Warrington and Halton Hospital NHS Foundation Trust
Board of Directors
Agenda

Wednesday 25th November 2015, time 1245-1700
Trust Conference Room, Warrington Hospital

1245	***W&HHFT/TB/15/212***	***Welcome, Apologies & Declarations of Interest***		Chairman
30mins	***W&HHFT/TB/15/212(i)***	***Device-related pressure ulcers project***	Presentation and paper	Rachael Browning, Associate Director of Nursing
1315 20mins	***W&HHFT/TB/15/213***	***Minutes of the previous meeting held on 28 October 2015***	Paper	
	W&HHFT/TB/15/214	***Action Plan***	Paper	
	W&HHFT/TB/15/215	***Chairman's Report***	Verbal	Chairman
1335 20mins	***W&HHFT/TB/15/216***	***Chief Executives Report***	Verbal	Chief Executive
People				
1355 10mins	***W&HHFT/TB/15/217***	***Verbal Report from the Chair of the Strategic People Committee***	Verbal	Anita Wainwright, Non-Executive Director
1405 15mins	***W&HHFT/TB/15/218***	***Workforce and Educational Development Key Performance Indicators – 31 October 2015***	Paper	Director of HR & OD
1420 10mins	***W&HHFT/TB/15/219***	***i. Six monthly Ward Staffing Report*** ***ii. Monthly Ward Staffing Report – 31 October 2015***	Paper paper	Director of Nursing and Governance
Sustainability				
1430 10mins	***W&HHFT/TB/15/220***	***Verbal Report from the Chair of the Finance and Sustainability Committee***	Verbal	Terry Atherton, Non-Executive Director
1440 20mins	***W&HHFT/TB/15/221***	***Finance Report – 31 October 2015***	Paper	Director of Finance and Commercial Development
1500 15mins	***W&HHFT/TB/15/222***	***Corporate Performance Report – 31 October 2015***	Paper	Acting Chief Operating Officer
1515 10mins	***Break***			
1525 10mins	***W&HHFT/TB/15/223***	***Improving and sustaining cancer performance***	Paper	Acting Chief Operating Officer
1535 10mins	***W&HHFT/TB/15/224***	***Board Assurance Framework***	Paper	Director of Nursing and Governance
Quality				
1545 10mins	***W&HHFT/TB/15/225***	***Verbal Report from the Chair of the Quality Committee***	Verbal	Lynne Lobley, Non-Executive Director
1605 15mins	***W&HHFT/TB/15/226***	***Quality Dashboard – 31 October 2015***	Paper	Director of Nursing and Governance

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.

1620 ***10mins***	***W&HHFT/TB/15/227***	***Complaints Q2 Report***	Paper	Director of Nursing and Governance
1630	***W&HHFT/TB/15/228***	***Other Board Committee Reports:*** ***Minutes for Noting:*** ***a) Finance and Sustainability Committee held on 21st October 2015*** ***b) Audit Committee on 20 October 2015*** ***c) Quality Committee on 4 August 2015***	 Paper Paper Paper	
	W&HHFT/TB/15/229	***Any Other Business***		
1700 ends		***Dates of next meeting*** *27th January 2016* *Trust Conference Room, Warrington Hospital*		

BOARD OF DIRECTORS

WHH/B/2015/ **212(i)**

SUBJECT:	**Device-related pressure ulcers project**
DATE OF MEETING:	28th October 2015
ACTION REQUIRED	**For Discussion**
AUTHOR(S):	Rachael Browning, Associate Director of Nursing
EXECUTIVE DIRECTOR:	Karen Dawber, Director of Nursing and Governance Choose an item.
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care SO3: To give our patients the best possible experience Choose an item.
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework SO3/3.3 Failure to provide staff, public and regulators with assurances post Francis and Keogh review Choose an item. Choose an item. Choose an item.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED:	Choose an item. Choose an item. Choose an item.
EXECUTIVE SUMMARY (KEY ISSUES):	This paper provides the Board with an update on the project work focused on eliminating device-related pressure ulcers. Although the Trust has made significant progress with the organisation-wide pressure ulcer work, there have been six grade-3 pressure ulcers in the past twelve months. In response to this, the Scheduled Care Division created a multidisciplinary task and finish group with key work-streams responsible for preventing such events from happening. Key actions include: ▪ The development of core competencies for orthopaedic nursing staff. ▪ A single-point lesson plan. ▪ A safety alert notifying staff of the prevalence of device-related pressure ulcers and their prevention. ▪ Key interventions for alerting staff to high risk patients including a red banded cast and a red alert sticker.

	As a result of the work, there have not been any device related pressure ulcers since July 2015.	
RECOMMENDATION:	***The Board is asked to:*** Note the actions taken by the Device-related pressure ulcers project team.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item. Or type here if not on list:
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

DEVICE RELATED PRESSURE ULCERS PROJECT

1. INTRODUCTION

This paper covers the work around initiatives developed and implemented by a multidisciplinary task and finish group that aims to eliminate all avoidable device related pressure ulcers. Pressure ulcers are the consequence of skin being placed under pressure or distortion that results in an impaired supply of blood. They typically occur in patients confined to a bed or chair and result in a reduced quality of life for people and their carers[1]. It is the consensus of evidence and key guidance that the majority of pressure ulcers are preventable and as a result, recovery and patient experience is improved[2]. This paper seeks to provide assurance that the Trust's focus on pressure ulcers is positively affecting their incidence, notably in this case, those caused by devices.

2. CONTEXT

The Trust has worked effectively over recent years to meet the requirements of the national CQUIN goal of "improvement against the *NHS Safety Thermometer*, particularly pressure ulcers"[3]. Although there have been significant reductions in pressure ulcers over the past two years (see Fig. 1), there have been six grade-3, device related pressure ulcers in the past twelve months. These have been identified predominantly in Trauma & Orthopaedics and ICU and they have ultimately resulted in harm and a negative patient experience. All avoidable events, including grade 3 pressure ulcers, are considered a poor standard of nursing care. Although the cases mentioned above were not all avoidable, work was immediately commenced to ensure that risk is eliminated.

Over the past five years, requests from commissioners for the rates of pressure ulcers have been highlighted under the CQUIN framework and the associated policy, such as High Impact Actions[4], National Patient Safety Agency[5] and Nurse Sensitive Outcome Indicators (NSOI) for NHS Provided Care[6]. This has led to an increase in reporting of incidents and, more importantly, the accuracy of reports. The Trust is pleased to report that we are in the 2nd percentile of all acute Trusts (previously we were in the top 5% of medium sized DGHs) for reporting of incidents. Notably, we have a consistently high level of low harm incidents. This demonstrates a culture of wanting to be open and to learn from incidents that occur.

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[1] NICE (2015) Pressure ulcers: Quality Standard 89, available online at: http://www.nice.org.uk/guidance/qs89/resources/guidance-pressure-ulcers-pdf [Accessed on 25th September 2015].
[2] Institute for Healthcare Improvement (2011) How-to Guide: Prevent Pressure Ulcers, available online at: http://www.ihi.org/resources/pages/tools/howtoguidepreventpressureulcers.aspx [Accessed on 24th September 2015].
[3] NHS England (2014) Commissioning for quality and innovation (CQUIN): 2014/15 guidance, available online at: http://www.england.nhs.uk/wp-content/uploads/2014/02/sc-cquin-guid.pdf [Accessed on 25th September 2015].
[4] NHS Institute for Innovation and Improvement (2010). High Impact Actions for Nursing and Midwifery: the essential collection. http://www.institute.nhs.uk/building_capability/general/aims/ [25th September 2015].
[5] National Patient Safety Agency (2010). 10 for 2010. http://www.nhs.npsa.resources/collections/10-for-2010/pressure-ulcers/ [Accessed on 25th September 2015].
[6] Department of Health Strategic Health Authorities (2010) Nurse Sensitive Outcome Indicators (NSOI) for the NHS and commissioned care. Version 3. http://www.ic.nhs.uk/webfiles/Services/Clinical%20Innovation%20Metrics/NSOI_Indicators_Version_3_FINAL.PDF [Accessed 25th September 2015].

3. CURRENT SITUATION: OVERALL PERFORMANCE DATA

Warrington and Halton Hospitals NHS Foundation Trust is committed to accurate reporting of pressure ulcers. We test the accuracy and reliability of reporting with the timely attendance of the tissue viability team to the reporting area where expert advice can assess the potential / actual pressure ulcer and assist with grading accuracy.

We need to ensure that a balanced view on these figures is conveyed to other NHS organisations and the public domain and our joint working with the commissioners and other providers will assist us to achieve this.

The chart (Fig. 1) below shows the number of patient who developed grade 2 and grade 3 pressure ulcers whist in our care between the 1st April 2013 and 31st March 2015.

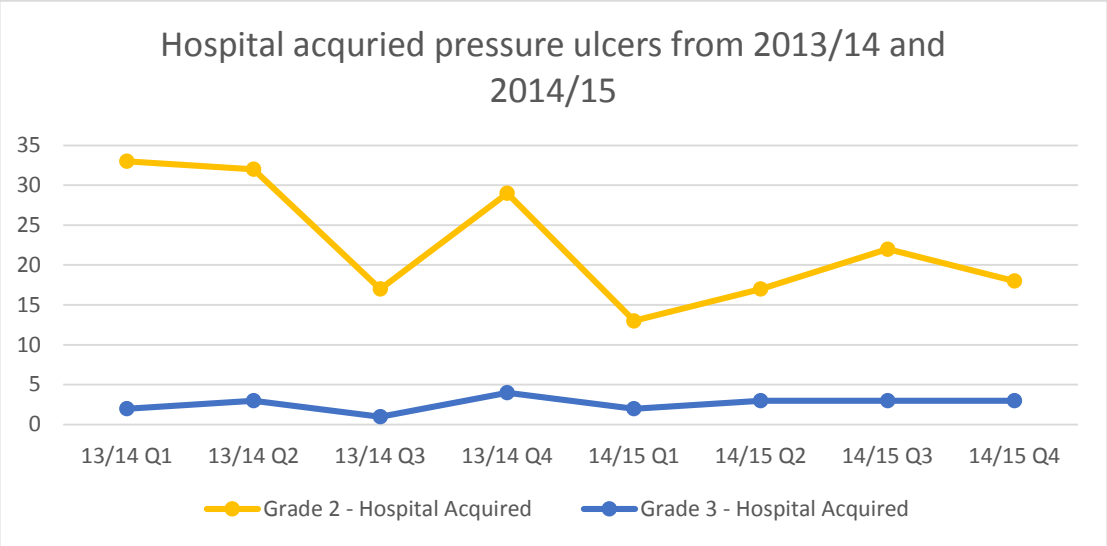


Figure 1: Hospital acquired pressure ulcers since 2013

The graph clearly shows a reduction the total number of patients developing grade 2 pressure ulcers over the past two years within the organisation. If a patient develops a hospital acquired pressure ulcer then the ward that is responsible for their care undergoes a mini route cause analysis (RCA) to determine if there were any lapses in care and if the pressure could have been avoided or not.

3.1 GRADE 3 PRESSURE ULCERS

As part of our Improvement Priorities and Quality Indicators for 2014/15, there was a further reduction in grade 3 & 4 (avoidable) = 6 cases, 1.5 per quarter (Maintain or reduce number on 2013/2014):

Grade 3 pressure ulcers (avoidable)	2013/14	2014/15
Q3	0	0
Q4	3	4

Incident date	Location (exact)	Sub Category	Avoidable	Unavoidable	RCA completed
06/10/14	A5	Left heel grade 3	Y		Yes
26/10/14	A3	Sacrum grade 3	Y		Yes
18/12/14	A9	Left groin grade 3		Y	Yes
13/02/15	A9	Right leg	Y		Yes
15/03/15	A1	Sacrum	Y		Yes

We achieved improvement priorities and quality indicators for 2014/15 as we reported 10 grade 3s in total in 2014/15 of which six were avoidable in nature. In 2013/14 we reported 18 in total six of which were avoidable.

We believe the overall data demonstrates our ability to sustain reduction in the number of hospital acquired pressure ulcers and we have not had a Grade 4 pressure ulcer within the Trust since March 2011. We know that it is the efforts of our nursing teams, supported by the Tissue Viability Team in increasing patient care interventions which has prevented Grade 3 pressure ulcers developing into Grade 4. Similarly, our plans to reduce Grade 2s by early intervention and planning are being achieved.

4. LEARNING FROM PRESSURE ULCERS INVESTIGATION

Each harm event has prompted a full Root Cause Analysis and review by a panel within the Trust. There has been some learning and improvement required in each of these cases which is detailed below.

Analysis of Grade 2 and 3 acquired pressure ulcers revealed the following trends:

- Acuity of illness.
- Poor nutritional status – MUST scores not always completed.
- Poor peripheral vascular supply to skin (peripheral vascular disease / inotropic drugs).
- Decrease in mobility.
- Related to devices – Plaster, Thomas splints.

Whilst we acknowledge that there have been a number of actions taken in order to support this reduction, the device related incidents are a concern. As such the Division has implemented a task and finish group in order to put a structured approach around the improvements that need to be seen. This is a multi-disciplinary group with membership as follows:

- Associate Director of Nursing – Chair.
- Matrons Scheduled Care.
- Trauma Nurse.

- Therapies Manager.
- Plaster room Manager.
- Tissue Viability Team.
- Corporate Nursing team.

The work of the task and finish group included:

- Review of the recent incidents and associated actions taken and required.
- Review of the current evidence including, device related pressure ulcers, best practice statements and the competency framework for orthopaedic and trauma practitioners.
- The group also considered the RCN guidance on traction and the principles of application[7].

5. ACTIONS FROM LEARNING

We continue to strive for improvements and have implemented the recommendations from trend analysis. These actions include the following:

- The issuing of a safety alert, which aimed to inform staff of the negative outcomes of device related pressured ulcers and key learning for preventing their occurrence. It also includes NPSA guidance[8]. The alert is embedded below:


Device related
Pressure Ulcers safety

- A single point lesson plan, which has been developed and presented to the nursing / practitioner teams. It aims to quickly and concisely inform staff of the nature of a device related pressure ulcer and their prevention. The lesson has been embedded below in Fig 4. It was initially aimed at the staff on Wards A9, B19 and ICU but will be rolled out further. See figure 4 below.

- There has also been key learning and development actions for staff, including:
  - The correct application and management of plaster casts and Thomas Splints.
  - The development of core competencies for orthopaedic nursing staff. Embedded here:


Traction thomas
splint and plaster cast

- The implementation of a care pathway for patients who have had a Thomas Splint / device in situ, which is currently in the governance approval process.

[7] RCN (2015) Traction: principles and application, available online at: http://www.rcn.org.uk/__data/assets/pdf_file/0004/608971/RCNguidance_traction_WEB_2.pdf [Accessed on 28th September 2015].
[8] NPSA (2009) Pressure ulcers under plaster casts, available online at: http://www.nrls.npsa.nhs.uk/resources/?EntryId45=65330 [Accessed on 28th September 2015].

- Review of the Care and Comfort documentation to include device related care.

- Option of daily review and support by the trauma nurse, Plaster Room staff or matron of any patient with a cast or a device on an outlying ward.

- The implementation of key initiatives to aid the alert of staff when a patient is at risk. This includes a red band placed around the cast to notify staff of the need to tailored care to prevent ulcers (Please see Fig 2). Information to identify high risk patient to the plaster room staff and patient information leaflets.

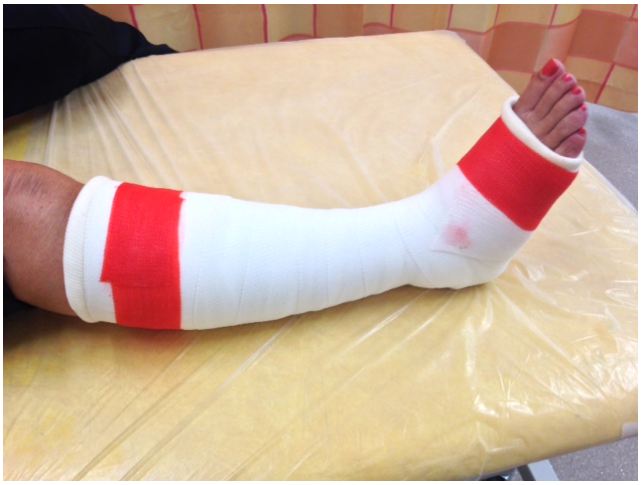


Figure 2: Red banded cast

Red alert stickers have also been produced to raise awareness in the Plaster Room and ensure that staff are conscious of the need to review high risk patients (Please see Fig 3).

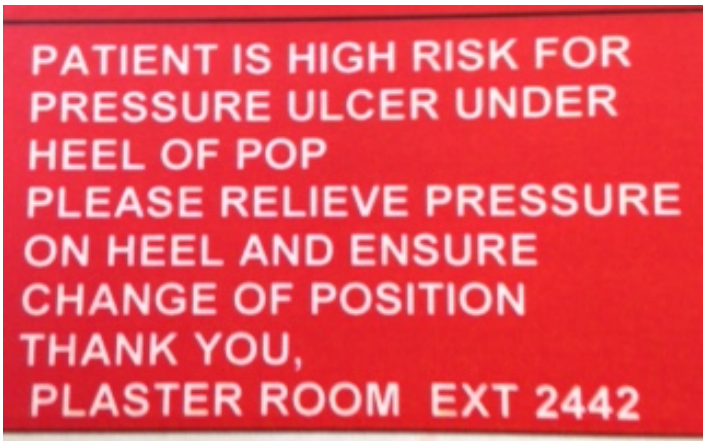


Figure 3: Red alert sticker

Single Point Lesson 9

NO AVOIDABLE PRESSURE ULCERS

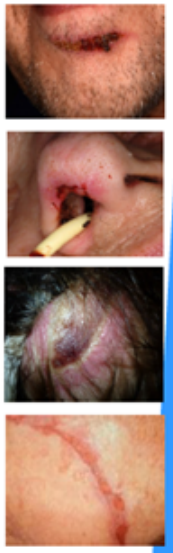
Device Related Pressure Ulcers

Rationale: To prevent the occurrence of device related pressure ulcers

Definition '***localised injury to the skin or underlying tissue as a result of sustained pressure from a device.***' Eg. nasal cannulae, oxygen mask, splints, plaster of Paris, prosthesis, ET tube/ fixation tape, naso-gastric tubes, anti embolism stockings, catheter tubing.

Characteristics of a device related pressure ulcer~

- ⇒ Occur directly under device and typically mimic the device shape.
- ⇒ Tend to progress rapidly as often occur over areas without adipose tissue.
- ⇒ Skin is often obscured by device.



Prevention~

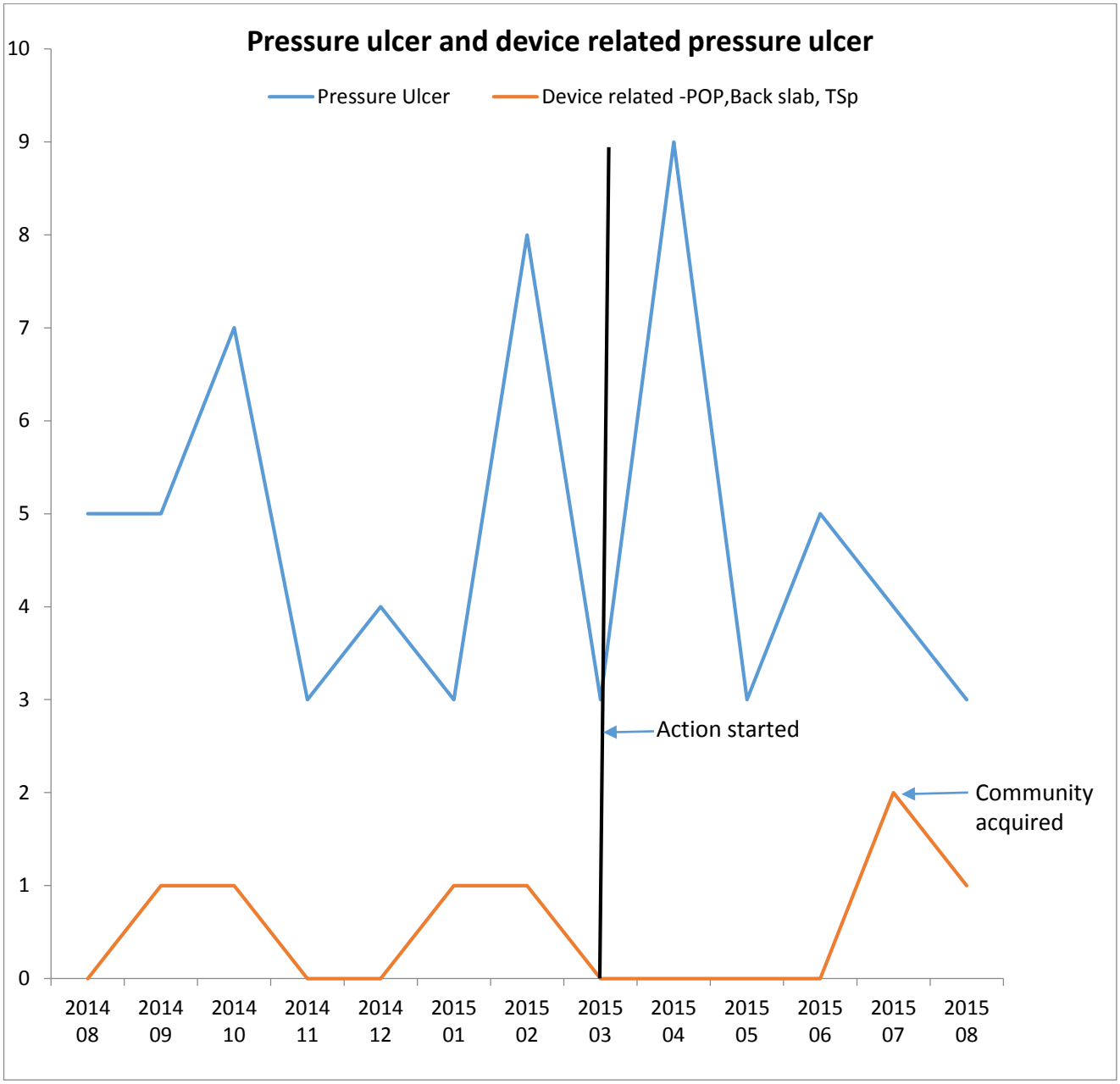
- ⇒ Ensure correct size and positioning of device
- ⇒ Cushion and protect skin with dressings/silicone pad in high risk areas
- ⇒ Vigilance around hard to see areas: scalp/hairline, under dressings etc.
- ⇒ Avoid placement of device over site of prior or existing pressure ulcer
- ⇒ Be aware of oedema under device
- ⇒ Educate staff on correct device use and prevention of skin breakdown
- ⇒ Remove/reposition and provide basic skincare under device
- ⇒ Regular repositioning of device if possible and record on care and comfort chart
- ⇒ Avoid positioning patient onto device if possible
- ⇒ Educate patient/family to inform staff of any discomfort

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Figure 4: Single-point lesson

As a result of the actions implemented there has been a decrease in device related pressure ulcers. It is pleasing to note that since these actions there have been no hospital acquired pressure ulcers related to a Plaster of Paris.

Figure 5: The graph illustrates data collected from 08/2014 to 08/2015.



Location of device related pressure ulcer:

Incident date	Location	Device related pressure ulcer
15/09/15, 9/02/15, (20/07/15 community)	**A9**	**Plaster of Paris**
15/10/15	**A9**	**Thomas Splint**
14/01/15	**A9**	**Back slab**
3/07/15, 3/08/15	**Fracture clinic**	**Plaster of Paris - Community**

NEXT STEPS

The work of the project has been successful to date and it is important that the initiatives are maintained. It is the primary focus of the group to continue communicating the importance of identifying patients at risk of developing device related pressure ulcers and teaching about their prevention.

