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

Wednesday 24th February 2016, time 1300-16.05
Conference Room, Warrington Hospital

13.00	16/046	Welcome, Apologies & Declarations of Interest		Chairman
13.02 10 mins	16/047	Staff story		Director of Nursing & Governance
13.12 5 mins	16/048	Minutes of the previous meeting held on 27th January 2016	Paper	Chairman
13.17 3 mins	16/049	Action plan	Paper	Chairman
13.20 10 mins	16/050	Chief Executive's Report	Verbal	Chairman
13.30 10 mins	16/051	Chairman's Report	Paper	Chief Executive

Sustainability

13.40 10 mins	16/052	Report from the Chair of the Finance and Sustainability Committee including approved minutes from 20 January 2016 Report for the Chair of the Audit Committee including draft minutes form the meeting on 2 February 2016	Paper Paper	Terry Atherton, Non-Executive Director Ian Jones, Non-Executive Director
13.50 20 mins	16/053	Finance Report – as at 31 January 2016	Paper	Director of Finance and Commercial Development
14.10 20 mins	16/054	Cost improvement plan report – as at 31 January 2016	Paper	Director of Transformation
14.30 20 mins	16/055	Corporate Performance Report – as at 31 January 2016	Paper	Chief Operating Officer
1450	Break			

Quality

15.00 10 mins	16/056	Report from the Chair of the Quality Committee including minutes of the meeting on 5 January 2016	Paper	Lynne Lobley, Non-Executive Director
15.10 20 mins	16/057	Quality Dashboard – as at 31 January 2016	Paper	Director of Nursing and Governance
15.30 20 mins	16/058	Q3 Complaints report	Paper	Director of Nursing & Governance

People

15.50 5 mins	16/059	Report from the Chair of the Strategic People Committee	Verbal	Anita Wainwright, Non-Executive Director
15.55 10 mins	16/060	Workforce and Educational Development Key Performance Indicators – 31 January 2016	Paper	Director of HR & OD
16.05	16/061	Any Other Business	Verbal	Chairman

Date of next meeting: Wednesday 30 March 2016

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Warrington and Halton Hospitals NHS Foundation Trust
Minutes of the Board of Directors meeting held in public on Wednesday 27th January 2016
Trust Conference Room, Warrington Hospital

Present:

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

In Attendance:

Andy Chittenden	Interim Trust Secretary
Andrea Chadwick	Designate Director of Finance and Commercial Development
Jan Ross	Deputy Chief Operating Officer (Item 16/009)
Lucy Gardner	Designate Director of Transformation
Mary's family	Patient story only

Apologies

There were none.

1	**16/015 – Welcome, apologies & declaration of interest** The Chair opened the meeting and welcomed those attending the meeting. Apologies: as above. Declarations of Interest: there were none.
2 *3*	**16/016 - Patient story** *Mary's family joined the meeting.* Mary's family explained to the Board their own experience when their loved one had been an inpatient at the Trust prior to and at the time of her death. They explained to the Board how they had found the experience very difficult. They had found Mary's care and treatment to be much less good than they expected and to be lacking in the compassion that they would expect. They explained how the way the Trust responded to their initial complaint after Mary's death had not satisfied them at all. They had felt that they had to get the Trust to listen harder to their complaint before the Trust properly responded.

4	The Trust had responded since, with a deeper investigation into Mary's care. This had included the ways in which the Trust had worked with the family since Mary's death. The Trust Chair apologised to Mary's family on behalf of the Board and the Trust. He invited Mary's family to return to meet with directors in six months' time so that the Trust could confirm to them how it had listened and changed. *Mary's family left the meeting.* *Actions* *The Quality Committee to assure itself of the learning and improvement made to the service.* *Directors to meet with Mary's family in July 2016 to discuss the Trust's response.*
5	**16/017 - Minutes of Meeting** The minutes of the meeting held on the 25th November 2015 were approved as a true and accurate record of the meeting.
6	**16/018 - Action Plan** All actions were either ongoing or discharged.
7	**16/020 - Chief Executive Report** Copies of recent regulatory correspondence had been provided to the Board, including a letter from NHS Improvement re the '15-16 outturn and 16-17 planning (15 January 16) and a letter jointly from NHS Improvement & CQC re regulatory collaboration (15 January 16). And a third letter from Monitor re agency frameworks and caps (15 January 16). These complemented Monitor's planning guidance for 16-17 (issued 23 December). The planning guidance had been issued system-wide (as opposed to commissioners alone) and identified the prioritisation of two key plans for the NHS: i. A five year sustainability and transformation plan (this 'STP' to be resultant from local system based plans), and ii. A single year operational plan 16-17, to be organisation based, but consistent with the emergent STP. iii.
8	The planning guidance had identified nine '*must dos*' for every local system. These are: 1. Develop a high quality and agreed STP 2. Return the system to aggregate financial balance 3. Develop a plan to address sustainability and quality of general practice 4. Get back on track with access standards for A&E and ambulance waits 5. Improve performance against 18 week targets for non-emergency pathways 6. Deliver the 62 day cancer waiting target 7. Achieve two new mental health access standards 8. Deliver plans to transform care for people with learning disabilities 9. Develop and implement an affordable plan for quality improvements, including publishing avoidable mortality rates by individual Trust.
9	The Trust's operational plan must be submitted in draft by 8 February, and in final form by 11 April, when it must be aligned with contracts. The sustainability and transformation plan for a wider footprint must be submitted by the end of June.

	The local discussions amongst neighbours in the mid Mersey and Liverpool city regions were described, and the roles the Trust plays in both health economies were clear. The CEO, Chair and Medical Director had recently met again with opposite numbers at St Helens and Knowsley NHS FT to discuss collaboration.
10	Correspondence from NHS Improvement had provided an opportunity until 8 February 16 to accept sustainability and transformation funding for 16-17 of £8.0M with two provisos. The first would be a commitment to plan to and achieve a deficit in 16-17 of no more than £4.4M (the 'control total'). The second would be to accept that any negative deviation from the Trust's declared forecast outturn of £14.2M for 15-16 would be deducted from the sustainability and transformation funding in 16-17.
11	*Resolution.* *The Board resolved to communicate its acceptance to Monitor before 8 February of the offer of £8M sustainability and transformation funding.*
12	Health Education North West General Medical Council enhanced monitoring annual assessment visit During their recent visit, inspectors had engaged with a wide variety of staff, including Executives, consultants, Education Centre colleagues and trainees (upto 200 of which might be working with the Trust at any time). Initial verbal feedback confirmed aspects of good practice and posed some challenges for further improvement.
13	16/019 – Chairman's Report The Chair thanked those who had prepared for further industrial action by junior doctors, the threat of which remained.
14	The Chair reminded the Board of the complex planning landscape external to the Trust and the importance for the Board in balancing its focus on internal operational challenges with the strategic horizon. As a result, the Board would be holding three workshops at which strategic discussions could be developed, during March, April and May.
15	16/021 – Report from the Chair of the Finance and Sustainability Committee including draft minutes from 16/12/15 The FSC Chair escalated to the Board the committee's concern that it had been unable to review the month 9 financial position satisfactorily when it met on 20 January. This was attributed to uncertainty in reporting activity, linked to the Trust's implementation of Lorenzo patient administration system in November 15.
16	The Board had met privately earlier on 27 January to discuss the availability and quality of financial data, the cost improvement plan position in year, assumptions made in the absence of high quality data and the difficulty in providing activity data to commissioners to substantiate payment for contracted activity.
17	The Board had reviewed the risks relating to three schemes in particular and was concerned that the full £10.326M would not be achieved in full. However, management assurances had been sought and received that Q4 would deliver the intended order of cost improvement and that any shortfall would be minor.
18	16/022 – Finance - Finance Report as at 31 December 2015 The Board reviewed the month 9 summary financial position and year end outturn forecast in three slides:

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Financial Position at Month 9

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Indicator	Monthly Plan £m	Monthly Actual £m	Monthly Variance £m	YTD Plan £m	YTD Actual £m	YTD Variance £m
Operating income	17.8	17.4	(0.4)	160.3	163.4	**3.1**
Operating expenses	(17.9)	(18.9)	(1.0)	(163.0)	(170.1)	**(7.1)**
EBITDA	(0.2)	(1.5)	(1.3)	(2.7)	(6.7)	**(4.0)**
Non-operating income and expenses	(1.0)	(1.0)	0.0	(8.4)	(8.3)	**0.1**
I&E surplus / (deficit)	(1.2)	(2.5)	(1.3)	(11.1)	(15.0)	**(3.9)**
Cash balance	-	-	-	2.2	2.8	0.6

Issues in December:

- Some clinical contract income reduced in-month, though still above plan year to date
- Pay expenditure c.£503K worse than expected (after adjusting for direct supported spend e.g. Lorenzo, UCC etc.)

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Forecast Financial Position

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Narrative	£m
Forecast deficit as at 31st December 2015	(19.9)
Capital to Revenue transfer	2.5
Cost reduction opportunities	1.0
Revised deficit as at 31st December 2015	(16.4)

The position remains extremely challenging, so it is important the trust focuses on the financial risks to ensure the deficit is reduced as much as possible, namely:

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

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Summary

Warrington and Halton Hospitals NHS
NHS Foundation Trust

- Position to 31 December 2016 is £3.9M off plan at £15.0M deficit
- Mitigations of £2.6M have been put in place, £3.5M by year end
- Current forecast (after £3.5M of mitigations) is £16.4M deficit, which is £2.2M away from target deficit
- Additional actions being considered/required to improve the position, but risks need to be managed

21 The Board considered the forecast year end outturn deficit of £16.4M in relation to the planned deficit of £14.2M. The letter from the CEO to Monitor on 18 January had indicated a year end outturn deficit in the range £15-£17M. This was net of a £2.5M capital to revenue transfer. NHS Improvement has connected any worsening position in the year end outturn below £14.2M with a reduction of equal value to the £8.0M sustainability and transformation funding offered for 16-17. These

22 Management assurances were sought and provided that the Executive had reviewed and put in place actions to address all areas covered in Monitor's *turnaround checklist*. Further assurances were sought and provided that the Trust's services and estate would not suffer deleteriously on account of a reduction in capital expenditure of £2.5M. Requests would be made within the operational plan for strategic and essential capital allocation requests to allow reprioritisation of capital in 16-17.

23 A series of staff engagement workshops would be planned for the spring to engage staff more deeply in the 16-17 cost improvement plans. The FSC committee would review further assurances at its February meeting of the financial position, forecast outturn and the governance supporting cost improvement planning for 16-17.

24 **16/023 - Corporate Performance Report as at 31 December 2015**

It had not been possible to circulate the corporate performance report prior to the meeting. The report was tabled. Data quality was low for a range of indicators which depend upon the patient administration system Lorenzo for data reporting, following *go live* in November 2015.

25 The Trust has been performing below its planned level against the A&E 4 hour waiting time target. Performance was worse in month 9 (84.3%) compared to the whole of quarter 3 (87.3%) and lower than in quarter 2 (92.9%). The Board had met privately earlier in the day to seek and receive assurance as to the improvement plans being made and executed.

26 The 18 week referral to treatment time targets had been met, although data returns had, by agreement, been later than planned. Ambulance turnaround times have been slower than planned. Diagnostics performance has been below plan. Cancer performance is at planned levels. There were no cases of *C.difficile* in December.

	Jan Ross joined the meeting.
27	The Trust has struggled to improve on its discharge performance. Too many patients remain in hospital too long after the point at which they are medically fit for discharge. As a result, performance statistics for delayed transfers of care are lower than planned. Management assurances were sought and provided that all aspects of discharge are under review. The *Living Well action* plan to improve four hour performance and patient flow is under continual review. It is shared with health economy stakeholders and advice sought on its further development. An example of health economy collaboration was explained by the forthcoming *MADE* event (multi-disciplinary accelerated discharge event).
28	The Board recognised that more remains to be done to stabilise performance at the required levels and to raise confidence in the service. *Jan Ross left the meeting*
29	**16/024 - Risk and assurance** The summary corporate risk register and Board assurance framework were reviewed. The Board noted that the totality of risk faced by the Trust had increased during the past quarter. Achievement of each of the four corporate objectives is jeopardised by one risk scored at 20 or 25. The sum of mitigating actions to control the risks were deemed to be insufficient to reduce the risk to a level the Board found acceptable. As a response, the Board determined to allocate additional time in workshops in March, April and May to develop and prioritise options that would deliver a step change in medium to long term performance.
30	The Board recognised that there were opportunities to reconcile the assurance framework more closely with high scoring risks in the corporate risk register.
31	**16/025 - Monitor quarterly reporting: Q3 governance statement** The Board considered the quarterly governance return to Monitor. In the light of the Trust's financial performance and challenges in some areas of operational performance the Board reolved to submit declarations as follows: *Cannot confirm* the Board anticipates maintaining a risk rating for finance of at least 3 over the next 12 months; *Confirms* that is anticipates that the Trust's capital expenditure for the remainder of the financial year will not materially differ from the revised forecast; *Cannot confirm* that plans are in place are sufficient to ensure ongoing compliance with all existing targets. Exception reports were to be provided in relation to A & E performance and Lorenzo data quality. It was confirmed that at present no major concerns of the CQC have been communicated to the Trust.
32	**16/026 – IM&T Strategy** A brief presentation was provided to the Board, setting out options for further refining the IM& T strategy over the medium term. The context for review of the IM & T strategy was the *go live* of the Lorenzo patient administration system in November 2016 and the consolidation of the system since that date.
33	The Board was eager to implement as many technical features as the availability of limited capital will allow. The Board wanted more understanding of how well the recent introduction of Lorenzo has

	translated into patient benefits. This will be tracked through the Board's (Lorenzo implementation) Overview Group and assurance provided to the FSC. The roll out of further technical advances had strong support from the Medical Director and Director of Nursing & Governance.
34	The Board was supportive of the direction of travel described by the strategy. It sought more information, and approval on a business case by business case basis for each of the planned steps in implementing new modules (such as EDRM, EPMA).
35	16/027 - Report from the Chair of the Quality Committee including approved minutes from 03/11/15 The committee chair summarised the work of the committee at its most recent meeting. No items were escalated to the Board.
36	16/028 - Quality Dashboard as at 31 December 2015 The quality of some data reported in the dashboard has reduced since the Lorenzo system went live in November 2016. Management assurances were sought and provided that progress is being made in stabilising the system and that data quality will be improved in the short term.
37	It was reported that in respect of indicators with poor data quality, the CCG will assume the Trust continues to be performing in line with performance as at the point in time when Lorenzo went live. The implication is that, whilst data quality remains low against some poorly performing metrics, there could be contractual penalties levied.
38	Overall, the month 9 quality dashboard confirms good performance in many areas. These include the patient experience metrics (example – reduction in two consecutive quarters for the incidence of patient falls, and the lowest number in December 15 for many months).
39	The Board welcomed the continued reduction in pressure ulcer incidence (examples – no Grade 3 or 4 pressure ulcers reported since quarter 1, 2015-16 and since 2011 respectively). The incidence of Grade 2 pressure ulcers continues to fall. Half of the Trust's front line staff have now received dementia awareness training.
40	The Trust is currently recruiting a new non-executive director ('NED'). The intention is that the new NED will play a role in the Quality Committee and, as a part of that committee, seek particular assurances as to the Trust's responsive and compassionate engagement with its patients and their families.
41	16/029 – Self-assessment using NHS England mortality toolkit In accordance with NHS England's requirements, the Trust had completed and would make a data return by the end of the month relating to mortality.
42	Two papers were tabled to complement the report provided within the Board pack. To add to the data which the Board already receives by way of HSMR and SHMI mortality indices, raw mortality data is also being evaluated by the Trust.
43	Collectively, as at 27 January 16, the Trust's mortality performance data can be summarised as: - Summary-level hospital mortality index (SHMI) to end June 15 is *'114 (higher than expected compared to peers)';* whilst to September 15 it is *'113 (higher than expected compared to peers)'.*

	- Hospital standardised mortality ratio ('HSMR') as published on *healthcare evaluation data* to October 15; *'106 (as expected after adjustment for the for the Trust's case-mix, but the 41st least good ranking of English acute care providers)'.* - The Trust's raw mortality weekly update as at 27 January 16: *90 deaths between 1-26 January (compared to 129 for the whole of January 15); and 878 deaths in the period 1 April 15 to 26 January 16 compared to 954 deaths for the whole of the 14-15 financial year).*
44	The Board noted that no single statistic or trend provided a full picture. There is more work to be done to improve mortality performance. NHS England's toolkit when applied to the Trust's performance, suggested that the Trust could identify approximately 30 additional opportunities for investigation and learning from mortality review and incident reporting each year. Some of these cases could be cases where mortality was avoidable.
45	Management assurances were sought and provided that a mortality review group is in operation and has adopted best practice guidance. There is a programme of clinical governance activity which aims to increase safety and clinical effectiveness. The Board seeks its confidence in the effective design and operation of controls over clinical governance through the Quality Committee. The Clinical Effectiveness sub-committee in particular has an overview of mortality and incident reporting. It reports to the Quality Committee by exception, as well as providing minutes to the Safety Committee for information. The Mortality Review Group reports to the sub-committee. The report was noted.
46	16/030 – Q3 Infection prevention and control report The Board was pleased to note that in quarter three, there were no cases of MRSA bacteraemia infection. There were five cases of *C. difficile* infection each of which is under review with the CCG to determine if they were due to lapses in care within the Trust or if they were acquired in the community prior to admission. No cases of *C. difficile* are yet known to have been acquired through lapses in care within the hospital during Q3.
47	Management assurances were sought and provided that action plans to reduce the incidence of healthcare acquired infections by these and other organisms. The report was noted.
48	16/031 - Report from the Chair of the Strategic People Committee, including draft minutes Strategic People Committee on 07/12/15 The committee chair summarised the work of the committee at its most recent meeting. Management assurances had been sought and provided that contingency plans were in place to provide high quality patient care amidst temporary disruption caused by junior doctors.
49	The committee chair explained to the Board that following a recent self-assessment review of its own performance, the committee wished to refocus on the acquisition and scrutiny of assurance that systems of internal control (in relation to people) were well designed and operating effectively. On account of this, management had determined to establish an operational HR/OD leadership meeting ('Operational People Group') at which management would be held to account by the Executive.
50	16/032 - Workforce and Educational Development Key Performance Indicators as at 31 December 2015

	The Trust closed its consultation on its proposed *clinical business unit* ('CBU') structure at the end of 2015. The final structure to be implemented has been communicated. The Trust has recognised that a corporate services review will be required to complement the new CBU structure.
51	HR key performance indicators were reviewed. Whilst above the Trust's performance in 14-15, the attendance trend has worsened throughout the past six months and is now only in line with (not better than) regional peers.
52	Indicators for staff churn, annual leave are *amber.* It was stated that challenges in unscheduled care are disproportionate and that the operational people committee (referred to in the minute above) will focus on improving performance.
53	**16/033 - Monthly Ward Staffing Report as at 31 December 2015** The staffing report indicated a variety of challenges across clinical areas continue to place services under pressure. Management assurances were sought and provided that operational teams have effective control systems in place to detect instances of potentially unsafe staffing and that escalation mechanisms work effectively. Additional controls over staffing risks are planned to be introduced. These include e-rostering software (subject to business case approval) and workforce staff mix planning software, which will inform workforce planning (for which the Trust has recently been awarded external funding to implement).
54	The newly constituted Operational People Group will make an early priority to review staffing effectiveness.
55	**16/034 - Charitable Funds Committee** <u>Draft Minutes from 03/12/15 (draft)</u> The minutes were approved as a true and accurate record. <u>Terms of Reference</u> The terms of reference were approved as amended. <u>Approval of the Charitable Funds Annual Report and Accounts 2014-15</u> The Board satisfied itself that the auditor's report did not alert them to any matters concerning the adequacy of internal controls. The Board approved the annual report and accounts for the charity for the year 2014-15.
56	**16/035 - Any Other Business** The Board recorded its thanks to the Head of Midwifery, Mel Hudson who will be moving on to a new role at another Trust. **Next Meeting: Wednesday 24th February 2016 in the Trust Conference Room.**

After the meeting closed, the Board invited comments from the Governors who had observed the meeting.

16/049

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

Meeting date	Minute Reference	Action	Responsibility & Target Dates	Status
27 January 2016	16/16	With regard to a Patient story, the Quality Committee to assure itself of the learning and improvement made to the service. Directors to meet with Mary's family in July 2016 to discuss the Trust's response.	DoN&G. Directors to meet family	Proposed: an informal session for NEDs with DoN&G in March to share understanding of the complaints and investigations process. Q3 complaints report in Feb 16 Board pack sets out proposed actions, including peer review.
29 July 2015	15/164	Trust Secretary to arrange a workshop with the Board and the Communications team to allow additional understanding on the Communication strategy presented	Trust Secretary	Proposed for March 4 Board time out.

BOARD OF DIRECTORS

16/050

SUBJECT:	Chief Executive Report
DATE OF MEETING:	24 January 2016
EXECUTIVE DIRECTOR:	Chief Executive

A verbal report will be provided to the Board.

A letter from NHS Improvement on transformation and sustainability follows.

To: CCG Accountable Officers,
Chief Executives of NHS trusts,
NHS foundation trusts and Local
Authorities and LETB Geographical
Directors

By email

16 February 2016

Dear colleague

Re: Developing Sustainability and Transformation Plans to 2020/21

The NHS Shared Planning Guidance asked every health and care system to come together to create their own ambitious local blueprint for accelerating implementation of the Five Year Forward View (5YFV). Sustainability and Transformation Plans (STPs) will be place-based, multi-year plans built around the needs of local populations. They will help ensure that the investment secured in the Spending Review does not just prop up individual institutions for another year, but is used to drive a genuine and sustainable transformation in patient experience and health outcomes over the longer-term. STPs are not an end in themselves, but a means to build and strengthen local relationships, enabling a shared understanding of where we are now, our ambition for 2020 and the concrete steps needed to get us there.

We have been encouraged by the speed and enthusiasm with which most areas have already come together to agree their footprints and start the conversations. The boundaries used for STPs will not cover all planning eventualities. As with the current arrangements for planning and delivery, there are layers of plans which sit above and below STPs, with shared links and dependencies. For example, neighbouring STP areas will need to work together when planning specialised or ambulance services or working with multiple local government authorities and, for areas within a proposed devolution footprint that cross STP boundaries, further discussion will be required in working through the implications. Other issues will be best planned at Clinical Commissioning Group (CCG) level.

If we get this right, then together we will:

- engage patients, staff and communities from the start, developing priorities through the eyes of those who use and pay for the NHS;
- develop services that reflect the needs of patients and improve outcomes by 2020/21 and, in doing so, help close the three gaps across the health and care system that were highlighted in the 5YFV (health and wellbeing, care and quality, and finance and efficiency);
- mobilise local energy and enthusiasm around place-based systems of health and care, and develop the partnerships, governance and capacity to deliver;
- provide a better way of spreading and connecting successful local initiatives, providing a platform for investment from the Sustainability and Transformation Fund; and

- develop a coherent national picture that will help national bodies support what local areas are trying to achieve.

This will require a different type of planning process – one that releases energy and ambition and that focusses the right conversations and decisions. It will require the NHS, at both the local and national level, to work in partnership across organisational boundaries and sectors.

This letter sets out our initial thinking on STPs – please see **Annex A** for further detail. We recognise that you and your teams are also working hard on operational plans, so over the next few weeks and months we will develop an active programme of support for our local and national teams, based on what you tell us you need.

We look forward to continuing to work closely with you to deliver this important work.

Yours faithfully

David Behan, Chief Executive, Care Quality Commission
Ian Cumming, Chief Executive, Health Education England
Sir Andrew Dillon, Chief Executive, National Institute for Health and Care Excellence
Jim Mackey, Chief Executive - Designate, NHS Improvement
Duncan Selbie, Chief Executive, Public Health England
Simon Stevens, Chief Executive, NHS England

Annex A

Stage 1: Before Easter – developing local leadership and collaboration

1. To have a realistic prospect of developing good plans by the summer, we will need to have agreed three things for each of the STP footprints by Easter:

   (i) the governance arrangements and processes needed to produce an agreed STP and then to implement it;
   (ii) the scale of the challenge locally for each of the three gaps; and
   (iii) key priorities identified to address each gap.

2. **Governance arrangements**: Building the relationships and collective leadership needed to make STPs real will take dedicated time, effort and resource. Different areas will be at different starting points. In some areas, local leaders are already working together on established transformation projects. In other areas, relationships and strategies are less mature, requiring intensive focus in the early stages.

3. Each footprint will need to set out governance arrangements for agreeing and implementing a plan. This should include the nomination of a named person who will be responsible for overseeing and coordinating their STP process – a senior and credible leader who can command the trust and confidence of the system, such as a CCG Chief Officer, a provider Chief Executive or a Local Authority Chief Executive. They will be responsible for convening and chairing system-wide meetings and facilitating open and honest conversations that will be necessary to secure sign-up to a shared vision and plan. We would expect to see time and resource dedicated to this system leadership role.

4. STPs will need to be developed with, and based on the needs of, local patients and communities and command the support of clinicians, staff and wider partners. We therefore anticipate robust plans for genuine engagement as part of the decision making process. This doesn't mean beginning from scratch. Where relevant, areas should build on existing engagement through Health and Wellbeing Boards and other existing local arrangements. Health Education England has agreed that they will establish a local Workforce Advisory Board to coordinate and support the workforce requirements for each STP footprint.

5. **The scale of the challenge:** Partners in each footprint area will need to quickly get a sense of the scale of the forecast challenge in their local area, by working out the extent of the three gaps. To accelerate this process, we will provide a method with data to enable local partners to diagnose current and projected gaps in health and wellbeing, care and quality and finance and efficiency, including current and expected delivery on key service priorities such as cancer and seven day services. We will publish more detail on this during the week commencing 29 **February 2016**.

6. **Identify key priorities:** An assessment of the three gaps, alongside a consideration of local challenges where patients and populations need to see most improvement, will help each area to identify the key priorities they need to tackle over the next five

years to achieve sustainable transformation. Where, for example, Vanguards and Integrated Care Pioneers are leading the transition to new care models, local leaders will want to set out how the learning from these can be applied in the coming years.

7. There is clearly a lot to do in a short space of time. To help support local and national learning, each footprint will be asked to attend one of four regional 'development days' to share their emerging thinking with one other and with the Chief Executives of the national bodies. This will help us to identify further areas for support and shape the next stage of the process. Ahead of these regional 'development days' we will ask each planning footprint to make a short return on the above three issues (governance, gap analysis and key issues).

8. **National support until Easter:** By March, we will provide each local system with:

   - **Input into assessing each of their three gaps** – this will set out the key health and well-being outcomes the NHS and partners need to improve by preventing illness, diagnosing disease earlier and treating it more effectively; the quality improvement and service change priorities by 2020, such as moving to seven day services and (by the end of March) provide each area with analytical support to help assess its financial gap.
   - **Share information and provide support –** based on what you tell us you need and using some of the tools that Vanguards and other collaborations have found useful as they have developed new systems and relationships. This will include using logic models as a basis for longer-term planning, and information about the core components of the different care models (e.g. multi-speciality community providers (MCPs) and primary and acute care systems (PACS) or devolved arrangements).
   - **Publish advice on engaging individuals, communities and staff** – drawing on exemplar practice from the service and partners and the 'six principles' developed by the People and Communities 5YFV Board.

   In addition we will:

   - ask our regional teams and partners to support the process of building local leadership and effective decision-making, sharing what we've learned from working with, for example, Vanguard sites and others through communities of practice;
   - work with you to identify and enlist a group of respected individuals who have the experience and credibility to mentor and catalyse system leadership where it is needed. This could include people with experience of health leadership roles, as well as local government and the voluntary sector. We will make this offer to all local areas that would benefit from individual support to accelerate progress; and
   - share some further tools, templates and guidance along with some exemplars to support local development of returns. For example we will work quickly with a small number of leading systems as they develop their plans to provide models for what good Easter returns and June plans look like and make these available to everyone.

Stage 2: after Easter – developing the STP

9. After Easter, local area partners will be able to focus on more of the detail of their plans and the actions required to close the three gaps over the next five years. To do this, they should consider their response to the set of questions outlined in the annex to the Shared Planning Guidance, given the results of their gap analysis and continuing engagement with local communities, staff and other partners.

10. The Shared Planning Guidance sets out nine 'must dos'. Many, if not all, of these will require action beyond 2016/17. A good STP will therefore set out how areas will maintain and deepen the progress they will make by implementing their operational plans. This is one tangible way in which 2016/17 operational plans need to be closely linked to STPs, and conceived as the first steps on the way to wider transformation.

11. Strong STPs will set out a broader platform for transforming local health and care services. We will work with the footprints to help us develop the detailed requirements. However, as a minimum, we expect that all plans will:

    - describe a local cross-partner prevention plan, with particular action on national priorities of obesity and diabetes and locally identified priorities to reduce demand and improve the health of local people;
    - increase investment in the out-of-hospital sector, including considering how to deliver primary care at scale;
    - set out local ambitions to deliver seven day services. In particular: (i) improving access and better integrating 111, minor injuries, urgent care and out-of-hours GP services; (ii) improving access to primary care at weekends and evenings; and (iii) implementing the four priority clinical standards for hospital services every day of the week;
    - support the accelerated delivery of new care models in existing Vanguard sites; or in systems without Vanguards, set out plans for implementing new models of care with partners;
    - set out collective action on quality improvement, particularly where services are rated inadequate or are in special measures;
    - set out collective action on key national clinical priorities such as improving cancer outcomes; increasing investment in mental health services and parity of esteem for mental health patients; transforming learning disabilities services; and improving maternity services;
    - ensuring these and other changes return local systems to financial balance, together with the increased investment that will come on-stream as set out in NHS England's allocations to CCGs; and
    - be underpinned by a strategic commitment to engagement at all levels, informed by the 'six principles'.

12. We must avoid creating distinct plans for each specialty or initiative, and instead grasp the opportunity to achieve greater alignment and coherence between programmes and priorities. Local leaders will also want to ensure that their plans are underpinned by action on the key enablers of change, including harnessing technology and workforce redesign, working closely with their Local Education and

Training Boards (LETBs). Local areas should also have considered the fit between their STP footprint and their local plans for integrated health and social care more broadly, and decided on the high-level model of person-centred, coordinated care that they would look to develop.

13. The aim should be to produce an STP that is based upon strong analysis and insight rather than a glossy brochure. The process of exposing these issues and having real conversations about the potential benefits for patients is as least as important as the final product itself. A robust process will enable STPs to set out the actions that will make a difference for local people rather than abstract principles or vision statements. The examples we publish at Easter will give local areas a better sense of what a good final document looks like, but we are clear that a good process is one that unleashes energy, facilitates real conversations and strengthens local relationships around a shared sense of purpose.

14. **National support after Easter:**

- In April and May, we will host a programme of regional workshops and webinars with subject matter experts to provide practical help with developing plans. We will continue to make available online collaborative tools so that local areas can share information and examples of emerging best practice, based on what you tell us would be most helpful.
- These will be supplemented by a suite of 'how to' materials so that we can develop a shared understanding of what good looks like on topics including implementing the Cancer and Mental Health Taskforce reports, developing and spreading new models of care, workforce redesign and planning for interoperability and digital services.
- Our regional teams and their partners will continue to work closely with local footprints as they develop the detail of their plans, to enable effective communication and learning across the system.

Sustainability and Transformation Funding

15. There will be tangible benefits for areas with good STPs. The Spending Review settlement enabled us to invest £2.139bn in a Sustainability and Transformation Fund in 2016/17. Of this total, £1.8bn of funding has been allocated to the sustainability element of the fund to bring the NHS provider trust sector back to financial balance.

16. Quarterly release of sustainability funds to NHS trusts and NHS foundation trusts will depend on achieving recovery milestones for (i) deficit reduction; (ii) access standards; and (iii) progress on transformation. It is not a case of recovery followed by transformation. They are not alternatives; we must do both simultaneously.

17. Mirroring the conditionality of providers accessing the Sustainability and Transformation Fund, the real terms element of growth in CCG allocations for 2017/18 onwards will be contingent upon the development and sign-off of a robust STP during 2016/17.

18. The Sustainability and Transformation Fund will grow from £2.1bn in 2016/17 to £2.9bn in 2017/18, rising to £3.4bn in 2020/21, with an increasing share of the growing fund being deployed on transformation.

19. The STPs will become the single application and approval process for being accepted onto programmes with transformation funding for 2017/18 onwards. This step is intended to reduce bureaucracy and help with the local join-up of multiple national initiatives.

20. Recognising that different systems are at different starting points, the most credible and compelling STPs will secure the earliest funding. We will assess plans in July, and – as the Shared Planning Guidance sets out – we will consider:

    - the quality of plans, particularly the scale of ambition and track record of progress already made in addressing each of the three gaps. The best plans will have a clear and powerful vision across health, quality and finance, owned by all local partners in the system. They will create coherence across different elements, for example a prevention plan; self-care and patient empowerment; workforce; digital; new models of care; trusts in special measures and finance. They will systematically borrow good practice from other geographies and adopt national frameworks;
    - the reach and quality of the local process, including community and voluntary sector engagement;
    - the strength, maturity and unity of local system leadership and partnerships, with clear governance structures to deliver them;
    - how confident we are that a clear sequence of implementation actions will follow as intended, through defined governance and demonstrable capabilities; and
    - the extent to which systems can already point to tangible, early progress.

21. Part of this process will involve a second series of regional events hosted by the Chief Executives of the national bodies. Taking place in July, these regional summits will be an opportunity to test the plans that local systems have submitted, and agree the actions we will take to deliver them.

22. **Contacts:**

For any queries, please contact the Regional Director from the relevant national body in the first instance or please email england.fiveyearview@nhs.net.

23. **Key Dates:**

What	Who	When
Further engagement and support on gap analysis and STP development	National bodies	Week commencing 29 February 2016
Gap analysis / data developed with each footprint	National bodies / Regional Directors / footprints	Throughout March 2016
Short return, including	Each footprint	11 April 2016

priorities, gap analysis and governance arrangements		
Outline STPs presented	Footprints to attend regional events to discuss emerging plans with peers and national bodies	w/c 22 April 2016
Each footprint area to develop plans and build support with their boards and partners	As set out in local governance arrangements	During April/May/early June 2016
Ongoing engagement and support from national policy experts and teams to support priority development	National policy teams and experts	During April and May 2016
Each footprint to submit their STP	To Regional Directors and then the 5YFV Board of national body Chief Executives	30 June 2016
Series of regional conversations between national teams and footprints	The NHS national body Chief Executives, National Directors, partners and footprints	Throughout July 2016

BOARD OF DIRECTORS

16/051

SUBJECT:	Chair's Report
DATE OF MEETING:	24 February 2016
DIRECTOR:	Chair

A verbal report will be provided to the Board.

