161**	**197,738**	**197,738**	**0**
Non Mandatory / Non Protected Income									
Private Patients	13	5	-7	25	9	-16	152	152	0
Other non protected	107	71	-36	214	207	-7	1,284	1,284	0
Sub total	**120**	**76**	**-43**	**239**	**216**	**-24**	**1,436**	**1,436**	**0**
Other Operating Income									
Training & Education	641	641	-1	1,283	1,282	0	7,696	7,696	0
Donations and Grants	0	0	0	0	0	0	0	0	0
Miscellaneous Income	573	614	40	1,146	1,203	57	6,876	6,876	0
Sub total	**1,215**	**1,254**	**40**	**2,429**	**2,485**	**56**	**14,572**	**14,572**	**0**
Total Operating Income	**17,442**	**17,304**	**-138**	**33,979**	**33,851**	**-128**	**213,746**	**213,746**	**0**
Operating Expenses									
Employee Benefit Expenses (Pay)	-12,618	-12,537	82	-25,237	-25,104	133	-147,753	-147,753	0
Drugs	-1,170	-996	173	-2,340	-2,076	264	-14,242	-14,242	0
Clinical Supplies and Services	-1,584	-1,590	-6	-3,168	-3,278	-110	-19,154	-19,154	0
Non Clinical Supplies	-1,998	-1,971	27	-3,996	-3,984	11	-23,828	-23,828	0
Total Operating Expenses	**-17,370**	**-17,094**	**276**	**-34,740**	**-34,442**	**298**	**-204,977**	**-204,977**	**0**
Surplus / (Deficit) from Operations (EBITDA)	**72**	**210**	**138**	**-761**	**-591**	**171**	**8,769**	**8,769**	**0**
Non Operating Income and Expenses									
Interest Income	3	2	-1	7	6	0	40	40	0
Interest Expenses	0	0	0	0	0	0	0	0	0
Depreciation	-524	-524	-1	-1,047	-1,048	0	-6,283	-6,283	0
PDC Dividends	-336	-336	0	-671	-671	0	-4,026	-4,026	0
Restructuring Costs	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Total Non Operating Income and Expenses	**-856**	**-858**	**-2**	**-1,711**	**-1,712**	**-1**	**-10,269**	**-10,269**	**0**
Surplus / (Deficit)	**-784**	**-648**	**136**	**-2,473**	**-2,303**	**170**	**-1,500**	**-1,500**	**0**
Activity Summary	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**
Elective Spells	2,910	3,191	281	5,824	6,294	470	38,181	38,181	0
Elective Excess Bed Days	72	107	36	140	195	55	1,003	1,003	0
Non Elective Spells	2,923	2,970	47	5,853	5,976	123	34,367	34,367	0
Non Elective Excess Bed Days	1,422	1,107	-315	2,839	2,466	-373	16,354	16,354	0
Outpatient Attendances	25,704	25,781	77	50,762	52,281	1,519	320,888	320,888	0
Accident & Emergency Attendances	8,929	9,169	240	17,735	17,710	-25	102,814	102,814	0
Continuity of Services Risk Ratings	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**
Liquidity Ratio - Metric (Days)	-1.4	-1.0	0.4	-7.0	-2.2	4.8	-9.0	-9.0	0.0
Liquidity Ratio - Rating	-1	-1	0	2	3	1	2	2	0
Capital Servicing Capacity - Metric (Times)	0.2	0.6	0.4	-1.1	-0.9	0.3	2.2	2.2	0.0
Capital Servicing Capacity - Rating	1	1	0	1	1	0	3	3	0
Continuity of Services Risk Rating	**2**	**2**	**0**	**2**	**2**	**0**	**3**	**3**	**0**

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

Cash Flow Statement as at 31st May 2014

	Actual April £000's	Actual May £000's	Forecast June £000's	Forecast July £000's	Forecast August £000's	Forecast September £000's	Forecast October £000's	Forecast November £000's	Forecast December £000's	Forecast January £000's	Forecast February £000's	Forecast March £000's	Annual Position March £000's
Surplus/(deficit) after tax	**(1,655)**	**(648)**	**(992)**	**(482)**	**(482)**	**(482)**	**479**	**479**	**481**	**654**	**654**	**494**	**(1,500)**
Non-cash flows in operating surplus/(deficit)													
Depreciation and amortisation	523	524	524	524	524	523	524	524	523	524	524	523	6,284
Impairment losses/(reversals)	0												0
(Gain)/loss on disposal of property plant and equipment	0												0
PDC dividend expense	336	336	335	336	335	335	336	335	335	336	335	334	4,024
Other increases/(decreases) to reconcile to profit/(loss) from operations	5	4	3	3	3	3	3	3	3	3	3	4	40
Non-cash flows in operating surplus/(deficit), Total	**864**	**864**	**862**	**863**	**862**	**861**	**863**	**862**	**861**	**863**	**862**	**861**	**10,348**
Operating Cash flows before movements in working capital	**(791)**	**216**	**(130)**	**381**	**380**	**379**	**1,342**	**1,341**	**1,342**	**1,517**	**1,516**	**1,355**	**8,848**
Increase/(Decrease) in working capital													
(Increase)/decrease in inventories	(36)	(93)											(129)
(Increase)/decrease in NHS Trade Receivables	775	(332)											443
(Increase)/decrease in Non NHS Trade Receivables	154	(430)											(276)
(Increase)/decrease in other related party receivables	(235)	(75)											(310)
(Increase)/decrease in other receivables	(1)	303											302
(Increase)/decrease in accrued income	261	417	210	(972)	605	(21)	(607)	(270)	395	(874)	657	199	(0)
(Increase)/decrease in prepayments	(1,833)	507	(100)	(100)	(100)	(100)	333	333	333	333	333	61	0
Increase/(decrease) in Deferred Income (excl. Govt Grants.)	(243)	612											369
Increase/(decrease) in Current provisions	5	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(116)
Increase/(decrease) in Trade Creditors	2,472	(3,205)	(917)	832	(743)	(117)	310	(26)	(314)	776	(753)	517	(1,168)
Increase/(decrease) in Other Creditors	163	(313)											(150)
Increase/(decrease) in accruals	(159)	(538)											(697)
Increase/(decrease) in Other liabilities (non charitable assets)													0
Increase/(Decrease) in working capital, Total	**1,323**	**(3,158)**	**(818)**	**(251)**	**(249)**	**(249)**	**25**	**26**	**403**	**224**	**226**	**766**	**(1,732)**
Increase/(decrease) in Non-current provisions	(27)	13											(14)
Net cash inflow/(outflow) from operating activities	**505**	**(2,929)**	**(948)**	**130**	**131**	**130**	**1,367**	**1,367**	**1,745**	**1,741**	**1,742**	**2,121**	**7,102**
Net cash inflow/(outflow() from investing activities													
Property - new land, buildings or dwellings	0	0	(245)	(38)	(38)	(38)	(323)	(323)	(323)	(342)	(342)	(587)	(2,599)
Property - maintenance expenditure	(158)	(115)	(114)	(318)	(318)	(318)	(362)	(362)	(363)	(467)	(467)	(422)	(3,784)
Plant and equipment - Information Technology	(39)	(165)	(237)	(210)	(210)	(209)	(167)	(167)	(168)	(223)	(223)	(495)	(2,513)
Plant and equipment - Other	(45)	(119)	(37)	(32)	(32)	(31)	(40)	(40)	(41)	(241)	(241)	(151)	(1,050)
Increase/(decrease) in Capital Creditors	(171)	(865)											(1,036)
Net cash inflow/(outflow() from investing activities, Total	**(413)**	**(1,301)**	**(670)**	**(598)**	**(598)**	**(596)**	**(892)**	**(892)**	**(895)**	**(1,273)**	**(1,273)**	**(1,655)**	**(11,055)**
Net cash inflow/(outflow) before financing	**92**	**(4,230)**	**(1,618)**	**(468)**	**(467)**	**(466)**	**475**	**475**	**850**	**468**	**469**	**466**	**(3,953)**
Net cash inflow/(outflow) from financing activities													
Public Dividend Capital received	0												0
PDC Dividends paid	0					(2,012)						(2,012)	(4,024)
Interest (paid) on non-commercial loans	0												0
Interest received on cash and cash equivalents	4	3	3	4	3	3	4	3	3	4	3	3	40
Drawdown of non-commercial loans							266	267	267	266	267	267	1,600
Repayment of non-commercial loans	0												0
(Increase)/decrease in non-current receivables	(99)	77	13	14	13	13	14	13	13	14	13	14	112
Net cash inflow/(outflow) from financing activities, Total	**(95)**	**80**	**16**	**18**	**16**	**(1,996)**	**284**	**283**	**283**	**284**	**283**	**(1,728)**	**(2,272)**
Net increase/(decrease) in cash	**(3)**	**(4,150)**	**(1,602)**	**(450)**	**(451)**	**(2,462)**	**759**	**758**	**1,133**	**752**	**752**	**(1,262)**	**(6,225)**
Opening cash	**12,956**	**12,953**	**8,803**	**7,202**	**6,752**	**6,301**	**3,839**	**4,598**	**5,356**	**6,489**	**7,241**	**7,993**	**12,956**
Closing cash	**12,953**	**8,803**	**7,202**	**6,752**	**6,301**	**3,839**	**4,598**	**5,356**	**6,489**	**7,241**	**7,993**	**6,731**	**6,731**

Forecast cash position as per Monitor plan	8,342	7,772	7,202	6,751	6,301	3,839	4,597	5,356	6,489	7,241	7,993	6,731
Actual cash position	12,953	8,803	7,202	6,752	6,301	3,839	4,598	5,356	6,489	7,241	7,993	6,731
Variance	4,611	1,032	0	0	0	0	0	0	0	0	0	0

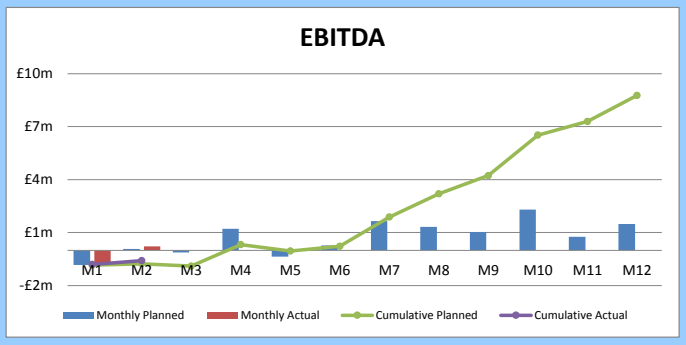
Warrington and Halton Hospitals NHS Foundation Trust **Appendix D**

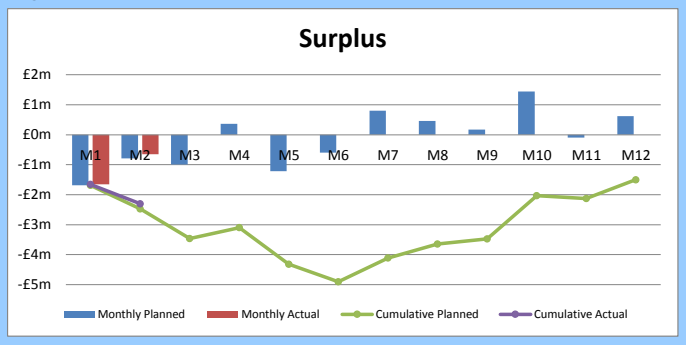
Statement of Position as at 31st May 2014

Narrative	Audited position as at 31.3.14 £000	Actual Position as at 30.04.14 £000	Actual Position as at 31.05.14 £000	Monthly Movement £000	Forecast Position as at 31.3.15 £000
ASSETS					
Non Current Assets					
Intangible Assets	316	311	305	-6	155
Property Plant & Equipment	132,588	132,343	132,253	-90	134,972
Other Receivables	1,233	1,332	1,255	-77	1,900
Impairment of receivables for bad & doubtful debts	-195	-210	-198	12	-465
Total Non Current Assets	**133,942**	**133,776**	**133,615**	**-161**	**136,562**
Current Assets					
Inventories	2,769	2,805	2,898	93	2,569
NHS Trade Receivables	3,052	2,277	2,609	332	1,164
Non NHS Trade Receivables	573	419	849	430	338
Other Related party receivables	200	435	510	75	606
Other Receivables	1,960	1,961	1,658	-303	1,153
Impairment of receivables for bad & doubtful debts	-355	-345	-356	-11	-188
Accrued Income	884	623	206	-417	764
Prepayments	1,727	3,560	3,053	-507	1,016
Cash held in GBS Accounts	12,937	12,930	8,784	-4,146	6,720
Cash held in commercial accounts	0	0		0	0
Cash in hand	19	23	19	-4	11
Total Current Assets	**23,766**	**24,688**	**20,230**	**-4,458**	**14,153**
Total Assets	**157,708**	**158,464**	**153,845**	**-4,619**	**150,715**
LIABILITIES					
Current Liabilities					
NHS Trade Payables	-1,513	-2,123	-1,673	450	-1,732
Non NHS Trade Payables	-5,728	-7,626	-4,871	2,755	-2,694
Other Payables	-4,433	-4,596	-4,283	313	-3,478
Capital Payables	-1,386	-1,215	-350	865	-1,124
Accruals	-5,986	-5,827	-5,289	538	-6,222
Interest payable on non commercial int bearing borrowings	0	0	0	0	0
PDC Dividend creditor	-49	-384	-720	-336	0
Deferred Income	-1,353	-1,110	-1,722	-612	-1,140
Provisions	-282	-287	-276	11	-317
Loans non commercial	0		0	0	0
Total Current Liabilities	**-20,730**	**-23,168**	**-19,184**	**3,984**	**-16,707**
Net Current Assets (Liabilities)	**3,036**	**1,520**	**1,046**	**-474**	**-2,554**
Non Current Liabilities					
Loans non commercial			0	0	-1,600
Provisions	-1,510	-1,483	-1,496	-13	-1,471
Total Non Current Liabilities	**-1,510**	**-1,483**	**-1,496**	**-13**	**-3,071**
TOTAL ASSETS EMPLOYED	**135,468**	**133,813**	**133,165**	**-648**	**130,937**
TAXPAYERS AND OTHERS EQUITY					
Taxpayers Equity					
Public Dividend Capital	90,063	90,063	90,063	0	90,014
Retained Earnings prior year	12,446	9,597	9,597	0	8,743
Retained Earnings current year	-2,849	-1,655	-2,303	-648	-1,500
Sub total	**99,660**	**98,005**	**97,357**	**-648**	**97,257**
Other Reserves					
Revaluation Reserve	35,808	35,808	35,808	0	33,680
Sub total	**35,808**	**35,808**	**35,808**	**0**	**33,680**
TOTAL TAXPAYERS AND OTHERS EQUITY	**135,468**	**133,813**	**133,165**	**-648**	**130,937**

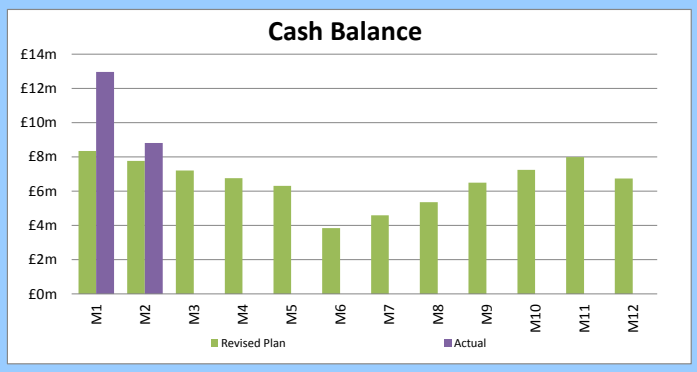
Finance Dashboard as at 31st May 2014 (Part A)

