Warrington and Halton Hospital NHS Foundation Trust
Board of Directors
Agenda
Wednesday 27th May 2015, time 1300 – 1700 hrs
Trust Conference Room, Warrington Hospital

1300 ***30mins***	***W&HHFT/TB/15/108***	***Welcome, Apologies & Declarations of Interest***		Chairman
	W&HHFT/TB/15/109	***Patient Story***		
	W&HHFT/TB/15/110	***Minutes of the previous meeting held on 29th April 2015***	Paper	
	W&HHFT/TB/15/111	***Action Plan***	Paper	
1330 ***15mins***	***W&HHFT/TB/15/112***	***Chairman's Report***	Verbal	Chairman
1345 ***20mins***	***W&HHFT/TB/15/113***	***Chief Executives Report***	Verbal	Chief Executive
People				
1405 ***10mins***	***W&HHFT/TB/15/114***	***Verbal Report from the Chair of the Strategic People Committee***	Verbal	Anita Wainwright, Non-Executive Director
1410 ***15mins***	***W&HHFT/TB/15/115***	***Workforce and Educational Development Key Performance Indicators***	Paper	Director of HR & OD
1425 ***10mins***	***W&HHFT/TB/15/116***	***Monthly Ward Staffing Report***	Papers	Director of Nursing and Governance
Sustainability				
1435 ***10mins***	***W&HHFT/TB/15/117***	***Verbal Report from the Chair of the Audit Committee***	Verbal	Ian Jones, Non-Executive Director
1445 ***15mins***	***W&HHFT/TB/15/118***	***Annual Reports and Accounts 2014/15***	Paper	Chair of Audit Committee
1500 ***10mins***	***Break***			
1510 ***10mins***	***W&HHFT/TB/15/119***	***Verbal Report from the Chair of the Finance and Sustainability Committee*** • ***Finance and Sustainability Committee annual Report 2015***	Verbal Paper	Terry Atherton, Non-Executive Director
1520 ***15mins***	***W&HHFT/TB/15/120***	***Finance Report – 30th April 2015***	Paper	Director of Finance & Corporate Development
1535 ***15mins***	***W&HHFT/TB/15/121***	***Corporate Performance Report – 30th April 2015***	Paper	Chief Operating Officer
1550 ***10mins***	***W&HHFT/TB/15/122***	***Compliance with Provider Licence Conditions G6 and COS7***	Paper	

1600 ***10mins***	***W&HHFT/TB/15/123***	***Verbal Report from the Chair of the Quality Governance Committee*** • ***Approval of the Terms of Reference of the Quality Committee***	Verbal Paper	Mike Lynch, Non-Executive Director
1610 ***15mins***	***W&HHFT/TB/15/124***	***Quality Dashboard – 30th April 2015***	Paper	Director of Nursing and Governance / Medical Director
1615 ***20mins***	***W&HHFT/TB/15/125***	***Mortality Overview Report***	Paper/ Presentation	Medical Director
1635 ***10mins***	***W&HHFT/TB/15/126***	***Complaints Annual Report 2015***	Paper	Director of Nursing and Governance
1645	***W&HHFT/TB/15/127***	***Other Board Committee Reports:*** ***Minutes for Noting:*** ***a) Finance and Sustainability Committee held on 21st April 2015***	Paper	
	W&HHFT/TB/15/128	***Any Other Business***		
1700 ***ends***		***Dates of next meeting*** *24th June 2015*		

BOARD OF DIRECTORS

WHH/B/2015/ **109**

SUBJECT:	**Patient Story**
DATE OF MEETING:	27th May 2015
DIRECTOR:	Director of Nursing and Organisational Development

W&HHFT/TB/15/111

TRUST BOARD
ACTION PLAN – Current / Outstanding Actions
Meeting: Trust Board 27th May 2015

Meeting date	Minute Reference	Action	Responsibility & Target Dates	Status	
28/01/2015	TB/15/008	The Director of Nursing and Governance review the reporting of heart failure on the dashboard to see if there was a more appropriate way of showing the position. Any changes would be included in the Quality Dashboards for 2015/16.	The Director of Nursing and Governance May 2015	As part of the refresh of the Quality Dashboard for 2015/16. April 2015 Dashboard will incorporate reporting requirements.	Action ongoing
29/04/2015	TB/15/071	The Medical Director to provide a report on the review being undertaken on mortality.	Medical Director	See agenda item TB/15/125	Action Complete

BOARD OF DIRECTORS

WHH/B/2015/ **112**

SUBJECT:	**Chairman's Report**
DATE OF MEETING:	27 May 2015
DIRECTOR:	Chairman

BOARD OF DIRECTORS

WHH/B/2015/ **113**

SUBJECT:	**Chief Executive Report**
DATE OF MEETING:	27 May 2015
EXECUTIVE DIRECTOR:	Chief Executive

BOARD OF DIRECTORS

WHH/B/2015/ **114**

SUBJECT:	**Verbal Report from the Chair of the Strategic People Committee**
DATE OF MEETING:	27 May 2015
DIRECTOR:	Anita Wainwright, Non-Executive Director

BOARD OF DIRECTORS

WHH/B/2015/ **115**

SUBJECT:	Human Resources / Education & Development Key Performance Indicators (KPIs) Report	
DATE OF MEETING:	27th May 2015	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Mick Curwen, Associate Director of HR	
EXECUTIVE DIRECTOR:	Roger Wilson, 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):	• With the exception of Health and Safety, very little change in Mandatory Training and PDR rates • No change in the number of doctors revalidated • In month reduction in sickness rate 4.47% • Turnover and Vacancy rates have stabilised. Headcount has decreased and vacancies have increased • Decrease in temporary staffing expenditure of £172k • High number of medical staff vacancies but some success with consultant appointments • All main Equality and Diversity targets achieved for 2014	
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

Appendix 1

Human Resources / Education & Development
Key Performance Indicators Report May 2015

1.0 Introduction

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

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

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

2.0 HR and E&D Trust Workforce Standards KPIs Overview

2.1 Mandatory Training

The target for all mandatory training is 85%.

There has been very little change to the mandatory training rates for April. Although there was an increase for Health and Safety, there was a slight reduction for Fire and no change for Manual Handling. However, individually, some Divisions/areas are meeting the trust target for some parts of the mandatory training.

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

Division	Fire Safety	Health & Safety	Manual Handling
Scheduled Care	71% (71%) (Amber)	41% (31%) (Red)	66% (62%) (Red)
Unscheduled Care	71% (72%) (Amber)	35% (35%) (Red)	57% (57%) (Red)
Women's & Children's	71% (73%) (Amber)	48% (46%) (Red)	79% (79%) (Amber)
Estates	85% (90%) (Green)	69% (72%) (Amber)	93% (97%) (Green)
Facilities	79% (85%) (Amber)	84% (62%) (Red)	89% (89%) (Green)
Corporate Areas	83% (82%) (Amber)	85% (79%) (Amber)	78% (82%) (Amber)

None of the areas are achieving all of the targets. For Fire and Manual Handling most areas remained similar to the previous month but there were significant increases in Health and Safety for Scheduled Care (10%) and Facilities (22%). Estates are the only area showing reasonable levels of compliance.

At a Corporate level the arrangements introduced in September 2012 for Corporate Induction continue to work well but there was a slight reduction to 95% of staff who attended corporate induction during April 2015.

2.1.1 Health & Safety (Red)

From the significant drop in February coinciding with the move to annual rather than 3 yearly reporting for Health and Safety, there has been some further recovery during April with an increase of 3% to 50%. However, the target of 85% is not being achieved.

2.1.2 Fire Safety (Amber)

There has been a very slight reduction of 1% to 74% and amber which means the target for 2015/16 is not being achieved.

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

There has been no change from the previous month and the rate is 72%. The status is amber and the target of 85% for 2015/16 is not being achieved.

2.1.3.1 Manual Handling Patient Training Only (Red)

There was no change from the previous month and the rate remains at 64% and red.

2.1.3.2 Manual Handling Non-Patient Training Only (Amber)

There was no change from the previous month and the rate remains at 80% and amber.

2.2 Staff Appraisals

The target for completed PDRs is 85%.

During April there was no change for Non- Medical staff but there was a slight increase for Medical and Dental staff.

Completion rates for the Divisions for non-medical staff are as follows (figures in brackets denotes the month of March 2015):

Division	PDR Rate
Scheduled Care	76% (74%) (Red)
Unscheduled Care	64% (62%) (Red)
Women's and Children's	67% (70%) (Amber)
Estates	53% (72%) (Amber)
Facilities	86% (85%) (Green)
Corporate Areas	79% (80%) (Amber)

Only Facilities are meeting the target but three areas are now showing red as follows: Unscheduled Care, Women's and Children's and Estates who in particular have dropped by 19% from the previous month.

2.2.1 Non-Medical Staff (Amber)

For the period up to April 2015 and the third month in succession, the percentage of non-medical staff having had an appraisal remained the same at 71% (amber) and the target for 2015/16 is not being met.

2.2.2 Medical & Dental Staff (Amber)

The combined rate for Consultant staff and Middle Grade doctors, up to April 2015 increased by 1% to 82%. The rate for Consultants increased by 2% to 89% and other M&D fell by 3% to 66%.

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

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

also introducing a new performance culture with a much greater emphasis on both PDR rates and mandatory training. This is underpinned by a new 'Performance Improvement Policy' and an 'Incremental Pay Progression Policy'.

2.3 Revalidation for Medical and Dental Staff (Green)

The Revalidation Decision Making Group meeting planned for 19 May 2015 was cancelled and is not to be rearranged as there was only one doctor to be discussed which is not urgent. Therefore, there has been no change to the number of doctors revalidated which is 120 with 20 doctors deferred. This maintains the rate at 86% and the status 'Green' which means the target is being achieved.

The next meeting of the Decision Making Group is arranged for 16 July 2015

2.4 Sickness Absence

2.4.1 Sickness Absence Rates (Amber)

The sickness absence target for 2015/16 is 3.75%.

Sickness absence for April 2015 remains high at 4.47% but this was an improvement of 0.31% 0.42% from the previous month and is the best month again since September 2015.

In the last two months (March 15 and April 150 sickness absence has fallen 0.73%

As this is the start of the financial year the cumulative rate is the same as the monthly rate, 4.47%

Other trusts have experienced similar increases in sickness absence and as at Feb-15 the North West Acute Hospital average was 4.4% sickness.

Sickness absence continues to be closely monitored and managed in all areas in the Trust in line with the Attendance at Work Policy. The number of staff being managed either through the Short Term Absence or Long Term Absence Sections of the policy, remains has risen to 351 staff.

2.4.2 Return to Work Interviews (RTW) (Red)

The target for this KPI is 85% and is only reported on a quarterly basis. The rate for Q4 was disappointing at 47% and Q1 results will not be available until the July Trust Board meeting.

At training sessions and when completing eSVLs, managers are reminded of the need to undertake RTW interviews and record these on ESR. It is still believed that more RTW interviews are actually taking place but managers are failing to record this on ESR. This is an issue which will also be addressed as part of the new performance culture.

2.5 Turnover Rate (Amber)

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

The rate for the previous 12 months up to April 2015 showed a marginal deterioration of 0.07% to 10.48% and the status is amber. The target for 2015/16 is between 8 – 9%. The turnover rate remains high in both Unscheduled Care and Scheduled Care at 11.32% and 11.81% respectively. As previously reported, both of these Divisions are undertaking further analysis of leavers by

personal interviews to understand in more detail why staff are leaving. Scheduled Care results have already been reported and Unscheduled Care has just completed their report which will be considered at the Strategic People Committee.

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

The Trust FE FTE was 3732 and staff in post 3433 FTE. This means the vacancies FTE has slightly deteriorated to 8.01%, but this remains within the target threshold of 6.5 – 10%. The status is therefore 'green' and the target was achieved.

The headcount has reduced to 4202 which was a decrease of 32 from the previous month.

This is still a positive position for the trust.

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

The threshold for this KPI is 4.5% of total pay bill. Total spend in April 2015 decreased by £172k and was £1226k, which represents 9.32% of the pay bill for the month. Against the agreed threshold for 2015/16 of 4.5% the status, therefore, is 'Red' and is not being achieved.

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

Nurse Bank and Agency Nursing - £447k (£526k for March)
Agency (exc Medical & Nursing Agency) - £306k (£550k for March)
Medical Locums and Medical Agency - £473k (£526k for March)

All three areas showed a reduction as follows: Nurse Bank/Agency by £79k; Agency by £244k and Medical Locums /Agency by £53k. It is important to note that agency expenditure is largely attributable to the Lorenzo project (41%) which showed £126k for April but the project as a whole is underspent on budget.

NB In order to staff the additional 24 intermediate care beds on Daresbury which were opened in March the trust had to recruit staff predominantly from agencies and some of these staff have continued to be needed to meet additional staffing pressures. The bed base between medicine and surgery is being changed to switch A4 Ward from surgical to medical to reduce the need for escalation beds and additional bank/agency staff. This followed the 'Perfect 14' project which commenced in April.

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

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

<u>Nurse Bank and Agency Nursing</u>
Elderly and Stroke - £122k (£53k on agency) (£145k in March)
A&E - £108k (£95k on agency) (£106k in March)
Acute Medicine – £58k (£34k on agency) (£47k in March)
Critical Care - £48k (£37k on agency) (£91k in March)
Specialty Medicine - £48k (£29k on agency) (£58k in March)
Women's - £23k (£32k in March)

<u>Agency</u>
Lorenzo - £126k (£414k in March)
Therapies - £67k
Pharmacy - £26k (£40k in March)
PMO – £7k (£25k in March)
Radiology - £19k (£25k in March)

Medical Locums/Agency
Elderly and Stroke - £225k (£294k in March)
T&O - £85k (£74k in March)
A&E - £52k (£31k in March)
Surgery - £35k (£53k in March)
Specialty Medicine - £25k (£20k in March)
Women's Health - £20k (£21k in March)
Child Health - £15k (£23k in March)

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

STAFFflow Savings

Information is received on a monthly basis which shows the year to date saving and the proportion of bookings being made through STAFFflow. The latest figures available show the position for March 2015 and in effect cover the full financial year. The savings from using STAFFflow in 2014/15 were £385,454 which is significant. The proportion on bookings made during March was 80% which is the target the trust was hoping to achieve.

Nursing Recruitment
Discussions have been held with Nurse Managers in Unscheduled Care and Scheduled Care and it has been agreed to have rolling adverts covering both Divisions and regular interviews on a monthly basis with support from Employment Services, Occupational Health and Nurse Education. This will be implemented very soon.

International Recruitment
The trust is working with an agency called Globalmedirec to recruit Consultant Radiologists. From the first round of interviews one doctor accepted an offer of employment and commenced on 10.11.14. Traditional advertising has also taken place and from interviews held on 9.4.15 three further consultant radiologists were appointed who will commence in post later in the year. This is excellent news for radiology and will significantly reduce the need for WLIs.

Unscheduled care have identified a number of consultant posts suitable for international recruitment and although a second block advert appeared in the BMJ, no applications were received. There were unavoidable problems in placing an advert in the Indian press but this will still be pursued at the same time as advertising through NHS Jobs. The Division is awaiting final responses from two applicants who were offered posts but who have yet to make a final decision.

The trust has held discussion with NHS Professionals to explore the possibility of recruiting nurses from overseas. A briefing report was considered by HMB on 14.5.15 and the Director of Nursing and Governance has been tasked with establishing the success or otherwise from her nursing colleagues in other trusts of international recruitment.

Recruitment Process
The trust has streamlined the recruitment process and shared this with Divisions. A new revised ECF/Vacancy Control process became operational on 4 May 2015 and the first Vacancy Panel meeting was held on 13 May 2015.

E-Rostering
23 Wards/areas are now live including 20 which are fully live through ESR and 3 more planned for May for ESR purposes. This will then be followed by Theatres and Maternity and the roll out will then be complete.

De Poel

Discussions are continuing with De Poel to resolve the contractual difficulties and commencement of the project is imminent.

Work is continuing on the Medical Productivity work stream. There has been some slippage with reviewing job plans but the Divisions are trying to recover this position. The trust is working with Allocate and a business case has now been agreed to roll out e rostering for medical and dental staff across the trust. This business case also covered the implementation of an electronic expenses system.

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

Division/Post	**Closing Date**	**Interview Date**	**Comments**
Women's and Children's			
LAS Senior Specialty Trainee in Paediatrics	20.5.15		
LAS JST in Paediatrics	26.3.15	27.4.15	
Clinical Fellow Glaucoma	21.5.15		
Scheduled Care			
LAS JST in Urology	6.4.15		Shortlisting completed. Skype interview considered but applicant requested to attend for formal interview
LAS SST Breast Surgery	14.4.15		Skype interview. Appointment made but delay in applicant completing employment checks
LAS JST T&O	30.3.15		Shortlisting completed and interview date being arranged
Consultant Anaesthetist x 3	26.4.15	1.6.15	7 candidates shortlisted
Unscheduled Care			
Consultant Respiratory Medicine	16.3.15	20.4.15	Offer made. Awaiting acceptance but given until 31.5.15 deadline to decide
LAS SST Elderly Care	14.5.15		No applicants. Rolling advert
Consultant in Gastroenterology	26.4.15	29.6.15	Appointment made but applicant has deferred start date on a number of occasions. Deadline of 14.5.15 to give firm commitment.
Consultant Elderly Care – Acute	22.2.15	27.4.15	Doctor appointed and will commence on 1.9.15
Consultant Elderly Care – Acute	26.4.15		No applicants. To be re-advertised.
Consultant Elderly Care – Orthogeriatric	26.4.15		No applicants. To be re-advertised.
Consultant Elderly Care – Dementia	26.4.15		No applicants. To be re-advertised.
Locum Consultant in Emergency Care	6.5.15	11.6.15	1 application and shortlisting taking place.
Consultant Stroke Medicine	26.4.15	4.6.15	No applicants. To be re-advertised.

LAS ST1-2 in Emergency Medicine			Awaiting VCF
Consultant Respiratory Medicine	26.4.15	22.6.15	
Clinical Leadership Fellow	11.6.15		

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

2.8 Equality & Diversity

2.8.1 E&D Specialist in place (Green)

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

2.8.2 Annual Workforce Equality Analysis Report published (Green)

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

2.8.3 Annual Equality Duty Assurance report published (Green)

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

2.8.4 Annual Equality Objectives published (Green)

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

2.8.5 Annual Equality Strategy published (Green)

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

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

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

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

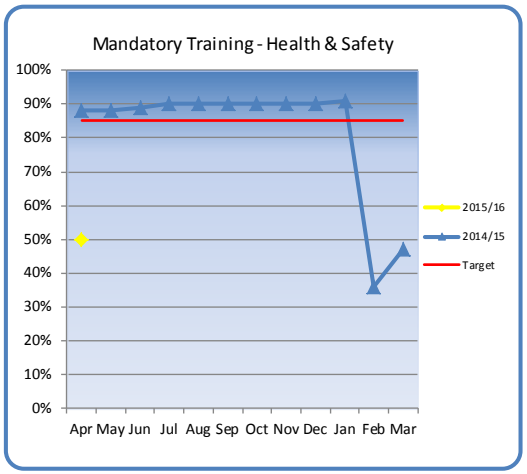
The position at Q4 for 2014/15 was 67%. Q1 figures will not be available until the July Trust Board meeting.

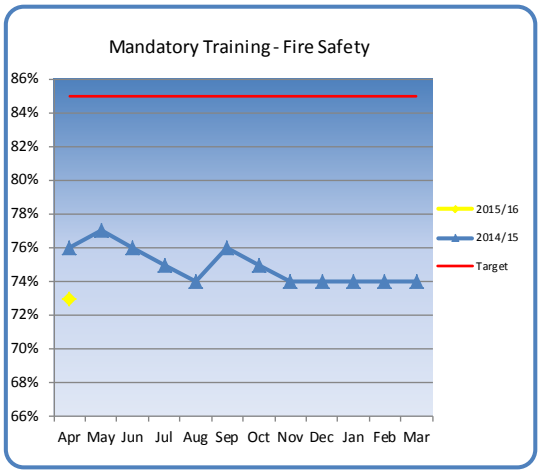
Warrington and Halton Hospitals NHS Foundation Trust
Governance & Workforce Division
Human Resources / Education & Development Workforce Key Performance Indicators

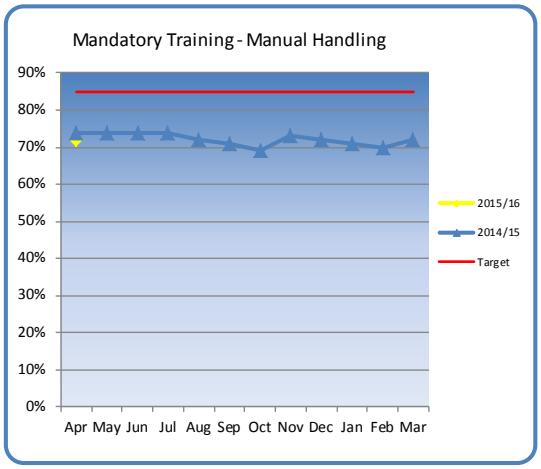
2015/16			Target / Threshold	Frequency	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year to Date	Criteria for RAG Status: Green	Amber	Red
Training & Development	Mandatory Training	Healthh & Safety	85% staff trained in last 3 years	Monthly	50%												**50%**	85 - 100%	70 - 84%	< 70%
		Fire Safety	85% staff trained in last 12 months	Monthly	73%												**73%**	85 - 100%	70 - 84%	< 70%
		Manual Handling - Patient	85% staff trained in last 2 years	Monthly	64%												**64%**	85 - 100%	70 - 84%	< 70%
		Manual Handling - Non-Patient			80%												**80%**			
		Manual Handling - Total			72%												**72%**			
	Staff Appraisals	Non Medical	85% staff received appraisal in last 12 months	Monthly	71%												**71%**	85 - 100%	70 - 84%	< 70%
		Medical & Dental - consultants & career grades, (exc Jnr Drs)			82%												**82%**			
	Revalidation for Medical & Dental Staff		85% of eligible M& D Staff revalidated	Monthly	86%												**86%**	85 - 100%	70 - 84%	< 70%
Sickness Absence	Sickness Absence Rates		4%	Monthly	4.47%												4.47%	3.75%	3.76-4.49%	> 4.50%
	Return to work interviews		85%	Quarterly													**47%**	85 - 100%	70 - 84%	< 70%
Workforce	Turnover (Leavers)		Min 8% or Max 9%	Monthly	10.48%												**10.48%**	8 - 9%	5 - 7.9% / 9.1 - 12%	< 5% / > 12%
	Establishment / SIP	Funded WTE (see NB 1 below)	Min 6.5% or Max 10% FE / SIP gap	Monthly	3732												**3732**	6.5 - 10%	5 - 6.4% / 10.1 - 12%	< 5% / > 12%
		Staff in Post WTE (see NB 1 below)			3433												**3433**			
		Staff in Post Headcount (see NB 2 below)			4202												**4202**			
		Vacancies WTE (see NB 1 below)			299												**299**			
		Vacancies %			8.01%												**8.01%**			
	Flexible Labour Expenditure (% of total paybill)	Bank / Agency / Medical Locums Total	4.5%	Monthly	9.32%												**9.32%**	4.5%	4.6 - 5.0%	> 5.0%
	Equality & Diversity	E&D Specialist in place	Achieved	6-monthly												Achieved	Achieved	Achieved	Work in progress	No progress
		Annual Workforce Equality Analysis report published	Achieved	Annual												Achieved	Achieved	Achieved	Work in progress	No progress
		Annual Equality Duty Assurance report published	Achieved	Annual												Achieved	Achieved	Achieved	Work in progress	No progress
		Annual Equality Objectives published	Achieved	Annual												Achieved	Achieved	Achieved	Work in progress	No progress
		Annual Equality Strategy published	Achieved	Annual												Achieved	Achieved	Achieved	Work in progress	No progress
		Staff have access to E&D information and resources	Achieved	6-monthly												Achieved	Achieved	Achieved	Work in progress	No progress
		Staff have undertaken E&D training	85% staff trained	6-monthly												67%	67%	85 - 100%	70 - 84%	< 70%

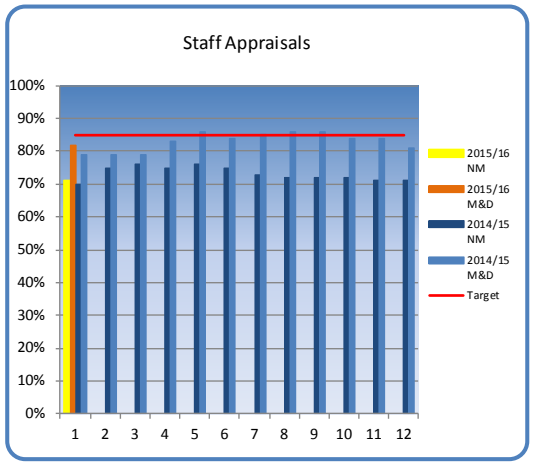
R	Red	A	Amber	G	Green

NB 1 Figures from Finance Ledger
NB 2 Figures from HR ESR


Mandatory Training - Health & Safety
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2015/16
2014/15
Target


Mandatory Training - Fire Safety
86%
84%
82%
80%
78%
76%
74%
72%
70%
68%
66%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2015/16
2014/15
Target


Mandatory Training - Manual Handling
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2015/16
2014/15
Target


Staff Appraisals
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
1 2 3 4 5 6 7 8 9 10 11 12
2015/16 NM
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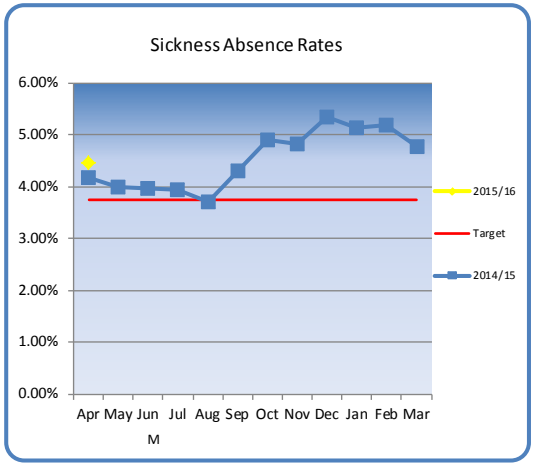
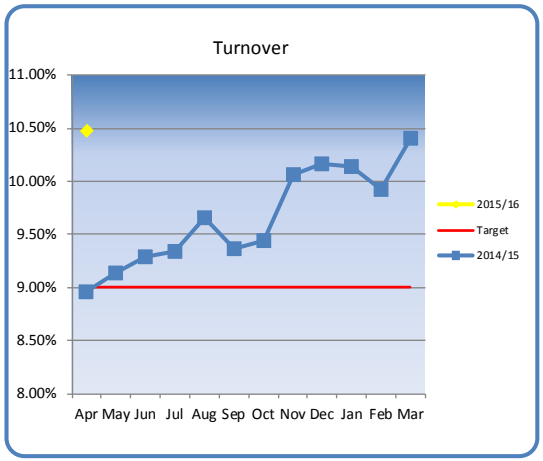
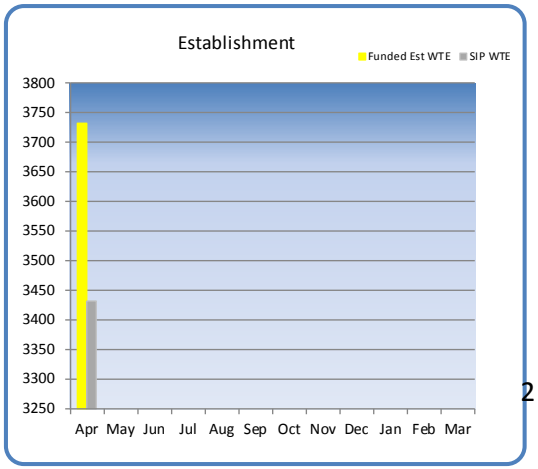
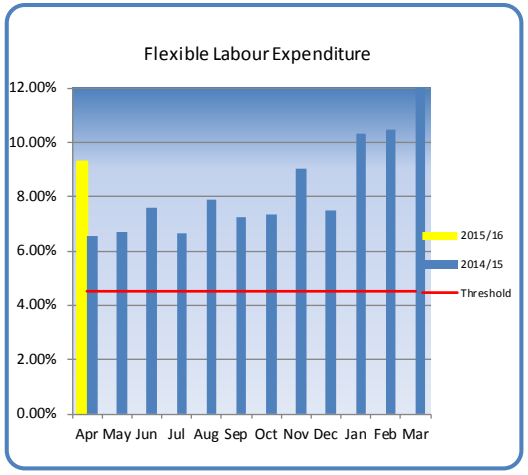
2014/15 M&D
Target


Sickness Absence Rates
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
M
2015/16
Target
2014/15


Turnover
11.00%
10.50%
10.00%
9.50%
9.00%
8.50%
8.00%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2015/16
Target
2014/15


Establishment
Funded Est WTE
SIP WTE
3800
3750
3700
3650
3600
3550
3500
3450
3400
3350
3300
3250
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar


Flexible Labour Expenditure
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2015/16
2014/15
Threshold

BOARD OF DIRECTORS

WHH/B/2015/ **114**

SUBJECT:	**Monthly Staffing Exceptions Report**	
DATE OF MEETING:	27th May 2015	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Alison Lynch (Deputy Director of Nursing Quality and Patient Experience)	
EXECUTIVE DIRECTOR:	Karen Dawber, Director of Nursing and Governance	
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care 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 March 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 April 2015 data based on the information included in this paper.

3.0 Divisional Breakdown

Ward name	DAY Average fill rate - registered nurses / midwives (%)	DAY Average fill rate - care staff (%)	NIGHT Average fill rate - registered nurses / midwives (%)	NIGHT Average fill rate - care staff (%)	Exception Report Comments with assurance provided by Associate Directors of Nursing
SCHEDULED CARE DIVISION					
A4	**87.5%**	**86%**	**100%**	**209%**	There has been a necessary increase on nights for the care staff due to SAU being bedded down over night The areas is not funded to cover over night, and ordinarily it should close.