BOARD OF DIRECTORS

16/052

SUBJECT:	Report from the Chair of the Finance and Sustainability Committee including: approved minutes from the meeting on 20/01/16
DATE OF MEETING:	24 February 2016
DIRECTOR:	Terry Atherton, Non-Executive Director – Committee Chair

Reports *not* received as agreed in the annual work plan:	Terms of reference review for the committee (Jan 16 to April 16). Service line reporting (Feb 16 to March or April 16) Commercial and business development (Feb 16 to March 16).
Any other relevant items the sub-committee wishes to escalate ?	- Financial position M10 and forecast outturn - Cost improvement 15-16 and forecast outturn - Cost improvement 16-17 plans - Exceptions to operational performance – A&E - Lorenzo implementation

FSC/16/12

FINANCE AND SUSTAINABILITY COMMITTEE

Minutes of Meeting of the Committee held on 20th January 2016

Present

Terry Atherton	Chair
Mel Pickup	Chief Executive
Mark Brearley	Interim Director of Finance and Commercial Development
Jason DaCosta	Director of IT (to Item 16/006(i))
Mark Partington	Interim Director of Transformation
Karen Dawber	Director of Nursing
Sharon Gilligan	Chief Operating Officer
Roger Wilson	Director of Human Resources and OD (to Item 16/001(i))
Simon Constable	Medical Director
Anita Wainwright	Nin-Executive Director

In attendance

Ian Jones	Non-Executive Director
Jan Ross	Deputy Chief Operating Officer
Andy Chittenden	Interim Trust Secretary
Steve Barrow	Deputy Director of Finance
Pat McLaren	Director of Community Engagement

Apologies:

Jan Ross	Deputy Chief Operating Officer
Lynne Lobley	Non-Executive Director

	Apologies and Declarations of Interest – 16/001
1	Apologies: As above
2	Declarations: None
3	**Attendance Record & FSC Work Plan – 16/002** The next review of the Board's assurance framework will be carried out at the March 16 meeting. The next review of the committee's terms of reference will also be carried through to that meeting, or the April meeting, dependent upon the work that the committee needs to undertake as a result of enforcement undertakings.
4	**Minutes of meeting & Actions – 16/003** The minutes of meeting of 16th December 2015 were approved.
5	**Matters arising** Star Ward commissioner funding. The Trust has contracted with commissioners for 15 beds to be available to the end of February. Beyond that date, further patient care would be chargeable. It was confirmed that not all activity had been invoiced as yet but that appropriate assurance had been provided that activity would be charged.
6	**Corporate Performance Report as at 30th November 2015 16/004(i)**

	(A three x A4 spreadsheet on cancer performance was tabled). Since the Lorenzo *go live* in November 15, the Trust has struggled to report cancer performance with satisfactory data quality assurance. Statutory returns and activity reporting to support commissioner invoicing are being prioritised. Notwithstanding these difficulties, the Trust expects to achieve on target performance for Q3 which will be reported in February.
7	*Referral to treatment target* data will be submitted on 21 February. Performance in T&O is below target (which now includes spine).
8	Six week wait access targets in diagnostics will be confirmed on 21 February but is likely to be missed. Management assurances were sought and provided that additional grip would be brought to bear by the COO.
9	AED performance was 87.5% meeting the 4 hour target, including walk in contribution, during Q3. In Q4 quarter to date, AED performance is 81.5% (unvalidated). On some days attendances have been above 200.
10	Ambulance turnaround times were not available. Since the end of 2015 NEDs have been receiving unvalidated AED data on a next day basis. NEDs have welcomed this, but recognised it as one point of triangulation amongst many and asked for further frequent AED updates to allow NEDs to understand the pressures and performance within AED.
11	**Outliers assessment: A&E; medical assessment; patient flow 16/004(ii)** (A briefing note on outliers was tabled).
12	The committee recognised that patients outlying could be a factor in a poor patient experience as well as a risk factor in poor patient care. Historically the Trust has experienced 50-70 medical outliers routinely and steps have been taken to prevent such a high incidence becoming 'normal'. The Trust's efforts to move to a clinical model that provides a seven day a week service is a critical success factor in improving patient flow and patient experience. Action: Director of Nursing & Governance and the Medical Director to propose to the Quality Committee new indicators of effective clinical practice (examples might be such as care plans existing for every patient; that the care plan is created within a specified time after admission; that the care plan is updated in real time; that the patient is reviewed by a consultant every day; that the patient is reviewed by the relevant specialty; that patients are not moved multiple times during their journey (March 16)).
13	**Waiting list initiative ('WLI') governance arrangements 16/004(iii)** Whilst not all recommendations made by a previous internal audit report had yet been completed, the consensus was that the paper established the Trust's waiting list initiatives as being in line with peers in many but not all services / staff groups; but also as being a valuable tool in some circumstances. With immediate effect, the COO will introduce further controls over approval of WLIs to enhance grip. The Executive Team will discuss further amendments to the system of internal control to implement fairer, more uniform rates of pay across the various service lines.
14	Management assurances were sought and provided that further opportunities for improving efficiency would be sought, and that this would include productivity gains as well as cost

	reductions. Potential productivity gains included collaboration for existing activity with private sector operators which is currently performed elsewhere. Actions: 1. Director of Community Engagement to explore accreditation with private sector providers. 2. A further review of WLI governance to be provided for the committee at the April meeting. COO.
15	Intermediate Care 16/004(iv) The Trust's existing shared pathway for intermediate care does not balance risk and reward well. Whilst the Trust bears the majority of risk associated with the pathway, it has fewer resources and rewards. The committee discussed how it might come to a view on an appropriate governance structure to use to develop the Warrington One Partnership. Such a partnership would be one of three parties playing an equal part in planning and delivering a service, and with a common and equal sharing or risks, costs and income.
16	The committee endorsed the direction of travel and the intention to acquire legal advice from a firm jointly commissioned and paid for by the three proposed participants in the service. The committee recognised that where a service was run by a collaborative effort amongst multiple organisation, Monitor would expect that robust governance arrangements were put in place to protect patients. Such arrangements should anticipate Monitor's interest irrespective of any metrics triggering special declarations, or evidence of investment decisions having been taken on the basis of published regulatory guidance (eg *REID, Transactions Manual)*. The report was noted.
17	Financial Position as at 31st December 2015 - 16/005(i) The implementation of Lorenzo has resulted in a reduced ability to report activity. Such reports are of a lower data quality. Management assurances were sought and provided that Executives are working to improve the effectiveness of Lorenzo reporting tools. The CEO, DoF&CD, DoIM&T and COO meet weekly to review and determine additional actions to be taken.
18	Provisional data for month 9 was tabled. Indicative in- month variance to plan on I & E were £1.338M below plan for the month and £3.960M below plan year to date, giving a year to date position of £15.050M deficit. It was emphasized that these figures were preliminary and not of the usual data quality expected. A higher level of certainty regarding operational expenditure exists that operating income. Month 9 expenditure includes £450k Lorenzo cost and £200k Urgent Care pressures. Under-reporting of outpatient attendances was one of many areas of poor data quality on income.
19	The month 9 position was noted as a worst case position, with improvements in data quality expected to add income. Assumptions and estimates have been made cautiously. The CCG remains supportive. Data for November is due to be frozen on 28 January and there is pressure to agree activity figures which are more accurate by that date.
20	Management assurances were sought and provided that other implementations of Lorenzo have been able to capture full benefits realization, including activity reporting, as planned after *go live*.

	The update was noted and further clarification expected at the Board meeting of 27th.
21	**CIP assurance report 16/005(ii)** A verbal report was provided. At M9, CIP performance for the year to date is £19k short of the budget of £5.454M. The annual CIP programme is heavily weighted to the final quarter with nearly £4.85M due to be achieved in that quarter alone.
22	A specialty by specialty programme is in place to maximise operational activity and to consolidate coding accuracy improvements. However, there is a lack of confidence in delivering planned efficiencies in maternity (£45k); acute *out of hours* team re-organisation (£60k); and medical productivity.
23	The Executive underlined to the committee the risks associated with delivering the full year CIP plan. Due to a lack of data quality, confidence in estimating degree of shortfall is low and a year-end outturn for CIP was estimated at under £10M against a plan of £10.3M.
24	The committee was insufficiently assured and sought a greater level of detail and assurance to be provided at the February meeting. Action The Board to be provided with a paper at its private meeting in January meeting providing upto date assurance on performance against the CIP programme. Trust Secretary.
25	**Pay Controls 16/005(iii)** The paper was noted. Action The FSC committee to review controls over pay, including temporary staffing, including an analysis on the effectiveness of Monitor's agency caps guidance, to the May 16 meeting. DoF&CD.
26	**Contract performance and risk assessment report as at 31st December 2015 16/005(iv)** The report was noted.
	Monitor Regulatory Activity 16/006
27	<u>Turnaround checklist 16/006(i)</u> Following the pre-Christmas performance review meeting between the Trust and Monitor, a checklist had been supplied to the Trust. The PMO, together with the Finance Team and some engagement with the Executive had, under the direction of the Interim Turnaround Director, completed a first draft position in relation to each proposed action. This had been shared with Monitor.
28	Management assurances were sought and provided that the Executive will now undertake a further, more rigourous approach to actions stimulated by the checklist, directed by the incoming Turnaround Director. The full checklist will be shared with the full Board. *Jason DaCosta and Roger Wilson left the meeting.*
29	<u>Outturn reforecast; cashflow; 16/006(ii)</u>

	A letter received from Monitor on 15 January had addressed concerns relating to the 15-16 outturn and access to sustainability funding in 16-17. The committee sought and received management assurances that the opportunities set out at Appendix 4 of the letter for improving the 15-16 outturn were being methodically reviewed and that the Trust would respond to each line in the schedule as a part of the M9 submission.
30	A letter from the CEO to Monitor dated 18 January and a response from Paul Chandler dated 19 January were tabled. These covered, amongst other topics, the proposed capital top revenue transfer of £2.5M. The Trust plans to proceed with such a transfer, pending engagement with Monitor and the Auditors.
31	Two particular risks relating to the 15-16 outturn were brought to the committee's attention. These were the ongoing dialogue with the CCG relating to the contracted activity (including any fines levied connected with under-performance) and the Trust's data quality for activity reporting. Paul Chandler had (in his letter of 19 January) offered to broker talks with the CCG if required.
32	A summary position statement was tabled. The revised year end position was a deficit of £16.4M, being £2.2M worse than the planned deficit of £14.2M, but within the range £15-£17M identified for Monitor in the CEO's letter of 18 January to Monitor. The report was noted. *Simon Constable left the meeting.*
33	<u>Monitor guidance re 16/17 plan 16/006(iii)</u> Planning guidance offers £8M up front monies to the Trust for 16-17 if a control total of no more than £4.4M deficit can be achieved. This offer of sustainability and transformation funding is contingent on the Trust's 15-16 outturn being no worse than a deficit of £14.2M (which is in doubt).
34	The committee was of the view that the CIP programme in 16-17 and beyond must be spread evenly across the year.
	Report from the Director of IM&T 16/007
35	<u>Lorenzo Assurance Report, incl. contract data sets 16/007(ii)</u> The Board's overview group of the Lorenzo project had received a report that the project was overspent by at least £127k and with a maximum in year overspend of £199k. The committee discussed the timing of Phase 2 of the Lorenzo project, the timing of which is flexible from early 2016 onwards. The committee sought and received management assurances that flexible (ie contract) staff would not be kept on retainers for the purpose of Phase 2 unnecessarily if Phase 2 was not triggered at the earliest possible date (which would be February '16). The project Board will evaluate risks and benefits in the timing of a Phase 2 implementation. The Board Overview Group will continue to seek and scrutinise assurances as to Lorenzo governance.
36	It was reported that reporting quality of contract data sets remains poor. There is considerable uncertainty in reporting.

37	**Reports from sub-committees and Groups 16/008** Minutes of recent meetings Capital Planning Committee - draft minutes 14 December 2015 were noted.
38	**Any other business 16/009** There was none.
39	**Date and time of next meeting** 2pm on 17th February in the Trust Conference Room

Action List

Finance and Sustainability Committee

Paper Reference	Action	Responsibility & Target Dates	

BOARD OF DIRECTORS

16/052

SUBJECT:	Report from the Chair of the Audit Committee including: approved minutes from the meeting on 2/2/16
DATE OF MEETING:	24 February 2016
DIRECTOR:	Ian Jones, Non-Executive Director – Committee Chair

Reports *not* received as agreed in the annual work plan:	-
Any other relevant items the sub-committee wishes to escalate ?	- The chairs of the assurance committees intend to meet informally, quarterly to triangulate their understanding of items escalated to the Board by each committee and to agree which committees will cover any overlapping areas or gaps in assurance. - The FSC and Quality Committee had escalated to the Audit Committee their concern regarding weaknesses in control over financial control; ability to report the financial position accurately, CQUIN performance.

AUDIT COMMITTEE MEETING

Final Minutes of the meeting held on Tuesday 2 February 2016, 1400hrs
Trust Conference Room, Warrington Hospital

Present:

Ian Jones	Non-Executive Director (Chair of the Committee)
Terry Atherton	Non-Executive Director
Lynne Lobley	Non-Executive Director & Deputy Chair
Anita Wainwright	Non-Executive Director

In attendance:

Andrea Chadwick	Director of Finance and Commercial Development
Roger Wilson	Director of Human Resources & Organisational Development
Simon Constable	Medical Director (part meeting)
Andy Chittenden	Trust Secretary
Louise Thornton	PWC
Fiona Kelsey	PWC
Sarah Blackwell	MIAA
Roger Causer	Counter Fraud Officer
Janet Oxley	Minute Secretary

Apologies:

1	**WHHFT/AC/16/01 – Apologies and Declarations of Interest - in Agenda Items** Declarations of Interest - in Agenda items: none.
2	**WHHFT/AC/16/02 – Minutes of the previous meeting** The minutes of the meeting held on 20 October 2015 were approved subject to an amendment to item 49 and the increase in tender waivers being related to the Lorenzo project and not a system problem. Terry Atherton, Non-Executive Director added that item AC/15/23-24 around Waiting List Initiatives (WLIs) highlighted the gap in governance and this had since been raised and discussed at the Finance and Sustainability Committee. It had been explained there that the Chief Operating Officer had now introduced further controls which will be embedded by the end of March 2016. An update is expected back to both committees by April 2016. *Action: Chief Operating Officer to provide update on WLIs and its governance to Audit and Finance and Sustainability Committees.*

	WHHFT/AC/16/03 - Action Plan
3	Update on previous actions: AC/15/33 (ii) - To set up a dedicated Trust Board Workshop entirely for discussion around workforce - It was agreed that this will be scheduled into one of the Board workshops in the following months based on specific areas for discussion such as workforce and engagement. **Action ongoing** AC/15/47(ii) - Follow up with Estates regarding security assessment management action for the OPAL unit and the Audit Committee needing assurance that patient safety was not at risk - Sarah Blackwell, MIAA updated on the current position - a risk assessment had been carried out and a recommendation placed on making the doors operational. The funding of £2K needs to be sought for this. **Action ongoing**
	WHHFT/AC/16/04 - Counter Fraud Progress Report Roger Causer, Counter Fraud Officer presented the MIAA Anti-Fraud Services Progress Report as at February 2016 to the Audit Committee which was noted. The progress report outlines the Trust's plan and sets out the ongoing pieces of work around fraud and the investigations. There are a number yet to be closed. An Anti-Fraud Staff Survey is to be considered for the future comprising questions on culture and awareness. Anita Wainwright, Non-Executive Director pointed out the list setting out the current status of on-going fraud enquiries at the Trust raised concerns of the impact that they had on each other specifically if HR investigations were running alongside each other. The Director of Human Resources and Organisational Development agreed to submit a report relating to all the strands around wider exclusions/counter fraud investigations to the Strategic People Committee for closer scrutiny and assurance. *Action: The Director of Human Resources and Organisational Development to submit a report pulling all the strands together around wider exclusions/counter fraud investigations to the Strategic People Committee for closer scrutiny and assurance.*
	WHHFT/AC/16/05 - Internal Audit Reports **i. MIAA Internal Audit Progress Report Estates strategy review** Sarah Blackwell, MIAA Internal Audit presented the Internal Audit Progress Report detailing the conclusions of reports which had been finalised, and provided an update in relation to the on-going reviews. Since the previous Audit Committee meeting the following reports have been finalised: – Estates Strategy – Significant assurance – Activity Targets (Cancer Waiting Times) – Significant assurance – Payroll – Significant assurance – Combined Financial Systems – Significant assurance **Key issues highlighted:** **Estates Strategy** • The services of a Principal Supply Chain Partner have been employed by the Trust for generation of a detailed strategy and a Project Manager for subsequent building work.

- An Estates Strategy is in place which aligns to the Trust's 5 year strategy
- An Outline Business Case has been produced and formally signed off by the Trust Board for phase 1 and full business cases, each project within this phase will further be produced and then presented to Trust Board for approval
- Reconfiguration of the estate

Cancer Waiting Times

- Process in place looking at the quality of data
- Testing information and data fully evidenced by GP referral/clinic letters
- Robust monitoring at corporate and management level
- There is a consistent approach and Lorenzo implications now made easier with its implementation

Payroll Review

- A recommendation was put in place to monitor overpayments due to late termination recordings
- Question raised on expenses module in allocate – which will be a topic for discussion at the Executive meetings in the following weeks

Combined Financial Systems Review

- The Waiver process is being monitored and controlled by its new processes
- Finance Team are managing the budgetary controls and Audit Committee do take a deep dive into the audit process around budget work at an advisory/consultancy level. Costs/internal systems and the controls will be areas that the Non-Executives will be looking at in the future. Forecasting/financial performance and the result of the controls that have been put in place will be monitored as it is about the accountability, culture and the competency of managing the finances

ii. Follow up Report

Sarah Blackwell, MIAA Internal Audit drew attention to the items listed in the summary and recommendations to be followed up. She advised that the management actions from the detailed reports were loaded onto the CIRIS so that managers could identify any that were outstanding.
There are 28 recommendations in total to be followed up in Quarter 3.

The Committee discussed the following points:

- A&E staffing – the action of a sickness absence update to be brought forward to June 2016 from September 2016. The Director of Human Resources and Organisational Development informed that it was an action for the HR Business Partner to do a 'deep dive' into the reasons behind the sickness absence in A&E and there is specific organisational development work being put in place around this to find out what is going on.

- Mortality Review – this will come in next year's Audit Plan showing a full review of the year

The Committee noted the content of the MIAA Internal Audit Follow Up Report Quarter 3.

At this point discussions ensued around Patient Experience and Complaints. It was felt that there was a gap in assurance. Lynne Lobley, Non-Executive Director and Chair of the Quality Committee explained that much of the work around this has been looked at by the Quality Committee and staff have recently shared their side of the story of a complaint that has recently been presented at Trust Board that had significant affect. Although the same complaint story, staff had shared their sense of shame and wrong/positive learning points, the lessons learnt and the impact it had on the whole ward.

Lynne Lobley, Non- Executive Director informed that assurance has been given by the Director of Nursing and Governance that there is an improved Complaints process now in place whereby serious complaints are investigated immediately and dealt with now differently than in the past.

Terry Atherton, Non-Executive Director felt that there was not enough assurance given around complaints and the key learnings and information was not getting through on a weekly basis.

Members felt that there was a cross-over of committees and that the Quality Committee would be best suited to track and give assurance to the Audit Committee.

Further discussions took place around benchmarking against other Trusts which is something that has not been set up internally at the Trust at this stage. The Director of Human Resources and Organisational Development explained that he had spoken to the family following the recently presented complaint at Trust Board and had explained to them the Level 1 investigation process. The investigation work will progress into the Operational People Committee and the cultural issues will be discussed at the Strategic People Committee looking at performance and disciplinary.

Anita Wainwright, Non-Executive Director added that the Ward Manager should have good patient experience skills and be able to see immediately what the patient is experiencing and to see a map of where they are not doing so well and to introduce buddying up. The Ward DAWES assessment was discussed and that the Patient Experience Committee had now been set up to deal with these issues and further feed information and developments up into Quality Committee. It was agreed that an informal meeting be set with the Trust Secretary and the Chairs of the Quality, Audit and Finance and Sustainability Committees to look at how information coming out of complaints can be monitored and triangulated through the committees in seeking assurance.

Sarah Blackwell, MIAA stated that Complaints could be part of the internal audit plan for next year.

Action: Informal quarterly meetings with Chairs of the Quality, Audit, Strategic People and Finance and Sustainability Committees to be set up for the triangulation of information around complaints for assurance to the committees by the Trust Secretary.

iii. Briefing note

The paper was submitted for information purposes and the Committee noted the content.

	WHHFT/AC/16/06 - External Audit Report **i. Agree External Audit Plan** Fiona Kelsey, PWC presented the External Audit Plan running through the risks highlighted within the report. PWC are focussing on getting the disclosures right and ensuring an accurate position reflected in the audit. In the case of value for money assessment, Monitor assesses whether each foundation trust is adhering to good practice with respect to delivering value for money and may investigate if there is sufficient evidence to suggest inefficient and/or uneconomical spending at a Trust. There are concerns about the risks related to the Quality Report and so which is individualised as one of the risks this year. All foundations trusts have been asked to complete a checklist around accruals and to scrutinise assets. 2014/15 saw the introduction of enhanced audit reporting for NHS foundation trusts and to look at improvements. The Committee noted the content of the report.
	WHHFT/AC/16/07 - Consultant job planning governance (Identified at extraordinary Board meeting on 15 Jan 16) The Medical Director gave an update on the current position of the Consultant job planning governance. There had been recent discussion relating to this in the Extraordinary Trust Board on the 15 January 2016 where talks took place around the difficulties of the CIP and that the job planning needed to be enacted immediately. The Medical Director informed that they had carried out a complete stock-take and re-examination of Consultant sessions/job plans and the Trust had invested in the e-job planning system Allocate. As from 1st January there has been put in place a complete review up to 31st March 2016 to enforce the implementation of the new job plans and stock take up to the next financial year and to ensure the best medical productivity and value for money is attained. The Medical Director informed that part of the CIP/medical productivity scheme had been in train for a lengthy period. Completion has proven difficult but some elements in the year have been actioned and some of the big gaps have been filled. In support of the professional activities it was identified through the PMO effectively that 0.25 SPA's were badged against audit/governance work but on scrutiny clinical activity was being lost to cover this work when in fact it had already been accounted for and therefore controls have since been put in place to stop this. It is deemed that 0.25 SPA's per week is a perfectly acceptable figure and with the Trust already experiencing waiting list issues the fact that the Trust was losing direct clinical care is not acceptable. The Medical Director explained that there had been a lot of concern raised by the Medical Body of Consultants specifically around the displacing of clinical activity and to reinstate if cancelled. Approximately 10 clinical sessions per year for some consultants have been cancelled to cover audit/governance work amounting to a huge amount of clinical activity being lost. He pointed out that two specific points being worked on were to (i) to enforce the quality and safety aspect of direct clinical care and access and (ii) to raise concerns about the already diluted CIP and facing the challenges

	against it. He informed that a figure of £150k is programmed activity per quarter and it was important to highlight and be careful about this. Since this things have settled down and as the Trust goes deeper into the review of job planning it needs to go forward with caution. There needs to be a robust approach looking at long term practices and to look at the difficulties surrounding flexibility which is less clear at this stage. The Medical Director informed that the job planning had been through both the JLNC and Strategic People Committee as a big piece of work and also at the Extraordinary Trust Board meeting looking at the practical aspects of implementation and taking an overall board view on this area. The Chair agreed that the work appeared to be moving forward and asked that the Audit Committee be used to discuss the difficulties and practices of the piece of work in the future. Further discussion ensued around historical issues and the need to get past this to move the work forward. It was pointed out that we are applying the existing policy which remains in place but this must be improved upon with a rigorous application. Lynne Lobley, Non-Executive Director questioned how long a period it would take to get the Job Plans fit for purpose as it was crucial to the financial/service plan. The Medical Director explained that a process has now been put in place and in year much of the improvement work had been accounted for and the CIP put in already. The Job Plans will be scrutinised for the period of 1st April 2016 to 31st March 2017 with a system in place which involves a three tier sign off and three gateways. There is already consideration of external support, BMA assurance and the use of MIAA to give external cover which will be built into the new model at this point. There has been scrutiny at specialty level and the lack of PA's which will be put in on a temporary basis and also encouraging teams at this ongoing level. It was noted that the assurance around SPA would be highlighted at Audit Committee going forward.
	WHHFT/AC/16/08 - Summary of MIAA Workforce Reviews The Director of Human Resources and Organisational Development reported that there had been one additional audit since the last meeting. The team are managing the plan and actions against the plan and monitored in the Operational People Committee and they are progressing towards the plan for 16/17.
	WHHFT/AC/16/09 - Annual report & accounts 15-16 The reports submitted on (i) the Completion of 2015/16 Annual Accounts – Key dates and (ii) Adoption of Accounting Policies for completion of Annual Accounts 2015/16 and their contents were noted by the Audit Committee.
	WHHFT/AC/16/10 - Tender Waivers - Quarter 3 The Head of Financial Services provided some analysis based on previous reporting. The Director of Finance and Commercial Development talked about retrospective waivers and that in her experience in working within another trust that staff were held to account and to explain their actions within the Audit Committee which had positive impact in the reduction of the figures. There were several queries raised on some of the orders submitted for which the Chair will take back to Finance and Supplies for clarification and why they did not go through the normal processes, namely

	the air ventilation system order at £330,360 and the T&O order of £114,000 for the provision of Pradhan Healthcare.
	WHHFT/AC/16/11 - Losses & Special Payments - Quarter 3 The report and the contents were noted by the Audit Committee. The Chair noted that work was going in the right direction from this time last year.
	WHHFT/AC/16/12 - Bad Debt Write Off - Quarter 3 The report and the contents were noted by the Audit Committee.
	WHHFT/AC/16/13 - Escalation by Board Committees
	Finance and Sustainability Committee (FSC): Terry Atherton, Non-Executive Director and Chair for FSC explained that he was aware of the issues but is concerned that it had been nearly two weeks since the January Finance and Sustainability Committee (FSC) and had not received data around the Finances, Performance (including A&E outputs to Monitor) and IM&T. The Finance paper tabled on the day at FSC year to date had not changed since first produced at Trust Board last week indicating a year end deficit of £14.2M forecast and the revised year end outcome before adjustments showing a worrying position of £19.9M He is concerned as to what this means and feels uncomfortable as to the scale of variance and lack of definitive information. The Non-Executive Directors also have real concerns as to the cash position in the short term. Financial penalties are risks that the Finance and Sustainability Committee needs to be made aware of.
	Quality Committee (QC): Lynne Lobley, Non-Executive Director and Chair for QC highlighted the risks around CQUINS specifically heart failure and pneumonia and not reaching the targets and so causing penalties. She further raised concern around the risk register and the need to drill down to each risk and to scrutinise more thoroughly.
	Strategic People Committee (SPC) Anita Wainwright, Non-Executive Director and Chair for SPC explained that the February SPC had been stood down to take forward the Operational People Committee and to re-scope the SPC going forward. The Director of Human Resources and Organisational Development updated on the progress of the Operational People Committee. At this stage the terms of reference had not yet been agreed and signed off. Initial stages are to ensure the HR and Organisational Development teams are held to account looking at gaps and to progress into providing proper levels of assurance to the SPC in the future. The Interim Trust Secretary who attended the OPC informed that the meeting promised an effective way of working in the future and felt it to be a constructive meeting. It would look at Performance Management and what it would look like going forward and the Clinical Business Units (CBU) and the rigour of this. The Director of Human Resources and Organisational Development updated on the latest around Clinical Leader roles and noted the positive number of staff who are enthusiastic to get involved in the CBU readiness assessments showing that the desire is out there for staff to take on these roles.

	WHHFT/AC/16/14 - Any Other Business
	It was noted that the Board Assurance Framework was seen at Trust Board in January 2016 and the gaps noted for which Sarah Blackwell, MIAA stated they will be part of the audit plan going forward.
	Date and time of next meeting 5 April 2016, at 1400hrs in the Trust Conference Room.

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

BOARD OF DIRECTORS

SUBJECT:	**Finance Report as at 31st January 2016**	
DATE OF MEETING:	24th February 2016	
ACTION REQUIRED	**For Discussion**	
AUTHOR(S):	Steve Barrow, Deputy Director of Finance	
EXECUTIVE DIRECTOR:	Andrea Chadwick, Director of Finance & Commercial Development	
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care SO3: To give our patients the best possible experience SO4: To provide sustainable local healthcare services	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework SO4/4.2 Failure to: Maintain a liquidity ratio and capital servicing capacity necessary to deliver a continuity of services risk rating of at least 3 on a quarterly basis; remain a going concern at all times remain solvent; and Comply with section G6 of th SO4/4.3 Failure to manage key contracts appropriately resulting in contract penalties or reduction in service standards; and failure of operational processes to deliver service to agreed contract targets, outputs or standard	
FREEDOM OF INFORMATION STATUS (FOIA):	Whole FOIA Exemption	
FOIA EXEMPTIONS APPLIED:		
EXECUTIVE SUMMARY (KEY ISSUES):	For the period ending 31st January 2016 the Trust has recorded a cumulative deficit of £15,623k, a cash balance of £3,329k and a Financial Sustainability Risk Rating 1. The forecast outturn for the year is a deficit of £19.9m, a cash balance of £2.3m and a Financial Sustainability Risk Rating 1.	
RECOMMENDATION:	***The Board is asked to note the contents of the report***	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee
	Agenda Ref.	FSC/16/14
	Date of meeting	17th February 2016

	Summary of Outcome	Noted

FINANCE REPORT AS AT 31st JANUARY 2016

1. PURPOSE

The purpose of the report is to advise the Board of Directors on the financial position of the Trust as at 31st January 2016 and the forecast outturn as at 31st March 2016.

2. EXECUTIVE SUMMARY

Year to date performance against key financial indicators is provided in the table below and further supplemented by the dashboards and appendices attached to this report.

Key financial indicators

Indicator	Monthly Plan £m	Monthly Actual £m	Monthly Variance £m	YTD Plan £m	YTD Actual £m	YTD Variance £m
Operating income	17.8	19.0	1.2	178.2	182.3	4.1
Operating expenses	(17.9)	(18.6)	(0.7)	(181.0)	(188.7)	(7.7)
EBITDA	(0.1)	0.4	0.5	(2.8)	(6.4)	(3.6)
Non-operating income and expenses	(1.0)	(0.9)	0.1	(9.4)	(9.2)	0.2
I&E surplus / (deficit)	(1.1)	(0.5)	0.6	(12.2)	15.6	(3.4)
Cash balance	-	-	-	3.2	3.3	0.1
CIP target	1.7	1.1	(0.6)	7.2	6.5	(0.7)
Capital Expenditure	1.2	1.1	0.1	7.6	6.8	0.8
Financial Sustainability Risk Rating	-	-	-	1	1	0

3. OVERVIEW

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

Position = Surplus/(Deficit)	January £000	Year to date £000
Plan	(1,102)	(12,191)
Actual	(573)	(15,623)
Variance	**529**	**(3,431)**

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

Variance = Favourable/(Adverse)	January £000	Year to date £000
Operating income	1,122	4,143
Operating expenses	(640)	(7,743)
Non-operating income and expenses	47	168
Total	**529**	**(3,431)**

The net divisional position for the month is an overspend of £522k (a combination of £640k expenditure overspend and £118k income over recovery), however there are some costs incurred that are covered by additional clinical income as demonstrated in the table below. The effect of removing these costs from the reported position results in a monthly divisional overspend of £62k as summarized in the table below:

Narrative	**NHS & Non NHS Clinical Income £000**	**Net Divisional Position £000**	**Other £000**	**Total £000**
Reported position	966	(522)	86	529
High cost drugs	(239)	239	0	0
Warrington ICU	(102)	102	0	0
Halton UCC	(119)	119	0	0
Total	**506**	**(62)**	**86**	**529**

The £573k deficit reported in January is £529k better than the planned deficit of £1,102k but in reporting this position there are a number of points that need to be brought to the attention of the Committee.

Implementation of Lorenzo

The implementation of Lorenzo has introduced significant changes to the capture, recording and production of clinical information that is used as the basis for the reporting of NHS clinical income. These changes have meant that not all the necessary information has been available at the time of reporting and therefore a number of assumptions have had to be made:

- There are 5,049 uncoded spells relating to December and January so these have been priced at a specialty average. The estimated income attached to each category is as follows: Day Cases – 1,558 spells at £1.2m, Elective Inpatients – 442 spells at £1.1m and Non Elective Inpatients - 3,049 spells at £4.5m.

  Risk – the value of uncoded activity priced at specialty average is £6.8m so once fully coded the income may increase or decrease income accordingly. A 1% movement in the actual price will increase or decrease income by £68k and a 5% movement will increase or decrease income by £340k.

- The high level of uncoded activity means that the excess bed day income cannot be quantified so based on previous months £0.2m is included as an estimate for December and January activity.

  Risk - a 1% movement in the excess bed day income will increase or decrease income by £2k and a 5% movement will increase or decrease income by £10k.

- The high level of uncoded activity means that unbundled chemotherapy and palliative care income cannot be quantified so based on previous months £0.1m is included as an estimate for December and January activity.

  Risk - a 1% movement in the unbundled chemotherapy and palliative care income will increase or decrease income by £1k and a 5% movement will increase or decrease income by £5k.

- Ante natal and post natal activity is not available, so £1.2m has been included as an estimate for

November to January based on the monthly average activity and income in the period April to October.

Risk – a 1% movement in the actual price will increase or decrease income by £12k and a 5% movement will increase or decrease income by £60k.

- Adult critical care discharged activity is not available and therefore uncoded, so £1.8m has been included as an estimate for November to January based on 1,500 occupied bed days priced at an average critical care daily rate of £1,200. The bed day tariff for adult critical care activity ranges from £400 to £1,900 per day (based on the level of care provided), so the actual income generated may vary significantly once all activity is coded.

  Risk – the value of uncoded activity priced at an average daily rate is £1.8m so once fully coded the income may increase or decrease income accordingly. A 5% movement in the actual price will increase or decrease income by £90k and a 10% movement will increase or decrease income by £180k.

- Neo Natal critical care discharged activity is not available and therefore uncoded, so £0.8m has been included as an estimate for November to January based on 1,400 occupied bed days priced at an average critical care daily rate of £550. The bed day tariff for neo natal critical care activity ranges £390 to £1,300 per day (based on the level of care provided), so the actual income generated may vary significantly once all activity is coded.

  Risk – the value of uncoded activity priced at an average daily rate is £0.8m so once fully coded the income may increase or decrease income accordingly. A 5% movement in the actual price will increase or decrease income by £40k and a 10% movement will increase or decrease income by £80k.

- The levels of outpatient activity appear to be extremely low compared to both the previous month's average and the planned levels of activity. The income included for outpatient activity is based on the recorded activity so may increase should additional activity be captured and recorded.

  The value of outpatient income is based on the actual type of activity captured and reported. Should the levels of outpatient activity and income increase to the monthly average pre Lorenzo income will increase by £1,074k and should the levels of outpatient activity and income increase to the planned levels post Lorenzo income will increase by circa £1,548k.

In summary, the value of income at risk based on the above assumptions may be up to £675k but conversely the additional income associated with additional outpatient activity may be up to £1,548k.

Sustainability and Transformational Fund

Monitor wrote to all Trusts on 15th January 2016 to announce that, as part of the recent Spending Review, there was opportunity for the provider sector to access to a £1.8 billion Sustainability and Transformation Fund in 16/17 provided that the provider sector delivered a deficit of no more than £1.8 billion in 15/16 and a position of breakeven in 16/17 after application of the fund. In order to support the provider sector in the current year the Department of Health have suggested a number of opportunities that may result in an improved financial performance, including the ability to transfer local funding from capital to revenue. The Trust has notified Monitor that we wish to transfer £2.5m funding from capital to revenue

and therefore a pro rata amount of £2.1m has been included in the January position.

Reinvestment of Operational and Readmission Penalties

In response to the letter from Monitor dated 3rd August 2015 the Trust agreed to a revised 15/16 forecast deficit of £14.2m. In order to achieve the £14.2m deficit there were a number of mitigating actions agreed by the Board that included a £0.3m reduction in commissioner levied operational penalties through improved performance, a £0.5m reinvestment of commissioner levied operational penalties and £0.7m reinvestment of commissioner levied readmission penalties. Therefore, an amount of £1.25m has been included in the financial position to 31st January based on anticipated improvement and reinvestment.

Cash Position

The operating performance continues to have an adverse effect on the amount of cash available to the Trust and even though the cash balance is £3.3m as at 31st January the value of trade creditors stands at £11.7m (partially covered by the value of trade receivables at £4.1m). The Trust has received £8.4m in respect of the working capital loan year to date but active management of the working balances is required in order to maintain a cash balance sufficient to pay creditors and repay both commissioners the cash advances received in the first half of the year.

Operating Income

Year to date operating income is £4,143k above plan due to an over recovery on NHS clinical income (£493k) and other operating income (£3,847k), partially offset by an under recovery on non NHS clinical income (£197k).