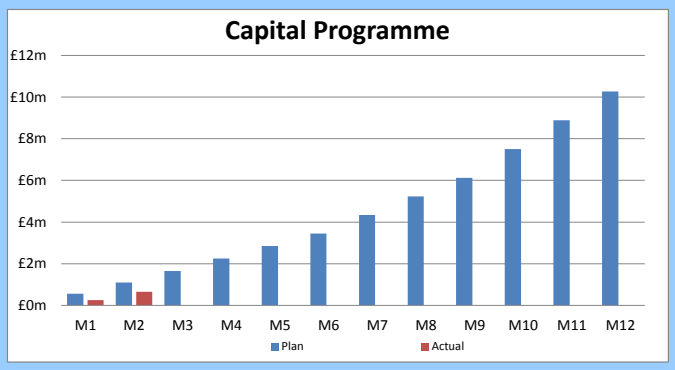
Profitability



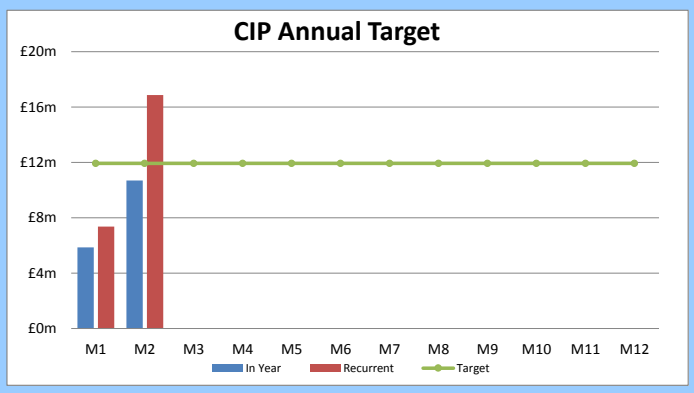


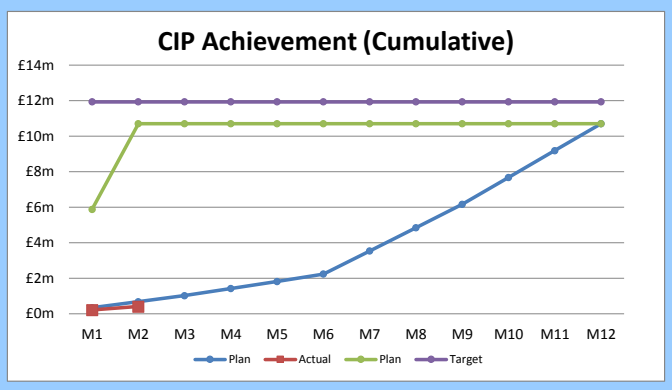
Cash and Investment





Cost Improvement Analysis





Divisional Position (net divisional income and expenditure)

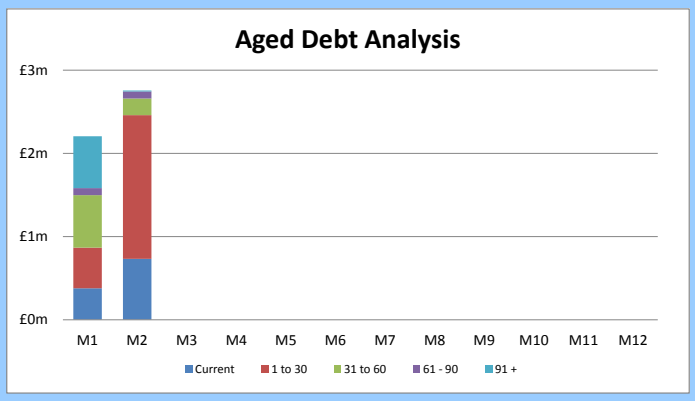
Division	Annual Budget £000	Budget to date £000	Actual to date £000	Variance to date £000	Variance date %
Clinical					
Scheduled Care	56,590	9,588	9,317	271	2.8
Unscheduled Care	42,811	7,353	7,474	-121	-1.6
Womens, Children & Support Services	55,801	9,957	9,809	148	1.5
Corporate					
Operations - Central	304	73	53	20	27.4
Operations - Estates	7,560	1,220	1,146	74	6.1
Operations - Facilities	8,095	1,348	1,370	-22	-1.6
Business Development	681	113	84	29	25.7
Finance	9,331	1,554	1,552	2	0.1
Governance & Workforce	4,676	783	705	78	10.0
Information Technology	3,986	670	631	39	5.8
Nursing	1,767	293	291	2	0.7
Trust Executive	1,999	518	495	23	4.4
Total	**193,601**	**33,470**	**32,927**	**543**	**1.6**

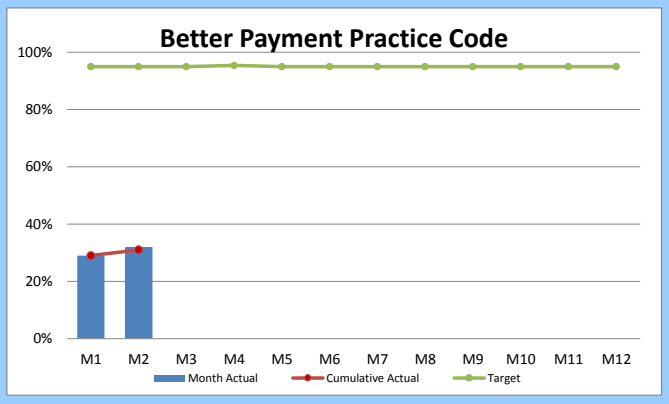
Continuity of Services Risk Rating

Continuity of Services Risk Rating	Actual Metric	Actual Rating
Liquidity Ratio (days)	-2.2	3
Capital Servicing Capacity (times)	-0.9	1
Overall Risk Rating		**2**

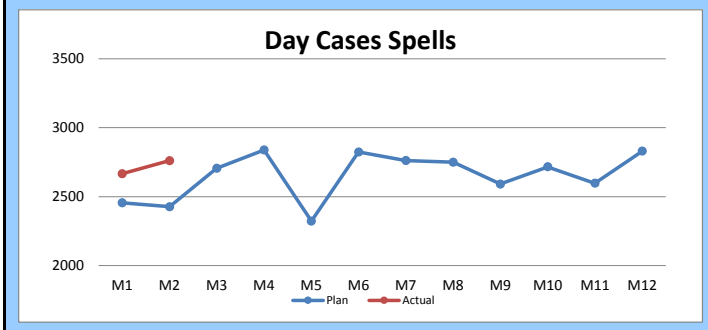
Finance Dashboard as at 31st May 2014 (Part B)

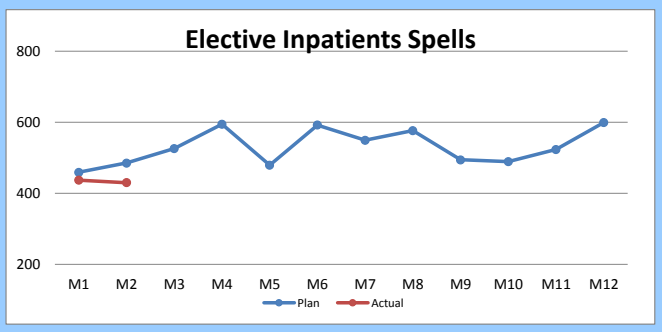
Balance Sheet and Liquidity

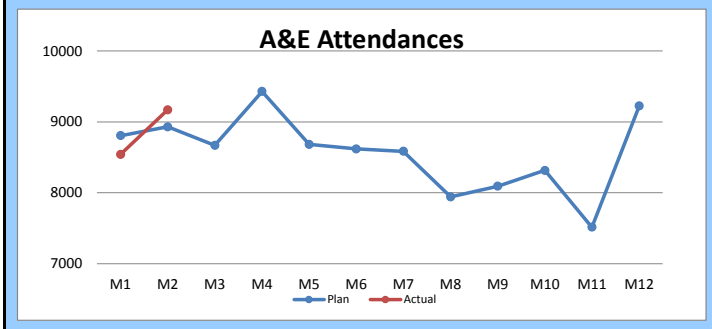


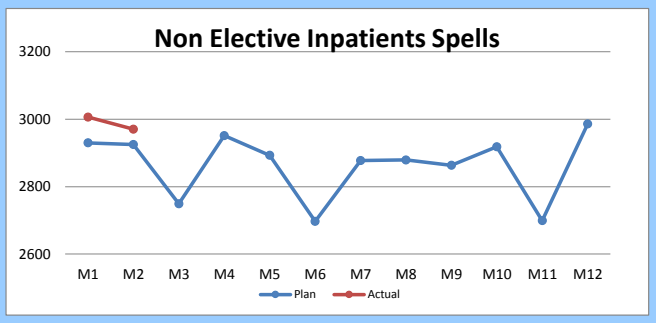


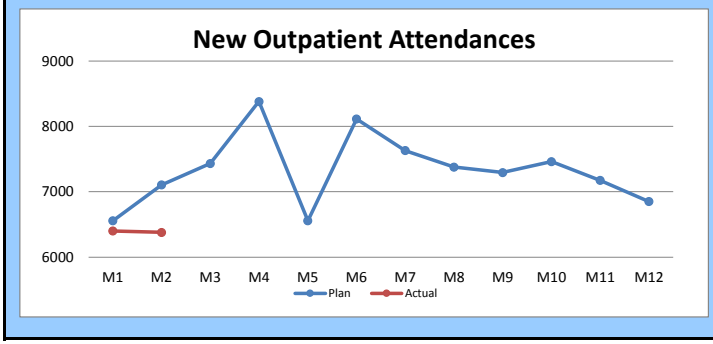
Activity Analysis

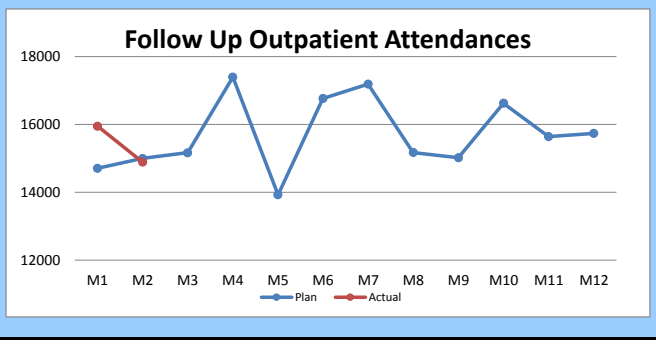












W&HHFT/TB/14/108

Board of Directors

Paper Title	Corporate Performance Report
Date of Meeting	25th June 2014
Director Responsible	Simon Wright – Chief Operating Officer/Deputy Chief Executive
Author(s)	Simon Wright – Chief Operating Officer/Deputy Chief Executive
Purpose	To update the Board on the Trust's operational performance for the month of May 2014

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

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

Key points arising from the Report/Paper

Page/Paragraph Reference

- There is a very serious risk that the Trust may fail to deliver the Q1 AED target.
-
-
-

Recommendation(s)

The Board is asked to note the contents of this paper

CORPORATE PERFORMANCE REPORT
May 2014

EXECUTIVE SUMMARY

1.0 Introduction

This corporate report updates the Board on the progress of the Trust in relation to activity, performance and workforce targets to 31st May 2014.

2.0 Performance

In overall terms, based on the performance in month 2, the Trust has an **Amber/Green** rating, as highlighted in Appendix 1.

3.0 National Key performance indicators

3.1 Accident and Emergency Department

- In May we achieved 92.66% against the 95% target given the serious challenge faced in AED several meetings with the ECIST, CCG, Social Services and Community Services have taken place to understand the nature of the problem.
  - Withdrawl by commissioners of re-ablement funded schemes from April 1st (circa £800k) have impacted on discharge rates
  - Home care provision difficulties have impacted on social cares ability to manage certain patients at home
  - Intermediate care access for home and bed based transfers has been under severe pressure with queues growing from 2/3 to over 36 causing flow problems
- Entire health system has been in difficulty but we are still looking to improve our position over the coming 27 days to the end of the quarter through the following interventions:
  - ECIST Perfect Week undertaken in May with Ward Liaison Officers and Silver control being introduced throughout June
  - Commissioner support to establish 16 additional Intermediate Care beds to arrest the current pressure and agree to review the baseline capacity during the summer to prevent problems in Q3/4.
  - Commissioner support to re-introduce the re-ablement schemes associated with admission avoidance and early discharge for a 3 month period then review their success.
  - Confirm the inclusion of Cat 1 walk in activity from the Widnes Urgent Care Centre in our AED performance
  - Introduction of ambulatory primary care into AED to avoid zero LOS admissions
  - Weekend provision in June from social services, community teams and hospital pharmacy, therapies, consultants and management to improve weekend discharges.
  - Weekly point prevalence study
  - Patient safety care bundle rolled out

- More assessment cubicles introduced into AED by moving minor injuries to a nearby location for June .
- ECIST are supporting a system response to the pressures

In addition to these steps the Trust has been in discussion with CCG and Bridgewater about the type 2 activity at the Widnes Learning and Resource Centre and is looking to conclude an assessment which will see some of this activity offset against the Trust AED performance following material changes in our involvement of the centre and the management of Urgent Care across Halton.

There is a very real risk that the Trust will fail to deliver the 95% AED target for quarter 1.

Mr Simon Wright

Chief Operating Officer

June 2014

May-14

Monitor Governance Risk Rating - 2014/15

Warrington and Halton Hospitals NHS
NHS Foundation Trust

All targets are QUARTERLY

Target or Indicator		Target	Weighting	Apr-13	May-13	Jun-13	QTR-1	Jul-13	Aug-13	Sep-13	QTR-2	Oct-13	Nov-13	Dec-13	QTR-3	Jan-14	Feb-14	Mar-14	QTR-4
Referral to treatment waiting time	Admitted patients	90%	1.0	92.61%	93.21%														
	Non-admitted patients	95%	1.0	98.03%	97.63%														
	Incomplete Pathways	92%	1.0	94.55%	94.56%														
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%														
All Cancers:62-day wait for First treatment	From Urgent GP Referral for Suspected Cancer **(Open Exeter Position)**	>85%	1.0 (Failure for either = failure against the overall target)	88.90%	89.00%														
	From NHS Cancer Screening Service Referral	>90%		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%														
	Anti Cancer Drug Treatments	>98%		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%														
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)	93.05%	93.00%														
	Symptomatic Breast Patients (Cancer Not Initially Suspected)	>93%		98.00%	96.00%														
Clostridium Difficile	Hospital Acquired	26	1.0 **	2	3														
Failure to comply with requirements regarding access to healthcare for people with a learning disability		N/A	1.0	No	No														

Cumulative
Qtr1: 6.5 Qtr2: 13
Qtr3: 19.5 Qtr4: 26

Target or Indicator	Target	Weighting	Apr-13	May-13	Jun-13	QTR-1	Jul-13	Aug-13	Sep-13	QTR-2	Oct-13	Nov-13	Dec-13	QTR-3	Jan-14	Feb-14	Mar-14	QTR-4
Risk of, or actual, failure to deliver commissioner requested services	N/A	Report by Exception	No	No														
CQC compliance action outstanding	N/A		No	No														
CQC enforcement action within last 12 months	N/A		No	No														
CQC enforcement action (including notices) currently in effect	N/A		No	No														
Moderate CQC concerns or impacts regarding the safety of healthcare provision	N/A		No	No														
Major CQC concerns or impacts regarding the safety of healthcare provision	N/A		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														
Score of 7 or less in standard 1 assessment at last NHSLA CNST inspection (maternity or all services)	N/A		No	No														
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A		No	No														
Overall Governance Risk Rating **Total Points 0 - 0.9 Green, 1 - 1.9 Amber-Green, 2 - 4 Amber-Red, 4 or above Red)**			1.0	1.0														

Additional Notes:

18 Weeks Referral to Treatment

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

**** Clostridium Difficile**

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

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

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

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/109

BOARD OF DIRECTORS

Paper Title	The Perfect Week
Date of Meeting	Wednesday 25th June 2014
Director Responsible	Simon Wright
Author(s)	Amanda Risino / Marie Higgin
Purpose	To provide an overview of the Perfect Week, the key learning points and next steps

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

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

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

	Page/Paragraph Reference
Following an invitation by the Trust to ECIST (Emergency Care Intensive Support Team) to review our health system in January 2014, a recommendation document was presented to key stake holders which identified the recommendation for the acute trust to carry out a 'Perfect Week' exercise. 'The Perfect Week' is an approach that has been designed and developed by NHS England's Urgent & Emergency Care Intensive Support Team (ECIST). Since several other trusts have used and been enthused by this intervention we invited ECIST to come on board to help us deliver The Perfect Week. WHH were the first Trust to deliver this project commencing on a Wednesday and running over a 7-day rather than a 5-day working period. This initiative has provided the Trust an opportunity to focus resources on delivering services and resolve problems in real-time and identify bottlenecks within the system. Post Perfect Week, a conclusion document has been completed which highlights the key learning points and post perfect week meetings will produce an action plan to address these. In addition to this learning, the issues log has been reviewed and staff surveys taken place, together with staff/steering group debriefing sessions.	Attached.

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

The Trust Board is asked to:

1. Acknowledge the content of the report, the conclusions reached and next steps (Page 8).

2. Acknowledge that a clear hot spot for Warrington regarding patient flow and care is the provision of both Intermediate Care bed based and home based services. Acknowledge that the whole system has agreed to review the current Intermediate Care infrastructure and capacity with the view to re-model.

3. Agree that the adoption of the SAFER bundle Trust-wide is a beneficial approach for improvements to patient care and enabler to LOS (Length of Stay) reduction.