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
A5	**95%**	**100%**	**82%**	**100%**	3-5 Escalation beds open for majority of April.
A6	**89%**	**100%**	**82%**	**100%**	2-4 Escalation beds open throughout April. Hospital acquired pressure ulcer occurred on the ward, during the mini investigation it was identified that the 3 days prior to the incident the ward did not have its full complement of staff on duty and this was identified as a possible contributory factor in the pressure ulcer happening
A9	**91%**	**89%**	**74%**	**100%**	2-4 Escalation beds open for majority of April. Ward Manager based in numbers for majority of April rather than agreed 80% supervisory role to support staffing.
B19	**99%**	**133%**	**100%**	**103%**	2-4 Escalation beds open majority of April and over on CSW due to escalation and NOF unit. Some increase of CSW on nights due to 1:1 patients at times.
B4	**96%**	**93%**	**96%**	**100%**	Shortfall in staffing has been covered by the ward. 1 new starter commencing next week however this still leaves 1.88 wte vacancies.
Ward 1 - CMTC	**82%**	**85%**	**77%**	**84%**	It has been difficult to match actual to planned staffing this month as there are a number of vacancies and staff are involved in the recruitment open days. 1 new carer has just started but there is still 2.6 vacancies
ICU	**89%**	**77%**	**85%**	**72%**	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 April 2015 was 80% therefore even though shifts fell short 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	**79%**	**69%**	**94%**	**78%**	Daily review of staffing across Division (Monday to Friday by Matrons and at weekend by Site Manager) to balance staffing. Division wide pressures have resulted in depletion of RN cover from A1 and other areas - particularly at night - to enable minimum staffing levels across the Trust. Where possible there has been replacement with care support nurse to support fundamental care.
A2	**92%**	**104%**	**75%**	**111%**	
A3	**99%**	**99%**	**84%**	**110%**	Daily review of staffing across Division (Monday to Friday by Matrons and at weekend by Site Manager) to balance staffing. Division wide pressures have resulted in depletion of RN cover from A3 and other areas - particularly at night - to enable minimum staffing levels across the Trust. Where possible there has been replacement with care support nurse to support fundamental care.
A7	**80%**	**98%**	**77%**	**100%**	Daily review of staffing across Division (Monday to Friday by Matrons and at weekend by Site Manager) to balance staffing. Awaiting recruitment. Ward had x2 maternity leaves currently. Ward manager supported ward to maintain safe levels
A8	**89%**	**93%**	**96%**	**107%**	Daily review of staffing across Division (Monday to Friday by Matrons and at weekend by Site Manager) to balance staffing.
B12	**100%**	**83%**	**100%**	**94%**	
B14	**93%**	**88%**	**77%**	**95%**	
B18	**78%**	**97%**	**80%**	**83%**	Daily review of staffing across Division (Monday to Friday by Matrons and at weekend by Site Manager) to balance staffing. B18 have had to revert to barrier rather than cohort nursing to provide safe care particularly at night
C21	**98%**	**97%**	**100%**	**65%**	CSW moved to support shortfall in division and maintain safety.
C22	**103%**	**75%**	**100%**	**100%**	Daily review of staffing across Division (Monday to Friday by Matrons and at weekend by Site Manager) to balance staffing.

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
CCU	79%	49%	97%	NA	CSW moved to support short fall in division and maintain safety
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	92%	90%	99%	NA	The ward experienced reduced occupancy during this month and staffing gaps covered by on call and specialist nurse cover as required
Neonatal Unit	78%	84%	100%	90%	ad hoc sickness covered by nurse specialist on call to maintain safe staffing levels.
C20	86%	73%	100%	NA	Daily review of staffing across Division (Monday to Friday by Matrons and at weekend by Site Manager) to balance staffing.
C23	146%	97%	131%	100%	

4.0 Assurance provided from the Divisional Associate Directors of Nursing:

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

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

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

Unscheduled Care – The Division has continued to experience high levels of vacancies in April 2015. All areas were safely staffed but there are some deficits across the Division.

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

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

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

Appendix 1

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Staffing Levels

Apr-15

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 Mar-15	Agreed nurse to patient ratios	**Total monthly planned staff hours**	**Total monthly actual staff hours**	**Total monthly planned staff hours**	**Total monthly actual staff hours**	Agreed nurse to patient ratios	**Total monthly planned staff hours**	**Total monthly actual staff hours**	**Total monthly planned staff hours**	**Total monthly actual staff hours**	Number of hours above or below planned	Length of a shift in hours	Number of shifts above or below planned	Variance	Falls	Hospital acquired pressure ulcers	Catheter associated UTIs	New VTEs
Scheduled Care	W-A4 - Ward A4	28	19.38	0.75	0.00	7.70	0.00	7.77%	1:8	1738.0	1520.5	874.0	753.5	1:8	690.0	690.0	330.0	690.0	22.0	11.5	1.9	0.61%	0	2	0	0
	W-A5 - Ward A5	28	18.03	1.46	0.00	14.60	0.82	7.42%	1:7	1380.0	1310.0	1035.0	823.0	1:9	1035.0	851.0	690.0	690.0	-466.0	11.5	-40.5	-11.26%	0	0	0	0
	W-A6 - Ward A6	28	19.57	4.43	0.00	13.60	1.07	1.48%	1:7	1453.0	1290.5	1035.0	1042.5	1:9	1035.0	851.0	690.0	690.0	-339.0	11.5	-29.5	-8.05%	0	0	0	1
	W-A9 - Ward A9	28	18.83	2.27	1.00	15.50	1.00	3.17%	1:7	1380.0	1257.0	1380.0	1234.0	1:9	1035.0	770.5	690.0	690.0	-533.5	11.5	-46.4	-11.90%	0	0	0	1
	W-B19 - Ward B19	18	13.68	2.00	0.00	13.90	0.61	1.34%	1:6	1035.0	1027.0	690.0	923.5	1:6	690.0	690.0	690.0	713.0	248.5	11.5	21.6	8.00%	0	1	0	0
	W-B4-H - Ward B4 - Halton	27	12.20	1.88	0.00	6.00	1.00	7.92%	1:9	874.0	836.0	552.0	514.5	13.5 :1	552.0	529.0	322.0	322.0	-98.5	11.5	-8.6	-4.28%	0	0	0	0
	W-CM1-H - Ward 1 - CMTC Treatment Centre	30	26.60	6.00	0.00	14.00	2.69	4.42%	1:5.5	1978.0	1621.5	1196.0	1017.0	10 : 1	966.0	839.5	644.0	540.5	-765.5	11.5	-66.6	-16.00%	0	0	0	0
	W-ICU - Intensive Care Unit	18	76.74	10.46	4.00	12.52	0.32	9.13%	1:1 Level 3 1:2 Level 2	4830.0	4301.0	1035.0	799.3	1:1 Level 3 1:2 Level 2	4830.0	4117.0	690.0	494.5	-1673.3	11.5	-145.5	-14.70%	0	0	0	0
Total		205	205.03			97.82		8.00											-3605.3		-313.5					
Unscheduled Care	AED			4.70	1.00	13.02	2.90	5.34%		4712.0	4520.0	1238.5	1066.0		3105.3	2964.4	773.5	720.1	-558.6	12.5	-44.7	-5.68%	0	0	0	0
	W-A1A - Ward A1 Asst	29	41.40	11.08	0.00	22.10	7.31	6.65%	5.5	2625.0	2046.0	1500.0	1030.0	0.0	1890.0	1772.5	630.0	493.0	-1303.5	12.5	-104.3	-19.62%	0	0	0	1
	W-A2A - Ward A2 Admission	28	18.83	1.10	0.00	12.90	2.00	6.71%	5.6	1380.0	1276.0	1035.0	1082.4	9.3	1173.0	885.5	690.0	770.0	-264.1	11.5	-23.0	-6.17%	1	0	0	2
	W-A3OPAL - Ward A3 Opal	34	18.83	1.12	0.00	15.46	0.00	3.39%	8.5:1	1380.0	1368.5	1403.0	1383.5	0.0	1069.5	897.0	690.0	759.0	-134.5	11.5	-11.7	-2.96%	1	0	0	0
	W-A7 - Ward A7	33	18.80	3.30	3.00	15.50	0.37	2.48%	8.3:1	1725.0	1394.5	1380.0	1357.0	0.0	1380.0	1058.0	690.0	690.0	-675.5	11.5	-58.7	-13.05%	0	0	0	2
	W-A8 - Ward A8	34	18.80	1.30	0.00	15.50	3.90	5.72%	8.5:1	1426.0	1281.0	1426.0	1326.0	0.0	1069.0	1028.0	713.0	770.0	-229.0	11.5	-19.9	-4.94%	0	3	0	1
	W-B12 - Ward B12 (Forget-me-not)	21	13.68	0.00	0.00	15.50	1.24	2.23%	7.0:1	1035.0	1043.5	1610.0	1340.0	0.0	690.0	690.0	954.5	897.0	-319.0	11.5	-27.7	-7.44%	0	0	0	0
	W-B14 - Ward B14	24	15.82	0.00	0.00	12.88	1.72	6.56%	6.0:1	1380.0	1283.0	1035.0	907.0	8.0	1035.0	793.5	690.0	655.5	-501.0	11.5	-43.6	-12.10%	0	0	0	0
	W-B18 - Ward B18	24	18.84	1.00	0.00	18.00	1.52	7.91%	6.0:1	1380.0	1072.0	1380.0	1342.0	0.0	1035.0	828.0	1035.0	862.0	-726.0	11.5	-63.1	-15.03%	0	0	0	0
	W-C21 - Ward C21	24	13.68	0.5	0.0	11.30	0.00	6.76%	8.0:1	1035.0	1011.9	825.0	825.0	0.1	690.0	690.0	552.0	356.5	-218.6	11.5	-19.0	-7.05%	0	0	0	20
	W-C22 - Ward C22	21	13.68	0.00	0.00	12.90	0.64	3.98%	7.0:1	1069.5	1030.5	1069.5	801.0	0.1	713.0	713.0	713.0	713.0	-307.5	11.5	-26.7	-8.63%	0	1	0	0
	W-CCU - Coronary Care Unit	8	21.2	1.5	0.0	2.6	0.00	2.27%	2.0:1	1725.0	1357.0	345.0	169.0	0.0	1035.0	1003.5	0.0	0.0	-575.5	11.5	-50.0	-18.53%	0	0	0	0
	W- WICU		18.8	6.0	6.0	18.0	11.83			1440.0	816.0	1740.0	1428.0		1080.0	600.0	0.0	0.0	-1416.0	11.5	-123.1	-33.24%	1	1	0	0
Total		280	232.36			185.70													-7228.8		-615.6					
WCSS	W-B11B/W-B11C - Ward B11	24	29.50	6.70	2.00	15.92	0.00	3.46%	1:1 level3 1:2 Level2	2100.0	1926.0	840.0	760.0	0.0	1488.0	1468.0	0.0	0.0	-274.0	7.5 day 10.63 night		-6.19%	0	0	0	0
	W-NHDU/W-NITU/W-NSC - Neonatal Unit	18	24.38	0.00	2.20	6.52	0.00	1.64%	7.5:18	1020.0	798.0	798.0	672.0	7.5:18	902.0	902.0	240.0	217.0	-371.0			-12.53%	0	0	0	0
	W-C20 - Ward C20	12	12.63	1.40	1.40	5.00	2.40	16.50%	1:4	1087.5	930.0	870.0	637.5	1:6	600.8	600.8	0.0	0.0	-390.0			-15.24%	0	0	0	0
	W-C23 - Ward C23	22	98.52	2.50	2.50	10.70	11.60	0.00	1:7.33	1348.5	1978.6	900.0	870.0	1:11	587.4	775.2	290.0	290.0	787.9			25.21%	0	0	0	0
Total		76	165.03	10.60	8.10	38.14	14.00	6.90											-247.1		0.0		0	0	0	0
Grand Total		561	602.42	10.60	8.10	321.66	14.00	7.60											-11081.2		-929.1		0	0	0	0

BOARD OF DIRECTORS

WHH/B/2015/ **117**

SUBJECT:	**Verbal Report from the Chair of the Audit Committee**
DATE OF MEETING:	27th May 2015
DIRECTOR:	Ian Jones, Non-Executive Director

BOARD OF DIRECTORS

WHH/B/2015/ **118**

SUBJECT:	**Approval Of the Annual Reports and Accounts 2015**	
DATE OF MEETING:	27th May 2015	
ACTION REQUIRED	**For Decision**	
AUTHOR(S):		
EXECUTIVE/ NON-EXECUTIVE DIRECTOR:	Ian Jones, Char of Audit Committee	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	All	
FREEDOM OF INFORMATION STATUS (FOIA):	Whole FOIA Exemption	
FOIA EXEMPTIONS APPLIED:	Section 22 – information intended for future publication	
EXECUTIVE SUMMARY (KEY ISSUES):	The Audit Committee had opportunity to review the Annual Reports, which included: the Strategic Report and Business Review; The Directors and Corporate Governance Report; the Quality Report; Remuneration Report; and Annual Governance Statement and the Annual Accounts at its meeting on 21st May 2015. The Committee had also received the External Audit Report ISA 260, which included the letters of representation that required approval and sign off.	
RECOMMENDATION:	***The Board is asked to:*** Approve the Annual Report and Accounts 2015 and authorise the signing of the letters of representation.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Audit Committee
	Agenda Ref.	
	Date of meeting	21 May 2015
	Summary of Outcome	Recommended for Approval

BOARD OF DIRECTORS

WHH/B/2015/ **119**

SUBJECT:	**Verbal Report from the Chair of the Finance and Sustainability Committee**
DATE OF MEETING:	27 May 2015
DIRECTOR:	Terry Atherton, Non-Executive Director

Attached FSC Annual Report for noting

Finance and Sustainability Committee

Annual Report 2014/15

Overview

The Finance and Sustainability Committee ensures a robust approach to the monitoring and delivery of the trust's financial and operational planning, performance and strategic and business development and provide the Board of Directors with the necessary assurances that areas under its responsibility are being addressed and managed.

Meetings

The committee meets monthly, one week before the Trust Board meeting. This is to allow for the Committee to review the Finance Report and the Corporate Performance Report and any other report that would require Board review, in greater detail prior to submission to the Board.

Membership

Membership of the committee includes one additional non-executive director and all the executive directors. The deputy director of finance, deputy director - strategy and commercial development and the associate director of estates would normally attend the meetings and associate directors from division and corporate areas are required to attend at the request of the committee. Meeting attendance target for the year was 75%. Details of membership and attendance record can be found in Appendix 1.

Committee Effectiveness and Terms of Reference

In November 2014 the committee undertook an effectiveness review of its activity over the period from its formation in February 2014 to November 2014. The review identified a number of actions that needed to be addressed which included:

1. Amendments to the terms of reference of the Committee. These changes related to the removal of specific areas of responsibility that the committee felt were more appropriate for the Board of Directors to approve, these included:

    a) Review progress against key financial and performance targets
    b) Review and monitor progress, on behalf of the Board, the Trust's temporary staffing levels
    c) Review, on behalf of the Board, Monitor quarterly and annual returns.

    Additional duties were also added to the terms of reference of the Committee including:

    a) Review the Risks identified in the Trust's Board Assurance Framework within the scope of the Committees areas of responsibility.
    b) Receive a monthly IM&T report on implementation of the Trust IM&T Strategy, Information Governance and project management, which included additional assurance reporting on the Lorenzo project.

    Following the decision to appoint a Director of HR and OD, the Committees membership increased to include this post, together with changes to the reporting Committees and Groups and quorum changed from three members to five members which had to include two NEDs.

The changes to the terms of reference of the Committee were approved by the Board of Directors at its meeting on 28th January 2015.

2. The Committee recognised that attendance at a number of meeting had been low from the executive team and requested that their diaries be cleared so that they are able to attend. It was recognised that if an executive director was unable to attend then they were able to nominate a deputy to attend the meetings. Such nomination could only be made on a meeting by meeting basis.

Work Plan 2015/16

In March 2015 a work plan was developed in order to structure the meetings appropriately. Standing Documents to each meeting included:

- Minutes and Actions
- Attendance Register
- Financial Position
- Operations Performance Reporting
- IM&T Steering Committee Strategy update
- Commissioner Contracts and performance updates

Other reports:

- Commercial and Business Development Committee Report (quarterly)
- Efficiency and Productivity (incl. Medical Productivity) Report (quarterly)
- Annual/Strategic Plan and performance update (quarterly)
- Service line Reporting (quarterly)
- Review of the BAF & Risks (F&S related activity) (quarterly)
- Annual Plan & Budget (Annually prior to Board)

Time limited reports:

- Financial Recovery – KPMG (monthly)
- Lorenzo Assurance Report (time limited project) (monthly)
- Estates Strategy Implementation and review – Report (quarterly)

Work of the Committee 2014/15

During the year under review the Committee received detailed reports on the Trust's financial position and its performance against national and local targets. Discussions surrounding these two documents allowed for the reports presented to the Board to be amended appropriately.

In January the Board approved the introduction of the implementation of a modern, fit for purpose electronic record system (Lorenzo) as a key component of the IM&T Strategy and delegated to the Committee the responsibility for obtaining the necessary assurances the Board required on for the delivery and implementation of Lorenzo and its wider impact on the Trust. In April 2015, the Committee having considered how such assurances could be achieved without impacting on its other responsibilities approved the formation of a Board Overview Committee – Lorenzo that would provide written assurances to the Committee on Lorenzo. The Board Overview Committee Lead Executive is the Director of IM&T and the membership includes one NED and four additional executive directors.

In March 2015 the Board approved the appointment of KPMG to undertake a financial review of the Trust in light of Monitor's Financial Governance investigation. The Committee would during 2015/16 receive reports on recommendations of the financial review and any actions arising from it. The scope of the Committees responsibility for assurance in this area has not as yet been agreed.

During the year the Committee received the following reports (other than those standing items) over the year including:

- IM&T Steering Committee Strategy update (monthly from July 2014)
- Commissioner Contracts and performance updates (monthly from July 2014)
- Commercial an Business Development (three times during the year)
- Board Assurance Framework (Quarterly from Formation of FSC in line with Board timetable)
- Review of Mission, Vision and Values (prior to Board approval)
- Service Line Reporting (Quarterly from formation of FSC)
- Budget and Annual Plan 2014/15 (April 2014 prior to Board approval)
- Review of External Auditor (prior to Audit Committee and Council of Governors Review)
- Capital plan 2014/15 and 10 year capital plan 2014-2024

Committee Reporting Requirements

The Minutes of the Committee are available from the Trust Secretary and are reported to the Board monthly. Since January 2015, the Chair of the Committee provides a more detailed verbal update at the Board at the next following Board meeting after the Committee is held. This verbal report is provided before the 'Sustainability' papers are discussed and provides additional assurances and re-assurances to the Board that a robust approach the Committee was taking to the monitoring and delivery of the Trust's financial and operational activity and that they were being managed and addressed.

External work Commissioned

None.

Policies Approved.

None

Terry Atherton
Chair
Finance and Sustainability Committee
May 2015

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Warrington and Halton Hospitals NHS
NHS Foundation Trust

Finance and Sustainability Committee Attendance Record

	2014									2015			% attendance Excl, Deputy	% attendance Incl, Deputy
	Feb	Mar	April	May	June	July	Sept	Oct	Nov	Jan	Feb	March		
Carol Withenshaw, Chair	X	X	X	A/D	X	X	X	A/D	X	X	X	X (member)	83%	100%
Rory Adam, Non-Executive Director	X	X	X	X (Chair)	X	X	X	X (Chair)	X				100%	100%
Terry Atherton, Non-Executive Director										X	X	X (Chair)	100%	100%
Mel Pickup, Chief Executive	X	X	A	A	X	A	X	X	A	A	X	A	50%	100%
Simon Wright, Chief Operating Officer & Deputy Chief Executive	X	X	X	X	X	X	X	X	X	X	X	X	100%	100%
Tim Barlow, Director of Finance and Commercial Development	X	X	X	X	X	X	X	X	X	X	X	X	100%	100%
Karen Dawber, Director of Nursing and Organisational Development	X	A	A/D	X	X	X	A	X	X	A			54%	63%
Karen Dawber, Director of Nursing and Governance											X	X	100%	100%
Paul Hughes, Medical Director	X	A	A	X	A	A	A	A	A	A			20%	20%
Simon Constable, Medical Director											A	A	0%	0%
Roger Wilson, Director of Human Resources and Org Development											X	X (Part)	100%	100%
Jason Da Costa Director of IT	A	A	A	X	X	X	A	X	X	X	X	X (Part)	67%	67%
Deputy asked to attend														
Alison Lynch, Deputy Director of Nursing (for Karen Dawber)			X/D											
Lynne Lobley Non-Executive Director (for Carol Withenshaw)								X/D						

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	2014									2015		
	Feb	Mar	April	May	June	July	Sept	Oct	Nov	Jan	Feb	March
In Attendance												
Colin Reid, Trust Secretary (Brenda Jackson attendance – Minutes)	X	X	X	A/D	X	X	X	X	X	X	A/D	X
Steve Barrow, Deputy Director of Finance		X	A	X	X	X	X	X	X	X	X	X
Mike Barker Deputy Director of Commercial Development		A	A	A	X	X	X	X	A	A	A	A
Terry Atherton Non-Executive Director							X	X	X			
Ian Jones Non-Executive Director							X	X	X			
George Creswell Associate Director of Estates		X	A	A	X	X	A	A	A	A	A	A
Lynne Lobley Non-Executive Director												X

Key:
A = Apologies
A/D = apologies with deputy attending
X/D = Attendance as Deputy

In attendance:
Standing invite for:
Steve Barrow, Deputy Director of Finance
Mike Barker, Deputy Director of Commercial Development (attends when required - Estates)
George Creswell, Associate Director of Estates (attends when required - Estates)

BOARD OF DIRECTORS

WHH/B/2015/ **120**

SUBJECT:	**Finance Report as at 30th April 2015**	
DATE OF MEETING:	27th May 2015	
ACTION REQUIRED	**For Decision**	
AUTHOR(S):	Steve Barrow, Deputy Director of Finance	
EXECUTIVE DIRECTOR:	Tim Barlow, Director of Finance and Commercial Development Choose an item.	
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care SO2: To be the employer of choice for healthcare we deliver SO3: To give our patients the best possible experience	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO4/4.2 Failure to: Maintain a liquidity ratio and capital servicing capacity necessary to deliver a continuity of services risk rating of at least 3 on a quarterly basis; remain a going concern at all times remain solvent; and Comply with section G6 of th 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 SO4/4.3 Failure to manage key contracts appropriately resulting in contract penalties or reduction in service standards; and failure of operational processes to deliver service to agreed contract targets, outputs or standard	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:		
EXECUTIVE SUMMARY (KEY ISSUES):	For the period ending 30th April 2015 the Trust has recorded an actual deficit of £1,936k, a Continuity of Services Risk Rating 2 and has a cash balance of £4,273k.	
RECOMMENDATION:	***The Board is asked to note the contents of the report.***	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee Or type here if not on list:
	Agenda Ref.	
	Date of meeting	20th May 2015
	Summary of Outcome	Approved

FINANCE REPORT AS AT 30th APRIL 2015

1. PURPOSE

The purpose of the report is to advise the Board of Directors on the financial position of the Trust as at 30th April 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 Appendices A to E attached to this report.

Key financial indicators

Indicator	**YTD Plan £m**	**YTD Actual £m**	**YTD Variance £m**
Operating income	17.1	17.2	0.1
Operating expenses	(18.2)	(18.3)	(0.1)
EBITDA	(1.0)	(1.1)	0.0
Non-operating income and expenses	(0.9)	(0.9)	0.0
I&E surplus/(deficit)	(1.9)	(1.9)	0.0
Cash balance	3.8	4.3	0.5
CIP target	0.3	0.2	(0.1)
Capital Expenditure	0.3	0.3	0.0
Continuity of Services Risk Rating	1	2	1

3. INCOME AND EXPENSES

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

Position = Surplus/(Deficit)	**April £000**	**Year to date £000**
Plan	(1,950)	(1,950)
Actual	(1,935)	(1,935)
Variance	**15**	**15**

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

Variance = Favourable/(Adverse)	**April £000**	**Year to date £000**
Operating income	117	117
Operating expenses	(130)	(130)
Non-operating income and expenses	28	28
Total	**15**	**15**

The planned Continuity of Services Risk Rating for the period is a 1 but performance to date results in a rating of 2.

While the in-month result is a significant deficit, it reflects the expected lower levels of activity and income in the month but the position is still marginally ahead of plan. In addition, the year to date performance reflects the planned profile of the cost improvement savings, the delivery of which is weighted towards the second half of the year.

The operating performance continues to have an adverse effect on the amount of cash available to the trust and even though the cash balance is controlled through the management of working balances, a working capital loan is required. The Trust has notified Monitor of a requirement for a £15m working capital loan but a formal decision is not expected until after 30th June.

Operating Income

Year to date operating income is £117k above plan due to an over recovery on Other Operating Income (£236k) partially offset by an under recovery on NHS Clinical Income (£108k) and non NHS Clinical income (£12k).

Operating Expenses

Year to date operating expenses are £130k above plan due to over spends on pay (£129k) and non clinical supplies (£101k) partially offset by underspends on drugs (£66k) and clinical supplies (£34k).

Non Operating Income and Expenses

Non operating income and expenses is £28k below plan mainly due to an underspend on depreciation.

4. COST IMPROVEMENT PROGRAMME

The Trust has an annual savings target of £9,500k and value of schemes identified to date is shown in the table below.

Narrative	**In Year £000**	**Recurrent £000**
Annual Target	9,500	9,500
Planned value of schemes identified	6,548	3,104
Over / (Under) Achievement against target	**(2,952)**	**(6,396)**

For the year to date the planned savings for the identified schemes equate to £300k, with actual savings amounting to £174k which results in an under achievement against the plan of £126k. The identified cost savings programme and the unidentified balance is materially weighted towards the second half of the year, so it is vital that in the first half of the year the planned savings are identified as it will become more difficult to identify and achieve

any shortfalls as the year progresses.

5. CASH FLOW

The cash balance is £4,273k which is £435k above the planned cash balance of £3,838k, with the monthly movements summarised in the table below.

Cash balance movement	**£000**
Opening balance as at 1st April	4,511
In month deficit	(1,936)
Non cash flows in surplus/(deficit)	879
Decrease in receivables	2,280
Decrease in payables	(1,635)
Capital Expenditure	(301)
Other working capital movements	475
Closing balance as at 30th April	**4,273**

The current balance equates to circa 7 days operational cash, however the value of trade creditors as at 30th April stands at £8.0m, the majority of which are overdue. Under the continuity of services risk rating the liquidity metric is -12.5 days which results in a score of 2. The calculation of the metric includes all current assets and liabilities excluding inventories, so masks the challenging cash position which is managed through working balances.

The operating performance will continue to have an adverse effect on the cash position and the ability to process creditor payments. In order to maintain this level of cash balance payments to creditors need to be extended, which has resulted in performance against the non NHS Better Payment Practice Code (BPPC) of only 23% in the month. This low level of compliance and performance will continue until there is an improvement in the cash position brought about by improved operating performance.

6. STATEMENT OF FINANCIAL POSITION

Non current assets have decreased by £276k in the month as capital expenditure is less than depreciation expenses.

Current assets have decreased by £1,220k in the month mainly due to the decrease in cash and receivables, partially offset by the increase in prepayments.

Current liabilities have decreased by £153k in the month mainly due to the decrease in payables, partially offset by an increase in accruals.

7. CAPITAL

The approved capital programme currently stands at £20,302k and to date expenditure of £301k has been incurred against a plan of £276k. The capital programme is planned to be funded through internally generated depreciation (£6,834k) and a capital loan (£13,468k)

although Monitor are only expected to make a formal decision on the loan after 30th June.

8. RISK AND FORECAST

For the period ending 30th April the Trust has recorded a deficit of £1,935k and although this is £15k better than plan, there are a number of financial risks that need to be avoided or mitigated, namely:

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

The Trust is currently forecasting the achievement of the £15m planned deficit, continuity of services risk rating 1 and all other key financial indicators.

Tim Barlow
Director of Finance & Commercial Development
21st May 2015

Appendix A

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Financial headlines as at 30th April 2015

Key Financial Metrics	Month			Year to date			Forecast		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income	17,139	17,256	117	17,139	17,256	117	213,281	213,281	0
Operating Expenditure	-18,175	-18,305	-130	-18,175	-18,305	-130	-216,910	-216,910	0
EBITDA	**-1,036**	**-1,049**	**-13**	**-1,036**	**-1,049**	**-13**	**-3,629**	**-3,629**	**0**
Financing Costs	-914	-886	28	-914	-886	28	-11,371	-11,371	0
Net Surplus / (Deficit)	**-1,950**	**-1,935**	**14**	**-1,950**	**-1,935**	**14**	**-15,000**	**-15,000**	**0**
Continuity of Services Risk Rating				1	2	1	1	1	0
Capital Expenditure	265	301	36	265	301	36	20,302	20,302	0
Cash Balance				3,838	4,273	435	4,471	4,471	0
Cost Savings	300	174	-126	300	174	-126	9,500	9,500	0

Summary Position

The reported position for the period is an actual deficit of £1,935k and a Continuity of Services Risk Rating 2 which is £15k better than the planned deficit of £1,950k and better than the planned Risk Rating of 1.

Year to date income is £117k above plan mainly due to overperformance other operating income, partially offset by underperformance on NHS and non NHS clinical income activity. Year to date expenditure is £130k above plan due to overspends on pay and non clinical supplies, partially offset by underspends on drugs and clinical supplies. Year to date non operating income and expenditure is £28k below plan due to an underspend on depreciation.

Key Variances

Operating Income - £117k above plan (favourable).
Operating Expenditure - £130k above plan (adverse).
Non operating income and expenses - £28k below plan (favourable).
Cost savings - £126k below plan.
Cash balances - £435k above plan.
Capital expenditue - £36k above plan.

Other matters to be brought to the attention of the Board

The Trust and Warrington CCG have not been able to agree a 14/15 year end outturn and the date set for dispute resolution is set for 15th June. The Board need to be aware that a decision in favour of the CCG that reduces the income of level below that included in the 14/15 accounts will reduce the level of income due and increase the financial pressure in 15/16.

The Trust has notified Monitor of the requirement for a £15m working capital loan and a £13.5m capital loan but a decision is not expected until after 30th June 2015.