The group aims to expand the key learning so that patients can also be cared for appropriately:

- Operational group to continue to meet.
- Cascade to Unscheduled care (for outlying patients).
- Cascade to our community colleagues with a plan to implement in the community setting.

As can be seen in the graph below (Fig. 6), the majority of pressure ulcers are community acquired. With that in mind, it is hoped that the red banded cast (Fig. 2) and some of the other initiatives can be cascaded into the community setting to alert the district nurses to high risk patients.

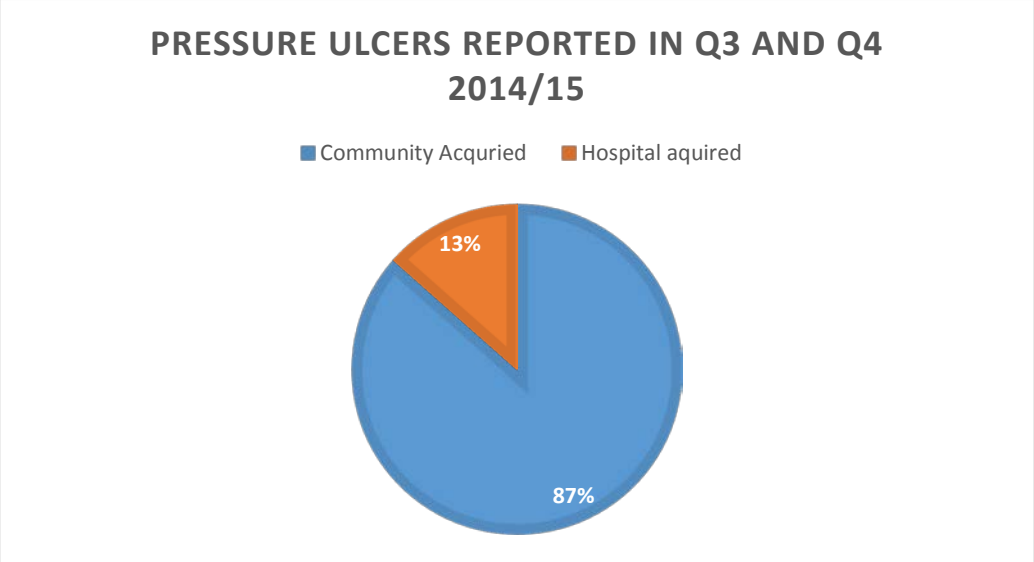


Figure 6: Hospital or community-acquired pressure ulcers

CONCLUSION

Once the initiatives and associated actions as detailed above have been approved, this will be launched across the organisation to ensure that all staff are aware of the correct care for patients who may be at risk of developing device related pressure ulcers.

The Associate Director of Nursing for Scheduled Care is meeting with the Nursing Team at the Clinical Commissioning Group (CCG) to cascade the learning to the community setting.

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

Rachael Browning

Associate Director of Nursing, Scheduled Care / Head of Midwifery

November 2015

W&HHFT/TB/15/214

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

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

BOARD OF DIRECTORS

W&HHFT/TB/B/15/215

SUBJECT:	**Chairman's Report**
DATE OF MEETING:	25th November 2015
DIRECTOR:	Chairman

BOARD OF DIRECTORS

W&HHFT/TB/B/15/216

SUBJECT:	**Chief Executive Report**
DATE OF MEETING:	25th November 2015
EXECUTIVE DIRECTOR:	Chief Executive

BOARD OF DIRECTORS

W&HHFT/TB/B/15/217

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

BOARD OF DIRECTORS

W&HHFT/TB/B/15/218

SUBJECT:	Human Resources / Education & Development Key Performance Indicators (KPIs) Report	
DATE OF MEETING:	25th November 2015	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Mick Curwen, Associate Director of HR	
EXECUTIVE DIRECTOR:	Roger Wilson, Interim Director of HR and OD	
LINK TO STRATEGIC OBJECTIVES:	SO2: To be the employer of choice for healthcare we deliver	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	• No change for in-month sickness rate and cumulative rate remains static. RTW rates still low • Although turnover and stability rates have increased, vacancies and vacancy rates have reduced. Headcount has increased. • More staff are commencing the trust than leavers • Increase in temporary staffing expenditure over budget to over £3.1m. Various initiatives in place including international recruitment in November and December • Recruitment times have fallen again and are achieving the target • Increase in employee cases	
RECOMMENDATION:	***The Board is asked to:*** Note progress on the achievement of the KPIs and the action being taken to try and address shortfalls where appropriate.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Not Applicable

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Trust Board Update

HR Performance Management Update

At the two previous Trust Board meetings the focus was on PDR and Mandatory Training compliance rates within the Clinical Divisions. Whilst this focus remains, the review and monitoring of the PDR and Mandatory Training compliance are planned to be discussed at the Strategic People Committee on 7 December 2015. This report therefore concentrates on the other workforce issues contained in the dashboard and the narrative which follows.

1. Position as at 31 October 2015

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

Warrington and Halton Hospitals

Period: 2015 10

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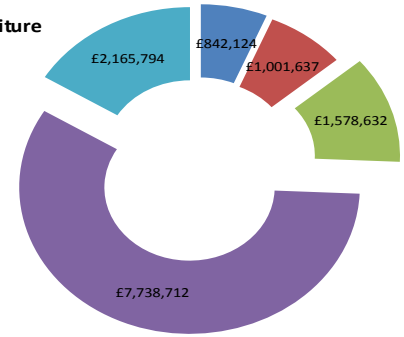
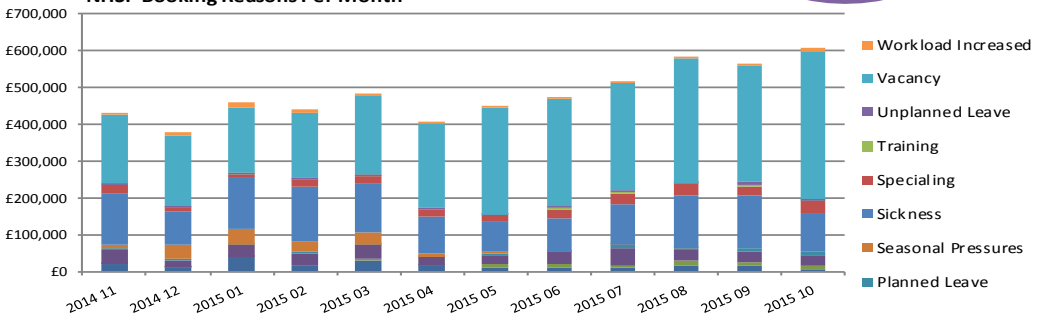
Expenditure

YTD Budget £	£91,329,131
YTD Contracted £	£81,155,912
YTD Non-Contracted £	£13,326,899
YTD Variance £	£3,153,683
Flex Labour Reliance %	14.1%
Overpayment Balance	£60,209

YTD Non Contracted Expenditure

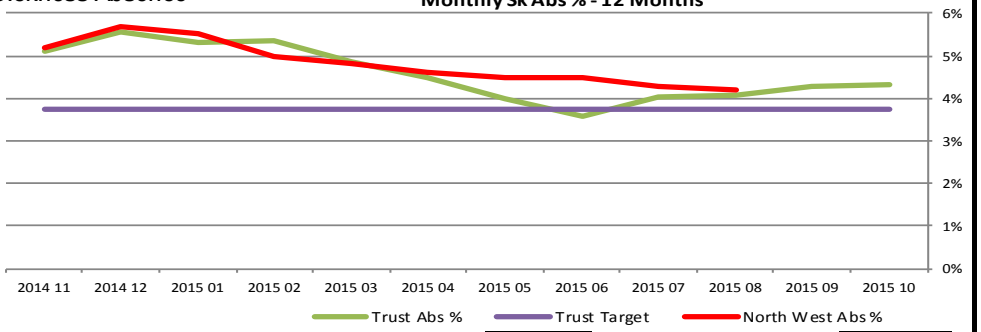


NHSP Booking Reasons Per Month

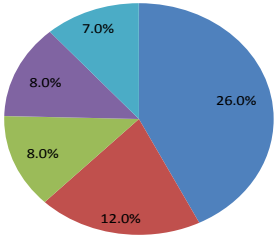


Sickness Absence

Monthly Sk Abs % - 12 Months

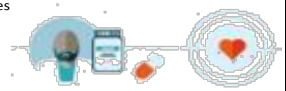


Top 5 Abs Reasons in 12 Months

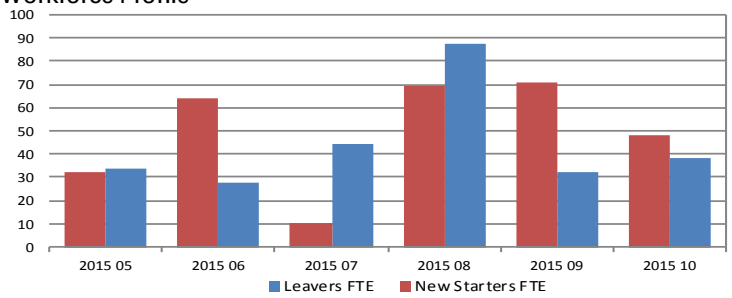


Monthly RTW %	49%	Cumulative RTW %	48%
Monthly Sk Abs %	4.3%	Trust Target	3.75%
YTD Sk Abs %	4.1%		
Long Term Sick %	2.4%	Short Term Sick %	1.9%
Calendar Days Lost	5332	No of Episodes	594
Est Monthly Cost	£321,647	Est Cumulative Cost	£4,333,439

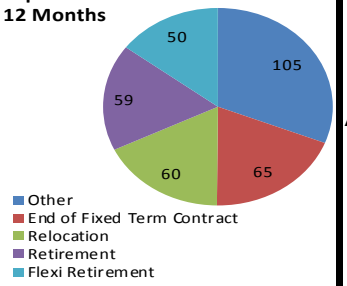
- S10 Anxiety/stress/depression/other psychiatric illnesses
- S12 Other musculoskeletal problems
- S11 Back Problems
- S25 Gastrointestinal problems
- S98 Other known causes - not elsewhere classified



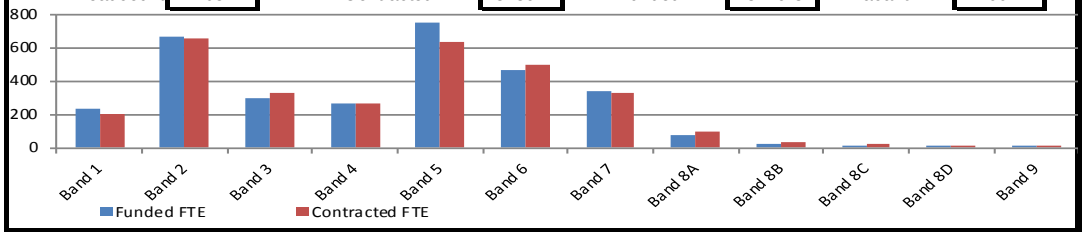
Workforce Profile



Top 5 Reasons for Leavers in 12 Months



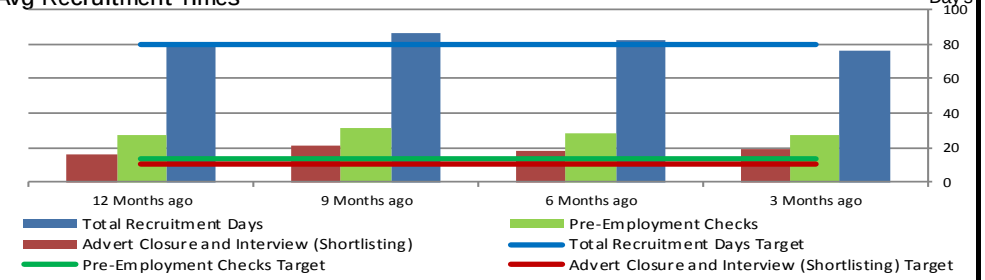
Annual Leave (Hrs)	523,151	:	553,766	Current Mat Leave FTE	66.6	Stability	14.0%
Headcount	4051	Contracted FTE	3489.2	Funded FTE	3749.3	Vacant FTE	260.2



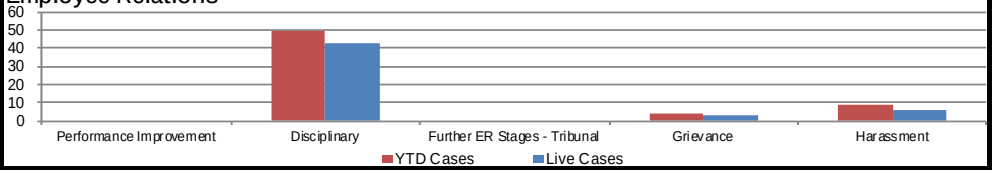
Recruitment

Overall Vacancy % & FTE	6.9%	Turnover	11.1%
Avg Monthly New Starters FTE	43.2		
Avg Monthly Leavers FTE	38.8		

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 higher than we would want, the reasons for this can be seen throughout the Dashboard, Turnover, Vacancy Rate, Sickness and Stability.

This month has seen a further deterioration of over £1.1m to £3,153.683 with agency expenditure of £7,738,712 largely accounting for the total non-contracted labour spend of £13,326.899. Clearly the amount spent on non-contracted labour does not represent best value for money and is being addressed through a variety of interventions as follows:

- Establishment of an Agency Nurse Spend Task and Finish Group designed to reduce reliance on agency nurses and to comply with the new national Monitor requirements on nurse agency spend. At each bi-weekly meeting the Matrons/Ward Managers are held to account of expenditure and plans to reduce this.
- International nurse recruitment in conjunction with NHSP with a visits confirmed to Romania from 23 – 26 November 2015 and Spain from 1 – 4 December 2015 with the intention of recruiting up to 40 nurses
- Working directly in conjunction with Monitor which has resulted in an extensive Action Plan which is reviewed regularly with Monitor
- Discussion with Medacs who are our Tier 1 supplier of Medical and Dental agency staff, to ensure that framework rates are maintained at all times
- Roll out of the Allocate system for job planning which commenced with awareness sessions on 19 & 20 October 2015 and has now moved into the implementation stage with job plans being loaded onto the system
- Nationally there has been a cap set on agency rates, the first phase of which comes into force from 23 November 2015 with full implementation expected from 1 April 2016
- Various initiatives with NHSP aimed at attracting agency workers to work through NHSP such as 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 etc

With regards to NHSP spend in October, expenditure was at its highest level so far this year at c£600k which was recorded as mainly due to the increase in vacancies as shown by the reason for the booking (see comment later under Workforce Profile).

Sickness Absence

There was no change to sickness absence during October at 4.3% and therefore the cumulative rate for April – October remained at 4.1% against the trust target of 3.75%. The trust does still compare favourably with the North West average percentage but the gap is narrowing. The main area of concern is long term sickness at 2.4% although the number of episodes of sickness absence increased to 594 compared with 538 in September.

There was a marginal improvement with the RTW rate at 49% (47% for September) for October and 48% for the last 12 months. Return to Work interviews are a key component to reducing sickness absence and a recent MIAA audit showed that in many cases these are being undertaken but not recorded on ESR. Managers 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 has increased slightly by 1% but is largely consistent with previous periods. The top 10 areas where Stress is most prevalent is being addressed by Divisional Managers and the SPC will review progress at its February 2016 meeting. Early results of an initial analysis would suggest that the areas with high stress levels are also the areas with high vacancies, therefore a causal link is demonstrated.

Other Musculoskeletal Problems makes up 12% (no change) of the sickness absence in the last 12 months although many staff do access the Staff Physiotherapy service in a timely manner and report good outcomes rather than wait for referrals from their GP.

Workforce Profile

October was another good month for the number of new starters compared with leavers. Almost 50 staff commenced compared with just under 40 leavers. Although the trust is still experiencing issues with retention and turnover, the monthly average position has improved again with more starters (43.2 wte) than leavers (38.8 wte). This does not seem consistent with the highest reason given for NHSP bookings as 'vacancy' especially when qualified nurse vacancies at band 5 fell by 12.6 wte to 85.36 wte in October 2015.

It is clear we need to be better at recording reasons for leaving as there have been 105 people in the last 12 months who have left our employment and the reason they left us has not been recorded. As reported at the previous meeting this facility on the leaver form has now been removed and managers will need to record the real reason for leaving and this will be a diminishing number. At the Strategic People Committee on 7 December 2015 it is planned that there will be a detailed discussion on retention and turnover which will include new initiatives on an improved Exit Interview and on-boarding.

The SPC will also concentrate on the areas with the worst retention rates to try and understand the reasons for this and to agree what action can be taken.

The ratio of annual leave taken compared with the proportion expected has deteriorated and is now amber. The concern would be that a higher proportion would need to be taken later which might be a contributory factor to increased agency spend later in the year.

The headcount has increased by 6 to 4051 and the number of vacancies has fallen to 260.17 from 279.5 the previous month.

The number of staff on maternity leave has increased slightly to 66.6 wte which will be a factor contributing to staffing shortages in some areas.

The stability rate has increased to 14% from 13.3% which is of some concern which illustrates 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 as mentioned above but the position should improve depending upon the success of the international recruitment and the trusts local rolling adverts.

Recruitment

Labour turnover has increased to 11.1% but there has been a reduction in the vacancy rate to 6.94%.

The average time taken to recruit has fallen again in Q4 ending 31 October 2015 in comparison with the previous 3 quarters. The time taken is now under 80 days and achieves the target of no longer than 80 days and reflects the work done by the Employment Services Team and the new measures introduced to encourage managers to advertise vacancies and shortlist much quicker. There is still improvements which can be made in shortlisting and interviewing quicker and undertaking employments checks.

In respect of Employee Relations, the greatest amount of activity relates to disciplinary cases (50 year to date) and these are largely concentrated within Unscheduled Care and WCSS. The number of dignity at work cases is also beginning to rise. In November there have been 6 new exclusions/suspensions.

A focus on recruiting Staff Nurses has been in place for the last 6 months, and we have recruited over 50 Staff Nurses during this period. This focus will continue with the rolling adverts already in place. Similarly, we are working hard to address Medical Staff shortages.

As mentioned above we are working with NHS Professionals on International recruitment for staff nurses in Romania and Spain and aim to recruit up to 40 nurses.

2. Recommendations

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

Roger Wilson
Director of Human Resources and Organisational Development
17 November 2015

BOARD OF DIRECTORS

SUBJECT:	Six Monthly Staffing Update to Board
DATE OF MEETING:	25th November 2015
ACTION REQUIRED	**For Discussion**
AUTHOR(S):	Interim Deputy Director of Nursing, Clare Pratt Associate Directors of Nursing Clare Pratt Rachael Browning Sue Franklin Mel Hudson Grace Delaney-Segar, Patient Quality and Safety Champion
EXECUTIVE DIRECTOR:	Karen Dawber, Director of Nursing and Governance Choose an item.
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care SO3: To give our patients the best possible experience SO4: To provide sustainable local healthcare services
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO2/2.1 Failure to engage and involve our workforce in the design and delivery of our services. SO2/2.2 Risk that the Trust does not have the right people with the right skills ie workforce is not competent and cannot deliver as commissioned. SO3/3.3 Failure to provide staff, public and regulators with assurances post Francis and Keogh review Choose an item. Choose an item.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED:	Choose an item. Choose an item. Choose an item.

EXECUTIVE SUMMARY (KEY ISSUES):	The aim of this paper is to provide an overview on the NHS Quality Board Recommendations – Hard Truths, and the next steps to the reviews of nurse staffing underway as part of a series of assessments using the Safer Nurse Care Tool.	
RECOMMENDATION:	The Board is asked to: 1. Authorise the People Committee to scrutinise and review the full document and report back to board in January 2016 2. Devolve the function of scrutiny and assurance for nurse staffing to the people committee with monthly update to the Board of Directors 3. Note that mitigations are in place whilst awaiting full discussion in January 2016	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

Introduction

This paper is a short executive summary as an alternative to the full November 2015 staffing review and should be read in conjunction with the Monthly Staffing Exceptions Report October 2015, which provides an overview of the staffing in our in-patient wards in line with NHS England requirements.

The full paper, that will be presented and discussed at People Committee in December, provides a comprehensive overview of the staffing in our in-patient wards and for the Divisions to provide assurance that there is safe staffing in place or to put forward mitigations and recommendations if this is not the case.

It also provides the Board with assurance that the trust has put in place one of the most important recommendations of the NHS Quality Board Hard Truth's paper; that the use of a Safer Nurse Care Tool (SNCT) is in place to review nurse staffing in general ward areas.

Front line nursing staff makes up the largest section of our workforce in Warrington and Halton Hospitals. There is a large amount of evidence showing that staffing levels have a direct impact on patient outcomes and experience, it also impacts on the quality of care, and the efficacy of the care delivered (RCN, 2011). NICE recommends that organisations use a systematic approach to ensure there is sufficient staff on duty each shift to provide patients with the care they need regardless of the ward, time of day or day of the week.

Background

It is widely acknowledged that there is no one single tool that can be used to determine accurate staffing levels. Instead it requires a triangulation of various methods which will help organisations to arrive at optimal staffing levels along with the use of informed professional judgement (NICE, 2014).

Previously, assurance on Safe Staffing levels has been provided based on the Professional Judgement Model and review of Nurse sensitive indicators alone. Professional Judgement Model requires the ward managers, matrons, and ADNS to agree on safe staffing on a shift by shift basis, based on their clinical knowledge and understanding of the unique needs of each ward. Nurse Care Indicators including details of reported incidents and complaints and staffing data have been included to allow for triangulation of indicators to inform Board level decisions relation to safe staffing levels.

In recent years several other models of reviewing nurse staffing have been developed and it is now recommended that a combination of Professional Judgement, Nurse Care indicators and an acuity based model be utilised. It is further recommended that 3 sets of patient acuity data be collected at 6 month intervals before any changes to staffing are made based on this information.

Since 2013 there have been several national reviews regarding staffing that have been published; The Keogh report, the Francis report, and the Berwick review. All of these reports detail the importance of adequate staffing levels to deliver safe care and highlighted that high rates of sickness and high use of bank and agency staff to compensate for high numbers of vacancies were noted in low performing trusts

In 2012 the RCN issued a position statement on its desire to set mandatory staffing level laid out in 2006 that recommended 65:35 registered: unregistered ratio split on adult acute general and surgical in-patient wards. It did not address how many patients a nurse should be allocated.

The National Nursing Research Unit (NNRU) at King's College London undertakes high quality empirical research and reviews to inform policy and practice relevant to the nursing workforce. They have reported that research demonstrates that RN staffing levels on hospital wards affect the ability of staff to deliver care well. Where staffing levels are low, care is compromised. An excessive number of patients per RN is associated with a higher than expected mortality rate and other harms and they recommend that a ratio of more than 8 patients per RN significantly increases the risk of harm and constitutes a breach in patient safety which should be escalated for investigation.

In 2014 NICE issued guidance on safe staffing in adult inpatient wards in acute hospitals; this guidance stated that each ward has to determine their staffing requirement based on the care their patents need and recommend that the Safer Nursing Care Tool be used to review staffing on inpatient adult wards as it incorporates the activity of the ward and the dependency of the patients.

The divisions are working hard to enhance patient flow and reduce sickness and turnover levels. In 2014 the Trust introduced the use of electronic rostering which gives opportunity for more scrutiny of shift pattern and maximising efficiency for filling gaps.

Each month the wards collect data comparing their planned and actual staffing levels, the matrons and ADNS monitor this and are able to give assurance that staffing is safe and that plans are put in place to ensure that staff are able to deliver safe reliable and excellent care to the patents if staffing dropped below the planned level. This information is sent to Board in a separate paper and publicly available on our website and sent to NHS England also.