4. Acknowledge that the findings of the Perfect week will form the basis of future Business Cases presented for additional resources within the support services (Pharmacy, Pharmacy prescribing cart, Portering facilities review, Physio and OT review)

5. Approve a further Perfect Week project for Autumn 2014.

Conclusion paper

Project Information			
Project Title	THE PERFECT WEEK		
Start Date	07/05/14	**End Date**	13/05/14
Project Executive	Simon Wright		
Project Lead	Amanda Risino		
Project Manager	Marie Higgin		

1 Project Summary

Background & Introduction

We have been contending with operational pressures that have seen our Trust more in than out of red status and bed escalation for many months. We needed a step-change in the way we deliver services if we are to deliver the quality of care we aspire to at the level of efficiency which our commissioners and the general public demand of us.

We need to break the cycle of repeated escalation measures and end the continuing disruption to normal clinical business as this disadvantages patients and frustrates clinical staff.

Therefore we committed to undertaking a significant intervention called 'The Perfect Week' that aimed to change behaviour and let us identify how we can work better. This took place on 7th May through to 13th May 2014, inclusive.

'The Perfect Week' is an approach that has been designed and developed by NHS England's Urgent & Emergency Care Intensive Support Team (ECIST). Since several other trusts have used and been enthused by this intervention we invited ECIST to come on board to help us deliver The Perfect Week.

As the first Trust to deliver this project commencing on a Wednesday and running over a 7-day rather than a 5-day working period, NHS IQ representatives attended Silver Command on 12th & 13th May 2014 to observe and make recommendations; particular interest was around the 7-day working possibilities and impact.

During the week the focus was on solving problems that stopped us meeting the SAFER bundle (See Appendix A) and escalating them when they could not be solved within a set timeframe.

A 'command and control' structure (See Appendix B) was set up within the trust to facilitate efficient and quick communication between different services, functions and our partner organisations, in Bridgewater Community Trust, 5 Boroughs Partnership NHS FT, Warrington & Halton Clinical Commissioning Groups and Borough Council Social Services. This was managed using a similar format to that used during a major incident.

Perfect Week processes impacted not only upon adult acute and rehabilitation wards but also upon a variety of community services and locations. This was why involving our partner organisations was critical to the success of this initiative.

Routine meetings and non-essential work was suspended wherever possible in order to support The Perfect Week and staff within corporate services volunteered to take on the role of ward liaison officers.

This paper provides an overview of the findings, lessons learnt and next steps.

2 Highlights from the perfect week

- **Trust status – changed from RED to GREEN** – achieved within the 1st 3 days
- **Senior medical review** – we hit over 85% of patients having senior review every week day by 1400hrs – reaching up to 96% on Thursday 8th May
- **Planned discharges** – around 87% of patients were given a clear estimated discharge date – helping us to plan discharge
- **Number of escalation beds** - dropped by half from 40 to 20 between the Wednesday and Monday
- **Outliers at 8am** – dropped from 28 at the start of the week to as low as 12 on Monday 12 May
- **Actual numbers of discharges** - reached up to 119 against our usual average of 81 a day
- **TTO turnaround times** – Were under our 120 min target – and as low as 43 mins
- **Partnership working** – community and social services partners worked with us to expedite discharge and also to look at future models that could help ensure patients ready to leave acute care can do so in a timely manner
- **Staff engagement** - In addition to the performance achievement of the week, staff across non-clinical services worked alongside their clinical colleagues enabling them to gain an understanding and appreciation of the work that our frontline staffs undertake on a day-to-day basis. A Ward Liaison feedback session was held on 19th May 2014 and a Survey Monkey has been carried out within pharmacy some quotes are shown as Appendix C.

Notably the above achievements were delivered whilst also dealing with a period of intense pressure on the emergency department and high levels of emergency admissions at the start of this week – a situation that was also seen in hospitals across the region due to a major spike in attendances.

3 Statistics.

(See Appendix D)

3.1 Outcomes

The aims of the week were both transactional (identify and fix) and transformational (pathway improvements).

In order to measure the impact of the changes that were made, the outcomes below were agreed. The table highlights at a high level whether these outcomes were achieved.

KEY	
	Achieved
	Nearly achieved
	Not achieved

***Data taken from performance board recordings within Silver Command:**

KPIs	Target	Achieved	Comment
Trust to move from Red Status to Green Status	Green		From Wednesday to Friday the Trust Status returned to Green. However due to a large number of admissions via A&E over the Weekend the Trust status ended the week on Red.
To increase the number of beds available in the AM (8am)	10		We achieved this Target on Friday to Sunday, 10th -12th May only.
To have twice daily Senior medical reviews	100%		Senior reviews were over 85% each day
Average TTO turnaround time	<120min		This was achieved on every day except Saturday. Weekday range: 43 to 65 min (Weekend range: 77 to 146min)
% patients with planned date of discharge	100%		Over 80% each day.
To transfer patients from the assessment ward prior to 10 am			No Target was set for this. This area is to receive further review by ECIST.
To achieve 40% of discharges before 12 noon	40%		Flow for expected discharges meant that we missed the 40% target before 12 noon. Lowest point was 18% and highest was 32%
Reduction in the number of Patients with LOS >21 days	<100		85 patients by the end of the perfect week
Reduction in outliers	0		Although the target of zero patients was not reached - there was a decrease overall from 28 to 6 by Sunday rising to 18 by the end of the week
Reduction in escalation beds	0		Although the target of zero was not reached - there was a decrease overall from 40 to 19 by Sunday and 20 at the end of the week
No A&E Breaches	0		A&E breaches ranged from lowest 6 on Saturday, but up to 40 on Monday
Increase in discharges	>81		The target was exceeded in the first 3 days (range: 100 to 119) but reduced towards the end of the week when admissions and attendances increased.

QUALITY KPIs			
QUALITY	Target	Achieved	Comment
Clinical incidents reported	<22		
Non Clinical incidents reported	<4		We had an increase in non clinical incidents reported on days 1 and 2
No of falls reported	<3		Target achieved every day except day 6 when 5 were reported
No of pressure ulcers (grade 2)	0		2 cases were reported
No of pressure ulcers (grade 2)	0		
No of medication errors	<3		
No of PALS contacts	<6		This was high most days
No of MET calls	<2		Target achieved on days 2 to 7
No of ibleep calls			
No of cardiac arrests	≤1		1 day had 3 patients who had cardiac arrest (Sat 10th May)
No of ops. cancelled on the day	0		

4 What did we do differently?

It was vital to have a collaborative approach to the Perfect Week involving all areas to create an understanding around the impacts and possibilities of the SAFER bundle. The Table below highlights the areas where change took place and the impact this had on the organisation.

Following the Perfect Week considerations have been given around what changes are sustainable within current resources and action plans have been drawn up which are to be carried forward and governed by the existing Operational Productivity Portfolio and also via our established Discharge Alliance Group – (whole systems approach).

Department	Changes	Impact	Future considerations, sustainability
Executive and Senior Management	• Established a Control 'Hub' (Trust Conference Room) with break out areas • Executives were allocated wards to visit/contact on a daily basis	Created a central point for reporting and feedback sessions Visibility of the executive team aided in staff engagement and a sense of whole system approach	• The command and control model isn't sustainable going forward but as a result a 'virtual' silver command structure has been agreed • Executive team members have adopted their wards and once a month plan to visit their adoptive wards for 2-way feedback sessions
External Partners	• Daily contact with key external partners	Access to external partners aided in building an integrated approach to patient care pathways and allowed the Trust to share real-time information on the patients moving through the system and awaiting intermediate or community care/ equipment	• Discharge Alliance meetings set up will continue to build on relationships/ alliances that were formed between the Trust and external partners
IT/informatics	• Standard Daily Sitrep Sheet development (Information gathering sheets) • Excel spread sheet for daily sitreps to be completed and outcomes analysed • Quality and KPI data for the white boards (results shown in Section 3)	Information could be analysed to see where blockages were occurring and action could be taken in real-time Information also used at the Bed meetings	• It is anticipated that this process will be adopted/adapted to collate similar types of information when the discharge facilitators are in post later this month • Interim measures for information collection are being pursued • Standard operating procedures for the bed meetings are being further developed
Pharmacy	• Work/meetings that could be delayed	This area achieved the highest positive	• With the current staffing levels it would not be

	were put on hold until after the Perfect Week • Staff on maternity leave and part-time staff volunteered to work extra days to allow increased ward coverage and free up 3 pharmacist prescribers • Staff start times adjusted; late rota staff agreed to start at 9am to facilitate earlier discharge • A voluntary late stay rota was agreed in the event that work also arrived late • Staff rotas changed to utilise the extra staffing to increase pharmacist & technician ward round time on each ward and form 3 ward teams • Pharmacist prescribers allocated to wards/ward rounds • Ward delivery runs adjusted to return TTOs to wards promptly • Discharge Cart acquired to trial to improve % discharges completed at ward level & thus reduce TTO turnaround times • Designated 3 staff members to act as 3 Pharmacy ward team coordinators-to walk the wards and re-direct / prioritise ward team time to wards with greater numbers of discharges & new admissions • Constructed a Pharmacy Sitrep-completed by coordinators for the 12noon meeting-the Pharmacy 'Bronze Command' • Medicines reconciliation data captured to assess impact of Perfect	impact, with highlights being:- a) Reduction in TTO turnaround times b) Increase in TTOs completed on the ward c) Reduction/elimination of instances where patients leave without taking their medication with them d) Cost savings through reduction in unnecessary discharge supplies e) An increase in the number of patients counselled about their medication by Pharmacy and an observed positive impact on the potential for medication adherence in patients who were unaware of changes in their medication f) Increased time spent on wards provided valuable opportunities to provide information, support, education/training for medical and nursing staff and to intervene to improve staff efficiency and effectiveness and improve the quality and safety of prescribed medication g) Perceived improvements in multidisciplinary team working (Pharmacy staff survey, feedback from WLOs, doctors and nurses)	possible to sustain all the changes implemented during the perfect week but this has provided an ideal opportunity to show what can be achieved and this will be reviewed. • The discharge cart trialled during the Perfect Week was particularly useful. The Department has not returned this to the Supplier yet and is attempting to use it from 11am to 4pm each day. Purchase of one discharge cart is deemed to be essential, purchase of 3 carts would be ideal if staffing is available to operate these.

	Week working		
Support Services	• Allocated slots for inpatients for same day imaging • Summary sheet for wards for prep • Phlebotomy-½hr earlier opening time	No impact. Although slots were available the feedback from point of prevalence indicated that inpatients were not awaiting imaging	• As no benefit was achieved from the availability of more slots for inpatients this will not be carried forward, effective use of available time slots requires optimal portering facilities
Therapies	• Increased demand on these services during the perfect week brought around an increase and review of the OT and Therapy provisions • Non-essential meetings were cancelled	This 'deep dive' review highlighted the need for Intermediate Care facilities to enable patients to move onto their next step and if OT & Physio were the only requirements then the patients could be suitable for ICB As all areas had performed board rounds therapies were able to do blanket referrals across medical and elderly care	• In order to provide 7 day working additional resources would need to be sought • The Warrington intermediate care ward has been set up as a short term solution for those patients in acute beds awaiting ICB
Ward Liaison Officers	• Each ward had a ward liaison officer allocated to assist with general chasing and administrative duties. They also acted as a 'go between' for the Ward and Silver Command reporting any issues raised and actions required	Information could be collected and issues logged for action. This allowed the issues being experienced on wards on a day to day basis to be highlighted to senior and executive management as well as our external partners	• The ward liaison officer is a required role going forward but the information collected and actions taken by this team will provide a framework to build on for the newly appointed Discharge co-ordinators
Welcome cards	• For the perfect week welcome cards were produced to enforce the provision of EDD to manage the patients expectations	This allowed Wards to focus on reviewing and providing an Estimated date of discharge (EDD)	• Prior to the perfect week a discharge pamphlet was being drafted – this will now be taken forward and finalised
Nursing	• Ensured each ward in unscheduled care had a coordinator for each day of the perfect week • Nurse to be available each day to support ward rounds • Matrons diaries cleared to enable them to support the wards effectively	Feedback from both Scheduled and Unscheduled wards nursing teams were that he Ward coordinators were key to ensuring plans of care were effectively communicated and the actions they carried out supported effective discharge planning. It was also stated that the Ward co-ordinators were	• Significant investment has been put into nursing budgets to support 0.8 supernumerary ward managers however, to sustain a coordinator for each shift would require further investment into nursing establishments

		extremely useful in doing the chasing this really helped moved thing along and helped free up nursing time	
Consultant	• Twice daily senior reviews for surgical and medical patients • Review and Discharge team for weekend cover with named clinician	Feedback provided by the clinical teams is that they could see the benefits of an AM daily review but a PM review had little impact on the flow of patients on the main wards but could potentially be of benefit to the assessment ward areas The Week-end review and discharge teams identified significant discharges over the weekend	• It is anticipated that the larger Workforce and Planning project being run throughout the Trust will review SPAs and ward / board round coverage against SPA allocation • Provision of a review and discharge clinical team is to be considered for bank holidays and known seasonal peaks

4.1 Key Learning

Key learning:

- The Impacts of the SAFER bundle
  - This approach can have a significant impact on patient flow through the organisation
  - All elements of the approach need to be adopted and data completed and analysed if earlier and appropriate patient flow is to be achieved with flow to commence at the earliest opportunity from assessment
  - Availability of Discharge lounge facilities can aid the flow and discharge of patients who are appropriate and medically fit
  - Adoption of a 'Bed meeting' SOP to facilitate compliance with the SAFER bundle key performance indicators
- The scale of resources needed to make organisation-wide change
  - Additional resources within support services (portering, therapies and pharmacy) would be required if this level of input was necessary on both the current day to day arrangements and any move towards 7-day working.
- The need to make changes at every level of the system;
  - Involvement is required at all levels (from primary care to emergency attendances, admissions, inpatient management and discharge into the community)
- Patient first and foremost: Right Patient, Right Bed, Right Consultant
  - A reduction in outliers is beneficial to patients (both patient care, safety) and staff (efficiency & effectiveness)
- Importance of information and evidence based data

- Information is essential and this needs to be highly visible, timely and in an appropriate format so problems can be identified early and in turn lead to corrective action. Information is required at a granular level e.g. the performance of every ward against a number of measures needs to be obvious.

- The need for working together to focus on the whole patient journey
  - Daily access to Key external stakeholders was essential to provide a complete integrated care pathway for patients
- Releasing time to care
  - The role of the WLO allowed ward staff to care for patients and this will provide a framework for the roles and responsibilities of the discharge facilitators going forward.

5 Next Steps…..? *S A F E R*

Senior Reviews …..

- Executive Teams have 'Adopted' their Wards and once a month plan to have one day dedicated to visit the wards to follow up on actions
- A 'Virtual Silver' command has been agreed to provide the discharge teams with a clear escalation route
- Progress towards a Review and Discharge multidisciplinary team provision to be available at times of known seasonal peaks and bank holidays
- Review of job plans to enable daily Senior Reviews
- Formal Monitoring and Information / Data recording of hot spots to be performed via the newly establish Discharge Facilitators

Assessment …..

- Repetition of the Point Prevalence to assess and review longer stay patients
- Early discharge planning to be embedded as business as usual - Development of 'The Welcome pamphlet' to manage the patients expectation on their care management with review of the EDD on ward/board rounds/reviews
- Monitoring of EDDs to be formalised and embedded into Business As usual

Flow…..

- Warrington Intermediate Care Ward in Daresbury (Short term)
- A Minor injuries unit to move to the ARC temporarily (Short term)
- Portering services to be reviewed
- Further work and review of Emergency Department and Assessment wards to aim for/ achieve the 10am transfer target
- Discharge Lounge opened – Its benefits to be analysised.
- Improve use of relevant data e.g. identification of patients for the Discharge Lounge, identification of specialty patients, records of transfer activities
- Therapies/Pharmacy review to aid flow
- Monitoring and recording for patient flow via standardised bed meetings

Early Discharge…..

- Discharge and transfer policy to be reviewed
- Recruitment and commencement of 6 discharge co-ordinators
- Ward Board standardisation rollout - this ensure's staff can find information around the patients' next step and EDDs
- Medicorr eDischarge changes – to enable pharmacy to complete discharge medication sections separate to the clinical information and to allow this data to be entered at various stages of the patients' pathway
- Therapies/Pharmacy review to aid early discharge
- Improve access to relevant discharge data, in particular utilisation of the Pharmacy data

Review…..

- Intermediate Care Ward to be set up on Daresbury Ward (Short term)
- Assessment of the Intermediate Care Bed usage to be recorded with Point prevalence being taken regularly with 'deep' dive into the long stay patients pathway
- Routine & regular repetition of the Point Prevalence Study to assess and review longer stay patients for a whole systems approach to patient flow

And other events…..?