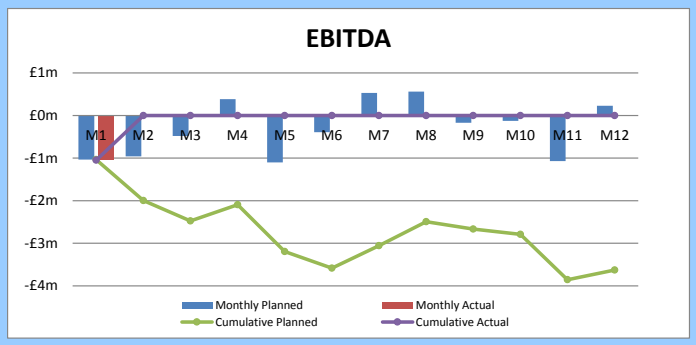
KPMG have produced a draft version of Phase 1 of Project Milford.

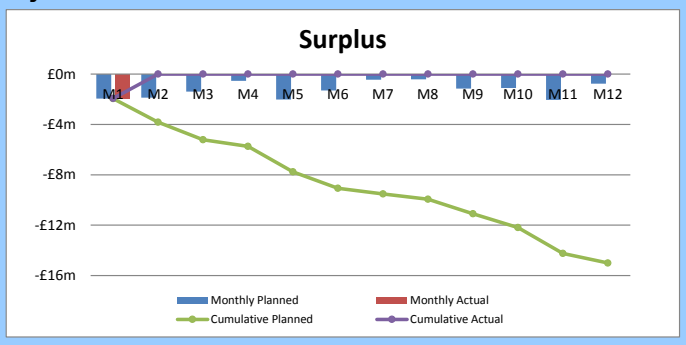
15/16 contract discussions with commissioners continue but contracts with the main commissioners remain unsigned.

Warrington & Halton Hospitals NHS Foundation Trust

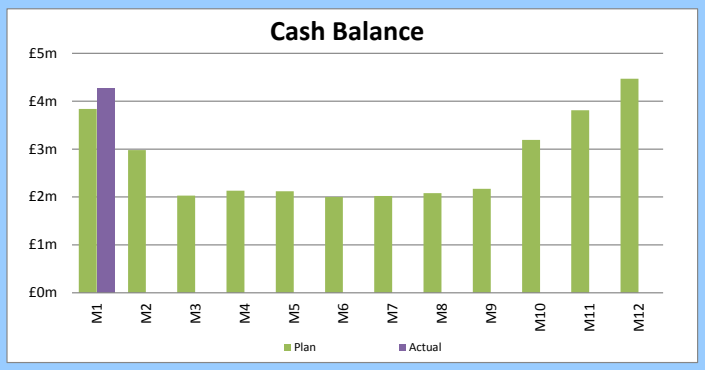
Finance Dashboard as at 30th April 2015 (Part A)

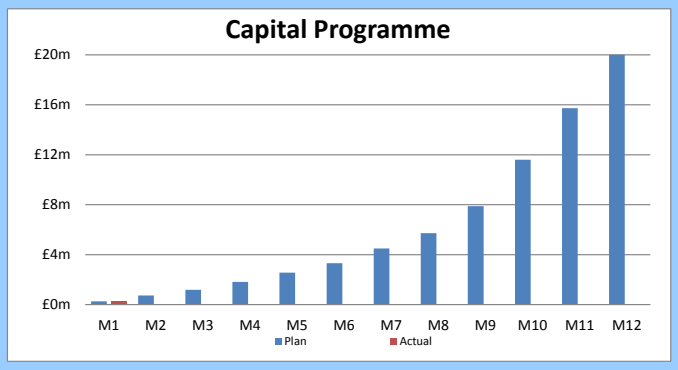
Profitability



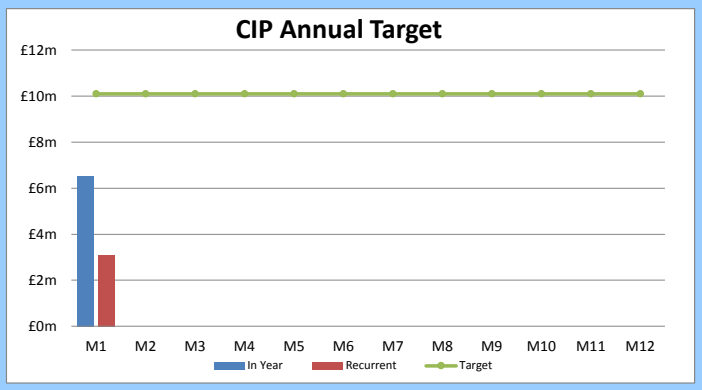


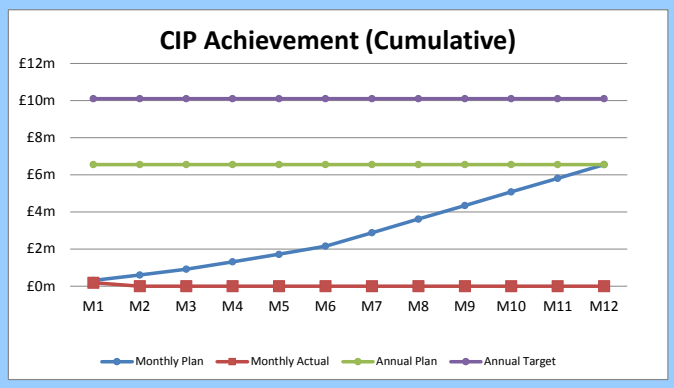
Cash and Investment





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	55,245	4,711	4,725	-14	-0.3	4,711	4,725	-14	-0.3
Unscheduled Care	43,283	3,830	3,856	-26	-0.7	3,830	3,856	-26	-0.7
Womens, Children & Support Services	56,093	5,039	5,026	13	0.3	5,039	5,026	13	0.3
Corporate									
Operations - Central	489	41	16	25	60.7	41	16	25	60.7
Operations - Estates	7,379	625	613	12	1.9	625	613	12	1.9
Operations - Facilities	7,847	656	674	-18	-2.7	656	674	-18	-2.7
Commercial Development	628	55	47	8	13.9	55	47	8	13.9
Finance	12,832	1,068	1,049	20	1.8	1,068	1,049	20	1.8
HR & OD	4,048	336	290	46	13.6	336	290	46	13.6
Information Technology	4,010	345	369	-24	-6.9	345	369	-24	-6.9
Nursing & Governance	2,874	238	239	-1	-0.5	238	239	-1	-0.5
Trust Executive	2,752	223	220	2	1.1	223	220	2	1.1
Total	**197,479**	**17,167**	**17,125**	**42**	**0.2**	**17,167**	**17,125**	**42**	**0.2**

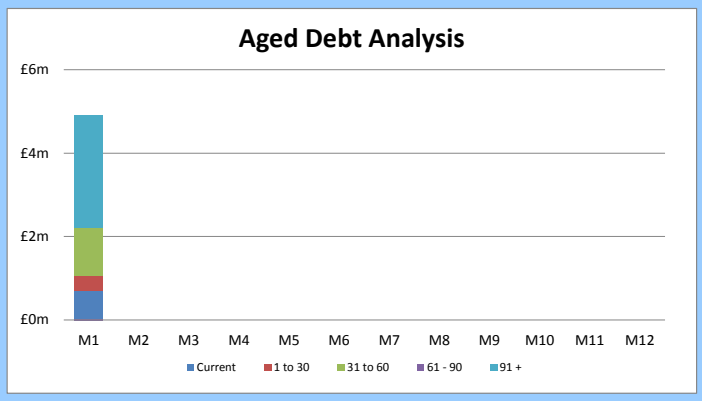
Positive variance = underspend, negative variance = overspend.

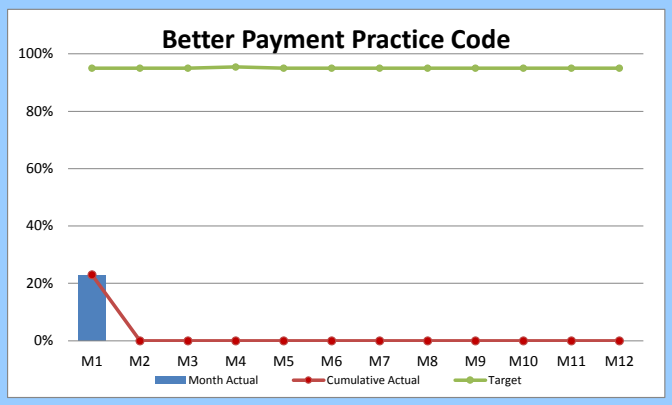
Continuity of Services Risk Rating

Continuity of Services Risk Rating	Actual Metric	Actual Rating
Liquidity Ratio (days)	-12.5	2
Capital Servicing Capacity (times)	-3.0	1
Overall Risk Rating		**2**

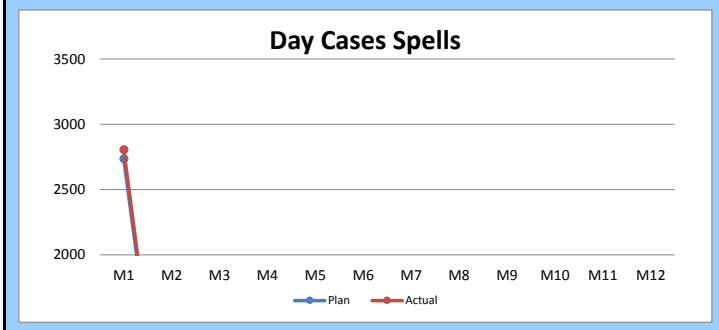
Finance Dashboard as at 30th April 2015 (Part B)

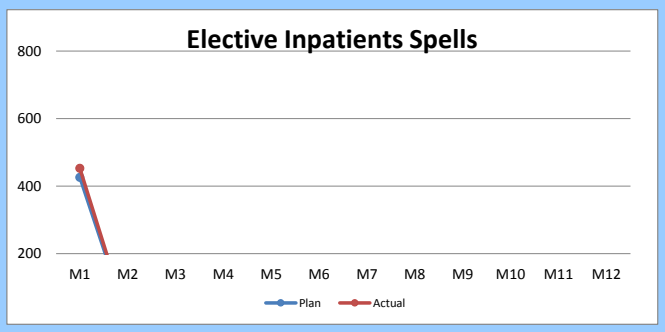
Balance Sheet and Liquidity

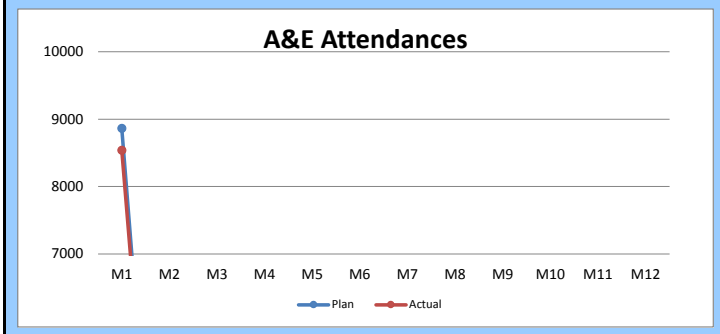


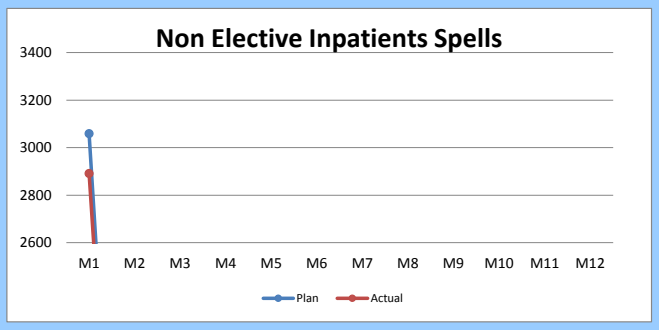


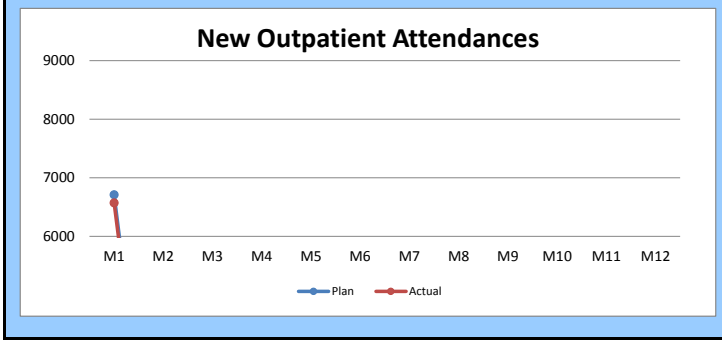
Activity Analysis

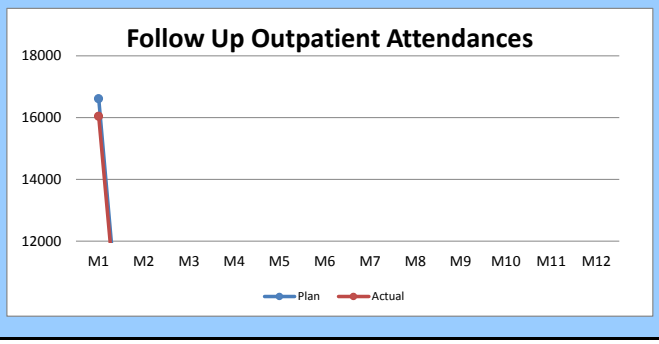












Income Statement, Activity Summary and Risk Ratings as at 30th April 2015

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	2,935	3,057	122	2,935	3,057	122	37,613	37,613	0
Elective Excess Bed Days	16	15	-1	16	15	-1	232	232	0
Non Elective Spells	4,225	4,329	104	4,225	4,329	104	51,746	51,746	0
Non Elective Excess Bed Days	261	246	-15	261	246	-15	3,190	3,190	0
Outpatient Attendances	2,787	2,694	-93	2,787	2,694	-93	35,756	35,756	0
Accident & Emergency Attendances	958	918	-40	958	918	-40	11,190	11,190	0
Other Activity	4,473	4,288	-185	4,473	4,288	-185	55,631	55,631	0
Sub total	**15,655**	**15,547**	**-108**	**15,655**	**15,547**	**-108**	**195,359**	**195,359**	**0**
Non Mandatory / Non Protected Income									
Private Patients	9	5	-4	9	5	-4	106	106	0
Other non protected	107	99	-8	107	99	-8	1,284	1,284	0
Sub total	**116**	**104**	**-12**	**116**	**104**	**-12**	**1,390**	**1,390**	**0**
Other Operating Income									
Training & Education	588	588	0	588	588	0	7,056	7,056	0
Donations and Grants	0	0	0	0	0	0	0	0	0
Miscellaneous Income	780	1,016	236	780	1,016	236	9,475	9,475	0
Sub total	**1,368**	**1,604**	**236**	**1,368**	**1,604**	**236**	**16,532**	**16,532**	**0**
Total Operating Income	**17,139**	**17,256**	**117**	**17,139**	**17,256**	**117**	**213,281**	**213,281**	**0**
Operating Expenses									
Employee Benefit Expenses (Pay)	-13,032	-13,161	-129	-13,032	-13,161	-129	-155,274	-155,274	0
Drugs	-1,156	-1,090	66	-1,156	-1,090	66	-13,802	-13,802	0
Clinical Supplies and Services	-1,611	-1,577	34	-1,611	-1,577	34	-19,530	-19,530	0
Non Clinical Supplies	-2,376	-2,477	-101	-2,376	-2,477	-101	-28,304	-28,304	0
Total Operating Expenses	**-18,175**	**-18,305**	**-130**	**-18,175**	**-18,305**	**-130**	**-216,910**	**-216,910**	**0**
Surplus / (Deficit) from Operations (EBITDA)	**-1,036**	**-1,049**	**-13**	**-1,036**	**-1,049**	**-13**	**-3,629**	**-3,629**	**0**
Non Operating Income and Expenses									
Interest Income	3	3	0	3	3	0	40	40	0
Interest Expenses	-4	-2	2	-4	-2	2	-451	-451	0
Depreciation	-569	-543	26	-569	-543	26	-6,834	-6,834	0
PDC Dividends	-344	-344	0	-344	-344	0	-4,126	-4,126	0
Restructuring Costs	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Total Non Operating Income and Expenses	**-914**	**-886**	**28**	**-914**	**-886**	**28**	**-11,371**	**-11,371**	**0**
Surplus / (Deficit)	**-1,950**	**-1,935**	**14**	**-1,950**	**-1,935**	**14**	**-15,000**	**-15,000**	**0**
Activity Summary	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**
Elective Spells	3,163	3,259	96	3,163	3,259	96	40,101	40,101	0
Elective Excess Bed Days	75	51	-24	75	51	-24	1,068	1,068	0
Non Elective Spells	3,059	2,891	-168	3,059	2,891	-168	36,672	36,672	0
Non Elective Excess Bed Days	1,232	1,160	-72	1,232	1,160	-72	15,020	15,020	0
Outpatient Attendances	28,061	27,041	-1,020	28,061	27,041	-1,020	345,746	345,746	0
Accident & Emergency Attendances	8,861	8,536	-325	8,861	8,536	-325	103,457	103,457	0
Continuity of Services Risk Ratings	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**
Liquidity Ratio - Metric (Days)				-14.2	-12.5	1.7	-11.5	-11.5	0.0
Liquidity Ratio - Rating				1	2	1	1	1	0
Capital Servicing Capacity - Metric (Times)				-3.0	-3.0	-0.1	-0.8	-0.8	0.0
Capital Servicing Capacity - Rating				1	1	0	1	1	0
Continuity of Services Risk Rating				**1**	**2**	**0**	**1**	**1**	**0**

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

Cash Flow Statement as at 30th April 2015

	Actual April £000's	Forecast May £000's	Forecast June £000's	Forecast July £000's	Forecast August £000's	Forecast September £000's	Forecast October £000's	Forecast November £000's	Forecast December £000's	Forecast January £000's	Forecast February £000's	Forecast March £000's	Annual Position March £000's
Surplus/(deficit) after tax	**(1,936)**	**(1,871)**	**(1,395)**	**(531)**	**(2,015)**	**(1,304)**	**(451)**	**(420)**	**(1,151)**	**(1,105)**	**(2,052)**	**(769)**	**(15,000)**
Non-cash flows in operating surplus/(deficit)													
Finance (income)/charges	1	1	0	1	1	0	68	68	67	68	68	68	411
Depreciation and amortisation	543	568	569	569	569	570	569	569	570	569	572	597	6,834
PDC dividend expense	344	343	344	344	344	344	344	344	344	344	344	343	4,126
Other increases/(decreases) to reconcile to profit/(loss) from operations	(9)	13	13	14	12	89	14	13	13	26	27	51	276
Non-cash flows in operating surplus/(deficit), Total	**879**	**925**	**926**	**928**	**926**	**1,003**	**995**	**994**	**994**	**1,007**	**1,011**	**1,059**	**11,647**
Operating Cash flows before movements in working capital	**(1,057)**	**(946)**	**(469)**	**397**	**(1,089)**	**(301)**	**544**	**574**	**(157)**	**(98)**	**(1,041)**	**290**	**(3,353)**
Increase/(Decrease) in working capital													
(Increase)/decrease in inventories	392											(392)	(0)
(Increase)/decrease in NHS Trade Receivables	1,832	150	150	1,400	250	250	(650)	250	250	250	250	(3,082)	1,300
(Increase)/decrease in Non NHS Trade Receivables	303	100	100	(375)	100	100	(250)	125	200	200	200	(3)	800
(Increase)/decrease in other related party receivables	(266)											266	(0)
(Increase)/decrease in other receivables	412											(412)	(0)
(Increase)/decrease in accrued income	(390)	565	(8)	(838)	651	(208)	(464)	(703)	0	(72)	867	596	0
(Increase)/decrease in prepayments	(1,302)	(500)	(250)	(250)	250	250	250	350	350	350	350	952	800
Increase/(decrease) in Deferred Income (Govt. Grants)	255											(255)	(0)
Increase/(decrease) in Current provisions	(71)	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(20)	31	(240)
Increase/(decrease) in Trade Creditors	(1,475)	(185)	0	(774)	(601)	(599)	649	(725)	(799)	(801)	(799)	3,210	(2,899)
Increase/(decrease) in Other Creditors	(160)											160	0
Increase/(decrease) in accruals	1,402											(1,402)	(0)
Increase/(decrease) in other Financial liabilities	64											(64)	0
Increase/(decrease) in Other liabilities (VAT, Social Security and Other Taxes)	75											(75)	(0)
Increase/(Decrease) in working capital, Total	**1,069**	**110**	**(28)**	**(857)**	**630**	**(227)**	**(485)**	**(723)**	**(19)**	**(93)**	**848**	**(470)**	**(240)**
Increase/(decrease) in Non-current provisions	58											(58)	(0)
Net cash inflow/(outflow) from operating activities	**70**	**(836)**	**(497)**	**(460)**	**(459)**	**(528)**	**59**	**(149)**	**(176)**	**(191)**	**(193)**	**(238)**	**(3,593)**
Net cash inflow/(outflow() from investing activities													
Property - new land, buildings or dwellings	(70)	(25)	(25)	(125)	(125)	(125)	(200)	(500)	(1,000)	(2,500)	(2,500)	(2,805)	**(10,000)**
Property - maintenance expenditure	(150)	(107)	(75)	(114)	(148)	(123)	(335)	(192)	(224)	(275)	(654)	(524)	**(2,921)**
Plant and equipment - Information Technology	(58)	(186)	(202)	(233)	(373)	(388)	(409)	(294)	(310)	(325)	(341)	(361)	**(3,480)**
Plant and equipment - Other	(23)	(140)	(152)	(164)	(104)	(117)	(230)	(238)	(632)	(620)	(627)	(854)	**(3,901)**
Increase/(decrease) in Capital Creditors													0
Net cash inflow/(outflow() from investing activities, Total	**(301)**	**(458)**	**(454)**	**(636)**	**(750)**	**(753)**	**(1,174)**	**(1,224)**	**(2,166)**	**(3,720)**	**(4,122)**	**(4,544)**	**(20,302)**
Net cash inflow/(outflow) before financing	**(231)**	**(1,294)**	**(951)**	**(1,096)**	**(1,209)**	**(1,281)**	**(1,115)**	**(1,373)**	**(2,342)**	**(3,911)**	**(4,315)**	**(4,782)**	**(23,895)**
Net cash inflow/(outflow) from financing activities													
Public Dividend Capital received													0
PDC Dividends paid						(2,138)						(2,064)	(4,202)
Interest (paid) on non-commercial loans	(2)	(4)	(4)	(4)	(4)	(4)	(71)	(71)	(71)	(71)	(71)	(74)	(451)
Interest received on cash and cash equivalents	3	3	4	3	3	4	3	3	4	3	3	4	40
Drawdown of non-commercial loans	0	0	0	1,200	1,200	3,300	1,200	1,500	2,500	5,000	5,000	7,568	28,468
Repayment of non-commercial loans													0
(Increase)/decrease in non-current receivables	(8)											8	0
Net cash inflow/(outflow) from financing activities, Total	**(7)**	**(1)**	**0**	**1,199**	**1,199**	**1,162**	**1,132**	**1,432**	**2,433**	**4,932**	**4,932**	**5,442**	**23,855**
Net increase/(decrease) in cash	**(238)**	**(1,295)**	**(951)**	**103**	**(10)**	**(119)**	**17**	**59**	**91**	**1,021**	**617**	**660**	**(40)**
Opening cash	**4,511**	**4,273**	**2,979**	**2,028**	**2,131**	**2,122**	**2,003**	**2,021**	**2,080**	**2,171**	**3,193**	**3,810**	**4,511**
Closing cash	**4,273**	**2,979**	**2,028**	**2,131**	**2,122**	**2,003**	**2,021**	**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	2,979	2,028	2,131	2,122	2,003	2,021	2,080	2,171	3,193	3,810	4,471
Variance	**435**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

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

Statement of Position as at 30th April 2015

Narrative	Un-Audited position as at 31/03/15 £000	Actual Position as at 30/04/15 £000	Forecast Position as at 31/03/16 £000
ASSETS			
Non Current Assets			
Intangible Assets	567	555	865
Property Plant & Equipment	143,355	143,124	156,525
Other Receivables	1,336	1,295	1,336
Impairment of receivables for bad & doubtful debts	-253	-245	-253
Total Non Current Assets	**145,005**	**144,729**	**158,473**
Current Assets			
Inventories	3,312	2,920	3,312
NHS Trade Receivables	5,627	3,796	4,326
Non NHS Trade Receivables	1,364	1,061	564
Other Related party receivables	585	852	585
Other Receivables	1,865	1,453	1,864
Impairment of receivables for bad & doubtful debts	-321	-324	-321
Accrued Income	882	1,273	882
Prepayments	2,498	3,800	1,698
Cash held in GBS Accounts	4,486	4,254	4,446
Cash held in commercial accounts	0	0	0
Cash in hand	25	19	25
Total Current Assets	**20,323**	**19,103**	**17,381**
Total Assets	**165,328**	**163,832**	**175,854**
LIABILITIES			
Current Liabilities			
NHS Trade Payables	-2,351	-1,058	-7,284
Non NHS Trade Payables	-8,134	-7,952	-301
Other Payables	-1,856	-1,696	-1,853
Other Liabilities (VAT, Social Security and Other Taxes)	-2,667	-2,742	-2,667
Capital Payables	-1,599	-1,070	-1,599
Accruals	-5,765	-7,167	-5,765
Interest payable on non commercial int bearing borrowings	0	0	0
PDC Dividend creditor (maunally input)	-76	-420	-76
Deferred Income	-974	-1,228	-974
Provisions	-335	-264	-295
Loans non commercial	0	0	0
Borrowings	-185	-192	-185
Total Current Liabilities	**-23,942**	**-23,789**	**-20,999**
Net Current Assets (Liabilities)	**-3,619**	**-4,686**	**-3,618**
Non Current Liabilities			
Loans non commercial	0	0	-28,468
Provisions	-1,395	-1,453	-1,395
Borrowings	-703	-646	-703
Total Non Current Liabilities	**-2,098**	**-2,099**	**-30,566**
TOTAL ASSETS EMPLOYED	**139,288**	**137,945**	**124,289**
TAXPAYERS AND OTHERS EQUITY			
Taxpayers Equity			
Public Dividend Capital	90,242	90,242	90,242
Retained Earnings prior year	3,970	4,561	3,970
Retained Earnings current year	0	-1,936	-15,000
Sub total	**94,212**	**92,868**	**79,212**
Other Reserves			
Revaluation Reserve	45,077	45,077	45,077
Sub total	**45,077**	**45,077**	**45,077**
TOTAL TAXPAYERS AND OTHERS EQUITY	**139,289**	**137,945**	**124,289**

BOARD OF DIRECTORS

WHH/B/2015/ **121**

SUBJECT:	**CORPORATE PERFORMANCE REPORT**	
DATE OF MEETING:	27th May 2015	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Simon Wright	
EXECUTIVE DIRECTOR:	Simon Wright, Chief Operating Officer and Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:		
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 30th of April 2015. In overall terms, based on the performance in month 1, the Trust has an Amber/Green rating, as highlighted in Appendix 1.	
RECOMMENDATION:	***The Board is asked to:*** ***Note the content***	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee Or type here if not on list:
	Agenda Ref.	
	Date of meeting	21 May 2015
	Summary of Outcome	Recommended for Approval

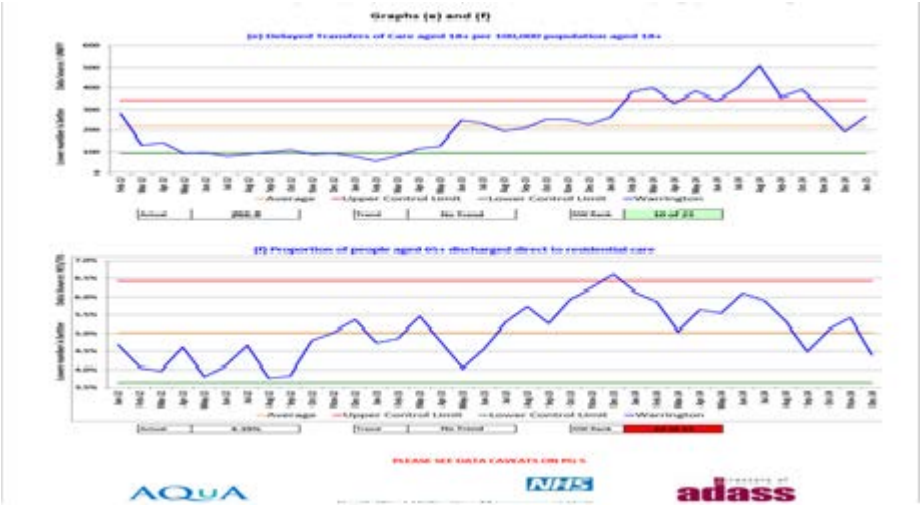
NATIONAL KEY PERFORMANCE INDICATORS

ACCIDENT AND EMERGENCY DEPARTMENT

The Trust has seen an upward trajectory in the AED 4 hour target in April linked to the opening of additional Intermediate care capacity half way through the month. This has continued in May with the performance moving over 90% for the first time since November.

The graphs and charts illustrate an increase in delays in transfer out of the hospital, and an increase in elderly admissions into the Trust.

ADASS information (below)



On average, the Trust reported an emergency admission for every 2.7 AED attendances. The lowest rate of (1.9) AED attendances to admissions was reported on Tuesday 28th April 2015. Tuesday 7th April 2015 saw a peak in AED Type 1 attendances to Warrington (271), closely followed by Monday 27th April (267) and Sunday 26th April 2015 (266). Emergency admissions peaked on Tuesday 28th April 2015 (120) whereas discharges of emergency admissions peaked on Thursday 23rd April 2015 (132).

The trust are working to double the size of the Medical Assessment Unit (MAU) and a two month project is underway to address a 12 hour medical shift rota, unified nurse staffing model for A1/2, 14 ambulatory pathways to be in place.

A4 is converting from a surgical ward to a 24 bedded medical ward.

New AED manager will commence in 6 weeks.

Regional Position

The following data is provided by UCAT team for Merseyside and Cheshire.