This is the second time the safer nursing care tool has been utilised at our hospital to collect the data and to assist the Ward Managers to do this a series of face to face tutorials were given supported by a "how to" guide.

The Safer Nursing Care Tool (SNCT) has been developed to help NHS Hospital staff measure patient acuity and/or dependency to inform evidence-based decision making on staffing and workforce. The tool, when allied to Nurse Sensitive Indicators, also offers nurses a reliable method against which to deliver evidence-based workforce plans to support existing services or to develop new services.

The Safer Nursing care tool data has been collected on every adult inpatient area for a maximum of 20 consecutive days between August and September 2015. All in-patients have been allocated a level of dependency/acuity based on the following levels.

Whilst that paper provides a comparison between two sets of data, it is recommended that 3 sets of data are analysed before adjustments are made to ward establishments.

The Safer Nurse Care Tool Methodology

The Safer Nursing Care Tool (SNCT) has been developed to help NHS Hospital staff measure patient acuity and/or dependency to inform evidence-based decision making on staffing and workforce. The tool, when allied to Nurse Sensitive Indicators, also offers nurses a reliable method against which to deliver evidence-based workforce plans to support existing services or to develop new services.

Following pilots in C20, A8 and CMTC, the safer nursing care tool has been utilised in the trust. In order to collect the data and to assist the Ward Managers to do this, a series of face to face tutorials were given supported by a "how to" guide. As the trust does not have an electronic method of gathering this data (an addition to the Allocate or other system would be required) we are reliant on manually gathering and inputting data which has proved onerous.

Data was collected at 3pm every day on each ward. The number of patients who fell into the Care Level Categories described below was noted by either the Ward Manager or one of two designated senior staff to ensure continuity. Patient dependency is collected for the 24-hour period leading to the data collection time; e.g., if there was a level 2 patient in a bed - from 6am till 12pm and it was empty at 3pm then the bed would be marked as a level 2 patent as they occupied it for longer than it was empty. However if the bed was only occupied by a level 2 patient in a bed from 6am till 8am and it was empty at 3pm then the bed would be marked as empty.

Care levels

Care Level	**Descriptor: patient status, care requirements may include the following:**
Level 0 Patient requires hospitalisation and needs met in a 'normal' ward.	· Elective medical or surgical admission · May have underlying medical condition requiring on-going treatment · Patients awaiting discharge · Post-operative/post-procedure care – observations recorded half-hourly initially then four-hourly. · Regular (two-four hourly) observations · Early Warning Score within normal threshold. · ECG monitoring · Fluid management · Oxygen therapy less than 35% · PCA · Nerve block · Single chest drain · Confused patients not at risk, · Patients requiring assistance with some activities of daily living, requires one person to mobilise · Experiences occasional incontinence

Level 1a Acutely ill patient requiring intervention or those who are unstable and may deteriorate	· Increased observations and therapeutic interventions · Early Warning Score – trigger-point reached and requiring escalation. · Post-operative care following complex surgery · Emergency admission requiring immediate therapeutic intervention. · Instability requiring continual observation/invasive monitoring · Oxygen therapy greater than 35% ; chest physiotherapy two to four hourly · Arterial blood gas analysis – intermittent · Post 24 hours following tracheostomy, central line, epidural or multiple chest or extra ventricular drain · Severe infection or sepsis
Level 1b Patient is stable but is dependant on nurses to meet most or all his/her daily living activities.	Complex wound management requiring more than 1one nurse or procedure takes more than one hour to complete. · VAC therapy, where ward-based nurses undertake the treatment · Patients with spinal instability/spinal cord injury · Mobility or repositioning difficulties requiring two staff · Complex intravenous drug regimes (including prolonged preparatory/ administration/post-administration care) · Patient and/or carers requiring enhanced psychological support owing to poor disease prognosis or clinical outcome. · Patients on end-of-life care pathway · Confused patients at risk **or** requiring constant supervision · Requires assistance with most or all daily living activities · Potential for self-harm and requires constant observation · Complex discharge, which is the ward-based nurse's responsibility.
Level 2 May be managed within clearly designated beds staffed with expert nurses and resources and requires transfer to a dedicated Level 2 unit	· Deteriorating/compromised single organ system · Post-operative optimisation (pre-op invasive monitoring)/extended post-op care. · Patient requiring non-invasive ventilation/respiratory support; CPAP/BiPAP in acute respiratory failure · First 24 hours following tracheostomy · Requires one or more therapeutic intervention, including: · Greater than 50% oxygen continuously · Continuous cardiac monitoring and invasive pressure monitoring · Drug infusion requiring more intensive monitoring; e.g., vasoactive drugs (amiodarone, inotropes, GTN) or potassium, magnesium. · Pain management such as intra-thecal analgesia · CNS depressed airway and protective reflexes · Invasive neurological monitoring

Level 3 Patient needing advanced respiratory support and/or therapeutic interventions for multiple-organ problems.	· Monitoring and supportive therapy for compromised/collapse of two or more organ/systems · Respiratory or CNS depression/compromise requiring mechanical/invasive ventilation · Invasive monitoring, vasoactive drugs, hypovolaemia/haemorrhage/sepsis treatment or neuro-protection

The data was inputted into a database that calculates whole time equivalent (WTE) staffing requirements for that ward based on the information provided. The SNCT requires that a minimum uplift of 22% is applied to calculate the required WTE. In our trust, nursing establishments are set with an uplift of 20% in place to reflect annual leave requirements, mandatory training and to allow for a threshold of sickness. The 20% uplift in place is in variance to the minimum of 22% stipulated by and applied to the SNCT and this in, some part, contributes to the differing staffing levels recommended when using the different models. The 20% uplift is currently under review due to this variance.

For each of the wards the ward clerk, house keeper and 0.8 of the ward manager's time was not included in the data as this time is not dedicated to providing direct patient care.

The SNCT tool was applied to ITU and CCU for the first time, however due to CCU having less than 10 inpatients during the data collection period, there was insufficient data to provide a reliable result and as a result only professional judgement modelling is included in this report.

ITU multipliers are applied in line with Critical Care Network guidance and this is standard practice across all Trusts utilising the SNCT

Maternity have reviewed their staffing utilising Birthrate+ and a summary of initial findings are included in this report.

As there is not a safer nursing care too for Paediatrics they were asked to review their staffing in accordance with the professional judgment model and liaise with other organisations regarding how they review their staffing number.

An AED specific SNCT was utilised within the AED Accident and Emergency also took part in the SNCT and a tool unique to that area was used. Unfortunately data was not collected for patients in Minors and CDU and for this reason the data should be viewed with caution.

Summary

Staffing establishments have received scrutiny over the past 12 months and monthly position statements on planned to actual staffing levels have been presented to the Board with associate directors of nursing giving assurance that care is safe and effective even in times of extreme pressure.

This is the second time we have used triangulation of SNCT information with professional judgement tool and quality indicators. For completeness we have included AED, CCU, ITU, Paediatrics and Maternity in the review.

The full document, the proposals and recommendations will need to be discussed at the People committee in December; this will enable full and open discussion with the operational and strategic leads prior to presentation to the January Board of Directors

Recommendations

The Board is asked to:

1 Authorise the People Committee to scrutinise and review the full document and report back to board in January 2016

2 Devolve the function of scrutiny and assurance for nurse staffing to the people committee with monthly update to the Board of Directors

3 Note that mitigations are in place whilst awaiting full discussion in January 2016

BOARD OF DIRECTORS

W&HHFT/TB/B/15/219(ii)

SUBJECT:	**Monthly Staffing Exceptions Report**	
DATE OF MEETING:	25th November 2015	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Angela Madigan (deputy Director of Nursing) Sue Franklin (associate director of nursing unscheduled) Claire Blackman (associate director of nursing scheduled) Rachael Browning (associate director of nursing midwifery) Grace Delaney-Segar (Patient Quality and Safety Champion)	
EXECUTIVE DIRECTOR:	Karen Dawber, Director of Nursing and Governance	
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care SO3: To give our patients the best possible experience SO4: To provide sustainable local healthcare services	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework SO3/3.3 Failure to provide staff, public and regulators with assurances post Francis and Keogh review Choose an item.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides an overview of nurse staffing for October 2015. Links to the Safety Thermometer are also included to assist in Triangulation of incidents with staffing levels.	
RECOMMENDATION:	***The Board is asked to:*** 1. Note the contents of this report, which describe the progress in the monitoring of complaints and to approve the actions as documented; and 2. Approve the staffing exemption Report	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

1.0 Introduction / Background

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

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

2.0 Staffing Report

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

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

3.0 Divisional Breakdown

SCHEDULED CARE DIVISION					
Ward name	**DAY Average fill rate - registered nurses / midwives (%)**	**DAY Average fill rate - care staff (%)**	**NIGHT Average fill rate - registered nurses / midwives (%)**	**NIGHT Average fill rate - care staff (%)**	**Exception Report Comments with assurance provided by Associate Directors of Nursing**
SAU	100%	86%	-	-	SAU has moved off the main ward and is now a stand-alone unit. The unit is closed overnight. They are almost fully established with a 0.68 assistant practitioner vacancy outstanding.
A5	99.1%	98.8%	101.1%	100.0%	Escalation beds open to plus 5 for majority of October, which requires additional staffing. On occasions these shifts haven't picked up. 1 RN on maternity leave. Posts been recruited to, commencing March 2016. Short term sickness throughout the month. There have been a number of one to one shifts booked on occasions. Unable to fill night shift so often only 2 RN. To ensure safety any gaps on Erostering are requested on NHSP and escalated to agency if not covered.

Ward name	DAY Average fill rate - registered nurses / midwives (%)	DAY Average fill rate - care staff (%)	NIGHT Average fill rate - registered nurses / midwives (%)	NIGHT Average fill rate - care staff (%)	Exception Report Comments with assurance provided by Associate Directors of Nursing
A6	93.6%	102.6%	95.6%	100.0%	A6 is now funded for 32 beds. However the ward is not yet fully established as well as 2 RN on maternity leave. On occasion one to one was booked for night shift. Short term sickness impacted on staffing levels throughout the month. To ensure safety any gaps on Erostering are requested on NHSP and escalated to agency if not covered.
A9	86.5%	80.4%	86.0%	100.0%	There has been a sustained increase in the requests for escalation beds throughout the month, which has maintained an element of risk when numbers are below core beds and added amount of patients from 1-4. This alters the nurse: patient ratio. Staff levels are discussed at daily bed meetings and a whole corporate approach to reducing risk and staffing areas for escalation is reviewed. There is still a significant vacancy level and this is in the most being covered by agency as NHSP trained has very poor fill rate. The acuity has been at times high due to need to bay tag and special 1:1 patients and shifts are not always covered. Nurse sensitive indicators have continued with some falls due to high risk patients and inability to cover all bay tagging. The ward has continued to utilise carers and staff to observe patients at risk. Nurse Sensitive indicators have seen a rise in medication errors and on investigation there are some related to agency staff and they have been investigated and the ward manager is monitoring.
B19	95.3%	134.3%	100.0%	98.4%	Escalation beds have remained open for a high percentage of the month, but closed to admission due to an outbreak of VRE and the escalation beds were not utilised for over 4 days in the month. Over on CSW due to escalation and NOF unit. The ward has an untrained vacancy and staff have returned from maternity leave. Nurse sensitive indicators have shown falls has been an issue due to the nature of high risk patients and some medication errors observed and investigated and is being monitored by the ward manager.
B4	95.7%	93.2%	0.0%	0.0%	B4 manages the staffing requirements flexibly in line with activity over the week. There have been no issues with staffing.
Ward 1 - CMTC	88.3%	85.6%	92.9%	0.0%	

ICU	89.2%	94.1%	89.2%	90.3%	18 beds funded but used flexibly depending on dependency of patients (i.e. can be at full capacity at 16 beds if 10 Level 3 and 6 Level 2) 14 Q nurses required per shift but if dependency/occupancy reduced then less nurses would still provide agreed nurse: patient ratios. Unit Occupancy for October 2015 was 87% therefore even though shifts fell short of 14 Q there was adequate nurses to provide standard nurse: patient ratios.

UNSCHEDULED CARE DIVISION					
Ward name	**DAY Average fill rate - registered nurses / midwives (%)**	**DAY Average fill rate - care staff (%)**	**NIGHT Average fill rate - registered nurses / midwives (%)**	**NIGHT Average fill rate - care staff (%)**	**Exception Report Comments with assurance provided by Associate Directors of Nursing**
A1	86.9%	94.4%	100.0%	100.0%	2.6 WTE bereavement leave. 0.6 WTE Carers leave. Stand-alone advert continues. Intentional recruitment to commence in November 2015. Practice educator interviews in October but unfortunately the successful candidate withdrew. Matron completes a staffing review daily at 2.15pm and staff are moved within the Division to make areas safe.
A2	90.0%	91.3%	83.8%	88.7%	2x RN waiting start dates. Interviewed for care assistants in October. Matron completes a staffing review daily at 2.15pm and staff are moved within the Division to make areas safe. 1:1 risk assessments completed as required and put out to NHSP to support 1:1's. almost 20% turnover of staff!
A3	95.1%	87.8%	93.5%	88.5%	Start dates agreed for CSW's at the end of November. 1:1 staff requested for every day shift and every night. Matron completes a staffing review daily at 2.15pm and staff are moved within the Division to make areas safe.
A4	101.4%	92.2%	100.0%	132.3%	
A7	98.0%	100.0%	97.9%	101.6%	

A8	92.7%	100.0%	100.0%	80.0%	All falls were no injury. Have been more pro-active with falls management. A list is behind the nursing station for at a glance information on who is on a falls alarm, for all the MDT to see, also added to safety brief, No hospital acquired pressure ulcers for the month of October.
B12	98.9%	106.1%	100.0%	120.5%	Extra staffing requested for patients requiring 1:1. observation risk assessment completed for the unit
B14	93.2%	83.3%	70.7%	101.9%	1:1 shifts required on most shifts for this month
B18	81.9%	94.5%	91.4%	89.2%	Long term sickness remains an issue but is being managed appropriately.
C21	96.8%	87.3%	100.0%	95.2%	CSW moved to support other areas. Area risk assessed prior to move.
C22	96.4%	84.5%	100.0%	100.0%	RGN reviewed each day according to acuity and demand on the unit. On occasions unit has not been full so staff moved. CSW moved regularly following assessment to support depleted areas in division
CCU	95.1%	55.3%	100.0%	-	

WOMEN'S & CHILDREN'S SUPPORT SERVICES					
Ward name	**DAY Average fill rate - registered nurses / midwives (%)**	**DAY Average fill rate - care staff (%)**	**NIGHT Average fill rate - registered nurses / midwives (%)**	**NIGHT Average fill rate - care staff (%)**	**Exception Report Comments with assurance provided by Associate Directors of Nursing**
B11	98.8%	100.0%	100.0%	-	
Neonatal Unit	93.7%	91.2%	93.6%	100.0%	
C20	56.5%	69.4%	48.4%	-	
C23	104.8%	91.9%	121.0%	100.0%	

4.0 Assurance provided from the Divisional Associate Directors of Nursing:

Scheduled Care -

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

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

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

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

Unscheduled Care – The Division has continued to experience high sickness levels in October 2015. Vacancies are being recruited into and this has reduced pressure somewhat. All areas were safely staffed but there are some deficits across the Division.
These were minimised by close observation and monitoring by the Matrons every day, with daily scrutiny by the Associate Director of Nursing ongoing monitoring of complaints/PALS and DATIX reports. All issues were escalated appropriately and registered nurses or carers were moved from other areas. These decisions were made based on the best use of staff at the time, taking account of acuity / dependency and skill mix available.

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

The Trust has a rolling recruitment programme which supports the recruitment to vacancies within the division. A focus on EU recruitment is ongoing with two planned trips; the first to Romania in November and the second trip to Spain in early December. There is a plan to interview at least 30 nurses in each country. Accommodation and support is currently being explore with HR and NHSP support.

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

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

Appendix 1

Staffing Levels

Oct-15

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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

This column will automatically calculate the number of shifts

									Day					Night									
									Registered midmives/nurses			Care Staff		Registered midmives/nurses			Care Staff						
Division	Ward	Non-escalation Beds	Budgeted Registered staff	Vacancies including maternity leave	Posts appointed to but not yet started	Budgeted Unregistered staff	Vacancies including maternity leave	Sickness & Absence for Sep-15	Agreed nurse to patient ratios	**Total monthly planned staff hours**	**Total monthly actual staff hours**	**Total monthly planned staff hours**	**Total monthly actual staff hours**	Agreed nurse to patient ratios	**Total monthly planned staff hours**	**Total monthly actual staff hours**	**Total monthly planned staff hours**	**Total monthly actual staff hours**	Number of hours above or below planned	Length of a shift in hours	Number of shifts above or below planned	Variance	Associate Director of Nursing/Matrons Assurance Statement
Scheduled Care	SAU			0.00	0.00	5.40	0.00			930.0	930.0	697.5	600.0		0.0	0.0	0.0	0.0					SAU has moved off the main ward and is now a stand alone unit. The unit is closed overnight. They still have a 0.68 assistant practitioner vacancy.
	W-A5 - Ward A5	28	18.03	1.71	1.00	12.88	0.62		1:7	1380.0	1367.5	1035.0	1023.0	1:9	1035.0	1046.5	713.0	713.0	-13.0	11.5	-1.1	-0.31%	Escalation beds open x5 for majority of October. X 1 RN on maternity leave. Posts been recruited to in March 2016. Short term sickness throughout the month.one to one booked on occasions. Unable to fill night shift so often only 2 RN. Unable to fill escalation shifts.To ensure safety any gaps on e rostering are requested on NHSP and escalated to agency if not covered.
	W-A6 - Ward A6	28	19.57	3.13	2.00	13.62	0.00		1:7	1481.5	1386.0	1031.0	1058.0	1:9	1035.0	989.0	713.0	713.0	-114.5	11.5	-10.0	-2.69%	A6 is now funded for 32 beds . However the ward is nt yet fully established.. . X2 RN on maternity leave. On occasion One to one was booked for night shift . Short term sickness ompacted on staffing levels throughout the month.To ensure safety any gaps on e rostering are requested on NHSP and escalated to agency if not covered.
	W-A9 - Ward A9	28	18.83	4.27	3.80	15.50	3.00		1:7	1426.0	1234.0	1426.0	1146.0	1:9	1069.5	920.0	713.0	713.0	-621.5	11.5	-54.0	-13.41%	There has been an sustained increase in the requests for escalation beds throughout the month, which has maintained an element of risk when numbers are below core beds and added amount of patients from 1-4. This alters the nurse:patient ratio. Staff levels are discussed at daily bed meetings and a whole corporate approach to reducing risk and staffing areas for escalation is reviewed. There is still a significant vacancy level and this is in the most being covered by agency as NHSP trained has very poor fill rate. The acuity has been at times high due to need to bay tag and special 1:1 patients and not always covered. Nurse sensitive indicators have continued with some falls due to high risk patients and inability to cover all bay tagging. The ward has continued to utilise carers and staff to observe patients at risk. Nurse Sensitive indicators has seen a rise in medication errors and on investigation there are some related to agency staff and they have been investigated and the ward manager is monitoring.
	W-B19 - Ward B19	18	13.68	0.00	0.00	13.90	2.00		1:6	1069.5	1019.5	713.0	957.5	1:6	713.0	713.0	713.0	701.5	183.0	11.5	15.9	5.70%	Escalation beds have remained open for a high percentage of the month, but closed to admission due to an outbreak of VRE and the escalation beds were not utilised for over 4 days in the month. Over on CSW due to escalation and NOF unit. The ward has an untrained vacancy and staff have returned from maternity leave. Nurse senitive indicators have shown falls has been an issue due to the nature of high risk patients and some medication errors observed and investigated and is being monitored by the ward manager.
	W-B4-H - Ward B4 - Halton	27	12.20	2.41	0.00	6.00			1:9	874.0	836.0	552.0	514.5	13.5 :1	552.0		322.0		-949.5	11.5	-82.6	-41.28%	
	W-CM1-H - Ward 1 - CMTC Treatment Centre	30	26.60	6.25	0.00	14.00	2.59		1:5.5	1978.0	1746.0	1196.0	1023.5	10 : 1	966.0	897.0	644.0		-1117.5	11.5	-97.2	-23.36%	
	W-ICU - Intensive Care Unit	18	76.74	9.00	1.00	11.52	0.00		1:1 Level 3 1:2 Level 2	4991.0	4450.5	1069.5	1006.3	1:1 Level 3 1:2 Level 2	4991.0	4450.5	713.0	644.0	-1213.2	11.5	-105.5	-10.31%	18 beds funded but used flexibly depending on dependency of patients (ie. can be at full capacity at 16 beds if 10 Level 3 and 6 Level 2) 14 Q nurses required per shift but if dependency/occupancy reduced then less nurses would still provide agreed nurse:patient ratios. Unit Occupancy for October 2015 was 87% therefore even though shifts fell short of 14 Q there was adequate nurses to provide standard nurse:patient ratios.
Total		177	185.65			92.82		0.00											-3846.2		-334.5		