Operating Expenses

Year to date operating expenses are £7,743k above plan due to over spends on pay (£5,771k), drugs (£883k), clinical supplies (£906k) and non clinical supplies (£182k).

Pay Costs

The monthly pay overspend is £643k and the year to date overspend is £5,771k however this includes the additional costs associated with the opening of Warrington Intermediate Care Unit, Halton Urgent Care Centre and Lorenzo that were not included in the original plan but are offset by the recovery of additional income. The pay variance after the exclusion of these costs covered by income is summarized in the table below:

Narrative	January Budget £000	January Actual £000	January Variance £000	Year to Date Budget £000	Year to date Actual £000	Year to date Variance £000
Reported Position	12,837	13,481	(644)	129,570	135,341	(5,771)
Warrington ICU	0	(93)	93	0	(1,138)	1,138
Halton UCC	0	(119)	119	0	(779)	779
Lorenzo	0	0	0	0	(2,219)	2,219
Revised Position	**12,837**	**13,269**	**(432)**	**129,570**	**131,205**	**(1,635)**

Note that the £3.1m funding from HSCIC towards the cost of implementation for Lorenzo has now been exhausted so any further costs are the responsibility of the Trust.

Non Operating Income and Expenses

Non operating income and expenses is £168k below plan.

4. COST IMPROVEMENT PROGRAMME

The Trust has an annual savings target of £10,300k (including £0.6m balance from 14/15 and an additional £0.2m included in the revised forecast deficit 15/16). The annual value of the planned schemes totals £12,351k however the value of schemes underpinned by detailed plans (evidenced by PIDs) is shown in the table below.

Narrative	In Year £000	Recurrent £000
Annual Target	10,300	10,100
Value of schemes identified	9,576	8,925
Over / (Under) Achievement against target	**724**	**1,175**

For the period to date the planned savings target is £7,150k, with actual savings amounting to £6,528k which results in an under achievement of £622k. The position is primarily due to an over achievement on the clinical coding (£982k), sustainability (£125k) and procurement (£69k) schemes, offset by an under achievement on Outpatients capacity and productivity (£449k), theatre utilization (£105k), Critical Care bed reduction (£200k), patient pathways (£543k), Clinical coding A&E HRGs (£133k), medical productivity (£333k) and temporary staffing reduction (£733k).

The estimated cost savings have reduced by £1.8m from £10.3m to £8.5m to reflect the latest outturn (£1.4m of income increases and £0.4m of expenditure reductions).

5. CAPITAL

The annual capital programme approved by the Board and submitted to Monitor was £20.3m, with £10.0m included for the current year cost of the Estates Strategy proposal. The funding of the programme was a combination of internally generated depreciation (£6.8m) and a planned capital loan (£13.5m) from the Department of Health. The value of the programme was then reduced to £10.9m due to a reduction in the value of the Estates Strategy in year spend and the MRI Scanner that is now funded via a lease. This

reduced the value of the 15/16 loan required from the Department of Health to £4.1m.

Section 3 (Overview) detailed the level of local funding to be transferred from capital to revenue, the impact of which is to reduce the capital funding available this year to £8.4m. The Capital Planning Group led the exercise to determine which schemes can be deferred or stopped, without having a significant impact on patient safety or legislative risk, in order that the yearly spend does not exceed the revised capital funding. The position below reflects the above revision to the capital programme and to date the Trust has spent £6.8m against the budget of £7.6m, with the overspend on IM&T covered by underspends on Estates and Medical Equipment.

Category	**Annual Budget pre capital to revenue transfer £m**	**Capital to revenue transfer £m**	**Annual Budget pre capital to revenue transfer £m**	**Budget to date £m**	**Actual to date £m**	**Variance to date £m**
Estates	5.2	(1.8)	3.4	3.0	2.5	(0.5)
IM&T	3.5	(0.0)	3.5	2.8	3.2	0.4
Medical Equipment	2.2	(0.7)	1.5	1.8	1.1	(0.7)
Total	**10.9**	**(2.5)**	**8.4**	**7.6**	**6.8**	**(0.8)**

6. CASH FLOW

The cash balance is £3,329k which is £136k above the planned cash balance of £3,193k, with the monthly movements summarised in the table below.

Cash balance movement	**£000**
Opening balance as at 1st January	2,753
In month deficit	(573)
Non cash flows in surplus/(deficit)	934
Increase in trade receivables (debtors)	(453)
Increase in trade payables (creditors)	2,052
Capital expenditure	(1,097)
Drawdown of working capital loan	3,726
Other working capital movements	(4,013)
Closing balance as at 31st January	**3,329**

The current balance equates to circa 6 days operational cash but as at 31st January the value of trade payables stands at £11.7m, although this is partially covered by the value of trade receivables which stands at £4.1m. Under the financial sustainability risk rating the liquidity metric is -24 days which results in a score of 1.

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

Cash balance movement	February £000	March £000	April £000
Opening balance	3,329	3,810	2,271
In month deficit	(2,900)	(1,624)	(126)
CCG Advance / (Repayment)	(3,766)	(2,276)	0
Non cash flows in surplus/(deficit)	903	903	973
Movement in receivables (debtors)	450	(2,329)	100
Movement in payables (creditors)	(719)	3,554	(100)
Capital expenditure	(900)	(752)	(444)
PDC Dividends	0	(2,128)	0
Drawdown of loans	3,265	4,177	900
Other working capital movements	4,148	(1,064)	(1,459)
Closing balance	**3,810**	**2,271**	**2,115**

The cash position, ultimately determined by the operating performance of the trust, is extremely challenging and even with a £14.2m loan the revised cash planned balance as at 31st March has reduced to £2.3m, subject to movements in other working balances. Any further deterioration in the financial position will result in a reduction in a cash balance, again subject to movements in other working balances. The minimum cash balance allowed by Monitor is 2 days operational cash which is approx £1.2m, so there is only £1.1m of headroom available.

The operating performance continues to have an adverse effect on the cash position and creditor payments, with performance against the non NHS Better Payment Practice Code (BPPC) at 31% in the month (27% year to date). This low level of compliance and performance will continue until there is an improvement in the operating position and the resultant cash position.

7. STATEMENT OF FINANCIAL POSITION

Non current assets have decreased by £514k in the month with capex spend exceeding depreciation and receivables.

Current assets have increased by £2,165k in the month mainly due to the increase in accrued income and cash.

Current liabilities have decreased by £373k in the month mainly due to the decrease in deferred income and accruals, partially offset by an increase in the PDC creditor and payables.

Non current liabilities have increased by £3,627k in the month due to the drawdown of the working capital loan.

8. RISK AND FORECAST OUTTURN

For the period ending 31st January the Trust has recorded a deficit of £15,623k despite the £2,083k additional income to reflect the agreed capital to revenue transfer.

An updated forecast has been prepared which shows that the forecast has now deteriorated to £19.9m

from that submitted to Monitor in August 2015 (£14.2m) and that submitted to the Board in January (£16.4m).

The basis and assumptions in calculating the latest forecast deficit of £19.9m are summarised below:

- Income outturn is based on the month 7 activity and income and extrapolated to a full year based on planned profile (last full month's activity and income data pre implementation of Lorenzo).
- Expenditure outturn is based on the month 10 position and extrapolated to a full year with known phasing adjustments.
- Funding of £2.5m for the capital to revenue transfer included.
- The estimated cost savings have reduced by £1.8m from £10.3m to £8.5m to reflect the latest outturn (£1.4m of income increases and £0.4m of expenditure reductions).
- Excess bed day income of £0.1m for patients on the STAR unit in March has been excluded but £0.1m that represents the funding from Warrington CCG to maintain 15 funded beds to 31st March is included.
- Paediatric HDU income of £0.1m has been excluded.
- Quarter 4 potential one-off measures / technical accounting adjustments of £1.0m suggested by Monitor have been excluded as the financial impact has not yet been quantified.
- Commissioners reinvest £1.0m of operational and readmission penalties.

There are some risks that have not been included, namely:

- Potential CQUIN penalties amounting to £0.4m.
- Potential reduction in income of £1.6m if the month 10 activity and income position was used as the basis for the forecast.

There are however some potential opportunities are still being explored which could help in reducing the deficit and mitigating the effect of the risks above, namely:

- Additional capital to revenue transfer of £0.4m (to be confirmed by Monitor).
- Revaluation of asset lives that could reduce depreciation by £2.0m (this is an initial estimate by the external advisor and subject to verification).
- Improvement in cost savings of £0.2m.
- Further negotiation with commissioners regarding reinvestment of readmission and operational penalties of £0.5m.

Should the full value of all the risks materialize (£2.0m) and none of the opportunities materialize (£3.1m) then the deficit could increase to £21.1m.

Should none of the risks materialize (£2.0m) and all the opportunities materialize in full (£3.1m) then the deficit could reduce to £16.8m.

Andrea Chadwick
Director of Finance & Commercial Development
18th February 2016

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Financial headlines as at 31st January 2016

Key Financial Metrics	Month			Year to date		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income	17,846	18,968	1,122	178,176	182,319	4,143
Operating Expenditure	-17,967	-18,607	-640	-180,959	-188,702	-7,743
EBITDA	**-121**	**361**	**482**	**-2,783**	**-6,383**	**-3,600**
Non Operating Income & Expenses	-981	-934	47	-9,408	-9,240	168
Net Surplus / (Deficit)	**-1,102**	**-573**	**529**	**-12,191**	**-15,623**	**-3,431**
Financial Sustainability Risk Rating				1	1	0
Capital Expenditure	1,179	1,097	-82	7,593	6,789	-804
Cost Savings	1,615	1,093	-522	7,150	6,528	-622
Cash Balance				3,193	3,329	136

Summary Position

The in month position is an actual deficit of £573k which is £529k better than the planned deficit of £1,102k. The year to date position is an actual deficit of £15,623k which is £3,431k worse than the planned deficit of £12,191k.

The Financial Sustainability Risk Rating is 1 which is in line with the planned Risk Rating of 1.

Year to date income is £4,143k above plan due to an over recovery on NHS clinical income and other operating income, partially offset by an under recovery on NHS clinical income. Year to date expenditure is £7,743k above plan due to overspends on pay, drugs, clinical supplies and non clinical supplies, although a significant element of the pay overspend is covered by the recovery of additional income. Year to date non operating income and expenditure is £168k below plan mainly due to an underspend on depreciation and interest expenses.

Key Variances on year to date position

Operating Income	
NHS Clinical Income	£493k above plan.
Non NHS Clinical income	£197k below plan.
Other Operating Income	£3,847k above plan.
Total	**£4,143k above plan**
Operating Expenditure	
Pay	£5,771k above plan.
Drugs	£883k above plan.
Clinical Supplies	£906k above plan.
Non Clinical Supplies	£182k above plan.
Total	**£7,743k above plan.**
Non operating income and expenses	
Loss on sale of fixed assets	£101k below plan.
Net Interest	£242k below plan.
Depreciation	£152k below plan.
PDC Dividends	£89k above plan.
Restructuring costs	£36k above plan.
Total	**£168k below plan.**
Capital expenditure	£804k below plan.
Cost Savings	£622k below plan.
Cash balance	£136k above plan.

Other matters to be brought to the attention of the Board

The Trust has updated the forecast outturn and based on the position as at 31st January the forecast deficit increases to £19.9m (including the application of the £2.5m capital to revenue transfer). This increase in the forecast deficit reflects the latest operating performance and the estimated cost savings achievable over the remainder of the year. There are however some potential opportunities that are still being explored that may reduce this deficit, including further capital to revenue transfers, revaluation of asset lives, further reduction in the cost base and further negotiation with commissioners regrding the reinvestment of operational and readmission penalties.

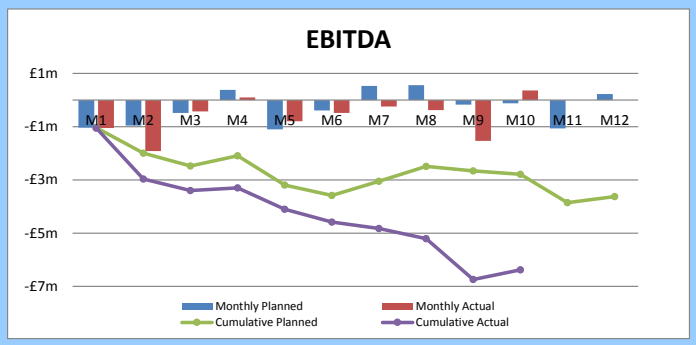
The reduction in the cash balance caused by the planned deficit, means that cash support was required, so a working capital loan of £14.2m has been agreed with the Department of Health, repayable over 30 months at 1.5%. The first instalment of the loan was drawn down in November and to date £7.2m has been drawn down with another £7.0m to be drawn down in Feebruary and March. The principal (£14.2m) is repaid 30 months after each draw down but the interest (approx. £530k) is repaid every six months after drawn down. Despite the working capital loan the value of trade creditors as at 31st January is £11.8m (although is partially covered by the value of trade debtors of £4.1m). An increase in the annual deficit will further reduce the amount of cash available to the organisation for investment purposes).

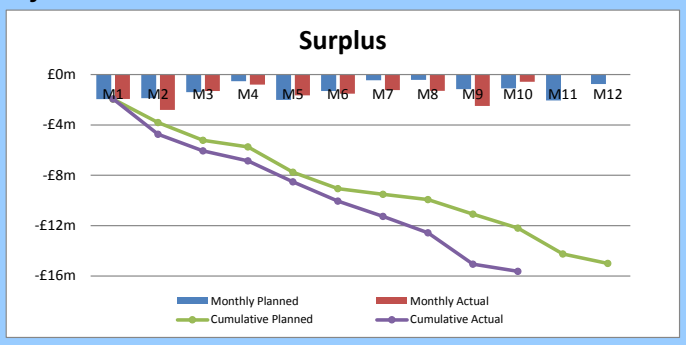
On 15th January the Trust received a letter from Monitor announcing that as part of the recent Spending Review, there was opportunity for the provider sector to access a £1.8 billion Sustainability and Transformational Fund in 16/17 provided that the provider sector delivered a deficit of no more than £1.8 billion in 15/16 and a position of breakeven in 16/17 after the application of the fund. The Trust share of this fund is £8.0m and the 16/17 control total is a deficit of £4.4m. The Trust has submitted the draft annual plan on 8th February based on a deficit of £10.8m (including the application of the £8.0m Sustainability and Transformational Fund) which reflects the continuing deterioration in the financial position resulting from operating performance.

Warrington & Halton Hospitals NHS Foundation Trust

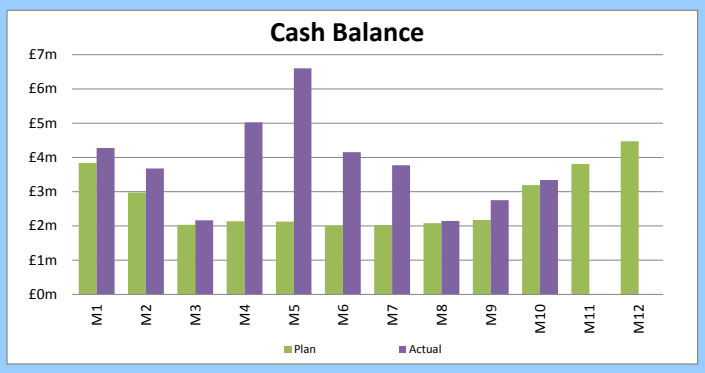
Finance Dashboard as at 31st January 2016 (Part A)

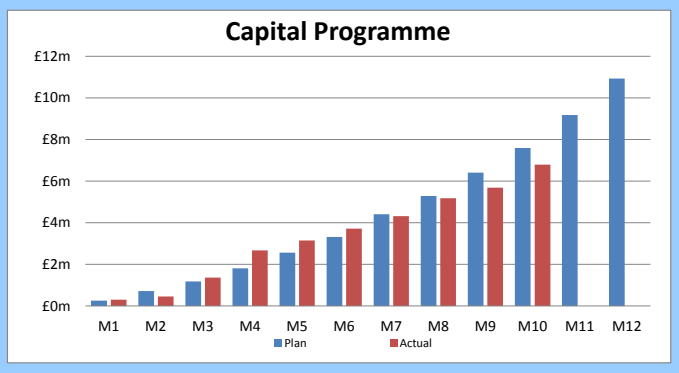
Profitability



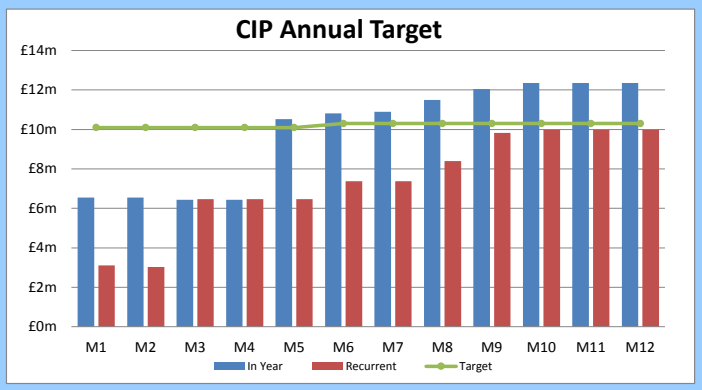


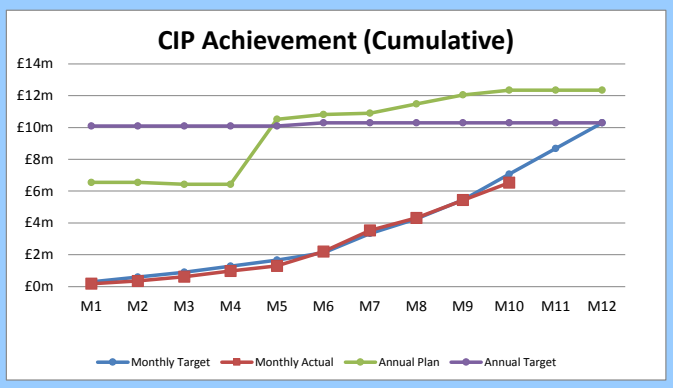
Cash and Investment





Cost Improvement Analysis





Divisional Position (net divisional income and expenditure)

Division	Annual Budget £000	Budget in month £000	Actual in month £000	Variance in month £000	Variance in month %	Budget to date £000	Actual to date £000	Variance to date £000	Variance date %
Clinical									
Scheduled Care	56,305	4,650	4,589	61	1.3	47,227	47,844	-617	-1.3
Unscheduled Care	47,014	4,118	4,506	-388	-9.4	39,577	42,057	-2,480	-6.3
Womens Children & Support Services	60,612	5,246	5,176	70	1.3	51,344	51,296	48	0.1
Corporate									
Operations - Central	680	98	88	9	9.6	598	582	17	2.8
Operations - Estates	7,439	681	595	87	12.7	6,092	5,947	146	2.4
Operations - Facilities	7,845	653	640	12	1.9	6,538	6,335	203	3.1
Finance	12,985	1,081	1,074	7	0.6	10,831	10,627	205	1.9
HR & OD	4,205	357	376	-19	-5.5	3,498	3,448	50	1.4
Information Technology	4,005	325	285	40	12.4	3,353	3,600	-247	-7.4
Nursing & Governance	2,930	248	230	17	7.0	2,434	2,355	79	3.3
Research & Development	36	3	3	0	-0.1	29	29	0	0.9
Strategy, Partnerships & Comms	741	49	33	15	31.4	643	613	30	4.6
Trust Executive	2,091	164	206	-42	-26.0	1,767	1,892	-125	-7.1
Total	**206,888**	**17,672**	**17,802**	**-130**	**-0.7**	**173,933**	**176,625**	**-2,692**	**-1.5**

Positive variance = underspend, negative variance = overspend.

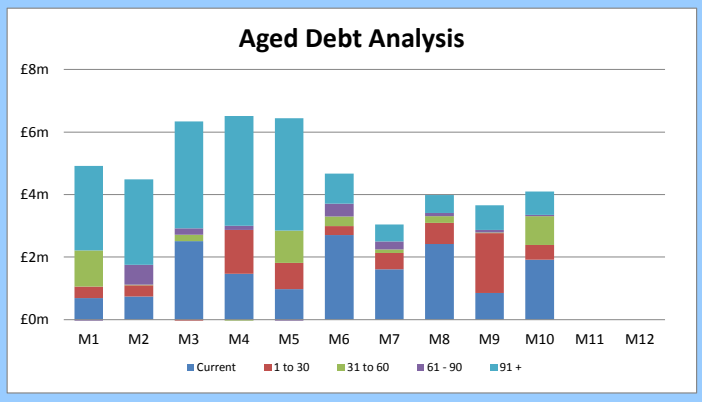
Financial Sustainability Risk Rating

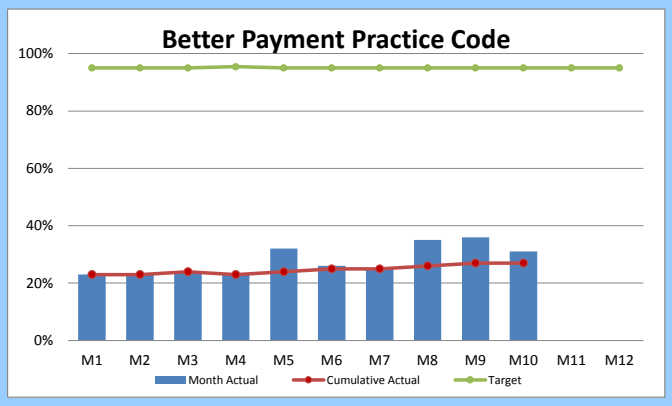
Financial Sustainability Risk Rating	Actual Metric	Actual Rating
Liquidity Ratio (days)	-1.8	1
Capital Servicing Capacity (times)	-23.7	1
Income & Expenditure Margin (%)	-8.5%	1
Income & Expenditure Margin as a % of plan (%)	-1.7%	2
Overall Risk Rating		**1**

Warrington & Halton Hospitals NHS Foundation Trust

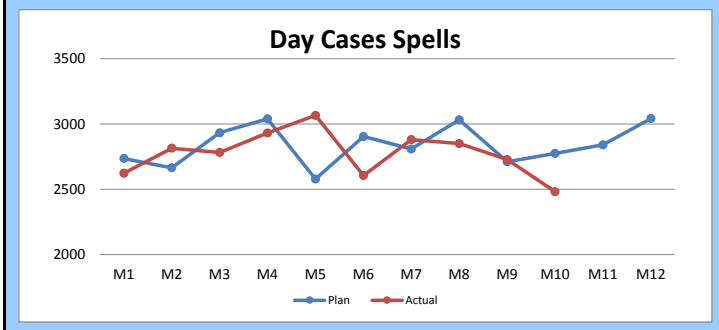
Finance Dashboard as at 31st January 2016 (Part B)

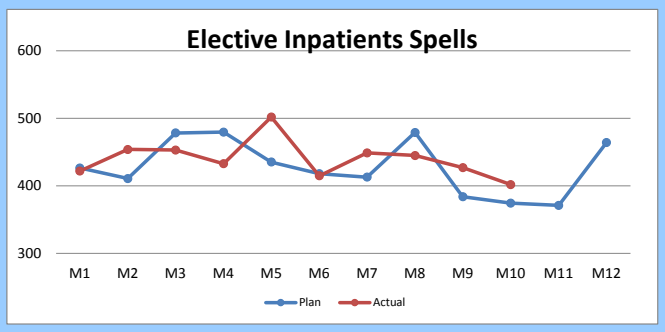
Balance Sheet and Liquidity

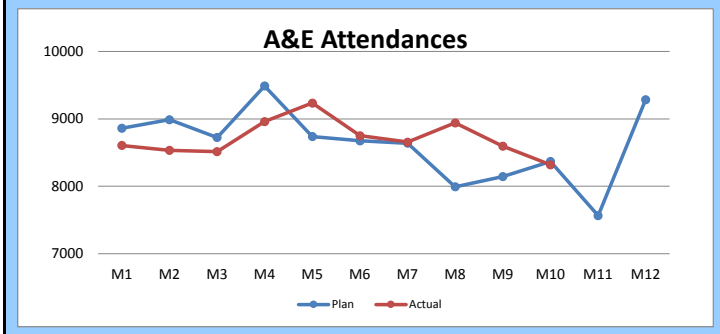


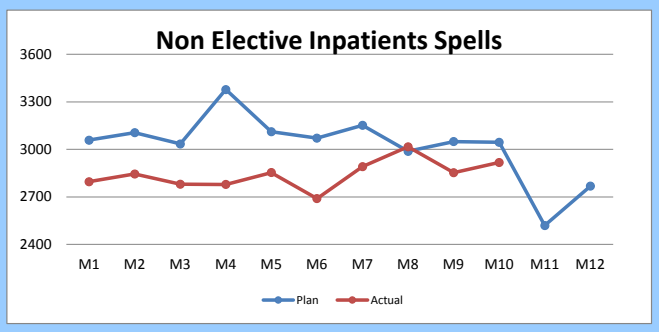


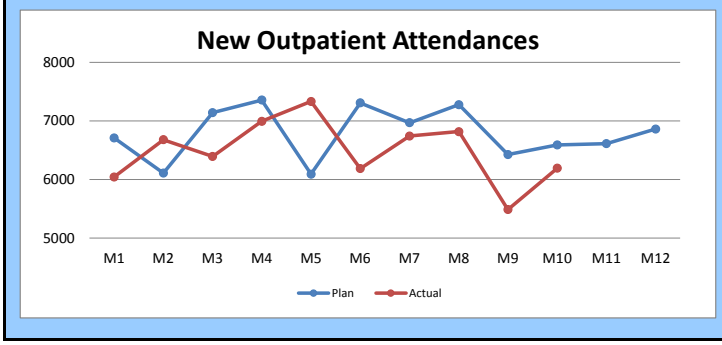
Activity Analysis

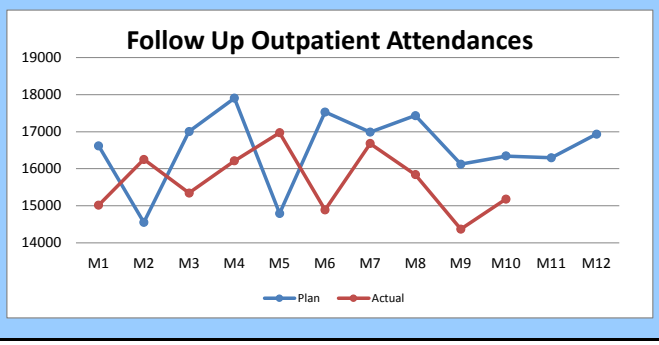












Warrington & Halton Hospitals NHS Foundation Trust **Appendix C**

Income Statement, Activity Summary and Risk Ratings as at 31st January 2016

Income Statement	Month			Year to date			Forecast		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income									
NHS Activity Income									
Elective Spells	3,069	2,756	-313	31,087	30,623	-464	37,608	37,404	-204
Elective Excess Bed Days	18	15	-3	193	148	-45	232	177	-55
Non Elective Spells	4,508	4,204	-304	45,670	43,503	-2,167	54,062	50,057	-4,005
Non Elective Excess Bed Days	280	77	-202	2,730	2,446	-284	3,195	3,024	-171
Outpatient Attendances	2,975	2,307	-667	29,148	27,412	-1,736	35,068	34,151	-917
Accident & Emergency Attendances	776	815	38	8,555	9,229	674	10,171	11,007	836
Other Activity	4,723	7,195	2,471	45,864	50,380	4,516	55,023	60,663	5,640
Sub total	**16,349**	**17,369**	**1,020**	**163,247**	**163,740**	**493**	**195,359**	**196,483**	**1,124**
Non Mandatory / Non Protected Income									
Private Patients	9	0	-9	88	61	-27	106	77	-29
Other non protected	107	62	-45	1,070	900	-170	1,284	1,118	-166
Sub total	**116**	**62**	**-54**	**1,158**	**961**	**-197**	**1,390**	**1,195**	**-195**
Other Operating Income									
Training & Education	588	626	38	5,880	6,189	309	7,056	7,398	342
Donations and Grants	0	1	1	0	5	5	0	4	4
Miscellaneous Income	793	911	118	7,890	11,424	3,534	9,475	13,128	3,653
Sub total	**1,381**	**1,537**	**157**	**13,770**	**17,618**	**3,847**	**16,532**	**20,530**	**3,998**
Total Operating Income	**17,846**	**18,968**	**1,122**	**178,176**	**182,319**	**4,143**	**213,280**	**218,208**	**4,928**
Operating Expenses									
Employee Benefit Expenses (Pay)	-12,837	-13,481	-643	-129,570	-135,341	-5,771	-155,274	-162,977	-7,703
Drugs	-1,148	-1,415	-267	-11,505	-12,389	-883	-13,802	-14,880	-1,078
Clinical Supplies and Services	-1,634	-1,547	87	-16,260	-17,167	-906	-19,530	-20,461	-931
Non Clinical Supplies	-2,348	-2,165	183	-23,624	-23,806	-182	-28,304	-28,647	-343
Total Operating Expenses	**-17,967**	**-18,607**	**-640**	**-180,959**	**-188,702**	**-7,743**	**-216,910**	**-226,965**	**-10,055**
Surplus / (Deficit) from Operations (EBITDA)	**-121**	**361**	**482**	**-2,783**	**-6,383**	**-3,600**	**-3,629**	**-8,757**	**-5,128**
Non Operating Income and Expenses									
Profit / (Loss) on disposal of assets	0	0	0	0	-101	-101	0	-101	-101
Interest Income	3	2	-1	33	20	-13	40	21	-19
Interest Expenses	-71	-12	59	-308	-53	255	-451	-106	345
Depreciation	-569	-571	-2	-5,695	-5,543	152	-6,834	-6,685	149
PDC Dividends	-344	-353	-9	-3,438	-3,528	-89	-4,126	-4,233	-107
Restructuring Costs	0	0	0	0	-36	-36	0	-36	-36
Impairments	0	0	0	0	0	0	0	0	0
Total Non Operating Income and Expenses	**-981**	**-934**	**47**	**-9,408**	**-9,240**	**168**	**-11,371**	**-11,140**	**231**
Surplus / (Deficit)	**-1,102**	**-573**	**529**	**-12,191**	**-15,623**	**-3,431**	**-15,000**	**-19,897**	**-4,897**
Activity Summary	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**
Elective Spells	3,166	3,107	-59	32,648	32,167	-481	39,201	38,124	-1,077
Elective Excess Bed Days	84	68	-16	889	694	-195	1,068	832	-236
Non Elective Spells	3,045	2,792	-253	30,995	28,423	-2,572	36,284	35,586	-698
Non Elective Excess Bed Days	1,301	331	-970	12,839	11,469	-1,370	15,044	14,211	-833
Outpatient Attendances	27,640	22,349	-5,291	280,570	267,865	-12,705	336,500	336,469	-31
Accident & Emergency Attendances	8,369	8,607	238	86,616	87,104	488	103,464	102,645	-819
Financial Sustainability Risk Ratings	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**
Metrics									
Capital Servicing Capacity (Times)				-0.7	-1.8	-1.0	-0.8	-2.0	-1.2
Liquidity Ratio (Days)				-15.1	-23.7	-8.5	-11.5	-24.0	-12.5
I&E Margin (%)				-6.8%	-8.5%	-1.7%	-7.0%	-9.1%	-2.0%
I&E Margin as % of plan (%)				-1.9%	-1.7%	0.3%	-1.9%	-2.0%	-0.1%
Ratings									
Capital Servicing Capacity (Times)				1	1	0	1	1	0
Liquidity Ratio (Days)				1	1	0	2	1	-1
I&E Margin (%)				1	1	0	1	1	0
I&E Margin as % of plan (%)				2	2	0	2	1	-1
Financial Sustainability Risk Rating				**1**	**1**	**0**	**2**	**1**	**0**

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

Cash Flow Statement as at 31st January 2016

	Actual April £000's	Actual May £000's	Actual June £000's	Actual July £000's	Actual August £000's	Actual September £000's	Actual October £000's	Actual November £000's	Actual December £000's	Actual January £000's	Forecast February £000's	Forecast March £000's	Annual Position March £000's
Surplus/(deficit) after tax	**(1,936)**	**(2,811)**	**(1,313)**	**(798)**	**(1,660)**	**(1,522)**	**(1,226)**	**(1,294)**	**(2,490)**	**(573)**	**(2,651)**	**(1,624)**	**(19,898)**
Non-cash flows in operating surplus/(deficit)													
Finance (income)/charges	1	1	3	2	2	2	2	2	2	10	32	32	91
Depreciation and amortisation	543	548	536	548	561	565	556	558	558	571	551	551	6,646
(Gain)/loss on disposal of property plant and equipment					(45)	7	137	2	0	0		0	101
PDC dividend expense	344	344	344	344	344	462	288	353	353	353	352	352	4,233
Other increases/(decreases) to reconcile to profit/(loss) from operations	(9)	(4)	8	(9)	(10)	(17)	(46)	2	4	0	25	56	0
Non-cash flows in operating surplus/(deficit), Total	**879**	**889**	**891**	**885**	**852**	**1,019**	**937**	**917**	**917**	**934**	**960**	**991**	**11,071**
Operating Cash flows before movements in working capital	**(1,057)**	**(1,922)**	**(422)**	**87**	**(808)**	**(503)**	**(289)**	**(377)**	**(1,573)**	**361**	**(1,691)**	**(633)**	**(8,827)**
Increase/(Decrease) in working capital													
(Increase)/decrease in inventories	392	(147)	(132)	(93)	232	(433)	441	(26)	(323)	108		(18)	1
(Increase)/decrease in NHS Trade Receivables	1,832	526	(1,082)	(675)	136	1,707	1,056	(1,181)	246	(141)	250	(1,479)	1,194
(Increase)/decrease in Non NHS Trade Receivables	303	12	(658)	(280)	16	(116)	595	237	52	(312)	200	(850)	(800)
(Increase)/decrease in other related party receivables	(266)	292	(277)	(256)	548	194	(209)	101	(204)	198		(121)	(0)
(Increase)/decrease in other receivables	412	(63)	66	19	(3)	(22)	(11)	(76)	(5)	12		(330)	(1)
(Increase)/decrease in accrued income	(390)	(1,518)	523	405	(469)	1,232	(984)	(79)	109	(1,671)		759	(2,083)
(Increase)/decrease in prepayments	(1,302)	(960)	1,692	(51)	50	(577)	569	(263)	(34)	227	350	(503)	(800)
Increase/(decrease) in Deferred Income (Govt. Grants)	255	2,912	254	5,769	1,002	665	421	(2,393)	(2,164)	(1,859)		(2,781)	2,082
Increase/(decrease) in Current provisions	(71)	1	6	8	7	3	(6)	(1)	7	16	(20)	92	40
Increase/(decrease) in Trade Creditors	(1,475)	(80)	474	(439)	1,776	(3,111)	(1,228)	1,623	1,628	2,052	(968)	3,554	3,805
Increase/(decrease) in Other Creditors	(160)	73	(33)	(156)	9	79	(64)	134	(21)	7		134	2
Increase/(decrease) in accruals	1,402	659	(1,289)	(328)	(482)	1,346	(178)	(598)	954	(1,150)		(303)	33
Increase/(decrease) in other Financial liabilities (borrowings)	64	3	695	(49)	4	4	4	(58)	(27)	(74)		(568)	(0)
Increase/(decrease) in Other liabilities (VAT, Social Security and Other Taxes)	75	11	(47)	51	(133)	92	49	(56)	65	(27)		(81)	(0)
Increase/(decrease) in Other liabilities (charitable assets)													
Increase/(Decrease) in working capital, Total	**1,069**	**1,721**	**192**	**3,924**	**2,694**	**1,064**	**456**	**(2,637)**	**287**	**(2,614)**	**(188)**	**(2,495)**	**3,472**
Increase/(decrease) in Non-current provisions	58	12	(66)	(17)	12	12	(32)	27	(62)	(25)		81	0
Net cash inflow/(outflow) from operating activities	**70**	**(188)**	**(296)**	**3,994**	**1,899**	**573**	**135**	**(2,987)**	**(1,349)**	**(2,278)**	**(1,879)**	**(3,047)**	**(5,354)**
Net cash inflow/(outflow() from investing activities													
Property - new land, buildings or dwellings	(70)	(90)	(18)	(326)	(122)	(23)	(206)	(165)	(137)	(494)	0	0	**(1,651)**
Property - maintenance expenditure	(150)	(58)	(56)	(28)	(160)	(33)	(49)	(125)	(77)	(114)	(300)	(352)	**(1,502)**
Plant and equipment - Information Technology	(58)	4	(718)	(530)	(80)	(490)	(283)	(440)	(278)	(364)	(600)	(400)	**(4,237)**
Plant and equipment - Other	(23)	(13)	(114)	(431)	(108)	(24)	(62)	(136)	(14)	(125)	0	0	**(1,050)**
Proceeds on disposal of property, plant and equipment					78		12					0	90
Increase/(decrease) in Capital Creditors		(252)	(300)	181	80	(263)	(14)	28	(25)	227		339	(0)
Net cash inflow/(outflow() from investing activities, Total	**(301)**	**(409)**	**(1,206)**	**(1,134)**	**(312)**	**(833)**	**(602)**	**(838)**	**(531)**	**(870)**	**(900)**	**(413)**	**(8,350)**
Net cash inflow/(outflow) before financing	**(231)**	**(597)**	**(1,502)**	**2,860**	**1,586**	**(260)**	**(467)**	**(3,825)**	**(1,880)**	**(3,148)**	**(2,779)**	**(3,460)**	**(13,705)**
Net cash inflow/(outflow) from financing activities													
PDC Dividends paid						(2,181)						(2,128)	(4,309)
Interest (paid) on non-commercial loans									0	0	0	0	0
Interest element of finance lease rental payments - other	(2)	(3)	(4)	(4)	(4)	(4)	(4)	(5)	(4)	(4)	(6)	(6)	(50)
Interest received on cash and cash equivalents	3	2	1	2	3	2	2	3	2	2	1	1	24
Drawdown of non-commercial loans	0	0	0					2,136	2,496	3,726	3,265	4,177	15,800
Repayment of non-commercial loans													0
(Increase)/decrease in non-current receivables	(8)	0	(11)	5	0	(12)	83	64	0			(123)	(0)
Net cash inflow/(outflow) from financing activities, Total	**(7)**	**(1)**	**(14)**	**3**	**(1)**	**(2,195)**	**81**	**2,198**	**2,494**	**3,724**	**3,260**	**1,921**	**11,465**
Net increase/(decrease) in cash	**(238)**	**(598)**	**(1,517)**	**2,864**	**1,586**	**(2,455)**	**(386)**	**(1,627)**	**614**	**576**	**481**	**(1,539)**	**(2,240)**
Opening cash	**4,511**	**4,273**	**3,675**	**2,159**	**5,022**	**6,608**	**4,153**	**3,766**	**2,139**	**2,753**	**3,329**	**3,810**	**4,511**
Closing cash	**4,273**	**3,675**	**2,159**	**5,022**	**6,608**	**4,153**	**3,766**	**2,139**	**2,753**	**3,329**	**3,810**	**2,271**	**2,271**