- All Acute Trusts (excluding Alder Hey) achieved a Type 1 AED performance below 95% for the month, the lowest of which was Southport (81.1%). Alder Hey achieved a performance of 97.5%.
- Cumulative Type 1 performance for all North Mersey & Warrington providers (including Alder Hey) has now been below the 95% AED target for 19 consecutive months. The 4,153 breaches

of the 4 hour AED target is lower than recent months but is the fifth highest monthly total from April 2012 onwards (the highest being the months of December 2014 and January 2015).

- Cumulative Type 1 performance was below 95% on 27 days in this period. The lowest cumulative performance was reported on Tuesday 14th April 2015 (79.3%).
- On average, there was an emergency admission for every 2.5 AED attendances across all Providers in April.
- Emergency admissions decreased at the beginning of 2015 but the number reported in March was the third highest monthly total of 2014/15. The 15,613 admissions reported throughout April 2015 represent a decrease to the previous month but activity during this month is above the equivalent periods in each of the last two years.
- Discharges of emergency admissions also decreased at the beginning of 2015 but the number reported in March was the fourth highest monthly total of 2014/15. The 15,665 discharges reported throughout April 2015 represent a decrease to the previous month but activity during this month is above the equivalent periods in each of the last two years.
- Three Acute Trusts (excluding Alder Hey) reported an overall average turnaround time above 30 minutes in April. Aintree averaged the highest turnaround time of all Trusts (38.1 minutes).

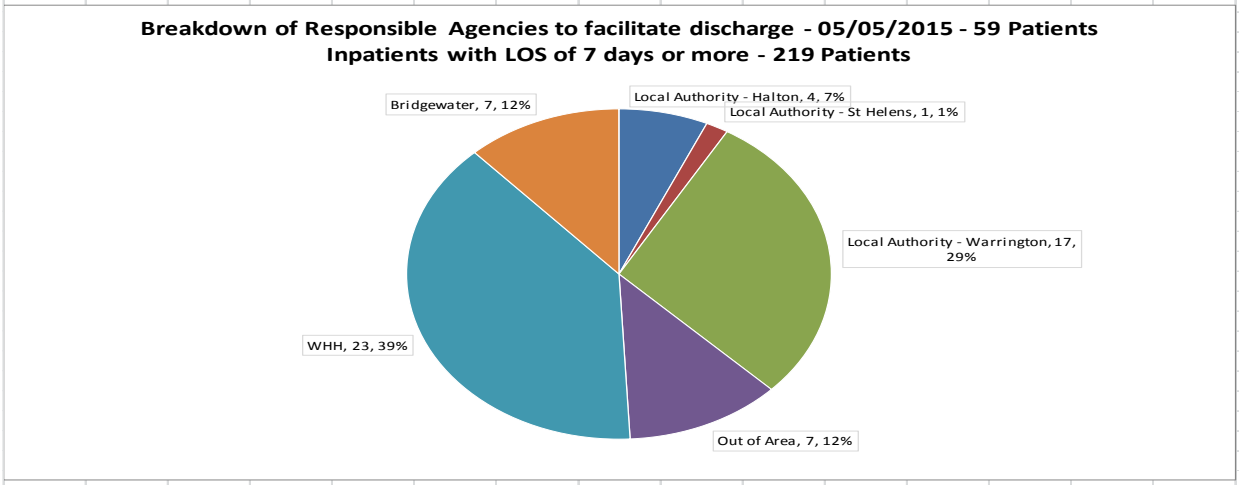
DTOC

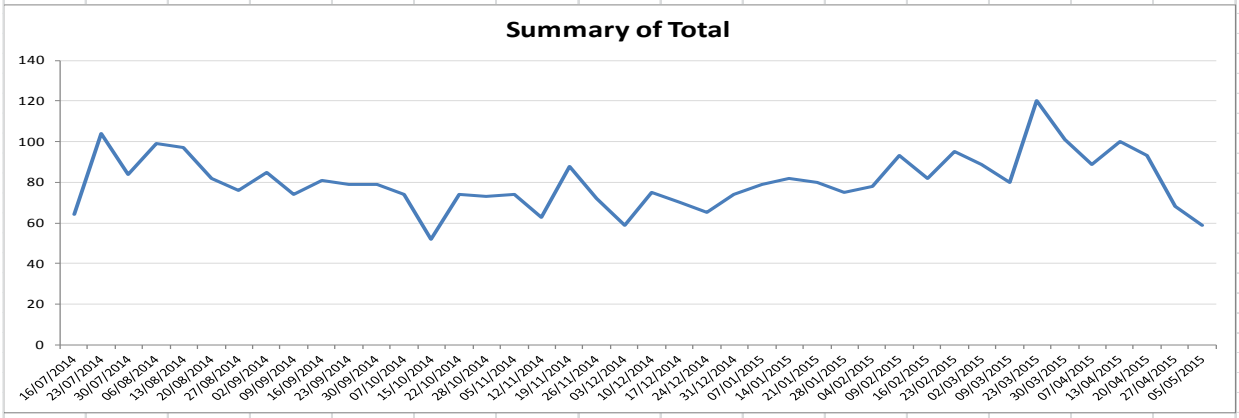
The reduction in delayed transfers of care (DTOC) to 59 in April talk directly to the opening of the WICU intermediate care facility 24 beds hence when compared to March the real term comparative is 83 (59+24) suggesting that the only impact since June 2014 when last the Trust introduced additional intermediate care beds.

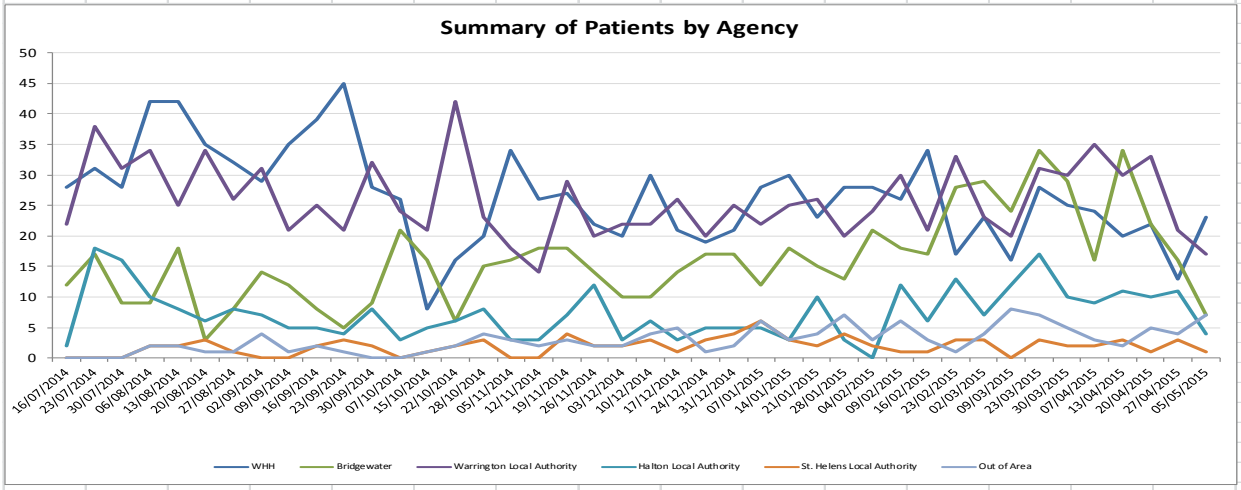
The current WICU unit is funded for 6 months but a permanent commissioning provision is required.

There are still disputes between providers and the CCG on 'one version of the truth' regarding the delays in discharge over and above the SITREP group which represent a third of the total figure as described by the point prevalence process.

The cost of funding the DTOC beds occupied across the Trust during 2014/15 was approximately £3,000,000


Breakdown of Responsible Agencies to facilitate discharge - 05/05/2015 - 59 Patients
Inpatients with LOS of 7 days or more - 219 Patients
Bridgewater, 7, 12%
Local Authority - Halton, 4, 7%
Local Authority - St Helens, 1, 1%
Local Authority - Warrington, 17, 29%
WHH, 23, 39%
Out of Area, 7, 12%


Summary of Total
140
120
100
80
60
40
20
0


Summary of Patients by Agency
50
45
40
35
30
25
20
15
10
5
0
WHH
Bridgewater
Warrington Local Authority
Halton Local Authority
St. Helens Local Authority
Out of Area

NWAS

The penalties for turnaround times for ambulance handovers in AED from April 1st 2015 will incur a range of penalties:

- £200 for every patient not recorded on the HAS screen under 85% entry compliance
- £200 for every patient waiting over 30 mins for handover
- £1000 for every patient waiting over 60 minutes for handover

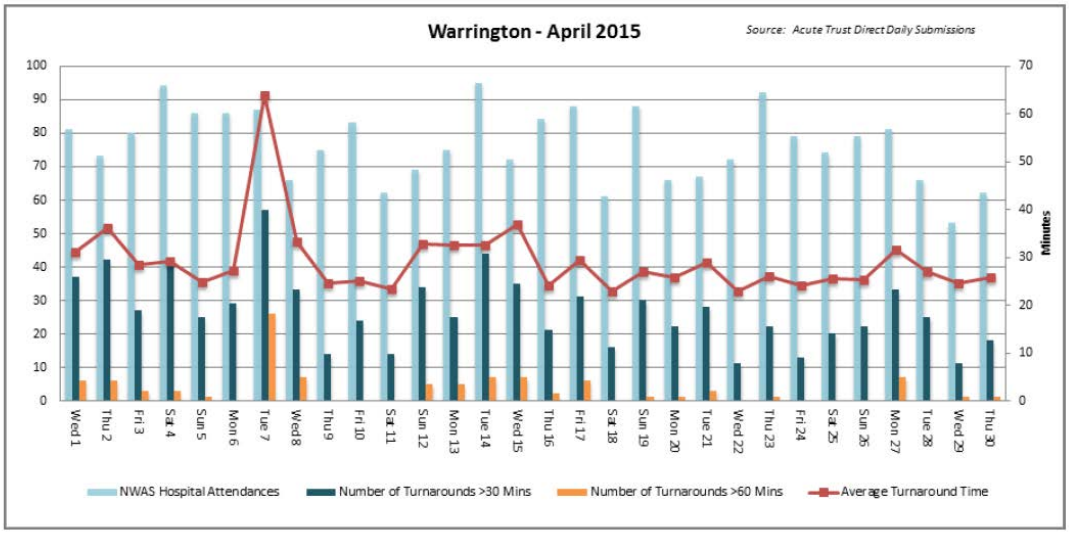
NWAS have a much smaller fine of failure occurs (95%less than our figures).

Issues causing problems:

- GPS on ambulances that trigger arrival occur 5 mins before AED arrival
- Ambulance staff not signing out and leaving AED for coffee breaks etc causing over run on times
- DTOC delays blocking acute beds back logs up to AED preventing cubical use for assessment as these are required to house delayed admission patients whilst acute beds are created.

The potential financial penalty risk is around £60,000 per month at present using last years figures.

AED staff are recording all patients and reporting NWAS staff when they fail to comply. AED nurses are being employed to support the safe management of patients who are queuing in AED due to the DTOC backlog.



CANCER

The reporting to Monitor does not fit in with the National reporting of Cancer Waiting Times for 62 referral to treatment you can see from table below that April is not due till 09/06/2015 and Q1 position not until 05/08/2015.

Monthly Reports	Quarterly Reports	Generation Date
Apr-15		Tuesday, 9 June 2015
May-15		Monday, 6 July 2015
Jun-15	Q1 2015-2016	Wednesday, 5 August 2015
Jul-15		Tuesday, 8 September 2015

Aug-15		Tuesday, 6 October 2015
Sep-15	Q2 2015-16	Thursday, 5 November 2015
Oct-15		Monday, 7 December 2015
Nov-15		Friday, 8 January 2016
Dec-15	Q3 2015-16	Monday, 8 February 2016
Jan-16		Monday, 7 March 2016

Month 1 of quarter is very difficult to predict for the quarter end in respect of re-allocations as we are working with partner organisations to ensure all data is uploaded, and at this point in the month that information isn't available as everyone is working to the timetable above. The re-allocation position is therefore based upon worst case scenario position until all data uploaded on to Cancer Waiting times system for other organisations.

The Breast Symptomatic Target relates to patients been seen within 14 days , this target was discussed at the KPI Meeting on Tuesday 12/05/2015.Gordon Robinson and Collette Hollins assured scheduled care that they had a plan regarding capacity to ensure all patients are dated within 7 days to allow them to re-appoint within 14 days should a patient defer/cancel the early date.

The cancer performance is expected to deliver the targets in full and discussion with the Head and Neck team at Aintree are underway to improve that part of the pathway and also in Urology to ensure full compliance with the pathways established.

NEXT STEPS

- Complete AMU redesign by August
- Convert A4 to a medical ward July
- Secure substantive provision for additional Intermediate Care beds September
- Fully open Runcorn/Widnes UCC July
- Introduce 'Discharge to assess' in social services
- Award new domiciliary contract in social services (TBC)
- Induct new AED manager (July)
- Secure 'one version of the truth' in delays in the system for discharge

CONCLUSION

The trust has seen the 4 hour AED target recovery continuing with the Trust performing in line with the rest of the region in April and in May climbing further into the 90% margins to ensure 95% is delivered in June.

RECOMMENDATION

The Trust is asked to note this report and the actions being taken to recover the 4 hour performance building on the continued recovery being seen.

Mr Simon Wright

Chief Operating Officer/Deputy Chief Executive

Apr-15

Monitor Governance Risk Rating - 2015/16

Warrington and Halton Hospitals NHS
NHS Foundation Trust

All targets are QUARTERLY

Target or Indicator		Target	Weighting	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4
Referral to treatment waiting time	Admitted patients	90%	1.0	92.55%															
	Non-admitted patients	95%	1.0	97.53%															
	Incomplete Pathways	92%	1.0	93.38%															
A&E Clinical Quality	A&E Maximum waiting time of 4 hrs from arrival to admission/transfer/discharge	>=95%	1.0	87.75%															
All Cancers:62-day wait for First treatment	From urgent GP referral - **post** local breach re-allocation (CCG)	85%	1.0	84.00%															
	From NHS Cancer Screening Service referral - **post** local breach re-allocation	90%	1.0	100.00%															
	From urgent GP referral - **pre** local breach re-allocation (Open Exeter - Monitor)	85%		86.00%															
	From NHS Cancer Screening Service referral - **pre** local breach re-allocation	90%		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%															
	Anti Cancer Drug Treatments	>98%		100.00%															
	Radiotherapy (not performed at this Trust)	>94%																	
All Cancers: 31-Day Wait From Diagnosis To First Treatment		>96%	1.0	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%															
	Symptomatic Breast Patients (Cancer Not Initially Suspected)	>93%		90.40%															
Clostridium Difficile - Hospital acquired **(CUMULATIVE)**	Due to lapses in care	27 (for the Yr)	1.0 **	0															
	Total (including: due to lapses in care, not due to lapses in care, and cases under review)			0															
	Under Review			3															
Failure to comply with requirements regarding access to healthcare for people with a learning disability		N/A	1.0	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															
CQC compliance action outstanding (as at time of submission)	N/A		No															
CQC enforcement action within last 12 months (as at time of submission)	N/A		No															
CQC enforcement action (including notices) currently in effect (as at time of submission)	N/A		No															
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A		No															
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A		No															
Unable to maintain, or certify, a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements	N/A		No															
Score of 7 or less in standard 1 assessment at last NHSLA CNST inspection (maternity or all services)	N/A		No															
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A		No															
Overall Governance Risk Rating **Total Points 0 - 0.9 Green, 1 - 1.9 Amber-Green, 2 - 4 Amber-Red, 4 or above Red)**			1.0															

Additional Notes:

18 Weeks Referral to Treatment

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

**** Clostridium Difficile**

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

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

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

BOARD OF DIRECTORS

WHH/B/2015/ **122**

SUBJECT:	Compliance with Provider Licence Conditions G6 and COS7	
DATE OF MEETING:	27th May 2015	
ACTION REQUIRED	**For Decision**	
AUTHOR(S):	Executive/Trust Secretary	
EXECUTIVE DIRECTOR:	Mel Pickup, Chief Executive Choose an item.	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	All	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None Choose an item. Choose an item.	
EXECUTIVE SUMMARY (KEY ISSUES):		
RECOMMENDATION:	***The Board is asked to:*** **To confirm compliance with the requirements of Provider Licence Condition G6 and COS 7 as set out in the paper.**	
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.

Introduction

On 1 April 2013 the Trust was issued with a Provider Licence from its regulator Monitor. The Provider Licence contains obligations for providers of NHS services that enable Monitor to fulfil its duties as the regulator of NUS Foundation Trusts and will enable Monitor to oversee the way that Foundation Trusts are governed.

The standard licence conditions are grouped in to seven sections. The first section, containing the General Conditions, sets out standard requirements and rules for all licence holders. Sections 2 to 5 of the licence are about Monitor's new functions: setting prices, enabling services to be provided in an integrated way, safeguarding choice and competition and supporting commissioners to maintain service continuity. Section 6 is about translating the well-established core of Monitor's current oversight of Foundation Trust governance in to the new provider licence. The final section, 7, contains definitions and notes.

In compliance with the Provider Licence the Trust is required to submit compliance statements during the year. Two Governance statements are required at the end of this May 2014 and further statements will be required at the end of June and submitted in conjunction with the Strategic Plan. Appendix 1 provides a screen shot of the submission document to Monitor.

Compliance Statements for submission May 2014

The two statements the Trust is required to confirm at the end of May 2014 relate to compliance with provider licence condition G6 and CoS7.

A. Provider Licence Condition G6

G6	***Systems for compliance with licence conditions and related obligations***
	1. The Licensee shall take all reasonable precautions against the risk of failure to comply with: (a) the Conditions of this Licence, (b) any requirements imposed on it under the NHS Acts, and (c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.
	2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include: (a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and (b) regular review of whether those processes and systems have been implemented and of their effectiveness.

The commentary below breaks down the compliance statement and provides supporting comments on why the Trust believes it complies with Provider Licence Condition G6.

Compliance statement (G6) and supporting comments

1. Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended 2014/15, the Licensee took all such precautions as were necessary in order to comply with

   a. the conditions of the licence;

   Response: ***Confirmed***

   Comment: During the financial year 2014/15 the conditions contained within the provider licence have been reviewed by the executive assigned to each condition to ascertain whether the trust is able to comply with its obligations and where appropriate any risks to compliance are included on the trust Board Assurance Framework (BAF). On a quarterly basis the Board reviews the BAF in order to assess the risk of compliance. During the year there have been no compliance issues arising from the reviews and any potential risks of compliance have been included were appropriate on the BAF. In support of compliance with the licence the Board also receives through its Governance Structure assurance that risks are managed appropriately through the Risk Management Strategy and via the Annual Governance Statement which provides additional assurances on internal control from the Chief Executive. Independent assurance on trusts processes and service provision is also provided by the Internal Auditor and External Auditor through the Audit Committee.

   b. any requirements imposed on it under the NHS Acts; and

   Response: ***Confirmed***
   Comment: There were no additional requirements imposed under the NHS Acts during 2014/15

   c. have had regard to the NHS Constitution in providing health care services for the purposes of the NHS

   Response: ***Confirmed***
   Comment: The Trust continues to have regard to the provisions contained within the NHS Constitution through the formulation and adoption of trust policies and procedures. The NHS constitution is in line with the Trust's overall vision of high quality care for all using the QPS framework. The Trust governance structure reflects the needs of the NHS constitution and the rights of patients, service users and staff. Assurance on this is via the CQC monitoring that we have in place.

2. The board declares that the Licensee continues to meet the criteria for holding a licence.

   Response: ***Confirmed***

   Comment: The Board continues to take into account the conditions of the provider licence in delivery of health care services.

Board Approval: With regard to Provider licence Condition G6 the Board is asked to confirm its compliance

B. Provider Licence Condition COS7

Provider Licence Condition COS7 requires

CoS7	***Availability of resources***
	1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.
	2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.
	3. The Licensee, not later than two months from the end of each Financial Year, shall submit to Monitor a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms: (a) "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate." (b) "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services". (c) "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate".

With regard to the three certifications contained within COS7 paragraph 3, the Trust confirms sub paragraph (b).

Comments to support compliance with 3b:

1. The Trust has informed Monitor that it requires a working capital loan of £15m and a capital loan of £13.5m. The working capital loan is required from July 15/16 to support the impact of the Trust planned deficit of £15m.

2. The timing of £10m of the £13.5m capital loan is subject to approval of the detailed outline business case and may not be required in 15/16.

3. Both loans are required to ensure that commissioner requested services are provided whilst the Trust develops a sustainability plan. Further capital loan will be required to support the Trusts major capital development programme.

4. Whilst income and expenditure budgets have been planned through a robust process there are a number of factors that remain outside the Trusts control that may impact on

the Trusts ability to provide commissioner requested services, these include:

5. Application of fines and penalties and direction of reinvestment of financial resources

6. Application of winter monies by the SRG, any material deviation from 14/15 amounts or application

7. Unfunded Winter pressures caused by insufficient resources in social care, GP or community provision

8. Application of the Better Care Fund and Elective Referral deflection schemes being introduced by commissioners in 15/16 that result in material changes

9. Additional costs brought about by changes in Government policy or legislation following any review of the NHS, examples may include changes to nursing staffing ratios, training and education allocations, pay and increment changes

10. Changes in NICE guidance

11. Loss of business through changes in NHSE commissioning decision between providers

Board Approval: With regard to Provider licence Condition COS7 the Board is asked to confirm its compliance paragraph 3b.

Appendix A

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2	**General condition 6 - Systems for compliance with license conditions**	
1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	**Confirmed**
	AND	
2	The board declares that the Licensee continues to meet the criteria for holding a licence.	**Confirmed**
3	**Continuity of services condition 7 - Availability of Resources**	
	EITHER:	
3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	
	OR	
3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	**Confirmed**
	OR	
3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.	
	Statement of main factors taken into account in making the above declaration	
	In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:	

BOARD OF DIRECTORS

WHH/B/2015/ **123**

SUBJECT:	**Verbal Report from the Chair of the Quality [Governance] Committee**
DATE OF MEETING:	27 May 2015
DIRECTOR:	Mike Lynch, Non-Executive Director

- **Approval of the Terms of Reference of the Quality Committee**

QUALITY COMMITTEE

TERMS OF REFERENCE

Document Title	Quality Committee
Document Reference	
Author	Trust Secretary
Intranet Location	TBC
Lead Executive Director	Director of Nursing and Governance
Reporting to	Board of Directors
Date Ratified	Board Approval: [27 May 2015]
Review Date	October 2015
Mandatory/ Statutory Standards or Requirements/related documents	Provider Licence Board Assurance Framework Trust Quality Strategy CQC Outcome 16 Monitor Quality Governance Framework
Issue Date	
Issue No.	

1. PURPOSE

The Quality Committee (the Committee) is accountable to the Board of Directors (the Board) for providing assurance on all aspects of quality, including strategy, delivery, governance, clinical risk management, information governance, clinical audit; and the regulatory standards relevant to quality and safety.

The Quality Committee is accountable to the Board for ensuring that the integrated quality governance framework is implemented throughout the organisation and that organisational risks are managed appropriately in line with the CQC Essential Standards of Quality and Safety.

2. AUTHORITY

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

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

3. REPORTING ARRANGEMENTS

The Committee will have the following reporting responsibilities:

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

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

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

4. DUTIES & RESPONSIBILITIES

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

Strategy and Performance

a) Oversee the development and implementation of the Quality Strategy with a clear focus on upholding the tenants of quality and avoiding harm (Governance, safety, patient experience and clinical effectiveness).

b) Ensure that the Quality Strategy and performance are consistent with the Trust's Mission, Vision and strategic objectives and the goals of the NHS Outcomes Framework.

c) Review trends in patient safety, experience and outcomes (effectiveness) to provide assurance to the Board on performance and commission 'deep dives' as appropriate.

d) Oversee the development and implementation of action plans arising from both in-patient and other care related surveys with recommendations to the Board as appropriate.

e) Oversee the implementation of key national reports and inquiries recommendations and provide assurance to the Board on its delivery

f) Oversee the any initiatives undertaken by the Trust that relates to the development and implementation of the Quality Strategy.

Governance

g) Oversee the effectiveness of the clinical systems developed and implemented to ensure they maintain compliance with the Care Quality Commission's Essential Standards of Quality and Safety.

h) Oversee the review of the Monitor Quality Governance Framework.

i) Monitor the progress against actions to mitigate the quality risks on the corporate risk register and provide assurance to the Board that adequate steps are taken to reduce the risks in line with the Board's risk appetite.

j) Review the controls and assurance against relevant quality risks on the Board Assurance Framework and provide assurance to the Board that risks to the strategic objectives relating to quality are being managed and facilitate the completion of the Annual Governance Statement at year end.

k) Obtain assurance that the Trust is compliant with guidance from NICE and other related bodies.

l) Obtain assurance of the Trust's ongoing compliance with the Care Quality Commission registration through appropriate systems of control.

m) Consider external and internal assurance reports and monitor action plans in relation to clinical governance resulting from improvement reviews / notices from Monitor, the Care Quality Commission, the Health and Safety Executive and other external assessors.

n) Receive the annual clinical audit programme and provide assurance to the Board that clinical audit supports the divisions to provide safe and clinically effective patient care.

o) Obtain assurance that the divisions deliver against their agreed annual clinical audit programme.

p) Implement and monitor the process for the production of the Trust's year end quality report before they are presented to the Trust Audit Committee and Board for formal approval;

q) Undertake an annual review of the Quality and Risk Management Strategies to ensure that they reflect all required priorities;

r) To have oversight of the local Commissioning, Quality and Innovation (CQUIN) proposals to ensure they are appropriate, challenging and lead to significant improvement in quality of services and receive quarterly CQUIN and Quality Improvement Priority Reports to provide assurance of compliance and escalate exceptions to Trust Board.

s) To review the proposed internal audit plan recommended by the Responsible Executive Director responsible for establishing the internal audit plan (MIAA) for all functions areas within its remit e.g. Clinical Audit, Safety and Effectiveness.

Overall

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

5. MEMBERSHIP

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

Chair:	- Non-Executive Director
Responsible Executive:	- Director of Nursing and Governance
Other Core Members:	- Non-Executive Director
	- Chief Executive

	- Chief Operating Officer - Director of Finance and Commercial Development - Medical Director (and as DiPSE) - Director of Human Resources and Organisational Development - Director of Information Technology - Deputy Director of Nursing - Associate Director of Governance and Risk - Chief Pharmacist - Head of Allied Health Professionals.
Divisional Representation	- Divisional Medical Directors – Scheduled Care - Divisional Medical Directors – Unscheduled Care - Divisional Medical Directors – Women and Children's - Divisional Associate Directors of Operations– Scheduled Care - Divisional Associate Directors of Operations– Unscheduled Care - Divisional Associate Directors of Operations– Women and Children's
In Attendance:	- Trust Secretary/ Executive Secretary - Co-opted members as appropriate - Chairs of each of the sub committees of the Quality Committee (some of which will already be attending as Executives)
By Invitation	- Warrington CCG & Halton CCG – Nursing, Quality and GP Leads - Patient/ Carer Representative

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

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

Core members who are unable to attend a meeting of the Committee may appoint a deputy who will attend in their stead. It is the responsibility of the core member to inform the secretary of the Committee if they are unable to attend and who will attend as their deputy.

6. ATTENDANCE

a. Members

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

b. Officers

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

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

7. QUORUM

A quorum shall be 4 members and shall include one Non-Executive Director, and two Executive Directors and one senior clinician. The Chair of the Trust may be included in the quorum if present at a meeting. In the event that a Non-Executive Director member cannot attend a meeting of the Committee, one of the Non Executives Directors who are not members of the Committee may attend in substitution and be counted in the quorum of the Committee.

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

8. FREQUENCY OF MEETINGS

Meetings shall be held monthly. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust. The Chair of the Committee with the agreement of the membership may hold the meetings of the Committee monthly.

9. REPORTING GROUPS

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

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

b) the formally recorded minutes of their meeting; and

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

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

DIGGs
Infection Control
Clinical Effectiveness
Patient Safety
Health and Safety
Patient Experience
In addition to the Safeguarding Strategy, Nursing and Midwifery Advisory and the Medical Advisory Groups on all issues risks relating to Quality

10. ADMINISTRATIVE ARRANGEMENTS

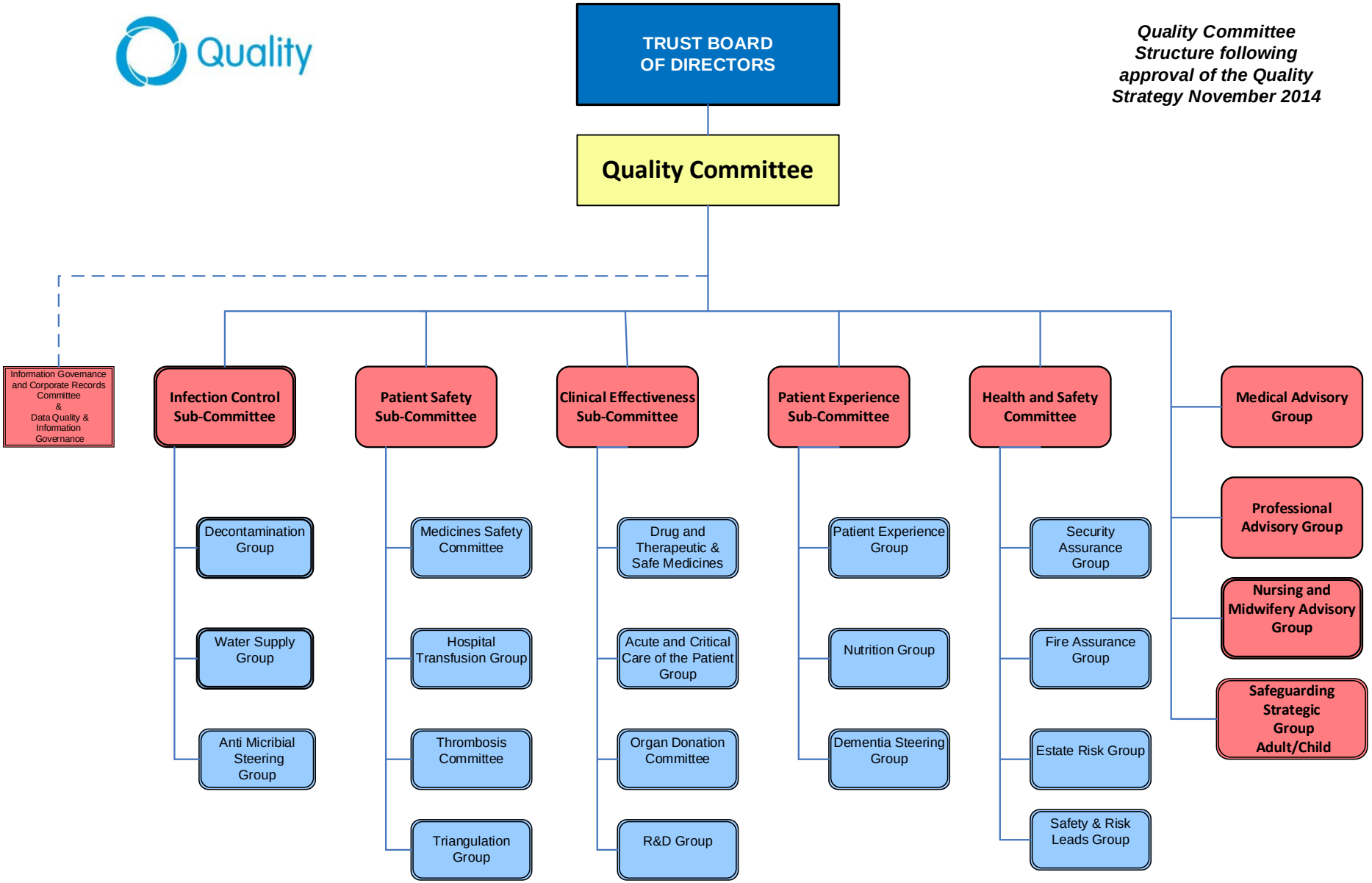
The Trust Secretary or his delegate will be secretary of the Committee.