Unscheduled Care	AED					13.02				4464.0		1162.5			3205.1		896.5		-9728.1	12.5	-778.2	-100.00%	
	W-A1A - Ward A1 Asst	29	41.40	10.80	0.00	22.10	3.90		5.5	2712.5	2357.5	1550.0	1462.5	0.0	1953.0	1953.0	651.0	651.0	-442.5	12.5	-35.4	-6.44%	Sickness in WTE not %. 2.6 WTE bereavement leave. 0.6 WTE Carers leave. Stand alone advert continues. Intenational recruitment to commence in November 15. Practice educator interviews in October but unfortunately the successfu;l candidate withdrew. Matron completes a staffing review daily at 2.15pm and staff are moved within the Division to make areas safe.
	W-A2A - Ward A2 Admission	28	18.83	1.10	0.00	12.90	2.00		5.6	1426.0	1283.0	1069.5	976.0	9.3	1207.5	1012.0	713.0	632.5	-512.5	11.5	-44.6	-11.61%	Sickness in WTE not %. 2x RN awaiting start dates. Interviewed for care assistants in October. Matron completes a staffing review daily at 2.15pm and staff are moved within the Division to make areas safe. 1:1 risk assessments completed as required and put out to NHSP to support 1:1's.
	W-A3OPAL - Ward A3 Opal	34	18.83	1.24	2.00	15.50	4.17		8.5:1	1426.0	1356.0	1702.0	1494.0	0.0	1069.5	1000.5	1058.0	936.0	-469.0	11.5	-40.8	-8.92%	Sickness in WTE not %. Start dates agreed for CSW's at the end of November. 1:1 staff requested for every day shift and every night. Matron completes a staffing review daily at 2.15pm and staff are moved within the Division to make areas safe.
	W-A4 - Ward A4	28	19.38	1.24	2.45	9.57			1:7	1069.5	1085.0	1069.5	986.0	1:7	713.0	713.0	713.0	943.0	162.0	11.5	14.1	4.54%	
	W-A7 - Ward A7	33	18.80	3.30	1.00	15.50	0.37		8.3:1	1449.0	1420.0	1426.0	1426.0	0.0	1092.5	1069.5	713.0	724.5	-40.5	11.5	-3.5	-0.87%	
	W-A8 - Ward A8	34	18.80	6.34	0.00	15.50	0.00		8.5:1	1426.0	1322.5	1426.0	1426.0	0.0	1035.0	1035.0	1035.0	828.0	-310.5	11.5	-27.0	-6.31%	All falls were no injury. Have been more pro-active with falls management. A list is behind the nursing station for at a glance informaiton on who is on a falls alarm, for all the the mdt to see, also added to saftey brief , No hospital acquired pressure ulcers for the month of September
	W-B12 - Ward B12 (Forget-me-not)	21	13.68	0.00	0.00	15.50	0.92		7.0:1	1069.5	1057.5	1426.0	1512.5	0.0	713.0	713.0	713.0	859.0	220.5	11.5	19.2	5.62%	extra staffing requested for patients requiring 1:1. observation risk assessment completed for the unit
	W-B14 - Ward B14	24	18.80	2.67	0.00	12.90	0.00		6.0:1	1426.0	1329.0	1069.5	891.0	8.0	1069.5	756.0	713.0	726.5	-575.5	11.5	-50.0	-13.45%	1:1 shifts required on most shifts for this month
	W-B18 - Ward B18	24	18.80	0.00	0.00	18.00	0.00		6.0:1	1426.0	1167.5	1426.0	1347.5	0.0	1069.5	977.5	1069.5	954.5	-544.0	11.5	-47.3	-10.90%	Long term sickness remains an issue but is being managed appropriately.
	W-C21 - Ward C21	24	13.68	0.0	0.1	11.30			8.0:1	1069.5	1035.0	816.5	713.0	0.1	713.0	713.0	713.0	678.5	-172.5	11.5	-15.0	-5.21%	CSW moved to support other areas. Area risk assessed prior to move.
	W-C22 - Ward C22	21	13.68	2.00	1.34	12.90			7.0:1	1069.5	1030.5	1069.5	904.0	0.1	713.0	713.0	713.0	713.0	-204.5	11.5	-17.8	-5.74%	
	W-CCU - Coronary Care Unit	8	21.2	2.2	1.0	2.6	0.0		2.0:1	1426.0	1356.5	356.5	197.0	0.0	1069.5	1069.5	0.0	0.0	-229.0	11.5	-19.9	-8.03%	rgn reviewed each day according to acuity and demand on the unit. On occassions unit has not been full so staff moved.csw moved regularly following assessment to support depleted areas in division
	STAR			8.0	1.0	3.0	3.0			1488.0	1476.0	744.0	744.0		744.0	744.0	744.0	744.0	-12.0			-0.32%	staffing reviewed and assessed daily.
Total		308	235.85			180.30		0.00											-12858.1		-1046.3		
WCSS	W-B11B/W-B11C - Ward B11	24	29.50			15.92			1:1 level3 1:2 Level2	2100.0	2075.0	930.0	930.0	0.0	1488.2	1488.2	0.0	0.0	-25.0	7.5 day 10.63 night		-0.55%	
	W-NHDU/W-NITU/W-NSC - Neonatal Unit	18	24.38			6.52			7.5:18	1092.0	1023.0	798.0	728.0	7.5:18	942.8	882.8	240.0	240.0	-199.0			-6.48%	
	W-C20 - Ward C20	12	12.63			5.00			1:4	1260.0	712.5	832.5	577.5	1:6	600.8	290.6	0.0	0.0	-1112.7			-41.31%	
	W-C23 - Ward C23	22	97.92			18.93			1:7.33	1393.5	1460.8	930.0	855.0	1:11	600.8	726.8	300.4	300.4	118.3			3.67%	
Total		76	164.43	0.00	0.00	46.37	0.00	0.00											-1218.4		0.0		
Grand Total		561	585.93	0.00	0.00	319.49	0.00	0.00											-17922.7		-1380.8		

BOARD OF DIRECTORS

W&HHFT/TB/B/15/220

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

BOARD OF DIRECTORS

W&HHFT/TB/B/15/221

SUBJECT:	**Finance Report as at 31st October 2015**	
DATE OF MEETING:	25th November 2015	
ACTION REQUIRED	**For Discussion**	
AUTHOR(S):	Steve Barrow, Deputy Director of Finance	
EXECUTIVE DIRECTOR:	Tim Barlow, Director of Finance and Commercial Development	
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care SO3: To give our patients the best possible experience SO4: To provide sustainable local healthcare services	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework SO4/4.2 Failure to: Maintain a liquidity ratio and capital servicing capacity necessary to deliver a continuity of services risk rating of at least 3 on a quarterly basis; remain a going concern at all times remain solvent; and Comply with section G6 of th SO4/4.3 Failure to manage key contracts appropriately resulting in contract penalties or reduction in service standards; and failure of operational processes to deliver service to agreed contract targets, outputs or standard Choose an item. Choose an item.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	Choose an item. Choose an item. Choose an item.	
EXECUTIVE SUMMARY (KEY ISSUES):	For the period ending 31st October 2015 the Trust has recorded a cumulative deficit of £11,266k, a cash balance of £3,766k 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 Not applicable

	Agenda Ref.	
	Date of meeting	17th November 2015
	Summary of Outcome	Noted

FINANCE REPORT AS AT 31st OCTOBER 2015

1. PURPOSE

The purpose of the report is to advise the Board of Directors on the financial position of the Trust as at 31st October 2015 and the forecast outturn as at 31st March 2016.

2. EXECUTIVE SUMMARY

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

Key financial indicators

Indicator	Monthly Plan £m	Monthly Actual £m	Monthly Variance £m	YTD Plan £m	YTD Actual £m	YTD Variance £m
Operating income	18.2	19.3	1.1	124.1	127.3	3.2
Operating expenses	(17.7)	(19.6)	(1.9)	127.1	(132.2)	(5.1)
EBITDA	0.5	(0.3)	(0.8)	(3.1)	(4.8)	(1.8)
Non-operating income and expenses	(1.0)	(1.0)	0.0	(6.4)	(6.4)	0.0
I&E surplus / (deficit)	(0.5)	(1.3)	(0.8)	(9.5)	(11.3)	(1.7)
Cash balance	-	-	-	2.0	3.8	1.8
CIP target	1.2	1.3	0.1	3.3	3.5	0.2
Capital Expenditure	1.1	0.6	0.5	4.4	4.3	0.1
Financial Sustainability Risk Rating	-	-	-	1	1	0

3. OVERVIEW

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

Position = Surplus/(Deficit)	October £000	Year to date £000
Plan	(450)	(9,519)
Actual	(1,226)	(11,266)
Variance	**(776)**	**(1,747)**

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

Variance = Favourable/(Adverse)	October £000	Year to date £000
Operating income	1,092	3,255
Operating expenses	(1,865)	(5,031)
Non-operating income and expenses	(2)	28
Total	**(776)**	**(1,747)**

Cash Position

The operating performance continues to have an adverse effect on the amount of cash available to the Trust but in July cash advances were secured from Warrington CCG (£6m) and Halton CCG (£1.2m) which has allowed the Trust to clear a number of overdue creditors, meet its PDC Dividends obligation and have a cash balance at the 31st October of £3,766k. The Trust needs to manage its working balances in order to maintain a cash balance sufficient to pay creditors and repay both commissioners the cash advances over the remainder of the year. The first installment of the working capital loan from the Department of Health was received on the 16th November.

Operating Income

Year to date operating income is £3,255k above plan due to an over recovery on other operating income (£2,572k) and NHS clinical income (£759k), partially offset by an under recovery on non NHS clinical income (£76k).

Operating Expenses

Year to date operating expenses are £5,031k above plan due to over spends on pay (£3,161k), drugs (£442k), clinical supplies (£854k) and non clinical supplies (£574k).

Non Operating Income and Expenses

Non operating income and expenses is £28k 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) and to date the planned value of the schemes equates to £10,818k. However the value of schemes underpinned by detailed plans (evidenced by PIDs) is shown in the table below.

Narrative	In Year £000	Recurrent £000
Annual Target	10,300	10,100
Value of schemes identified	10,898	7,373
Over / (Under) Achievement against target	**598**	**2,727**

For the period to date the planned savings target is £3,333k, with actual savings amounting to £3,528k which results in an over achievement of £195k. The position is primarily due to an over achievement on the clinical coding (£993k), sustainability (£92k) and lung function tests (£50k) schemes, partially offset by an under achievement on a number of other schemes.

5. CAPITAL

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

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

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

The position below reflects the revision to the capital programme and to date the Trust has spent £4.3m against the budget of £4.4m, with the £0.5m underspend in September bringing the programme back in line with budget.

Category	**Annual Budget £m**	**Budget to date £m**	**Actual to date £m**	**Variance to date £m**
Estates	5.2	1.6	1.4	0.2
IM&T	3.5	1.9	2.1	(0.2)
Medical Equipment	2.2	0.9	0.8	0.1
Total	**10.9**	**4.4**	**4.3**	**0.1**

6. CASH FLOW

The cash balance is £3,766k which is £1,745k above the planned cash balance of £2,021k, with the monthly movements summarised in the table below.

Cash balance movement	**£000**
Opening balance as at 1st October	4,153
In month deficit	(1,973)
Non cash flows in surplus/(deficit)	935
Decrease in trade receivables (debtors)	1,652
Decrease in trade payables (creditors)	(1,228)
Capital expenditure	600
Other working capital movements	(373)
Closing balance as at 31st October	**3,766**

The current balance equates to circa 6 days operational cash but as at 31st October the value of trade payables stands at £6.4m, although this is partially covered by the value of trade receivables which stands at £3.0m. Under the financial sustainability risk rating the liquidity metric is -25 days which results in a score of 1.

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

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

Cash balance movement	**November £000**	**December £000**	**January £000**
Opening balance	3,766	2,080	2,171
In month deficit	(420)	(186)	(605)
CCG Advance / (Repayment)	(2,570)	(2,520)	(2,520)
Non cash flows in surplus/(deficit)	1,028	1,030	1,043
Movement in receivables (debtors)	375	450	450
Movement in payables (creditors)	(3,482)	(2,580)	(2,630)
Capital expenditure	(949)	(1,016)	(1,070)
Drawdown of loans	2,136	2,644	3,655
Other working capital movements	2,195	2,269	2,698
Closing balance	**2,080**	**2,171**	**3,192**

The cash position, ultimately determined by the operating performance of the trust, is extremely challenging and even with a £14.2m loan the cash planned balance as at 31st March is £4.5m, 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 table below summarises the cash impact of a worsening financial position.

Narrative	£m	£m	£m
Deficit			
Forecast deficit	(14.2)	(14.2)	(14.2)
Increase in deficit	0.0	(3.3)	(4.5)
Revised forecast deficit	(14.2)	(17.5)	(18.7)
Cash			
Forecast cash balance as at 31st March	4.5	4.5	4.5
Increase in deficit	0.0	(3.3)	(4.5)
Revised cash balance as at 31st March	4.5	1.2	0.0

Assuming no other movements in working capital an increase in the deficit to £17.5m will reduce the cash by £3.3m and result in a year end cash balance of £1.2m. This equates to 2 days operational cash which is the minimum that Monitor requires all Foundation Trusts to have at the end of each month. An increase in the deficit to £18.7m will result in a year end cash balance of zero.

Should the position deteriorate beyond £14.2m then the Trust will need to manage the working balances by a combination of some or all of the following: reducing the outstanding debt, continuing to extend creditor payments or by reducing the capital programme.

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 25% in the month (25% year to date). This low level of compliance and performance will continue until there is an improvement in the operating position and the resultant cash position.

7. STATEMENT OF FINANCIAL POSITION

Non current assets have decreased by £1k in the month with capex spend matching depreciation and receivables.

Current assets have decreased by £1,986k in the month mainly due to the decrease in receivables, prepayments and cash.

Current liabilities have decreased by £732k in the month mainly due to the decrease in payables, partially offset by an increase in the PDC creditor and deferred income.

Non current liabilities have decreased by £28k in the month.

8. RISK AND FORECAST OUTTURN

For the period ending 31st October the Trust has recorded a deficit of £11,226k, which is £1,747k worse than the planned deficit of £9,519k.

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

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

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

Tim Barlow
Director of Finance & Commercial Development
18th November 2015

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Financial headlines as at 31st October 2015

Key Financial Metrics	Month			Year to date		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income	18,237	19,329	1,092	124,079	127,335	3,255
Operating Expenditure	-17,706	-19,572	-1,865	-127,133	-132,164	-5,031
EBITDA	**531**	**-243**	**-773**	**-3,054**	**-4,830**	**-1,776**
Financing Costs	-981	-983	-2	-6,465	-6,437	28
Net Surplus / (Deficit)	**-450**	**-1,226**	**-776**	**-9,519**	**-11,266**	**-1,747**
Continuity of Services Risk Rating				1	1	0
Capital Expenditure	1,099	600	-499	4,415	4,319	-96
Cost Savings	1,202	1,324	122	3,333	3,528	195
Cash Balance				2,021	3,766	1,745

Summary Position

The in month position is an actual deficit of £1,266k which is £776k worse than the planned deficit of £450k.

The year to date position is an actual deficit of £11,266k which is £1,747k worse than the planned deficit of £9,519k.

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

Year to date income is £3,255k above plan due to an over recovery on NHS clinical income and other operating income, partially offset by an under recovery on non NHS clinical income. Year to date expenditure is £5,031k above plan due to overspends on pay, drugs, clinical supplies and non clinical supplies. Year to date non operating income and expenditure is £30k below plan mainly due to an underspend on depreciation.

Key Variances on year to date position

Operating Income	
NHS Clinical Income	£759k above plan.
Non NHS Clinical income	£76k below plan.
Other Operating Income	£2,572k above plan.
Total	**£3,255k above plan**
Operating Expenditure	
Pay	£3,161k above plan.
Drugs	£442k above plan.
Clinical Supplies	£854k above plan.
Non Clinical Supplies	£574k above plan.
Total	**£5,031k above plan.**
Non operating income and expenses	
Loss on sale of fixed assets	£98k below plan.
Net Interest	£59 below plan.
Depreciation	£131k below plan.
PDC Dividends	£62k above plan.
Total	**£30k below plan.**
Capital expenditure	£96k below plan.
Cost Savings	£195k above plan.
Cash balance	£1,745k above plan.

Other matters to be brought to the attention of the Board

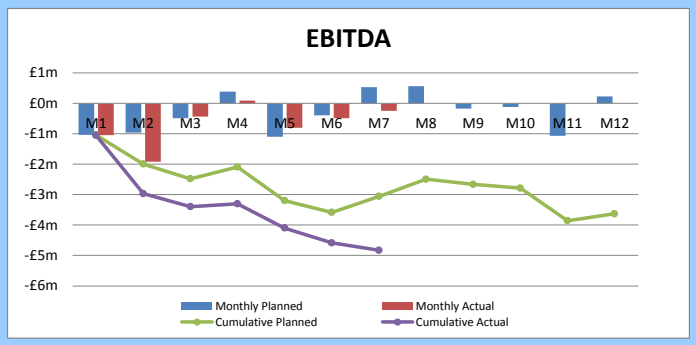
On the 12th August the Trust was placed in breach of it's licence with Monitor and therefore agreed to a number of Enforcement Undertakings which have resulted in the Trust forecasting a revised 15/16 deficit of £14.2m. The Enforcement Undertakings the Trust is required to submit an initial 16/17 financial plan by 30th November that with all actions that are reasonably possible, seeks to minimise the deficit and in addition to seek to move to a breakeven position.

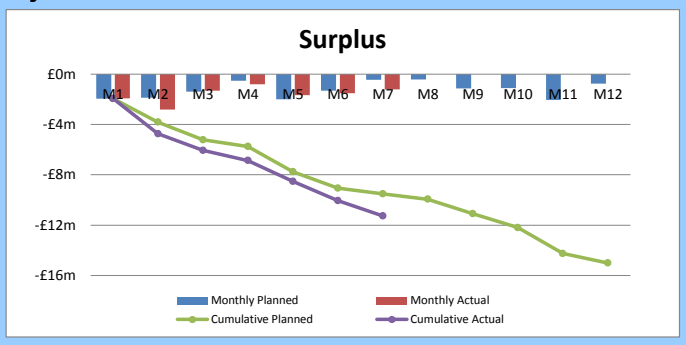
The reduction in the cash balance caused by the deteriorating financial performance, means that cash support is required, so a working capital loan of £14.2m has been agreed with the Department of Health, repayable over 30 months at 1.5%. The first instalment of the loan equating to £2.1m was drawn down by the Trust on 16th November and monthly draw downs are planned over the remainder of the year.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.

Warrington & Halton Hospitals NHS Foundation Trust

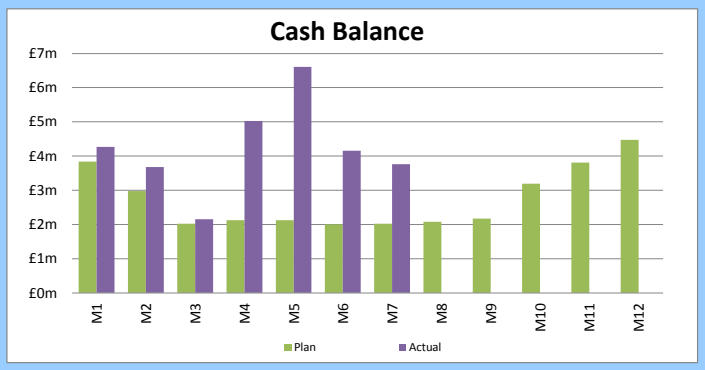
Finance Dashboard as at 31st October 2015 (Part A)

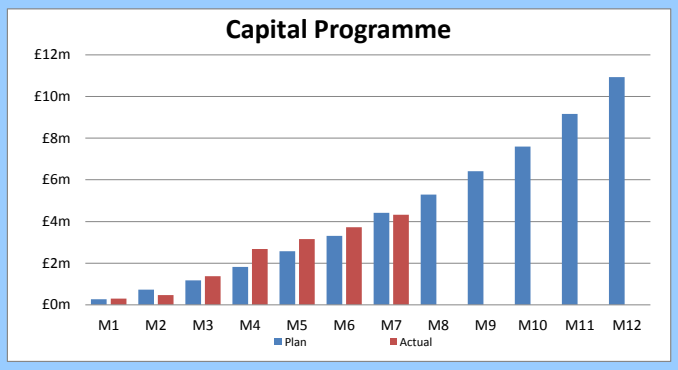
Profitability



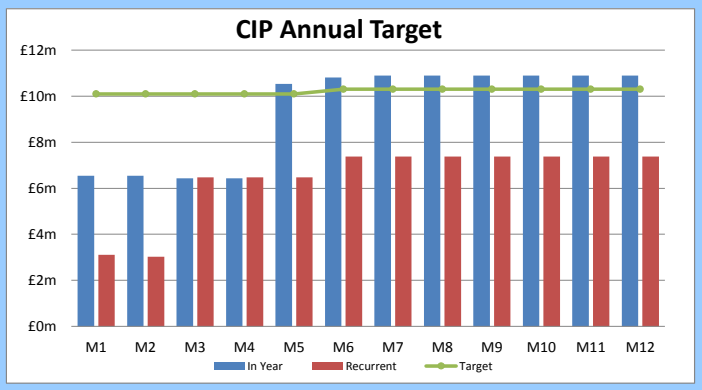


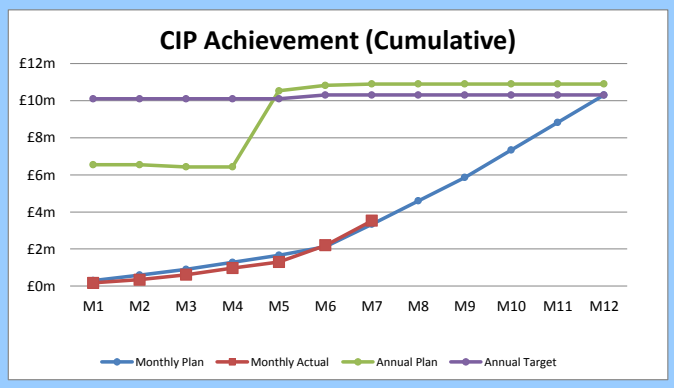
Cash and Investment





Cost Improvement Analysis





Divisional Position (net divisional income and expenditure)

Division	Annual Budget £000	Budget in month £000	Actual in month £000	Variance in month £000	Variance in month %	Budget to date £000	Actual to date £000	Variance to date £000	Variance date %
Clinical									
Scheduled Care	55,995	4,649	4,899	-250	-5.4	33,292	33,787	-495	-1.5
Unscheduled Care	46,037	4,036	4,283	-247	-6.1	27,440	28,836	-1,396	-5.1
Womens Children & Support Services	58,971	5,205	5,183	21	0.4	35,813	35,757	55	0.2
Corporate									
Operations - Central	533	85	138	-53	-62.8	330	313	17	5.3
Operations - Estates	7,440	588	599	-11	-1.9	4,104	4,137	-33	-0.8
Operations - Facilities	7,847	653	613	40	6.2	4,580	4,389	192	4.2
Finance	12,940	1,076	1,053	23	2.1	7,558	7,408	151	2.0
HR & OD	4,140	346	361	-15	-4.3	2,405	2,315	89	3.7
Information Technology	4,007	338	487	-149	-44.1	2,379	2,462	-83	-3.5
Nursing & Governance	2,931	248	229	19	7.5	1,690	1,639	52	3.1
Research & Development	37	3	1	2	77.5	20	19	0	1.4
Strategy, Partnerships & Comms	621	49	162	-113	-232.5	377	497	-120	-31.7
Trust Executive	2,091	163	158	6	3.6	1,277	1,349	-73	-5.7
Total	**203,591**	**17,438**	**18,166**	**-728**	**-4.2**	**121,265**	**122,907**	**-1,642**	**-1.4**

Positive variance = underspend, negative variance = overspend.