Forecast cash position as per Original Monitor plan	3,838	2,979	2,028	2,131	2,122	2,003	2,021	2,080	2,171	3,193	3,810	4,471
Actual cash position	4,273	3,675	2,159	5,022	6,608	4,153	3,766	2,139	2,753	3,329	3,810	2,271
Variance	**435**	**696**	**131**	**2,891**	**4,486**	**2,150**	**1,745**	**59**	**582**	**136**	**0**	**-2,200**

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

Statement of Position as at 31st January 2016

Narrative	Audited position as at 31/03/15 £000	Actual Position as at 31/12/15 £000	Actual Position as at 31/01/16 £000	Monthly Movement £000	Forecast Position as at 31/03/16 £000
ASSETS					
Non Current Assets					
Intangible Assets	567	1,416	1,694	278	865
Property Plant & Equipment	143,355	143,036	143,284	248	144,660
Other Receivables	1,336	1,259	1,244	-15	1,336
Impairment of receivables for bad & doubtful debts	-253	-277	-274	3	-253
Total Non Current Assets	**145,005**	**145,435**	**145,949**	**514**	**146,608**
Current Assets					
Inventories	3,312	3,400	3,293	-108	3,312
NHS Trade Receivables	5,627	3,063	3,205	141	4,326
Non NHS Trade Receivables	1,364	611	923	312	564
Other Related party receivables	585	663	464	-198	585
Other Receivables	1,865	1,528	1,511	-17	1,864
Impairment of receivables for bad & doubtful debts	-321	-372	-367	4	-321
Accrued Income	882	2,054	3,725	1,671	882
Prepayments	2,498	3,372	3,145	-227	1,698
Cash held in GBS Accounts	4,486	2,735	3,320	586	2,246
Cash held in commercial accounts	0	0	0	0	0
Cash in hand	25	19	19	0	25
Total Current Assets	**20,323**	**17,073**	**19,238**	**2,165**	**15,181**
Total Assets	**165,328**	**162,508**	**165,187**	**2,679**	**161,789**
LIABILITIES					
Current Liabilities					
NHS Trade Payables	-2,351	-1,861	-2,527	-666	-1,801
Non NHS Trade Payables	-8,134	-7,791	-9,177	-1,386	-11,782
Other Payables	-1,856	-1,717	-1,724	-7	-1,853
Other Liabilities (VAT, Social Security and Other Taxes)	-2,667	-2,775	-2,748	27	-2,667
Capital Payables	-1,599	-504	-731	-227	-1,599
Accruals	-5,765	-7,252	-6,101	1,150	-5,765
Interest payable on non commercial int bearing borrowings	0	-6	-14	-8	0
PDC Dividend creditor	-76	-994	-1,347	-353	-76
Deferred Income	-974	-7,696	-5,837	1,859	-974
Provisions	-335	-287	-303	-16	-295
Loans non commercial	0	0	0	0	0
Borrowings	-185	-332	-332	0	-185
Total Current Liabilities	**-23,942**	**-31,214**	**-30,841**	**373**	**-26,997**
Net Current Assets (Liabilities)	**-3,619**	**-14,141**	**-11,603**	**2,538**	**-11,816**
Non Current Liabilities					
Loans non commercial	0	-4,632	-8,358	-3,726	-15,803
Provisions	-1,395	-1,340	-1,314	25	-1,395
Borrowings	-703	-1,083	-1,009	74	-703
Total Non Current Liabilities	**-2,098**	**-7,055**	**-10,681**	**-3,627**	**-17,901**
TOTAL ASSETS EMPLOYED	**139,288**	**124,239**	**123,665**	**-574**	**116,891**
TAXPAYERS AND OTHERS EQUITY					
Taxpayers Equity					
Public Dividend Capital	90,242	90,242	90,242	0	87,742
Retained Earnings prior year	3,970	3,969	3,969	0	3,970
Retained Earnings current year	0	-15,049	-15,623	-574	-19,898
Sub total	**94,212**	**79,162**	**78,588**	**-574**	**71,814**
Other Reserves					
Revaluation Reserve	45,077	45,077	45,077	0	45,077
Sub total	**45,077**	**45,077**	**45,077**	**0**	**45,077**
TOTAL TAXPAYERS AND OTHERS EQUITY	**139,289**	**124,239**	**123,665**	**-574**	**116,891**

Board of Directors

SUBJECT:	**Cost Improvement Programme (CIP) Update**	
DATE OF MEETING:	17 February 2016	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Lucy Gardner, Director Of Transformation	
EXECUTIVE DIRECTOR:	Mel Pickup, Chief Executive Andrea Chadwick, Director of Finance and Commercial Development	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO4/4.2 Failure to: Maintain a liquidity ratio and capital servicing capacity necessary to deliver a continuity of services risk rating of at least 3 on a quarterly basis; remain a going concern at all times remain solvent. SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	• The Trust has a CIP target of £10.3m to deliver in 2015/16 (£9.5m as per Monitor plan plus £0.6m full year effect of 14/15 schemes not deducted from divisional budgets plus £0.2m anticipated over delivery added to the CIP plan as part of the Monitor submission in September 15) • At the end of Month 10 against a CIP plan of £7.150m the Trust has delivered £6.528m (91.3%) in actual CIP savings. • At Month 10 the forecast outturn for the 2015/16 CIP programme is £8.563m.	
RECOMMENDATION:	***The FSC is asked to:*** • Note the contents of the report • Note the progress to date against the transformational programmes of work • Note that there is a significant amount of the CIP programme which is profiled for the final 2 months and efforts need to be focused on the achievement of the associated CIP schemes supported by mitigation if necessary.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Not Applicable

COST IMPROVEMENT PROGRAMME (CIP) 2015/16 PROGRESS REPORT

EXECUTIVE SUMMARY

To update the Board on the 2015/16 Cost Improvement. The key points arising from the report are:

- The Trust has a CIP target of £10.3m to deliver in 2015/16. This is made up of £9.5m target for 2015/16 plus £0.6m to account for the full year effect of 14/15 schemes not deducted from divisional budgets relating to the medical productivity and beds/LOS reduction schemes plus £0.2m anticipated over delivery added to the CIP plan as part of the Monitor submission in September 15.
- At the end of Month 10 against a CIP plan of £7.150m the Trust has delivered £6.528m (91.3% of plan) in actual CIP savings.
- At Month 10 the forecast outturn for the 2015/16 CIP programme is £8.563m.

CONTEXT

An updated financial forecast has been prepared which shows that the forecast outturn for the Trust has now deteriorated to £20.1m from that submitted to Monitor in August 2015 (£14.2m) and that submitted to the Board in January (£16.4m). The £20.1m deficit is predicated on achievement of the £8.563m forecast outturn for the 2015/16 CIP programme. The Trust needs to deliver its 2015/16 CIP forecast outturn and put plans in place for longer term financial and clinical sustainability.

OVERVIEW OF THE 2015/16 CIP

For 2015/16 the Trust has an annual savings target of £10.3m. The values of the plans and the forecast outturn for the 2015/16 schemes are detailed on the next page:

	£000s	£000s
Annual target	10,300	10,300
Tactical	**CIP schemes planned M10**	**CIP Forecast outturn M10**
Sustainability	3,300	3,317
Best Practice Tariff	178	95
Procurement	733	892
Drugs procurement & optimisation	300	191
Clinical coding – comorbidities & escalation	2,000	2,757
Outpatients – capacity and productivity improvement	600	0
Clinical Coding A&E HRGs	400	0
Clinical Coding – Multi Professional Clinics	300	300
Treasury Discount Rate Change	100	100
	7,911	**7,652**
Transformational change		
Scheduled Care		
Improve theatre utilisation	380	380
Critical Care (ITU/HDU) bed reductions	300	40
Acute Care Team/Hospital out of Hours	60	0
Unscheduled Care		
Patient pathway & LOS reductions overall plan is for £900k		
• A8/A4/STAR	84	0
• Coronary Care Unit	50	50
• T&O	80	0
Balance of 900k target	686	-
Lung Function tests	220	220
Continuous Positive Airway Pressure (CPAP)	13	13
Thyroid Patient Pathway	18	18
Womens Childrens & Support Services		
DNA reduction - anti coagulation, radiology, inpatients, MSK	40	0
Non EU patient reporting (DH initiative from 1 April 15)	10	10
Recording of maternity pathway via technology	38	38
Ultrasound in Musculoskeletal (MSK)	2	2
Midwifery Vacancy factor	0	0
MRI replacement (increased throughput)	99	99
Workforce		
Buy back annual leave	10	27
Temporary staffing reductions (reducing usage of nursing & medical agency and medical locums)	1,100	0
Medical productivity & reductions in WLIs	1,000	0
	4,190	**897**
Strategic change – business development		
Income generation programme (contribution)	250	14
	250	**14**
Value of Schemes identified / forecast	**12,351**	**8,563**
(Surplus) / Gap in CIP plan/forecast	**(2,051)**	**1,737**
2015/16 CIP Plan /Forecast	**10,300**	**10,300**

PMO ARRANGEMENTS

Lucy Gardner from EY commenced as Director of Transformation 1 February 2016 on a twelve month secondment. Lucy replaced Mark Partington who left the Trust end January 2016 and will be reviewing the PMO structure over the coming months in line with the new Clinical Business Units and the requirements of the 2016/17 CIP plan.

REPORT AT END OF MONTH 10 2015/16

The following graphs provide the details of performance against plan at the end of Month 10. The graphs/tables illustrate:

- The Trust has a CIP target of £10.3m to deliver in 2015/16
- At the end of month 10, against a plan of £7.150m the Trust has delivered £6.528m (91.3% of plan) in actual CIP savings.
- At Month 10 the forecast outturn for the 2015/16 CIP programme is £8.563m.
- To achieve the CIP forecast outturn of £8.563m, £2.035m will need to be delivered in the final 2 months of 2015/16.

The variance against plan at the end of month 10 is £622k and this is due to:-

- over delivery of the clinical coding scheme £982k, sustainability schemes (including additional sustainability for corporate divisions) £125k and procurement £69k which has been offset by:
  - no actuals being reported against the outpatients productivity and efficiency scheme (YTD plan £449k). This scheme is unlikely to deliver as the OP activity and income is significantly below plan;
  - under delivery (£105k) of the theatre scheme to date;
  - under delivery of the patient pathway/beds/length of stay reduction scheme (YTD plan £543k) – £50k planned savings have been identified and delivered for the Coronary Care Unit, planned savings with an in year target of £84k for A4/A8/STAR are unlikely to be realised because of the extent of escalation in these areas. Planned savings of £80k for T&O are still to be identified;
  - under delivery of the Critical Care HDU/ITU bed reduction scheme (YTD plan £200k) – non recurrent savings taken by Scheduled Care sustainability. An agreed programme for savings of £40k in year, £163k full year effect is being actioned;
  - no actuals being reported against the Temporary Staffing Reduction scheme (YTD plan £733k) – the Trust is working towards but not yet achieving Monitor targets on Nurse agency spend. Medical agency and locum spend is being monitored although spend is not reducing due to recruitment difficulties;
  - no actual being reported against the medical productivity scheme (YTD plan £333k) – this scheme was predicated on savings being realised from several sources; a review of re-charge arrangements with Chester for Vascular surgery, comprehensive job plan reviews for Consultants, monitoring of clinical activity using a new software package called Allocate, and minimising loss of fixed clinical sessions at times of clinical audit. However it is unlikely that there will be any contribution to CIP in 2015/16.
  - Clinical coding A&E HRGs (£133k) the review of how A&E attendances are coded and charged for is underway but it is unlikely that any significant contribution to CIP will be achieved in 2015/16.

Current Month Jan-16

CIP / Transformation Programme Performance 15-16

	Number of Schemes	% of Schemes by Number
GREEN	38	48%
AMBER	6	8%
RED	36	45%
(See key below*)	**80**	**100%**

Overall Status of CIP scheme identification	CIP Schemes Identified vs 15 -16 Annual CIP Target of £10.3m	120%	GREEN

RAG Status for scheme identification

GREEN	*CIP Schemes identified is equal to or greater than 96% of Annual Plan*
AMBER	*CIP Schemes identified is equal to or greater than 75% of Annual Plan*
RED	*CIP Schemes identified is equal to or less than 74% of Annual Plan*

* **REPORTED RAG:For schemes that have started:**

GREEN	*YTD delivery is equal to or greater than 96% of YTD plan*
AMBER	*YTD delivery is equal to or greater than 75% of YTD plan*
RED	*YTD delivery is equal to or less than 74% if YTD plan*

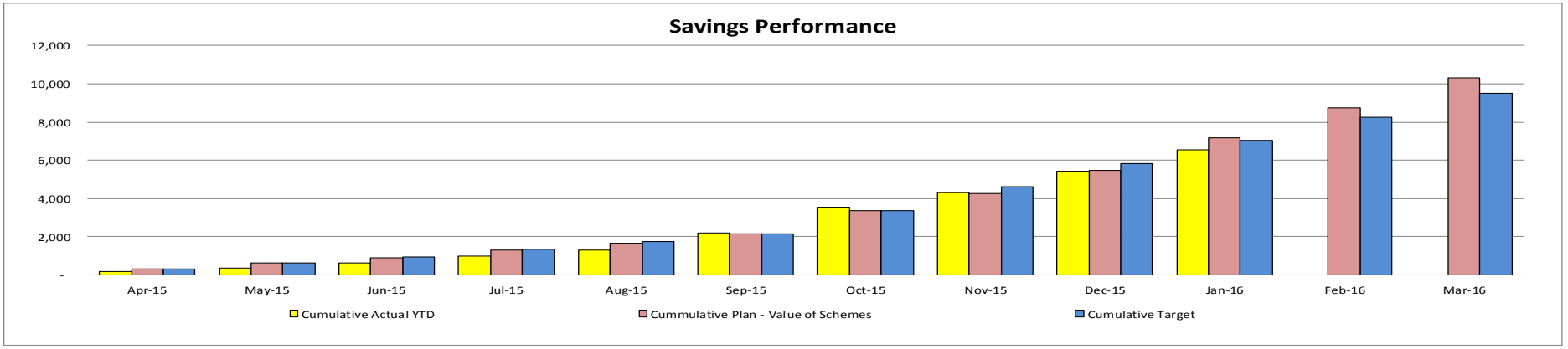
For schemes that have not yet started - Default to Planning RAG:

GREEN	*Planning complete and signed off or awaiting formal sign off*
AMBER	*Planning in progress*
RED	*No planning evident*

CIP Plans - Schemes identified against Annual Plan

CIP Category	Annual Plan as at 31 December 15	Planned value of schemes PYE	Forecast outturn	% of Annual Target covered by planned schemes	Forecast FYE
	£000	£000	£000	%	£000s
Tactical	7,911	7,911	7,653	100%	7,349
Transformational Change - Scheduled Care	820	820	420	100%	543
Transformational Change -WCSS	189	189	149	100%	252
Transformational Change -Unscheduled Care	1,071	1,071	301	100%	525
Transformational Change -Workforce	2,110	2,110	27	100%	27
Strategic Change - Business Development	250	250	14	100%	0
Strategic Change - IT/Lorenzo	0	0	0	0%	0
Contingency	-2,051	0	0	0%	0
Totals	10,300	12,351	8,564	120%	8,696

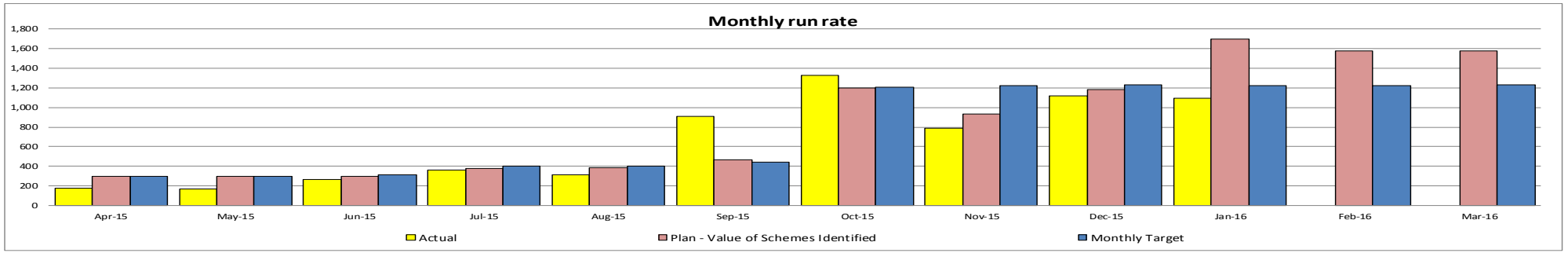
Identified value is the value of schemes covered by detailed PIDs or were analysis has been worked up to support the scheme.

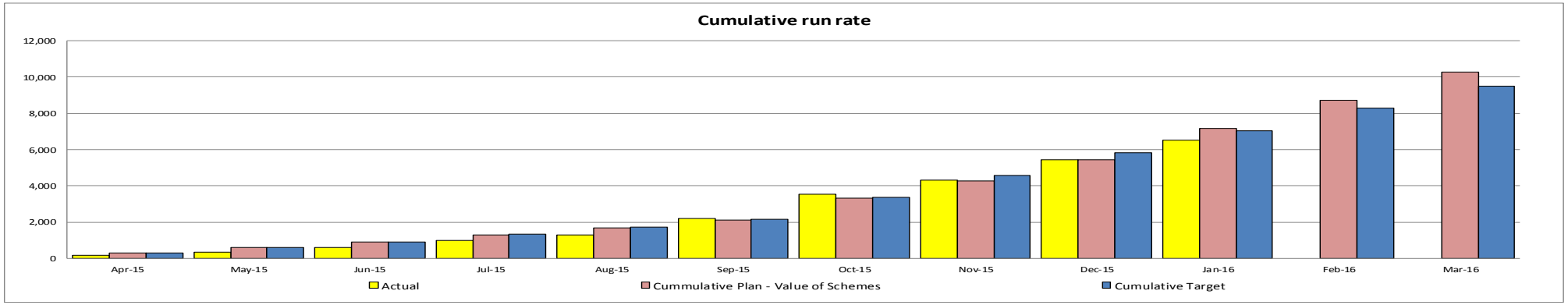


Jan - 16 **Select Month**

Summary by CIP Workstream

2015-16 Trust Plan at 31 January 16 £000s	CIP Theme / Workstream	In Month £000 Plan	In Month £000 Actual	In Month £000 Var.	Year To Date £000 Plan	Year To Date £000 Actual	Year To Date £000 Var.	Forecast Outturn £000 Plan	Forecast Outturn £000 Realistic Outturn	Forecast Outturn £000 Var.	FYE Forecast Outturn £000
7,911	Tactical	1,279	1,013	(267)	5,593	6,071	479	7,911	7,653	(258)	7,349
820	Transformational Change - Scheduled Care	126	59	(67)	567	216	(352)	820	420	(400)	543
189	Transformational Change -WCSS	29	0	(29)	131	21	(111)	189	149	(40)	252
1,071	Transformational Change -Unscheduled Care	165	18	(147)	742	195	(546)	1,071	301	(770)	525
2,110	Transformational Change -Workforce	518	3	(515)	1,075	24	(1,051)	2,110	27	(2,083)	27
250	Strategic Change - Business Development	83	0	(83)	83	0	(83)	250	14	(236)	0
0	Strategic Change - IT/Lorenzo	0	0	0	0	0	0	0	0	0	0
(2,051)	Contingency	(505)	0	505	(1,041)	0	1,041	(2,051)	0	2,051	0
10,300	Totals	1,695	1,092	(603)	7,150	6,527	(623)	10,300	8,564	(1,736)	8,696

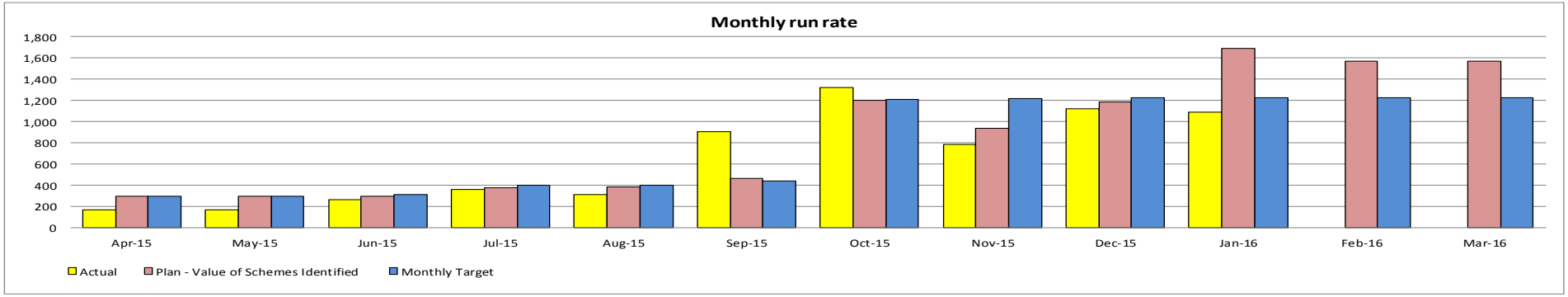


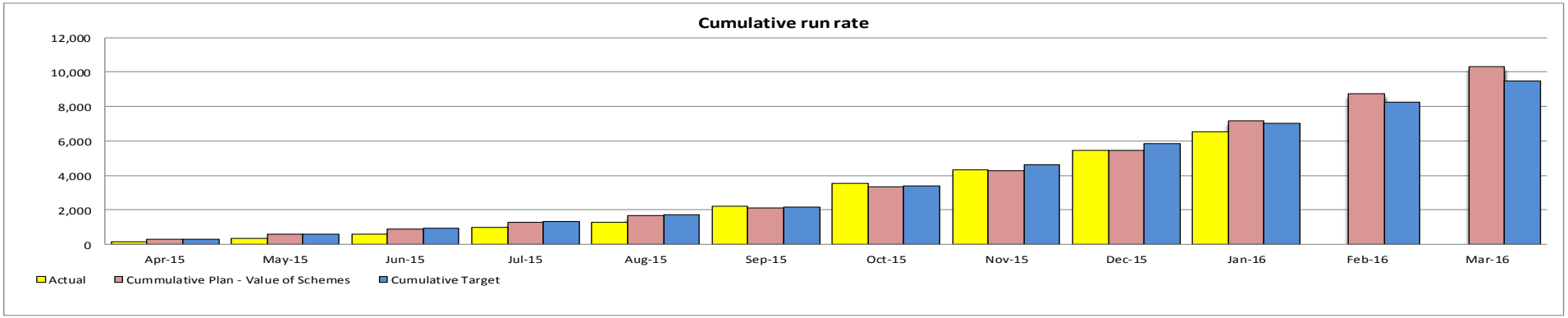


Jan - 16

Summary by Division

2015-16 Trust Plan at 31 January 16 £000s	Divisions	In Month £000 Plan	In Month £000 Actual	In Month £000 Var.	Year To Date £000 Plan	Year To Date £000 Actual	Year To Date £000 Var.	Forecast Outturn £000 Plan	Forecast Outturn £000 Realistic Outturn	Forecast Outturn £000 Var.	FYE Forecast £000
1,311	WCSS	126	106	(20)	1,059	841	(218)	1,311	1,209	(102)	1,245
1,104	Unscheduled Care	122	59	(63)	860	780	(80)	1,104	1,068	(36)	837
339	Facilities	36	43	8	268	330	62	339	355	16	280
259	Estates	29	49	20	200	190	(11)	259	260	1	182
1,781	Scheduled Care	244	207	(36)	1,293	985	(308)	1,781	1,419	(362)	1,450
138	Governance & Workforce	17	16	(1)	105	120	16	138	138	0	76
174	Finance	42	37	(5)	91	99	9	174	174	(0)	147
7	Central Ops	1	0	(0)	5	3	(2)	7	7	0	4
47	Trust Execs	5	3	(3)	37	51	14	47	47	(0)	30
30	Nursing	3	13	11	25	50	25	30	30	0	30
14	Business Development	2	14	12	11	39	28	14	14	(0)	9
126	IT	21	30	9	83	80	(3)	126	123	(3)	21
7,020	Trust Wide	1,553	515	(1,038)	4,154	2,958	(1,196)	7,020	3,720	(3,300)	4,385
-2,051	Contingency	-505	0	505	-1,041	0	1,041	(2,051)	(1,751)	300	0
10,300	Totals	1,695	1,092	(603)	7,150	6,527	(623)	10,300	8,564	-1,736	8,696





The Board is asked to:

- Note the contents of the report
- Note the changes to the PMO

Lucy Gardner

February 2016

BOARD OF DIRECTORS 16/055

SUBJECT:	**Corporate Performance Report**	
DATE OF MEETING:	24th February 2016	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Sharon Gilligan, Chief Operating Officer	
EXECUTIVE DIRECTOR SPONSOR:	Sharon Gilligan, Chief Operating Officer Choose an item.	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework	
FREEDOM OF INFORMATION STATUS (FOIA):	Release document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	The corporate report updates the Board of Directors on the progress of the Trust in relation to activity, performance and workforce targets to 31st January 2016	
RECOMMENDATION:		
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee
	Agenda Ref.	
	Date of meeting	17th February 2016
	Summary of Outcome	

Corporate Performance Report

1.0 INTRODUCTION

This corporate report updates the Board of Directors on the progress of the Trust in relation to activity, performance and workforce targets to 31st of January 2015.

2.0 PERFORMANCE

In overall terms, based on the performance in month 10 the Trust has a Service Performance Score of 1, as highlighted in Appendix 1. The RTT target has been achieved but validation is ongoing to reduce the number of specialty breaches, therefore, the exact percentage is not available at the time of writing.

3.0 NATIONAL KEY PERFORMANCE INDICATORS

3.1 Accident and Emergency National Indicators:

National Indicators		Target	Jan	Qtr1	Qtr2	Qtr3	Qtr4	YTD Position
A&E, UCC and Walk-in	% Departed < 4hrs	95%	81.33%	91.13%	92.92%	87.53%		89.49%
	Number of patients breaching 4hrs		1847	2170	2034	3661		9712

The January position includes 20 breaches at the walk-in centre, which is symptomatic of general system pressures.

The Chief Executive, Chief Operating Officer, Medical Director and Director of Nursing have been invited to a workshop on 1st March with NHS Improvement to discuss and learn from colleagues that are delivering consistently high standards.

Ambulance Handovers:

Local Indicators		Target	Jan	Qtr1	Qtr2	Qtr3	Qtr4	YTD Position
Ambulance Handovers	Number handed over 30 to 60 mins	0	134	155	79	227		595
	Number handed over >60 mins	0	108	35	13	87		243
	HAS Compliance Score	90%	90.78%	81.51%	91.18%	91.32%		88.42%

Accident and Emergency Quality Indicators

The AED monthly monitoring metrics which is submitted to Monitor on a monthly basis is attached as appendix 2. This is submitted on the third Friday of every month and currently January data is not yet available for each indicator, although plans are in place to obtain all of the required to submit in line with timescales. This data has been consistently submitted since August 2016. The team are working on splitting the NHS attributed DToCs between the Trust and other NHS providers.

3.2 18 Week Referral to Treatment:

National Indicators		Target	Jan	Qtr1	Qtr2	Qtr3	Qtr4	YTD Position
RTT - 18 Weeks	Completed Admitted Pathways <18 Weeks (Adjusted position)	>=90%	85.44%	93.05%	92.57%	92.94%		92.27%
	Completed Non-Admitted Pathways <18 Weeks	>=95%	96.10%	97.64%	97.58%	96.92%		97.16%
	All Waiters <18 Weeks	>=92%	93.75%	93.87%	93.23%	93.40%		93.53%

The Trust has consistently achieved the RTT targets since Lorenzo go live, but increased validation has been necessary in line with expectation. The number of patients on an incomplete pathway has increased significantly and this is being closely monitored to ensure that it is entirely a data issue. Although the Trust submits data on all 3 RTT targets it is only the incompletes target that has a financial penalty attached to non achievement. At the time of writing the RTT target for incomplete pathways has been achieved, but an extension to the submission of data has been agreed with the Department of Health to allow further validation to reduce the number of breaches which have arisen due to data issues post Lorenzo implementation. It is entirely normal to have data quality issues when implementing a new PAS.

3.3 Infection Control

National Indicators		Target	Jan	Qtr1	Qtr2	Qtr3	Qtr4	YTD Position
MRSA Bacteraemia	Hospital Acquired	<=0	0	0	2	0		2
	Community Acquired		1	0	1	0		2
	Total		1	0	3	0		4
Clostridium Difficile	Hospital Acquired - Due to lapses in care	<=27	0	4	4	2		10
	Hospital Acquired - Not due to lapses in care		0	8	1	3		12
	Hospital Acquired - Under Review		0	0	0	0		0
	Hospital Acquired - Total		0	12	5	5		22
	Community Acquired		3	5	12	7		27
	Total		3	17	17	12		49

MRSA bacteraemia

One community apportioned case was reported in January 2016.

Clostridium Difficile

No hospital apportioned Clostridium difficile cases were reported in January 2016. YTD the Trust has reported 22 hospital apportioned cases of Clostridium difficile. This includes the 12 cases removed from contractual sanctions.

3.4 Diagnostics

National Indicators		Target	Apr	May	Jun	Qtr1	Jul	Aug	Sep	Qtr2	Oct	Nov	Dec	Qtr3	Jan
Diagnostics - 6+ Week Waiters	% of Patients waiting >= 6 Weeks	<1%	0.00%	0.00%	0.00%		0.00%	0.00%	0.00%		0.00%	0.00%	3.58%		0.00%
	No of Patients waiting >= 6 Weeks		0	0	0	0	0	0	0	0	0	0	120	1	0

The issues around the implementation of the new IT system and the management of potential breaches in Endoscopy which led to the Trust breaching the target in December have now been addressed and all affected patients treated.

3.5 Cancer:

National Indicators		Target	Jan	Qtr1	Qtr2	Qtr3	Qtr4	YTD Position
Cancer	2 Week Wait	>=93%	93.80%	93.00%	93.90%	94.40%		93.91%
	Breast Symptom 2 Week Wait	>=93%	98.30%	93.20%	95.80%	96.00%		93.43%
	31 Day First Treatment	>=96%	100.00%	100.00%	100.00%	100.00%		99.33%
	31 Day Subsequent Treatment : Surgery	>=94%	100.00%	98.67%	100.00%	100.00%		99.00%
	31 Day Subsequent Treatment : Drugs	>=98%	100.00%	100.00%	100.00%	100.00%		100.00%
	62 Day First Treat - Urgent GP - Open Exeter	>=85%	85.00%	85.25%	85.71%	86.90%		85.54%
	62 Day First Treat - Urgent GP - Reallocation	>=85%	85.00%	86.10%	85.65%	85.06%		85.04%
	62 Day First Treatment - Screening	>=90%	100.00%	93.80%	100.00%	100.00%		96.88%
	CRS 62 Day Consultant Upgrade		0.00%	100.00%	94.10%	83.30%		50.00%

Please see Appendix 3 for a summary by month and by tumour group. This shows that, as with many Trusts, the tumour group which struggles most to achieve these targets is Urology; work is on-going to review pathways in this area.

3.6 **Trajectory for achievement of some of our reduced performance key indicators in 2016/17**.

Delivery to an improved trajectory is one of the key objectives for access to the Sustainability and Transformation Fund. The Regional Ttripartites will review the trajectories and there will be 3 submissions before approval. These trajectories must be agreed with the CCG. The table below summarises the first submission, due 19th February, following discussions with lead commissioners. It is strongly suggested in the guidance that plans need to be realistic and deliverable.

	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
A&E 4 Hour waiting time	95%	87%	87.5%	88%	88.3%	88.6%	88.9%	89.2%	89.5%	89.9%	89.8%	89.9%	90%
RTT Incomplete Pathway	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
62 Day Cancer Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Over 6 week diagnostic	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%

4.0 LOCAL TARGETS

4.1 Treatment Milestones

Local Indicators		Target	Jan	Qtr1	Qtr2	Qtr3	Qtr4
RTT Backlog at month end	Number of patients waiting 18+ Weeks - All Specialties		1405	744	832	1216	
	Number of patients waiting 52+ Weeks - All Specialties	0	0	0	0	0	
	Number of patients waiting 36+ Weeks - Spinal ONLY		366	7	6	353	
IP/DC and OP Waiters at Month and Qtr end	Number of Outpatients waiting >21days (GP Refs only)		842	617	757		
	Number of Inpatients and Daycases on the waiting list - all theatres, exc Planned (Endo in brackets)		5917 (751)	4545 (846)	4429 (924)	5369 (609)	

In-patient waiting list size end the end of January was 5917 (excluding Endoscopy) which is an increase on previous months as shown in appendix 4 and is a consequence primarily of the introduction of Lorenzo. The validation team are in the process of validating this and it is expected to decrease as a result.