- Post Perfect Week debriefing and follow up meetings with a further Action plan drawn up to address the issues raised.
- A review of ED, AMU, Short stay and ambulatory emergency care with ECIST
- Discharge Alliance Group meetings (a whole systems approach) to maintain relationships and alliances with our external partners to tackle and take forward recommendations
- Supplementary papers for a Pharmacy Business case
- A 2nd Perfect week is being considered for Autumn 2014

6 Conclusion

The Trust used a command and control approach to focus on identifying and acting upon the causes of poor patient flow during **The Perfect week** and will continue to maintain focus on the key issues and critical success factors identified. E.g. Transfer of patients from assessment units prior to 10am, Discharge of patients prior to 12 noon, recording and review of EDDs to allow identification of patients medically fit for discharge and promptly access other required services such as Intermediate Care, Community Care and/or Social Care.

A shared sense of purpose throughout the week improved staff engagement at all levels and increased knowledge of ward processes and patient flow.

The focus on measurement during the week ensured that the outcomes were reviewed daily to demonstrate progress. The Daily Sitreps were reviewed to ensure that beneficial information was captured and these were updated to reflect the requirements during the week. It is anticipated that the newly appointed discharge facilitators will build on this and an electronic solution will be reached.

The week has provided a start to permanently embed the SAFER bundle but there is still a significant amount of work to do to implement this. It is felt that review and redesign of the services will assist with this and as such steps are being taken within a larger Beds programme to review the patient flow and bed base as well as services such as Ambulatory Care, Sub Acute beds and intermediate care. Work also continues in Pharmacy to identify ways in which the successes of the perfect week in this area can be maintained.

The point prevalence studies have proved invaluable and this will be repeated on a regular/routine basis. This will maintain a focus on the SAFER bundle as well as prove to be a useful record of the patients in acute beds.

The main objective of the week was right patient, right bed and improved patient experience; early discharge planning and integrated care pathways. For the reasons stated above and the patient and staff outcomes achieved during the week the overarching comment was that it was a great success. WHH was the first trust to conduct a Perfect Week starting on a Wednesday and continuing over a 7-day period and some invaluable lessons were learnt.

It is hoped to build on these experiences and achievements of the week and we plan to repeat the project in Autumn 2014, in the mean time we will work with ECIST to improve elements of patient flow across the health and social care system.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

High Quality, Safe Healthcare
Quality People Sustainability

Appendices

Appendix A: The SAFER Bundle.

SAFER is a national best practice bundle that puts five clear steps in that are proven to reduce blockages in the system and reduce mortality.

S - Senior review, all patients will have consultant review before12 midday

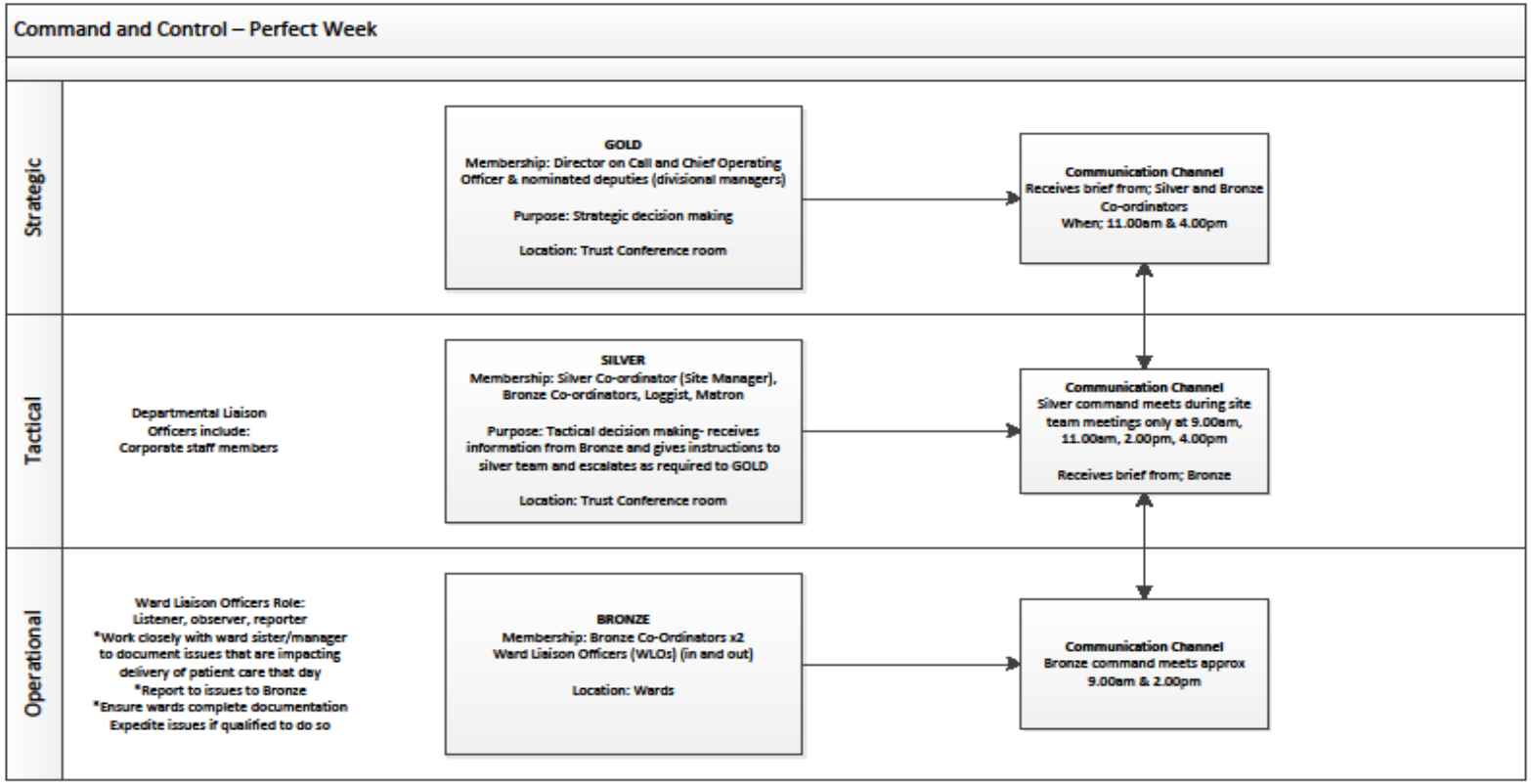
A - All patients will have an Expected Discharge Date (that patients are made aware of) based on the medically suitable for discharge status agreed by the clinical teams

F - Flow of patients will commence at the earliest opportunity from assessment units to inpatient wards. Receiving to wards from assessment units will commence before 10am daily

E - Early discharge, 40% of our patients will be discharged from base inpatient wards before midday. TTO's for planned discharges should be prescribed and with pharmacy by 3pm the day prior to discharge

R - Review, a weekly systematic review of patients with extended lengths of stay (> 7 days) to identify the issues and actions required to facilitate discharge. This will be led by senior leaders within the trust.

Appendix B: Control & Command



Appendix C: My week as a WLO? – Quotes from debriefing session

"…It was a positive experience…I feel more connected with the Trust…."

"chasing up actions on behalf of nurses meant that they could spend time caring for patients…."

"It seemed that the nursing staff had to chase up for referrals to be done…."

"…I learnt a lot from seeing how they worked on their ward and have taken this away to apply to my own role…seeing how things are working at the weekend was extremely useful to me…."

".it was good to see that the wards are very patient-centred,.but communication between them appeared problematic at times…"

"….I was in awe of the Ward Staff…."

"…I'd be happy to receive treatment here at Warrington clinically but I feel I'd stay longer than was necessary due to unnecessary delays…."

ENVIRONMENT… (Daresbury)

"…I thought…is this the best environment for patients?..."

" I was surprised they didn't use more technology! Many follow up actions were written on bits of paper

"…Board rounds were led well by the ward managers and co-ordinators…but if they weren't around then this all fell down…."

Highlights from the Pharmacy Survey (full survey results available on request)

NEGATIVES

Negative : Drs reverted to old habits of completing TTOs after ward rounds.

1 discharge cart so 30minutes wait, staff crossing over more wards, need for more bleeps to allow communication

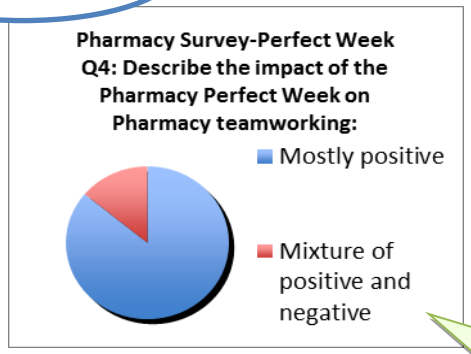
Concerned that unwell newly admitted patients' needs may be delayed by prioritising discharges

On the 1st day and on the final day of the perfect work the doctors had training in the afternoon. This led to TTOs being written later and this affected turnaround due to reduced staffing on the Pharmacy late rota.

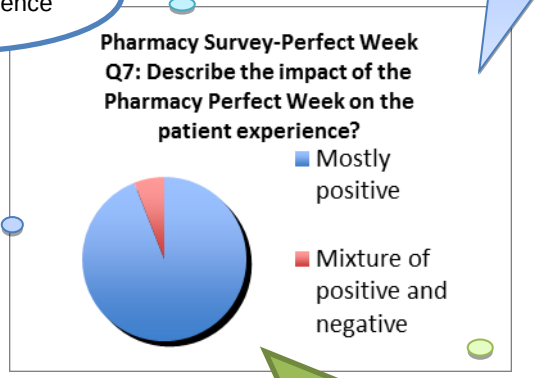
Staff Opinion: Staff

Staff Opinion: Patient Experience

Enjoyed doing other work during the Perfect Week but my work had to be put on hold



Push for discharge when some patients still needed social care issues to be finalised



POSITIVES

Able to work as a Pharmacy Team across wards

Tech support on wards and more time on the ward enabled me to give a better clinical pharmacy service to patients

The Pharmacy coordinator role worked well, identifying and directing staff to where the discharges were, allowing us to work more effectively

I work in the Dispensary, the work was very intense but I enjoyed the feeling of being efficient

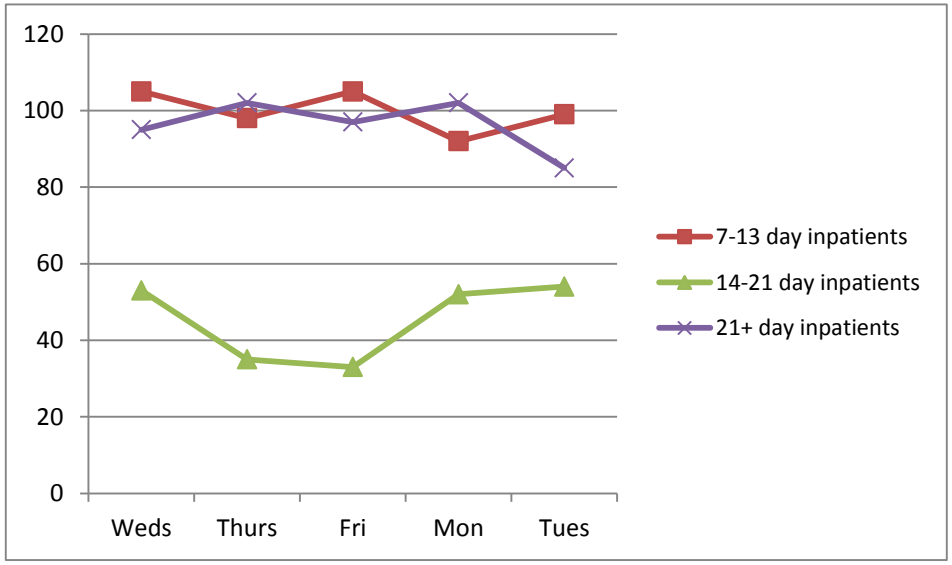
more patients received a drug history/medication review and counselling on their medicines due to increased time on wards

Patient's were surprised as to how quickly they were able to go home when I told them the medicines were in their lockers.

Appendix D: Statistics (From the white boards within Silver Command)

REVIEW LONG STAY PATIENTS – Numbers during the Perfect Week

	Weds	Thurs	Fri	Mon	Tues
7-13 days	105	98	105	92	99
14-21	53	35	33	52	54
21+	95	102	97	102	85



Commentary:

A point prevalence study showed that 100 patients, whose LOS exceeded 7 days, were actually Medically fit to go onto their next stage of treatment and did not require an Acute bed.

Conclusion:

A deep dive into longer stay patients was required. This revealed the problems with the availability of intermediate care beds or community care settings.

The data recorded showed high numbers of patients needing OT and Physio input before discharge, however further deep dive revealed that most of these patients were requiring this whilst waiting for ICB or social inputs also.

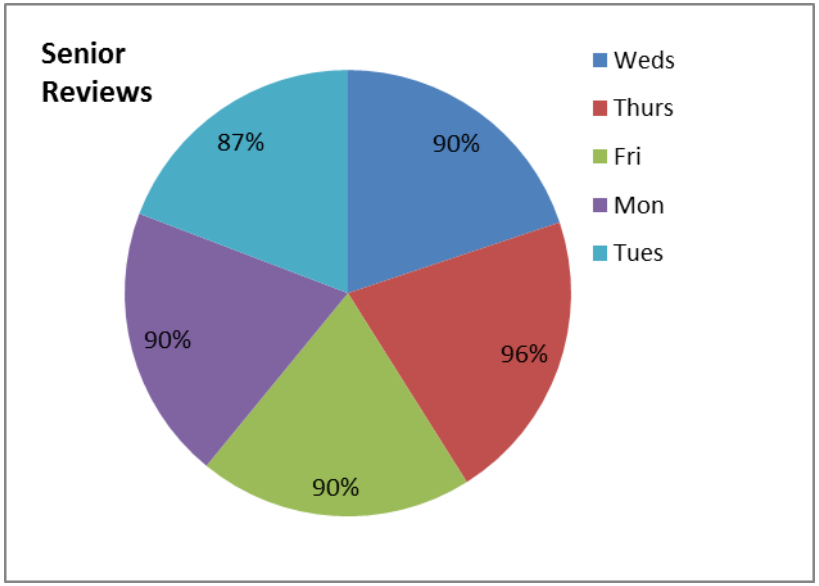
The results of the point prevalence study proved invaluable in identifying sources of discharge delays and so the approach will be repeated regularly.

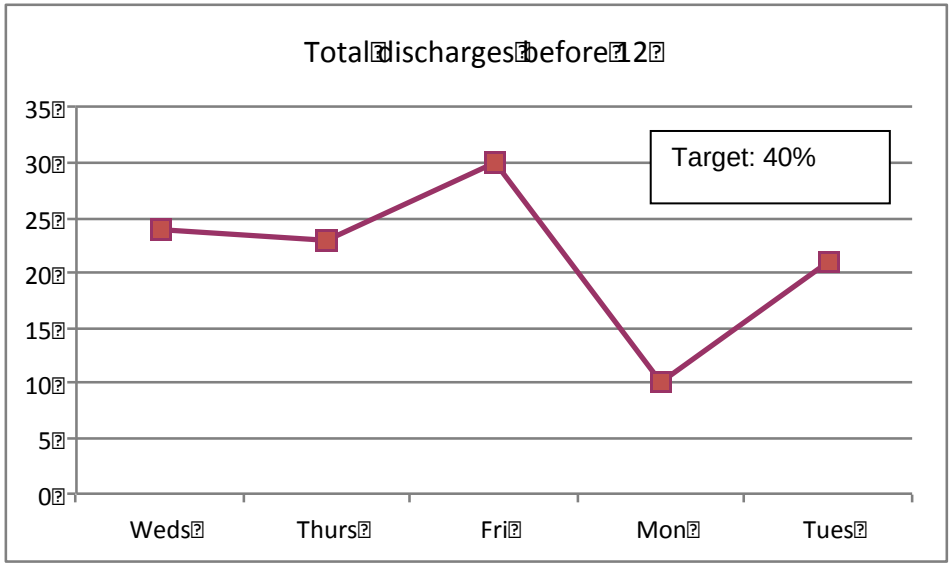
Snapshot Point of Prevalence taken 12 May 2014 (See coded reasons)

Fit Patients	
0	Waiting return to other Acute Hosp - fit to travel
3	Waiting for transfer to Acute Hospital for treatment - fit to travel
12	Waiting for community hospital/other bedded intermediate care setting
0	Waiting for continuing health care panel decision
1	Waiting for continuing health care package
2	Waiting for equipment / adaptations
1	Housing needs / homeless
10	Waiting for patient/family choice
4	Waiting for internal CHC processes e.g. checklists, completion of assessments
9	Waiting for occupational therapy/physiotherapy approval for discharge
8	Ready for home today
5	Waiting for hospice place
2	Waiting for internal transfer - w ard to w ard
0	Discharge planned for tomorrow - w hat is stopping them going today?
11	Waiting for social care reablement or intermediate care at home
8	Waiting for internal assessments/results before discharge
6	Waiting for external agency assessment - social care,MH,RH,NH etc
7	Waiting for Start Domiciliary Care Package - long term packages
1	Out of county assessments
7	Waiting for placement Nursing/Residential Home including Self Funder
3	No plan
0	Waiting for DST to be completed
	#N/A
	#N/A
	#N/A

Senior Review

EARLY Discharges





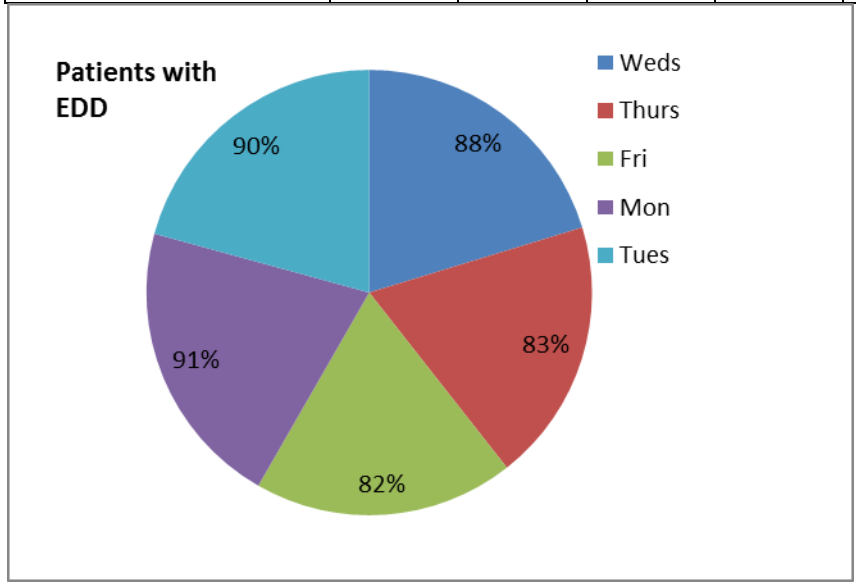
Commentary:
High levels of patients received daily senior reviews throughout the week. Despite this, discharges before 12 noon were below the target set.