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

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

11. REVIEW / EFFECTIVENESS

The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements. These terms of reference will normally be reviewed at least annually by the Committee. The Committee shall undertake the first review following approval after 6 months.


Quality
TRUST BOARD OF DIRECTORS
Quality Committee Structure following approval of the Quality Strategy November 2014
Quality Committee
Information Governance and Corporate Records Committee & Data Quality & Information Governance
Infection Control Sub-Committee
Patient Safety Sub-Committee
Clinical Effectiveness Sub-Committee
Patient Experience Sub-Committee
Health and Safety Committee
Medical Advisory Group
Professional Advisory Group
Nursing and Midwifery Advisory Group
Safeguarding Strategic Group Adult/Child
Decontamination Group
Water Supply Group
Anti Micribial Steering Group
Medicines Safety Committee
Hospital Transfusion Group
Thrombosis Committee
Triangulation Group
Drug and Therapeutic & Safe Medicines
Acute and Critical Care of the Patient Group
Organ Donation Committee
R&D Group
Patient Experience Group
Nutrition Group
Dementia Steering Group
Security Assurance Group
Fire Assurance Group
Estate Risk Group
Safety & Risk Leads Group

BOARD OF DIRECTORS

WHH/B/2015/ **124**

SUBJECT:	**QUALITY DASHBOARD (2015/2016) MAY 2015**
DATE OF MEETING:	27th May 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
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED:	None
EXECUTIVE SUMMARY (KEY ISSUES):	The Quality Dashboard (at Appendix 1) has been revised this month to include 2015/2016 'quality' 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 the May QDB.	
RECOMMENDATION:	***The Board is asked to:*** 1. Approve the revised template, with regard to format and content. 2. Note that the data for a number of indicators can change month on month. This applies to incidents (including pressure ulcers and falls), as incident type and severity can alter once reviewed, complaints and concerns as complaints can become concerns (and vice versa), with the agreement of complainants, and to mortality data which is rebased. 3. Note progress and compliance against the key performance indicators 4. 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

Introduction

The May 2015 quality dashboard has been revised in line with changes to the following for 2015/16:

- 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

At this Trust Board meeting, the members are asked to consider the revised template, with regard to format, scope and content. Details of several exceptions are provided below, however, more detailed exception reporting will be provided in the June 2015 report when there is more data available to be considered, and the Trust Board members have agreed to the scope.

Details of exceptions

1. Pressure Ulcers

There has been an increase in pressure ulcers in April 2015. All these ulcers have been subject to root cause analysis. Areas for improvement noted are: risk assessments to be undertaken within six hours if still in AED if patients are to be admitted. An extension to our successful existing Not on Our Watch campaign, called On Your Marks is being developed and will focus efforts earlier on in patients journey in hospital whenever reddened skin is noted. One root cause analysis investigation identified that in the 3 days prior to the incident the ward did not have its full complement of staff on duty and this was identified as a possible contributory factor in the pressure ulcer happening, our SNCT will monitor this in the future.

2. C-difficile

The infection prevention and control team have reviewed the process whereby C-difficile cases are reviewed. This has included streamlining the investigation tool with input from our lead commissioner, and the lead commissioners are now attending our internal review meeting which will further enhance understanding and learning from cases both internally and externally to the trust to work toward delivering the target. Additionally, the medical director's role of director of infection prevention and control will put additional focus on medical engagement in prevention.

3. Always Events

The data for this is incomplete, hence a score of 87%. The data capture systems are being reviewed in order that that they are more robust and this improvement will be reflected in future reports.

4. Complaints

Following the removal of 4 formal complaints to the concerns category, there were 474 formal complaints finally agreed for 2014/2015.

5. SHMI and HSMR

A comprehensive report is being presented at the May 2015 Trust Board meeting.

May-15

Quality Dashboard May 2015

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: NYP = Not yet published, 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
INTELLIGENT MONITORING	BANDING	None set	CQC	NYP																
	NUMBER OF ELEVATED RISKS	None set	CQC	NYP																
	NUMBER OF RISKS	None set	CQC	NYP																
Safety																				
MORTALITY	HSMR (12 MONTH ROLLING)	<=100 = G, As expected = A, Higher than expected = R	QI, IP, QC	NYP												107	106			
	SHMI (12 MONTH ROLLING)	<=100 = G, As expected = A, Higher than expected = R	QI, IP, QC	NYP												117				
	TOTAL DEATHS IN HOSPITAL	None set	reporting only	88																88
	MORTALITY PEER REVIEW	Q1 - 35% Q2 – 55% Q3 – 75% Q4 – 95%	IP, SU2S	55%																
	REGULATION 28 - PREVENTION OF FUTURE DEATHS REPORT	None set	Reporting only	0																0
INCIDENTS	MODERATE, MAJOR OR CATASTROPHIC HARM (APPROVED)	TBC	QC	1																1
	MODERATE, MAJOR OR CATASTROPHIC HARM (UNDER REVIEW)	N/A		54																54

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
FALLS	ALL FALLS (APPROVED)	913	IP (5% reduction)	79																79
	FALLS PER 1000 BED DAYS	<=5.6	IP (national benchmark)	4.89%																4.89%
	MODERATE, MAJOR AND CATASTROPHIC HARM FALLS (APPROVED)	<=13	IP (10% reduction)	0																0
	MODERATE, MAJOR AND CATASTROPHIC HARM FALLS (UNDER REVIEW)	N/A		4																4
	MODERATE HARM FALLS (APPROVED)	<=12	SU2S (10% reduction)	0																0
PRESSURE ULCERS	GRADE 3 AND 4 HOSPITAL ACQUIRED (AVOIDABLE)	<=5	QI, SU2S (10% reduction)	0																0
	GRADE 3 AND 4 HOSPITAL ACQUIRED (UNAVOIDABLE)	N/A		0																0
	GRADE 3 AND 4 HOSPITAL ACQUIRED (UNDER REVIEW)	N/A		1																1
	GRADE 2 HOSPITAL ACQUIRED, AVOIDABLE AND UNAVOIDABLE (APPROVED)	<=63	QI (5% reduction)	9																9
	GRADE 2 HOSPITAL ACQUIRED, AVOIDABLE AND UNAVOIDABLE (APPROVED)	<=59	10% reduction internal stretch target	9																9
	GRADE 2 HOSPITAL ACQUIRED, AVOIDABLE AND UNAVOIDABLE (UNDER REVIEW)	N/A		6																6
HEALTHCARE ACQUIRED INFECTIONS	MRSA	0= green, 1-5=amber, >5 red	QC, QI	0																0
	CLOSTRIDIUM DIFFICILE	<=27 per year	QC, QI	3																3
TRANSFERS	OUT OF HOURS TRANSFERS	TBC	BK	1																1
	NON-ESSENTIAL WARD TRANSFERS	TBC	QI	DC																
NEVER EVENTS		0	QC	0																0
CARDIAC ARRESTS	Annual: <75 = G, 75 – 85 = A, >85 = Red	see left	QC	4																4

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
VTE	% OF PATIENTS RISK ASSESSED	>=95%	QC	95.19%																
	% OF ELEIGBLE PATIENTS HAVING PROPHYLAXIS (SAFETY THERMOMETER)	100%	QC	97.52%	100%															
	NUMBER OF PATIENTS WHO DEVELOPED A HA VTE (APPROVED)	TBC	QC	NYP																
	NUMBER OF PATIENTS WHO DEVELOPED A HA VTE (UNDER REVIEW)	N/A	N/A	NYP																
HARM FREE CARE	% OF PATIENTS FREE FROM HARM (SAFETY THERMOMETER)	TBC	OH	97.70%	92.60%															
	% OF PATIENTS FREE FROM HARM (MEDICINES SAFETY THERMOMETER)	TBC	QI	QR																
DEMENTIA	DEMENTIA ASSESSMENT % (PART 1)	>=90%	C	96.58%																
	DEMENTIA ASSESSMENT % (PART 2)	>=90%	C	86.96%																
	DEMENTIA ASSESSMENT % (PART 3)	>=90%	C	100%																
	DEMENTIA - STAFF TRAINING	TBC	C	Baseline to be established at end Q1																
CARE INDICATORS RISK ASSESSMENTS	FALLS	>=95%	IP	91%																
	WATERLOW (PRESSURE ULCERS)	>=95%	IP	91%																
	MUST (MALNUTRITION)	>=95%	IP	78%																
	DIABETIC FOOT	Q1 - 61% Q2 – 71% Q3 – 81% Q4 – 91%	C	QR																
Effectiveness																				
ADVANCING QUALITY (RAG rating for Jan and Feb scores are based on 2014/15 targets)	ACUTE MYOCARDIAL INFARCTION	>=95%	QI, C	NYP												96.6%	100%	NYP		
	HIP AND KNEE	>=95%	QI	NYP												97.8%	98%	NYP		
	HEART FAILURE	>=84.1%	QI, C	NYP												87.0%	85%	NYP		
	PNEUMONIA	>=78.1%	QI, C	NYP												71.3%	74.10%	NYP		
APPROPRIATE DISCHARGE PLANNING FOR PATIENTS WITH AKI		TBC	C	Quarter one data for establishing baseline																

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
SEPSIS SCREENING OF ALL ELIGBLE PATIENTS ADMITTED TO EMERGENCY AREAS		TBC	C	Quarter one data for establishing baseline																
SEPSIS SCREENING: ANTIBIOTICS GIVEN WITHIN AN APPROPRIATE TIMESCALE		TBC	C	Quarter one data for establishing baseline																
Patient Experience																				
ALWAYS EVENTS		100%	QI	89%																
MIXED SEX OCCURENCES		0	QC	6																6
FRIENDS AND FAMILY (PATIENTS' VIEWS)	STAR RATING	N/A	Reporting only	NYP																
	% RECOMMENDING TRUST: INPATIENTS	>=95%	IP, QI, QC	NYP																
	% RECOMMENDING TRUST: A&E	>=87%	IP, QI, QC	NYP																
	RESPONSE RATE: A%E WARINGTON	Contract target to be agreed	IP, QI, QC	22.03%																
	RESPONSE RATE: URGENT CARE CENTRE HALTON	Contract target to be agreed	IP, QI, QC	3.54%																
	RESPONSE RATE: A%E COMBINED	Contract target to be agreed	IP, QI, QC	17.42%																
	RESPONSE RATE: INPATIENTS	Contract target to be agreed	IP, QI, QC	30.30%																
COMPLAINTS AND CONCERNS	NUMBER OF COMPLAINTS RECEIVED	2013/2014 received 478 (No threshold set)	IP	56																56
	% OF COMPLAINTS RESOLVED WITHIN THE AGREED TIMESCALE	<=94%	IP, QC	100%																
	NUMBER OF CONCERNS RECEIVED	NOT SET	IP	4																4
END OFLIFE STRATEGY: STAFF TRAINING (KPI UNDER CONSTRUCTION)		TBC	IP	DC																
REDUCING AVOIDABLE EMERGENCY ADMISSIONS TO HOSPITAL		TBC	C	Quarter one data for establishing baseline																

BOARD OF DIRECTORS

WHH/B/2015/ **125**

SUBJECT:	**Mortality Overview Report**	
DATE OF MEETING:	27th May 2015	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Hannah Gray, Clinical Effectiveness Manager Simon Constable, Medical Director	
EXECUTIVE DIRECTOR:	Simon Constable, Medical Director	
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care	
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 overviews trust mortality data and provides local and national context. It also outlines the actions in place to ensure robust oversight and monitoring, through a comprehensive mortality peer review process, as well as improvement plans to reduce trust mortality rates and the trust mortality ratio figures.	
RECOMMENDATION:	***The Board is asked to:*** *note the contents of the report and discuss and approve the recommended options*	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable Or type here if not on list:
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

Mortality Overview Report

EXECUTIVE SUMMARY

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

CONTEXT

- The importance of reporting mortality statistics at Board level was highlighted in the Francis Report into the failures at the Mid-Staffordshire Trust (February 2010) to which Warrington and Halton Hospitals NHS Foundation Trust provided a full position response reported at Board in September 2010.
- On February 6th 2013 the Prime Minister announced that he had asked Professor Sir Bruce Keogh, NHS Medical Director for England, to review the quality of care and treatment provided by those NHS trusts and NHS foundation trusts who were persistent outliers on mortality indicators. A total of 14 hospital trusts were investigated as part of this review. After the reviews, 11 of the 14 trusts were placed into special measures by Monitor and the NHS Trust Development Authority.
- The Secretary of State for Health announced in March 2015 that clinical mortality reviews will be compulsory in all Trusts (date and details not yet confirmed).
- The Care Quality Commission's Intelligent Monitoring process encompasses the monitoring and reporting of around 100 mortality related indicators.
- Reducing the HSMR and SHMI have been identified as local quality indicators for the Trust in 2015/2016 (Quality Report 2014/2015).
- Reducing Mortality is one of three commitments we have made in the national Sign up to safety campaign 2014 - 2017.

MORTALITY DATA

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

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

a) Trust Crude Mortality

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

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

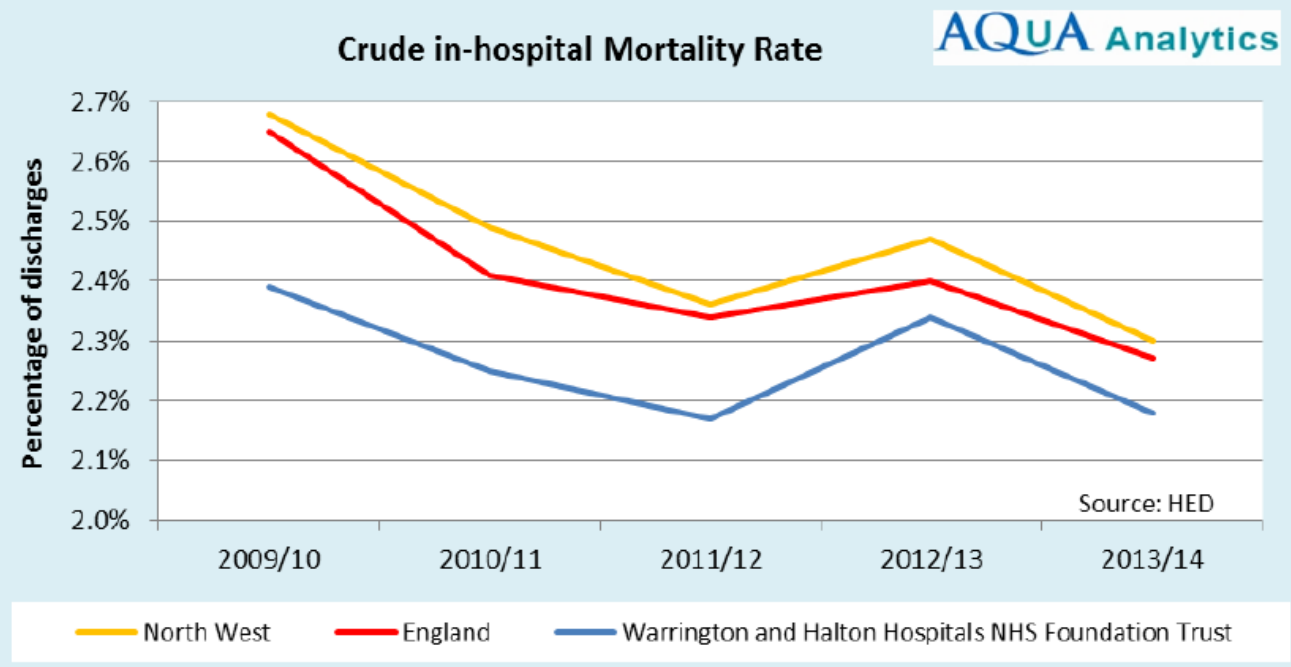


Chart 2: WHHNHSFT, England average and North West Acute Trusts October 2013 – September 2014 (latest available national data).

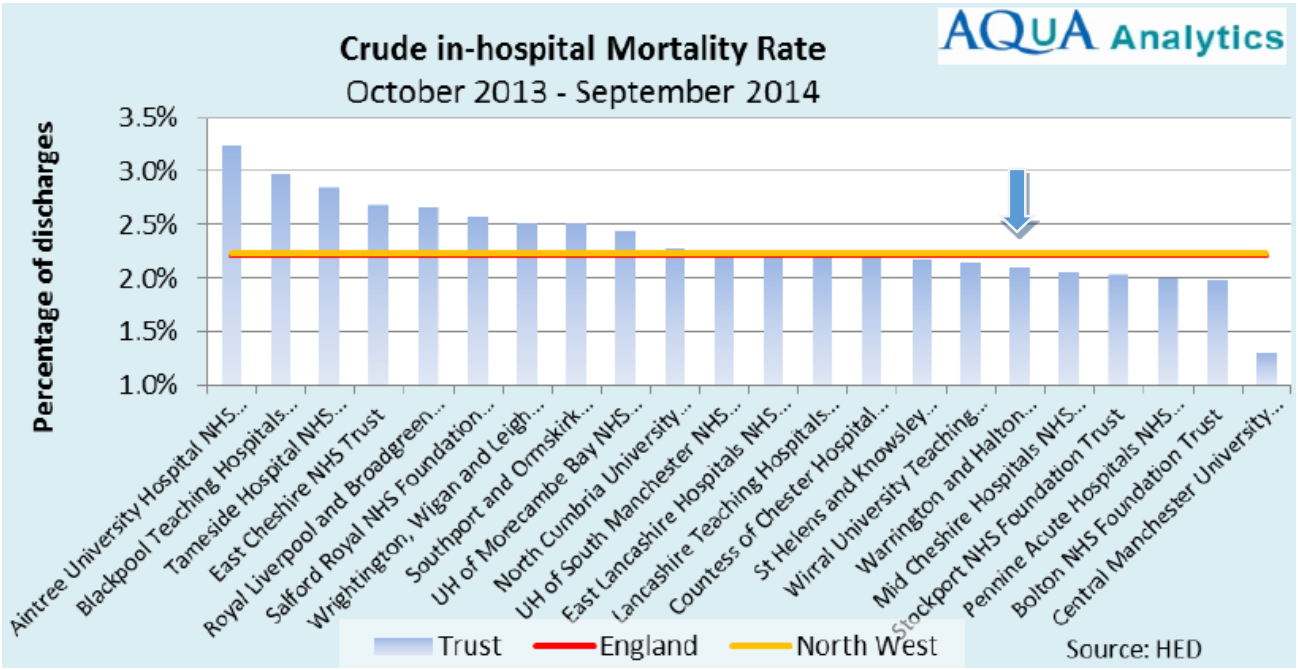


Chart 3: Crude Mortality Rates for WHHNHSFT and local peers (HSMR patients only), April 2014 – February 2015 (latest data available).

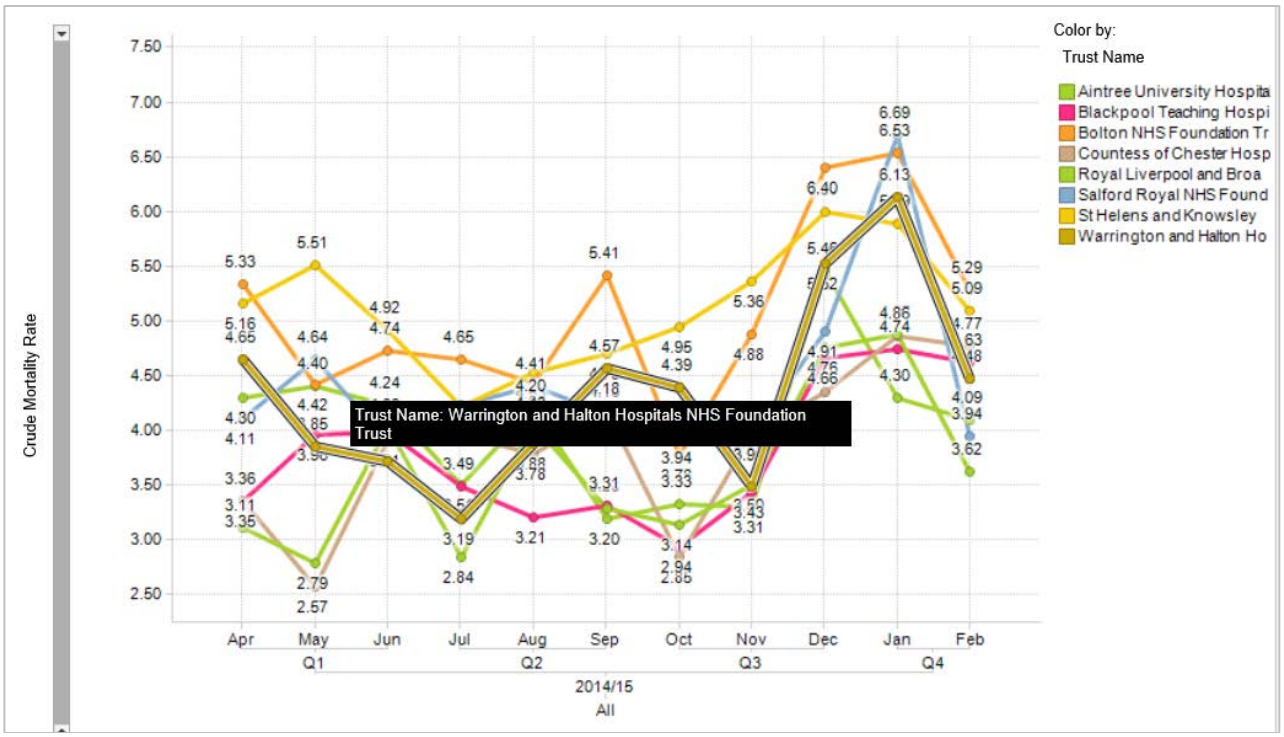
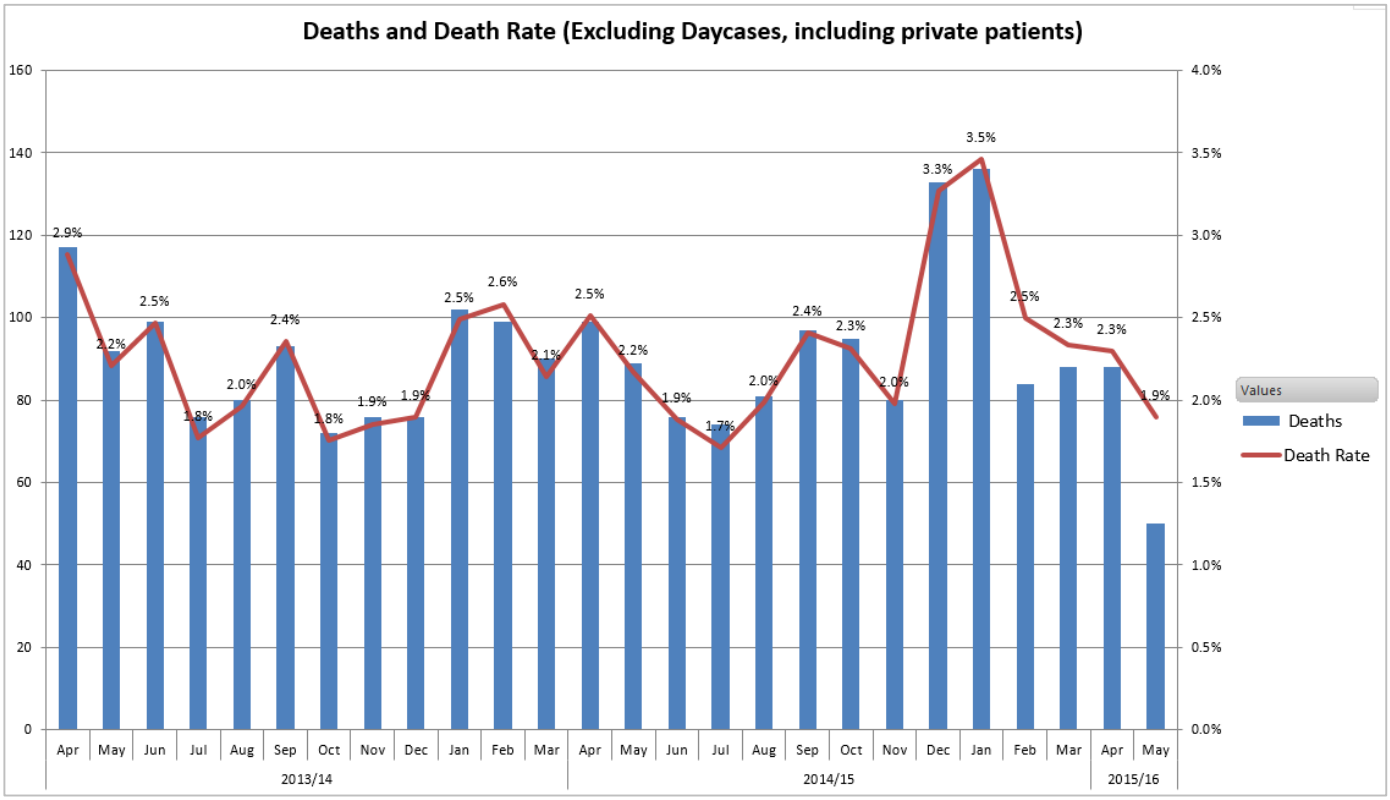


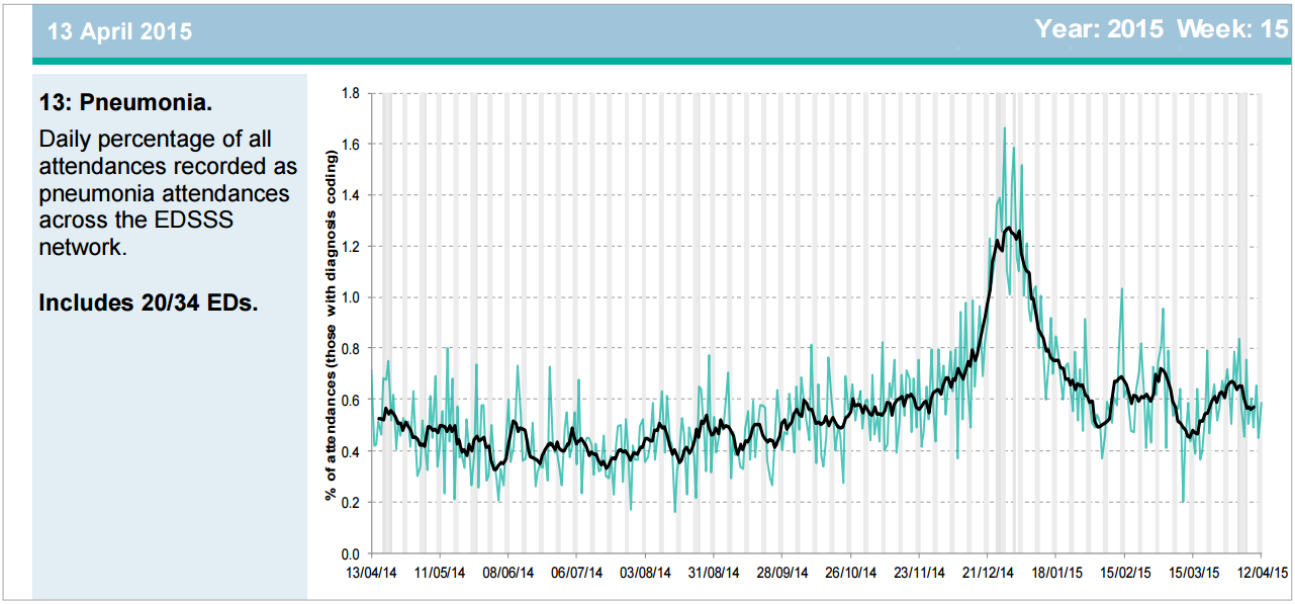
Chart 4: WHHNHSFT total deaths and death rate (deaths as a % of all discharges) per month (as at 21st May 2015).



Source: WHHNHSFT Information Department

The Office for National Statistics released figures showing that the 2014/15 winter death rate in England and Wales was running about one-third higher than its normal rate for that time of year with the driving force being recurrent cold snaps and influenza as this winter's prevalent strain particularly hits the elderly, and the flu vaccination at this time was largely ineffective against it. (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/407912/Weekly_report_mortality_week_9_26February2015_updated.pdf). The trust's figures reflect national and regional trends and are consistent with the national figures for pneumonia attendances (see chart 5 below).

Chart 5: Daily % of all attendances recorded as pneumonia attendances across the EDSSS network.