4.2 Diagnostic Waiting times

Local Indicators		Target	Jan	Qtr1	Qtr2	Qtr3	Qtr4
Diagnostic Waits	Number of patients waiting >=4 weeks - MRI	0	0	65	5	2	
	Number of patients waiting >=3 weeks - CT	0	28	8	18	115	

4.3 Delayed Discharge

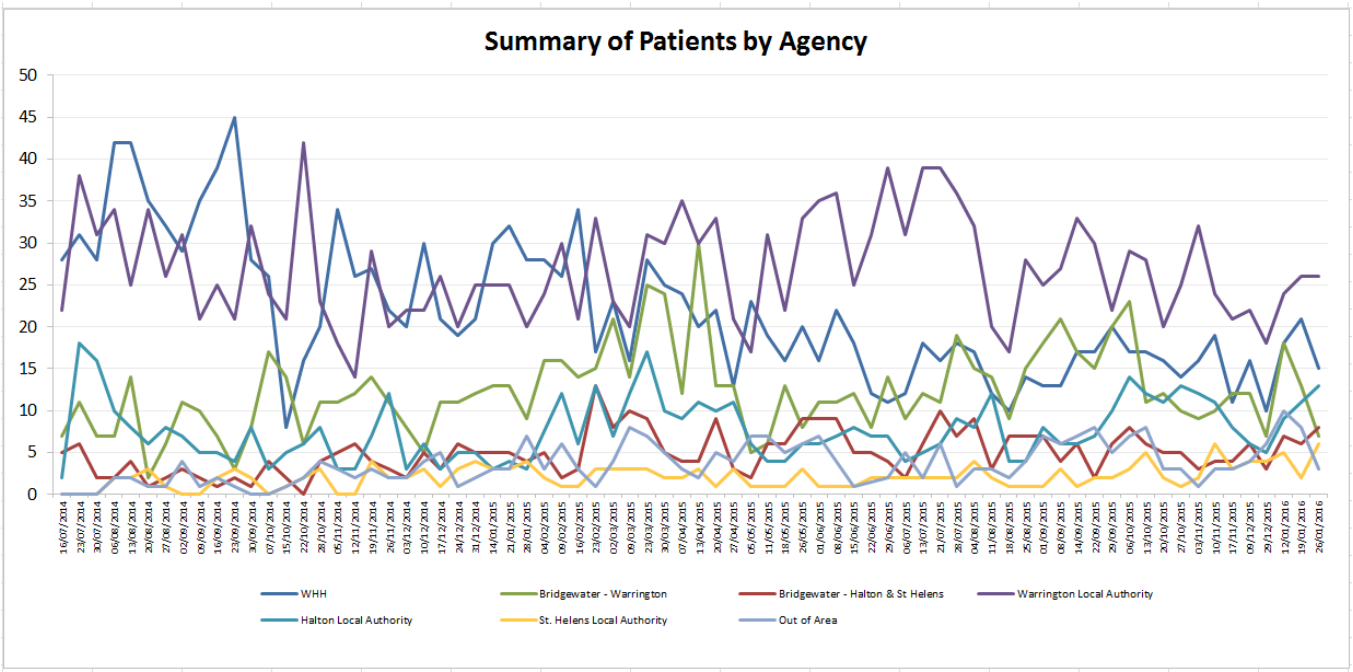
Local Indicators		Target	Jan	Qtr1	Qtr2	Qtr3	Qtr4
Delayed Discharges (based on Operating Framework)	% of Delayed Discharges	<=0.5%		4.04%	5.29%	3.09%	
	Number of Delayed Discharges			21	28	15	

There continues to be delays with our partner agencies in the transfer of our patients out to community beds or IMCH. The main reason is a lack of capacity in the community beds, and delays in assessments, which is escalated daily in the teleconference call. An ECIP recommended MADE will be run w/c 22nd February in conjunction with our economy partners.

Funding for STAR ward has been extended until the end of March 2016 for 15 patients. The remaining patients on the ward are funded via PBR.

21 day length of stay audit has continues and we have remained at a 100% with this.

Points Prevalence by Responsible agency


Summary of Patients by Agency
50
45
40
35
30
25
20
15
10
5
0
16/07/2014
23/07/2014
30/07/2014
06/08/2014
13/08/2014
20/08/2014
27/08/2014
02/09/2014
09/09/2014
16/09/2014
23/09/2014
30/09/2014
07/10/2014
15/10/2014
22/10/2014
28/10/2014
05/11/2014
12/11/2014
19/11/2014
26/11/2014
03/12/2014
10/12/2014
17/12/2014
24/12/2014
31/12/2014
14/01/2015
21/01/2015
28/01/2015
04/02/2015
09/02/2015
16/02/2015
23/02/2015
02/03/2015
09/03/2015
23/03/2015
30/03/2015
07/04/2015
13/04/2015
20/04/2015
27/04/2015
05/05/2015
11/05/2015
18/05/2015
26/05/2015
01/06/2015
08/06/2015
15/06/2015
22/06/2015
29/06/2015
06/07/2015
13/07/2015
21/07/2015
28/07/2015
04/08/2015
11/08/2015
18/08/2015
25/08/2015
01/09/2015
08/09/2015
14/09/2015
22/09/2015
29/09/2015
06/10/2015
13/10/2015
20/10/2015
27/10/2015
03/11/2015
10/11/2015
17/11/2015
09/12/2015
29/12/2015
12/01/2016
19/01/2016
26/01/2016
WHH
Bridgewater - Warrington
Bridgewater - Halton & St Helens
Warrington Local Authority
Halton Local Authority
St. Helens Local Authority
Out of Area

4.4 LOS Indicators

Local Indicators-Trust		Target	Jan	Qtr1	Qtr2	Qtr3	Qtr4	YTD Position
Average Length of Stay	Elective		2.82	2.66	2.53	2.96		2.72
	Non-Elective		4.37	4.45	4.25	4.41		4.37
	Elective - excluding zero days		3.26	3.00	2.85	3.48		3.11
	Non-Elective - excluding zero days		6.45	6.70	6.31	6.65		6.54
Daycase Rates	Basket of 25	>=75%	73.33%	84.59%	82.51%	81.50%		82.98%
	All Procedures		86.17%	85.21%	84.74%	85.13%		85.13%

Local Indicators-Specialties		Target	Jan	Qtr1	Qtr2	Qtr3	Qtr4	YTD Position
ELECTIVE (INPATIENT) Average Length of Stay (Based on the Discharge Episode)	100 - General Surgery		2.85	3.05	3.20	2.66		2.96
	101 - Urology		2.10	2.35	1.85	1.73		2.00
	110 - Trauma and Orthopaedics		2.80	2.90	2.89	2.70		2.83
	120 - ENT		0.93	1.02	0.98	1.02		1.00
	320 - Cardiology		7.00	2.33	10.67	5.67		6.27
	340 - Respiratory Medicine		0.67	2.11	1.82	14.20		6.68
	502 - Gynaecology		3.51	2.56	2.14	2.22		2.48
NON-ELECTIVE Average Length of Stay (Based on the Discharge Episode)	100 - General Surgery		3.00	2.94	2.89	3.25		3.03
	101 - Urology		3.67	4.55	4.50	3.73		4.22
	110 - Trauma and Orthopaedics		8.19	8.09	7.15	7.06		7.51
	120 - ENT		2.24	1.52	1.40	1.51		1.56
	320 - Cardiology		9.30	8.66	8.09	7.42		8.15
	340 - Respiratory Medicine		12.49	13.16	11.86	13.64		12.82
	430 - Geriatric Medicine		33.43	32.86	32.58	31.20		32.17
	502 - Gynaecology		1.69	1.13	1.14	1.79		1.37
Average Length of Ward Stay	Ward stays on A1A			1.19	1.31			
	Ward stays on A2A			3.31	2.57			
	Ward stays on A3OPAL			12.30	12.88			

	Ward stays on B14 (Stroke)			8.76	9.02			

Local Indicators bed days		Target	Jan	Qtr1	Qtr2	Qtr3	Qtr4	YTD Position
% Bed Days occupied by pats with a LOS of…. (Warrington site, NE only)	Zero LOS			3.36%	3.58%			
	1-6 days			44.84%	47.22%			
	7-21 days			30.54%	30.59%			
	+21 days			21.27%	18.61%			

4.5 DNA Management

Local Indicators		Target	Jan	Qtr1	Qtr2	Qtr3	Qtr4	YTD Position
Outpatient DNA Rate	New		10.57%	7.31%	7.32%	9.14%		8.14%
	Follow-up		11.98%	7.91%	8.35%	10.36%		9.21%
	Paediatric (<18) New		11.24%	9.18%	8.89%	8.81%		9.16%
	Paediatric (<18) Follow-up		14.57%	9.13%	9.37%	13.15%		11.00%

There has been an increase in DNAs since the introduction of Lorenzo. There have also been some issues around the patient reminder service which ceased at the end of January. A number of options are being explored to reintroduce an enhanced patient reminder service.

4.6 Rapid Access Chest Pain Service

- 2 Week Wait for Rapid Access chest Pain **100%** against an internal target of 100% (contractual target is 90%)

APPENDIX 1

Jan-16

Monitor Access Targets & Outcomes - 2015/16

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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

All targets are QUARTERLY

Target or Indicator		Threshold	Weighting	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4
Referral to treatment waiting time	Admitted patients	90%	N/A	92.55%	93.48%	93.14%	93.05%	92.05%	93.01%	92.74%	92.57%	92.31%	93.85%	92.65%	92.94%	85.44%			
	Non-admitted patients	95%	N/A	97.53%	97.18%	98.13%	97.64%	97.71%	97.52%	97.51%	97.58%	97.91%	96.57%	96.46%	96.92%	96.10%			
	Incomplete Pathways	92%	1.0	93.38%	94.30%	93.84%	93.87%	93.10%	93.49%	93.08%	93.23%	92.83%	93.41%	93.72%	93.40%	93.75%			
A&E Clinical Quality	A&E Maximum waiting time of 4 hrs from arrival to admission/transfer/discharge	>=95%	1.0	87.75%	94.05%	92.68%	91.13%	93.96%	93.17%	91.69%	92.92%	90.74%	86.49%	85.19%	87.53%	81.33%			
All Cancers:62-day wait for First treatment	From urgent GP referral - **post** local breach re-allocation (CCG)	85%	1.0 (Failure for either = failure against the overall target)	88.10%	86.40%	83.80%	86.10%	87.65%	82.00%	82.48%	85.65%	90.00%	85.00%	78.30%	85.06%	85.00%			
	From NHS Cancer Screening Service referral - **post** local breach re-allocation	90%		100.00%	100.00%	87.50%	93.80%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%			
	From urgent GP referral - **pre** local breach re-allocation (Open Exeter - Monitor)	85%		88.10%	86.00%	81.00%	85.25%	88.90%	86.21%	83.53%	85.71%	92.00%	85.10%	78.30%	86.90%	85.00%			
	From NHS Cancer Screening Service referral - **pre** local breach re-allocation	90%		100.00%	100.00%	87.50%	93.80%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%			
All Cancers:31-day wait for second or subsequent treatment	Surgery	>94%	1.0 (Failure for any of the 3 = failure against the overall target)	100.00%	100.00%	96.00%	98.67%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%			
	Anti Cancer Drug Treatments	>98%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%			
	Radiotherapy (not performed at this Trust)	>94%																	
All Cancers: 31-Day Wait From Diagnosis To First Treatment		>96%	1.0	100.00%	100.00%	96.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%			
Cancer: Two Week Wait From Referral To Date First Seen	Urgent Referrals (Cancer Suspected)	>93%	1.0 (Failure for either = failure against the overall target)	93.70%	93.80%	92.00%	93.00%	95.20%	93.30%	93.10%	93.90%	95.80%	94.90%	93.90%	94.40%	93.80%			
	Symptomatic Breast Patients (Cancer Not Initially Suspected)	>93%		92.80%	98.30%	89.70%	93.20%	93.30%	96.60%	97.90%	95.80%	96.30%	93.50%	93.30%	96.00%	98.30%			
Clostridium Difficile - Hospital acquired **(CUMULATIVE)**	Due to lapses in care	27 (for the Yr)	1.0 **	0	1	4	4	5	5	8	8	9	10	10	10	10			
	Not due to lapses in care			3	7	8	8	8	8	9	9	11	12	12	12	12			
	Total (including: due to lapses in care, not due to lapses in care, and cases under review)			3	8	12	12	13	13	17	17	20	22	22	22	22			
	Under Review			0	0	0	0	0	0	0	0	0	0	0	0	0			
Failure to comply with requirements regarding access to healthcare for people with a learning disability		N/A	1.0	No	No	No	No	No	No	No	No	No	No	No	No	No			

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

APPENDIX 1

Target or Indicator	Target	Weighting	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4
Risk of, or actual, failure to deliver Commissioner Requested Services	N/A	Report by Exception	No	No	No	No	No	No	No	No	No	No	No	No	No			
Date of last CQC inspection	N/A		26/01/2015															
CQC compliance action outstanding (as at time of submission)	N/A		No	No	No	No	Yes	Yes	Yes	Yes	Yes	No	No	No	No			
CQC enforcement action within last 12 months (as at time of submission)	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No			
CQC enforcement action (including notices) currently in effect (as at time of submission)	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No			
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission) Breach of regulation 23 (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010 regarding the safety of healthcare provision	N/A		No	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission) Breach of regulation 23 (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010 regarding the safety of healthcare provision	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No			
Overall rating from CQC inspection (as at time of submission)	N/A		Not received at the time of reporting				Requires Improvement											
CQC recommendation to place trust into Special Measures (as at time of submission)	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No			
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No			
Trust has not complied with the high secure services Directorate (High Secure MH trusts only)	N/A																	
Service Performance Score			**2.0**	**1.0**	**3.0**	**1.0**	**1.0**	**1.0**	**2.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**			

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

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

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

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

18 Weeks Referral to Treatment

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

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

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

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

**** Clostridium Difficile**

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

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

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

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

Monitor will not accept a trust's own internal phasing of their annual objective or that agreed with their commissioners.

APPENDIX 2

Warrington and Halton NHS Foundation Trust

AED monthly monitoring metrics for Monitor

#	Metric	Target trajectory	Jul-15	Aug-15	Sep-15	Qtr2	Oct-15	Nov-15	Dec-15	Qtr3	Jan-16	Feb-16	Mar-16	Qtr4
1	A&E 4 hour wait target (including walk-in activity from Widnes from August)	95% by end of Sept 2015	93.96%	93.17%	91.69%	92.92%	90.74%	86.49%	85.19%	87.53%	81.33%			
2a	Median time to initial assessment in AED	Q2 <70mins Q3 <65mins Q4 <60mins	13.0	14.0	13.0	14.0	12.0	13.0	16.0	14.3	16.0			
2b	95th percentile time to initial assessment in AED	Q2 <120mins Q3 <110mins Q4 <100mins	63.0	65.0	69.0	66.0	63.0	70.0	85.0	72.4	94.3			
3	Median time to treatment in AED	Q2 <200mins Q3 <190mins Q4 <180mins	70.0	66.0	73.0	70.0	76.0	88.0	77.0	79.8	69.0			
4	Medical outliers on last day of the month / quarter	<10 patients by end of Sept 2015	0	18	12		26	13	8		41			
5	% discharges taking place before midday (average for month / quarter)	Q2 20% Q3 28% Q4 35%	16.92%	16.19%	16.19%	16.45%	18.41%	16.78%	18.30%	17.82%	18.44%			
6a	NHS attributable DToC (patients)	Q2 15 patients Q3 10 patients Q4 5 patients	9	10	22		18	23	14					
6b	NHS attributable DToC (days)	Q2 45 days Q3 30 days Q4 15 days	295	261	332		532	292	552					
6c	External partner attributable DToC (patients)	Q2 50 patients Q3 40 patients Q4 30 patients	4	9	6		2	4	1					
6d	External partner attributable DToC (days)	Q2 150 days Q3 120 days Q4 90 days	123	176	145		58	32	53					
7	% of patients in hospital for 21 days who receive an MDT case note review	Q2 40% Q3 60% Q4 80%			95.14%		91.61%	85.79%	75.86%		82.81%			

Note: 6a, 6b, 6c & 6d – data is taken from the monthly sitrep guidance/submission and is data on the last Thursday of the month.
NHS = WHHFT, Bridgewater and other NHS providers
Extend partners = Local Authority and Social Care

APPENDIX 3

2015/16 Cancer Performance

Trust

National Targets and Minimum Standards		Target	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD
All Cancers:31-day wait for second or subsequent treatment	Surgery	94%	100.00%	100.00%	96.00%	98.67%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%				99.00%
	Anti Cancer Drug Treatments	98%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%				100.00%
	Radiotherapy	94%																	
All Cancers:62-day wait for First treatment	From urgent GP referral - **post** local breach re-allocation (CCG)	85%	88.10%	86.40%	83.80%	86.10%	87.65%	82.00%	82.48%	85.65%	90.00%	85.00%	78.30%	85.06%	85.00%				85.04%
	From NHS Cancer Screening Service referral - **post** local breach re-allocation	90%	100.00%	100.00%	87.50%	93.80%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%				96.88%
	From urgent GP referral - **pre** local breach re-allocation (Open Exeter - Monitor)	85%	88.10%	86.00%	81.00%	85.25%	88.90%	86.21%	83.53%	85.71%	92.00%	85.10%	78.30%	86.90%	85.00%				85.54%
	From NHS Cancer Screening Service referral - **pre** local breach re-allocation	90%	100.00%	100.00%	87.50%	93.80%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%				98.50%
All Cancers: 31-Day Wait From Diagnosis To First Treatment		96%	100.00%	100.00%	96.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%				99.33%
Cancer: Two Week Wait From Referral To Date First Seen	All Cancers	93%	93.70%	93.80%	92.00%	93.00%	95.20%	93.30%	93.10%	93.90%	95.80%	94.90%	93.90%	94.40%	93.80%				93.91%
	Symptomatic Breast Patients (Cancer Not Initially Suspected)	93%	92.80%	98.30%	89.70%	93.20%	93.30%	96.60%	97.90%	95.80%	96.30%	93.50%	93.30%	96.00%	98.30%				93.43%
All Cancers: 62-day wait for First treatment - Consultant Upgrade			100.00%	0.00%	100.00%	100.00%	0.00%	83.33%	100.00%	94.10%	0.00%	0.00%	0.00%	83.30%	0.00%				50.00%

APPENDIX 3

Breast

National Targets and Minimum Standards		Target	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD
2 Week Wait		93%	96.50%	96.20%	94.50%	95.80%	92.10%	90.60%	92.50%	91.73%	97.80%	96.00%	97.00%	96.93%					
31-Day Wait From Diagnosis To First Treatment		96%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%					
62-day wait for First treatment	From urgent GP referral	85%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%					
	Screening Service referral	90%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%					
	Consultant Upgrade		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%					

Breast Symptomatic

National Targets and Minimum Standards	Target	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD
2 Week Wait	93%	92.80%	98.30%	89.70%	93.30%	93.30%	96.60%	95.20%	95.03%	96.30%	93.50%	93.30%	96.00%					
31-Day Wait From Diagnosis To First Treatment	96%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%					

Dermatology

National Targets and Minimum Standards		Target	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD
2 Week Wait		93%	0.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%					
31-Day Wait From Diagnosis To First Treatment		96%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	0.00%	0.00%	0.00%	0.00%					
62-day wait for First treatment	From urgent GP referral	85%	0.00%	100.00%	100.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%					
	Consultant Upgrade		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%					

Gynaecology

National Targets and Minimum Standards		Target	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD
2 Week Wait		93%	95.60%	93.30%	97.40%	95.40%	96.20%	97.00%	92.00%	95.07%	98.30%	97.00%	91.00%	95.43%					
31-Day Wait From Diagnosis To First Treatment		96%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	0.00%	100.00%	100.00%	100.00%	100.00%	100.00%					
62-day wait for First treatment	From urgent GP referral	85%	100.00%	66.70%	80.00%	75.00%	75.00%	100.00%	100.00%	75.00%	90.00%	84.00%	85.00%	85.00%					
	Screening Service referral	90%	100.00%	50.00%	100.00%	75.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%					
	Consultant Upgrade		100.00%	66.70%	100.00%	80.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%					

Haematology

National Targets and Minimum Standards		Target	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD
2 Week Wait		93%	100.00%	100.00%	88.90%	94.70%	85.70%	100.00%	100.00%	95.23%	71.40%	85.00%	89.00%	81.50%					
31-Day Wait From Diagnosis To First Treatment		96%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%					
62-day wait for First treatment	From urgent GP referral	85%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%					
	Consultant Upgrade		0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%					

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Sarcomas

National Targets and Minimum Standards		Target	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD
2 Week Wait		93%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%					
31-Day Wait From Diagnosis To First Treatment		96%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	0.00%	100.00%					
62-day wait for First treatment	From urgent GP referral	85%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	100.00%	0.00%	0.00%	0.00%	0.00%					
	Consultant Upgrade		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%					

Urology

National Targets and Minimum Standards		Target	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD
2 Week Wait		93%	91.80%	90.90%	94.30%	92.00%	96.20%	91.80%	80.00%	89.00%	92.50%	91.70%	91.70%	91.97%					
31-Day Wait From Diagnosis To First Treatment		96%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%					
62-day wait for First treatment	From urgent GP referral	85%	94.70%	79.20%	66.70%	83.70%	81.20%	25.00%	57.10%	75.00%	80.00%	80.00%	75.00%	78.33%					
	Consultant Upgrade		100.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%					

Other

National Targets and Minimum Standards		Target	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD
2 Week Wait		93%	100.00%	100.00%	0.00%	80.00%	0.00%	100.00%	100.00%	100.00%	0.00%	0.00%	0.00%	0.00%					
31-Day Wait From Diagnosis To First Treatment		96%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%					
62-day wait for First treatment	From urgent GP referral	85%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	100.00%	100.00%	100.00%					
	Consultant Upgrade		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%					

APPENDIX 4

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Jan-16

National Indicators		Target	Apr	May	Jun	Qtr1	Jul	Aug	Sep	Qtr2	Oct	Nov	Dec	Qtr3	Jan	Feb	Mar	Qtr4	YTD Position
MRSA Bacteraemia	Hospital Acquired	0	0	0	0	0	0	1	1	2	0	0	0	0	0			0	2
	Community Acquired		0	0	0	0	0	1	0	1	0	0	0	0	1			1	2
	Total		0	0	0	0	0	2	1	3	0	0	0	0	1			1	4
Clostridium Difficile	Hospital Acquired - Due to lapses in care	<=27	0	1	3	4	1	0	3	4	1	1	0	2	0			0	10
	Hospital Acquired - Not due to lapses in care		3	4	1	8	0	0	1	1	2	1	0	3	0			0	12
	Hospital Acquired - Under Review		0	0	0	0	0	0	0	0	0	0	0	0	0			0	0
	Hospital Acquired - Total		3	5	4	12	1	0	4	5	3	2	0	5	0			0	22
	Community Acquired		1	3	1	5	3	3	6	12	3	1	3	7	3			3	27
	Total		4	8	5	17	4	3	10	17	6	3	3	12	3			3	49
RTT - 18 Weeks	Completed Admitted Pathways <18 Weeks	>=90%	92.55%	93.48%	93.14%	93.05%	92.05%	93.01%	92.74%	92.57%	92.31%	93.85%	92.65%	92.94%	85.44%			85.44%	92.27%
	Completed Non-Admitted Pathways <18 Weeks	>=95%	97.53%	97.18%	98.13%	97.64%	97.71%	97.52%	97.51%	97.58%	97.91%	96.57%	96.46%	96.92%	96.10%			96.10%	97.16%
	All Waiters <18 Weeks	>=92%	93.38%	94.30%	93.84%	93.87%	93.10%	93.49%	93.08%	93.23%	92.83%	93.41%	93.72%	93.40%	93.75%			93.75%	93.53%
Cancer	2 Week Wait	>=93%	93.70%	93.80%	92.00%	93.00%	95.20%	93.30%	93.10%	93.90%	95.80%	94.90%	93.90%	94.40%	93.80%				93.91%
	Breast Symptom 2 Week Wait	>=93%	92.80%	98.30%	89.70%	93.20%	93.30%	96.60%	97.90%	95.80%	96.30%	93.50%	93.30%	96.00%	98.30%				93.43%
	31 Day First Treatment	>=96%	100.00%	100.00%	96.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%				99.33%
	31 Day Subsequent Treatment : Surgery	>=94%	100.00%	100.00%	96.00%	98.67%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%				99.00%
	31 Day Subsequent Treatment : Drugs	>=98%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%				100.00%
	62 Day First Treat - Urgent GP - Open Exeter	>=85%	88.10%	86.00%	81.00%	85.25%	88.90%	86.21%	83.53%	85.71%	92.00%	85.10%	78.30%	86.90%	85.00%				85.54%
	62 Day First Treat - Urgent GP - Reallocation	>=85%	88.10%	86.40%	83.80%	86.10%	87.65%	82.00%	82.48%	85.65%	90.00%	85.00%	78.30%	85.06%	85.00%				85.04%
	62 Day First Treatment - Screening	>=90%	100.00%	100.00%	87.50%	93.80%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%				96.88%
	CRS 62 Day Consultant Upgrade	>=90%	100.00%	0.00%	100.00%	100.00%	0.00%	83.33%	100.00%	94.10%	0.00%	0.00%	0.00%	83.30%	0.00%				50.00%
A&E & MIU	% Departed < 4hrs (based on the Weekly SITREP Submissions)	>=95%	87.75%	94.05%	92.68%	91.13%	93.96%	93.17%	91.69%	92.92%	90.74%	86.49%	85.19%	87.53%	81.33%				89.49%
	Number of patients breaching 4hrs		1207	461	502	2170	557	666	811	2034	933	1320	1408	3661	1847				9712
Diagnostics - 6+ Week Waiters	% of Patients waiting >= 6 Weeks	<1%	0.00%	0.00%	0.00%		0.00%	0.00%	0.00%		0.00%	0.00%	3.58%		0.00%				
	No of Patients waiting >= 6 Weeks		0	0	0	0	0	0	0	0	0	0	120	1	0				

APPENDIX 4

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Jan-16

National Indicators		Target	Apr	May	Jun	Qtr1	Jul	Aug	Sep	Qtr2	Oct	Nov	Dec	Qtr3	Jan	Feb	Mar	Qtr4	YTD Position
IP/DC and OP Waiters at Month End	Number of Outpatients waiting >21days (GP Refs only)		766	797	617		663	903	757		842								
	Number of Inpatients and Daycases on the waiting list - all theatres, exc Planned (Endo in brackets)		4315 (788)	4934 (980)	4545 (846)		4299 (853)	4677 (804)	4429 (924)		4720 (920)	5856 (757)	5369 (609)		5917 (751)				
Diagnostic Waiters at Month End	Number of patients waiting >=4 weeks - MRI	0	19	35	65		125	92	5		2	1	2		0				
	Number of patients waiting >=3 weeks - CT	0	29	49	8		15	12	18		10	8	115		28				
Non-Clinical Cancelled Operations	% of Cancelled Operations on the Day	<=2%	1.08%	0.61%	1.07%	0.92%	0.44%	1.64%	1.88%	1.29%	0.67%								
	Number of Cancelled Operations on the Day		34	19	34	87	15	47	59	121	21								
	Number of Cancellations not offered a date for readmission within 28 days	0	3	0	3	6	2	0	2	4	0								
	% of Cancellations Readmitted within 28 days	>=95%	86.89%	100.00%	95.00%	91.96%	94.87%	92.86%	95.35%	94.79%	96.67%								
	Number of breaches of the 28 day rule		8	0	1	9	2	1	2	5	2								
Daycase Rates	Basket of 25	>=75%	83.76%	84.02%	86.06%	84.59%	81.55%	83.68%	82.44%	82.51%	81.22%	83.91%	71.43%	81.50%	73.33%			73.33%	82.98%
	All Procedures		84.94%	84.64%	86.03%	85.21%	84.31%	84.91%	85.06%	84.74%	84.74%	86.34%	84.21%	85.13%	86.17%			86.17%	85.13%
Delayed Discharges (based on Op Framework)	% of Delayed Discharges	<=0.5%	3.65%	3.95%	4.04%		2.55%	3.71%	5.29%		3.77%	5.18%	3.09%						
	Number of Delayed Discharges		19	20	21		13	19	28		20	27	15						
Outpatient DNA Rate	New		6.95%	7.62%	7.35%	7.31%	7.53%	7.73%	6.74%	7.32%	7.54%	8.48%	11.46%	9.14%	10.57%			10.57%	8.14%
	Follow-up		7.93%	8.07%	7.74%	7.91%	8.17%	8.27%	8.62%	8.35%	8.80%	9.55%	12.65%	10.36%	11.98%			11.98%	9.21%
	Paediatric (<18) New		8.34%	9.64%	9.56%	9.18%	9.38%	9.50%	7.76%	8.89%	7.99%	7.75%	11.28%	8.81%	11.24%			11.24%	9.16%
	Paediatric (<18) Follow-up		8.93%	9.83%	8.72%	9.13%	9.91%	9.11%	9.08%	9.37%	10.45%	11.87%	16.78%	13.15%	14.57%			14.57%	11.00%
A&E Clinical Indicators	Total time in A&E (95th percentile)	<=240mins	424.6	297.0	338.0	359.0	285.0	339.0	345.0	314.0	374.0								
	Time to initial assessment (95th percentile)	<=15mins	82.2	66.0	70.0	73.0	62.0	57.0	67.0	61.0	62.0								
	Time to treatment decision (median)	<=60mins	71.0	65.0	68.0	68.0	70.0	60.0	67.0	64.0	70.0								
	Unplanned reattendance rate	<=5%	0.81%	0.93%	0.63%	0.78%	0.76%	0.81%	0.61%	0.70%	0.73%								
	Left without being seen	<=5%	5.10%	4.29%	4.51%	4.63%	3.91%	3.37%	4.15%	3.67%	4.53%								
Ambulance Handovers	Number handed over 30 to 60 mins	0	72	40	43	155	12	28	39	79	51	75	101	227	134			134	595
	Number handed over >60 mins	0	30	0	5	35	1	1	11	13	28	12	47	87	108			108	243
	HAS Compliance Score	90.00%	70.54%	84.02%	89.11%	81.51%	91.52%	92.81%	89.23%	91.18%	89.34%	90.62%	93.95%	91.32%	90.78%			90.78%	88.42%

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Warrington and Halton Hospitals NHS
NHS Foundation Trust

Jan-16

Local Indicators		Target	Apr	May	Jun	Qtr1	Jul	Aug	Sep	Qtr2	Oct	Nov	Dec	Qtr3	Jan	Feb	Mar	Qtr4	YTD Position
RTT Backlog at month end	Number of patients waiting 18+ Weeks - All Specialties		736	742	744		752	844	832		796	924	1216		1405				
	Number of patients waiting 52+ Weeks - All Specialties	0	0	0	0		0	0	0		0	0	0		0				
	Number of patients waiting 36+ Weeks - Spinal ONLY		3	9	7		11	10	6		2	53	353		366				
TRUST Average Length of Stay	Elective		2.33	2.93	2.70	2.66	2.55	2.57	2.46	2.53	2.92	3.07	2.91	2.96	2.82			2.82	2.72
	Non-Elective		4.75	4.01	4.60	4.45	4.19	4.49	4.09	4.25	4.14	4.61	4.50	4.41	4.37			4.37	4.37
	Elective - excluding zero days		2.75	3.20	3.05	3.00	2.87	2.89	2.79	2.85	3.29	3.60	3.58	3.48	3.26			3.26	3.11
	Non-Elective - excluding zero days		7.15	6.11	6.82	6.70	6.32	6.61	6.03	6.31	6.28	6.94	6.72	6.65	6.45			6.45	6.54
ELECTIVE (INPATIENT) Average Length of Stay (Based on the Discharge Episode)	100 - General Surgery		2.63	2.72	3.77	3.05	3.25	3.05	3.31	3.20	2.98	2.39	2.64	2.66	2.85			2.85	2.96
	101 - Urology		1.64	3.51	2.01	2.35	1.76	2.27	1.48	1.85	1.61	1.75	1.83	1.73	2.10			2.10	2.00
	110 - Trauma and Orthopaedics (including 108-Spinal)		2.72	2.94	3.08	2.90	2.90	2.86	2.90	2.89	2.76	2.92	2.42	2.70	2.80			2.80	2.83
	120 - ENT		0.79	1.19	1.07	1.02	0.94	0.89	1.11	0.98	0.95	0.92	1.21	1.02	0.93			0.93	1.00
	320 - Cardiology		1.00	2.00	4.00	2.33		20.00	6.00	10.67	1.00	3.75	18.00	5.67	7.00			7.00	6.27
	340 - Respiratory Medicine		1.75	3.67	0.50	2.11	2.83	1.50	0.00	1.82	13.33	4.00	17.86	14.20	0.67			0.67	6.68
	502 - Gynaecology		2.85	2.29	2.58	2.56	1.64	2.51	2.28	2.14	2.21	2.29	2.17	2.22	3.51			3.51	2.48
NON-ELECTIVE Average Length of Stay (Based on the Discharge Episode)	100 - General Surgery		3.55	2.27	3.07	2.94	2.78	2.86	3.03	2.89	2.68	3.74	3.33	3.25	3.00			3.00	3.03
	101 - Urology		6.38	3.54	3.35	4.55	4.20	5.12	4.27	4.50	3.39	4.11	3.87	3.73	3.67			3.67	4.22
	110 - Trauma and Orthopaedics (including 108-Spinal)		8.60	8.18	7.58	8.09	7.52	7.45	6.54	7.15	7.07	6.79	7.34	7.06	8.19			8.19	7.51
	120 - ENT		2.16	1.18	1.24	1.52	1.08	1.73	1.44	1.40	2.00	1.17	1.28	1.51	2.24			2.24	1.56
	320 - Cardiology		7.56	10.01	8.59	8.66	7.11	8.41	8.90	8.09	7.57	7.76	6.98	7.42	9.30			9.30	8.15
	340 - Respiratory Medicine		12.68	11.23	14.88	13.16	12.62	11.76	10.95	11.86	13.32	13.44	14.06	13.64	12.49			12.49	12.82
	430 - Geriatric Medicine		28.00	40.67	31.76	32.86	29.85	34.89	34.53	32.58	23.18	39.96	28.67	31.20	33.43			33.43	32.17
	502 - Gynaecology		1.24	1.18	1.00	1.13	1.00	1.28	1.19	1.14	1.57	1.88	1.97	1.79	1.69			1.69	1.37
Average Length of Ward Stay	Ward stays on A1A		1.11	1.20	1.28	1.19	1.11	1.42	1.40	1.31	1.48								
	Ward stays on A2A		3.48	3.47	3.02	3.31	2.37	2.68	2.67	2.57	2.79								
	Ward stays on A3OPAL		11.67	12.85	12.55	12.30	11.73	12.89	14.34	12.88	9.18								
	Ward stays on B14 (Stroke)		8.79	9.55	7.96	8.76	9.85	8.79	8.37	9.02	5.11								
% Bed Days occupied by pats with a LOS of....(Warr site, NE only)	Zero LOS		3.21%	3.23%	3.65%	3.36%	3.73%	3.74%	3.30%	3.58%	3.01%								
	1-6 days		42.43%	45.73%	46.57%	44.84%	47.16%	48.44%	46.13%	47.22%	45.48%								
	7-21 days		30.99%	29.33%	31.25%	30.54%	29.95%	30.29%	31.47%	30.59%	30.86%								
	+21 days		23.37%	21.71%	18.53%	21.27%	19.17%	17.53%	19.10%	18.61%	20.65%								

BOARD OF DIRECTORS

16/056

SUBJECT:	Report from the Chair of the Quality Committee including approved minutes of the committee meeting on 5 January 2016.
DATE OF MEETING:	24 February 2016
DIRECTOR:	Lynne Lobley, Non-Executive Director – Committee Chair

Reports *not* received as agreed in the annual work plan:	-
Any other relevant items the sub-committee wishes to escalate ?	- At the February meeting, the committee was unassured that the controls supporting listening and responding to complaints was delivering the results that the Trust intends. It is planned for the NEDs to engage with the Director of Nursing & Governance.