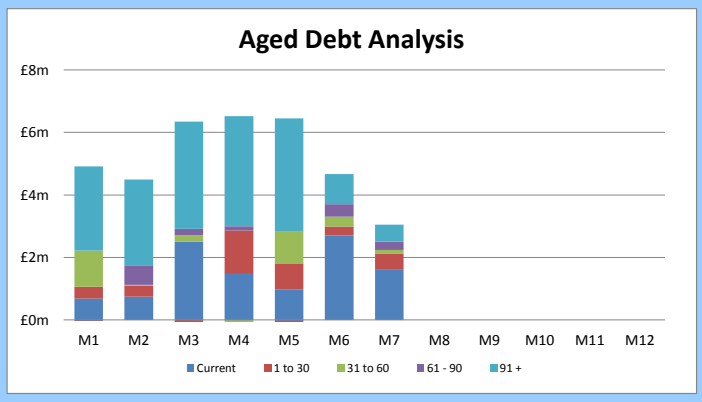
Financial Sustainability Risk Rating

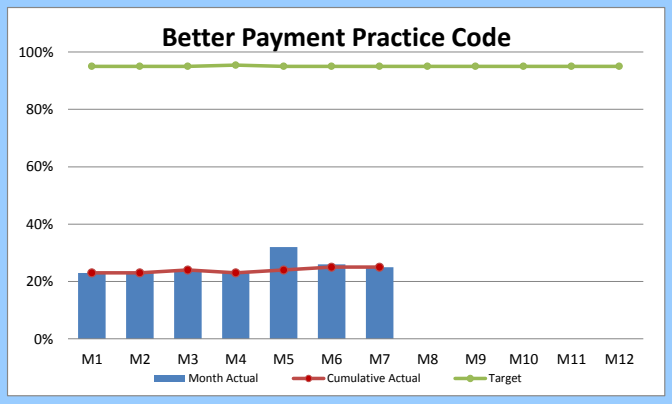
Financial Sustainability Risk Rating	Actual Metric	Actual Rating
Liquidity Ratio (days)	-1.9	1
Capital Servicing Capacity (times)	-24.1	1
Income & Expenditure Margin (%)	-8.8%	1
Income & Expenditure Margin as a % of plan (%)	-1.1%	2
Overall Risk Rating		**1**

Warrington & Halton Hospitals NHS Foundation Trust

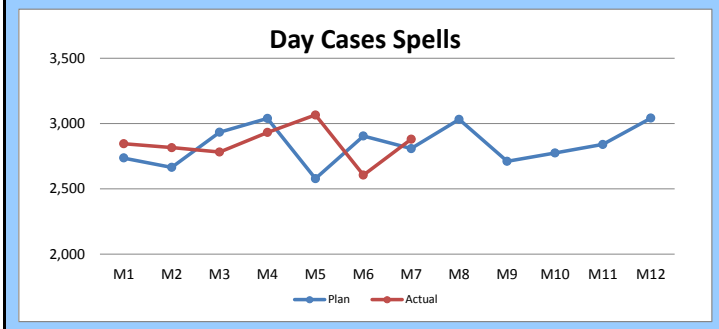
Finance Dashboard as at 31st October 2015 (Part B)

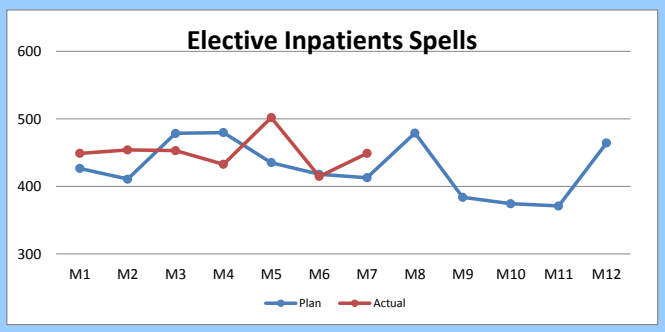
Balance Sheet and Liquidity

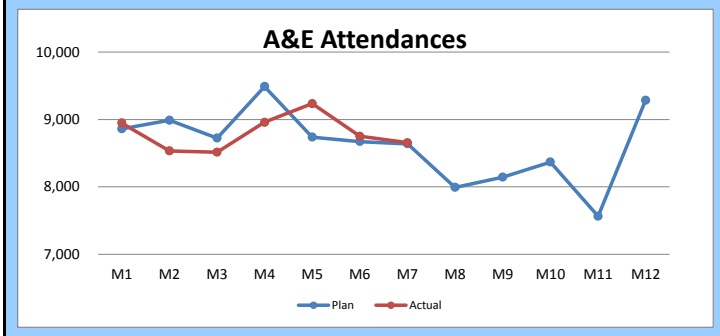


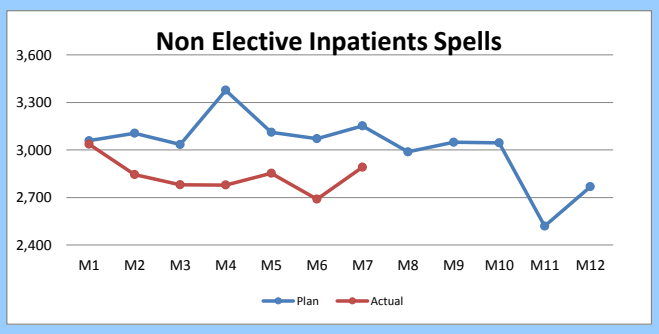


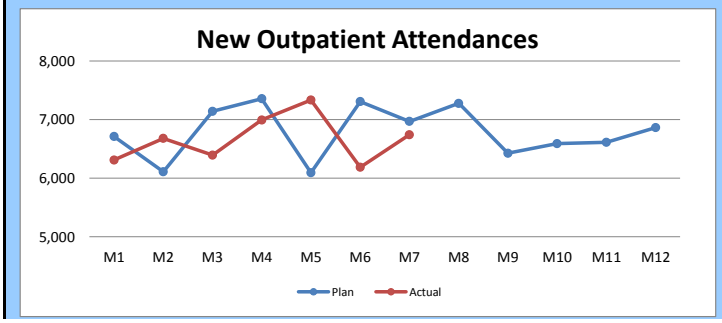
Activity Analysis

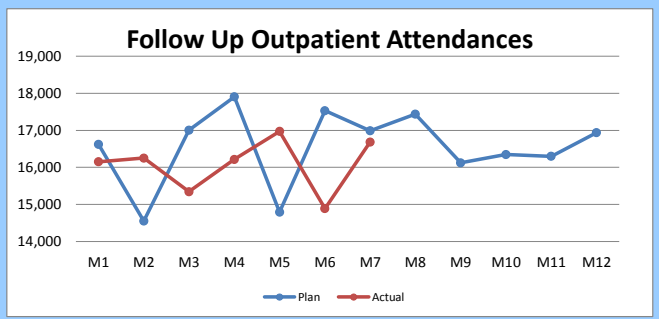












Warrington & Halton Hospitals NHS Foundation Trust **Appendix C**

Income Statement, Activity Summary and Risk Ratings as at 31st October 2015

Income Statement	Month			Year to date			Forecast		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income									
NHS Activity Income									
Elective Spells	3,136	3,120	-16	21,545	22,022	478	37,608	39,281	1,673
Elective Excess Bed Days	20	19	-1	136	102	-34	232	201	-31
Non Elective Spells	4,730	4,720	-10	31,816	30,030	-1,786	54,067	50,210	-3,857
Non Elective Excess Bed Days	279	216	-62	1,930	1,814	-116	3,190	3,572	382
Outpatient Attendances	3,058	2,784	-274	20,128	19,900	-227	35,068	35,235	167
Accident & Emergency Attendances	856	953	97	6,132	6,580	449	10,171	10,823	652
Other Activity	4,661	5,568	906	31,955	33,951	1,996	55,023	59,121	4,098
Sub total	**16,741**	**17,379**	**639**	**113,641**	**114,400**	**759**	**195,359**	**198,443**	**3,084**
Non Mandatory / Non Protected Income									
Private Patients	9	7	-2	62	79	17	106	104	-2
Other non protected	107	91	-16	749	655	-94	1,284	1,175	-109
Sub total	**116**	**98**	**-18**	**811**	**734**	**-76**	**1,390**	**1,279**	**-111**
Other Operating Income									
Training & Education	588	586	-2	4,116	4,099	-17	7,056	7,080	24
Donations and Grants	0	2	2	0	2	2	0	0	0
Miscellaneous Income	793	1,264	471	5,512	8,099	2,588	9,475	12,737	3,262
Sub total	**1,381**	**1,852**	**471**	**9,628**	**12,200**	**2,572**	**16,532**	**19,817**	**3,285**
Total Operating Income	**18,237**	**19,329**	**1,092**	**124,079**	**127,335**	**3,255**	**213,281**	**219,539**	**6,258**
Operating Expenses									
Employee Benefit Expenses (Pay)	-12,658	-13,748	-1,090	-91,076	-94,237	-3,161	-155,274	-160,227	-4,953
Drugs	-1,148	-1,298	-150	-8,061	-8,503	-442	-13,802	-14,619	-817
Clinical Supplies and Services	-1,633	-2,066	-433	-11,360	-12,214	-854	-19,530	-20,142	-612
Non Clinical Supplies	-2,267	-2,460	-192	-16,636	-17,211	-574	-28,304	-27,495	809
Total Operating Expenses	**-17,706**	**-19,572**	**-1,865**	**-127,133**	**-132,164**	**-5,031**	**-216,910**	**-222,483**	**-5,573**
Surplus / (Deficit) from Operations (EBITDA)	**531**	**-243**	**-773**	**-3,054**	**-4,830**	**-1,776**	**-3,629**	**-2,944**	**685**
Non Operating Income and Expenses									
Profit / (Loss) on disposal of assets	0	-137	-137	0	-98	-98	0	0	0
Interest Income	3	2	-2	23	13	-10	40	23	-17
Interest Expenses	-71	-4	67	-95	-26	69	-451	-312	139
Depreciation	-569	-556	14	-3,986	-3,856	131	-6,834	-6,734	100
PDC Dividends	-344	-288	56	-2,407	-2,469	-62	-4,126	-4,233	-107
Restructuring Costs	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Total Non Operating Income and Expenses	**-981**	**-983**	**-2**	**-6,465**	**-6,437**	**28**	**-11,371**	**-11,256**	**115**
Surplus / (Deficit)	**-450**	**-1,226**	**-776**	**-9,519**	**-11,266**	**-1,747**	**-15,000**	**-14,200**	**800**
Activity Summary	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**
Elective Spells	3,238	3,294	56	22,842	23,081	239	39,201	40,249	1,048
Elective Excess Bed Days	93	90	-3	625	481	-144	1,068	782	-286
Non Elective Spells	3,153	2,970	-183	21,913	19,877	-2,036	36,284	32,702	-3,582
Non Elective Excess Bed Days	1,312	1,007	-305	9,088	8,528	-560	15,020	16,616	1,596
Outpatient Attendances	28,734	27,160	-1,574	196,010	194,389	-1,621	336,500	344,328	7,828
Accident & Emergency Attendances	8,639	8,945	306	62,110	61,594	-516	103,464	102,033	-1,431
Financial Sustainability Risk Ratings	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**
Metrics									
Capital Servicing Capacity (Times)				-1.2	-1.9	-0.7	-0.8	-0.6	0.1
Liquidity Ratio (Days)				-14.2	-24.1	-9.9	-11.5	-9.9	1.6
I&E Margin (%)				-0.1	-0.1	0.0	-0.1	-0.1	0.0
I&E Margin as % of plan (%)				0.0	0.0	0.0	0.0	0.0	0.0
Ratings									
Capital Servicing Capacity (Times)				1	1	0.0	1	1	0.0
Liquidity Ratio (Days)				1	1	0.0	2	2	0.0
I&E Margin (%)				1	1	0.0	1	1	0.0
I&E Margin as % of plan (%)				2	2	0.0	2	4	2.0
Financial Sustainability Risk Rating				**1**	**1**	**0**	**2**	**2**	**0**

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

Cash Flow Statement as at 31st October 2015

	Actual April £000's	Actual May £000's	Actual June £000's	Actual July £000's	Actual August £000's	Actual September £000's	Actual October £000's	Forecast November £000's	Forecast December £000's	Forecast January £000's	Forecast February £000's	Forecast March £000's	Annual Position March £000's
Surplus/(deficit) after tax	**(1,936)**	**(2,811)**	**(1,313)**	**(798)**	**(1,660)**	**(1,522)**	**(1,226)**	**(420)**	**(933)**	**(605)**	**(665)**	**(311)**	**(14,200)**
Non-cash flows in operating surplus/(deficit)													
Finance (income)/charges	1	1	3	2	2	2	**2**	78	80	80	80	80	411
Depreciation and amortisation	543	548	536	548	561	565	**556**	595	595	595	595	597	6,834
(Gain)/loss on disposal of property plant and equipment					(45)	7	**137**					(99)	0
PDC dividend expense	344	344	344	344	344	462	**288**	342	342	342	342	395	4,233
Other increases/(decreases) to reconcile to profit/(loss) from operations	(9)	(4)	8	(9)	(10)	(17)	(46)	13	13	26	27	284	276
Non-cash flows in operating surplus/(deficit), Total	**879**	**889**	**891**	**885**	**852**	**1,019**	**937**	**1,028**	**1,030**	**1,043**	**1,044**	**1,257**	**11,754**
Operating Cash flows before movements in working capital	**(1,057)**	**(1,922)**	**(422)**	**87**	**(808)**	**(503)**	**(289)**	**608**	**97**	**438**	**379**	**946**	**(2,446)**
Increase/(Decrease) in working capital													
(Increase)/decrease in inventories	392	(147)	(132)	(93)	232	(433)	441					(260)	0
(Increase)/decrease in NHS Trade Receivables	1,832	526	(1,082)	(675)	136	1,707	1,056	250	250	250	250	(3,199)	1,300
(Increase)/decrease in Non NHS Trade Receivables	303	12	(658)	(280)	16	(116)	595	125	200	200	200	203	800
(Increase)/decrease in other related party receivables	(266)	292	(277)	(256)	548	194	(209)					(25)	0
(Increase)/decrease in other receivables	412	(63)	66	19	(3)	(22)	(11)					(398)	(0)
(Increase)/decrease in accrued income	(390)	(1,518)	523	405	(469)	1,232	(984)					1,202	0
(Increase)/decrease in prepayments	(1,302)	(960)	1,692	(51)	50	(577)	569	350	350	350	350	(23)	800
Increase/(decrease) in Deferred Income (Govt. Grants)	255	2,912	254	5,769	1,002	665	421					(11,279)	(0)
Increase/(decrease) in Current provisions	(71)	1	6	8	7	3	(6)	(20)	(20)	(20)	(20)	(106)	(240)
Increase/(decrease) in Trade Creditors	(1,475)	(80)	474	(439)	1,776	(3,111)	(1,228)	(4,184)	(2,333)	(2,701)	(3,340)	13,547	(3,095)
Increase/(decrease) in Other Creditors	(160)	73	(33)	(156)	9	79	(64)					252	0
Increase/(decrease) in accruals	1,402	659	(1,289)	(328)	(482)	1,346	(178)					(1,130)	(0)
Increase/(decrease) in other Financial liabilities (borrowings)	64	3	695	(49)	4	4	4					(727)	(0)
Increase/(decrease) in Other liabilities (VAT, Social Security and Other Taxes)	75	11	(47)	51	(133)	92	49					(98)	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**	**(3,479)**	**(1,553)**	**(1,921)**	**(2,560)**	**(2,041)**	**(435)**
Increase/(decrease) in Non-current provisions	58	12	(66)	(17)	12	12	(32)					20	(0)
Net cash inflow/(outflow) from operating activities	**70**	**(188)**	**(296)**	**3,994**	**1,899**	**573**	**135**	**(2,871)**	**(1,456)**	**(1,483)**	**(2,181)**	**(1,075)**	**(2,880)**
Net cash inflow/(outflow() from investing activities													
Property - new land, buildings or dwellings	(70)	(90)	(18)	(326)	(122)	(23)	(206)	(225)	(225)	(225)	(225)	(245)	**(2,000)**
Property - maintenance expenditure	(150)	(58)	(56)	(28)	(160)	(33)	(49)	(192)	(224)	(275)	(654)	(1,042)	**(2,921)**
Plant and equipment - Information Technology	(58)	4	(718)	(530)	(80)	(490)	(283)	(294)	(235)	(250)	(216)	(330)	**(3,480)**
Plant and equipment - Other	(23)	(13)	(114)	(431)	(108)	(24)	(62)	(238)	(332)	(320)	(327)	(547)	**(2,539)**
Proceeds on disposal of property, plant and equipment					78		12					(90)	0
Increase/(decrease) in Capital Creditors		(252)	(300)	181	80	(263)	(14)					569	0
Net cash inflow/(outflow() from investing activities, Total	**(301)**	**(409)**	**(1,206)**	**(1,134)**	**(312)**	**(833)**	**(602)**	**(949)**	**(1,016)**	**(1,070)**	**(1,422)**	**(1,685)**	**(10,940)**
Net cash inflow/(outflow) before financing	**(231)**	**(597)**	**(1,502)**	**2,860**	**1,586**	**(260)**	**(467)**	**(3,820)**	**(2,472)**	**(2,553)**	**(3,603)**	**(2,760)**	**(13,820)**
Net cash inflow/(outflow) from financing activities													
PDC Dividends paid						(2,181)						(2,052)	(4,233)
Interest (paid) on non-commercial loans									(78)	(78)	(78)	(78)	(312)
Interest element of finance lease rental payments - other	(2)	(3)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	41	0
Interest received on cash and cash equivalents	3	2	1	2	3	2	2	2	1	2	2	1	23
Drawdown of non-commercial loans	0	0	0					2,136	2,644	3,655	4,300	5,568	18,303
(Increase)/decrease in non-current receivables	(8)	0	(11)	5	0	(12)	83					(59)	(0)
Net cash inflow/(outflow) from financing activities, Total	**(7)**	**(1)**	**(14)**	**3**	**(1)**	**(2,195)**	**81**	**2,134**	**2,563**	**3,575**	**4,220**	**3,421**	**13,781**
Net increase/(decrease) in cash	**(238)**	**(598)**	**(1,517)**	**2,864**	**1,586**	**(2,455)**	**(386)**	**(1,686)**	**91**	**1,022**	**617**	**661**	**(40)**
Opening cash	**4,511**	**4,273**	**3,675**	**2,159**	**5,022**	**6,608**	**4,153**	**3,766**	**2,080**	**2,171**	**3,193**	**3,810**	**4,511**
Closing cash	**4,273**	**3,675**	**2,159**	**5,022**	**6,608**	**4,153**	**3,766**	**2,080**	**2,171**	**3,193**	**3,810**	**4,471**	**4,471**

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

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

Statement of Position as at 31st October 2015

Narrative	Audited position as at 31/03/15 £000	Actual Position as at 30/09/15 £000	Actual Position as at 31/10/15 £000	Monthly Movement £000	Forecast Position as at 31/03/16 £000
ASSETS					
Non Current Assets					
Intangible Assets	567	1,178	1,183	6	865
Property Plant & Equipment	143,355	143,081	143,015	-66	146,360
Other Receivables	1,336	1,215	1,341	126	1,336
Impairment of receivables for bad & doubtful debts	-253	-228	-295	-67	-253
Total Non Current Assets	**145,005**	**145,245**	**145,244**	**-1**	**148,308**
Current Assets					
Inventories	3,312	3,492	3,051	-441	3,312
NHS Trade Receivables	5,627	3,184	2,128	-1,056	4,326
Non NHS Trade Receivables	1,364	1,496	900	-595	564
Other Related party receivables	585	350	560	209	585
Other Receivables	1,865	1,537	1,422	-115	1,864
Impairment of receivables for bad & doubtful debts	-321	-330	-347	-16	-321
Accrued Income	882	1,100	2,084	984	882
Prepayments	2,498	3,645	3,075	-569	1,698
Cash held in GBS Accounts	4,486	4,134	3,748	-386	4,446
Cash held in commercial accounts	0	0	0	0	0
Cash in hand	25	19	19	0	25
Total Current Assets	**20,323**	**18,627**	**16,641**	**-1,986**	**17,381**
Total Assets	**165,328**	**163,872**	**161,885**	**-1,987**	**165,689**
LIABILITIES					
Current Liabilities					
NHS Trade Payables	-2,351	-776	-1,031	-255	-6,484
Non NHS Trade Payables	-8,134	-6,853	-5,371	1,482	-301
Other Payables	-1,856	-1,667	-1,604	64	-1,853
Other Liabilities (VAT, Social Security and Other Taxes)	-2,667	-2,717	-2,765	-49	-2,667
Capital Payables	-1,599	-516	-501	14	-1,599
Accruals	-5,765	-7,073	-6,895	178	-5,765
Interest payable on non commercial int bearing borrowings	0	0	0	0	0
PDC Dividend creditor	-76	0	-288	-288	-76
Deferred Income	-974	-11,831	-12,252	-421	-974
Provisions	-335	-287	-281	6	-295
Loans non commercial	0	0	0	0	0
Borrowings	-185	-332	-332	0	-185
				0	
Total Current Liabilities	**-23,942**	**-32,053**	**-31,321**	**732**	**-20,199**
Net Current Assets (Liabilities)	**-3,619**	**-13,426**	**-14,679**	**-1,254**	**-2,818**
Non Current Liabilities					
Loans non commercial	0	0	0	0	-18,303
Provisions	-1,395	-1,407	-1,375	32	-1,395
Borrowings	-703	-1,164	-1,168	-4	-703
Total Non Current Liabilities	**-2,098**	**-2,570**	**-2,543**	**28**	**-20,401**
TOTAL ASSETS EMPLOYED	**139,288**	**129,249**	**128,022**	**-1,227**	**125,089**
TAXPAYERS AND OTHERS EQUITY					
Taxpayers Equity					
Public Dividend Capital	90,242	90,242	90,242	0	90,242
Retained Earnings prior year	3,970	3,969	3,969	0	3,970
Retained Earnings current year	0	-10,039	-11,266	-1,227	-14,200
Sub total	**94,212**	**84,172**	**82,945**	**-1,227**	**80,012**
Other Reserves					
Revaluation Reserve	45,077	45,077	45,077	0	45,077
Sub total	**45,077**	**45,077**	**45,077**	**0**	**45,077**
TOTAL TAXPAYERS AND OTHERS EQUITY	**139,289**	**129,249**	**128,022**	**-1,227**	**125,089**

BOARD OF DIRECTORS

W&HHFT/TB/B/15/ 222

SUBJECT:	**CORPORATE PERFORMANCE REPORT**	
DATE OF MEETING:	25th November 2015	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):		
EXECUTIVE DIRECTOR:	Jan Ross Acting Chief Operating Officer	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework Choose an item. Choose an item. Choose an item. Choose an item.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None Choose an item. Choose an item.	
EXECUTIVE SUMMARY (KEY ISSUES):	This corporate report updates the Board on the progress of the Trust in relation to activity, performance and workforce targets to 31st of October 2015.	
RECOMMENDATION:	***The Board is asked to:*** Note the content of the Report	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee
	Agenda Ref.	
	Date of meeting	16th November 2015
	Summary of Outcome	Noted

NATIONAL KEY PERFORMANCE INDICATORS

EXECUTIVE SUMMARY

The corporate report gives the Board an update on current performance and key actions being taken to address areas of concern. The report is in relation to activity performance targets to 31st October 2015.

CONTEXT

The Trust continues to meet the majority of national and local performance targets, with the exception of the four hour standard.

MAIN BODY

With the support of a team of interim managers we have set about some key actions throughout the organisation to enable sustainable delivery of the four hour standard. There is a detailed action plan which incorporates all the keys issues raised through the UM report. The team meet weekly as a task force to ensure the key actions are happening within the agreed time frame, and issues are logged and escalated as appropriate.

The main changes to date have been the move to define assessment space in both scheduled and unscheduled care. SAU was moved the first week in October to an area where patients cannot be bedded overnight therefore enabling us to have assessment space free at 8am every morning. GPAU was redefined as assessment space on the 4th November again ensuring we have assessment space to start each day. Although these actions have been difficult and have had an impact on performance the long term plan will ensure we assess and manage our patients in the most appropriate place, thus impacting on correct bed allocation a reduction in outliers and overall Length of stay.

We have also had a focus on patient flow through the hospital bringing the teams together both geographically as well as in the bed meetings. The bed meetings have been restructured and the information required at those meetings defined to ensure accurate information is being acted upon.

NEXT STEPS

There remain a lot of further key actions including defining roles and responsibilities within the Accident and Emergency department. A focus on triage and senior clinical decision making to ensure the majority of patients are seen within 60 minutes. We are in the process of setting up the ED task force and establishing the baseline data.

RECOMMENDATIONS

The Board is recommended to take note of the report and key actions.

CONCLUSION

The Board is asked to take assurance from the report that key actions are taking place to sustainably address ongoing failure to achieve the four hour standard, whilst noting that Lorenzo go live in November may have an impact on performance targets.

APPENDIX 1

Oct-15

Monitor Access Targets & Outcomes - 2015/16

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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

All targets are QUARTERLY

Target or Indicator		Threshold	Weighting	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4
Referral to treatment waiting time	Admitted patients	90%	N/A	92.55%	93.48%	93.14%	93.05%	92.05%	93.01%	92.74%	92.57%	92.31%							
	Non-admitted patients	95%	N/A	97.53%	97.18%	98.13%	97.64%	97.71%	97.52%	97.51%	97.58%	97.91%							
	Incomplete Pathways	92%	1.0	93.38%	94.30%	93.84%	93.87%	93.10%	93.49%	93.08%	93.23%	92.83%							
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%							
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%	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%							
	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%	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%							
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%							
	Anti Cancer Drug Treatments	>98%		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%							
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%							
	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%							
Clostridium Difficile - Hospital acquired **(CUMULATIVE)**	Due to lapses in care	27 (for the Yr)	1.0 **	0	1	4	4	5	5	8	8	8							
	Not due to lapses in care			3	7	8	8	8	8	9	9	9							
	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							
	Under Review			0	0	0	0	0	0	0	0	3							
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							

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							
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							
CQC enforcement action within last 12 months (as at time of submission)	N/A		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							
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							
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission) Breach of regulation 23 (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010 regarding the safety of healthcare provision	N/A		No	No	No	No	Yes	Yes	Yes	Yes	Yes							
Overall rating from CQC inspection (as at time of submission)	N/A		Not received at the time of reporting				Requires Improvement											
CQC recommendation to place trust into Special Measures (as at time of submission)	N/A		No	No	No	No	No	No	No	No	No							
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A		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**							

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.