Source: Public Health England

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

Recommendation	**Assurance Forum**	**Deadline**
The trust should review its policy for Admission to ICU, to ensure that there is clarity regarding which patients should be referred and that grounds for refusal of admission are appropriate**.**	Acute and Critical Care of the Patient Group	Q3 2015/16
The trust should engage with external stakeholders to explore what systems and processes (and resources) need to be in place in order to minimise the possibility of patients being admitted to hospital in the last days/hours of their life. Clear care plans should also be in place such that if patients are admitted then the appropriate discussions regarding patient's wishes, limitation of	Via the Care Quality Review Group, the trust is working alongside group members, Warrington CCG's Quality Lead for Nursing Homes and GP Governing Member, to share information on deaths of patients admitted from nursing homes; to identify learning and to collaborate to make cross sectoral improvements. The number of GPs per head of population is understood to be associated with mortality	Ongoing

therapy etc. have already occurred.	rates, an issue which will be further investigated.	
All deaths in the hospital should be reviewed on an ongoing basis**.**	Clinical Effectiveness Sub-Committee	Q4 2015/16

Trust Deaths Detail

Numbers of deaths and death rates on wards in 2013/2014 and 2014/2015.

		Number of deaths		Death Rate	
Ward	**Lead Speciality**	**2013/2014**	**2014/2015**	**2013/2014**	**2014/2015**
A1	Acute Medicine	101	105	2.2%	2.3%
A2	Acute Medicine	92	88	5.1%	5.5%
A3	Elderly Medicine	76	103	8.3%	13.6%
A4	General Surgery	36	10	2.9%	0.6%
A5	General Surgery	14	38	1%	2.4%
A6	Colorectal Surgery	25	29	1.3%	1.9%
A7	Respiratory Medicine	138	133	10.4%	13.6%
A8	General Medicine/ Neuro-rehab/Elderly	82	96	10.4%	13.2%
A9	Trauma & Orthopaedics	32	33	2.7%	2.6%
B11	Paediatrics	1	1	0.1%	0.1%
B12	Elderly Care/Dementia	56	52	11.7%	14%
B14	Stroke	67	81	10.1%	10.9%
B18	General Medicine and infection control cohort ward	44	45	8.2%	9.5%
B19	Trauma & Orthopaedics	7	10	1.2%	1.9%
C20	Gynaecology & Women's Health	3	6	0.1%	0.3%
C21	Cardiology	36	47	3.3%	4.7%
C22	Gastroenterology	43	60	4.1%	6.3%
Coronary Care Unit	Cardiology	33	30	8%	6.5%
Clinical Decisions Unit	Emergency Medicine	1	2	0.02%	0.04%
CMTC	Trauma & Orthopaedics	0	1	N/A	0.1%
Intensive Care Unit	Critical Care Medicine	152	131	59.4%	63.6%
Labour Ward (including still births)	Obstetrics & Paediatrics	14	9	0.67%	0.46%
Neonatal Unit	Neonatology	7	4	3.02%	1.69%

Surgical Assessment Unit	General Surgery	1	3	0.05%	0.1%
Theatre Recovery	General Surgery	7	11	36.8%	45.8%
Urgent Care Centre	General Medicine	1	3	0.2%	1.3%
Halton Intermediate Care Unit	Intermediate Care	1	2	1.1%	0.8%
Total		**1076**	**1134**	**2.3%**	**2.5%**

Source: WHHNHSFT Information Department

The crude death rate for 2015/2016 to date (1/4/15 – 17/5/15) is 2.2%.

Deaths by day of admission

This table shows a weekday / weekend split for crude numbers of deaths (patients who died in hospital or within 30 days of discharge), and SHMI* figures for WHHNHSFT and other North West trusts for comparison, for the period February 2014 – January 2015 (latest available on HED). The SHMI for all 22 NW acute trusts for this period is 109 for weekend admissions and 104 for weekday admissions. Both these figures are statistically significantly high. 17 of the 22 Acute Trusts in the NW have a higher weekend than weekday SHMI, and 18 Trusts have a weekend SHMI over 100. The average weekend SHMI for all NW Trusts is 110. Although other trusts have a similar gap between their weekday and weekend SHMI, and we have identified no concerns regarding weekend care in general (as part of any focussed or general mortality review to date) we will investigate this further to better understand the reason for this difference, and take action as required.

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

Trust Name	Day of Admission	SHMI	Statistically significant?	Expected number of deaths	Number of patients discharged who died in hospital or within 30 days	Percentage of mortalities occurring in hospital	Percentage of admissions with palliative care coding	Average comorbidity score per spell	Crude mortality rate
ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	Weekday	106.34	Yes	1552.5	1651	70.80%	1.21%	3.7	3.26%
	Weekend	112.2	Yes	484.8	544	72.40%	1.28%	3.85	3.78%
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	Weekday	106.86	Yes	1451.4	1551	68.30%	3.10%	4.64	4.30%
	Weekend	105.03	No	421.8	443	71.60%	3.43%	4.89	5.13%
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	Weekday	108.19	Yes	1030.6	1115	70.30%	1.45%	2.84	3.03%
	Weekend	109.62	No	298.3	327	77.70%	1.50%	2.76	3.45%
SALFORD ROYAL NHS FOUNDATION TRUST	Weekday	101.18	No	1276	1291	73.90%	2.68%	4.14	3.40%
	Weekend	95.54	No	456.4	436	77.10%	3.23%	5.08	4.44%
BOLTON NHS FOUNDATION TRUST	Weekday	105.14	No	1231.7	1295	76.20%	1.18%	2.89	2.62%
	Weekend	114.61	Yes	424.9	487	72.70%	1.39%	2.88	3.28%
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	Weekday	106.39	Yes	1399.6	1489	72.70%	2.04%	4.1	3.70%
	Weekend	108.43	No	415.9	451	72.30%	2.13%	3.99	3.98%
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	Weekday	114.16	Yes	1053.8	1203	71.40%	1.59%	3.26	3.10%
	Weekend	124.74	Yes	316.7	395	74.40%	1.72%	3.28	3.85%
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	Weekday	114.25	Yes	1543.9	1764	71.40%	1.13%	4.08	3.98%
	Weekend	125.91	Yes	488.4	615	75.30%	1.26%	3.86	4.55%

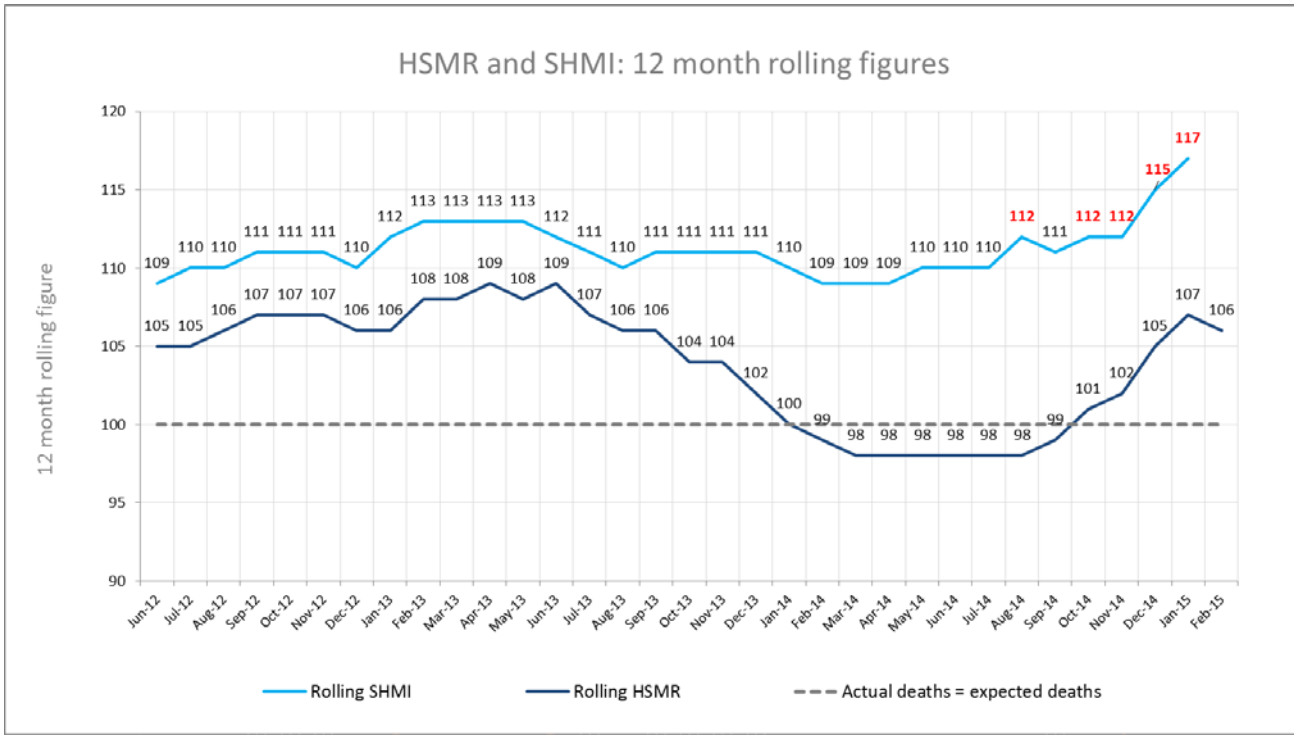
b) SHMI and HSMR

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

	HSMR	SHMI
Numerator	All spells culminating in death at the end of the patient pathway, defined by specific diagnosis codes for the primary diagnosis of the spell: uses 56 diagnosis groups which contribute to approx 80% of in hospital deaths in England*.	Total number of observed deaths (in-hospital and 30 day post discharge deaths)
Denominator	Number of in hospitals admissions where the primary diagnosis at the beginning of the spell i.e. the first or second episode is one of those from the 56 diagnosis groups known to be responsible for around 80% of in hospital mortality. (percentage will vary dependent on the case mix of the hospital)	Total number of patient admissions
Adjustments	• Sex • Age in bands of five up to 90+ • Admission method • Source of admission • History of previous emergency admissions in last 12 months • Month of admission • Socio economic deprivation quintile (using Carstairs) • Primary diagnosis based on the clinical classification system • Diagnosis sub-group • Co-morbidities based on Charlston score • Number of previous emergency admissions • Palliative care • Year of discharge	Risk-adjusted, based on age, sex, admission method, co-morbidity
Exclusions	None	• Specialist, community, mental health and independent sector hospitals. • Stillbirths • Day cases, regular day and night attenders
* HSMR does not exclude 20% of deaths, it looks for the diagnosis groups that account for the majority of deaths, hence the figure of 80% is quite variable dependent on the case mix of the trust.		

Following a significant focus on mortality reduction in the trust, we improved from a previously 'higher than expected' SHMI score, to having an 'as expected' score between June 2013 and July 2014. The latest SHMI figure published on the HSCIC website is 109, for the period July 2013 – June 2014. We monitor mortality ratios on a monthly basis using the HED system and have reported internally a 'higher than expected' score in the rolling 12 month periods ending August 2014 (112), October 2014 (112), November 2014 (112), December 2014 (115) and January 2015 (117). The figures are rebased regularly nationally and it is not possible to tell at this time whether the HSCIC published figures for January 2014 – December 2014 (to be published around June 2015) will show the trust position as 'as expected' or 'higher than expected', although the latter is likely. The latest HSMR is 106, for March 2014 – February 2015, this is 'as expected', and a decrease on the previous 12 month period (HED). The same reduction is expected for the SHMI for the same period, in line with crude death numbers, as explained in the next section.

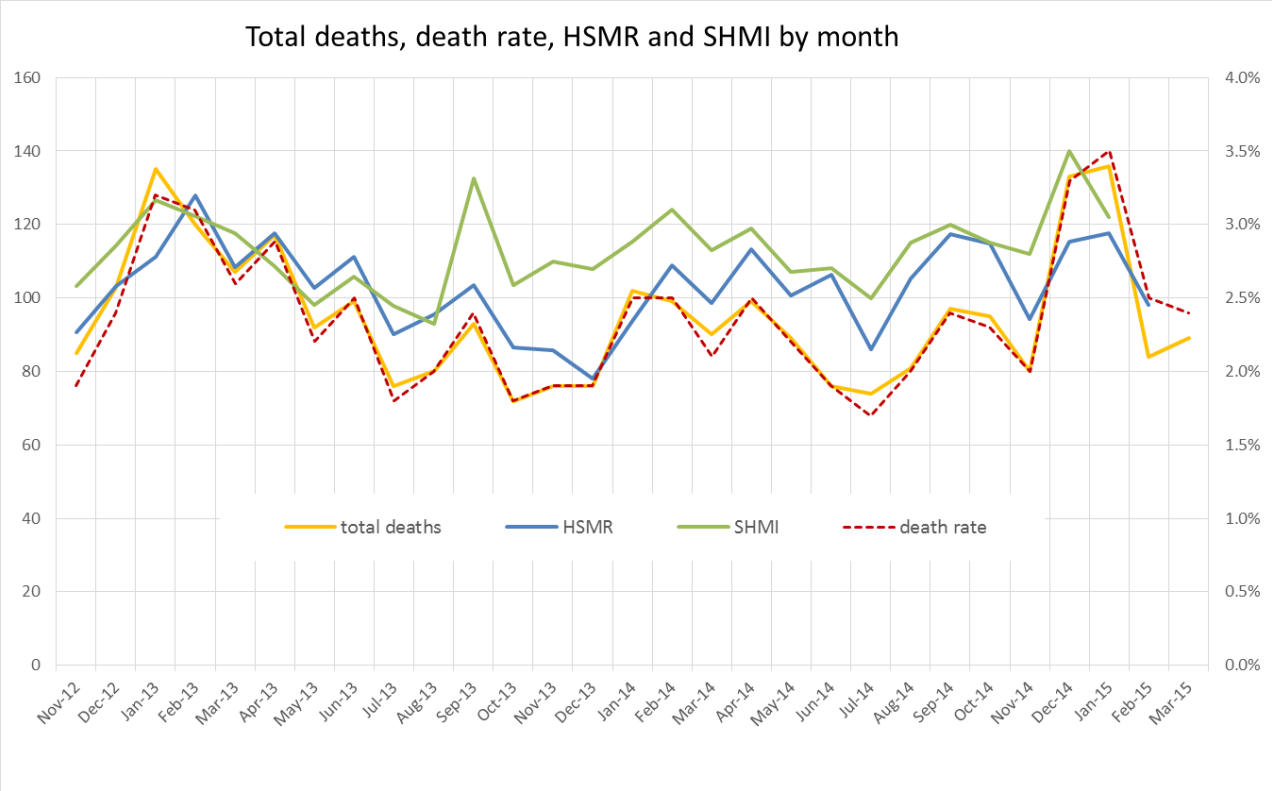
Chart 6: Rolling 12 month HSMR and SHMI figures (i.e. the February 2015 HSMR of 106 is for the period March 2014 - February 2015).



c) Crude death rate compared with mortality ratios

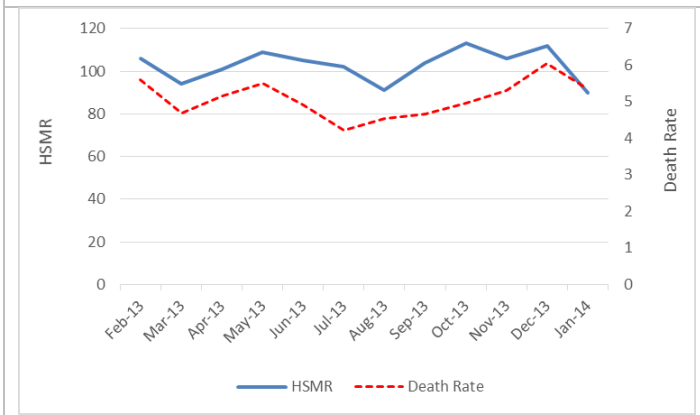
A strong correlation between crude death and mortality ratio figures has been identified. Chart 7 below suggests that the SHMI will fall in February 2015. If the HSMR and SHMI were perfect measures, this would suggest that a rise in crude deaths always equates to an increase in avoidable deaths. Consultation with experts at HED reveals otherwise; they confirm that it is far more likely to be a flaw in the methodology of the ratio than an actual increase in avoidable deaths. Similar correlations at other trusts further support this view (see charts 8 - 11).

Chart 7: Trust total deaths, death rate, HSMR and SHMI.

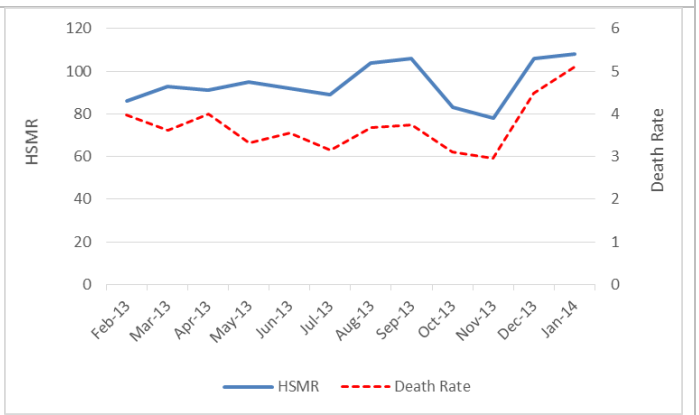


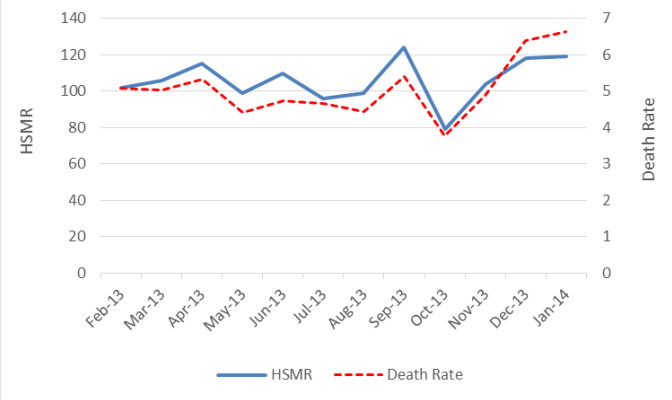
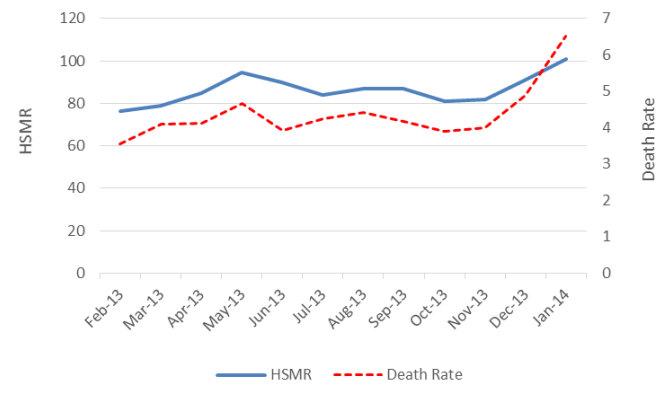
Charts 8 – 11: Correlation between crude death rates (for HSMR patients only) and mortality ratios for local trusts

8: St Helens and Knowsley NHS Trust



9: Mid Cheshire Hospitals NHS FT



10: Bolton NHS FT	11: Salford Royal NHS FT
	

d) Documentation and coding

Signs and symptom codes

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

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

The CCS groups that R codes map to have relatively low mortality rates and, therefore, low numbers of expected deaths. If a trust has a high level of R coding then it is more likely to have a higher level of deaths with an R code as the primary diagnosis (first and second episode). Charts 12 and 13 show that our use of R codes is higher than the NW average and the England average.

Chart 12: Non-elective Finished Consultant Episodes with an R code as the primary diagnosis (WHHNHSFT and England and NW average)

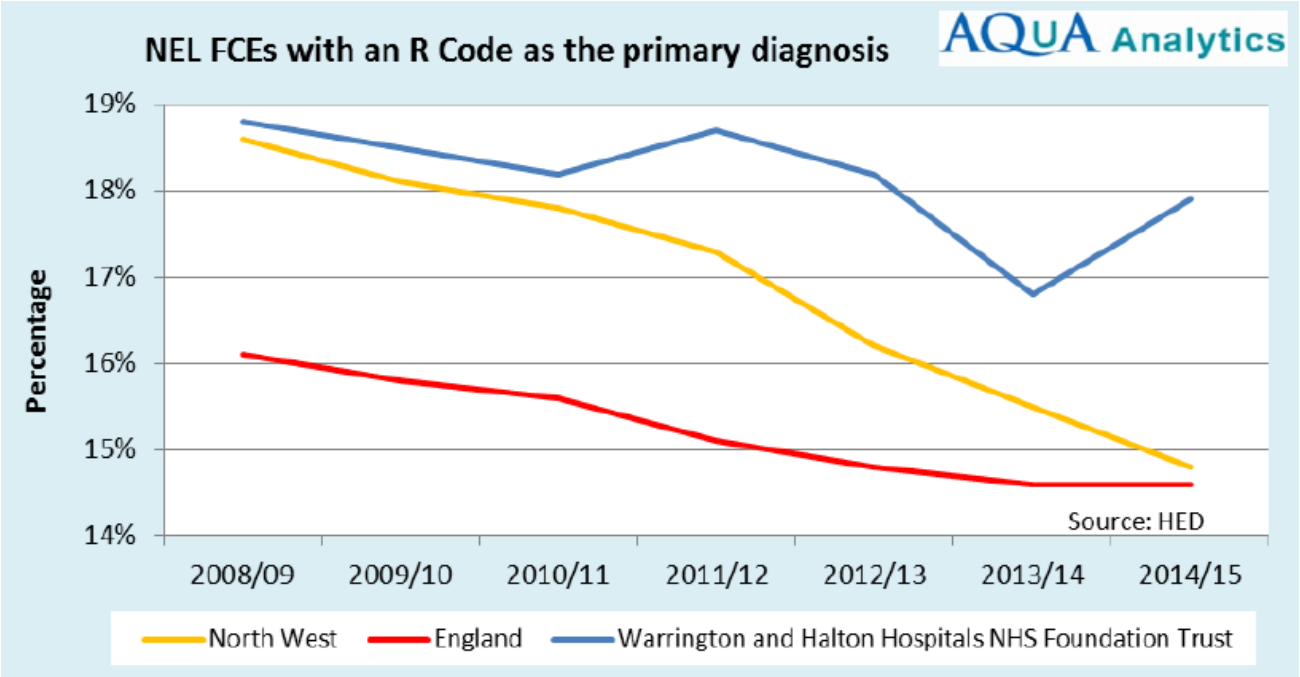
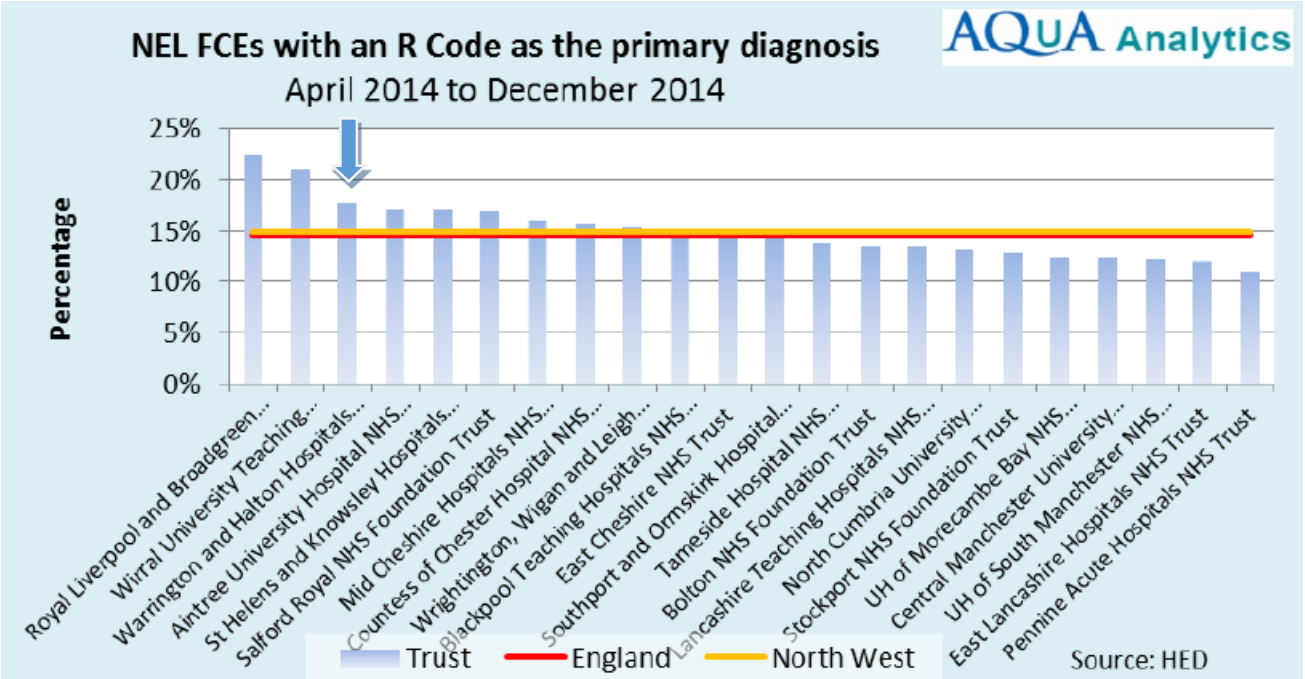


Chart 13: Non-elective finished consultant episodes with an R code as the primary diagnosis in the first 2 episodes only (NW Acutes).



Quality of documentation and coding

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

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

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

Chart 14: WHHNHSFT and local peers average diagnosis coding depth.

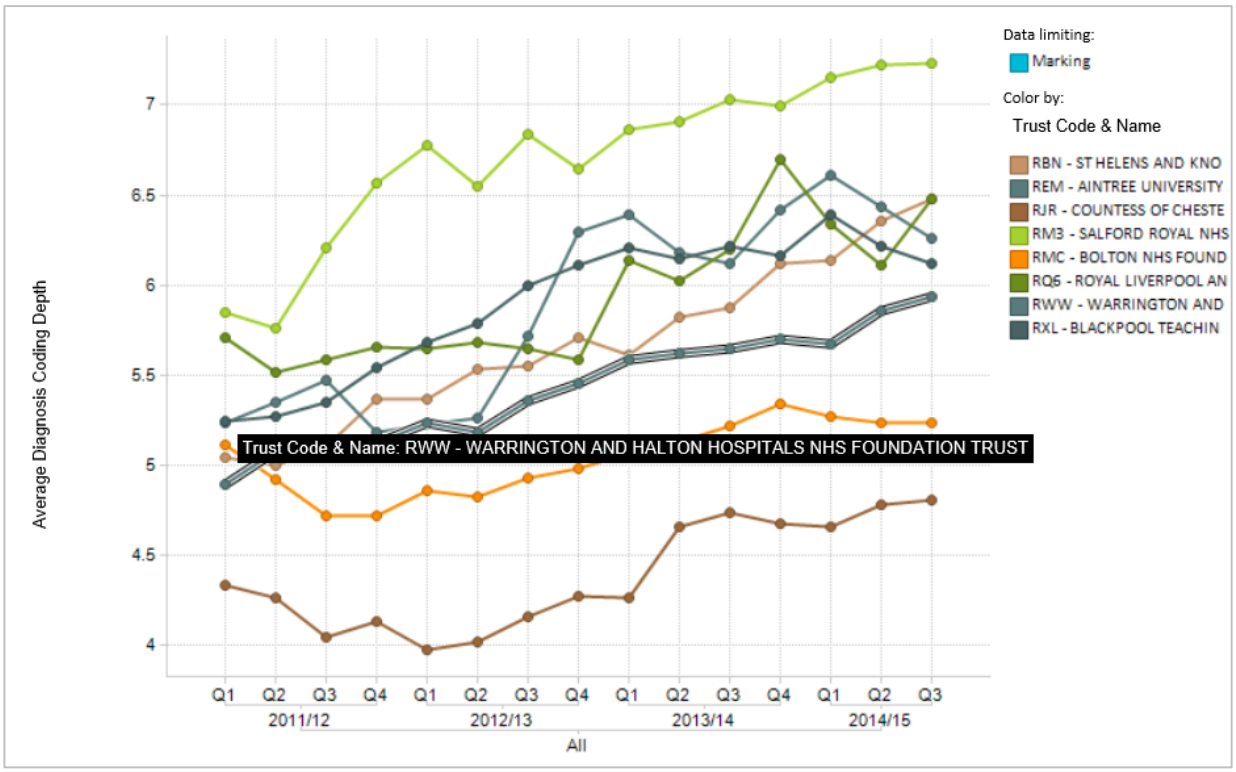
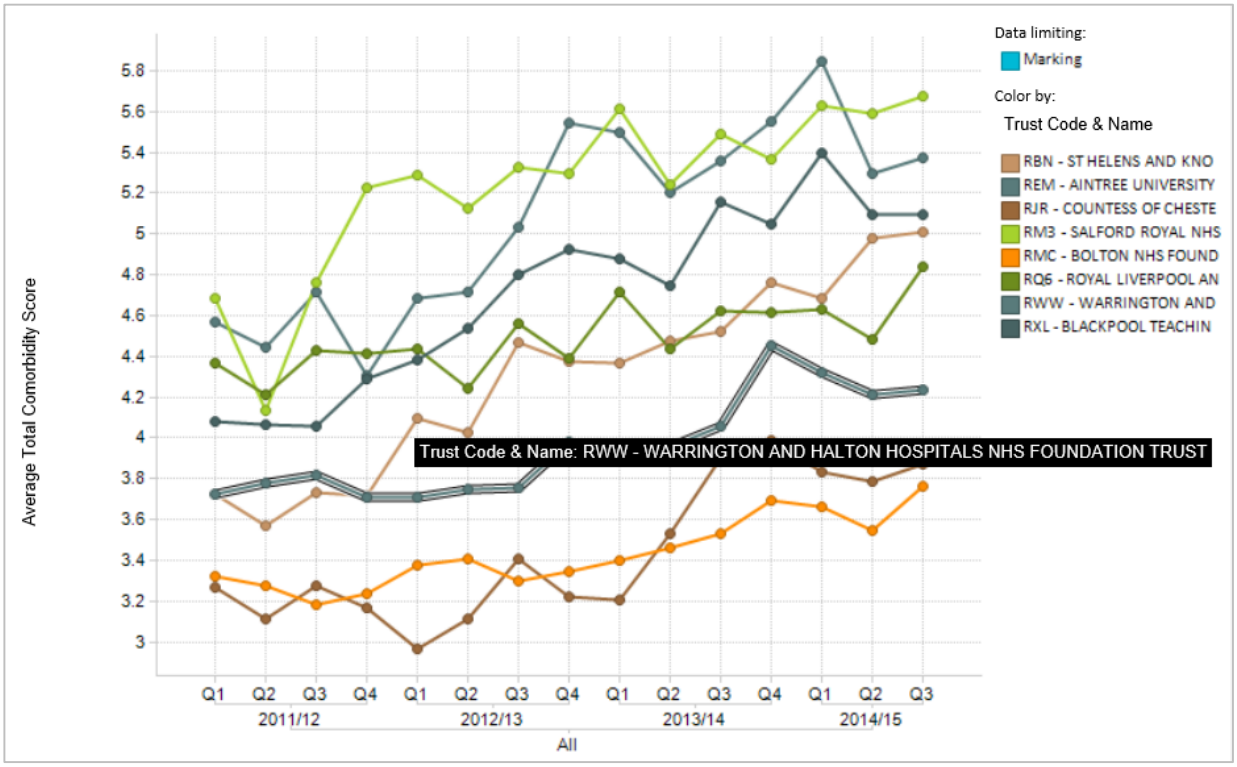


Chart 15: WHHNHSFT and local peers' average total comorbidities



e) Specialist Palliative Care

The coding of the provision of this service is included in the HSMR criteria but not the SHMI. Through investigating the detail behind the ratio numbers, we identified that our rate of service provision was the lowest in the North West prior to 2012/2013, and we have worked hard to now be in a position in which we compare favourably with local peers.