QUALITY COMMITTEE

Minutes of the Meeting held on Tuesday 5th January 2016
Trust Conference Room, Warrington Hospital

Present:

Lynne Lobley	Non-Executive Director – Chair
Steve McGuirk	Chairman
Diane Matthew	Chief Pharmacist (part)
Anne Robinson	Associate Medical Director, Quality Improvement
Karen Dawber	Director of Nursing
Kate Warbrick	Associate Director of Operations, Scheduled Care
Millie Bradshaw	Associate Director of Governance and Risk
Dawn Chalmers	Deputy Chief Nurse, Warrington CCG
Jennifer Owen	Deputy Chief Nurse, Halton CCG
Carol Millington	Acting Head of Therapies
Pat McLaren	Director of Community Engagement
Lesley McKay	Associate Director of Nursing – Infection Control
Claire Blackman	Interim Associate Director of Nursing WCSS

In Attendance:

Jennie Taylor	Executive Assistant (minutes)

	WHHFT/GC/16/001 - Apologies for Absence and Introductions	**Responsibility and Target date**
1	Apologies received from: Terry Atherton, Non-Executive Director Dawn Forrest, Associate Director of Operations, Unscheduled Care Jason DaCosta, Director of IT John Wharton Rachael Browning, Associate Director of Nursing, Scheduled Care Roger Wilson, HR Director Paula Chattington, Consultant Mel Pickup, Chief Executive Jan Snoddon, Chief Nurse, Halton CCG Mark Brearley, Interim Finance Director Nick Jenkins, Deputy Medical Director Sharon Gilligan, Chief Operating Officer Jan Ross, Deputy Chief Operating Officer Angela Madigan, Deputy Director of Nursing Simon Constable, Medical Director Melanie Hudson, Associate Director of Nursing Sue Franklin, Associate Director of Nursing, Unscheduled Care	
	WHHFT/GC/16/002 - Declarations of Interest	
2	There were no declarations of interest made in relation to the agenda items for the Quality Committee meeting.	
	WHHFT/GC/16/003 – Minutes of the previous meeting held on 3rd November 2015	**Members**
3	The minutes of the meeting held on 3rd November 2015 were accepted as a true record of the meeting with no amendments.	

	WHHFT/GC/16/004 - Action Plan	
4	Salford Dashboard This item is on the main agenda.	
5	CQC Action Plan – Outpatient Clinics New interim outpatient manager has been appointed and daily improvement meetings are taking place.	
6	Text Reminder Service This has been suspended for a period whilst options are appraised following a query raised relating to Information Governance but Mel Pickup, Chief Executive, reported that call centre staff have been hired and are working nights calling patients to confirm attendance and rebooking where gaps are identified.	
7	Updates on CQC Action Plan Continue to embed and promote the care of low risk women in line with NICE guidance and Ensure there is a clear vision and strategy for midwifery and Gynaecology Services Karen Dawber, Director of Nursing reported that Draft Maternity Review has been circulated and will be submitted to this Committee in February which will cover this item.	
8	Development of a business case for a neonatal enhanced practitioner Karen Dawber, Director of Nursing reported that Rachael Browning has reviewed this. There have been some changes in roles that means there is no longer a need for this post.	
9	Increase Incident Reporting in the OPD relating to availability of medical records Kate Warbick, Associate Director of Operations reported that there is a reinforcement of reporting as part of the way to implement Lorenzo, this includes a weekly clinical risk meeting where any OPD issues are discussed.	
10	To ensure full review of the usage of STAB bay Kate Warbrick, Associate Director of Operations reported that STAB bay no longer available (since 4th November) although 2 appropriate patients have been treated in the theatre recovery bay. This action is now complete although reports submitted quarterly for monitoring purposes.	
11	RMO at Halton Site Kate Warbrick, Associate Director of Operations reported that Mark Halliwell has run a staff group at Halton and has written a draft report that will be submitted to Patient Safety Group.	
12	WHHFT/QGC/15/127 – Governance Report Millie Bradshaw, Associate Director of Governance and Risk reported that the statistical process has been implemented.	
13	WHHFT/QGC/15/130 – Quality Dashboard Item on agenda	
14	WHHFT/1GC/138 – Medicines Management Diane Matthew not in attendance at start of meeting.	

15	Corporate Risk Register – Litigation Karen Dawber, Director of Nursing explained that the NHSLA premium will be increasing therefore item to remain on Action Plan until figure is known. She will discuss with Mark Brearley, Interim Director of Finance.	**Director of Nursing February 2016**
	WHHFT/QGC/16/005 – Coroner Letter re PFD and Action Plan	
16	Karen Dawber, Director of Nursing reported that we have done all that was expected of us and have responded in a timely fashion.	
	WHHFT/QGC/16/006 –Falls – Back to Basics Initiative	
17	Karen Dawber, Director of Nursing explained that the Falls, Back to Basics Initiative ran in November and December and was piloted on the wards with highest number of incidents. "Call don't Fall" is the promotion and shows a reduction of 30-40% where it has been piloted. She confirmed that this will now be rolled out across the Trust.	
	WHHFT/QGC/16/007– Mock up – New Dashboard	
18	Lynne Lobley, Non-Executive Director explained that the Salford Dashboard was discussed at the recent Away Day. Karen Dawber, Director of Nursing explained that this is the first draft of a dashboard using our own data and could be used to replace some of the reporting processes we already have and welcomed comments from the Committee.	
19	Lynne Lobley, Non-Executive Director explained that there has been little time to review due to the late circulation of the agenda but she confirmed that it was easy to work through and felt it showed potential.	
20	Mel Pickup, Chief Executive approves of the principle of having everything reported in the same place. The Directors will have discussions around their areas and have mechanisms to obtain this information. Dawn Chalmers, Deputy Chief Nurse/Clinical Lead, Warrington CCG agreed that triangulation of data is very useful. Anne Robinson, Associate Medical Director, Quality Improvement would like quality indicators added and it was agreed these can be built in.	
21	Steve McGuirk, Chairman agreed that this document makes data transparent although he commented that there is a desire to compare with other trusts and once this report is fully populated it will be dynamic and very visible. He asked if other Trusts are using this method? Karen Dawber, Director of Nursing responded that not all other trusts report the way we do on everything but some areas are easy to benchmark. All the information contained is already reported to the Board but this report just collates it so that it is easy to view.	
22	Mel Pickup, Chief Executive explained that there is a view of Salford being "best in class". In terms of shared learning adopting this style of reporting is a positive move.	
23	Karen Dawber, Director of Nursing explained that this dashboard will be circulated and discussed at other committee meetings and with the CCGs. Lynne Lobley, Non-Executive Director requested that productivity data is added and asked to keep item on the agenda for launch in the new financial year.	

24	Mel Pickup, Chief Executive explained that if this is discussed at other committees each Director's discipline will be examined and their own KPIs can be reported.	
25	Millie Bradshaw, Associate Director of Governance and Risk explained that it might be possible to include CQC action plans in this dashboard.	
26	Steve McGuirk, Chairman recommended obtaining good quality reporting data linked together with the aim of replacing so many reporting mechanisms.	
	WHHFT/QGC/16/008 – Quality Report Timetable	
27	Karen Dawber, Director of Nursing reported that this document shows the timescales and key milestones for this year's Quality Report.	
	WHHFT/QGC/16/009 – Collating Quality Data Issues (VTE and Dementia)	
28	Karen Dawber, Director of Nursing explained that on the back of changes via Lorenzo we are seeing some data issues. Using dementia as an example she explained this is on the agenda for the CQC meeting and also for discussion at CCG meeting tomorrow as we could pull all records to provide data and this was supported by Dawn Chalmers, Deputy Chief Nurse and Quality Lead.	**Karen Dawber Update Now agreed with CCG**
	WHHFT/QGC/16/010 – HSMR/SHMI Data	
29	Anne Robinson, Associate Medical Director Quality Improvement commented that we know we are slightly higher compared to others and explained that the Action Group has taken the route to focus on areas identified and have established an Audit Group for these areas. Clinical Coding manager is working with the clinical teams to highlight diagnosis entering. Lorenzo is built to record co-morbidities but needs to be used effectively.	
30	Anne Robinson, Associate Medical Director, Quality Improvement explained that all deaths are being reviewed and reported that this is currently 75% complete. Any deaths considered avoidable are reviewed by the Mortality Group and we also have 4 GPs on board to review deaths occurring 30 days post discharge.	
31	Anne Robinson, Associate Medical Director, Quality Improvement that a Trust Wide Education Event is being led by new Sepsis Consultant and this will include all areas.	
32	Karen Dawber, Director of Nursing drew attention to page 13 of the report explaining that we have not received any triggers.	
33	Lynne Lobley, Non-Executive Director agreed work is needed on avoidable mortality and Anne Robinson, Associate Medical Director, Quality Improvement commented that the group was renamed to reflect this. She explained that every area of the Trust now reviewed in the same way and shared the learning to get all areas reflecting on these lessons in order to change the way we work.	

34	Steve McGuirk, Chairman asked if everything we do around shared learning is transparent and Anne Robinson confirmed this was the case and other Trusts eg. Aintree have been reviewing longer than us but that we are making progress and reporting monthly at Board.	
	WHHFT/QGC/16/011 - CQUIN Update	
35	Karen Dawber, Director of Nursing explained that National CQUINs not available yet. Dawn Chalmers, Deputy Chief Nurse, Quality Lead, Warrington CCG advised they are expected to be around integrated working. Anne Robinson, Associate Medical Director, Quality Improvement advised that no update available yet but confirmed that Lorenzo will be an asset for reporting.	
	WHHFT/QGC/16/012 – Risk Register	
36	Infection Control Testing – Lesley McKay, Associate Director of Nursing, Infection Control advised that there is a plan for medical education antimicrobial pharmacist but this is delayed due to staffing issues. It was agreed that Karen Dawber would write to Diane Matthew, Chief Pharmacist recommending this issue is resolved within existing pharmacy staffing. Diane Matthew, Chief Pharmacist joined the meeting negating the need for discussion.	
37	Other Infection Control risks – Lesley McKay reporting that she is reviewing IT systems for early identification of infections. Mel Pickup, Chief Executive, recommended examining an option of Lorenzo integration and suggested asking other Trusts who use Lorenzo if they have done this. Anne Robinson explained we are already leading in our electronic development with Lorenzo and suggested speaking to IT Director around a Lorenzo 'bolt on'.	
38	Domestic Abuse referrals - Karen Dawber, Director of Nursing explained that at the Board meeting we were informed that the workload around this is increasing and she will be reviewing further with Pauline Owens as changes have already taken place in safeguarding through retirement of key personnel.	
39	Mel Pickup, Chief Executive explained that we make a donation towards safeguarding budget and an increase has been requested and expects this will increase further although not aware of why this is happening. Lynne Lobley, Non-Executive Director, agreed that investigation and reporting is increasing and therefore we may feel it inappropriate to fund a central pot at a time when we need to increase investment in our own services.	
40	Mel Pickup, Chief Executive confirmed we will be not be increasing our contribution to the central pot and Karen Dawber, Director of Nursing agreed that this saving will enable us to increase our own department resources.	
41	Lynne Lobley, Non-Executive Director asked if we would be criticised for not fulfilling our obligations. Mel Pickup, Chief Executive confirmed we are and Anne Robinson, Associate Medical Director, Quality Improvement advised we can provide assurance that A&E attendance of Domestic Abuse issues has an adequate process.	

42	Lynne Lobley, Non-Executive Director was assured we are fulfilling our obligations.	
43	Fire – It was agreed that Millie Bradshaw, Associate Director of Governance and Risk would write to the Fire Officer explaining that all actions are being undertaken and recommending this action be removed from the Trust Risk Register.	
44	Lynne Lobley, Non-Executive Director asked for confirmation from the Committee that all risks have been reviewed. This was agreed.	
	WHHFT/QGC/16/014 – Serious Incident Update	
45	Millie Bradshaw, Associate Director of Governance and Risk explained there has been one new incident but confirmed that no harm has occurred.	
46	Lynne Lobley, Non-Executive Director enquired why this incident took so long to be identified. Millie Bradshaw, Associate Director of Governance and Risk explained the errors and Karen Dawber, Director of Nursing confirmed that actions have been taken to avoid this happening again.	
	WHHFT/QGC/16/015 – Infection Control (verbal update)	
	The Pseudomonas incident in NNU has been concluded. There is some outstanding Estate work which has been agreed but is yet to commence. Year to date the Trust has reported 22 cases of Clostridium difficile. 9 of these cases have been removed from contractual sanctions. Nil hospital apportioned cases were reported in December.	
	WHHFT/QGC/16/016 – Medicines Management (verbal update)	
47	Diane Matthew, Chief Pharmacist reported:	
48	Medicines Safety Officer is being appointed working one day per week.	
49	She reported that there have been no NICE guidance breaches.	
50	Discharge Summaries – the Lorenzo modules are being utilised.	
51	Medicines Clerking – Emergency Department is working hard and is supporting getting this information into Lorenzo.	
52	Further discussion then took place around the antimicrobial pharmacist, Diane Matthew explained what has already been undertaken and described the role of the ward pharmacist who has the skills to identify inappropriate antibiotic prescribing. Diane explained that obtaining the data is time consuming but that once this is received this will drive the development of software.	
53	It was agreed that Lesley McKay, Associate Director of Nursing, Infection Control and Diane Matthew, Chief Pharmacist will have discussion around reviewing the risk on the Risk Register with the intention of reducing this risk.	**Chief Pharmacist/ Associate Director of Nursing, Infection Control February 2016**

	HIGH LEVEL BRIEFING AND MINUTES FROM REPORTING COMMITTEE CHAIRS	
	WHHFT/QCG/16/017 – Information Governance and Corporate Records and SIRO report	
54	No meeting has taken place	
	WHHFT/QCG/16/018 – Health and Safety Sub Committee	
55	The action notes of meeting dated 12th November 2015 were noted by the Committee.	
	WHHFT/QCG/16/019 – Strategic People Committee	
56	The minutes of the meeting dated 12th October 2015 were noted by the Committee.	
	WHHFT/QCG/16/020 – Clinical Effectiveness Sub Committee	
57	The notes of the meeting held on 23rd October 2015 were noted by the Committee.	
	WHHFT/QCG/16/021 - Event Planning Group	
58	The notes of the meeting held on 23rd October 2015 were noted by the Committee.	
	WHHFT/QCG/16/022 – Patient Safety Sub Committee	
59	No meeting has taken place.	
	WHHFT/QCG/16/023 – Patient Experience Committee	
60	The Minutes of the meeting held on 24th November 2015 were noted by the Committee.	
	WHHFT/QCG/16/024 - Infection Control Sub Committee	
61	The HLBP dated 15th December was noted by the Committee.	
	Date and time of next meeting: **2nd February 2016 – Trust Conference Room – 9am**	

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

BOARD OF DIRECTORS 16/057

SUBJECT:	**QUALITY DASHBOARD (2015/2016) FEBRUARY 2016**
DATE OF MEETING:	24th February 2016
ACTION REQUIRED	**For Assurance**
AUTHOR(S):	Ros Harvey (Corporate Nursing Programmes Manager) Hannah Gray (Clinical Effectiveness Manager)
EXECUTIVE DIRECTOR:	Karen Dawber, Director of Nursing and Governance
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework SO1/1.3 Failure to achieve infection control targets in accordance with the Risk Assessment Framework
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED:	None
EXECUTIVE SUMMARY (KEY ISSUES):	The Quality Dashboard (at Appendix 1) includes 2015/2016 quality related KPIs from the:- • CQUINs – National (Local CQUINs will be monitored by the CQUIN monitoring group and reported by exception if required). • Quality Contract • Quality Account - Improvement Priorities and Quality Indicators • Sign up to Safety – national patient safety topics • Open and Honest initiative Please note that VTE and dementia are extracted for the purpose of the QDB in advance of submission via UNIFY at months' end and may not show compliance with the threshold. (VTE – 95% and Dementia – 90%). This will be updated in next month's Quality Dashboard. The KPI titles in red text denote data which has been

	affected by the switch from Meditech to Lorenzo. The leads and information department are working on these issues.	
RECOMMENDATION:	***The Board is asked to:*** 1. Note that the data for a number of indicators can change month on month. This applies to mortality peer review, incidents (including pressure ulcers and falls), as incident type and severity can alter once reviewed, complaints and concerns as complaints can become concerns (and vice versa), with the agreement of complainants, and to mortality data which is rebased. 2. Note progress and compliance against the key performance indicators 3. Approve actions planned to mitigate areas of exception 4. Note the change in incident figures	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

Please see Appendix 1 for the quality dashboard data

Patient Safety

1. **VTE**

There are issues with extracting data from the new Lorenzo system as the relevant reports are not yet available and the data capture systems (including the use of paper and e-forms) require refinement.

VTE Root Cause Analysis (RCA)

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

IT solutions, supported by the Clinical Governance Department are being implemented to help mitigate this delay.

Clinical Effectiveness

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

The SHMI has reduced to 112 for the period November 2015 – October 2016. The Trust continues to compare well with local peers regarding crude death rates; this is 2.4% for 2015/2016 (to the end of January). Actual numbers of deaths continue to be closely monitored and there is a significant reduction in deaths in December 2015 and January 2016 compared to the same months in the previous year. The Mortality Review Group (MRG) is monitoring progress against the revised Reducing Avoidable Mortality action plan. The Trust Board will receive the next Mortality Overview Report at the April 2016 Trust Board meeting.

3. SEPSIS

Issues have been identified relating to both the capture and extraction of this data in Lorenzo; actions to resolve these are in progress.

4. AQ Measures

We are narrowly missing the cumulative target for the Heart Failure and Pneumonia measures. The compliance for each aspect of the measures for October only (for which the heart failure target has been achieved) is provided below:

Heart Failure

- (DCM) Heart failure specialist review prior to discharge 3/18 (16.7%)
- HF Specialist review <72 hours of HF documentation 18/20 (90%)
- Evaluation of left ventricular systolic function 5/7 (71.4%)
- Written Discharge Instructions Given and Discussed 17/18 (94.4%)
- ACEi or ARB prescribed at discharge 9/9 (100%)
- Beta-blocker prescribed at discharge 8/8 (100%)
- Referral for appropriate heart failure follow-up 14/15 (93.3%)

Pneumonia

- Oxygen assessment within 4 hours 63/63 (100%)
- Chest x-ray within four hours of arrival 57/62 (91.9%)
- Initial antibiotic received within 4 hours of hospital arrival 28/29 (71.8%)
- CURB-65 score 42/47 (89.4%)
- Appropriate antibiotic selection 26/27 (96.3%)

Patient Experience

5. Pressure Ulcers

We have not met the 10% or 5% reduction targets (59 and 63) for grade 2 pressure ulcers, having had 72 by the end of January 2016. The Trust continues to implement its planned programed of actions to further reduce pressure ulcers which include:-

- Root cause analysis is conducted on all Grade 3/4 pressure ulcers which develop within the trust
- As agreed with our commissioners the trust is piloting the 72 hour incident review tool
- Mini investigations of all grade 2 hospital acquired pressure ulcers
- Adult Safeguarding team is now part of the pressure ulcer investigation panel
- A task and finish group led by the Associate Director of Nursing for Scheduled Care focussed on preventing orthopaedic device related pressure ulcers
- Clearer guidance and support around patient non-compliance and capacity

- Bands 1-4 staff will be receiving basic education around nutrition which will include MUST and E-learning is now available
- Standby Phase III mattresses are located on several wards on the Warrington site and in the Porters' Lodge on the Halton site for out of hours use to eliminate delay in obtaining a high risk dynamic mattress
- Repose trolley toppers have been purchased for use on A&E trolleys for high risk patients
- New monthly Pressure Ulcer Prevention training commences January 2015, facilitated by Park House Healthcare.

6. Dementia CQUIN

Issues have been identified relating to both the capture and extraction of this data in Lorenzo; actions to resolve these are in progress.

7. Always Events

Although the target of 100% is not yet being met, we have sustained an improvement each month since April 2015, from 89% in April 2015, to 97% for January 2016. Compliance for quarter 1 is 90%, rising to 93% for quarter 2 and 95% for quarter 3.

8. Care Indicators: risk assessments

The care indicators audit process was developed as part of the High Quality Care CQUIN for 2013/2014 to audit compliance (random sample) with risk assessments for Falls, Waterlow and MUST. The Trust monitored this as a Quality Indicator for the Quality Accounts in 2014/2015 and due to non-compliance at year end (achieving below 95%), has decided to continue monitoring this for 2015/2016. The audit includes all patients and any non-compliance issues will be addressed by ward managers and the patient quality and safety champion, with compliance and progress monitored by the Patient Experience Sub Committee. Although we failed to achieve 95% for falls and Waterlow in December we did achieve the threshold for both for Q3. Although not yet meeting the target for MUST, the data shows increasing compliance from 85% for quarter 1, 86% for quarter 2, and 88% for quarter 3.

9. Mixed Sex Occurrences

There were three reported breaches of same sex accommodation in January 2016. Two occurred in HDU beds and one in CCU. These have been investigated in line with policy and an RCA completed. Though there were three breaches, the number of breach days was six in total.

Patient Experience Return:

Q.1 3 patients said they had shared accommodation when they were first admitted.
Q.2 3 patients said they had shared accommodation after they were moved to another ward.
Q.3 4 patients said they had used the same bathroom as the opposite sex. 1 said it was not applicable and 12 did not know.

10. Friends and Family

We have experienced a significant decrease in the number of FFT returns, particularly from A&E, since November 2015. This coincided with the roll out of the Lorenzo system and increasing activity across the Trust. Another factor has been that the new booking in system in A&E means that patients don't speak directly to the reception staff and are not offered forms at that point. In January, a box of completed forms arrived too late for scanning with iWGC. This meant that 300+ forms were not included in the count.

Actions:

- Issue raised with leads in A&E

- Additional visits to A&E to encourage staff to give forms out
- Investigating options for the booking in system to include a reminder to complete FFT
- Look at buying a stand for forms to be situated next to book in kiosk.

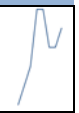
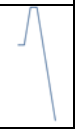
Feb-16

Quality Dashboard 2015/16

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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

Target or Indicator		Target	IC	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD	Trend
Safety																					
INCIDENTS	MODERATE, MAJOR OR CATASTROPHIC HARM: APPROVED	TBC	QC	7	5	7	19	7	4	9	20	18	1	2	21	3				63	changes monthly
	MODERATE, MAJOR OR CATASTROPHIC HARM: UNDER REVIEW	N/A		1	0	2	3	2	5	5	12	4	3	6	13	14				42	changes monthly
	SERIOUS UNTOWARD INCIDENTS (SUIs) Level 2	N/A		3	1	2	6	3	1	1	5	2	1	0	3	0				14	
HEALTHCARE ACQUIRED INFECTIONS	MRSA	0= green, 1-5=amber, >5 red	QC, QI	0	0	0	0	0	1	1	2	0	0	0	0	0				2	
	CLOSTRIDIUM DIFFICILE (due to lapses in care)	<=27 per year	QC, QI	0	1	3	4	1	0	3	4	0	0	0	0	0				8	
	CLOSTRIDIUM DIFFICILE (no lapse in care)	None set	N/A	3	4	1	8	0	0	1	1	0	0	0	0	0				9	
	CLOSTRIDIUM DIFFICILE (under review)	None set	N/A	0	0	0	0	0	0	0	0	3	2	0	5	0				5	
NEVER EVENTS		0	QC	0	1	0	1	0	0	0	0	0	0	0	0	0				1	
VTE	% OF PATIENTS RISK ASSESSED	>=95%	QC	97.52%	96.21%	96.01%		95.33%	95.77%	94.02%		95.04%	65.63%	67.23%		65.20%					
	% OF ELIGBLE PATIENTS HAVING PROPHYLAXIS (SAFETY THERMOMETER)	100%	QC	100.00%	100%	99.82%		100%	100%	99.82%		99.65%	100%	99.47%		100%					
	NUMBER OF PATIENTS WHO DEVELOPED A HOSPITAL ACQUIRED VTE (APPROVED)	TBC	QC	3	0	0	3	0	1	0	1	1	0							5	
	NUMBER OF PATIENTS WHO DEVELOPED A HOSPITAL ACQUIRED VTE (UNDER REVIEW)	N/A	N/A	4	6	9	19	1	2	3	6	3	2							30	
HARM FREE CARE	% OF PATIENTS FREE FROM HARM (SAFETY THERMOMETER)	TBC	OH	97.70%	92.60%	98.34%		95.51%	97.33%	98.52%		96.81%	94.04%	96.26%							
	% OF PATIENTS FREE FROM HARM (MEDICINES SAFETY THERMOMETER)	TBC	QI	100%	97.5%	98.1%		100%	100%	98.5%		100%	92.60%	96.60%	No Audit Dec						

Target or Indicator		Target	IC	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD	Trend
Effectiveness																					
MORTALITY	HSMR (12 MONTH ROLLING)	<=100 = G, As expected = A, Higher than expected = R	QI, IP, QC	104	105	106		109	109	107		107	108								
	SHMI (12 MONTH ROLLING)	<=100 = G, As expected = A, Higher than expected = R	QI, IP, QC	114	114	115		115	114	113		112									
	TOTAL DEATHS IN HOSPITAL	None set	reporting only	92	80	107	279	87	81	77	245	88	93	82	263	108				895	
	MORTALITY PEER REVIEW (NB figures change as reviews are conducted)	Q1 - 45% Q2 – 55% Q3 – 75% Q4 – 95%	IP, SU2S	78%	81%	64%	74%	77%	73%	76%	75%	86%	76%	56%	73%					74%	
	REGULATION 28 - PREVENTION OF FUTURE DEATHS REPORT	None set	Reporting only	0	0	0	0	0	0	1	1	0	0	0	0	0				1	
CARDIAC ARRESTS	Annual: <75 = G, 75 – 85 = A, >85 = Red	see left	QC	4	2	11	17	10	5	6	21	4	9	6	19	14				71	
ADVANCING QUALITY	ACUTE MYOCARDIAL INFARCTION	>=95%	QI, C	93.18%	94.94%	96.83%		97.16%	97.14%	97.01%		97.31%								97.31%	
	HIP AND KNEE	>=95%	QI	98.51%	99.22%	98.97%		98.85%	99.01%	99.22%		99.33%	99.40%							99.40%	
	HEART FAILURE	>=84.1%	QI, C	72.22%	73.17%	75.44%		78.85%	81.15%	82.89%		83.24%								83.24%	
	PNEUMONIA	>=78.1%	QI, C	80.00%	78.83%	78.65%		78.00%	77.82%	78.47%		77.11%								77.11%	
APPROPRIATE DISCHARGE PLANNING FOR PATIENTS WITH AKI		25% Q3	C	Absence of AKI Calculator in current system resulted in CCG agreeing for baseline to be set at Q2				Achieved 20.7% for Q2 established 25% as a baseline for Q3			20.70%	31%	38%	35%	35%						
SEPSIS SCREENING OF ALL ELIGIBLE PATIENTS ADMITTED TO EMERGENCY AREAS		40% for Q3	C	Quarter one data for establishing baseline				26%	40%	28%	31.3%	18%*	26%	32%	25.33%						
SEPSIS SCREENING: ANTIBIOTICS GIVEN WITHIN AN APPROPRIATE TIMESCALE		20% for Q3	C	Quarter 1: establishing indicator detail				25%	23.1%	0%	15.4%	22.22%	27.27%	33.33%	26.92%						
Patient Experience																					
FALLS	ALL FALLS (APPROVED)	913	IP (5% reduction)	82	89	80	251	75	73	87	235	96	81	43	220	57				763	
	FALLS PER 1000 BED DAYS	<=5.6	IP (national benchmark)	4.97	6.22	5.03		4.97	4.53	4.84		5.02	4.60	2.65		3.77				4.76	
	MODERATE, MAJOR AND CATASTROPHIC HARM FALLS (APPROVED)	<=13	IP (10% reduction)	2	1	2	5	1	0	2	3	2	0	0	2	0				10	
	MODERATE, MAJOR AND CATASTROPHIC HARM FALLS (UNDER REVIEW)	N/A		0	0	0	0	0	0	1	1	0	0	1	1	1				3	
	MODERATE HARM FALLS (APPROVED)	<=12	SU2S (10% reduction)	1	1	2	4	1	0	2	3	1	0	0	1	0				8	
Target or Indicator		Target	IC	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD	Trend

PRESSURE ULCERS	GRADE 3 AND 4 HOSPITAL ACQUIRED (AVOIDABLE)	<=5	QI, SU2S (10% reduction)	1	1	1	3	0	0	0	0	0	0	0	0	0				3	
	GRADE 3 AND 4 HOSPITAL ACQUIRED (UNAVOIDABLE)	N/A		1	1	0	2	0	0	0	0	1	0	1	2	0				4	
	GRADE 3 AND 4 HOSPITAL ACQUIRED (UNDER REVIEW)	N/A		0	0	0	0	0	0	0	0	0	0	0	0	1				1	
	GRADE 2 HOSPITAL ACQUIRED, AVOIDABLE AND UNAVOIDABLE (APPROVED)	<=63	QI (5% reduction)	15	8	6	29	10	6	4	20	12	9	1	22	1				72	
	GRADE 2 HOSPITAL ACQUIRED, AVOIDABLE AND UNAVOIDABLE (APPROVED)	<=59	10% reduction internal stretch target	15	8	6	29	10	6	4	20	12	9	1	22	1				72	
	GRADE 2 HOSPITAL ACQUIRED, AVOIDABLE AND UNAVOIDABLE (UNDER REVIEW)	N/A		0	0	0	0	0	0	1	1	1	2	5	8	3				12	
TRANSFERS	OUT OF HOURS TRANSFERS	TBC	BK	1	0	1	2	0	0	DC		DC	DC	DC		DC					
	NON-ESSENTIAL WARD TRANSFERS	TBC	QI	DC	DC	DC		DC	DC	DC		DC	DC	DC		DC					
ALWAYS EVENTS		100%	QI	89%	90%	92%	90%	96%	96%	88%	93%	94%	96%	96%	95%	97%				93%	
DEMENTIA	DEMENTIA ASSESSMENT % (PART 1)	>=90%	C	96.85%	97.62%	95.53%		96.80%	94.86%	94.36%		92.18%	81.30%	26.9%		58.44%					
	DEMENTIA ASSESSMENT % (PART 2)	>=90%	C	100%	100%	100%		100%	95.12%	100%		85.71%	73%	88.9%		62.30%					
	DEMENTIA ASSESSMENT % (PART 3)	>=90%	C	100%	100%	100%		100%	100%	100%		100%	100%	CCG		CCG					
	DEMENTIA - STAFF TRAINING	Q3 = 50%	C	Compliance established at 27.02% end Q1 plus additional 15% for Q2			27.02%				42%	44.50%	46.50%	49.64%	49.64%	51.43%				49.6%	
CARE INDICATORS RISK ASSESSMENTS	FALLS	>=95%	IP	82%	92%	93%	93%	97%	97%	93%	96%	96%	94%	96%	97%	92%					
	WATERLOW (PRESSURE ULCERS)	>=95%	IP	77%	93%	92%	91%	96%	95%	92%	94%	96%	95%	97%	98%	94%					
	MUST (MALNUTRITION)	>=95%	IP	78%	85%	89%	85%	91%	80%	87%	86%	90%	88%	93%	92%	93%					
	DIABETIC FOOT	Q1 - 61% Q2 – 71% Q3 – 81% Q4 – 91%	C	QR	QR	77.60%	77.60%	72.00%	81.40%		76.80%				95%					77.2%	
MIXED SEX OCCURENCES		0	QC	6	0	1	7	0	0	0	0	0	3	0	3	3				13	
FRIENDS AND FAMILY (PATIENTS' VIEWS)	STAR RATING	N/A	Reporting only	4.61	4.66	4.70		4.66	4.65	4.72		4.71	4.70	4.73		4.72					
	% RECOMMENDING TRUST: INPATIENTS	>=95%	IP, QI, QC	97%	96%	97%		98%	98%	96%		97%	96%	96%		96%					
	% RECOMMENDING TRUST: A&E	>=87%	IP, QI, QC	83%	83%	83%		88%	87%	90%		85%	86%	85%		82%					
	RESPONSE RATE: A&E WARRINGTON	Contract target to be agreed	IP, QI, QC	22.03%	19.47%	13.16%		6.96%	6.49%	20.29%		12.52%	8.51%	3.55%		1.05%					
	RESPONSE RATE: URGENT CARE CENTRE HALTON	Contract target to be agreed	IP, QI, QC	3.54%	22.81%	24.00%		44.90%	10.86%	17.77%		20.95%	22.84%	4.19%		3.39%					
Target or Indicator		Target	IC	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD	Trend

FRIENDS AND FAMILY (PATIENTS' VIEWS)	RESPONSE RATE: A&E COMBINED	Contract target to be agreed	IP, QI, QC	17.42%	20.26%	16.11%		17.62%	7.66%	19.58%		14.95%	11.8%	3.74%		1.60%					
	RESPONSE RATE: INPATIENTS	Contract target to be agreed	IP, QI, QC	30.30%	33.80%	31.44%		31.96%	6.13%	63.10%		35.09%	30%	31.45%		10.54%					
COMPLAINTS AND CONCERNS	NUMBER OF COMPLAINTS RECEIVED	2014/2015 received 478 (No threshold set)	IP	49	23	31	103	24	35	37	96	45	32	24	101	39				339	
	% OF COMPLAINTS RESOLVED WITHIN THE AGREED TIMESCALE	>=94%	IP, QC	100%	97.50%	97.56%	98.08%	97.67%	100%	100%	98.90%	96.15%	97.87%	100%	98.4%	100%				98.13%	
	NUMBER OF CONCERNS RECEIVED	NOT SET	IP	10	8	26	44	39	19	6	64	4	5	10	19	11				138	
END OF LIFE STRATEGY: STAFF TRAINING (KPI UNDER CONSTRUCTION)		TBC	IP	Training workshops in development, delivery in Q3				Training workshops in development, delivery in Q3				Training has commenced	Training has commenced	Training has commenced		Training has commenced					
REDUCING AVOIDABLE EMERGENCY ADMISSIONS TO HOSPITAL		TBC	C	4 pathways identified, awaiting CCG agreement				Adult and paediatric conditions identified, report shared with CCG				Audit underway & completed		Results to be presented to CCG		Results to be presented to CCG & Audit					

BOARD OF DIRECTORS 16/058

SUBJECT:	**Complaints: Patient Experience Quarter 3 Report 2015/2016**
DATE OF MEETING:	24 February 2016
ACTION REQUIRED	**For Assurance**
AUTHOR(S):	Michele Lord, Patient Experience Matron
EXECUTIVE DIRECTOR:	Karen Dawber, Director of Nursing and Governance
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care SO3: To give our patients the best possible experience SO4: To provide sustainable local healthcare services
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework SO3/3.3 Failure to provide staff, public and regulators with assurances post Francis and Keogh review
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED:	None
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides an overview of complaints and other feedback received by the Trust in Quarter 3, • The Trust received a total of 102 formal complaints between 1 October and 31 December 2015, which is an increase of 8 on the previous quarter (allowing for adjustments). • The top four themes of complaints were waiting time, attitude, treatment and communication. • 1 case has been closed by the PHSO in quarter 3. Four cases have been partly upheld by the PHSO and the Trust is either reviewing the draft report or complying with recommendations made. The records of two patients have been requested for review and two further complaints will be investigated by the PHSO. • 566 people contacted PALS in Quarter 3; this is an increase of 53 contacts on the previous quarter. • There is an overview of feedback left on the *NHS Choices* website. • Graphs demonstrate the total complaints by subject and divisional/departmental top 5 complaint themes.