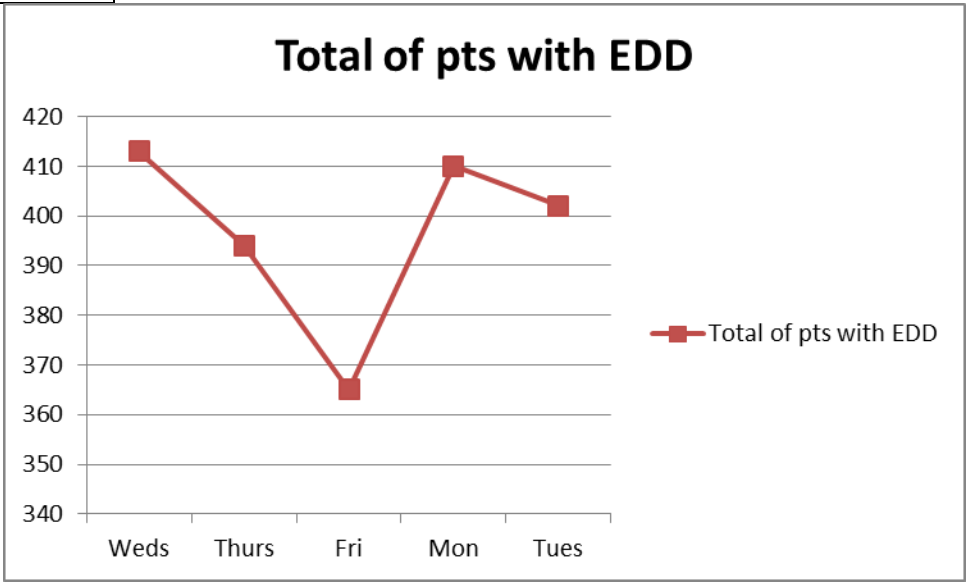
Conclusion:
Although patients had reviews and management plans in place with Estimated Discharge dates there are other constraints preventing early discharge.

ECIST recommendations include a review of the discharge lounge arrangements and use.
Intermediate Care Beds was a known issue.
Patient transfers before 10am was also a key factor in postponing patient flow.
This all indicated that greater adherence to all parts of the SAFER bundle is needed.
There is a need to explore the value of increasing the use of pharmacist prescribers to facilitate prescribing of discharges in advance/earlier in the day.
Northumbria NHS FT utilises 30 prescribing ward pharmacists to support admissions and discharges and a visit is being organised to enable an assessment of this approach and of 7-Day working, since Northumbria NHS FT recently presented their 7-day working plans at the Mersey 7-Day workshop.

ASSESSMENT

	Weds	Thurs	Fri	Mon	Tues
Total number of patients	472	473	443	453	449
Total of pts with EDD	413	394	365	410	402
%	88%	83%	82%	91%	90%



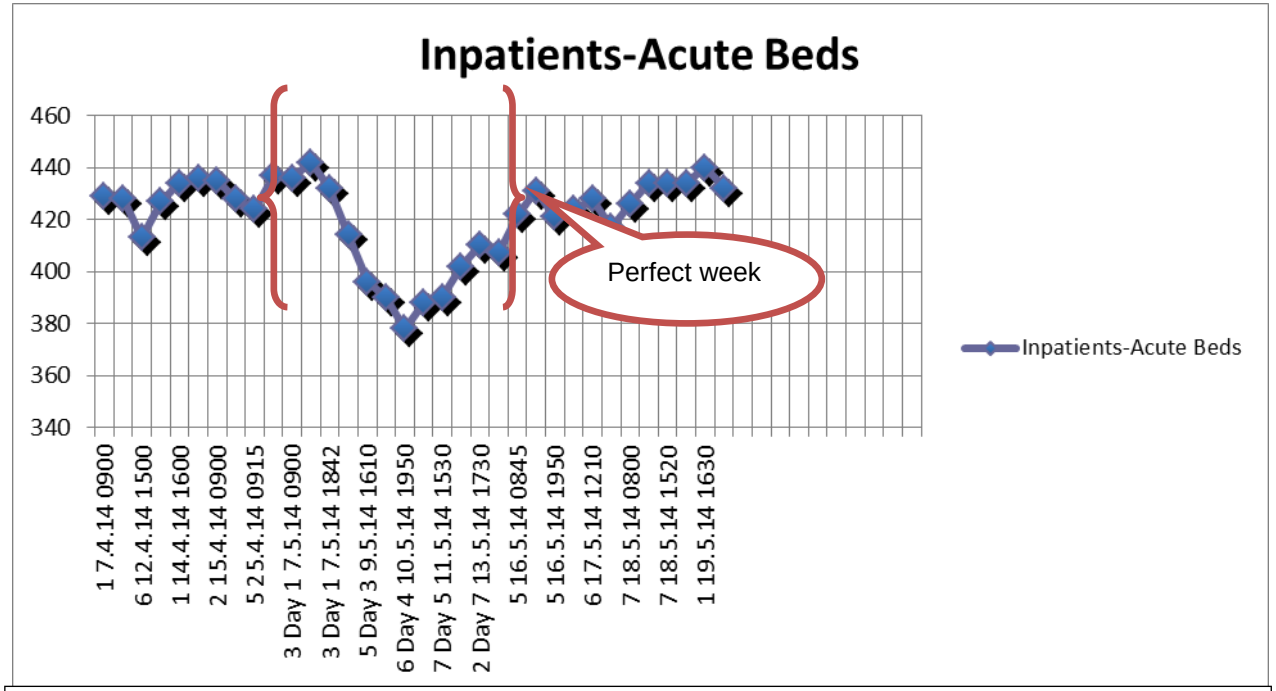


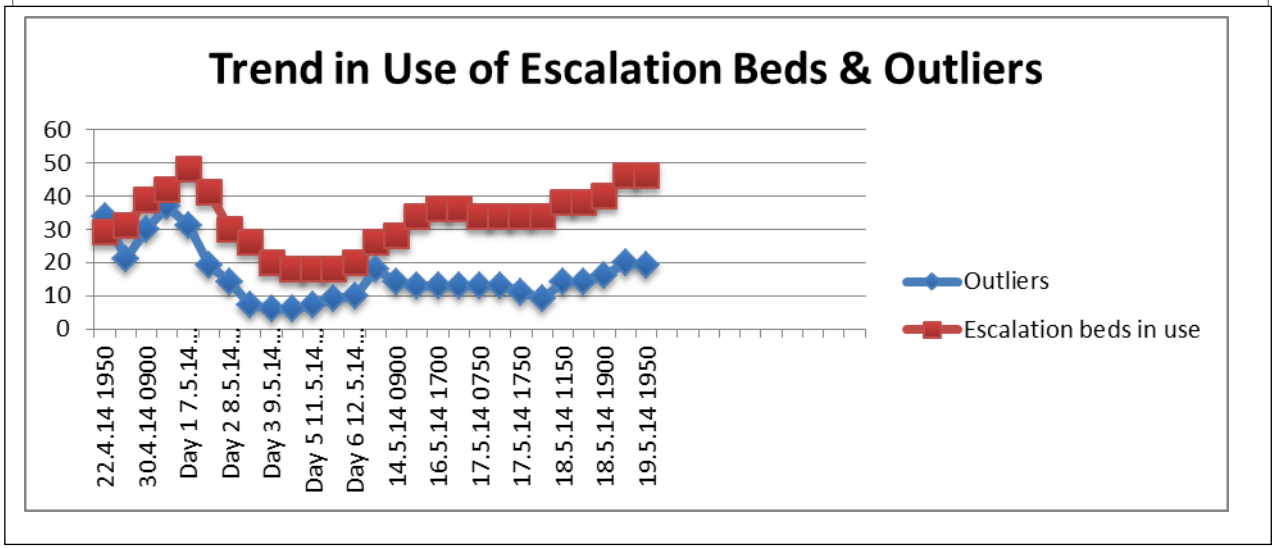
Commentary:
The welcome cards were introduced as a way to focus the ward staff on providing estimated dates of discharge for/to patients. It was clear during the week that EDDs were being recorded on the white boards but that this sometimes showed dates in the past. In some instances it was reported that the patient did not know their EDD due to their clinical state.

Conclusion:
The Target of 100% may not be achievable.
On wards where a standard 'traffic light' white board was in use this maintained the focus on the EDD and acknowledged what was required for the next step of the patients journey – Standardising Use of the Ward White Board is an action being taken forward.

Project Identifier: THE PERFECT WEEK – CONCLUSION DOCUMENT
Version: 0.5 - DRAFT
Contact: A Risino / M Higgin
Date: May 2014

EARLY DISCHARGE
PHARMACY DATA





Commentary:

During the perfect week Pharmacy used the data to monitor Inpatient – Acute beds and trends in the use of escalation beds and outliers.

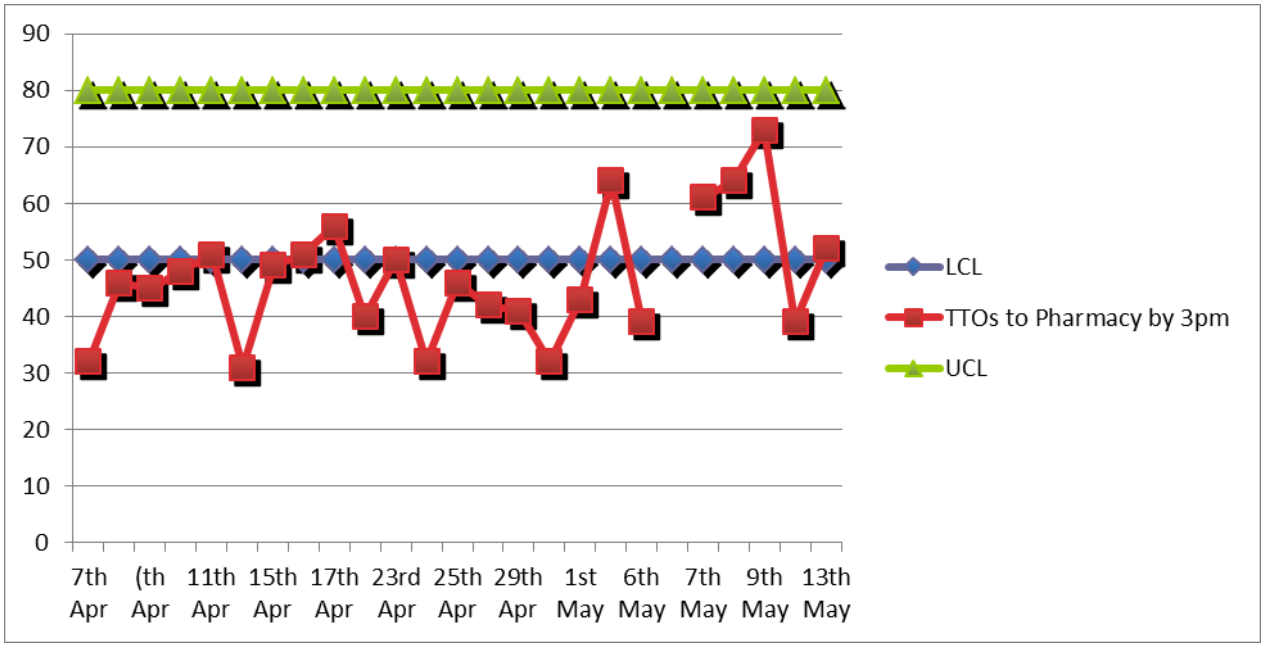
The graphs indicate that during the perfect week these parameters improved dramatically in the 1st four days but this began to reverse as a result of the lower discharges at the weekend and the increase in admissions at the latter end of the week.

Conclusions:

Using the SAFER bundle had a positive impact on reducing:

- The usage of acute beds
- Outliers
- Escalation beds

If the SAFER bundle is embedded within WHH and there is a greater shift towards 7 day working (6 day working for instance) then there is an indication that cost savings could be achieved and would be an enabler to the wider beds programme for 14/15.

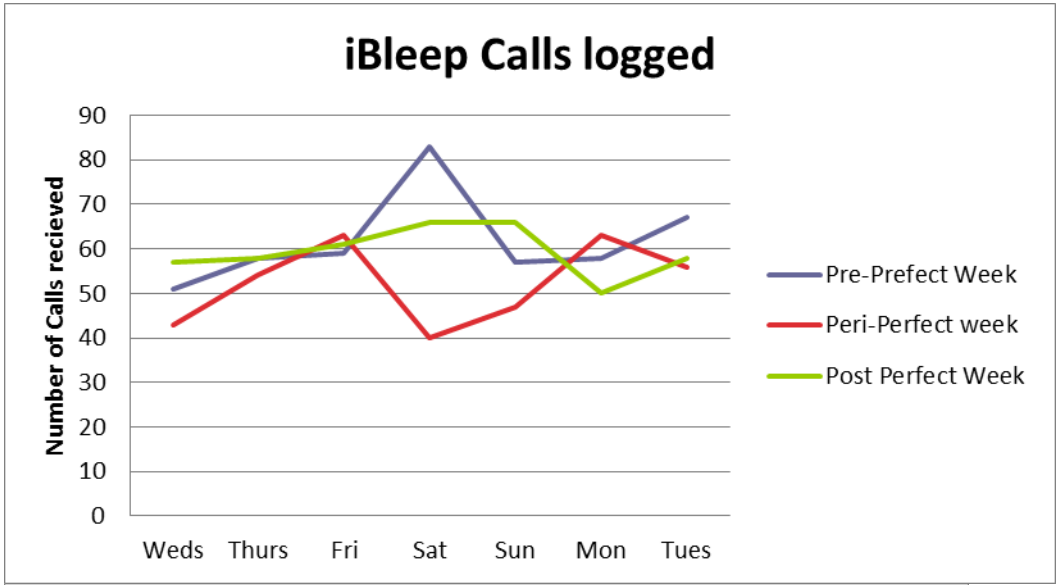


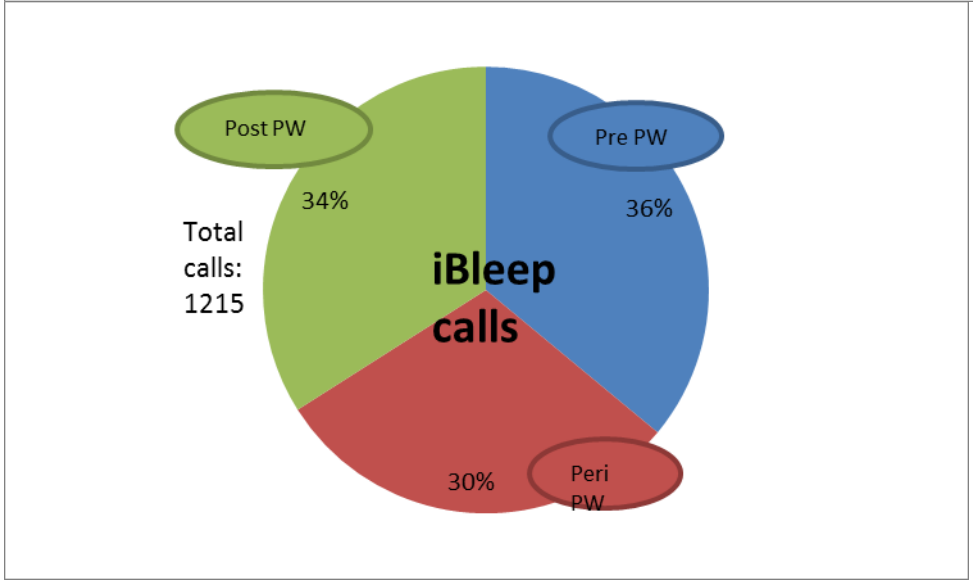
Commentary:

There was an improvement in the number of TTOs written earlier in the day on most wards on days 1 to 3 of the Perfect Week and the total number of discharges per day exceeded the target of 81 by between 19 and 38 on days 1 to 3.
Prescribing of TTO's earlier and steadily throughout the day helped to reduce the discharge delays usually caused by batching the work at the end of the day. Intelligence about discharges derived from the SitReps, coupled with a much greater Pharmacy presence on wards earlier in the morning and throughout the day reduced the dead time between the TTO being written and being reviewed and processed by Pharmacy. This together with faster TTO turnaround times (made possible by an increased Pharmacy presence at ward level and use of the discharge cart) enabled discharge of patients earlier in the day and reduced the inefficiency created by patients' returning for medicines later/use of taxis/staff to deliver medicines. These are likely to have been significant factors in reducing LOS, increasing the number of beds earlier in the day, reducing the outliers and reducing the overall bed use.