BOARD OF DIRECTORS

W&HHFT/TB/B/15/223

SUBJECT:	Improving & Sustaining Cancer Performance	
DATE OF MEETING:	25th November 2015	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Anita Corrigan, Senior Manager	
EXECUTIVE DIRECTOR:	Jan Ross, Acting Chief Operating Officer	
LINK TO STRATEGIC OBJECTIVES:	SO3: To give our patients the best possible experience	
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):	In July 2015 a national tripartite letter concerning the 62 day cancer standard was sent to all providers. This required every Trust to complete an assurance statement on the eight high priority actions identified by the national Cancer Waiting Times Taskforce. The following report is to provide the Trust Board with an update on local compliance against the eight priorities.	
RECOMMENDATION:	***The Board is asked to:*** Note progress on the achievement of the eight high priority actions and the action being taken to address shortfalls where appropriate.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Not Applicable

Improving and Sustaining Cancer Performance

1. EXECUTIVE SUMMARY

Monitor, the National Trust Development Authority and NHS England have agreed to lead a national delivery group for improving 62 day performance which will work closely with the Cancer Waiting Time Taskforce and Intensive Support Team. This paper, and associated action plan, sets out the requirements of the Trust with regards to the key streams of work.

2. BACKGROUND

Whilst the overall performance against cancer targets has been generally good, national performance against the 62 day standard has been below the 85% threshold for the last 5 consecutive quarters. Conversely, WHH has consistently achieved this target throughout 2014/15 & Q1/2 2015/16.

In an effort to tackle these inequalities in outcomes and experience of people with cancer, the Cancer Waiting Time Taskforce has identified 8 key priorities for all local health systems to implement. These priorities offer practical actions to help providers, and also support CCGs with effective commissioning of cancer services, to ensure that robust cancer resilience planning is undertaken in the current financial year (2015/2016). The attached Action Plan charts WHH's progress to date and will be monitored through the monthly KPI Group.

3. INTER-PROVIDER TRANSFERS (IPT)

Further tripartite correspondence is expected requesting further action to improve overall 62 day cancer performance and specially focussing on those patients referral transfer to a specialist provider for treatment. Local agreement is that patients should be referred to the specialist provider on or before day 42; with delayed referrals resulting in a full breach reallocation to the referring organisation. This is currently being discussed at national level. In anticipation of this correspondence we are currently reviewing all Q2 inter-trust referrals to determine what actions need to be taken to improve local pathways.

	Recommendation	Lead	Timescale	Progress	Status/Action
1.	Does the Trust Board must have a named Executive Director responsible for delivering the national cancer waiting time standards?	Chief Operating Officer	N/A	Chief Operating Officer is the Executive Lead for the delivery of national cancer waiting times standards.	Complete
2.	Does the Board receive 62 day cancer wait performance reports for each individual cancer tumour pathway, not an all pathway average?	Cancer Manager	N/A	In place as of September 2015.	Complete
3.	Does the Trust have a cancer operational policy in place and approved by the Trust Board? *This should include the approach to auditing data quality and accuracy, the Trust approach to ensure MDT coordinators are effectively supported, and have sufficient dedicated capacity to fulfil the function effectively.*	Cancer Manager	Jan. 2016	Draft developed based on July 2015 recommendation. This is currently being reviewed in light of further recent (29.10.2015) tripartite guidance in relation to: • Backstop policy of 104 days • Demand and Capacity Planning • Inter-provider transfers and breach allocation • PTL management • Good Practice The draft policy will be circulated to operational managers/CCG colleagues for consultation in December 2015.	The final policy will presented to the Board in January 2016 for approval.
4.	Does the Trust maintain and publish a timed pathway, agreed with the local commissioners	Cancer Manager/Local CCG Commissioners	Jan. 2016	Clinical Leads in lung, colorectal, prostate and breast have reviewed & updated their	Appendices to cancer

	and any other Providers involved in the pathway, taking advice from the Clinical Network for the following cancer sites: lung, colorectal, prostate and breast? *These should specify the point within the 62 day pathway by which key activities such as OP assessment, key diagnostics, inter-Provider transfer and TCI dates need to be completed.*	/CMSCN		clinical pathways. These have been circulated to wider clinical leads for review & agreement 03.12.15. These will then form appendices in the cancer operational policy. Further pathway review is planned with head & neck; haematology; upper GI; gynaecology and remaining urology tumour sites. Timed Breast Pathway v.1.pdf Timed Colorectal Pathway v.1.pdf Timed Lung pathway v.1.pdf Timed Prostate Pathway v.1.pdf	operational policy which will presented to the Board in January 2016 for approval.
5.	Does the Trust maintain a valid cancer specific PTL and carry out a weekly review for all cancer tumour pathways to track patients and review data for accuracy and performance? *The Trust to identify individual patient deviation from the published pathway standards and agree corrective action.*	Cancer Manager	N/A	Cancer Tracker in place which provides operational managers with patient level detail for pathway escalation. Weekly cancer tracking meeting in place which reviews tracked patients & data for accuracy. A monthly KPI meeting reviews all access targets. In addition a monthly meeting takes place with CCG colleagues to review all cancer breaches & agree corrective actions.	Complete

6.	Is root cause breach analysis carried out for each pathway not meeting current standards, reviewing the last ten patient breaches and near misses (defined as patients who came within 48 hours of breaching)? *These should be reviewed in the weekly PTL meetings.*	Cancer Manager/ Divisional Managers/Local CCG commissioners	Dec. 2015	A root cause breach analysis is carried out for each pathway not meeting current standards. With effect from 01.12.15 this will include all near misses. In addition to weekly PTL and monthly KPI meeting, these will be reviewed monthly CCG colleagues. Q1/Q2 audit of near misses underway. This will be included in breach analysis for those pathways not achieving 85% target & reviewed at weekly PTL.	Implementation 01.12.2015
7.	Is capacity and demand analysis for key elements of the pathway not meeting the standard (1st OP appointment; treatment by modality) carried out? *There should also be an assessment of sustainable list size at this point.*	Cancer Manager/ Divisional Managers/ MDT Leads	Mar. 2016	Capacity & demand is reviewed annually. In addition, capacity is reviewed on an ad hoc basis when there are specific service issues. For 2016/17 we are mapping demand and capacity for some key elements of the cancer pathway – 2 week wait, diagnostic test e.g. endoscopy, cancer treatment and for each cancer tumour group utilising IST tools.	For completion March 2016.
8.	Is an Improvement Plan prepared for each pathway not meeting the standard, based on breach analysis, and capacity and demand modelling, describing a timetabled recovery trajectory for the relevant pathway to achieve the national standard. *This should be agreed*	Cancer Manager/ Divisional Managers/ MDT Leads	Jan. 2016	A network project group has been established to look at the issues affecting compliance with the cancer 62 day waiting times operating standard for lung cancer patients. The project group has been commissioned by NHSE. It has been	Appendix to cancer operational policy which will be presented to the Board in

	by local commissioners and any other providers involved in the pathway, taking advice from the local Cancer Clinical Network. Regional tripartite groups will carry out escalation reviews in the event of non-delivery of an agreed Improvement Plan.			identified that the issue in the pathway which requires focusing on is the time taken between first seen and decision to treat which can be variable due to a number of issues e.g. complexity/access to diagnostics/reporting times. A company called Methods Analytics, are assisting with the data collection for the project. In addition to the above & capacity/demand exercise (7.), we will develop action plans for each of our tumour sites, which will include: - Current performance issues - IPT performance - Risks to delivery - Investment/resource implication - Performance improvement trajectory	January 2016 for approval.

BOARD OF DIRECTORS

W&HHFT/TB/B/15/225

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

BOARD OF DIRECTORS

WHH/B/2015/ **226**

SUBJECT:	**QUALITY DASHBOARD (2015/2016) OCTOBER 2015**
DATE OF MEETING:	25th November 2015
ACTION REQUIRED	**For Assurance**
AUTHOR(S):	Ros Harvey (Corporate Nursing Programmes Manager) Hannah Gray (Clinical Effectiveness Manager)
EXECUTIVE DIRECTOR:	Karen Dawber, Director of Nursing and Governance Choose an item.
LINK TO STRATEGIC OBJECTIVES:	All Choose an item. Choose an item.
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework SO1/1.3 Failure to achieve infection control targets in accordance with the Risk Assessment Framework Choose an item. Choose an item. Choose an item.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED:	None
EXECUTIVE SUMMARY (KEY ISSUES):	The Quality Dashboard (at Appendix 1) includes 2015/2016 quality related KPIs from the:- • CQUINs – National (Local CQUINs will be monitored by the CQUIN monitoring group and reported by exception if required). • Quality Contract • Quality Account - Improvement Priorities and Quality Indicators • Sign up to Safety – national patient safety topics • Open and Honest initiative Please note that VTE and dementia are extracted for the

	purpose of the QDB in advance of submission via UNIFY at months end and may not show compliance with the threshold. (VTE – 95% and Dementia – 90%). This will be updated in next month's Quality Dashboard.	
RECOMMENDATION:	***The Board is asked to:*** 1. Note that the data for a number of indicators can change month on month. This applies to 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	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

Please see Appendix 1 for the quality dashboard data

1. HCAI

Clostridium difficile – 3 hospital apportioned Clostridium difficile cases were reported in October. YTD the Trust has reported 20 hospital apportioned cases of Clostridium difficile. The CCG review panel have removed 1 further case from contractual sanctions (Q2). Currently 9 cases have been removed from the total of hospital apportioned cases reported.

MRSA bacteraemia – A nil return was submitted for October. The review of the case reported in September identified difficulty in determining where the infection came from. The patient was MRSA negative on admission. Learning included use of a longer term IV access device and improvements to documentation of VIP score.

2. Regulation 28

The Trust received a PFD (Prevention of Future Deaths) from the Coroner as a result of an Inquest held into the death of a patient resulting from a fall which occurred in 2014. PFD's are issued under Schedule 5, Coroners and Justice Act 2009, which provides coroners with the duty to make reports to a person, organization, local authority or government department or agency where the coroner believes that action should be taken to prevent future deaths; formerly known as Rule 43 reports. The Trust has 56 days to respond to the Coroner to say what action is being taken (6thDecember 2015) to which the Trust will have the actions completed.

The Coroner issued 3 Concerns within the PFD:

1. The patient had been left unattended on 2 occasions in close proximity by two different staff and therefore 1-1 care was not provided
2. The documentation completed stated that the fall was witnessed when in fact it was not and this meant the patient should have been placed on neurological observations

3. There was lack of Clarity at the Inquest that the patient who had a Glasgow Coma Scale of 15 should have been put on neurological observations and that the Guidance provided by the Trust was unclear

Assessment and Risk:
The PFD has been reviewed and an action plan put in place led by the Executive Director of Nursing. The Action Plan includes:

- Sending out a Safety Alert to all Clinical staff to remind them of the importance of 1-1 care and record keeping standards re documentation. **Completed**
- Review of the 1-1 Policy to see if any changes need to be made. **In progress**
- Review of the Falls Training Programme to ensure clear, consistent and important messages run through the educational sessions provided. **In progress**
- Review of the Falls Pathway to see if any changes are required. **In progress**
- Review of Level 1 &2 Investigations to the Falls Group and reporting Learning and Improvements Trust wide. **In progress**
- Review of the Policy for Standard Physiological and Neurological Observations to there is clarity for staff to the level of observations. **In progress**
- To present at NMAC, Patient Experience Group and Patient Safety Sub Committee and onto DIGGs re Findings of the PFD and Learning and Improvement as a result. **Dates planned and presentation completed**

Recommendations
1. That progress is monitored via the Quality Committee
2. All actions to be completed within 56 days of issue of the notice

3. Sepsis

Part 1 - Sepsis screening of all eligible patients admitted to emergency areas and Part 2 - antibiotics given within an appropriate timescale. These results will be shared with the CCG in order to agree the threshold for quarter 3. The main issues for part one were the omission of lactate.

Part 2 - areas of non-compliance, the patients:

- Did not get antibiotics at all
- Were given antibiotics after 60 min of presentation, and no lactate was available
- Were given antibiotics within an hour of the lactate being taken but not within an hour of presentation

4. SHMI (Summary Hospital-level Mortality Indicator)

The 12 month rolling SHMI has been rebased and the 12 month rolling figure has remained static at 114 for 4 months. The Trust continues to compare well with local peers regarding crude death rates; this is 2.3% to date in 2015/2016. The trust's death rate for the same period in 2014/15 was 2.2% and for whole of 2014/2015 was 2.5%. The Mortality Review Group has agreed the revised Reducing Avoidable Mortality action plan and will monitor progress against this. The Trust Board will receive the next Mortality Overview Report at the January 2016 Trust Board meeting.

5. Advancing Quality

Advancing Quality (AQ) is a local CQUIN for the trust and we are performance managed for each agreed condition in order to demonstrate an annual improvement against the targets. AQ measures

are monitored and reported via a designated monthly AQ Group, which meets to share good practice and explore ways of improving compliance.

Heart Failure – the cumulative appropriate care score to include August is 81.15%; below the target of 84.1% for the Q1 CQUIN. The CQUIN payment is based on quarterly cumulative data and we have not achieved the Heart Failure measure, with a penalty of £21,888 for Q1. Although the target is still not being met, cumulative compliance has increased each month in 2015/2016.

The non-compliance issues relate to the following:-

- HF Specialist review <72 hours of HF documentation
- Written Discharge Instructions Given and Discussed

6. Always Events

Although the target of 100% is not yet being met, we have sustained an improvement each month since April 2015, from 89% in April 2015, to 96% in both July and August 2015. September fell to 88% and October is at 94%. Quarter 1 compliance is 90%, rising to 93% for quarter 2.

7. Care Indicators: risk assessments

The care indicators audit process was developed as part of the High Quality Care CQUIN for 2013/2014 to audit compliance (random sample) with risk assessments for Falls, Waterlow and MUST. The Trust monitored this as a Quality Indicator for the Quality Accounts in 2014/2015 and due to non-compliance at year end (achieving below 95%), has decided to continue monitoring this for 2015/2016. The audit includes all patients* and any non-compliance issues will be addressed by ward managers and the patient quality and safety champion, with compliance and progress monitored by the Patient Experience Sub Committee. Although not yet meeting the target for MUST, the data shows increasing compliance from quarter 1 to quarter 2, and 90% for October 2015.

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

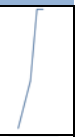
Nov-15

Quality Dashboard 2015/16

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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

Target or Indicator		Target	IC	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD	Trend
INTELLIGENT MONITORING	BANDING	None set	CQC		no banding				NYP	NYP			NYP								
	NUMBER OF ELEVATED RISKS	None set	CQC		2				NYP	NYP			NYP								
	NUMBER OF RISKS	None set	CQC		4				NYP	NYP			NYP								
Safety																					
INCIDENTS	MODERATE, MAJOR OR CATASTROPHIC HARM (APPROVED)	TBC	QC	2	1	0	3	0	0	0	0	0								3	
	MODERATE, MAJOR OR CATASTROPHIC HARM (UNDER REVIEW)	N/A		21	17	58	96	64	64	82	210	62								368	continually changing figures
HEALTHCARE ACQUIRED INFECTIONS	MRSA	0= green, 1-5=amber, >5 red	QC, QI	0	0	0	0	0	1	1	2	0								2	
	CLOSTRIDIUM DIFFICILE (due to lapses in care)	<=27 per year	QC, QI	0	1	3	4	1	0	3	4	0								8	
	CLOSTRIDIUM DIFFICILE (no lapse in care)	None set	N/A	3	4	1	8	0	0	1	1	0								9	
	CLOSTRIDIUM DIFFICILE (under review)	None set	N/A	0	0	0	0	0	0	0	0	3								3	
NEVER EVENTS		0	QC	0	1	0	1	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%									
	% OF ELIGBLE PATIENTS HAVING PROPHYLAXIS (SAFETY THERMOMETER)	100%	QC	100.00%	100%	99.82%		100%	100%	99.82%		99.65%									
	NUMBER OF PATIENTS WHO DEVELOPED A HOSPITAL ACQUIRED VTE (APPROVED)	TBC	QC	3	0	0	3	0	1	NYP		NYP								4	
	NUMBER OF PATIENTS WHO DEVELOPED A HOSPITAL ACQUIRED VTE (UNDER REVIEW)	N/A	N/A	4	6	7	17	1	0	NYP		NYP								18	
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%									
	% OF PATIENTS FREE FROM HARM (MEDICINES SAFETY THERMOMETER)	TBC	QI	100%	97.5%	98.1%		100%	100%	98.5%		Quarterly Report									

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												
	SHMI (12 MONTH ROLLING)	<=100 = G, As expected = A, Higher than expected = R	QI, IP, QC	114	114	114		114													
	TOTAL DEATHS IN HOSPITAL	None set	reporting only	92	80	107	279	87	81	77	245	88								612	
	MORTALITY PEER REVIEW (NB figures change as reviews are conducted)	Q1 - 45% Q2 – 55% Q3 – 75% Q4 – 95%	IP, SU2S	77%	74%	65%	72%	71%	69%	77%	72%	51%								69%	
	REGULATION 28 - PREVENTION OF FUTURE DEATHS REPORT	None set	Reporting only	0	0	0	0	0	0	1	1	0								1	
CARDIAC ARRESTS	Annual: <75 = G, 75 – 85 = A, >85 = Red	see left	QC	4	2	11	17	10	5	6	21	4								42	
ADVANCING QUALITY	ACUTE MYOCARDIAL INFARCTION	>=95%	QI, C	93.18%	94.94%	96.83%		97.16%	97.14%											97.14%	
	HIP AND KNEE	>=95%	QI	98.51%	99.22%	98.97%		98.85%	99.01%											99.01%	
	HEART FAILURE	>=84.1%	QI, C	72.22%	73.17%	75.44%		78.85%	81.15%											81.15%	
	PNEUMONIA	>=78.1%	QI, C	80.00%	78.83%	78.65%		78.00%	77.82%											77.82%	
APPROPRIATE DISCHARGE PLANNING FOR PATIENTS WITH AKI		TBC	C	Absence of AKI Calculator in current system resulted in CCG agreeing for baseline to be set at Q2				Achieved 20.7% for Q2 need to establish baseline with CCG for Q3			20.70%										
SEPSIS SCREENING OF ALL ELIGIBLE PATIENTS ADMITTED TO EMERGENCY AREAS		TBC for Q3	C	Quarter one data for establishing baseline				26%	40%	28%	31.3%										
SEPSIS SCREENING: ANTIBIOTICS GIVEN WITHIN AN APPROPRIATE TIMESCALE		TBC for Q3	C	Quarter 1: establishing indicator detail				25%	23.1%	0%	15.4%										
Patient Experience																					
FALLS	ALL FALLS (APPROVED)	913	IP (5% reduction)	82	89	80	251	75	69	70	214	76								541	
	FALLS PER 1000 BED DAYS	<=5.6	IP (national benchmark)	4.97	6.22	5.03		4.97	4.53	4.84		5.02								4.93	
	MODERATE, MAJOR AND CATASTROPHIC HARM FALLS (APPROVED)	<=13	IP (10% reduction)	2	2	2	6	1	0	1	2	2								10	
	MODERATE, MAJOR AND CATASTROPHIC HARM FALLS (UNDER REVIEW)	N/A		1	0	1	2	0	0	3	3	3								8	
	MODERATE HARM FALLS (APPROVED)	<=12	SU2S (10% reduction)	2	2	2	6	1	0	1	2	2								10	

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								3	
	GRADE 3 AND 4 HOSPITAL ACQUIRED (UNAVOIDABLE)	N/A		0	1	0	1	0	0	0	0	1								2	
	GRADE 3 AND 4 HOSPITAL ACQUIRED (UNDER REVIEW)	N/A		0	0	0	0	0	0	0	0	0								0	
	GRADE 2 HOSPITAL ACQUIRED, AVOIDABLE AND UNAVOIDABLE (APPROVED)	<=63	QI (5% reduction)	16	9	6	31	8	5	5	18	3								52	
	GRADE 2 HOSPITAL ACQUIRED, AVOIDABLE AND UNAVOIDABLE (APPROVED)	<=59	10% reduction internal stretch target	16	9	6	31	8	5	5	18	3								52	
	GRADE 2 HOSPITAL ACQUIRED, AVOIDABLE AND UNAVOIDABLE (UNDER REVIEW)	N/A		0	0	0	0	0	1	1	2	10								12	
TRANSFERS	OUT OF HOURS TRANSFERS	TBC	BK	1	0	1	2	0	0	DC		DC									
	NON-ESSENTIAL WARD TRANSFERS	TBC	QI	DC	DC	DC		DC	DC	DC		DC									
ALWAYS EVENTS		100%	QI	89%	90%	92%	90%	96%	96%	88%	93%	94%								92%	
DEMENTIA	DEMENTIA ASSESSMENT % (PART 1)	>=90%	C	96.85%	97.62%	95.53%		96.80%	94.86%	94.36%		92.18%									
	DEMENTIA ASSESSMENT % (PART 2)	>=90%	C	100%	100%	100%		100%	95.12%	100%		85.71%									
	DEMENTIA ASSESSMENT % (PART 3)	>=90%	C	100%	100%	100%		100%	100.00%	100%		100%									
	DEMENTIA - STAFF TRAINING	Q2 = 42%	C	Compliance established at 27.02% end Q1 plus additional 15% for Q2			27.02%				42%	44.50%								44.5%	
CARE INDICATORS RISK ASSESSMENTS	FALLS	>=95%	IP	82%	92%	93%	93%	97%	97%	93%	96%	96%									
	WATERLOW (PRESSURE ULCERS)	>=95%	IP	77%	93%	92%	91%	96%	95%	92%	94%	96%									
	MUST (MALNUTRITION)	>=95%	IP	78%	85%	89%	85%	91%	80%	87%	86%	90%									
	DIABETIC FOOT	Q1 - 61% Q2 – 71% Q3 – 81% Q4 – 91%	C	QR	QR	77.60%	77.60%	72.00%	81.40%		76.80%									77.2%	
MIXED SEX OCCURENCES		0	QC	6	0	1	7	0	0	0	0	0								7	
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									
	% RECOMMENDING TRUST: INPATIENTS	>=95%	IP, QI, QC	97%	96%	97%		98%	98%	96%		97%									
	% RECOMMENDING TRUST: A&E	>=87%	IP, QI, QC	83%	83%	83%		88%	87%	90%		85%									
	RESPONSE RATE: A&E WARRINGTON	Contract target to be agreed	IP, QI, QC	22.03%	19.47%	13.16%		6.96%	6.49%	20.29%		12.52%									
	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%									

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%									
	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%									
COMPLAINTS AND CONCERNS	NUMBER OF COMPLAINTS RECEIVED	2014/2015 received 478 (No threshold set)	IP	50	23	32	105	24	36	37	97	46								248	
	% 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%								98.19%	
	NUMBER OF CONCERNS RECEIVED	NOT SET	IP	9	8	25	42	39	18	6	63	2								107	
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									
REDUCING AVOIDABLE EMERGENCY ADMISSIONS TO HOSPITAL		TBC	C	4 pathways identified, awaiting CCG agreement				Adult and paediatric conditions identified, report shared with CCG													

BOARD OF DIRECTORS

W&HHFT/TB/B/15/227

SUBJECT:	**Complaints: Patient Experience Quarter 2 Report 2015/2016**
DATE OF MEETING:	28th October 2015
ACTION REQUIRED	**For Assurance**
AUTHOR(S):	Michele Lord, Patient Experience Matron
EXECUTIVE DIRECTOR:	Karen Dawber, Director of Nursing and Governance
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care 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 2, • The Trust received a total of 99 formal complaints between 1 July and 30 September 2015, which is a decrease of 6 on the previous quarter. • Six cases have been closed by the PHSO in quarter 2. One case has been upheld by the PHSO and the Trust is complying with recommendations, another three cases were partly upheld and two were not upheld. • 513 people contacted PALS in Quarter 2; this is a decrease of 149 contacts on 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. • 99.22% of complaints were closed within agreed timescales. • Examples of learning from complaints (Quarter 2 2015/2016)

	from the divisions is provided.	
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.