Chart 16: NW Acutes' Specialist Palliative Care service rates October 2013 – September 2014

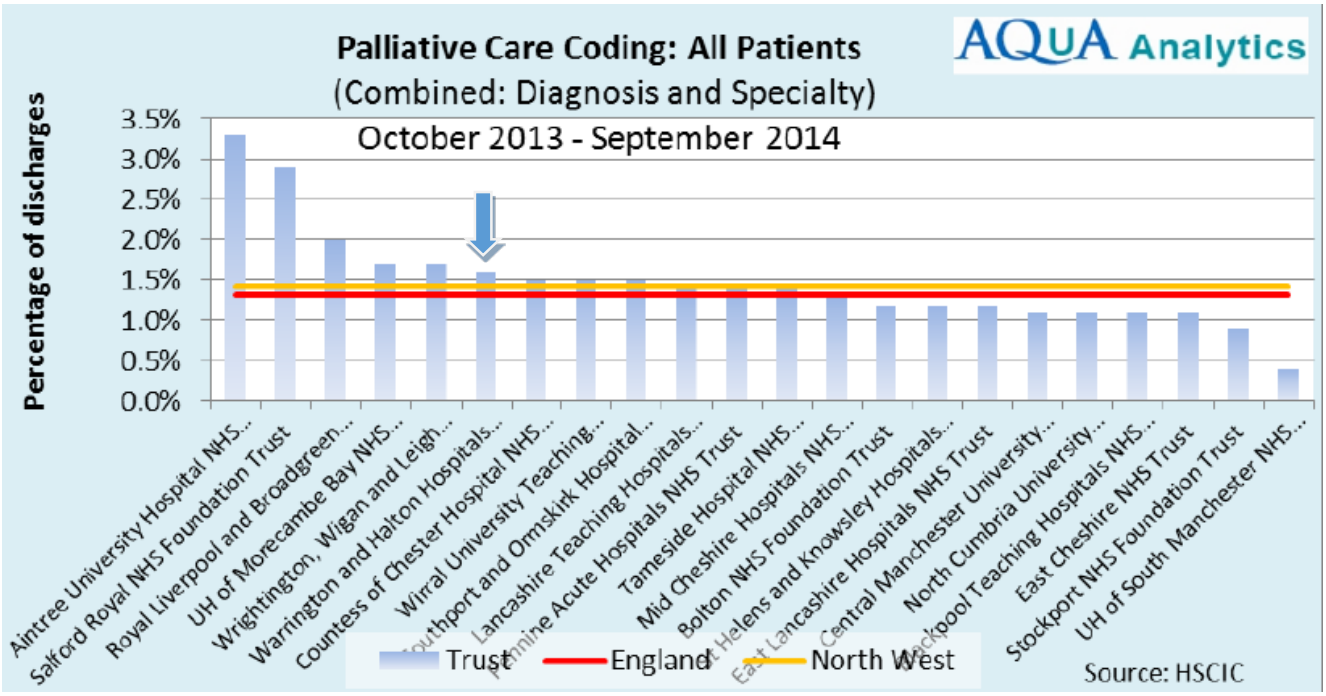
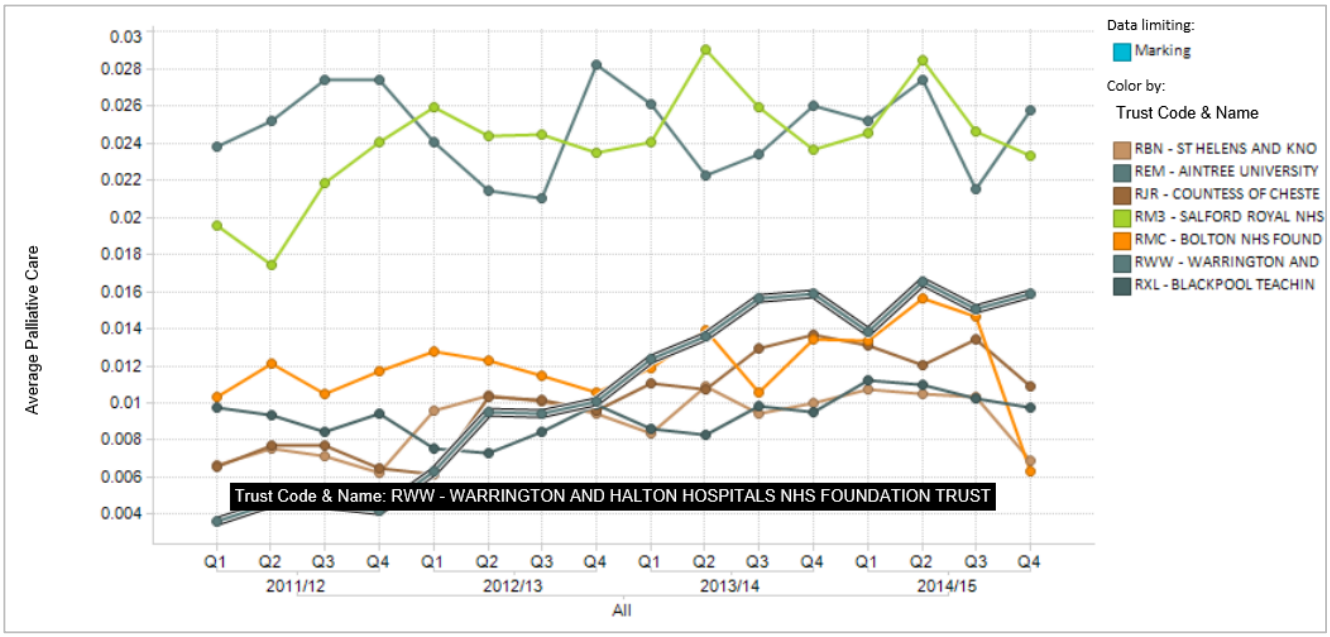


Chart 17: Local trusts' Specialist Palliative Care service provision rates April 2011 – February 2015

(NB: Q4 2014/2015 includes January 2015 and February 2015 only. March 2015 data is not yet available)



NB: WHHNHSFT is the thickest line. Aintree is the higher grey line, Blackpool is the lower grey line.

f) CQC monitoring

There are no open CQC outliers for the trust, the last one being related to UTI in 2012. Since the CQC began publishing the Intelligent Monitoring reports, the trust has had two mortality related indicators with a status of 'risk'. These were for Haematological conditions and Cardiological conditions and reviews were carried out for each indicator. The Haematological conditions risk related to four deaths, two of which were miscoded and the other two cases revealed no areas for concern. The Cardiological conditions review also revealed no areas of concern. Neither of these 'risks' has instigated contact from the CQC requesting a response from the trust. The latest draft May 2015 report, states three new mortality 'risks'; one 'Elevated risk' regarding 'conditions associated with mental health', and two 'risks', of 'Endocrinological' and 'Nephrological' conditions. The Haematological conditions and Cardiological conditions highlighted in previous reports are no longer deemed to be 'risks'. Although none of these new 'risks' have instigated contact from the CQC requesting a response from the trust, we will investigate the details to provide internal assurance of the quality of our care for these patients.

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

ICNARC monitor the performance of Intensive Care Units across England. The latest quarterly ICNARC report, published April 2015, reveals that the trust has a standardised mortality rate of 97 for quarter four 2014/2015; the lowest in the Cheshire and Mersey region, and the second lowest in the North West. To provide further assurance, alongside the routine review of all in-unit deaths, we will be conducting a review of all cases of post-discharge deaths for the quarter.

ACTIONS

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

1. Mortality Peer Review

The early draft findings of a review conducted by Mersey Internal Audit Agency in 2015 reflects our own internal knowledge, that despite there being clear processes in place, full compliance is not being achieved with our own mortality review process. There are some areas of good practice but there is not a standardised system across the organisation. This then impacts on the amount and value of information gleaned from the reviews, to then drive forward focussed improvement. Thus we need to establish a high quality and effective mortality review process which is both trust-wide and standardised in a way that is

helpful. This also needs to be capable of being individualised to meet the specific needs of any given speciality. We are thus moving towards the concept of mortality peer review (MPR) where every death is reviewed by a colleague through a straightforward process which is escalated to an overview group as necessary and where learning and improvement is the underlying rationale. Such a process need not necessarily be cumbersome or disproportionately time-consuming. Arguably something can be learned from every patient and every death – the nature of that learning may be clinical/technical. Equally it could be about documentation, adherence to policy and best practice or indeed issues of care and compassion. We will be expected to have a process that is robust and thus we have an opportunity to revisit the nature of that process. This key element of clinical governance has important implications for quality of care, death certification and clinical coding and will form the basis for key improvement work which incorporates the care of the acutely unwell patient as well as end-of-life care (and thus the other elements of this action plan detailed below).

To address these issues, the Medical Director has gathered together key staff to develop a revised mortality peer review system, which is in the final stages of consultation, with the aims of increasing engagement, reintroducing peer review, integrating the centralised and specialty processes and strengthening organisational learning (please see Appendix 1 for the review tool and process). We have reviewed processes in place in trusts across the UK and in the USA, and are collaborating with the Royal Liverpool and Broadgreen NHS Trust and East Cheshire NHS Trust to develop robust systems. The Clinical Effectiveness Manager and Divisional Medical Director (WCSS) are presenting the new MPR system to the Grand Round on Friday, 22nd May 2015. Implementation will take place by end Q2 2015/2016, with a target of 95% compliance to be achieved by the end of Q4, set as a Quality Indicator for 2015/2016. The MPR activity forms part of a proposal to streamline the processes that occur following a patient death across multiple departments and external stakeholders. These include:

- Bereavement office who ensure that Clinicians complete the appropriate certification and make referrals to the Cheshire Coroner's office.
- Pathology Department for completing post mortem examinations.
- Governance department for managing inquests.
- Clinical Effectiveness team who ensure the MPR takes place.

The proposal is to have one integrated system to manage the entire process (with a uniform output), which will reduce the amount of duplication and will ensure that all appropriate staff have access to all relevant information when needed. The proposed model is that of a desktop screening tool used to differentiate which deaths should undergo further, more detailed, multi-professional/multi-speciality review. This will be reported through the Clinical Effectiveness Sub-Committee to Quality Committee.

2. Child Death Overview Panels

The trust's Dr Mir (Consultant Paediatrician and HM Assistant Coroner for Cheshire) is chairing the National Network of Child Death Overview Panels. He will be leading a group of paediatric clinicians and experienced coordinators from 108 Child Death Overview Panels around England and Wales. The group

will review child death review process, emerging themes from data analysis and make recommendations to the secretaries of Health and Education to influence the child death agenda with a view to improve outcomes for children and families in the UK. Dr Mir has also been invited to join a group of national experts, representing the Royal College of Paediatrics & Child Health and the Royal College of Pathologists, headed by Baroness Kennedy, to prepare a report on Investigating Sudden Unexpected Deaths in infants and Children. Dr Mir was commended by Judge Peter Thornton HM Chief Coroner England and Wales for his contribution, as a Paediatrician and as HM Assistant Coroner Cheshire, in developing Child Death Data Base in Cheshire and for developing a model of investigative tools which have now been implemented all over the country.

4. Focussed Reviews

The following reviews have been identified as a priority to be completed before end Q2 2015/2016.

- Review the care of a sample of patients who died after being admitted at the weekend, and those discharged at the weekend. The aim of this is to better understand the difference between the weekday and weekend mortality ratios, to provide assurance of the quality of care for these patients and to check the accuracy of documentation and coding.
- Review the care of a sample of patients who had an R code (signs and symptoms) as the primary diagnosis, to provide assurance of timely and accurate diagnosis, and better understand the detail behind our above average use of these codes.
- Review of SHMI out of hospital deaths, to provide assurance that the patients were safely and appropriately discharged.
- Review of the care of patients who have died, having a primary diagnosis on the WHO's list of comorbidities unlikely to cause death. The aim of this is to provide assurance of the quality of care for these patients and to check the accuracy of documentation and coding.

5. Care Pathways and Care Bundles

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

The Medical Director, Clinical Effectiveness Manager and Knowledge and Evidence Service Manager are working to identify key pathways for development in line with best practice. The focus will be on high volume, high mortality and high HSMR and SHMI diagnoses.

The Trust is working hard to continually achieve the existing Advancing Quality measures, and committed to complying with the new measures of Hip Fracture, Sepsis, Acute Kidney Injury, Diabetes and Alcoholic Liver Disease. These care bundles are based on the best available evidence and in ensuring we comply with them, we continue to strive for the best available care to patients with these conditions.

6. Management of the Deteriorating Patient

A review of the Acute Care Team is underway**.** Following the merging of two teams and the development of the Medical Emergency Team (MET), it is now a suitable time to review how this team operates and whether it meets the needs of the trust. This review is being led by the Deputy Director of Nursing, Quality and Patient Experience and the Acute Care Matron.

The Acute and Critical Care of the Patient Group continues to be an effective forum, with current activity including the development of an 'AKI calculator' and continuously improving data, for example on MET activity, transfers from Halton and deteriorating patients incidents, with service improvements following.

We have revised our own policy in light of the new North West DNARCPR policy, ensuring that we are acting in line with other North West trusts in this aspect of care.

It has been agreed that the Advanced Nurse Practitioner Roles will continue for another year, providing a valuable resource for the trust in providing safe and effective care to patients.

7. Staffing

Like many Trusts, we are working toward a number of workforce priorities to drive forward quality of care provision 7 days a week. We plan to build on previously successful international and local recruitment as well as skill mix adjustments and changes to what have, to date, been seen as traditional medical or nursing roles. Consultant Physician presence for at least 12 hours 7 days a week is being implemented as a key initiative for quality. We are working closely with Health Education North West to align training programmes to deliver roles such as Physician's Assistants who may be drawn from a variety of health care backgrounds, and also with local universities to provide advanced and assistant practitioners. Additionally, in line with national drivers, we are seeking to review where 7 day working would most benefit our patients and provide seamless care from assessment, admission and discharge. Access to senior decision-makers is especially relevant given the apparent difference in outcomes associated with a weekend admission.

8. End of Life Care

A new Palliative Care Consultant Physician is in post, strengthening the Specialist Palliative Care Team's (SPCT) capacity and range of services. In addition to this, the SPCT want to undertake a review of the current service, to develop and augment skills by a variety of methods, including communication training in essential areas and improved signposting to bereavement services based on individual's needs. The Trust has volunteered to be a pilot site for the national end of life care audit prior to the main audit in the summer. The quality of end of life care is also assessed as part of the mortality review process, as well as in regular audits undertaken by the SPCT. The SPCT is continuing to roll out the new End of Life Care Plan

documentation and training. This aspect of the action plan will be reported through the Patient Experience Sub-Committee.

9. Documentation and coding

There is opportunity to further develop the relationship between medics and coders, so that they can jointly better understand the impact of how they document and then code this information. The scope of the Trust's Coding Manager role has been revised; this is now the Clinical Information and Engagement Manager, with a key focus on strengthening this vital link.

An issue has been identified with the recording of the patients' admission source i.e. where the patient was admitted into the hospital from. This has an impact on the HSMR as this measure considers patients who are admitted from a nursing home to be at increased risk of death. We are inaccurately reporting that patients are admitted from their own home, rather than a nursing home in 10% - 15% of cases. Work is underway to rectify this issue at a system level, and the implementation of Lorenzo will support greater accuracy of this information. In the meantime, since 1st February, these details have been checked for each patient who died, and amended in Meditech (patient information system) to the correct code.

The Trust has an above average use of 'signs and symptom' codes, the detail of which is provided on pages 11 and 12 of this report. The DIGG lead for Unscheduled Care is aware of this issue and is working with colleagues to address this. A review into a sample of cases will take place in Q1 2015/2016 to identify any issues regarding patients' care and any areas for improvement.

NEXT STEPS

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

RECOMMENDATIONS

Close monitoring of crude deaths rates and mortality ratios will continue, and progress against identified actions will be monitored. It is recommended that the Trust Board receive a quarterly mortality report. It is recommended that crude death rates be monitored monthly against ward (and therefore, broadly, speciality) against best available historical data. All deaths will be subject to mortality peer review and compliance with this process will also be reported. In the interests of continuous improvement such a report, and the processes underpinning it, shall be monitored closely to ensure that is provides the most useful information from board to ward.

CONCLUSION

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

Acknowledgements:

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

References:

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

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

Advancing Quality Alliance (May 2015) Warrington Hospitals NHS Foundation Trust: Quarterly Mortality Report: Issue 8, May 2015

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

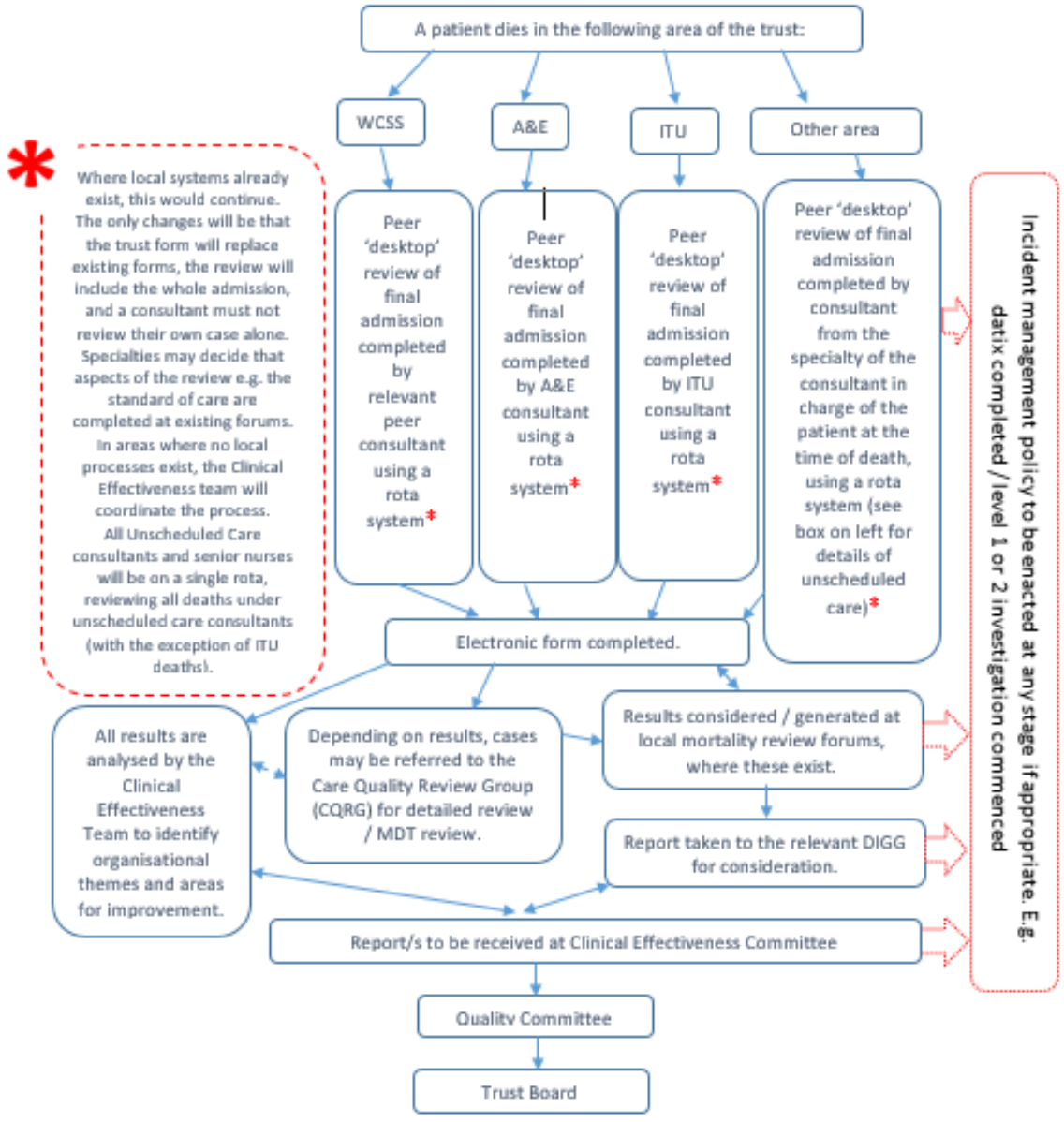
Appendix 1: Mortality Review Process and Screening Tool

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Mortality Review Process

Aim: The aim is to assess the quality of care at an individual and system level, for patients who died in our hospitals. The findings will be used to improve systems and care.

NB: The details of the electronic system to be used, and responsibilities regarding coordinating the process are to be agreed and will be included in a new Trust Mortality Review Policy. The same review tool is to be used by all areas. Work is underway to have as much as possible pre populated electronically. The format of reports between groups and committees is still to be agreed.



Warrington and Halton Hospitals NHS
NHS Foundation Trust

Mortality Peer Review: Screening Tool

Patient's Name		W no.		D.O.B	
Admission date	Admission time		Date of death		
Reviewer name/s	Designation/s		Date review completed		

1. What was the recorded cause of death?	1a	
	1b	
	1c	
	2	

2. Was the primary diagnosis accurate?	Yes		No	
If no, please give details				

3. What was the length of time from admission to Consultant review?					
<=12 hrs		12 – 24hrs		>24hrs	
If over 12 hours, please give all details available					

4. Was there evidence of end-of-life expectancy and appropriate management and documentation? Please consider discussion/agreement regarding whether the death was expected, use of Amber Care, Ceiling of Care, Specialist Palliative Care involvement, escalated care (ICU/HDU) or uDNACPR arrangements (including arrangements in the community).				
Yes		No		
If no, please give details				

5. Was the patient's death expected or unexpected?				
Expected		Unexpected		

Institute for Healthcare Improvement definitions:

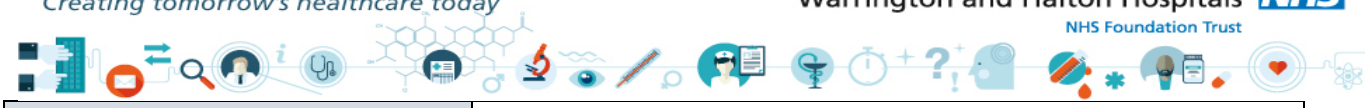
Expected Death where there was clear evidence of preparation for death.
This normally includes a DNAR (Do Not Attempt Resuscitation) form, evidence of discussion with family members, and comments from the team caring for the patient about limitations of provision of care (such as not suitable for ITU, and Non-invasive Ventilation).
Unexpected Death where there was no evidence of preparation for the death of the patient. Such deaths would include any, where there was an "arrest call" made, or deaths where there were ongoing unresolved care issues (such as assessments for ITU care, or Non-invasive Ventilation).

6. **How would you rate the care received by this patient?** (adapted NCEPOD classification of care)		
Good Practice	A standard you would accept for yourself, your trainees and your institution	
Room for improvement	Aspects of clinical and or organisational care that could have been better (but they made no difference to the outcome)	
Less than satisfactory	Several aspects of clinical and/or organisational care that were below satisfactory (which may have, or did contribute to the patient's death)	
Unable to rate	Detailed review required	

BOARD OF DIRECTORS

WHH/B/2015/ **126**

SUBJECT:	**Complaints: Patient Experience Annual Report – 2014/2015**
DATE OF MEETING:	27th May 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 during 2014/2015: • The Trust received a total of 474 formal complaints between 1 April 2014 and 31 March 2015, which is an increase of 56 on the previous year. • 21 cases have been closed by the PHSO during the year. There are three cases ongoing at the moment. • 1,921 people contacted PALS during the year, this is an increase of 241 contacts on previous year. • Numbers of posts on *NHS Choices* are included and the star rating assigned by the website. • 40 formal compliment letters were sent to the Chief Executive. • Graphs demonstrate the total complaints by subject and divisional top 5 complaint themes. • 100% of complaints were closed within agreed timescales.
RECOMMENDATION:	***The Board is asked to:*** The Board is asked to note the contents of this report, which



	describe the progress in the monitoring of complaints and to approve the actions recommended.	
PREVIOUSLY CONSIDERED BY:	**Committee** **NA**	Choose an item. Or type here if not on list:
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

Executive Summary

This is the third annual report from the Patient Experience Team, primarily providing an overview of complaints received, complaint handling and also including some information on other forms of feedback from patients, relatives and other services users from 1 April 2014to 31 March 2015. This report is written in accordance with the NHS Complaints Regulations (2009).

The types of feedback reported in this document are:

- Formal complaints
- Concerns
- PALS
- NHS Choices
- Compliment letters

Quarterly reports to the Board have included the information to be found in this report, specifically for the time period specified. Yearly figures for Parliamentary Health Service Ombudsman (PHSO) cases, returns, meetings with complainants are provided. There is also demographic information on who made complaints by age, gender etc.

During 2014/2015, there were 614,213 attendances to the Trust. The vast majority of those patients and their families/carers have been satisfied, or happy with the care and treatment they received. When the experience of care is not as expected or is poor, the Trust continues to be committed to providing open, honest responses to complaints and to demonstrate that where there are failings, action will be taken to improve.

Hard Truths: The Journey to Putting Patients First, is the Government response to the Mid Staffordshire NHS Foundation Trust public inquiry, published in January 2014. This report contained exhaustive recommendations to ensure that patients are empowered to complain if necessary and that complaints are "owned" at every level, from the staff delivering the care and treatment to the executive directors. This includes simplifying the complaints process for patients and their families, ensuring staff are competent in investigating complaints, in accepting responsibility for failings and in making improvements and in the provision of open and honest reporting of complaints.

In November 2014 the PHSO produced a report, *My expectations for raising concerns and complaints,* identifying a user-led "vision" of the complaints system. This provides an outcomes framework for implementation and the CQC will use this framework in its new inspection regime, see appendix 1.

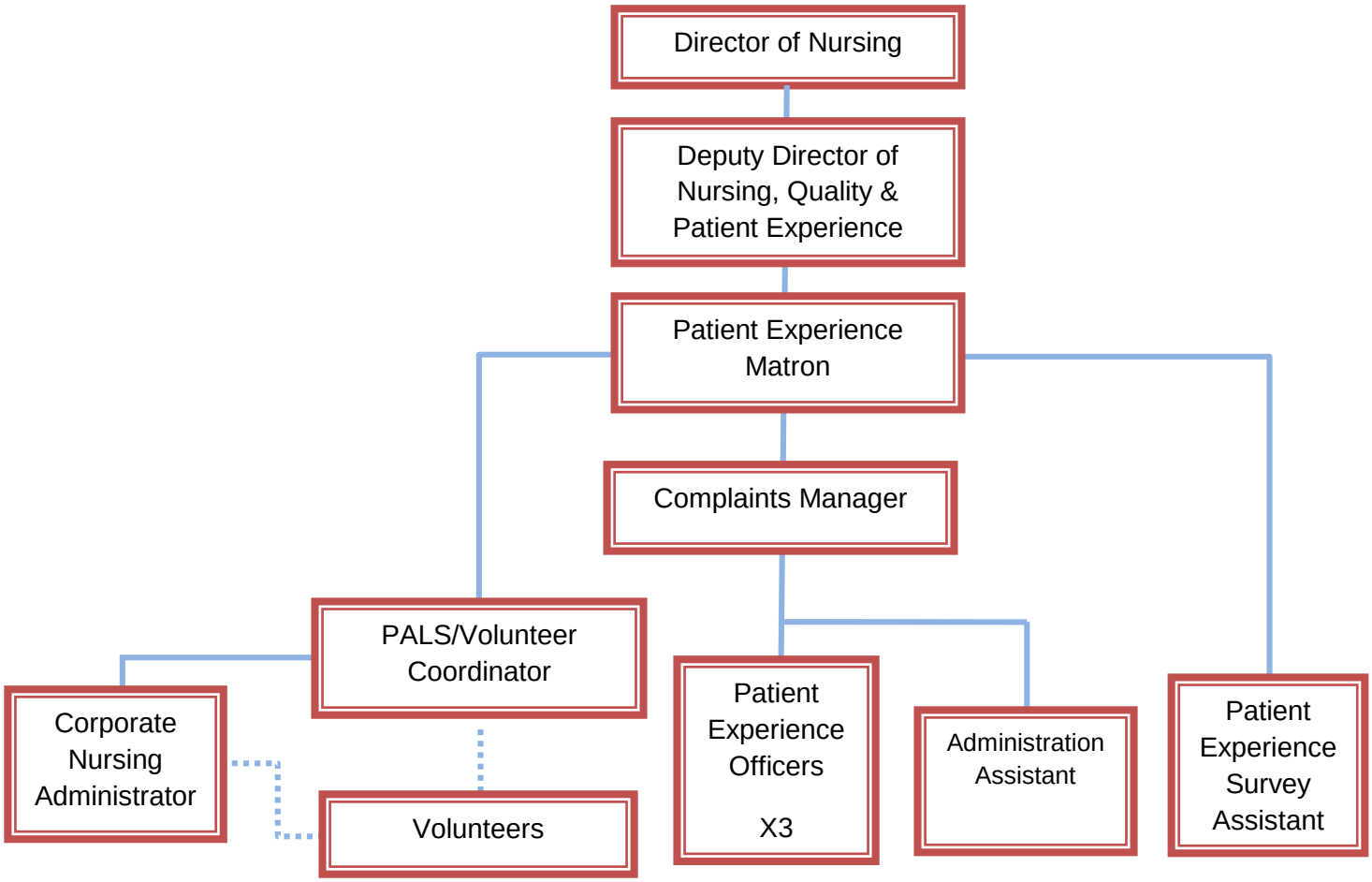
In their report *Complaints about acute trusts 2013 and Q1, Q2 2014-15,* the PHSO calls upon chief executives and Trust board members to use complaints data to examine how the organisation is performing, relative to others and to ask some searching questions.