An additional benefit arising from this was that patients were able to leave the hospital with their medication and with information to support improved medication adherence.

Conclusion:
There is a need for more ward based Pharmacy team time to facilitate early discharge ideally provided across 7-days. There is also a need for prescribing to occur in advance or earlier in the day. Extending the availability/use of pharmacist prescribers should be considered to enable the Trust to achieve 40% discharge by noon**.**





Commentary:

On looking at the number of calls received via iBleep there was a decrease in the number of calls logged via iBleep when compared to pre and post perfect week.

Conclusion

It was felt that twice daily senior reviews (S from the SAFER bundle) had impacted positively on reducing the number of bleeps made.

Calls logged with MET were also investigated. This had disappointing results and will be looked into further.

The trust already Audit the MET calls quarterly in depth and the report will be reviewed.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/110

BOARD OF DIRECTORS

Paper Title	Monitor Corporate Governance and additional Compliance Statements
Date of Meeting	25th June 2014
Director Responsible	Chief Executive
Author(s)	Trust Secretary
Purpose	To seek the Board approval to the Monitor Corporate Governance Statements for submission by 30 June 2014

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

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

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

		Page/Paragraph Reference
•	Monitor require Board of Directors to confirm or unconfirmed compliance with each Corporate Governance Statement and provide any risks and mitigations where appropriate. The Corporate Governance Statements are forward looking for the financial year 2014/15.	**Part 1; Appendix 1**
•	Additional Compliance Statements are also required relating to Joint Ventures and Governor Training.	**Part 2; Appendix 1**

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

The Board is asked to confirm compliance with the Corporate Governance statements and additional statements relating to Joint Ventures and Governor Training

Introduction

Monitor revised its governance reporting requirements for trusts in 2013/14. In order to comply with both the provider licence and the Risk Assessment of their licence, the Trust is required to provide a "forward looking governance statement" in the form of a Corporate Governance Statement (CGS) to Monitor. The statement, which is required to be submitted to Monitor by 30 June 2014 as part of the Strategic Planning process, will confirm compliance with the licence condition FT4 and provide any risks to compliance with this condition during the next year and any mitigating actions it proposes to take to manage such risks.

Licence Condition FT4 and Appendix D of Monitor's guidance 'Risk Assessment Framework' - 27th August 2013 - sets out the criteria that the Trust has to assess itself against when completing the Corporate Governance Statement.

In addition the Trust was required to describe the ways in which it was able to assure itself of the validity of its Corporate Governance Statement in its Annual Governance Statement (AGS). The AGS was submitted with the Trust Annual Report and Accounts 2013/14 as part of the year end reporting timetable 30th May 2014

The CGS replaces the board statements that NHS Foundation Trusts were previously required to submit with their annual plans under the FT Compliance Framework.

Additional compliance statements are also required relating to Joint Ventures and Governor Training.

Corporate Governance Statement (CGS)

a. MIAA Internal Audit Review

As part of the Internal Audit Plan, the Trust asked MIAA to carry out a gap analysis of its position against the criteria set out in Monitor's CGS. In particular to; map the current arrangements/assurances in place against the criteria set out; undertake a gap analysis against these; and identify any actions required as appropriate. The findings of the Report has been discussed recognising that the Report sets out the overall view of the audit and provides evidence of assurance of compliance and opportunities of enhancement. The Board have reviewed the report and actions are included to address the areas of enhancement which will be undertaken over the year.

b. Board of Directors Review

The Board also undertook a review of the Corporate Governance Statements at its meeting on 29th May 2013 when certifying requirements annual plan 2013/14 and reviewed the statements in the Board effectiveness review 2013.

c. Compliance with the Corporate Governance Statements

The Table in Part 1 of appendix 1 sets out the Corporate Governance statements that the Board is required to confirm together with any risks and mitigating actions.

The Board is asked to confirm compliance with each statement taking into account the findings of the review undertaken by Internal Audit and the Board of Directors views reported in the paper to the Meeting held on 29th May 2013.

Additional compliance statements

The additional compliance statements can be found at Part 2, Appendix 1.

a. The first relates to Certification on Academic Health Science Centres and governance - for NHS foundation trusts: that are part of a major Joint Venture or Academic Health Science Centre (AHSC); or whose Boards are considering entering into either a major Joint Venture or an AHSC.

   The Trust response to this statement is **'Not applicable'** as the Trust is not is not part of an AHSC or Major Joint Venture and is not at considering entering into a major joint venture or AHSC.

b. The second relates to the training requirements of Governors in order to fulfil their role. The proposed response is '**confirmed'**. The Council at its meeting in November 2014 approved an evaluation and training programme for implementation throughout the year. All Governors receive induction training and have one to one sessions with the Trust Secretary at appointment. External training is provided through the NW Secretaries Group, FTGA and MIAA.

   Internal training is also provided at and during Council and Council Committee meetings to deal with specific areas of their roles and responsibilities. The Trust Secretary is available to respond to any matters that Governors may require clarification and if appropriate ad hoc training is provided should this be required.

Recommendation(s)

The Board is asked to confirm compliance with the Corporate Governance Statements and additional statements relating to Joint Ventures and Governor Training

Appendix 1.

MONITOR SUBMISSION

Part 1: Corporate Governance Statements

The Trust is required to make a submission to Monitor by 30 June 2014. The declarations, and proposed responses, are provided below:

	CORPORATE GOVERNANCE STATEMENT	CURRENT ARRANGEMENTS	PROPOSED RESPONSE	RISKS AND MITIGATING ACTIONS (To be included even if the Board Confirms Compliance)
1	The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	- External review of corporate governance statements and implementation any agreed actions. - Review of Monitor Code of Governance – Non Compliance only in relation to external evaluation of the Board following the "Led Well Monitor guidance"- May 2014 - Membership of FTN and the Company Secretary networks - Reviews of Monitor and other bulletins by the board and regular updates from the external auditors through the audit committee. - The Trust has an internal audit programme and assurance cycle. - External auditors provide assurance on the content of the Trust Annual Report and Accounts, the Quality Report and provide an opinion on Trust annual governance statement.	**CONFIRMED**	**No Material Risk identified**
2	The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time	- External review of corporate governance statements and implementation any agreed actions. - Trust Secretary in post - Receipt and Review of regular updates from Monitor - Membership of NW FT Company Secretary network and FTN Company Secretary Network. - Regular communications from legal advisors and internal and external auditors.	**CONFIRMED**	**No Material Risk identified**

	CORPORATE GOVERNANCE STATEMENT	CURRENT ARRANGEMENTS	PROPOSED RESPONSE	RISKS AND MITIGATING ACTIONS (To be included even if the Board Confirms Compliance)
3	The Board is satisfied that the Trust implements: a) Effective board and committee structures; b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and c) Clear reporting lines and accountabilities throughout its organisation.	External review of corporate governance statements and implementation any agreed actions. - Review of Committee structure undertaken in 2013 and follow up review in 2014. - Board approved terms of reference of Board Committees providing details of reporting lines, responsibilities and membership - Workforce strategy being developed in line with agreed timescales	**CONFIRMED**	**No Material Risk identified**
4	The Board is satisfied that the Trust effectively implements systems and/or processes: a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS	External review of corporate governance statements and implementation any agreed actions. a) Strong systems of financial and quality governance in place. All statutory audits and reporting requirements fulfilled via Audit Committee. Action plan in place to review Trust performance against Monitors Quality Governance Framework. b) Performance review, service line reporting arrangements, service review, performance dashboards at all levels within the organisation with divisional and corporate systems for appropriate escalation and review to ensure timely and effective scrutiny and oversight of all operations. c) Effective systems and processes in place to ensure with national and local healthcare standards - internal and external assurance systems in place.	**CONFIRMED**	**No Material Risk identified**

	CORPORATE GOVERNANCE STATEMENT	CURRENT ARRANGEMENTS	PROPOSED RESPONSE	RISKS AND MITIGATING ACTIONS (To be included even if the Board Confirms Compliance)
	Commissioning Board and statutory regulators of health care professions;			
	d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);	d) Financial plans in place, approved by the Board and discussed with Governors. Cost Improvement programme agreed with clinical divisions and corporate departments supported by focus on improving profitability and margins. Contracts and business development managed appropriately. Workforce strategy being developed to meet service demands, and workforce plans reviewed to minimise the use of temporary staff. Robust procurement scrutiny to minimise costs. Annual and rigorous review of the Trust as a Going Concern overseen by Audit Committee and reported to Board.		
	e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;	e) Robust integrated governance structure in place. Board and committee structures fully serviced. Accurate, comprehensive, timely, up-to-date information available for Board and Board committees.		
	f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;	f) Board Assurance Framework/Corporate Risk Register in place that identifies and ensures appropriate oversight of all principal and material risks. Quarterly review of Provider licence Checklist to identify and areas of risk to compliance		
	g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and	g) Effective Strategic and business planning arrangements in place, embedded within the trust and reviewed with Governors and CCG prior to approval. External assurance provided by KPMG as part of the 2nd stage review in 2013 and through EY as part of the delivery of the Trust financial plan.		
	h) To ensure compliance with all applicable			

	CORPORATE GOVERNANCE STATEMENT	CURRENT ARRANGEMENTS	PROPOSED RESPONSE	RISKS AND MITIGATING ACTIONS (To be included even if the Board Confirms Compliance)
	legal requirements.	h) Applicable legal requirements, against principal objectives and activities of the organisation reviewed and managed appropriately as part of the Trust's governance arrangements. Required to consider as part of the external review of corporate governance statements whether an appropriate formal process should be adopted.		
5	The Board is satisfied that the systems and/or processes referred to in paragraph ~~5~~ 4 should include but not be restricted to systems and/or processes to ensure:	External review of corporate governance statements and implementation any agreed actions.	**CONFIRMED**	**No Material Risk identified**
	a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;	a) Board capability reviewed against strategic direction and business plans. Focus on quality of care. Robust appraisal arrangements in place across the Trust. Medical Revalidation and appraisal systems in place and Leadership Management Development implemented across the Trust		
	b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;	b) Quality of care fully integrated within all planning and decision-making processes.		
	c) The collection of accurate, comprehensive, timely and up to date information on quality of care;	c) (and d) Quality dashboards, patient experience and quality of care initiatives routinely provided to Board.		
	d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;	d) Board receives a Patient Story every two months and receives presentations on quality of Care through its Board development workshops. Quality of Care (part of QPS) is prominent within each Board agenda.		

	CORPORATE GOVERNANCE STATEMENT	CURRENT ARRANGEMENTS	PROPOSED RESPONSE	RISKS AND MITIGATING ACTIONS (To be included even if the Board Confirms Compliance)
	e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and	e) Board and Board Committees receives Patient Stories and presentations from staff on quality of care provided by the trust. Executive and NED ward and department visits undertaken to assess staff and patient care. Friends and Family Test systems in place and reported through the Governance Structure. Patient Experience Strategy in place and reviewed by the Board. The Board receives quarterly reports on complaints. There is active engagement between the Board and the Council of Governor (CoG)s, Board members attend all CoG meetings and NEDs and Executives attend CoG Committee meetings and training events. CoG undertakes unannounced ward observation visits- real time feedback on Quality of Care provided to Boarad and CoG,		
	f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	f) Escalation of reporting embedded in the Trust. Systems and structures in place to allow for escalation to the Board as required.		
6	The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	External review of corporate governance statements and implementation any agreed actions. • Constitution sets out required numbers and qualifications for Board members. • Reviews undertaken by the Board and Governors Nominations and Remuneration Committee at time of recruitment of Executive and Non-Executive directors • The NEDs provide substantial challenge and scrutiny through attendance a Board and Board Committees	**CONFIRMED**	**No Material Risk identified**

	CORPORATE GOVERNANCE STATEMENT	CURRENT ARRANGEMENTS	PROPOSED RESPONSE	RISKS AND MITIGATING ACTIONS (To be included even if the Board Confirms Compliance)
		regarding appropriate staffing levels. • through use of board assurance framework and risk management Strategy at Board, Board Committees and Sub Committees and Groups within the Trust Governance Structure • The strategic plan includes details on transformation and HR requirements including mitigation of risks associated with future workforce requirements.		

MONITOR SUBMISSIONS

Part 2: Other Declarations

DECLARATION TEXT	PROPOSED RESPONSE
Certification on AHCs and governance For NHS foundation trusts: ▪ that are part of a major Joint Venture or Academic Health Science Centre (AHSC); or ▪ whose Boards are considering entering into either a major Joint Venture or an AHSC. The Board is satisfied it has or continues to: ▪ ensure that the partnership will not inhibit the trust from remaining at all times compliant with the conditions of its licence; ▪ have appropriate governance structures in place to maintain the decision making autonomy of the trust; ▪ conduct an appropriate level of due diligence relating to the partners when required; ▪ consider implications of the partnership on the trust's financial risk rating having taken full account of any contingent liabilities arising and reasonable downside sensitivities; ▪ consider implications of the partnership on the trust's governance processes; ▪ conduct appropriate inquiry about the nature of services provided by the partnership, especially clinical, research and education services, and consider reputational risk; ▪ comply with any consultation requirements; ▪ have in place the organisational and management capacity to deliver the benefits of the partnership; ▪ involve senior clinicians at appropriate levels in the decision-making process and receive assurance from them that there are no material concerns in relation to the partnership, including consideration of any re-configuration of clinical, research or education services; ▪ address any relevant legal and regulatory issues (including any relevant to staff, intellectual property and compliance of the partners with their own regulatory and legal framework); ▪ ensure appropriate commercial risks are reviewed; ▪ maintain the register of interests and no residual material conflicts identified; and ▪ engage the governors of the trust in the development of plans and give them an opportunity to express a view on these plans.	**NOT RELEVANT**
Training of governors The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	**CONFIRMED**

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/111(i)

BOARD OF DIRECTORS

Paper Title	Verbal update on activity of Board Committees
Date of Meeting	25th June 2014

Board Committee Verbal Update

a) Strategic People Committee held on 9th June 2014 – Lynne Lobley

b) Finance and Sustainability Committee held on 17th June 2014 – Carol Withenshaw

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/111 (ii)

BOARD OF DIRECTORS

Paper Title	Board Committee Minutes for noting only
Date of Meeting	25th June 2014
Director Responsible	Chair of Board Committees
Author(s)	
Purpose	The Board had received verbal updates from the Chair of each Committee regarding the meetings held. The minutes are for noting only

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

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

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

		Page/Paragraph Reference
•	None	

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

The Board is asked to note the Board Committee minutes:

a) Strategic People Committee – 7th April 2014

b) Finance and Sustainability Committee – 21st May 2014

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Strategic People Committee

Minutes of the Meeting held on Monday, 7th April 2014
Trust Conference Room

Present:

Lynne Lobley	Non Executive Director (Chair)
Karen Dawber	Director of Nursing and Organisational Development
Alison Lynch	Deputy Director of Nursing
George Cresswell	Associate Director of Estates and Facilities
Kate Warbrick	Associate Director of Operations, Scheduled Care
Mick Curwen	Associate HR Director
Carol Withenshaw	Non Executive Director
Roger Wilson	Workforce Transformation
Wendy Johnson	Associate Director of Education and Development
Richard Brown	Associate Director of Operations WC&SS
Karol Edge	Associate Director of Nursing, Scheduled Care

In Attendance:

Jennie Taylor	Executive PA

	WHHFT/SPC/14/019 - Apologies and Welcome	
1	Apologies for absence were received from Chris Horner, Associate Director of Communications Simon Wright, Chief Operating Officer, Deputy CEO Millie Bradshaw, Associate Director of Governance Amanda Risino, Associate Director of Operations, Unscheduled Care, Mel Hudson, Associate Director of Nursing, WC&SS. Karol Edge, Associate Director of Nursing, Unscheduled Care	
	WHHFT/SPC/14/020 – Declarations of Interest	
2	It was noted that L. Lobley, Chair/Non-Executive Director also works for Health Education North West (Mersey).	