"A health service that does not listen to complaints is unlikely to reflect its patients' needs."

Francis Report

EXECUTIVE SUMMARY

This is the sixth quarterly report providing an overview of complaints received by the Trust from 1 July to 30 September 2015. The report is written in accordance with the NHS Complaints Regulations (2009) and complements the patient experience annual report presented in May 2015.

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, NHS Choices 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 1 are provided in the report to show the various tools employed by divisional, ward and service teams to ensure learning from poor performance.

The PHSO (2015) tell us that "complaints offer an insight into how Trusts are performing". Complaints are an excellent indicator of patient's experience of care and the more we can learn from them, the better we can meet people's expectations.

1. COMPLAINTS OVERVIEW

During Quarter 2 there were 154,686 attendances to our services. This makes the number of complaints received in quarter 2 (99) just 0.06% of the total attendances.

Table 1: Trust activity, 1 July – 30 September 2015

Month	Day case	In-patient	Non-elective	New	Follow up	A&E	MIU	WIC	Ward attender	Outside clinic attend-ance	Grand Total
Jul	2,906	541	3,227	11,044	25,861	7,247	1,996	1,087	1,199	120	**55,228**
Aug	2,450	437	3,058	9,318	22,110	7,002	1,752	1,052	1,129	72	**48,380**
Sep	2,687	475	3,263	10,225	24,456	6,851	1,811	-	1,240	70	**51,078**
Grand Total	**8,043**	**1,453**	**9,548**	**30,587**	**72,427**	**21,100**	**5,559**	**2,139**	**3,568**	**262**	**154,686**

Figure 1: Complaints received per 1000 patient attendances for Quarter 2

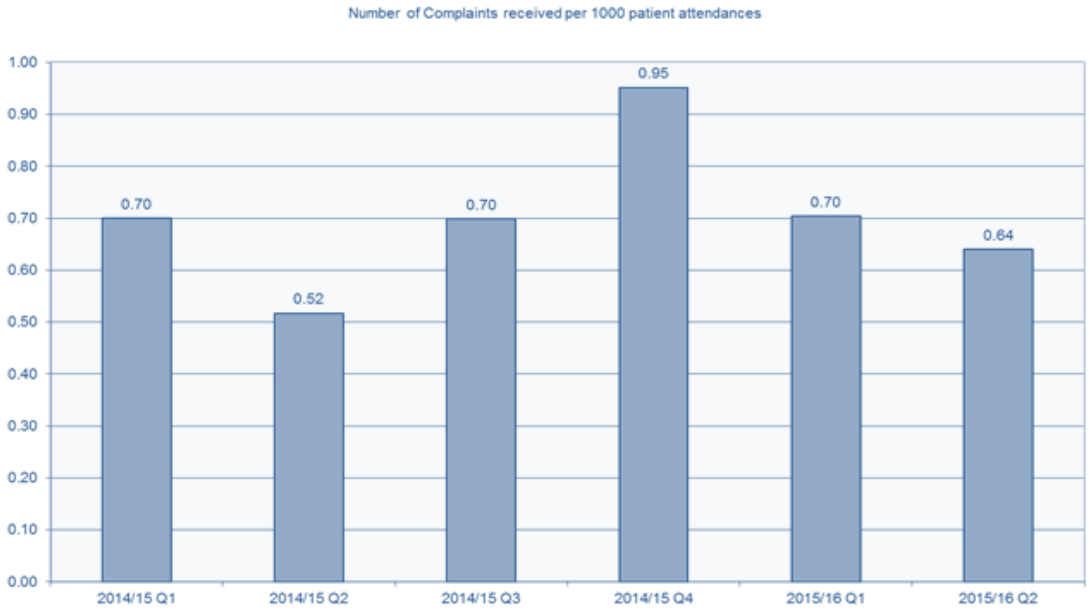


Table 2: Formal complaints received in Quarter 2

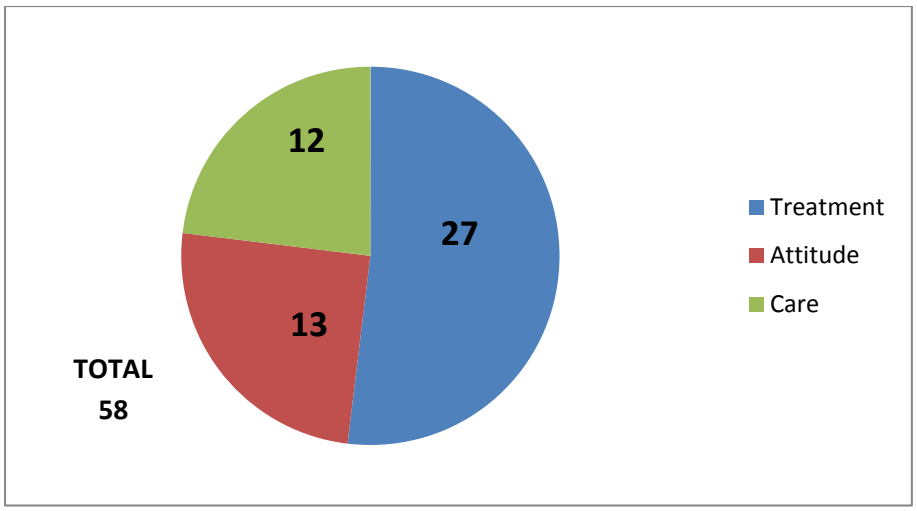
Quarter	Formal complaints received
Quarter 2, July – September 2015	99
Quarter 1, April – June 2015	105
Quarter 4, Jan – March 2015	141
Quarter 3, October – December 2014	107

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

The number of formal complaints received in Quarter 2 was 99. A further 12 were withdrawn and designated as concerns. This is a decrease on Quarter 1 of 6.

There has been a reduction in the number of low (4) and moderate (10) risk graded complaints compared to Quarter 1. High risk graded complaints have increased by 7 on previous quarter.

Figure 2: Top three themes for complaints made in Quarter 2



A more detailed breakdown of the subjects, by all and by division, can be found in figures 3-9.

The picture for the top two themes remains unchanged from previous quarters, being treatment and attitude. Last quarter cancellations were the third top subject with 12 complaints. For Quarter 2 cancellations has dropped to seventh position with a total of six complaints.

Table 3: Risk rating of complaints, by quarter

	2014/15 Q3	2014/15 Q4	2015/16 Q1	2015/16 Q2	Change from last Quarter
Complaints Received	**107**	**141**	**105**	**99**	↓
Low	38	70	44	**41**	↓
Moderate	54	62	57	**47**	↓
High	15	9	5	**11**	↑

The distribution across the risk grades is generally consistent, with the exception of the hike in numbers of high risk graded complaints in Quarter 2.

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 known disability or a mental health condition.

Parliamentary Health Service Ombudsman (PHSO)

The PHSO have recently published its annual report "Complaints about acute Trusts: 2014-15". This report details all information collected about complaints involving acute trusts in England. In 2014-15 the PHSO upheld 44% of their investigations into complaints. In light of this, the Patient Experience Team will provide a report on PHSO cases for 2014-2015 for the Medical Governance Lead to review to consider any learning or improvements for the Trust.

During Quarter 2 of the six PHSO cases closed, one was upheld and a further three have been partly upheld, with two cases not upheld. Originally, the PHSO had decided to partly uphold a complaint that the division had not upheld. A further review and evidence were sent to the PHSO, who reversed their previous decision and decided to not uphold the complaint. We are waiting to hear about two further cases. Having sent all records, the PHSO is reviewing the merits of the complaints and we await a decision on whether they will be pursued.

The complex and long debated case mentioned in the previous report is now coming to a close. An exhaustive action plan and evidence has been compiled by senior scheduled care staff to be sent to the PHSO, CQC, Monitor and the Trust Development Authority. This case will be closed in October 2015.

Patient Advice and Liaison Service (PALS)

513 people contacted PALS in Quarter 2, compared to 662 in the previous quarter. The main contributory factor to the decrease in PALS contacts has been a decline in grievances against the parking regulations and charges.

The need for training to deal with an increase in face to face meetings with people behaving aggressively has been raised and this is going to be delivered to all members of the patient experience team and the volunteers.

A new approach to PALS is needed in order to respond to both the current workload and to provide a modern "fit for purpose" service. Nationally, there is a debate on the future development of the service and as a Trust we await the outcome. Meanwhile, the Patient Experience Matron and PALS & Volunteer Coordinator are discussing improvements that can be made in a range of areas, from the way the service is delivered, record keeping and how to improve data capture to demonstrate outcomes, performance and the value of the service to the Trust and the wider community.

PALS volunteers cover the Hub and are invaluable in supporting the PALS & Volunteer Coordinator in her work. The volunteers are growing in confidence in their dealings with patients and members of the public. They are able to provide assistance and support to people struggling with the logistics of their, or a relative's care and show a lot of compassion and kindness to them. Some examples are included.

Table 4: Examples of PALS contacts by quarter

Q3	Contacts	Q4	Contacts	Q1	Contacts	Q2	Contacts
October	175	January	173	April	211	July	175
November	126	February	188	May	183	August	133
December	106	March	229	June	268	September	205
Total	**407**	**Total**	**590**	**Total**	**662**	**Total**	**513**

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

PALS Enquiry	Outcome
A patient visited the Hub in a very distressed state. His plaster cast was extremely tight and his leg was inflamed and hot. The patient was agitated and very uncomfortable and the PALS volunteer asked the patient to take a seat and offered him a cup of tea. The patient requested help to remove the plaster prior to his follow up appointment in two weeks' time.	The volunteer made arrangements for the patient to attend the fracture clinic immediately and escorted /remained with the patient in fracture clinic. The patient had the plaster removed and replaced with a dressing. The volunteer then escorted the patient to the shuttle bus stop.
A member of the PALS team noticed an elderly gentleman struggling to catch his breath whilst walking across the main entrance. The patient was making his way to the main out-patient department. The PALS officer asked the patient if he needed a wheelchair and the patient said he did as he could not walk any further. Upon	The PALS officer took the patient, in a wheelchair, to his clinic appointment and made arrangements for staff to call a porter to take the patient back to the main entrance following his consultation. The staff member also contacted NWAS to inform them that the patient could not manage to walk further than a couple of

PALS Enquiry	Outcome
further discussion the patient informed the staff member that he had been dropped off at the main entrance by a taxi that had been ordered by NWAS.	yards. NWAS took note of this and stated they would arrange ambulance transport for the patient from here on.
A relative of a patient was found crying in the ladies cloakroom by a PALS volunteer. Her daughter had been transferred to ICU and she was so distressed that she could not find the unit, nor could she see the signs due to her tears.	The volunteer escorted the relative to ICU and waited with her until she was called in to the unit. The lady asked the volunteer to go into the unit with her, as she was very frightened. As soon as the volunteer introduced the relative to the named nurse the volunteer left the unit. The relative hugged the volunteer and thanked her for her kindness.
The relative of a recently deceased patient visited the PALS office due to not having understood what caused the patient's death.	The PALS officer made arrangements for the family to meet with a consultant to discuss the patient's deterioration and cause of death. Following on from the meeting with the consultant the family stated they could now grieve as they had the relevant answers.
A relative attended the Hub in a distressed state, having spent the night in AED with her very sick daughter. The lady had left her purse at home and did not have a way of getting home to Runcorn.	A PALS volunteer provided the relative with a shuttle bus timetable and the volunteer highlighter the following departure times and also took the relative to the bus stop so that she knew where she was going, a s she was still feeling very anxious.

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 2, by site

Star rating	Warrington	Halton	CMTC
★★★★★	10	11	4
★★★★	1	-	-
★★★	-	-	-
★★	3	-	-
★	6	-	-
No star rating assigned	-	1	-
Total for Q2	20	14	4

Table 7: Number of patient comments left on *NHS Choices* for Quarter 2, by service

Ward/Department	Warrington	Halton	CMTC
Acute Medicine	3	-	-
Appointments	1	-	-
Audiology	1	-	-
Care of older people	1	-	-
Diabetic medicine	-	1	-
Emergency Services	1	7	-
General surgery	3	3	-
Gynaecology	2	1	-
Maternity	2	-	-
Patient Experience	1	-	-
Ophthalmology	1	-	-
Orthopaedics	3	-	4
Unspecified	1	-	-
TOTAL	20	12	4

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

Warrington

Visit to colposcopy clinic

Yesterday I attended the colposcopy clinic. The staff were extremely kind and helpful. They did all they could to make me feel at ease during the procedure which was most professionally carried out. I was given all the information I needed and my questions answered clearly.

Visited in July 2015. Posted on 31 July 2015

Wonderful service yesterday

I arrived at a e they said the waiting time would be about 4 hours I was out in just over two and a half hours. The staff were all wounded full the sister who attended to my badly cut arm was very efficient and very professional in every way. They made me feel relaxed and did a perfect job of stitching my arm.

Visited in July 2015. Posted on 09 July 2015

Acceptable Standard?

Disappointed. Having waited 3 months to see a specialist for their expert opinion, diagnosis & advice on suitable treatment, I received a rushed 10 minutes. Outcome - suggested "wait for another 3 months to see if injury repairs itself" ...then return for another appointment."... "Or don't if you don't wish to". (quote). Professional? Obviously a very off day for somebody (polite interpretation). No, I won't be returning I'm choosing to seek a second opinion elsewhere. I've no wish to waste another 10 minutes of somebody's time there.

Visited in July 2015. Posted on 02 July 2015

Maternity experience

Excellent maternity care received my second baby was transverse lie, under the expert care he was turned twice midwife care was exceptional stayed on shift to deliver my baby.

Visited in March 2015. Posted on 20 August 2015

Halton

X Ray service at Urgent care centre

Visited GP on the Wednesday who referred me for X-Rays. Phoned X-Ray department on the Thursday and was offered an appointment that day, which I unfortunately couldn't make due to prior commitments. I was then offered an appointment on the Friday at Halton Hospital at 5.30 p.m. which fitted round work hours. Very friendly prompt service by reception staff on the Urgent Care Centre and also by the radiologist in the X-Ray department.

Visited in September 2015. Posted on 26 September 2015

B4 you are amazing!!

I've been a patient on Ward B4 three times since 10 June 2015. Each time the care I received was outstanding. Such a dedicated and friendly team. All of the staff I came into contact with made me feel safe and cared for. I owe my speedy recovery to you all - from the surgeon who came in on his day off to check on me to the student nurse who was so good - efficient, warm and confident. You all work long, hard shifts and still manage to shine. Please know how much it is appreciated - we are lucky to have you and Halton Hospital. Long live the NHS!!

Thank you xxx

Visited in July 2015. Posted on 29 July 2015

CMTC

Consultant at weekend - never

I recently came into the Treatment Centre in Runcorn for surgery on my spine. All the staff I came into contact with were really good. I stayed in for 3 nights so met several staff members. Nothing was too much trouble, I was kept informed of how things went, Ward was very clean and staff appear to actually enjoy being in work. I was very pleased with the treatment received and even saw my Consultant every day even Saturday and Sunday.

Visited in July 2015. Posted on 17 July 2015

Hip Replacement - July 2014

Day 9 of my hip replacement surgery recovery and I am amazed at the difference this has and will continue to make to my life. I am already off my crutches (carefully) and managing so much more than anticipated. I have suffered with hip problems for a number of years despite being a "young" 49 and eventually opted for the THR op. I can only sing the praises of everyone involved in my care for the couple of days I was at the CMTC. I was probably not the easiest patient they had to deal with due to my constant desire to be up and about as soon as possible but all they ever did was support and encourage me in the recovery process. I stayed on Ward 1 where the all the staff were fantastic and quite happy to have a chat and laugh with a bored patient!! Food was tasty and plentiful. The personal TV was essential for me and not too expensive at £5 for my whole stay. Shame about no Wi-Fi but *hey ho* it's not a hotel as I had to keep reminding myself.

I was in a 4 bed area and for the first and second night I had it to myself then I moved in with two others for my final night. Wards are immaculate and the cleaning girls were regular visitors chatting and keeping the standards about as high as I could imagine possible. This really is a private hospital by any other name in my mind and the staff make a lovely environment even better with their genuine friendly attitude, care and attention to detail.

Thank you so much CMTC you really should be proud of the care you give to your patients.

Visited in July 2014. Posted on 18 July 2014

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 for the next report and going forward to reflect the proposed business unit model.

2.2 *Formal complaints, Themes for Quarter 2*

Figure 3: Graph showing **all complaints** by subject, Quarter 2

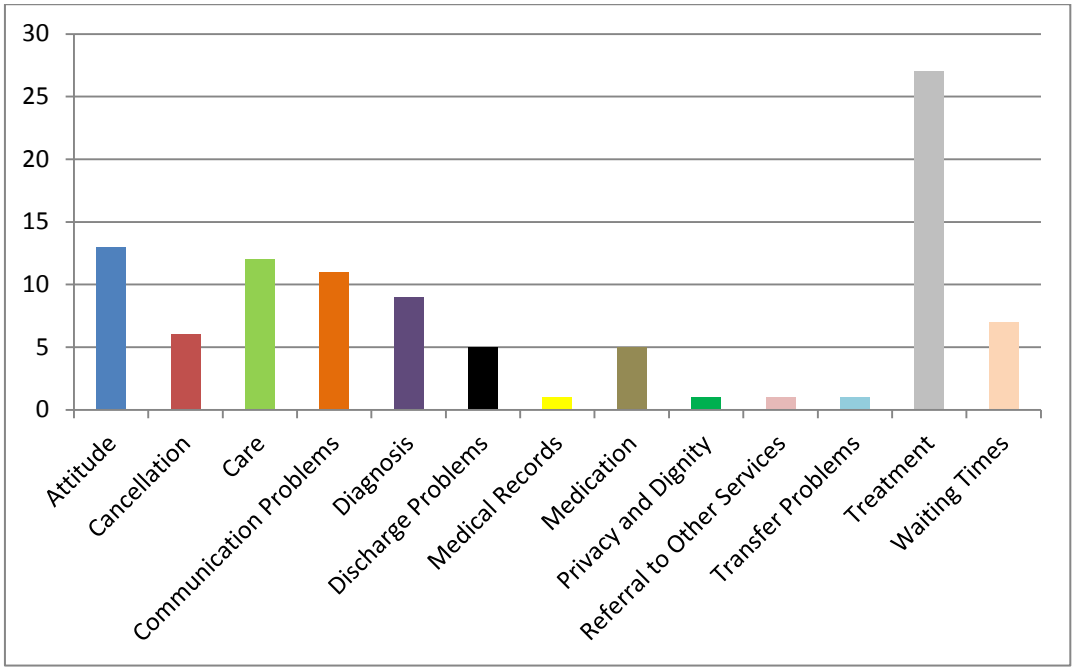


Figure 4: Graph showing top 5 subjects for **Unscheduled Care**, Quarter 2

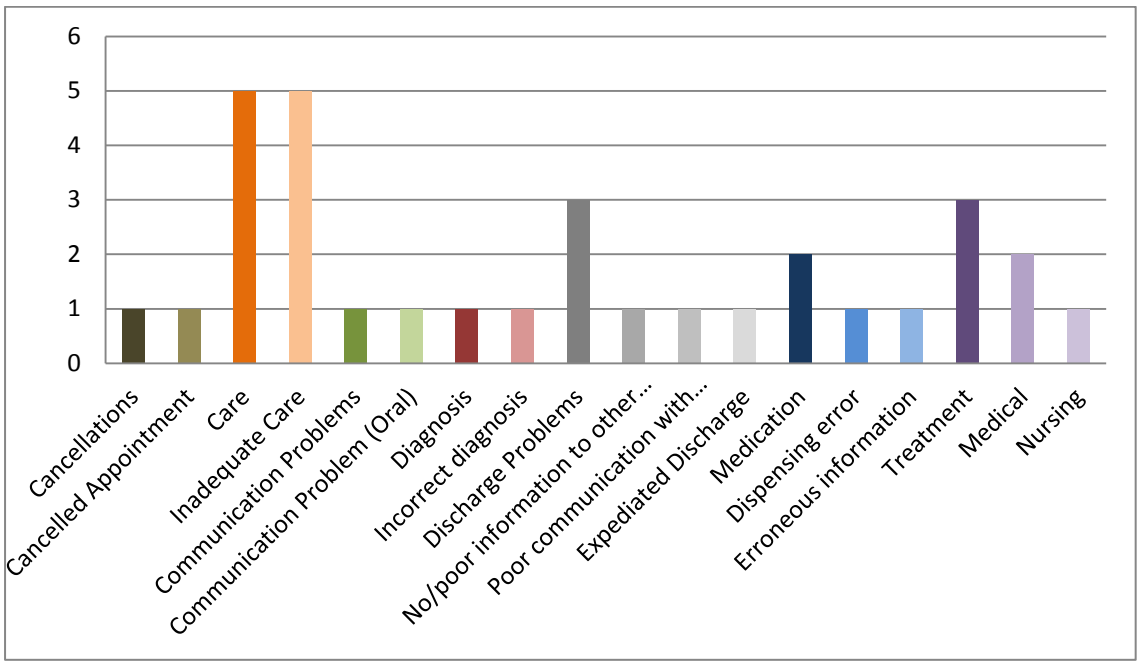


Figure 5: Graph showing top 5 subjects for **Accident & Emergency Department**, Quarter 2