	• 98% of complaints were closed within agreed timescales. • Examples of learning from complaints (Quarter 2 2015/2016) are provided. • Proposed audit of both process and data in Q1 16/17	
RECOMMENDATION:	***The Board is asked to:*** The Board is asked to note the contents of this report, which describe the progress in the monitoring of complaints and to approve the actions recommended.	
PREVIOUSLY CONSIDERED BY:	**Committee** **NA**	Choose an item. Or type here if not on list:
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

EXECUTIVE SUMMARY

This report provides an overview of complaints received by the Trust from 1 October to 31 December 2015. The report is written in accordance with the NHS Complaints Regulations (2009) and complements the patient experience annual report presented in May 2015. The next annual report is due after 1 April 2016. In addition, there will be a review of reporting of complaints and other patient experience information that will correspond with the new structures and provide a more comprehensive set of data for Trust executives and non-executive members.

As part of the testing for the annual quality account PWC will be looking at the full year data set, in addition to this we intend to have a peer review of the complaints process and the lessons learnt. This will then inform the revised *Complaints and Concerns Policy* that is currently under review.

Background

In accordance with the *NHS Complaints Regulations* (2009), this report sets out a detailed analysis of the nature and number of formal complaints made to Warrington and Halton Hospitals NHS Foundation Trust. The report also offers feedback from other sources, the *NHS Choices* website and PALS to provide a wider picture of the nature of feedback and to provide a balanced view of positive and negative experiences. Examples of learning from complaints closed in Quarter 2 are provided in the report to show the various tools employed by divisional, ward and service teams to ensure learning from poor performance.

A new report from the Parliamentary & Health Service Ombudsman, *Breaking down the Barriers: Older people & complaints about healthcare was* launched in 2015 following a national survey of 4,263 people exploring experiences and perceptions of complaining about the NHS in England. The responses of 689 respondents aged over 65 years were used in this report. In addition, the PHSO worked with *Independent Age,* a national charity, holding three focus groups across the country and several case studies from the PHSO files were also included in the report.

In the executive summary of the report the PHSO advises that,

> *"People are more likely to need to use health care services as they enter later life. Yet when it comes to complaining about poor care, evidence we have gathered for this report shows that older people are often reluctant to speak up or simply don't know how to."*

A review and action plan is being developed in response to this report in order to ensure that, as an organisation, we do our utmost to encourage older people to make complaints and raise concerns without fear of reprisal, to demonstrate that we take complaints seriously and to make the complaints process accessible to all.

The Hospital and Community Health Services Complaints Collection (KO41a) is the mandatory national reporting system for complaints and last year became quarterly, rather than annual reporting to the Health & Social Care Information Centre. The data sets requested have been modified and provides the national statistics on complaints in the NHS and care. The data collected supports the NHS Plan to improve the patient experience, contributing to delivering the *Improving Patients' Experience PPF/2004 PSA (objective 4)* targets.

1. COMPLAINTS OVERVIEW

The information on Trust activity is based on *Lorenzo* data since November 2015, but at the moment does not contain any ward attender/outside clinic attender information and the outpatient numbers are incorrect at this time. The Data Warehouse team are working to correct this but we do not, at present have a date when this will be resolved. The October data is gleaned from the previous system and is correct.

Table 1: Trust activity, 1 November – 31 December 2015

Month	Day case	In-patient	Non-elective	New	Follow up	A&E	MIU	WIC	Ward Attender	Outside Clinic Attend-ance	Grand Total
Oct	2672	481	3368	10117	23952	7034	1917	1141	1153	50	51885
Nov	758	141	1037	793	1697	2069	613	-	7	12	7127
Dec	2272	452	3278	3200	6612	6504	1812	-	28	71	24229
Grand Total	**5702**	**1074**	**7683**	**14110**	**32261**	**15607**	**4342**	1141	**1188**	**133**	83241

Figure 1: Complaints received per 1000 patient attendances for Quarter 3

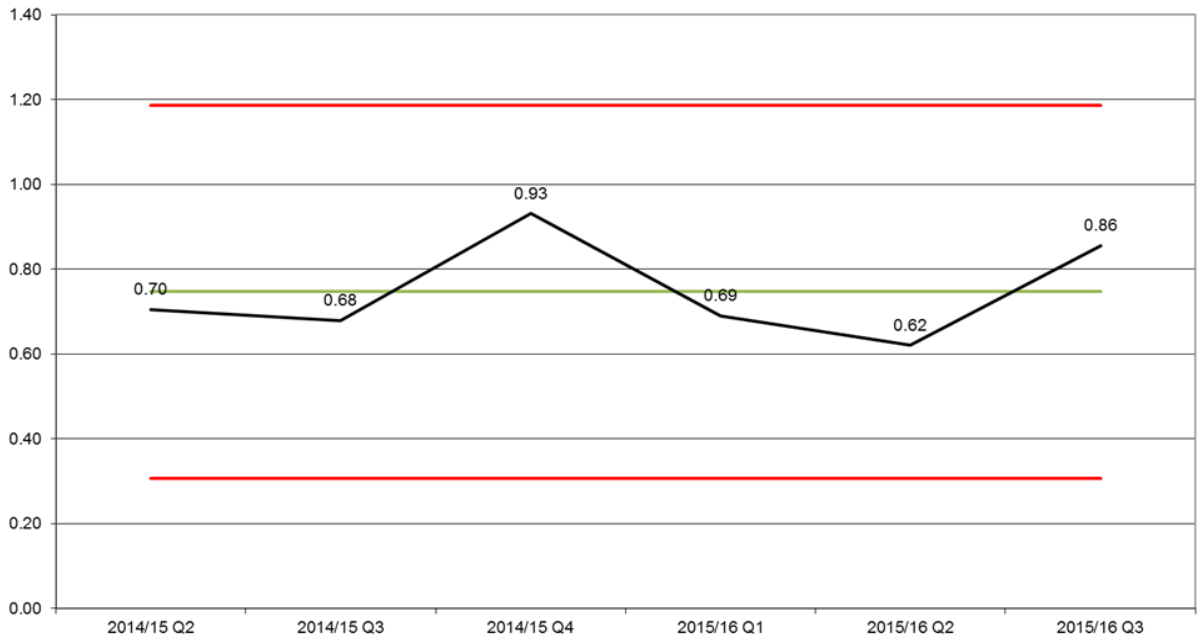


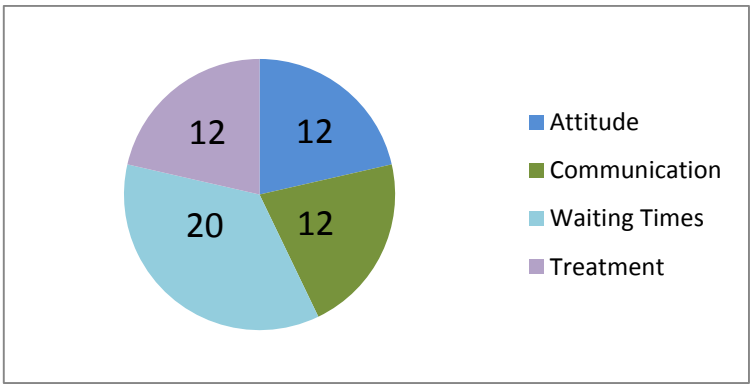
Table 2: Formal complaints received in Quarter 2

Quarter	Formal complaints received
Quarter 3, October – December 2015	102
Quarter 2, July – September 2015	96
Quarter 1, April – June 2015	103
Quarter 4, Jan – March 2015	138

NB. Total numbers of complaints from previous quarters have been adjusted to account for withdrawn complaints.

The number of formal complaints received in Quarter 3 was 102, an increase on Quarter 2 of 6. A further 8 complaints were withdrawn and designated as concerns. Since Quarter 2 there has been an increase in the number of low (20) risk graded complaints. Moderate risk graded complaints have been reduced by14 and high risk graded complaints have remained the same.

Figure 2: Top four themes for complaints made in Quarter 3



A more detailed breakdown of the subjects, by all and by division, can be found in figures 3-8.

The fact that there is a rise in low risk complaints is reflected here in the relatively high number of complaints about waiting times, as these are normally categorised as low risk. Previous quarterly reports have shown that complaints about treatment and attitude are consistently higher than other subjects. The trend of complaints about attitude has been highlighted in divisions and teams, but continues to be an issue. There is a need to build on training, performance management and disciplinary processes in order to reduce the number of complaints made about staff attitude.

Table 3: Risk rating of complaints, by quarter

	2014/15 Q4	2015/16 Q1	2015/16 Q2	2015/16 Q3	Change from last Quarter
Complaints Received	**138**	**103**	**96**	**102**	↑
Low	67	44	41	61	↑
Moderate	61	55	45	31	↓
High	10	4	10	10	↔

The distribution across the high risk grade complaints is generally consistent. The numbers of moderate risk graded complaints has dropped for the three consecutive quarters and the number of low risk complaints has risen.

All formal complaints were received in the English language with no requests made by a complainant (or enquirers) for the use of the Trust Interpreter Service. There were no formal complaints from or about the care of patients with a declared disability or a mental health condition.

Parliamentary Health Service Ombudsman (PHSO)

The previously reported complex and long debated case was finally closed in October 2015. An exhaustive action plan and evidence was sent to the PHSO, CQC, Monitor and the Trust Development Authority. An action plan for a previously reported case is being written by the

division and is due to be closed soon. We challenged a case that the PHSO had partly upheld and were asked to supply further information for consideration. A decision on this case is awaited. We have received a draft report for a patient where the PHSO have partly upheld the complaint. This has been sent to the division for a response/acceptance of decision and recommendations. A final report has been sent to division and we have until March to complete the recommendations made.

The PHSO have asked for the clinical and complaints records of two patients in order to review and decide if they will investigate and we have been informed that they will investigate two other cases referred to them.

Patient Advice and Liaison Service (PALS)

566 people contacted PALS in Quarter 3, compared to 513 in the previous quarter. Car parking issues continue to be raised, though not as regularly. Both PALS and the complaints team have received complaints about problems arising from the *Lorenzo* implementation in November 2015. Some of these were possibly avoidable as we have anecdotal evidence that clerical staff and telephonists have advised people to make a complaint or go to PALS when the caller evinced dissatisfaction at the problems they were encountering. There needs to be some work done to reach all grades of staff with training on resolving concerns raised at the time they are raised and the value of avoiding more formal complaint processes.

Table 4: Examples of PALS contacts by quarter

Q4	Contacts	Q1	Contacts	Q2	Contacts	Q3	Contacts
January	173	April	211	July	175	October	203
February	188	May	183	August	133	November	172
March	229	June	268	September	205	December	191
Total	**590**	**Total**	**662**	**Total**	**513**	**Total**	**566**

Table 5: Examples of the type of issues that have been raised with PALS in Quarter 3

PALS Enquiry	Outcome
The mother of a minor was extremely worried and anxious due to her daughter having had been admitted 2 days previously and she had not received a diagnosis or treatment plan.	Arrangements were made for the consultant to meet with the patient's mother to discuss the patient's care/treatment plan, thus alleviating the mother's anxieties.
A 24 year man, who was an inpatient, visited the PALS office with concerns about his treatment. He felt no-one was listening to his concerns.	The PALS Officer arranged a meeting with the consultant and attended the meeting to support the patient. As a result the patient felt he had been heard and the treatment ordered following the meeting led to relief of his symptoms.
A lady visited the PALS office when visiting outpatients' clinic in a very distressed state, she had informed the officer that she had lost her husband and was not coping, so much so she had morbid thoughts of ending her life.	The PALS officer contacted the service user's GP and an urgent appointment was arranged. Contact details for local counselling services were also provided. When the service user arrived home, after having seen her GP she contacted PALS to say she now felt better now that she was receiving support.

1.1 NHS Choices

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

Table 6: Number of patient comments left on *NHS Choices* for Quarter 3, by site

Star rating	Warrington	Halton	CMTC
★★★★★	12	14	3
★★★★	-	-	-
★★★	-	-	-
★★	1	-	-
★	5	-	1
No star rating assigned	3	-	-
Total for Q3	21	14	4

Table 7: Number of patient comments left on *NHS Choices* for Quarter 3, by service

Ward/Department	Warrington	Halton	CMTC
Acute Medicine	2	-	-
Cardiology	1	-	-
Car parking	1	-	-
Emergency Services	5	6	-
Endoscopy	2	2	-
General surgery	1	4	-
Gynaecology	1	-	-
Maternity	4	-	-
Ophthalmology	1	-	-
Orthopaedics	2	-	4
Radiology	1	-	-
Waiting Time	-	1	-
Vascular	-	1	-
TOTAL	**21**	**14**	**4**

Table 8: Examples of comments received to the *NHS Choices* website

Warrington

5 star treatment in the endoscopy department

I was very impressed by the standard of professionalism and care provided by the staff in the unit. They put me at ease and I can honestly say that the endoscopy and colonoscopy was done well and I was relaxed during the 2 procedures. Thanks to you all in the unit.

Visited in November 2015. Posted on 30 November 2015

Poor care in A& E

Our teenage son went to A&E with his dad with a suspected fractured wrist. The department was empty apart from one other family, and all my son could hear was staff chatting and drinking tea! We arrived at 4:15 pm and when eventually seen 2 hours later the doctor examined my son's wrist. He could not move his hand or thumb and they did an X-ray form and put wrong wrist, so had to wait a further 10 mins to be corrected. After X-ray doctor said they would put a cast on and immobilise his hand from thumb down to mid-way down his arm. 20 mins later a nurse came with a fabric splint which didn't support hand or thumb and barely covered his wrist, and in questioning the nurse they said the doctor had changed their mind and decided on splint without letting us know or explaining why change if heart, and in fact the doctor didn't come back again, My son came home nearly in tears with pain and a hand he cannot use and a splint which is nearly useless - I wouldn't never go to this A&E again.

Visited in December 2015. Posted on 04 December 2015

Kept fully informed about my condition and treatment

My treatment on ward C21 was lovely; the doctors/carers were wonderful. The consultant explained everything and was not in a rush. My husband was also involved. This is the third time I have been on the ward and I would advise anyone, don't be afraid you will have first class treatment and respect.

Visited in November 2015. Posted on 28 November 2015

Car Parking

I have recently had need to use your car park. A number of issues, the first ticket machine wouldn't accept my registration even though I tried a number of times. I had to go to the shop to buy something I didn't need to get change. There was no one around to ask for help and no 'phone number to call for assistance. In all the difficulty I then mis-typed one digit of my registration, I do not expect to receive a fine given that I have paid the fee and I will be interested to see just how such monies are being spent on patient care/ facilities. To add insult to injury on searching the website I cannot find any contact number for Hillview, who are responsible for the car park, so it isn't possible to contact them one is obviously just expected to wait until one receives a ticket and fine. The website should at least have such basic details.

Visited in December 2015. Posted on 07 December 2015

Halton

Day care visit

I quite recently had Hernia repair performed at the Day Care Centre and was very happy with every aspect of my care and treatment. I was treated with respect and a degree of good humour and was kept informed of everything that was happening regarding my treatment.

I even quite enjoyed the food. Well done and thanks to all on B4.

Visited in December 2015. Posted on 14 December 2015

My mother's recent stay

My 86 years old mother has just returned from a short stay in ward B4. I would like to thank them for the excellent care she received. The room was spotless and my mother said the staff were absolutely lovely and very caring. They also passed on messages when I phoned from Italy to ask as to my mother's welfare. I would also like to thank the surgeon who made my Mother feel special and treated her like an old friend. Thank you all x

Visited in November 2015. Posted on 11 November 2015

CMTC

Knee Arthroscopy

On Tuesday 22nd December I was admitted to CMTC for a knee arthroscopy. My main concern is that I am usually very sick after an anaesthetic but the anaesthetist reassured me that they would give me something to stop the sickness. After I had been in the recovery room I managed to drink a cup of tea and had some lunch before I went home. I have got to say I got the best treatment than I ever have had in any hospital, all of the staff are very friendly and make you feel totally relaxed and nothing was too much trouble for them. It left me feeling a lot less anxious about having surgery and would not hesitate in being asked to be referred there again if need be. I would like to thank everybody involved in looking after me, thank you very much.

Visited in December 2015. Posted on 23 December 2015

Abdication of Responsibility for Care

Following a minor complication after a knee replacement surgery, my mother was unceremoniously shipped to Warrington Hospital in the middle of the night for an urgent CT scan (a service that is supposedly provided at CMTC) and this scan has still not taken place some 30 hours after she was moved and she has been told by staff at Warrington that her scan is not regarded as a priority, leading me to assume that if CMTC does indeed have scanning facilities, then my mother's scan could have been done without the need for a move and in a much more timely fashion than if she had not been moved.

At this time, my mother was expecting to receive physiotherapy to speed her recovery. There has been no physiotherapy since her move and has been told that it could take a further two days for a physiotherapist to visit her on the ward at Warrington Hospital. Once again, there is no follow up

from CMTC staff. My mother was moved to Warrington without anybody ensuring that a bed was available and as a consequence was stuck in A&E rather than receiving care on a ward for some 15 hours after she was moved. There has been no follow up from CMTC staff and they appear to have completely abdicated their responsibility for my mother's care.
I am, quite frankly, appalled at what has happened in the last 36 hours. I could not recommend CMTC to family and friends unless you could be absolutely certain that there will be no complications following surgery.

Visited in November 2015. Posted on 17 November 2015

2. FORMAL COMPLAINTS

2.1. Data collection and analysis

Top 5 themes for the quarter are generated to assist the divisions in identification of themes and trends. These will be adjusted to serve the new divisional and corporate structures going forward to reflect the proposed business unit model.

2.2 *Formal complaints, Themes for Quarter 3*

Figure 3: Graph showing **all complaints** by subject, Quarter 3

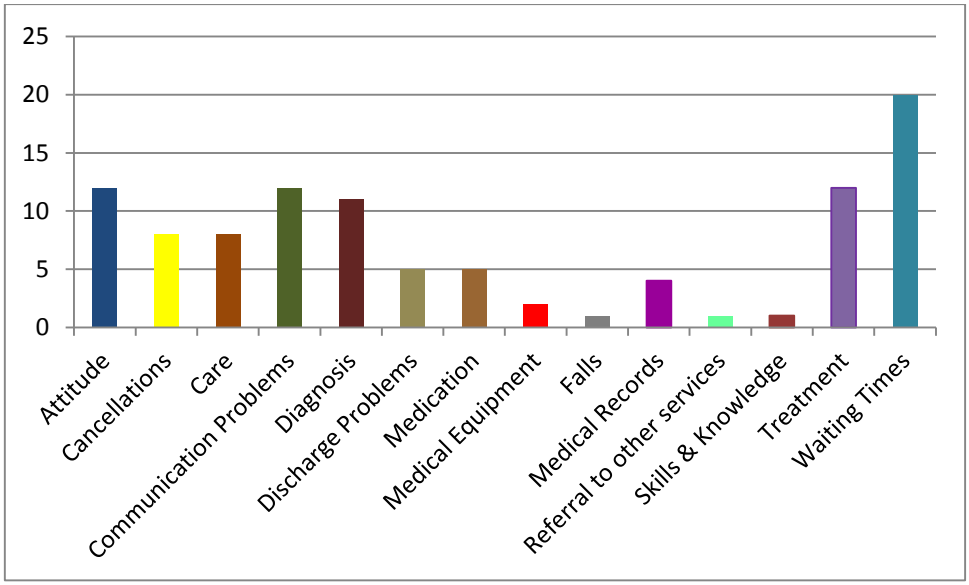


Figure 4: Graph showing top 5 subjects for **Unscheduled Care**, Quarter 3

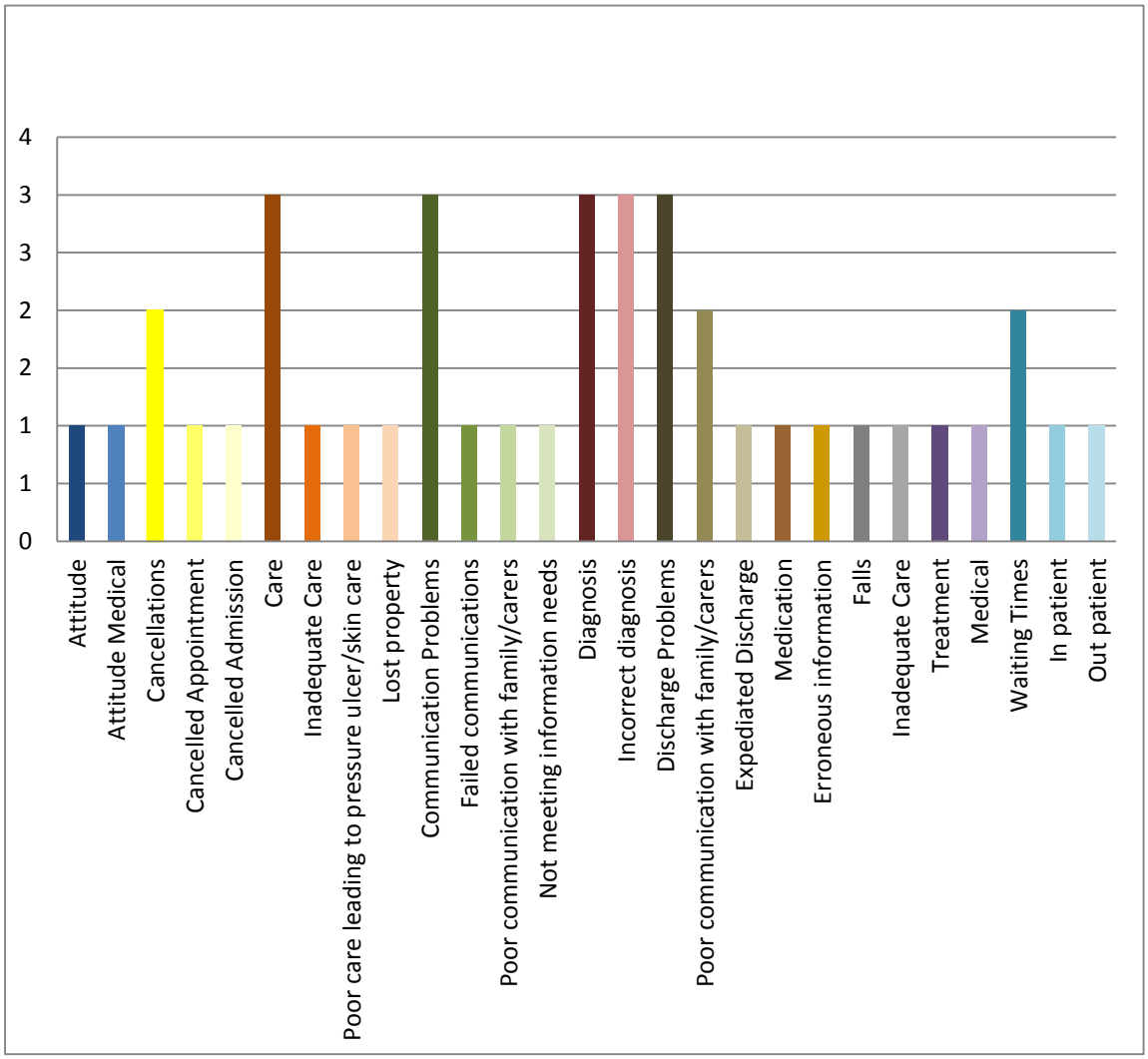


Figure 5: Graph showing top 5 subjects for **Accident & Emergency Department**, Quarter 3

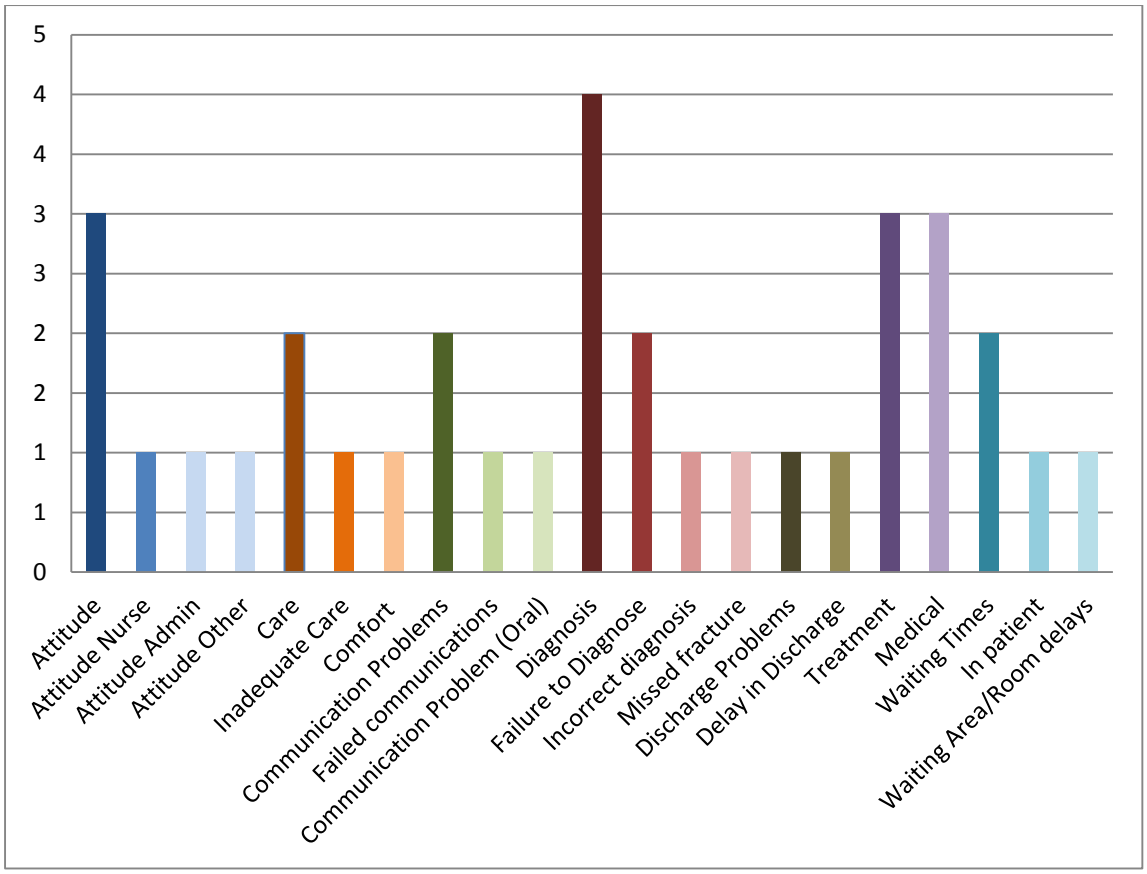


Figure 6: Graph showing top 5 subjects for **Scheduled Care**, Quarter 3

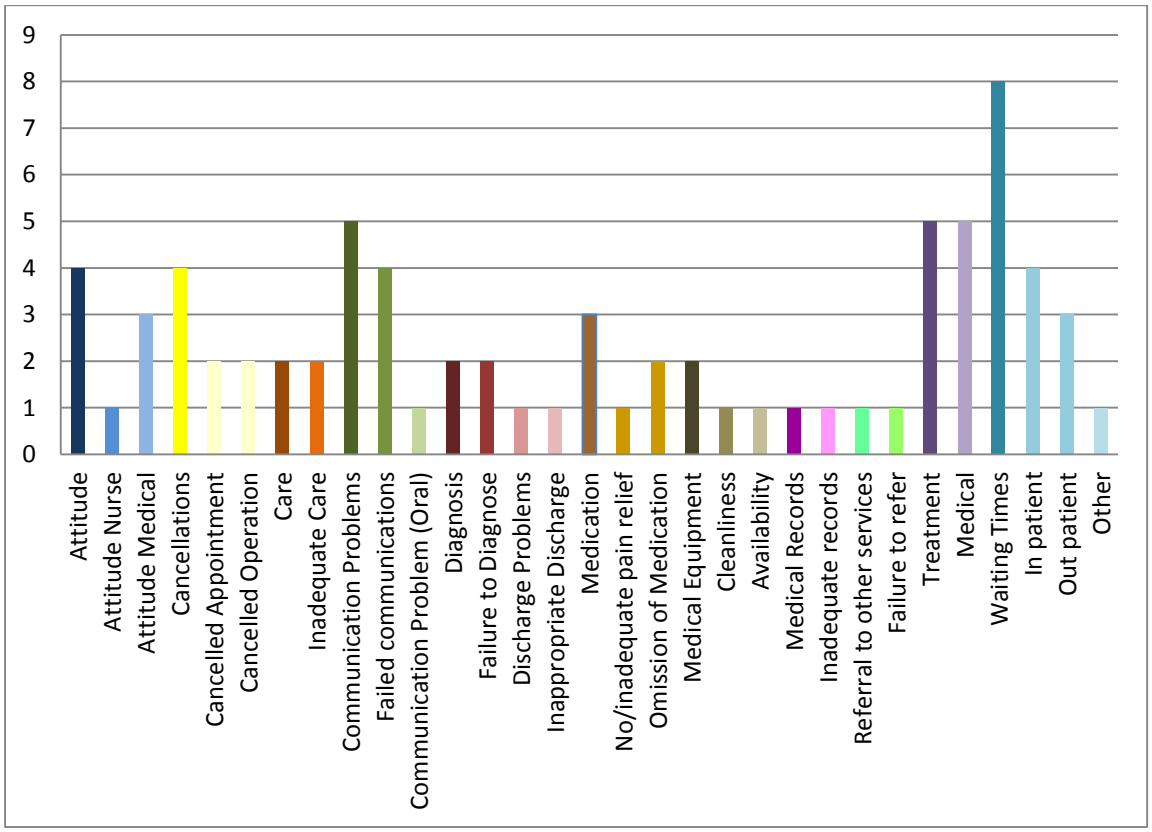


Figure 7: Graph showing top 5 subjects for Women's and Children's Health, Quarter 3

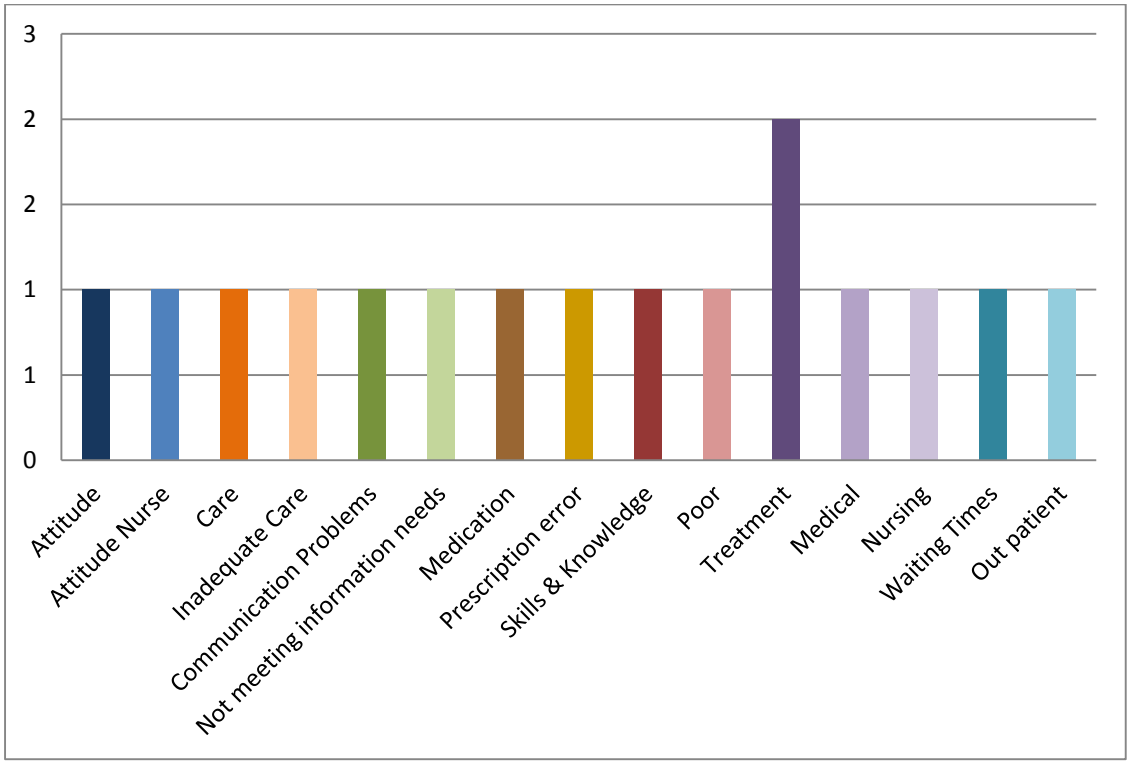
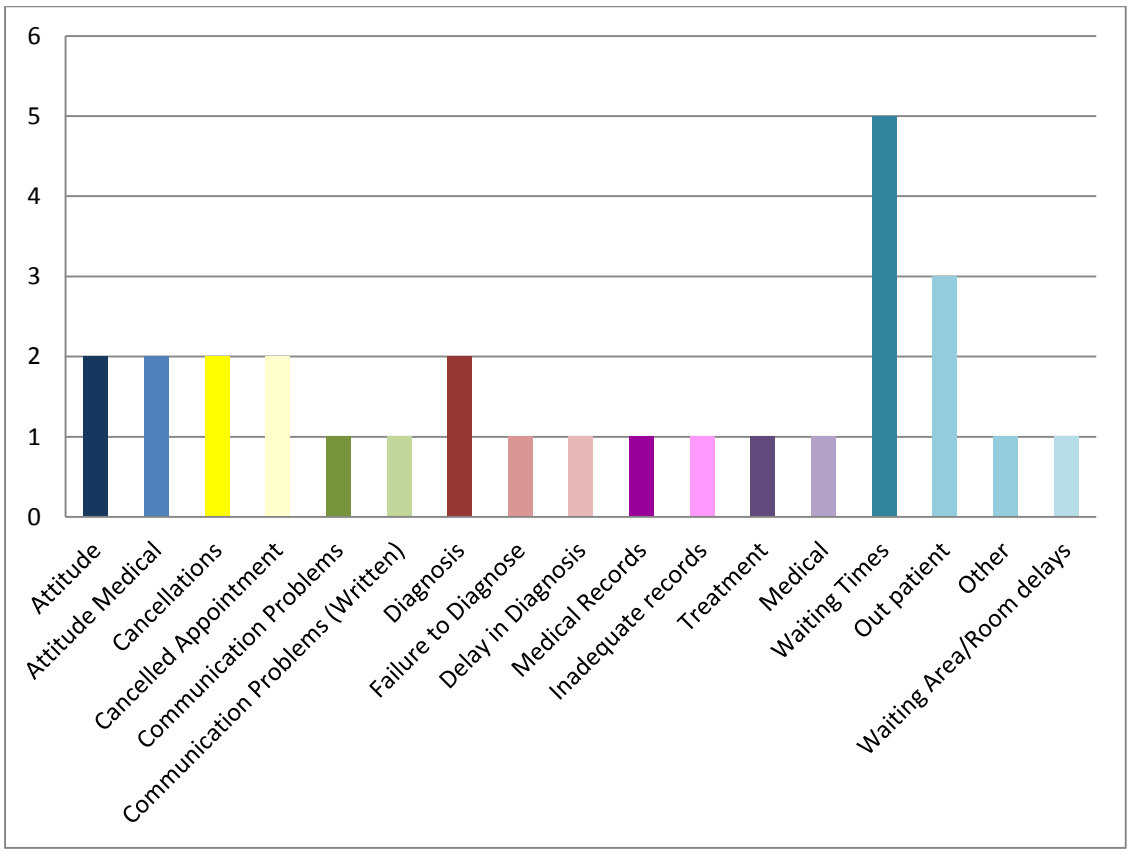


Figure 8: Graph showing top 5 subjects for Support Services, Quarter 3



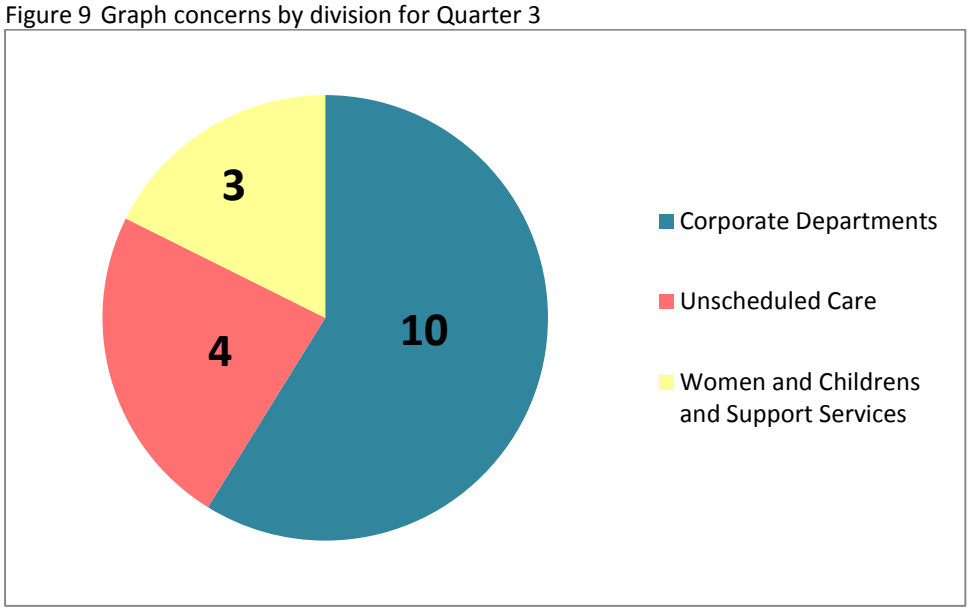
2.2 *End of Life Care complaints review*

In line with recommendations made by Norman Lamb MP, following his review of the Liverpool Care Pathway, complaints made that raise concerns about any aspect of end of life care are reviewed. In Quarter 3 there were no complaints raised where end of life care was a component.