	WHHFT/SPC/14/021 - Minutes of the Previous meeting held on 10th February 2014	
3	The minutes of the meeting held on 14th October were accepted as an accurate record.	
	WHHFT/SPC/14/022 - Action Plan	
4	WHHFT/SPC/13/083 – Volunteers Update The Director of Nursing and Governance explained that following an overview of recruitment and training it was found that approximately 1/3 of volunteers drop out. Part of the problem has been the time it takes to recruit and train and she reported that there is a plan to speed up the process from application, interview, training and then hopefully retention. She advised that some of the difficulty is that there is no resource for this. L. Lobley, Non- Executive Director/Chair suggested looking at whether Charitable Funds could be utilised to fund this. It was agreed that this element of HR is to be included on the HR Dashboard and also reported on quarterly.	
5	WHHFT/SPC/14/008 – KPI Report Deputy Director of HR explained that there has been a slight increase in reports of bullying. These claims often result in a counter-claim, followed by mediation. This is a very time consuming process and is usually concluded internally with very rare cases needing external intervention.	
6	Deputy Director of HR reported that some of the requirements of NHSLA has ceased to exist (31.03.14) an audit report will be prepared for 2013/14 to be discussed at the next meeting.	
	WHHFT/SPC/14/023 – Presentation **Annual Workforce Equality Analysis – Equality & Diversity Specialist**	
7	Joe O'Grady, Equality & Diversity Specialist explained that Annual Workforce Equality Analysis is a mandatory report and shows the demographic breakdown of Warrington and Halton Hospitals NHS FT workforce and is produced at the end of every year (31st December). He explained that the results have a shortage of responses on disability with 67% not declaring either way. Using ESR to report is being considered as a better way of collecting the data. The age profile shows there is a large group of staff over 40, although this is not unusual is does indicate that workforce planning does need to be raised in importance.	
8	The report concluded with a list of 6 recommendations, these mainly focussed on collecting data more effectively.	
9	L. Lobley, Non-Executive Director/Chair enquired about whether Equality & Diversity training is sufficient and can we give assurance that training is appropriate and available to all. J O'Grady explained that doctors have their own training via the Deanery and all other staff are trained or retrained every three years. Training can be tailored to suit different areas to make it more relevant.	

10	J. O'Grady was thanked for explaining this report to the members.	
	WHHFT/SPC/14/023– HR Update Report	
11 12 13 14 15 16 17 18	The Associate Director of HR reviewed his update report which has been produced in a 'bullet point' format. He drew attention to the following: ESR – Total Reward Statements will be introduced later this year, these will include pension statements. Pay Deal The introduction of the two year pay deal is quite controversial as the 1% increase will not be consolidated. Payroll Tender This was unsuccessful – no further feedback Friends and Family This will be introduced shortly and will have an impact on the department workload. HR Activity 658 cases of long term sickness (4 weeks or more) dealt with last year. Director of Nursing and Organisational Development thanked the Associate Director of HR and his team for all the work that they are coping with currently. All agreed that this new format is clear and concise.	
	WHHFT/SPC/14/025 – Annual Report of the Committee	
19	The Annual Report was received and approved. It is now to go to the Board meeting together with HR Update (WHHFT/SPC/14/024) as an Appendix.	
20 21	**WHHFT/SPC/14/026 – Legislation update** The Deputy Director of HR explained: • End of Immigration restrictions for Bulgarian and Romanian workers • Changes to TUPE • Right to extend flexible working, we have applied to our staff anyway so this will not affect WHHFT. • ACAS will take a stronger role with employment tribunals • Tackling workplace sickness – the National Scheme will not affect us much. • School leaving age being raised to 18 • Fathers gain right to time off for antenatal appointments. L. Lobley, Non-Executive Director/Chair thanked the Deputy Director of HR for producing this report which clearly indicates the amount of work being covered by the HR department and also the increased workload that continually arrives due to these changes.	

	WHHFT/SPC/14/027 – Administration and Clerical Review	
22	The Director of Nursing and OD explained that patient administration is currently distributed across the 3 divisions within the Trust. The associate cost currently stands at £8.156m per annum for the whole Trust, broken down to Scheduled £2.139m, Unscheduled is £1.052m and WC&SS is £4.285m with £680k for ward clerks. This has proven to be higher than average costs associated with administration compared to other trusts.	
23	The review of patient administration project is one of a number of Trust Wide schemes seeing to achieve reform through the introduction of new models of working, reducing duplication and adopting key IT functionality to enhance delivery and improve efficiency.	
24	She explained that this is a large project, communication has not been good and therefor Roger Wilson has been tasked with improving this. Risks and benefits have not been established quite yet.	
25	L. Lobley, Non-Executive Director/Chair agreed that this needs careful planning, we need to get these changes right and have a risk register and project plan.	
26	It was agreed that there will be updates on this review each meeting.	
	WHHFT/SPC/14028 – Temporary Staffing Report – Medical Staff	
27	The Director of Nursing and OD advised that there has been a reduction in expenditure in February. For future meetings the report will be produced in dashboard format.	
28	L. Lobley, Non-Executive Director/Chair asked if assurance was possible around foresight being applied to senior vacancies. Associate Director of Operations, Scheduled Care explained that in her division 52% are aged over 50 and there is a need to get ahead of the game.	
29	Director of Nursing and OD explained that succession planning is a huge task but work has already commenced.	
	WHHFT/SPC/14/029– Annual Staff Survey	
30	The Deputy Director of HR explained that the main areas on the report are improved and shows we are probably one of the top 20. C. Withenshaw, Non-Executive Director praised the team for producing this report and asked whether feedback can be split between Warrington and Halton. It was agreed the Deputy Director of HR will see what can be done.	
	WHHFT/SPC/14/030 – CIP/Workforce	
31	Director of Nursing advised that structures have been examined over the last two months. Two roles have been frozen. Transformational Change post (12 months) and Roger Wilson's (3-6 months) roles have been created to see what changes can be made. The Director of Nursing and OD explained that Roger's style is to meet senior managers face to face and get a clear understanding of the organisation before he makes any recommendations.	

	WHHFT/SPC/14/031 – Induction Report	
32	The Deputy Director of HR explained that a Task and Finish group has been established. Corporate Induction figures are very good but local induction is not. The Task and Finish group believe the existing Induction Policy needs to be reviewed and updated with the following issues identified/recommended for change:	
33	The over-riding view was that the existing Induction Policy needed to be reviewed and updated and the following issues were identified/recommended for change:	
34	i. Although the existing threshold of 4 months for corporate induction was debated, it was felt that where staff have their appointment extended beyond 4 months, it is **not necessary for staff to attend corporate induction**. This was on the basis that primarily the purpose of corporate induction is to welcome staff to the trust and after 4 months this was felt to be unnecessary and the far more important issue was for staff to receive local induction which was deemed essential. If staff are working for the trust for much longer periods they will be routinely identified as needing mandatory training and subsequent refreshers. Therefore, there is a degree of mitigation if staff do not receive corporate induction.	
35	ii. Under current arrangements staff have 4 weeks to complete their local induction. The Group felt this was too long and wanted to put in place an arrangement which would incentivise the completion of local induction. The consensus was that staff **should not be paid** until they have completed local induction and provided confirmation of this. The only way this would work is if corporate induction was held in the first week of every month and it was made a requirement that permanent staff and temporary staff employed for longer than 4 months, would have a maximum of 10 working days from their date of commencement during which to complete their local induction and provide the confirmation to the Training Department who would enter the details on ESR. This would allow sufficient time for the Payroll Department to run off a report in the middle of the month at the payroll deadline to check for confirmation of local induction. Anyone not having provided the confirmation, would not get paid that month or indeed until the confirmation is received.	
36	iii. For temporary staff who do not require corporate induction but are employed by the trust for longer than a shift or weekend, they will be **encouraged to commence in post in the first two weeks of the month** on the understanding that they must complete the local induction by the payroll deadline for payment that month otherwise **they will not get paid**.	
37	Any temporary staff commencing after the payroll deadline date will not be paid in any event that month and will have to provide confirmation by the deadline of the following month to receive payment.	

38	iv.	NHSP staff could operate on a similar basis but as they are paid on a weekly basis and only usually work one or two shifts per week, the local induction would need to be completed when they commence the shift which ideally is the most appropriate time. NHSP staff could be told that **if the ward staff refuse to complete the local induction, they would be entitled to leave the ward and not complete the shift**. There would therefore be an incentive for both parties to complete the local induction. This may not be as onerous as first imagined given that most staff work in the same areas and would only need the local induction once and then a confirmation at each subsequent shift that the local induction has previously been completed. This would be done as part of the authorisation process. Obviously if an NHSP nurse worked in an unfamiliar area they would need to complete a new local induction.	
39	v.	A similar process could be put in place for agency medical staff either through StaffFlow agencies or with other agencies as part of the authorisation process. The same could apply to other non-medical agency workers such as those working in the therapy areas, pharmacy or radiology or indeed non-clinical areas.	
40	vi.	The local induction checklist itself needs to be **restricted to two versions** rather than the current four, one for clinical staff and one for non-clinical staff regardless of the length of appointment. The content also needs to be reviewed to ensure that it is 'fit for purpose' and covers the essential requirements and is not too long and onerous to complete.	
41	vii.	The local induction checklist should be available as an electronic version and available on The Hub so it is accessible for all.	
42	The Associate Director of Estates and Facilities asked where the responsibility lies to ensure that local induction takes place and the Associate Director of Nursing, Scheduled Care advised that a lot of NHSP staff are employed by WHHFT and have therefore received corporate induction. Therefore local induction is not too time consuming. Discussion took place around what really needs to be covered and it was agreed that anyone being on a ward/in a new area for the first time deserved to receive basic introduction to the layout, fire exits, etc.		
43	L. Lobley, Non-Executive Director/Chair supports these changes and so did the rest of the Committee.		
44	Associate Director of Nursing, Scheduled Care recommended tying the safety brief and local induction together when anyone new starts on the ward.		
45	**WHHFT/SPC/14/031 – Summary Report of the National Audit of NHS Trust for Implementation of NICE public health guidance** Director of Nursing and OD explained that the work around producing the 6 pieces of evidence based guidance for the workplace has shown we have a place in the top 20 of those trusts in England that have participated. An excellent result.		

46	**WHHFT/SPC/14/032 – KPI Report** The Deputy Director of HR briefly reviewed his report: • Mandatory Training figures remain stable • Appraisal rates are dropping, figures are expected to increase now we are out of the winter pressures. PDR completion may start to be linked to incremental pay rises which will be beneficial. • Sickness – level expected to be similar to same figure as at start of year. • Return to Work – this figure is low but is likely to be due to poor reporting	
47	**WHHFT/SPC/14/033 – Response to Francis 2** Annual Ward Staffing Review Director of Nursing and OD advised that this paper had been submitted to Board and approval had been given. She explained that this report provides the information required by NHS England. The Director of Nursing and OD also explained the introduction of Ward Information Boards and the importance of having the communications around these correct, the cost implication of these is £25 each. The report provides assurance that the issues raised in the Francis report have been addressed.	
48 49 50	**WHHFT/SPC/14/034 - Update from Health Education England** The Associate Director of Education and Development advised that she has attended a workshop which explained that workforce planning will be different and there will be a deanery integration project. L. Lobley explained that she is a member of the project board. L.. Lobley, Non-Executive Director/Chair suggested looking at within bands 1-4 at a 'fore-runner fund' and asked if the Associate Director of Education and Development would submit a statement of interest. It was advised that the Associate Director of Education and Development would be attending the next stakeholder conference on 15th May 2014.	
51	**WHHFT/SPC/14/035 – Workforce Planning Discussion re 14/15 process** **Frontline First Royal College of Nursing** The Director of Nursing and OD had included this report which is a useful document for workforce planning. She wished it to be noted that it reflects there is a reduction in higher grades of nursing.	
52	**WHHFT/SPC/14/036 – Stress Related Sickness Absence** The Director of Nursing and OD chaired the Staff Wellbeing meeting last week and advised that the stress reports of the Top 10 areas was quite a surprise. Figures increased November to February although no breakdown currently of work related stress on ESR.	

53	The area reporting the highest was WC&SS, Deputy HR Director advised that it is important to know that the top scoring areas have received individual and departmental stress risk assessments and had action plans drawn up to try and tackle the problem.	
54	Director of Nursing and OD recommended this item is reported to the Board and also be scored for the Risk Register.	Director of Nursing and OD
55	L. Lobley, Non-Executive Director/Chair advised that this is something that we need to understand better and asked the Associate Directors of Operations to raise at their divisional meeting to seek clarity particularly around reporting and progress.	
56	It was agreed that progress on these reports should be included within the relevant Divisional Workforce Assurance Reports which are submitted to the Committee and for the issue to become an agenda item at Bi-Lateral meetings.	Executive PA Deputy Director of HR
	WHHFT/SPC/14/037 – Directorate Assurance Reports	
57	<u>WC&SS</u> The Associate Director of Operations, WC&SS reported shortage of radiologists and explained that they are looking at over recruiting and also at international recruitment.	
58	Anti-Coagulation services are being reviewed by the Medical Director following the circulation of paper last week.	
59	<u>Unscheduled Care Division</u> Associate Director of Nursing highlighted that sickness in the division was 5.16% which is higher than other areas. A pilot has been introduced in collaboration with Occupational Health where staff must visit before going home sick. This does not apply to anyone that is vomiting.	
60	Junior Doctor EWTD returns poor in November 2013 so this is being run again in March 2014.	
61	<u>Scheduled Care Division</u> The Associate Director of Operations, Scheduled Care advised the hot spot issues are: • EWTD – poor reporting • Sickness is being managed well • Spinal Business Case approved and staff are being recruited • SAU are moving to Ward A4 The contents of the report were noted.	
62	<u>HR</u> The Deputy Director of HR advised that long term sickness are all resolved.	
63	Turnover is above Trust average but there are no concerns.	

64 65	Two senior vacancies haven't been filled due to finances but restructure of the department is expected. The contents of the report were noted.	
  66 67 68	<u>Finance</u> It was reported that temporary staffing levels are high. No representation from the department, deputy director to be contacted for nomination of representative. It was also noted that the format of the report is not correct..	 Deputy Director of HR
  69 70	<u>Estates</u> The Associate Director of Estates and Facilities reported no notable hot spots, sickness levels are slightly higher than Trust average but this is down to one long term sickness which is almost resolved. The contents of the report were noted.	
  71 72	<u>Facilities</u> The Associate Director of Estates and Facilities reported no notable hot spots. He explained that a number of appointments are due to be made but these will be part time. The Director of Nursing and OD asked about "as and when contracts" and explained that at the JNCC meeting zero hours were condemned by staff side. The Associate Director of Estates and Facilities explained that it was surprising how many people wanted to work like this. It was agreed that he would include details of zero hour staff in future reports. The contents of the report were noted.	 Associate Director of Estates and Facilities
  73 74	<u>IT</u> The Director of Nursing and OD explained that there are currently 9 vacancies and an open day was planned. The Director of IT has been in post 12 months and is hoping to have new structure in place soon. The contents of the report were noted.	
	WHHFT/SPC/14/038 – Preceptorships	
75	This item was covered in the Education Report.	
	WHHFT/SPC/14/039 - Risk Register	
76 77	The Director of Nursing and OD advised that temporary staffing has been actively targeted and a group has been put in place to deal with it and a workshop has been organised. The Deputy Director of Nursing explained that the risk relating to continuity of care has been looked into and is expected to be removed.	