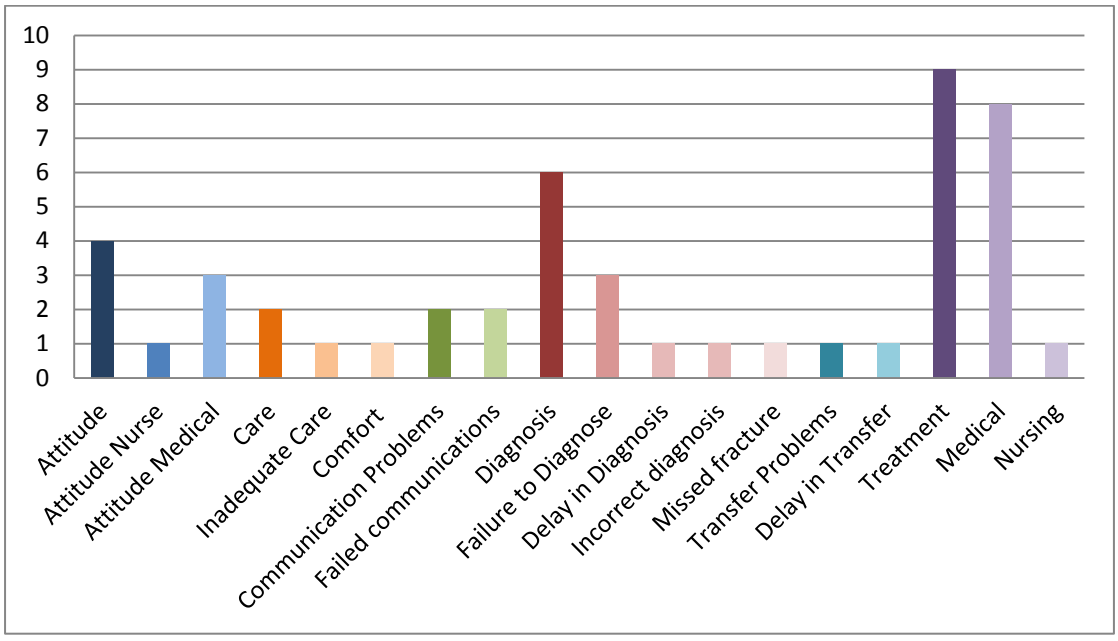


Figure 6: Graph showing top 5 subjects for **Scheduled Care**, Quarter 2

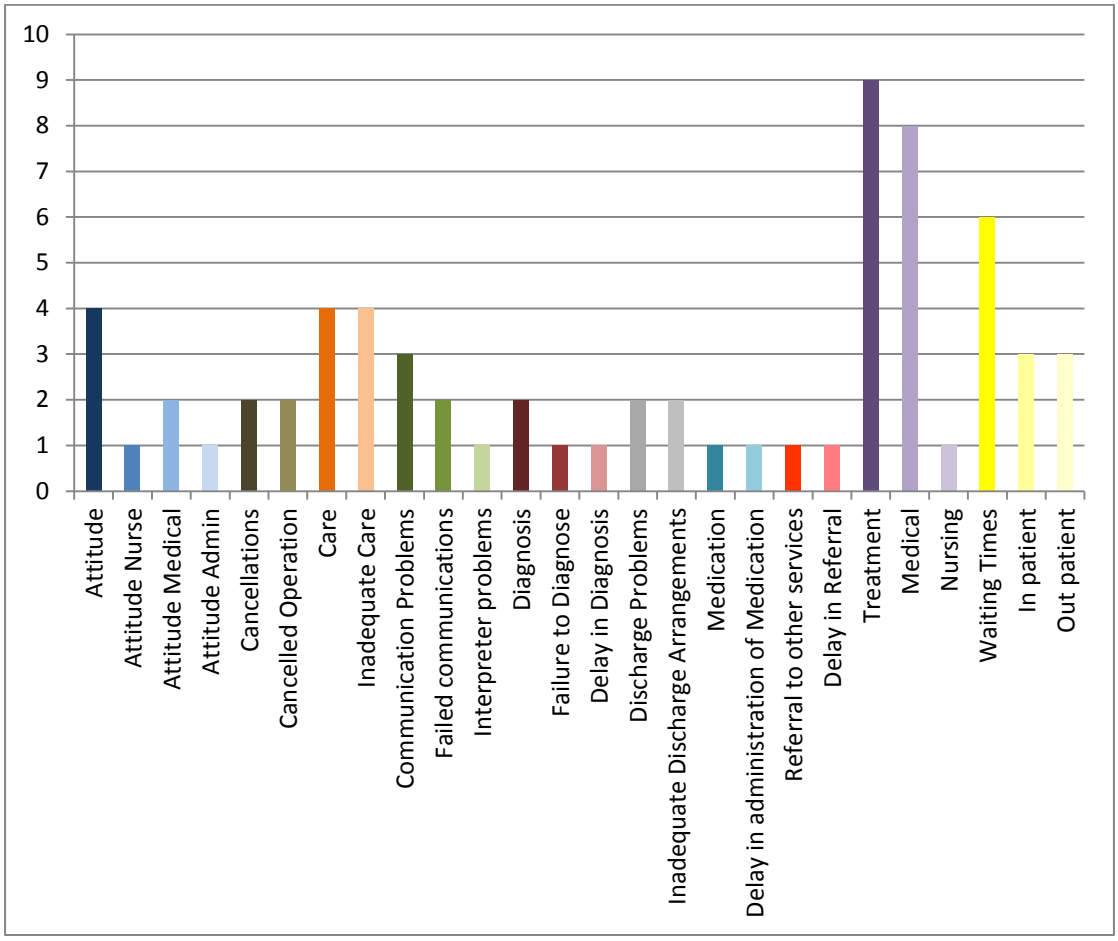


Figure 7: Graph showing top 5 subjects for Women's and Children's Health, Quarter 2

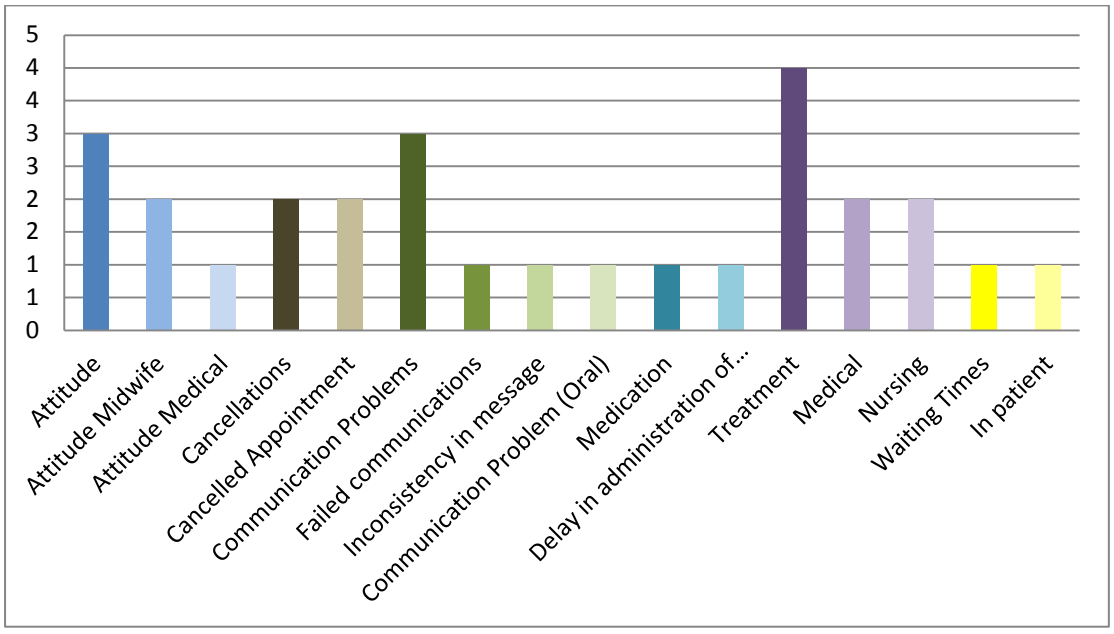


Figure 8: Graph showing top 5 subjects for Support Services, Quarter 2

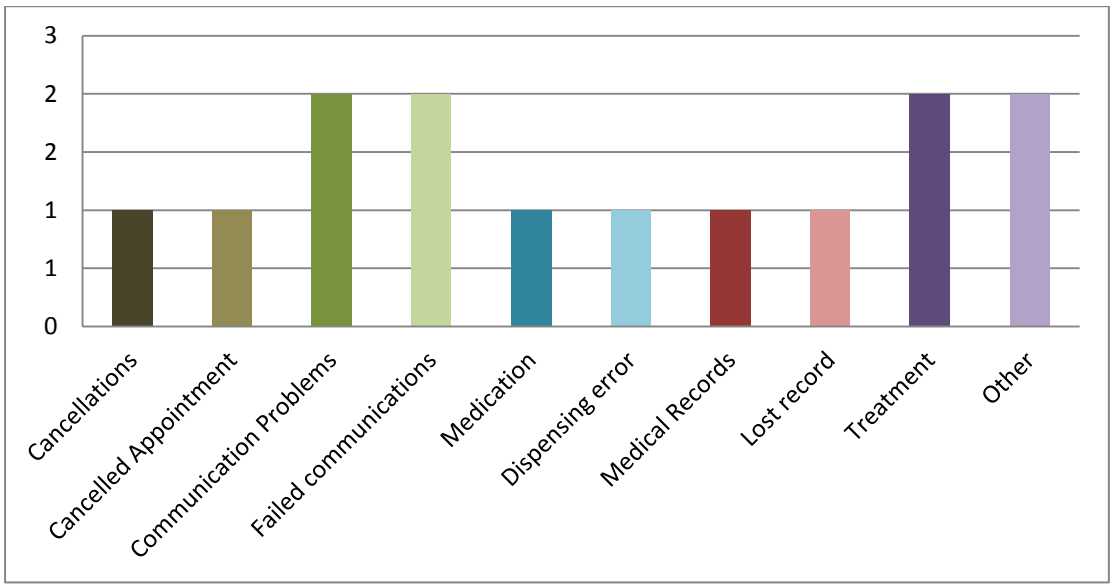
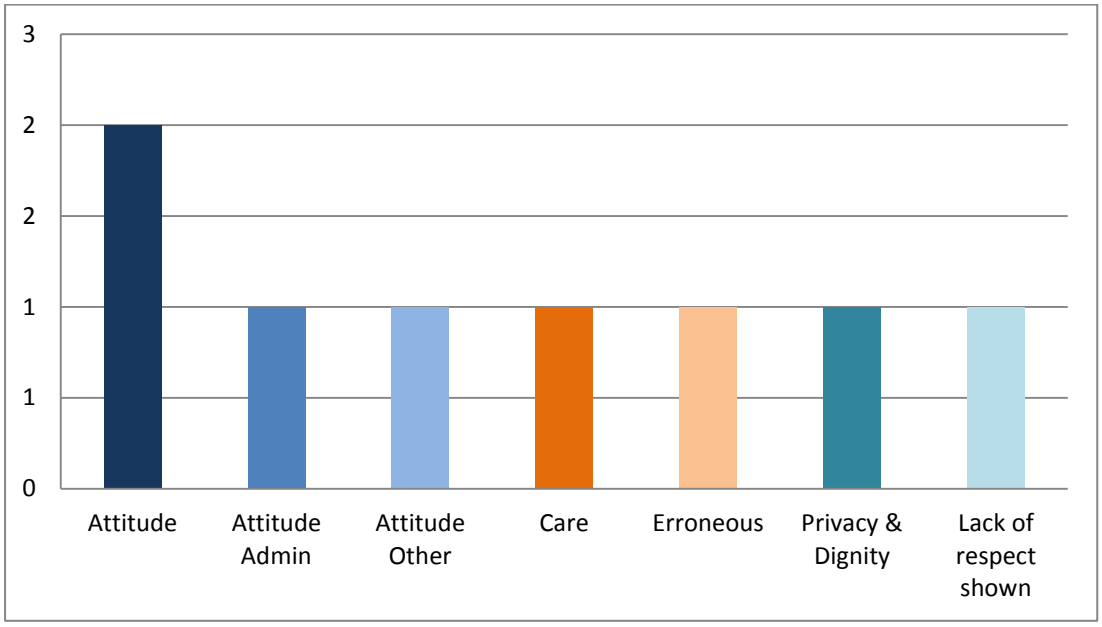


Figure 9: Graph showing top 5 subjects for **Corporate Services**, Quarter 2



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 and included in this report. For Quarter 2, there were no complaints raised where end of life care was a component.

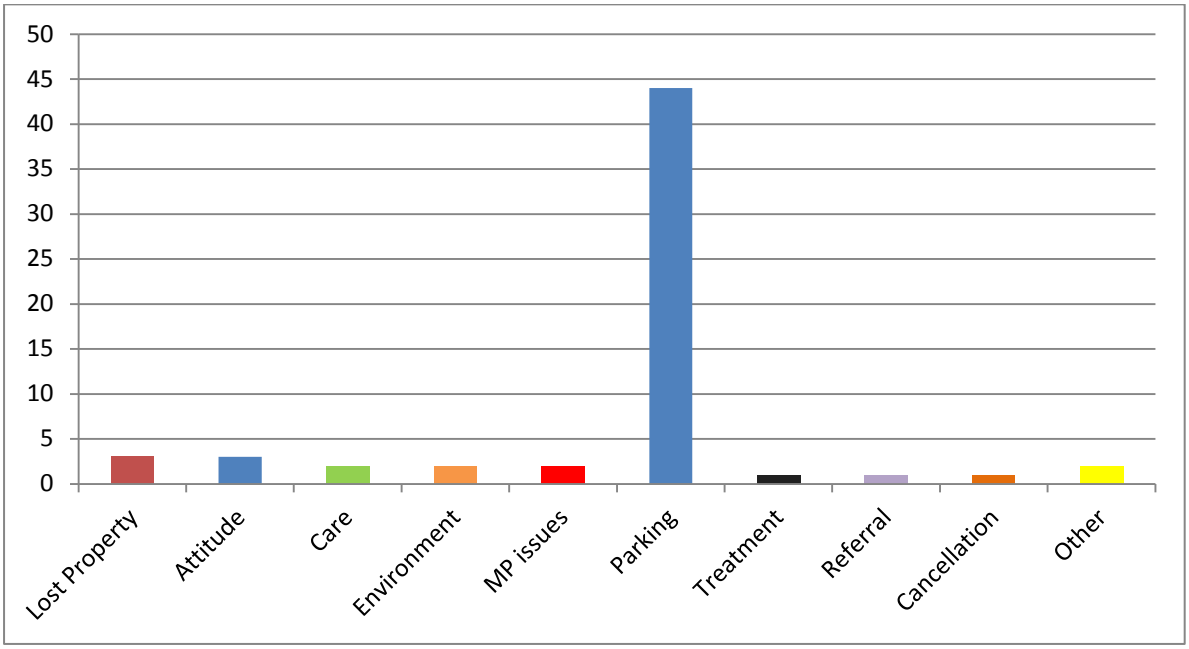
2.4 Concerns raised in Quarter 2

Total concerns logged for Quarter 2 was 61. As in the previous report, the lion share of concerns are about car parking, though the numbers of PALS and concerns about cart parking have subsided somewhat.

Table 13: Concerns for Quarter 2, by division

Corporate Departments	46
Scheduled Care	7
Unscheduled Care	4
Women and Children	1
Support Services	3
Totals:	61

Figure 8: Concerns by subject, Quarter 2



2.5 Responding to people in a timely manner

In Quarter 2 we responded to 99.22% of formal complaints within agreed timescales. Provision of high quality, well investigated and thorough responses is equally important to both patients and the Trust. Though we often achieve this objective, we do have to re-negotiate the response date with complainants when the division is struggling to complete their response or the Patient Experience Team is processing a high number of draft responses through the quality assurance processes in place. Feedback from complainants (completed voluntarily and anonymously at the end of the complaints process) has improved over the last two years with the team communicating more often and more effectively. There is a need to improve our general response to complaints from that of reactive to proactive. While there is an understanding of this at a strategic level, it is difficult to inspire and motivate a dynamic response to complaints in some patient facing staff/services.

Table 9: Complaints closed in agreed timescales for Quarter 2

	July	August	September
Number of complaints closed in month, resolved within the agreed timescale	42	19	29
Number of complaints closed in month, not resolved within the agreed timescale	1	0	0
Number of complaints closed in the month	43	19	29
% complaints closed in month, resolved within agreed timescale	97.67%	100.00%	100.00%

2.6 Complaints withdrawn

During the period from July – September 2015, a total of 12 complaints were withdrawn. Examples of the reasons for withdrawal were:

- Complainant decided to withdraw.
- Contact with patient led to feedback being given and complaint being withdrawn.
- Out of time request, division may agree to review of notes.
- Referral from Coroner's but no issues that can be investigated. Complainant asked to provide issues.
- Patient attended appointment and was able to resolve issues.

2.7 Returned complaints

During Quarter 2, 23 complaints were returned with ongoing concerns. We are not consistently meeting the informal thirty day response target for answering returns. This is mainly because the divisions prioritise open complaints that have a deadline and are the bulk of the complaints workload. Sometimes, delays are because we are trying to arrange meetings with complainants, but overall there is still a need for divisional investigators to be more proactive in responding to returns. An early review of returns will show if the response will be "nothing to add" and we can respond promptly. 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. Anecdotally we know that waiting for responses and missing deadlines prompts more threats of legal action and press involvement as the complainant becomes more frustrated. The best way to mollify complainants is to keep in touch with them regularly and be realistic about when a delayed response will be received.

Table 10: Returned complaints by division for Quarter 2 and outcome

Division	Not Upheld	Partly Upheld	Upheld
Unscheduled	5	3	2
Scheduled	3	5	0
WCSS	1	0	1
Corporate	2	0	1
Total	11	8	4

2.8 Complaints linked to serious untoward incidents

During Quarter 2, there have been no complaints that have been the subject of serious incident investigation. A total of 7 complaints were linked to a reported 8 incidents that included falls and other patient safety incidents already reported and acted upon. Two of the incidents were about the care of a child who is the subject of a high level complaint. The division is reviewing the case and a level 1 investigation is being done.

2.9 Formal meetings organised

The total number of meetings to discuss formal complaints in Quarter 2 was 13. Of these, 8 meetings were to discuss open complaints. Though meetings can be very useful, the logistics are difficult, given the commitments of clinical and managerial staff that need to attend. Going forward, we have asked the divisions to coordinate the appropriate staff members attendance and the Patient Experience Team will liaise with complainants and organise the venue. There is sometimes reluctance by some staff to attend meetings and the divisional staff will be in a better position to escalate any problems to clinical/managerial leads.

A review of the 5 meetings elicited from return complaints can be seen below and they will be tracked to see if there are any further developments in these, either escalation to PHSO or legal claim for compensation.

Table 11: Summary of meetings held bout returned complaints, Quarter 2

Date of meeting	Date of original response	Upheld?	Outcome of meeting (as at today)
21/07/15	03/06/15	Partly upheld	Specific questions were answered regarding the CT scan. The matron agreed to provide an updated copy of the nursing issues action plan to the complainant's son. Recording of the meeting sent with letter. No further correspondence or contact from complainant.
21/08/15	16/07/15	Not Upheld	Complainant attended with Healthwatch advocate. Patient able to tell staff about her distress about the time she waited for breast screening. Reassured by consultant that waiting time was in line with policy. Patient said she would like to make a claim and was advised how to pursue this. Request for medical records was forwarded to medico-legal. Recording of the meeting sent with letter. No further correspondence or contact from complainant.
11/09/15	13/05/15	Partly Upheld	Complainant remained dissatisfied by response at the meeting. Agreed to provide copy of case notes before further response. No further correspondence or contact from complainant.
09/09/15	20/07/15	Not Upheld	Consultant explained treatment was appropriate, but

Date of meeting	Date of original response	Upheld?	Outcome of meeting (as at today)
			complainant was not reassured and remained dissatisfied. Complainant raised issues about a previous episode in AED, but this proved not to be at this Trust. Request for medical records was forwarded to medico-legal. No further correspondence or contact from complainant.
23/09/15	10/06/15	Not Upheld	Complainant had discussion with two matrons and was reassured by explanations. No further correspondence or contact from complainant.

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.

Table 11: Examples of complaints, action taken and learning from Quarter 1

Description of Complaint	Actions	Learning
Scheduled Care: Patient complained that he waited seven hours to go to theatre for his orthopaedic surgery. He wanted to know why he could not have come in at lunch time and not have to fast all day. Upheld	Investigated by T&O Matron (Halton). It is routine practice to ask all patients to come in early morning, so that medical/theatre staff can decide the list order the day prior. Matron apologised, saying that this should have been explained to the patient. Action: Day case unit nurse in charge will review next day's list to try to stagger arrival times of patients.	Staff asked to reflect on poor communication and to ensure any patient who can eat and drink is offered refreshment.
Wife of deceased patient was unhappy with communication prior to her husband's death in ICU. Despite his asking to be told no details of his prognosis, staff continued to update the patient. Patient's wife felt that there was no	Apologies were made as it was acknowledged that staff did not adhere to patient's desire not to be informed of his clinical prognosis.	Matrons for ICU and the medical ward where the patient was transferred, are conducting a review on how patient's wishes are communicated to clinical teams and identify best practice. This will be shared with clinical

compassion and his wishes were no respected.		teams.
Description of Complaint	**Actions**	**Learning**
Unscheduled Care: Patient was disgusted with the attitude of a nurse in AED. She felt that the nurse's attitude was appalling and she completely disregarded her concerns about her injury.	Investigated by assistant matron in AED. Investigation highlighted that the complainant had been aggressive in the department. She had asked the nurse for her name in an aggressive manner and the nurse had refused to give it. Action: • Nurse interviewed by sister about incident and asked to reflect on her behaviour. • Investigation raised the fact that no ID badges was worn and led to a review of this and the AED coordinator is now responsible for checking that badges are worn by all staff.	Nurse completed *Care and Compassion* workbook following incident.
Complainant feels that the constipation and the strain on her father's heart contributed to his death. She is unhappy with the care received from the ward and the doctor. Part Upheld	Investigated by matron and consultant respiratory physician. The matron apologised that communication with the family had not been as effective as it should. Medical concerns were not upheld. Action: • Issues to be discussed with medical and nursing team during weekly communication meetings. • Implementation of open visiting means that families are not all asking for updates at the same time.	Staff asked to consider the impact of poor communication for the family of a very sick patient. This will help to ensure that communication occurs frequently and in a timely way between the medical and nursing teams, patients and their relatives and will help to promote a more individualised approach with the patient and their relatives.

Description of Complaint	Actions	Learning
Women's and Children's Health: Complainant is unhappy with the care received from a midwife and not being given adequate pain relief following her caesarean section. Patient also had concerns about pain relief on post-natal ward.	Matron investigated the complaint and found that the patient did wait over four hours for analgesia. Matron apologised for this unacceptable delay. Matron found that pain relief could have been improved on post-natal ward. Action: • Feedback to all ward staff about the experience the patient had due to ineffective pain relief. • A meeting was offered to the patient to discuss her concerns further and discuss actions taken.	Concerns raised with midwife on duty who was asked to reflect on both the delay in analgesia and her "dismissive" attitude toward the patient.
Patient was unhappy that her gynaecology operation was cancelled the first time. When she returned she was prepared for surgery only to be told that it had to be cancelled due to her sleep apnoea. Patient lost two day's pay and wanted reimbursing. Upheld	Investigated by consultant gynaecologist who apologised for the distress and inconvenience caused. The patient had reminded staff about her condition and it was recorded in the notes. Action: Discussion held with the sister for the oversight who confirmed that the patient should have been reviewed by an anaesthetist to assess if she were suitable for a Halton admission.	The member of staff reflected on this incident and will ensure that she double checks the self-assessment checklist before booking patients in future.
Support Services: Patient was unhappy that he had attended to have blood taken. On more than one occasion results were not received either by him or his GP. Partly Upheld	Consultant biochemist investigated and there had been human error/computer problems in the requesting of samples and the reporting of results. Action: An alert sent to GP practices to reiterate correct practice for requests.	Reiteration of correct requesting systems for surgery staff.
Patient complained about administration errors	Investigated by outpatient access manager who apologised for the	1. Reflection by reception/ appointment staff about day

concerning two appointments in ophthalmology clinics.	mistakes made. The first regarding an appointment made for six months rather than 6-8 weeks and the second due to a breakdown in communication between optometrist and reception staff, where the optometrist was not clear in instructions as to which clinic the patient was to be sent to and the reception/appointment team have not checked. Action: • Issue discussed with the clinic reception staff to reiterate they are vigilant in following the instructions on outcome forms. • Reception/appointment staff directed to check any ambiguities in instructions before making an appointment. • Concerns shared with all clinicians to ask them to be specific and clear in their instructions to other staff.	to day systems to ensure ambiguities are checked and the impact of mistakes on patients. 2. Clinicians to improve record keeping and documentation..

4. ACTIONS

The following identifies any progress on actions/improvements:

- Medical Governance Lead is to review all PHSO cases for 2014-15 and feedback to the Clinical Governance and Patient Experience Committees. As part of this review, the Patient Experience Matron will review all returns the same period to determine how many returned complaints progress to PHSO. This review will provide insight into PHSO complaints and hopefully identify learning for the organisation.
- Violence and Aggression training to be provided in-house for PET and volunteers during the next quarter.
- Review of policy to consider several adjustments to the policy:
    - Review timescales to reflect complexity of investigations
    - Include CCG guidance for high risk complaints
    - Incorporate flow charts for escalation in delayed responses and MP complaints
- Development of a learning tool that can be used by individuals for personal study/development, under the supervision of a manager/other or in a facilitated learning environment, e.g. workshop.

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.