2.4 Concerns raised in Quarter 3

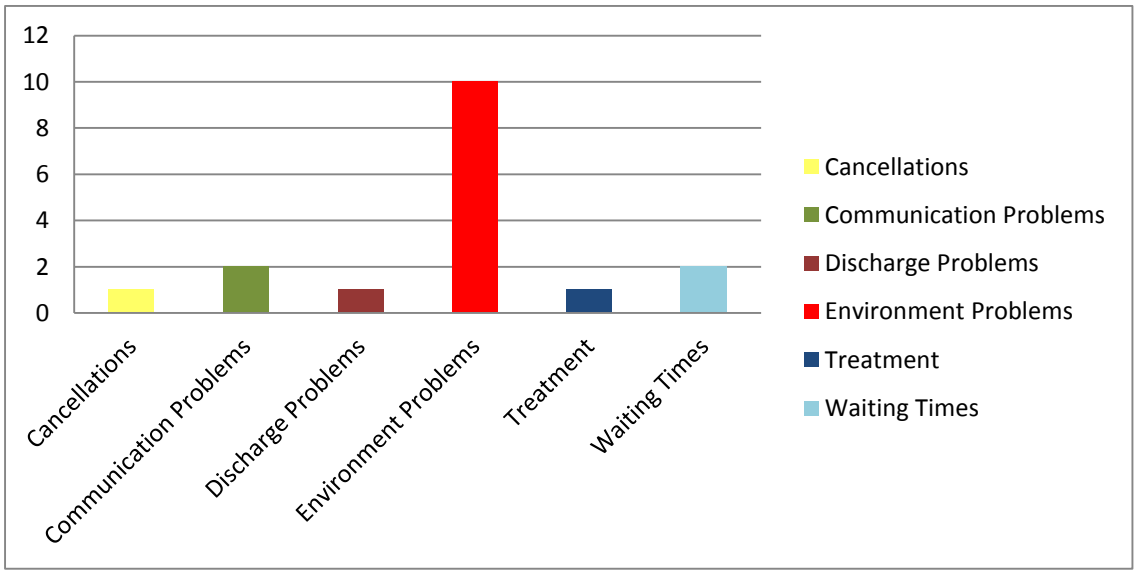
The total number of concerns logged for Quarter 3 was 17.

Figure 9 Graph concerns by division for Quarter 3



Of the 10 concerns raised about the corporate departments, 8 were about car parking, 1 was about lack of parking for bicycles and 1 was about patient's and visitors smoking by entrances/exits of hospital building. One of the concerns about parking was also about food and the cost of the Hospedia service.

Figure 10: Concerns by subject, Quarter 3



2.5 Responding to people in a timely manner

In Quarter 3 we responded to 98% of formal complaints within agreed timescales. As part of a review of the complaints and concerns policy, the timescales for first response letters to formal complaints is being simplified. All grades of internal complaint, regardless of risk rating or complexity, will be answered in thirty days, unless the investigative team informs the Patient Experience Team that they require longer. This is an attempt to encourage divisional staff investigating complaints to take ownership of the investigation and to triage new complaints in a timely manner, i.e. within one week of the division receiving the complaint.

Table 9: Complaints closed in agreed timescales for Quarter 3

	October	November	December
Number of complaints closed in month, resolved within the agreed timescale	25	46	56
Number of complaints closed in month, not resolved within the agreed timescale	1	1	0
Number of complaints closed in the month	26	47	56
% complaints closed in month, resolved within agreed timescale	**96.15%**	**97.87%**	**100.00%**

2.6 Complaints withdrawn

During the period, a total of six complaints were withdrawn. This number may rise and prompt changes in this quarter's number in the next report because withdrawal of complaints can happen some time after the complaint has been opened. Withdrawn complaints are re-categorised as concerns to ensure we reflect the issues raised and work undertaken in logging and investigating them.

2.7 Returned complaints

Fourteen formal complaint responses were returned with ongoing concerns. The process for a return is that the complainant identifies his/her ongoing concerns. These are sent for divisional consideration. If the division decide that they have nothing to add, a letter to the complainant explains this and that there will be no further local resolution. At this time complainants are advised to progress to the next stage of the NHS complaints procedure and contact the PHSO. If the division feels they can offer more information, clarify issues or reassure the complainant they will either propose a meeting or write a second response.

This is an area where the Trust consistently fails to provide a timely service. To wait a long time to be told that we have fully answered the complaint in the first letter will compound the complainant's dissatisfaction and may lead to more contact, conflict and PHSO intervention. To wait even longer for answers can be very distressing for people. Returns need to be more closely monitored and delays must be appropriately escalated. In addition, complaints with return issues must be informed of any delay beyond thirty working days.

Table 10: Returned complaints by division for Quarter 3 and outcome

Division	Not Upheld	Partly Upheld	Upheld	Total
Unscheduled	3	0	1	4
Scheduled	1	3	1	5

Division	Not Upheld	Partly Upheld	Upheld	Total
WCSS	2	1	2	5
Total	**6**	**4**	**4**	**14**

2.8 Complaints linked to serious untoward incidents

During Quarter 3, a total of twelve complaints were linked to reported clinical incidents. When a complaint is graded as high risk, the division are asked to review it to determine:

- Is there a reported clinical incident linked to the concerns raised by the complainant?
- Do the concerns raised warrant a level 1 or 2 investigation being carried out?

During Quarter 3 there were 11 new complaints graded as high risk. Divisional staff are asked shortly after receiving the complaint to confirm if this has been reviewed. This enables an update in the weekly complaint report for executive/non-executive board members. Sometimes, this review may take longer, i.e. if records are needed from other organisations, or members of staff who are on leave or no longer employed by the Trust need to be contacted/involved. Of the 11 high risk complaints, 7 were downgraded, 1 was referred for level 1 investigation and 3 are still under review for the reasons cited.

All level 1 and 2 are recorded on CIRIS, but this list is not up to date. In order to improve communication, divisions need to ensure they inform patient experience when an investigation is going ahead and this be recorded on Datix. This will be included in the updated policy document.

2.9 Formal meetings organised

The total number of meetings to discuss formal complaints in Quarter 3 was 14. Of these, 3 meetings were to discuss open complaints and the other 11 to discussion ongoing issues from a closed complaint.

3. LESSONS LEARNED

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

Divisional reports on complaints, as well as case studies and patient stories are standing agenda items on the Patient Experience Committee. Divisional complaints staff have developed a report template to ensure consistency of information.

Table 11: Examples of complaints, action taken and learning from Quarter 2

Description of Complaint	Actions & Learning
Scheduled Care: Number of complaints received from ENT patients awaiting clinic appointments and specifically for ear dressing appointments.	ENT service has experienced pressure meeting the demands of the Outpatient service. Ear Dressing Nurse left the Trust, resulting in the subsequent impact on ENT medical staff. Clinic working at full capacity impacting on waiting times. Recruitment of locum Doctors to cover additional clinic sessions to reduce backlog of appointments. Recruitment process in place to employ specialist ENT Nurse to facilitate a return to the previous nurse clinic sessions - Led by AGM Special Surgery
Patient was not able to summon assistance in the ward bathroom area, causing distress.	The call bell was found not in working order. All ward housekeepers will check all bathroom / toilet call bells on a daily basis. Matron to lead implementation.
No BSL interpreter was available for paediatric patient when attending the ophthalmic clinic.	Investigation showed that the BSL interpreter was not booked due to human error. Request had not been passed from patient access to dept. staff. Current process reviewed by AGM. New process implemented for requesting both language and BSL interpreters. Requests now made formally via e mail to a named staff member.
Patient was unhappy about the way he was given bad news in AED from a registrar.	Issues discussed with the registrar and her educational supervisor. Having reflected on the situation the doctor felt that she had been busy and distracted by the demands on the service at that time. She acknowledged that her attention was not appropriately focused on the patient. Learning points were identified and the complaint details will be reported as part of medical revalidation. The doctor visited the patient during a subsequent hospital admission and personally apologised to him.
Complainant was unhappy that reasonable adjustments were not made for her ECG appointment. She felt that we need to change the policy for not providing restrictive times as due to this she had to wait until the school holidays before being able to attend and felt that she would now be unable to attend in the future.	An apology was made for the lack of flexibility shown around appointment times. Patient was told that any future appointment would be at a convenient time for her. Supervisor spoke to administrative team making it clear that they must be flexible and make reasonable adjustments. Staff have been told that where there are any problems doing this, they must refer the issue to a senior physiologist for advice.

Description of Complaint	Actions & Learning
Patient's son complained that his mother had received an overdose of medication whilst an inpatient.	The medication error had been reported as a clinical incident and a level 1 investigation was initiated. The matron met the son to discuss the findings of the investigation and the actions that had been taken. A safety notice was issued. The nurse involved did not administer medicines until further learning was undertaken and the nursing team reflected on what had been learned. The incident and learning was included in the ward safety briefing.
Women & Children: Patient complained after her chair collapsed whilst she was sitting on it holding her baby daughter in clinic.	Investigation completed by Sister, estates department and the Health and Safety advisor. The report and actions taken were shared with complainant. An apology was made. A review of the inspection process for chairs and inspection of the chairs in that waiting area was completed. It was found that the chairs are appropriate for waiting areas and the staff did carry out visual checks. This this was not documented and the chair that broke had not been seen to be broken. The Trust has now implemented a formal, monthly inspection process for the checking of waiting area chairs. A formal notification was also sent out across the Trust informing staff of this new procedure. Compliance to be picked up on corporate inspections carried out by the Health and Safety Department. There were several issues raised by the complainant. Most were not upheld.

4. ACTIONS

The following identifies any progress on actions/improvements:

1. The current reorganisation of services and staffing attrition, mean that the service as a whole is being reviewed. Current and future needs across the spectrum of experience of care process and systems need to be considered and the new strategy also will be influential on the shape of the Patient Experience Team going forward.
2. A review of reporting of complaints and other patient experience information that will correspond with the new structures and provide a more comprehensive set of data in the form of a dashboard. This will correspond with the new configuration of clinical business units and management structures currently being developed.
3. A draft review and action plan in response to the PHSO (2015) report *Breaking down the barriers: Older people & complaints about healthcare* will be agreed.
4. Divisional leads to identify learning deficits/standards for behaviour and attitude of staff. Development of an action plan aimed at reducing complaints about attitude and communication. A breakdown of attitude complaints - where and who, to inform this work.
5. Review of PALS in conjunction with proposed separation of the recruitment, selection, training and coordination of the Trust volunteer service, which will be outsourced to another provider.

6. Development of training for a range of staff, but especially those staff in switchboard, waiting list and appointments teams, to promote better practice around dealing with complaints made. The Patient Experience Matron and the Interim Outpatients Manager are meeting to look at how best to improve the skills of staff.
7. New standard operating procedures, as part of the updated policy, will propose more investigator control of timescale and more formal/proactive escalation of late complaints will be applied. This will also include a section on the links to serious incident investigations.
8. Apply escalation process to return responses. Develop template letter for "nothing to add" letters and finalise, implement new PHSO information leaflet.
9. Review 15/16 complaints data as part of the quality report process (PWC) and include a peer review of the complaints service in Q1 16/17

5. RECOMMENDATIONS

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

BOARD OF DIRECTORS

16/059

SUBJECT:	Report from the Chair of the Strategic People Committee
DATE OF MEETING:	24 February 2016
DIRECTOR:	Anita Wainwright, Non-Executive Director – Committee Chair

Reports *not* received as agreed in the annual work plan:	-
Any other relevant items the sub-committee wishes to escalate ?	-

The committee has not met since the Board last met.

BOARD OF DIRECTORS

16/060

SUBJECT:	Human Resources / Education & Development Key Performance Indicators (KPIs) Report	
DATE OF MEETING:	24 February 2016	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Mick Curwen, Associate Director of HR	
EXECUTIVE DIRECTOR:	Roger Wilson, Interim Director of HR and OD	
LINK TO STRATEGIC OBJECTIVES:	SO2: To be the employer of choice for healthcare we deliver	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	• An increase in-month for sickness rate and cumulative rate. Marginal improvement in RTW rates but still low • Turnover rate has slightly increased and the stability rate has been maintained but the vacancy rate has reduced. Headcount has increased. • More staff are commencing the trust than leavers • Increase in temporary staffing expenditure over budget to c£5.8m but the rate has slowed down. • The Romanian nurses are due to commence with the trust on 29.2.16 • Recruitment times are achieving the target • No significant increase in employee cases but the number completed in month was 10	
RECOMMENDATION:	***The Board is asked to:*** Note progress on the achievement of the KPIs and the action being taken to try and address shortfalls where appropriate. Note the position of the trust against the targets set out in the Lord Carter report for corporate and administration functions.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Not Applicable

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Trust Board Update

HR Performance Management Update

At the Strategic People Committee meeting/Operational Committee the PDR and Mandatory Training compliance rates are regularly monitored. At the bi-lateral meetings there is also a key focus on PDR and mandatory training compliance. Therefore, this report concentrates on the other workforce issues contained in the dashboard and the narrative which follows.

At the end of the report there is also reference to the Lord Carter Report and the position of the trust against the targets for corporate and administration functions.

1. Position as at January 2016

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

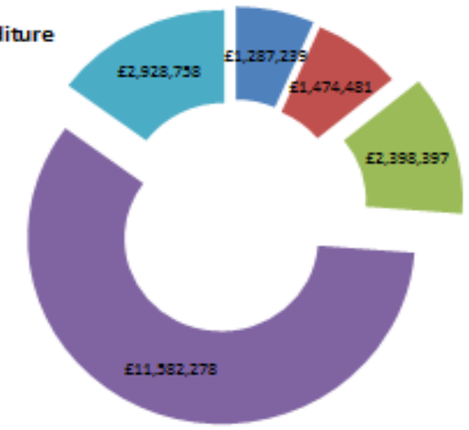
Warrington and Halton Hosptials

Period: 2016 01 | Export PDF | Print | Return Home | Exit

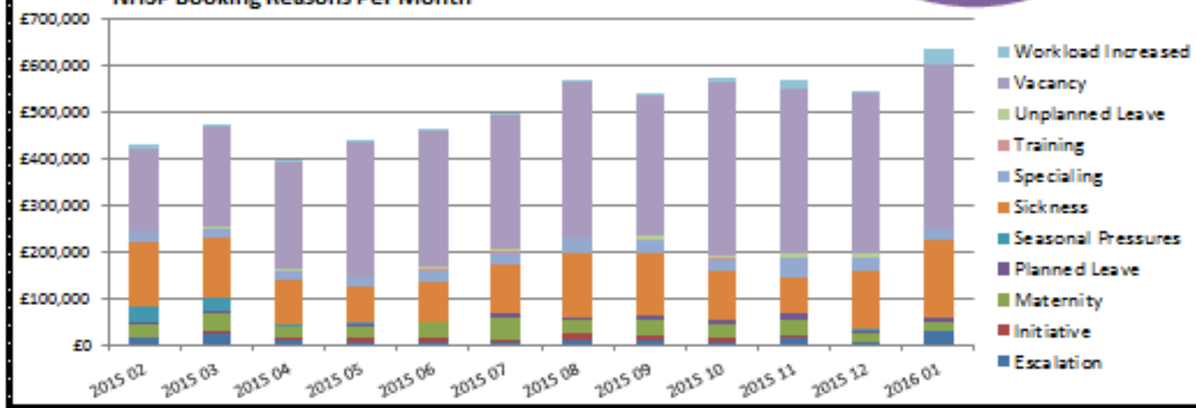
Expenditure

YTD Budget £	£130,045,258
YTD Contracted £	£116,151,820
YTD Non-Contracted £	£19,671,154
YTD Variance £	£5,777,713
Flex Labour Reliance %	14.5%
Overpayment Balance	£24,348

YTD Non Contracted Expenditure

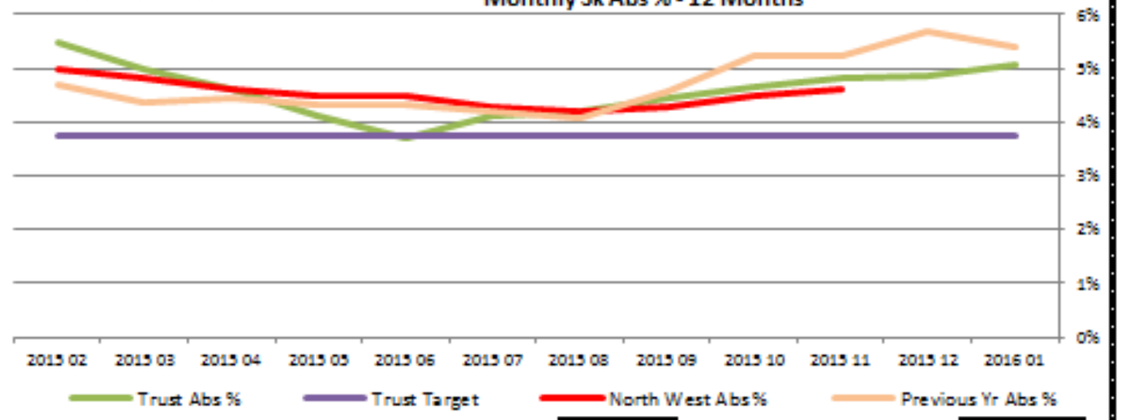


NHSP Booking Reasons Per Month

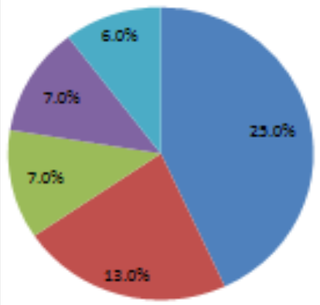


Sickness Absence

Monthly Sk Abs % - 12 Months

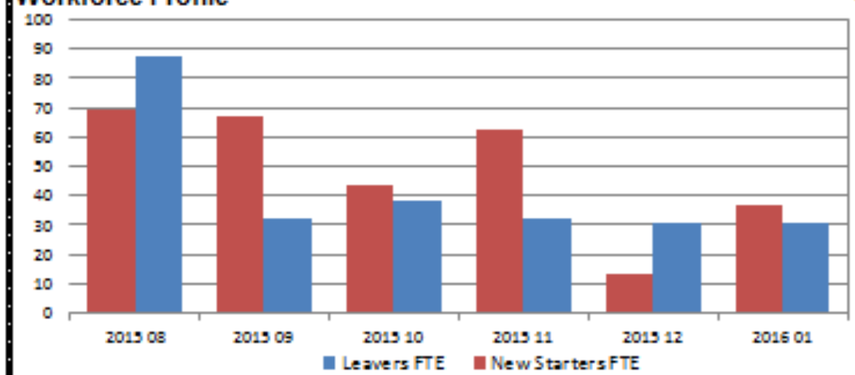


Top 5 Abs Reasons in 12 Months

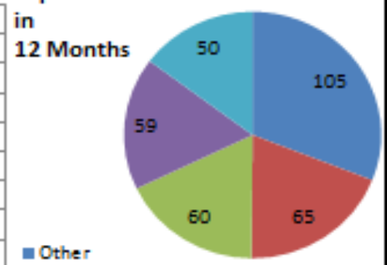


Monthly RTW %	53%	Cumulative RTW %	51%
Monthly Sk Abs %	5.1%	Trust Target	3.75%
YTD Sk Abs %	4.5%		
Long Term Sick %	2.6%	Short Term Sick %	2.5%
Calendar Days Lost	6104	No of Episodes	723
Est Monthly Cost	£391,779	Est Cumulative Cost	£4,174,814

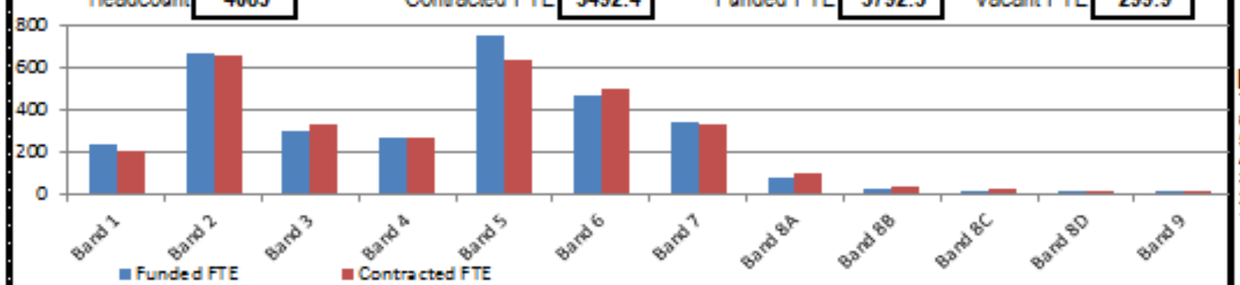
Workforce Profile



Top 5 Reasons for Leavers in 12 Months



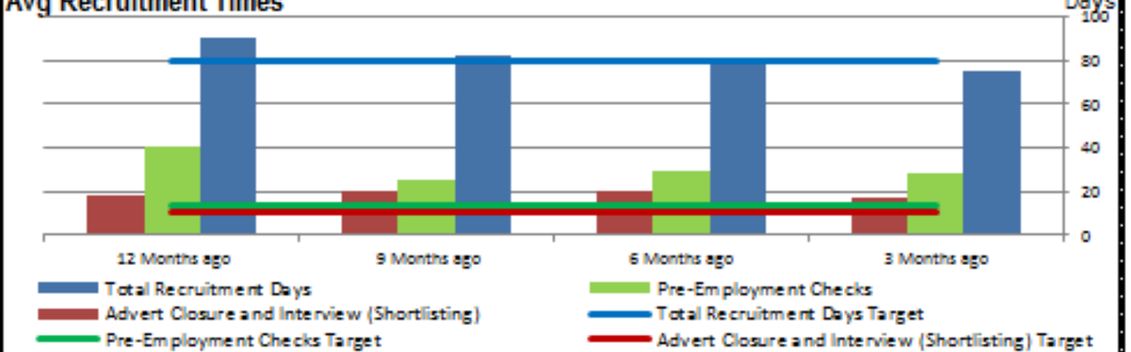
Annual Leave (Hrs)	708,355 : 778,900		Current Mat Leave FTE	54.0	Stability	15.2%
Headcount	4085	Contracted FTE	3492.4	Funded FTE	3792.3	Vacant FTE	299.9



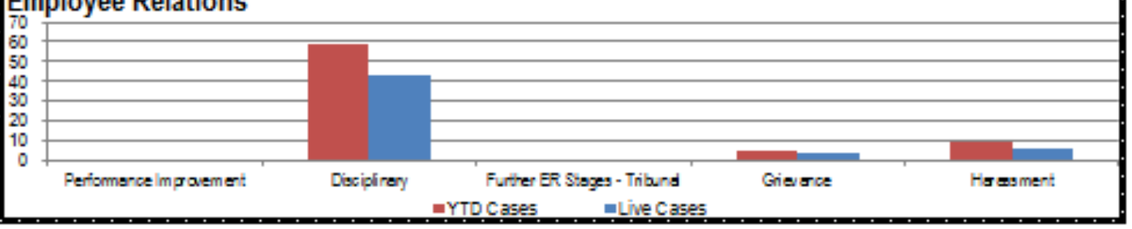
Recruitment

Overall Vacancy % & FTE	7.9%	Turnover	11.0%
Avg Monthly New Starters FTE	41.9		
Avg Monthly Leavers FTE	38.3		

Avg Recruitment Times



Employee Relations



Division/Directorate/Department Name

Period: Monthly date the data is produced

Expenditure

YTD Budget £: Year to Date Budget from Finance
YTD Contracted £: Year to date amount spent on contracted employees
YTD Non-Contracted £: Year to date amount spend on non-contracted employees, such as locums, other agency, overtime, NHSP, additional hours, WLIs etc
YTD Variance £: Difference between Budget and actual spend on the budget
YTD Non Contracted Expenditure: Breakdown of non-Contracted expenditure
Flex Labour Reliance %: Percentage of hours worked through non-contracted agreements compared to the contracted hours within the Division/ Directorate/Department - demonstrating reliance on non contracted hours
Overpayment Balance: Outstanding balance of overpayments the Trust is attempting to recover
NHSP Booking Reasons: Further breakdown of NHSP spend by reason, grade and month

Sickness Absence

RTW % : Percentage of Return to Work interviews completed monthly and annually
Monthly Sk Abs %: The in month sickness percentage with the graph showing the monthly sickness percentages for the last 12 months, comparing it with the Trust and the Trust Target
Trust Target: Sickness absence percentage target set by the Trust
Cumulative Sk Abs %: Cumulative sickness absence percentage for the last 12 months
Divisional Sk Abs %: Divisional sickness absence monthly percentage
Long Term Sick %: Percentage of employees absent for 28 days or more in the month
Short Term Sick %: Percentage of employees absent of 28 days or less in the month
Calendar Days Lost: Number of calendar days lost due to sickness in the month
No of Episodes: Number of sickness episodes within the month
Est Monthly Cost: Estimated monthly cost due to sickness absence, only takes into account the cost of salary
Est Cumulative Cost: Estimated 12 month costs due to sickness absence, only takes into account the cost of salary
Top 5 Abs Reasons: Chart showing the top 5 sickness absence reasons for the last 12 months

Workforce Profile

Leavers/Starters: Graph showing the number of monthly leavers and new starters
Top 5 Reasons for Leavers: Chart showing the top 5 reasons for employees leaving the Division/Directorate/Department in the last 12 months
Annual Leave: Amount of annual leave taken compared to the target amount
Mat Leave FTE: Current number of employees on Maternity leave in FTE
Stability %: A percentage indication of how stable the workforce is within the selected Division/Directorate/Department, by reviewing the number of permanent leavers with less than 12 months service, 0% being very stable
Headcount: Number of employees
Contracted FTE: Total employed FTE
Funded FTE: Total FTE available
Vacant FTE: Difference between Funded and Contracted FTE
Staff Profile: Graph showing the make up of staff within the Division/Directorate by banding comparing the funded (budget) FTE and contracted (actual) FTE.

Recruitment

Overall Vacancy %: Percentage difference between Budgeted FTE and Actual Staff in Post FTE
Avg Monthly New Starters FTE: Average number of new starters each month (12 month period)
Avg Monthly Leavers FTE: Average number of leavers each month (12 month period)
Turnover: Turnover percentage, the number of leavers in the last 12 months as a percentage against the average headcount
Rec Process Start: Average calendar days taking to start the recruitment process

Advert Closure and Interview (Shortlisting): Average calendar days between advert closing and interview. Target = 10 Days
Pre- Employment Checks: Average calendar days between successful candidates ID checks being completed and agreeing the start date (excluding notice period). Target = 14 Days
Total Recruitment Days: Average total number of calendar days taken to recruit from Advert to Start Date (includes notice period). Target = 80 Days

Employee Relations: A graph showing, by Division the number of Employee Relation Cases, both year to date and currently live

Expenditure

The flexible labour reliance (Percentage of hours worked through non-contracted agreements compared to core workforce contracted hours - demonstrating our level of reliance on non-contracted hours) remains significantly higher than we would want at 14.5% (14.6% for December). The reasons for this can be seen throughout the Dashboard, Turnover, Vacancy Rate, Sickness and Stability.

This month has seen a further deterioration of over £553k to £5,777,713 but a marked improvement from December when the increase was £1.2m. Agency expenditure of £11,582,278 largely accounts for the total non-contracted labour spend of £19,671,154. Clearly the amount spent on non-contracted labour does not represent best value for money and continues to be addressed through a variety of interventions as follows:

- Agency Nurse Spend Task and Finish Group continues to meet bi-weekly with the Matrons/Ward Managers who are held to account of expenditure and plans to reduce this. A representative from Monitor has also attended some of these meetings

- International nurse recruitment in conjunction with NHSP. 14 nurses have been appointed from Romania and will commence with the trust on 29 February 2016 to complete their induction and orientation into this country. There is another opportunity to recruit up to a further 9 Romanian nurses who have been shortlisted and consideration is being given as to how best to support this recruitment drive.

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

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

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

- Our framework provider: HealthTrust Europe (HTE) has met with the Head of Procurement in Cheshire and Merseyside with a view to the development of a C&M Strategy for the management of agencies (and which agencies to use) to meet the price caps. This would give greater purchasing power to maintain and even push down rates. In addition, some rates have been re-negotiated with one of our main nurse agency suppliers to reduce the cost.

- Various initiatives with NHSP aimed at attracting agency workers to work through NHSP have been implemented. These include increasing NHSP rates to attract agency nurses, auto-enrolment of

new trust starters onto NHSP, allowing multi-post holders who leave the trust but want to continue working work with NHSP the opportunity to do so automatically, changing the cascade arrangement to giver agencies offering lower rates the opportunity to fill some shifts etc

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

With regards to NHSP spend in January, expenditure did rise by nearly £100k to c£630k but this was to be expected as the rates offered by NHSP were increased to try and attract agency staff to work for NHSP. This was offset by a significant reduction in agency expenditure of £558k which would suggest that this has been quite successful. The reason recorded for expenditure for vacancies slightly increased but there were more noticeable increases for sickness and escalation.

Sickness Absence

January saw an increase in sickness absence from 4.7% to 5.1% which was the highest in month amount since April. This affected the cumulative rate for April – January which rose to 4.5% against the trust target of 3.75%. Over the last 3/4 months the trust rate has virtually matched the North West average percentage and the trust is showing a steady increase since August 2015. Long term sickness absence now equates to 2.6% (2.8% in December) and short term, 2.5% (1.9% in December). This clearly shows that the increase has directly related to more short term absence. This is reflected in the number of episodes of sickness absence which increased to 723 compared with 644 in December.

There was a slight improvement with the RTW rate at 53% (48% for December) for January and 51% for the last 12 months. Return to Work interviews are a key component to reducing sickness absence and a recent MIAA audit showed that in many cases these are being undertaken but not recorded on ESR. Managers are reminded on a monthly basis in writing to undertake both RTW interviews and to record this information on ESR. The Board are reminded that this is also one of our key performance measures for acceptable performance for managers.

The main reason for sickness absence is Stress, which reduced by 1% to 25%. More work has been completed to improve the recording of whether stress is work related or not. Our initial analysis would suggest that 92% of stress is not work related stress. The top 10 areas where Stress is most prevalent is being addressed by Divisional Managers and the SPC regularly review stress at its meeting. Early results of an initial analysis would suggest that the areas with high stress levels are also the areas with high vacancies, therefore a causal link is demonstrated.

Other Musculoskeletal Problems makes up 13% (no change) of the sickness absence in the last 12 months although many staff do regularly access the Staff Physiotherapy service in a timely manner and report good outcomes rather than wait for referrals from their GP. At the last Staff Engagement and Wellbeing Group, the Staff Physiotherapy service produced an audit of their service which showed that this was well used by staff and was effective in getting staff back to work quicker.

Workforce Profile

January was a better month for the number of new starters compared with leavers. Although 30 staff left the trust, they were replaced by 37 new starters. However, the number of qualified nurse vacancies remained fairly static at 93.87 wte (92.64 for December). The position will improve with the 14 Romanian nurses although it should be noted that these nurses are actually employed by NHSP for the first 12 months. The overall trend over the last 12 months shows that the monthly average position remains positive with more starters (41.9 wte) than leavers (38.3 wte).

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

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

The ratio of annual leave taken compared with the proportion expected remains at 'amber' but the gap has increased. The concern would be that a higher proportion would need to be taken in the last 2 months of the year which might be a contributory factor to increased agency spend later in the year.

The headcount has increased by 17 to 4085 and the number of vacancies has reduced to 299.9 wte.

The number of staff on maternity leave has fallen by almost 6 wte to 54 wte but will still be a factor contributing to staffing shortages in some areas.

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

The analysis of the Staff in Post shows that the biggest differential remains at Band 5 where there are significantly more vacancies that staff in post. The greatest proportion of these are nursing vacancies but the position should improve as mentioned above with the Romanian nurses and the trusts local rolling adverts. It should also be noted with the staff in post figures that the staff in post at Band 3, Band 6 and the Band 8 grades, are all above the funded establishment.

Recruitment

Labour turnover has slightly increased to 11% from 10.9% but there has been a reduction in the vacancy rate to 7.9% from 9.1%.

The average time taken to recruit has slightly increased to just over 70 days but still achieves the target of under 80 days. This reflects the hard work done by the Employment Services Team and the new measures

introduced to streamline recruitment processes and encourage managers to advertise vacancies and shortlist much quicker. The current initiative being worked on is to create an electronic new starter process.

In respect of Employee Relations, the number of cases remains at almost 60 but 10 cases have now been completed from the previous month. It should be noted that the total number of cases at January already surpasses the total for 2015/16. These are largely concentrated within Unscheduled Care and WCSS. The number of dignity at work cases remains at 10 cases in total but half of these have now been completed. In January were no new exclusions/suspensions but there was one new case in February.

2. Lord Carter Report

The Lord Carter report: 'Operational Productivity and Performance in English NHS Acute Hospitals – Unwarranted Variations' was published on 5 February 2016.

The report sets out a challenging agenda for the NHS to deliver £2bn of savings from its workforce spend by 2021, as part of an overall saving of £5bn. It argues that such savings can be delivered without damaging patient care by improving productivity especially in clinical areas, reducing costs such as agency spend and sickness absence and by all trusts adopting good people management practices.

There are 15 key recommendations but no 7 deals with corporate and administration functions and reads as follows:

'Trusts should rationalise their corporate and administration functions to ensure that their costs do not exceed 7% of their income by April 2017 and 6% of their income by 2020 (or have plans in place for shared service consolidation with, or outsourcing to, other providers by January 2017) so that resources are used in a cost effective manner.

Based on information supplied by the Finance Department, this trust currently achieves 6.4% based on the budget and 6.5% based on actual spend. Therefore, the trust has already achieved the target for April 2017 and is making good progress to the target for 2020.

Consideration is being given to the remaining recommendations and will be reported in due course.

3. Recommendations

That the Board notes the contents of the report and the action being taken to improve the workforce performance indicators and the position of the trust against the targets set by the Lord Carter report for corporate and administration functions.

Roger Wilson
Director of Human Resources and Organisational Development
17 February 2016