78	L. Lobley, Non-Executive Director/Chair requested that this item is moved up on future agendas so that more time can be spent on it.	Executive PA
	WHHFT/SPC/14/040 - Education and Development Report	
79	The Associate Director of Workforce and Development reviewed her report highlighting: • Organisational Development • Mandatory Training • Trust Triennial Review Status • CPD and Business Development • Resuscitation training courses • Trainee Assistant Practitioners • Preceptorships • Medical Appraisals – Warrington has achieved 3rd place out of 250 hospitals for Delivery of the Foundation Programme. • Workforce Transformational Change – CBWF has been abandoned in favour of enhanced recovery	
80	The Associate Director of Estates and Facilities advised that a sum of money had been provided by the Deanery to improve Post Grad facilities and we have submitted a bid.	
	WHHFT/SPC/14/041 – Emergency Preparedness	
81	The Director of Nursing and OD explained the contamination event which was very successfully dealt with although there was a shortage of response by the Area Wide Team.	
82	Lock down at A&E was successfully handled.	
	WHHFT/SPC/14/042– Minutes and Reports from Reporting Groups	
83	Event Planning and Local Health Resiliance Partnership Meeting of 21st March	
84	JNCC minutes of meeting 12th February	
85	JLNC minutes of meeting of 13th February	
86	Special joint JNCC and JLNC minutes of 9th January	
87	Temporary Staffing Meeting minutes of 18th February	
88	Appraisal and Revalidation Group minutes of 14th January	
89	ESR Operational Group meeting minutes of 5th February and 5th March	
90	Medical Education Quality Committee meeting minutes of 27th February	
91	These were all recorded and accepted by the Strategic People Committee.	

	WHHFT/SPC/14/043 Any Other Business	
	There was no further business.	
	Date and time of next meeting	
	The next meeting is to be held on 9th June in the Trust Conference Room, Warrington.	

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

High Quality, Safe Healthcare
Quality People Sustainability

Warrington and Halton Hospitals NHS
NHS Foundation Trust

FINANCE AND SUSTAINABILITY COMMITTEE

Minutes of Meeting of the Committee held on 16th April 2014

Present

Carol Withenshaw	Non-Executive Chair
Rory Adam	Non-Executive Director
Tim Barlow	Director of Finance and Commercial Development
Simon Wright	Chief Operating Officer/ Deputy Chief Executive (delayed - attended from 1425hrs)
Alison Lynch	Deputy Director of Nursing

In attendance

Colin Reid	Trust Secretary

Apologies:

Mel Pickup	Chief Executive
Jason DaCosta	Director of IT
Karen Dawber	Director of Nursing and Organisational Development
Paul Hughes	Medical Director

Apologies and Declarations of Interest – FSC/14/13

1 Apologies: As stated above
Declarations: None

Minutes of meeting & Actions – FSC/14/14

2 The minutes of the meeting held on 20th March 2014 were amended and approved.

The action on the Medical Director to consider the re-establishment of the Medical Devices Group remained ongoing.

Year End Financial Position – FSC/14/15

The Director of Finance and Commercial Development presented the Trust year-end financial position and reported that he was pleased that the trust had achieved below the agreed deficit with Monitor of £2.9m at £2.8m (£2.849m), this equated to a year-end position of £4,001k worse than the planned surplus of £1,152k. The Director of Finance and Commercial Development advised that the results meant that the Trust achieved a Financial Risk rating of 2 against a planned rating of 3 and a Continuity of Services rating of 3 against a planned rating of 4.

The Director of Finance and Commercial Development advised that NHS activity was £1.3m better in month whilst other income activity also increased following receipt of extra income from Alder Hey, pathology and Bridgwater community services.

The Director of Finance and Commercial Development advised that the year-end settlements had been agreed with Warrington, Halton and St Helens CCGs together with a number of other commissioners, with the overall position of a £3.0m over recovery against the income target. He advised that with regard to Warrington CCG, the trust had reached an agreement that at year end certain elements of patient costs would be paid to the trust which was accounted for in a similar to work in progress.

The Director of Finance and Commercial Development advised that as with previous months pay costs continued to be higher primarily driven by the continued use of Bank, Agency and Locum costs (£11,297k), overtime (£1,176k) and Waiting List Initiatives (£3,715k) in the clinical divisions.

The Director of Finance and Commercial Development advised that cash flow was below plan and as at 31 March 2014 cash stood at £13m against a planned cash balance of £14m. The £13m equated to 23 days operational cash.

With regard to the balance sheet the Director of Finance and Commercial Development advised that as at 31st March 2014 the value of land and buildings had increased by £2.9m. This increase has been reflected by an increase in the revaluation reserve, however as a result of the increase in asset value the PDC Dividends had increased by £0.1m. The Director of Finance and Commercial Development advised that there was a £0.7m impairment charge to the income and expenditure statement due to a number of assets that were no longer in use and accounting standards required that the net book value of the asset is charged to income and expenditure as an impairment expense.

The Director of Finance and Commercial Development thanked the staff for all their hard work and diligence in delivering the £2.9 deficit. The Chair thanked the Director of Finance and Commercial Development for his report noting that although this was not a successful year for the trust it had delivered against a target agreed with Monitor and echoed the Director of Finance and Commercial Development thanks to the staff at the trust who had made this possible.

Update on Budget 2014/15 and Annual Plan Submission 2014/16 – FSC/14/16

Budget 2014/15 & 2015/16

The Director of Finance and Commercial Development provide the committee with a presentation that set out the changes made to the budget submitted to Monitor for 2014/15. In particular the Director of Finance and Commercial Development referred to income and expenditure quarterly plan which showed the trust delivering a £1.5m deficit for the year. Contracted income on page 5, provided details of the agreed positions with all the commissioners. In response to a question from Rory Adam, the Director of Finance and Commercial Development advised that the trust has one contract with the commissioners, with Warrington CCG being the primary commissioner.

With regard to non-contracted income, this had been left out of the contract, however it was recognised by the commissioners that this would require payment. The trust however had a duty to inform the commissioners if activity levels exceeded plan. Referring to clinical coding and consultant to consultant referrals, the Director of Finance and Commercial Development advised that the commissioners had agreed to pay for these from 1 April 2014 subject to a review that the changes and referrals were above board.

The Director of Finance and Commercial Development referred the committee to the Continuity of Services (CoS) risk rating slide and reported that the trust was planning to deliver CoS rating of 2 for Q1-Q3 and 3 for Q4 which he felt was not out of kilter with other DGH's.

With regard to financial year 2015/16, the Director of Finance and Commercial Development advised that the trust was showing delivery of a £1m deficit. He advised that having considered the risks, he felt that it would not be prudent to try and deliver a break even budget. This would deliver a CoS rating of 2 for Q1-Q3 and 3 for Q4 and an end of year cash position of £6.9m.

The committee recognised that this budget was stretching for the trust and that to achieve the planned deficit's the trust had to deliver against cost improvement plans in 2014/15 and 2015/16 and keep expenditure under control whilst delivering greater activity.

The committee noted the 2014/15 and 2015/16 budget.

Operational [Annual] Plan Submission 2014/16

The Director of Finance and Commercial Development presented the Operation Plan submission advising that as with the budget the Operational Plan had been submitted to Monitor prior to the submission date of 4 April 2014.

The Operational Plan was noted with the following comments:

- The front page required changing as the picture was out of date regarding the hair policy implemented by the trust.
- Page 17 refers to the development of specialist 'centre of excellence', the Chair supported the view and felt that the CMTC provided the vehicle to support centre of excellence.
- The Chief Operating Officer felt that the CMTC needed a change of name to link it to the trust. He felt that the name did not convey what services were provided within the facility. The Chief Operating Officer advised that the facility was state of the art and should be sold as such. He also felt that once Halton received JAG accreditation this would provide a bigger opportunity to market the services.

Commissioner Contract 2014/15 and future reporting on performance– FSC/14/17

The Director of Finance and Commercial Development reported on the contract that had been signed with the Commissioners for 2014/15 and referred to the penalty risks in the contract the majority of which were nationally mandated.

The Chief Operating Officer referred to the A&E breaches and advised that the trust would be penalised for monthly breaches, whereas Monitor requirements for delivery of the 4 hour target remained quarterly. This was being addressed.

The Committee recognised the zero threshold for MRSA and in particular the financial penalty of £10,000 each incidence over the threshold. C.diff threshold had increased from 19 to 26 and any cases over the new threshold amounted to circa £10,000 per case.

Rory Adam referred to page 8 of the report and the requirement to ensure patients had a minimum supply of 2 weeks newly prescribed (initiated) medication on discharge and asked whether two weeks was appropriate. In response the Director of Finance and Commercial Development advised that this requirement was being investigated further and was hopeful that the number of days could be reduced to 7. It was recognised that 2 weeks medication added an extra cost burden to both the CCG and the trust.

The Director of Finance and Commercial Development advised that he hoped to have a quarterly paper that would come to the committee setting out the trust performance against the contract and any potential risks.

The Committee noted the status of the Commissioner Contract 2014/15.

Corporate Performance Report (Board paper of 26 March 2014)– FSC/14/18

The Chief Operating Officer presented the corporate performance report that went to the Board in March 2014. He advised that at the Board he was asked to present the performance by exception, however he felt that in doing this the Board did not receive the full details on how certain services were continuing to outperform national and local targets in the provision of quality healthcare and felt that staff should be recognised for the work they were doing in supporting the delivery of the targets.

The Chief Operating Officer ran through the report highlighting each services performance.

With regard to A&E the Chief Operating Officer advised that there was only a very small group of acute trusts delivering the 4 hour target. He advised that staff had been looking at different ways of delivering the service which had supported the delivery of AED's performance. The Chief Operating Officer reported that from 7th to 13th May the trust would be undertaking the Perfect Week initiative and advised that the aim of the week was a focus on achieving the best possible operational performance in order to provide the best possible outcomes for the trusts patients through the transition from admission to discharge. This initiative was being supported by all stakeholders and community providers and a full presentation on what was being envisaged would be presented to the Board at its April meeting.

The Chair, referring to A&E asked for an update on workforce moral. In response the Chief Operating Officer reported that generally this was improving although there was a need to improve on quality and the emphasis surrounding it. He advised that security of staff issues were being addressed which was sometimes seen as a moral issue which included better such things as closer staff parking for night shift staff. One area that has impacted on the staff moral had been the implementation of the Symphony system. The Chief Operating Officer advised that when the system went down due to technical problems, staff had to revert back to a paper system until it was back up again. Once the system was up and running there was an added complication and resource issue as the paper data had to be entered onto the system.

Rory Adam asked why the trust was performing against the 4 hour A&E target when other trusts weren't. In response the Chief Operating Officer advised that there was an argument that consistency was a factor. The staff in A&E have been in place for a long period of time and this would almost certainly support better delivery of service. He also felt that there was a culture and ownership within the department that seeks to manage patients' pathway and this only comes with having a stable workforce.

With regard to 18 week referral to treatment, the Chief Operating Officer reported that the trust had for the 6th year in a row delivered its commitment for access from GP referral to treatment for over 90% of all referrals. He further advised that the trust had seen the second and third phase of the planned transfer of activity across to Halton with Orthopaedics and spines in phase II and the remaining general surgery, Urology, Breast and Gynae in phase III. The Chief Operating Officer advised that this had seen the trust achieving 18 weeks for orthopaedics in January and continuing to receive the highest patient's ratings for quality and service at the Halton site of any hospital across the North West. The Chief Operating Officer advised that this had been achieved with the considerable hard work from all the trust's staff who had worked in a unified way to deliver the best outcomes and service for all of the trust's elective patients.

The Chief Operating Officer reported on the continued high performance within the trust's cancer services, which was one of the highest performing serve in the north west. He advised that this year saw the introduction of a new local rule on allocation of breaches at day 42 on a pathway. This had seen most hospital trusts failing at least one of the national access targets. Staff within the trust's cancer services had worked incredibly hard to manage, amend, support and seek changes at other hospitals in order to continue to deliver the commitment and target.

The Committee reviewed the remainder of the Corporate Performance Report which was noted.

Business and Commercial Development Update – FSC/14/19

The Director of Finance and Commercial Development presented the Business & Commercial Development Report which was taken as read.

With regard to the development of the trust strategy the Director of Finance and Commercial Development reported that this was on target to be completed in time for submission at the end of June 2014. He advised that as part of the development of the strategy the Board would be undertaking Monitors strategy toolkit at the next Board workshop which would help to develop the Board's effectiveness in delivering a 5 year strategic plan. The Director of Finance and Commercial Development advised that developing the 5 year plan would be a challenge given the Commissioners plan to develop 8 hubs in Warrington that would, if successful impact on a number of services provided by the trust. The Chief operating Officer supported this view and advised that the trust did not feature in the higher levels within the local health economy referring to the Health and Well Being Board at which the trust was not a member and felt this had a bearing on the Commissioners views regarding the impact of services provided by the trust. The Committee noted that if the implementation of hubs were successful there would have to be a resultant downsizing in trust services. The Committee further noted that the Commissioners were looking to have them in place with the next 18months which did not seem feasible given the scale of the project. Given the concerns regarding the impact to the trust the Committee recognised the importance of putting in place Board to Board workshops with the Commissioners so that the concerns of the trust can be aired.

The Director of Finance and Commercial Development referred the Committee to the section 'Developing' and reported that the team was reviewing all possible tenders and AQP's to

ensure that due diligence is applied to each bid process to support the development of sustainable commercial opportunities for the trust. The Director of Finance and Commercial Development advised that the team was supporting both Orthopaedics and Children's Surgery in developing business plans to attract new business from within existing and emerging markets. These business plans, once developed, would be presented at Divisional Bi-lateral meetings for approval and reported to the committee for ratification.

The Director of Finance and Commercial Development advised that the trust was actively pursuing a formal partnership with Widnes based GP Consortium *Platform 7*. The partnership would provide community based ENT services in Widnes with a view to submitting a joint bid for a Halton-wide community ENT service that was being put to AQP by Halton commissioners. The Director of Finance and Commercial Development reported that *Platform 7* represented seven of the eight GP practices in Widnes and as such was a highly influential consortium. He felt that by entering into partnership with *Platform 7* on services where they have aspirations to develop local service provision the Trust would be able to generate reciprocal benefit in other areas and thereby improve market share in Widnes.

With regard to the section on 'Delivery', the Director of Finance and Commercial Development advised that a suite of commercial reports are being developed that would support a Commercial Development dashboard. He reported that the dashboard would be an integral part of the Commercial functions reporting to the Committee in the future and would provide at a glance, an indication of the impact of Commercial Development schemes on the trust's financial position.

The Chair asked whether the Board would have opportunity to discuss in detail the longer terms plans, recognising that it had not had as much opportunity to do so when with the 2 year operational plan. In response the Director of Finance and Commercial Development felt that it would be appropriate that this was the case and felt that when the Board undertook the Strategy Toolkit workshop this would be identified in the outcomes. The Trust Secretary was asked to note that it would be appropriate to hold a workshop on the development of a 5-10 year plan.

The Committee noted the contents of the Business & Commercial Development Report. The Committee felt that it was important that the a Board to Board workshop with the Commissioners was put in place before the Board was required to approve the 5 year strategic plan.

External Auditor Appointment – FSC/14/20

The Director of Finance and Commercial Development reported that the term of office of PwC the external auditor was due to expire on 1 October 2014. He explained that under the terms of their appointment in 2011, they were appointed by the Council of Governors for three years with an option to extend the term for up to an addition period of two years, subject to the approval of the Council of Governors.

Rory Adam advised that this matter would be brought up at the Audit Committee in May to seek approval to extend. Subject to getting that approval the matter would be raised with the

Council of Governors through the Monitor Quarterly Reporting Compliance Committee and thereafter the full Council.

Review of Minutes of Reporting Committees/Groups – FSC/14/21

i. Innovation and Cost Improvement Committee: the Committee received and noted the minutes of the ICIC of 21 March 2014.
ii. Capital Planning Group: the Committee received and noted the minutes of the Capital Planning Group of 5 March 2014.
iii. KPI Group: The Chief Operating Officer and Deputy Chief Executive presented the notes of the meeting of the KPI Group which were noted. It was recognised that the KPI Group was not a constituted committee and was to provide the Chief Operating Officer with updates on the operation aspects of the KPIs. Consideration would be given on whether the KPI Group should be a fully constituted group or remain an operational group.
iv. IM&T Steering Committee: the Chair noted that the minutes were not available and that the Director of IM&T was not present to provide an update. She asked that for the next meeting the Director of IM&T provide an update on the current status of the IM&T Strategy.
v. Estates Strategy Group: The Director of Finance and Commercial Development reported that this committee had not met for some time. He advised that now that the Board was in the process of approving the estates strategy it would be resurrected with improved terms of reference that would be fit for purpose in moving the estates strategy forward. The Director of Finance and Commercial Development advised that he would present new terms of reference of the group at the May meeting.

Any Other Business – FSC/14/22

24 There being no further business the Chair closed the meeting.

Warrington and Halton Hospitals NHS
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W&HHFT/TB/14/112

BOARD OF DIRECTORS

Paper Title	**Any Other Business**
Date of Meeting	25th June 2014