Moving forward, the Trust must engage with all lessons from high level inquiries and ensure that all service development is congruent with the recommendations of the PHSO and other relevant bodies.

1. The service

The Patient Experience Team, in recognition of both the importance of effective complaints handling and the growing profile of the wider patient experience agenda, has employed a part-time Complaints Manager to support the Patient Experience Matron in ensuring the efficient functioning of the complaints process.

1.1. Patient Experience Team structure – 2014/2015



2. Background

This report sets out a detailed analysis of the nature and number of formal complaints, concerns, PALS contacts and other forms of feedback received. The Trust complaints system is in accordance with the *NHS Complaints Regulations* (2009) and is compliant with CQC Regulation 19, Outcome 17.

2.1 Complaints overview

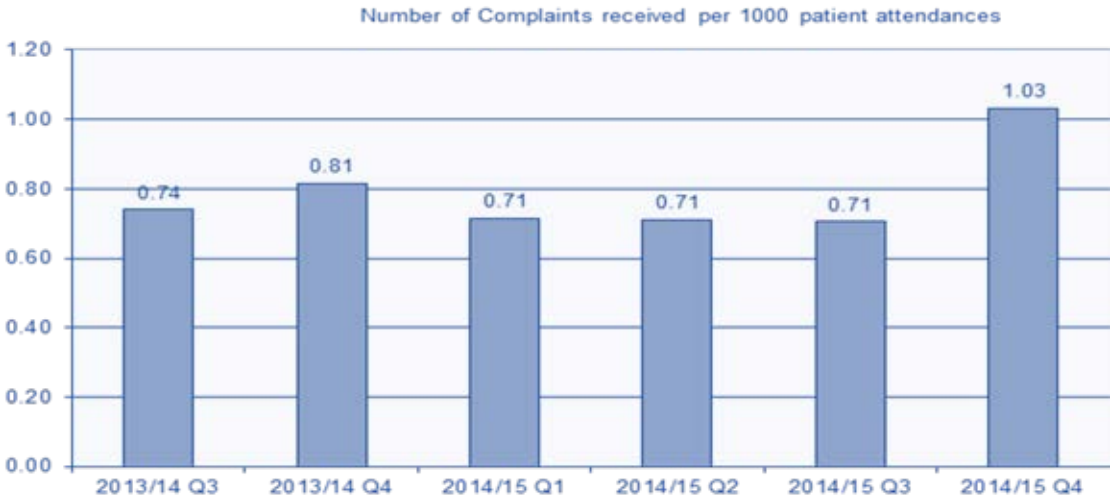
During 2014/2015 there were 612,413 attendances to our services.

Activity	Type									
	Day case	Inpatient	Non-elective	New	Follow up	A&E	MIU	Ward attender	Outside clinic attend-ance	Grand total
2014/2015	32581	5524	39769	123047	295654	86039	16585	13784	960	614213

Table 1 – Trust activity 2014/2015

This includes 5,524 inpatients and 102,624 attendances to the Accident and Emergency Department and Minor Injuries Department combined.

Figure 1 – Complaints received per 1000 patient attendances



The Trust received a total of 474 formal complaints during the year and these were investigated in accordance with the Trust Complaints and Concerns policy. This is a 13.39% increase on the previous year.

Table 2 – Formal complaints 2012 – 2014

Financial Year	Formal Complaints Received
2012/2013	574

2013/2014	418
2014/2015	474

Table 3 – Risk grading of complaints, by quarter

	2014/15 Q1	2014/15 Q2	2014/15 Q3	2014/15 Q4	Change from last quarter
Complaints Received	105	110	108	151	⇧
Low	48	41	39	79	⇧
Moderate	39	58	54	62	⇧
High	18	11	15	10	⇩

All formal complaints were received in the English language with no requests made by a complainant for access to the interpreter service. There was one formal complaints from the foster carer of a patient with learning disabilities. There were four patients reporting a physical or sensory disability and one with Alzheimer's disease or dementia. Two patients were recorded as having a mental health condition.

Staff are encouraged to record any disabilities on the complaints file, but we have no assurance that this always happens, as we sometimes don't initially have the information, or in some cases, ever during the time the complaint is open. The team is trialling a new front sheet and this information will be a mandatory field to ensure this information is captured.

All complaints are subject to quality assurance processes before being sent to the complainant from the Chief Executive Officer or Deputy Chief Executive Officer. This includes reading/editing by Patient Experience Matron and final check by Deputy Director of Nursing, Quality and Patient Experience. Any problems with readability are fixed, but the draft may be returned to the division if it is felt that questions are not answered or if issues needs clarifying. The Patient Experience Team is about to trial different formats for these letters to see if there is a better way to present information to complainants.

2.2 Parliamentary and Health Service Ombudsman (PHSO)

The PHSO have closed 21 cases during the year. Four cases were upheld and nine were partly upheld. The Trust has complied with recommendations with all but two of these, where we are asking for adjustments in the findings or recommendations. Seven cases were not upheld and there are three cases ongoing at the moment. The PHSO closed one case because the complainant is seeking legal redress.

Given that the PHSO has asked boards to look at Trust performance, in comparison with other Trusts, table 4 shows PHSO data for Quarter 1 and 2 in 2014/2015.

Table 4 – PHSO figures for Q1 and Q2 2014/2015

Trust	Enquiries received by PHSO	Enquiries accepted for investigation by PHSO	Investigations upheld/partly upheld
Countess of Chester	9	1	1
East Cheshire	11	1	2
Mid Cheshire	8	4	0
Southport & Ormskirk	21	5	2
St Helens & Knowsley	18	4	1
Warrington & Halton	23	9	5

Comparing the previous year's complaints (2013/2014), Warrington and Halton received the highest number of complaints of the Trusts listed in table 4. In addition, we had the highest number of referrals to PHSO with 66, of which 15 were investigated though only 2 were upheld/partly upheld. More analysis is needed to make sense of this information and the Patient Experience Matron will investigate and monitor the situation.

It has been a challenging year in terms of PHSO investigations. The Trust has been in the position of questioning the findings of three reports, including recommended "financial remedies". It is difficult to challenge the PHSO since there are no procedural safeguards for those complained against and while we try to work cooperatively, there have been occasions where we have felt strongly that findings and/or recommendations have been unwarranted. In one case the PHSO secured the services of a second clinical advisor and those findings were more palatable to the Trust clinician's involved in the case who had felt there had been no wrongdoing.

2.3 Patient Advice and Liaison Service (PALS)

A total of 1,921 people contacted PALS in 2014/2015, compared to 1,680 in the previous year. This is an increase of 241. 38 PALS cases became formal complaints during 2014/2015.

Table 5: Total PALS contacts by Quarter

Q1	Contacts	Q2	Contacts	Q3	Contacts	Q4	Contacts
April	137	July	154	October	175	January	173
May	181	August	140	November	126	February	188
June	137	September	175	December	106	March	229
Total	455	Total	469	Total	407	Total	590

The PALS/Volunteer Coordinator continues to be assisted by a temporary member of staff and additional support is provided by the patient experience officers. Despite this additional support, keeping up with the demand for PALS intervention remains a challenge. Our response rates are not as fast as we would like, despite the best efforts of the team. A great benefit to the service has been moving into the former membership office, now named the *Patient Information Hub.* Trust volunteers man the office most weekdays and support PALS by taking calls and enquiries. This means that callers can leave their contact details and basic queries and relieves the burden of additional calls to the complaints telephone when the PALS Officer is busy. This might also account for some of the increase in contacts, as people are able to drop in with queries. Eventually we would like to make the back office into the PALS office, but some building work is required for it to be fit for purpose.

User feedback on the PALS experience has not been sought in the past and what feedback we have received has been unsolicited. For formal complaints a questionnaire is sent with the response letter. Due to the nature of PALS a less formal approach was sought. In April 2015, a PALS volunteer rang 40 people who had contacted PALS in the previous quarter. She was successful in speaking to 22 of these individuals to ask for their feedback on the service they had received from PALS. All feedback was positive, see some of the comments below:

"Very pleased with the service, the PALS staff were very helpful".

"The staff were pleasant and made me feel supported".

"Having someone to listen helped me with my recovery and helped me feel at ease during a difficult time".

"I received help and support during my bereavement – this service is very helpful".

"The staff went above and beyond to help my dad when he was very poorly".

"Good service, helpful to know you can pop in to get advice immediately".

The Hard Truths report includes a recommendation that,

> "Patient and advice liaison services should be re-branded and reviewed so it is clearer what the service offers to patients and it should be adequately resourced in very hospital."

In trying to review our service we are taking the following actions:

- Wait to see if more concrete recommendations around the future of PALS are forthcoming in the next months.
- The PALS Datix module has been adapted to include the same subjects as the complaints module. This will enable a range of reports to be generated, going forward. There remains some upgrades needed for the PALS module and the team are attempting to deal with a backlog of PALS sheets needing to be recorded on Datix.

- The PALS/Volunteer Coordinator is setting up a local PALS network as an opportunity to share ideas, good practice and to bench mark performance. The first meeting is arranged for 30 June 2015.
- Keep a log of "walk ins" to the patient information hub and types of issues raised.
- Provide more training to patient experience team and volunteers in dealing with difficult situations, including breakaway training.
- Raising awareness of PALS at various events in the community.

Table 6 – Examples of PALS cases

PALS Issue	Action
Family were very upset as they could not afford a funeral and they had failed to receive any help.	Having made several calls to the Borough Council the Business Compliance Team Manager agreed that she would be able to assist the family with the funeral costs. The family were relieved and extremely grateful to have received the help as they did not know who to turn to.
Patient passed away and his grandson was extremely upset that Granddad's feet would be cold as his slippers had gone missing on the ward.	A member of the PALS team visited the ward and found the slippers, which were returned the family. The family wrote to PALS to thank them for their help as the patient's grandson was happy knowing that his granddad would no longer have cold feet.
Patient's husband had not been apart from his wife for over 60 years and had to go over to Italy for an Army award and was very concerned about leaving her.	PALS mediated between the ward staff and patient to ensure the husband received a daily call to let him know how his wife was feeling/progressing. This contact happened on a daily basis, up to his return. This contact provided reassurance and comfort to both the patient and her husband.

2.4 *NHS Choices*

Patients and visitors can post comments about their experience in our hospitals on the *NHS Choices* website. They can also rate the service in terms of whether they would recommend the hospital to friends and family if they needed similar care and treatment; cleanliness; staff co-operation; dignity and respect; involvement in decisions; and same sex accommodation. *NHS Choices* calculate a star rating for each site, based on the feedback, with 5 stars being the highest.

Table 7 –Overall star rating by site

Warrington Hospital	Halton Hospital	CMTC
3.5 Stars	5 Stars	5 Stars

Examples of the feedback through the year has been included in quarterly reports. The feedback is monitored and appropriate responses are posted on the site, encouraging people to raise concerns through PALS or the complaints process.

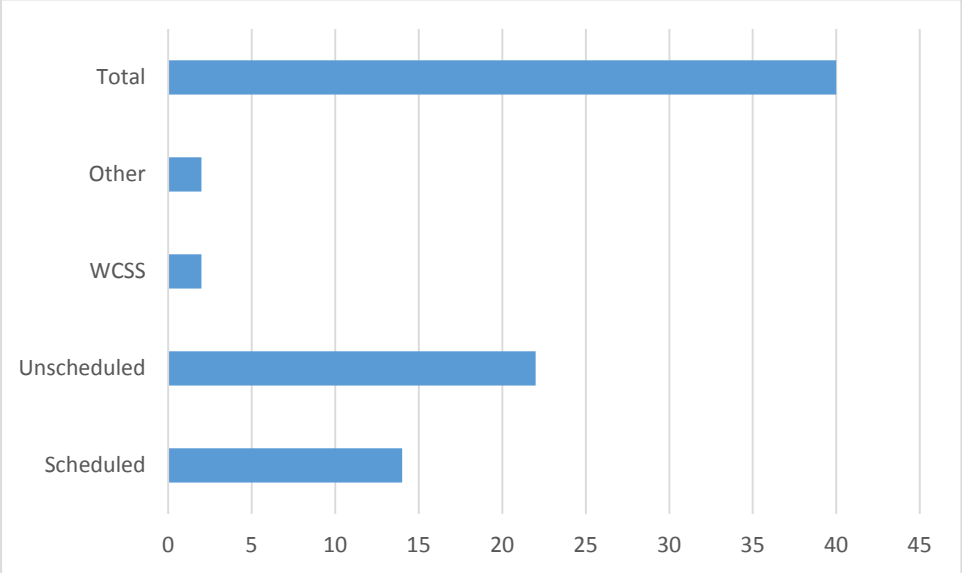
Table 7 - Numbers of comments posted for 2014/2015 by star ratings and site

Star rating	Warrington	Halton	CMTC
★★★★★	50	35	17
★★★★	8	1	1
★★★	3	0	0
★★	4	0	0
★	24	2	0
Total for 2014/15 **141**	85	38	18

2.5 Compliments

A total of 40 compliment letters were received by the Chief Executive. Positive feedback is always shared with the relevant teams. Sometimes compliments come through other routes, for example a nomination for employee or team of the month may be received form a member of the public who has either experienced excellent care, or has witnessed the care of a loved one that has prompted a nomination.

Figure 2 – Compliments received, by division



3. Formal complaints

3.1 Data collection and analysis

Since the decision was made to re-assign all withdrawn complaints as concerns, the formal complaint figures have become more subject to change than previously. The point at which a complaint is withdrawn can vary so the patient experience team have identified the need to reconcile these figures both monthly, when the KPI report is done and quarterly to ensure that any case that has been withdrawn at a later date is correctly assigned and the quarterly figure is correct.

Quarterly reports now include top 5 themes for all three division, corporate and Accident and Emergency to provide the opportunity for further inquiry into trends. In addition, end of life care reports for the Director of Nursing and falls reports for the falls group are now run regularly. The board requested an assurance report in response to the rise in complaints about attitude that was tabled at the March 2015 board meeting. This included data about complaints about the attitude of trust staff, with examples of learning and comparison to both national increases in complaints about or including attitude and other organisations. The PHSO report, *Complaints about acute trusts 2013-14 and Q1,Q2 2014-15* says that staff attitude accounts for 20% of complaints made and poor communication for 30%. The report has been shared with divisions for consideration and will continue to be highlighted. Recommendations made in that report were:

- Where there is a complaint about a member of staff's attitude, the manager or clinical lead for that person should be the one to respond. Complainants are not likely to be impressed by a response from the person they had a problem with. This also means that the manager can speak about the individual's usual performance and instigate disciplinary processes if these are indicated, either because this is one of several issues, or because of the seriousness of the incident. The manager is also

in a position to monitor future performance and identify appropriate development activities.

- In addition to apologising, there should be some evidence that the individual has reflected, learned, improved etc. Though apologies are important, it is also important to demonstrate that action was taken. Complainants often only want to ensure that what happened to them will not happen to someone else.
- If the member of staff is very insistent that there was no inappropriate behaviour or attitude on their part, this needs to be clearly stated and not confuse the issue by then identifying actions or training to be taken.
- Also interview any witnesses and include their accounts in the investigation and response.
- Managers must note any repeated complaints about attitude and review actions to be taken to prevent future problems.

3.2 Formal complaints received in 2014/2015

In line with Trust policy, a complaint becomes formal in accordance with patients' wishes. This may originate from a concern (written or verbal) that has not been possible to resolve in the clinical environment, through PALS, or directed to the service for formal investigation. A total of 474 formal complaints were received and investigated by the Trust during 2014/2015 compared to 418 received during 2013/2014.

The following graphs provide a quarterly and monthly analysis of complaints for 2014/2015:

Figure 3 - Complaints received 2011/2012 – 2014/2015

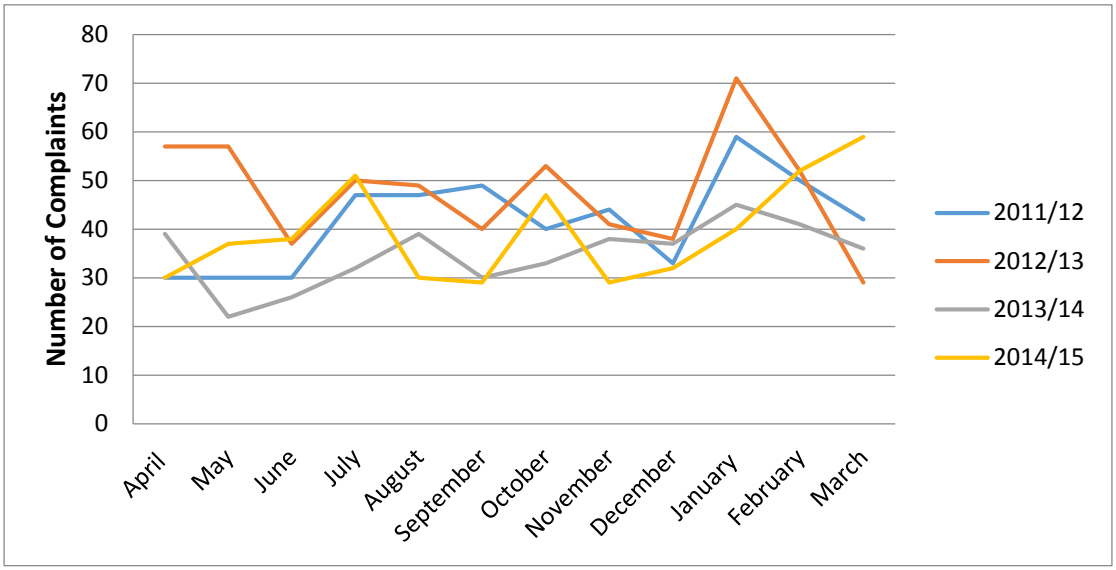


Figure 4 – Complaints received, by quarter 2014/2015

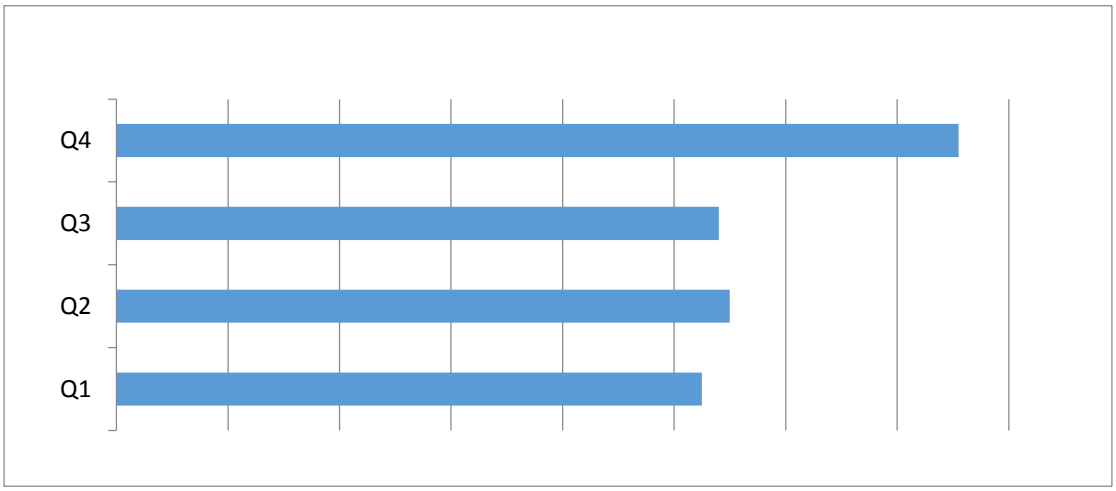


Figure 5 – Complaints, total by month 2014/2015

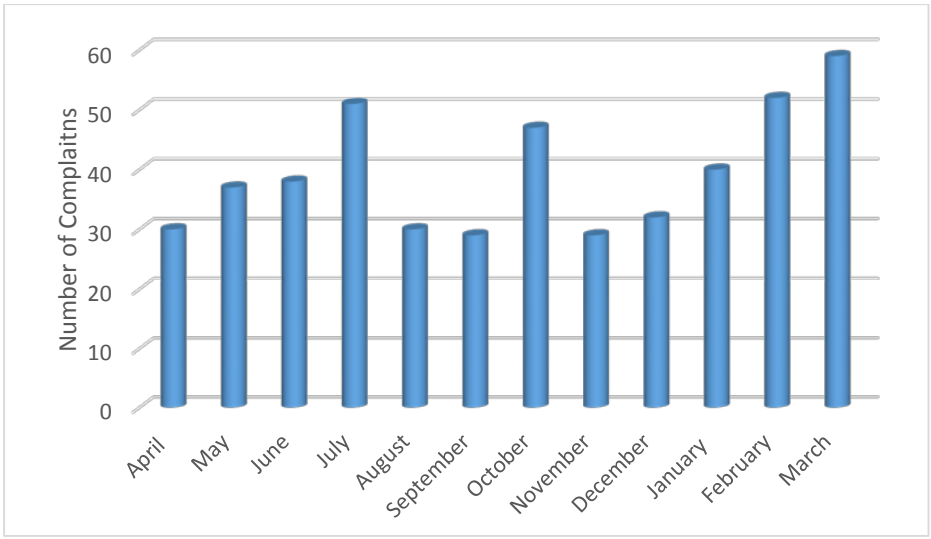


Figure 6 – Top 5 Subjects for Unscheduled Care (excluding AED) for 2014/2015

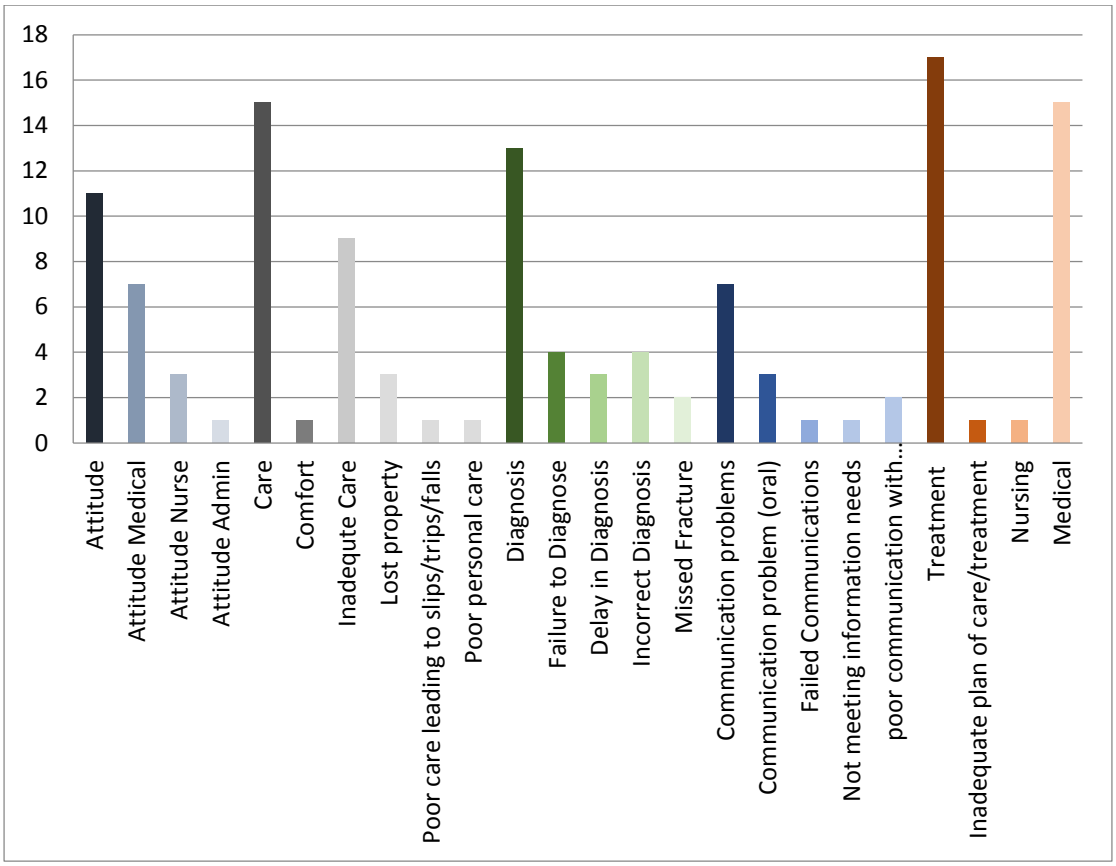


Figure 7 - Top 5 Subjects for AED for 2014/2015

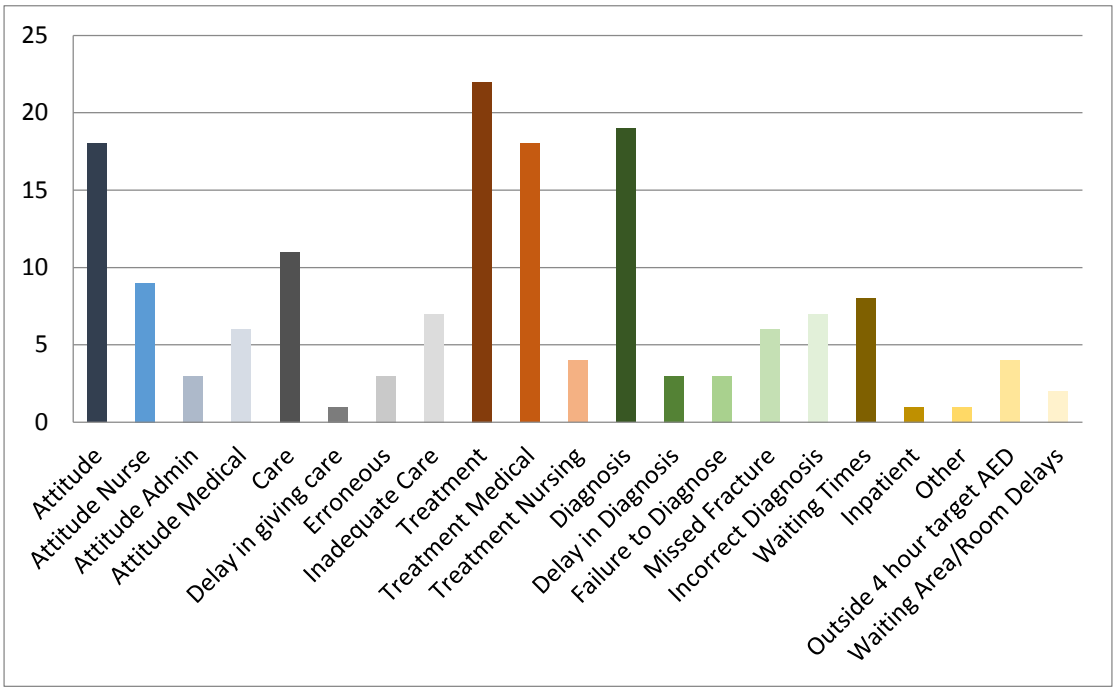


Figure 8- Top 5 Subjects for Scheduled Care for 2014/2015

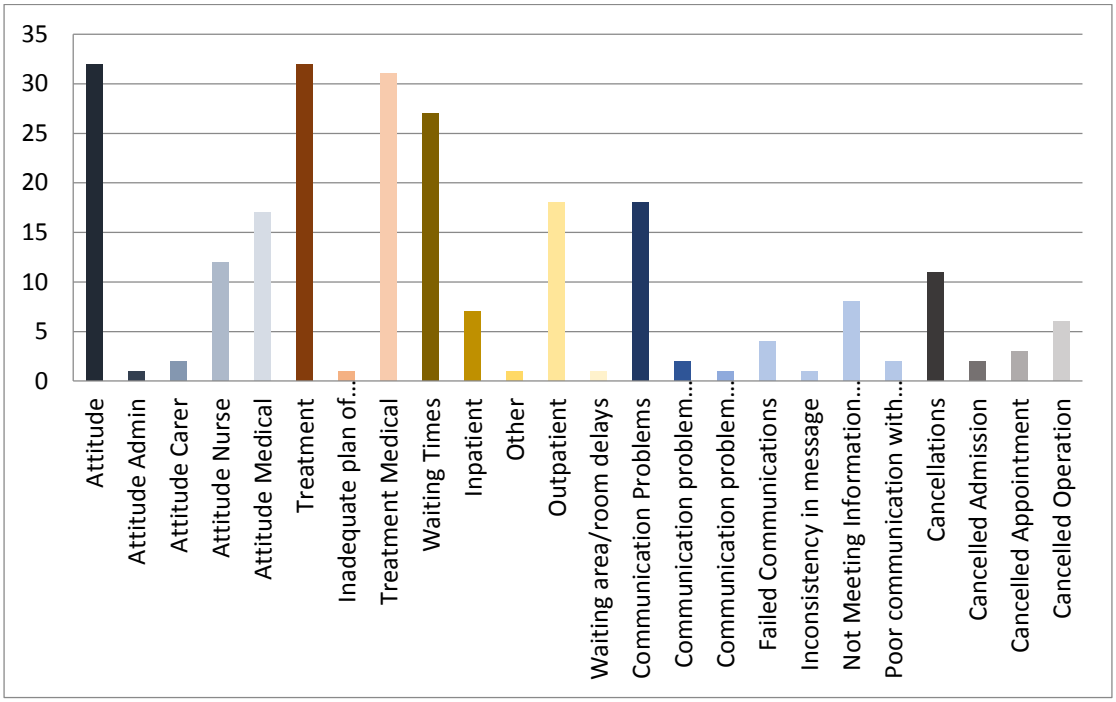


Figure 9 - Top 5 Subjects for WCSS for 2014/2015

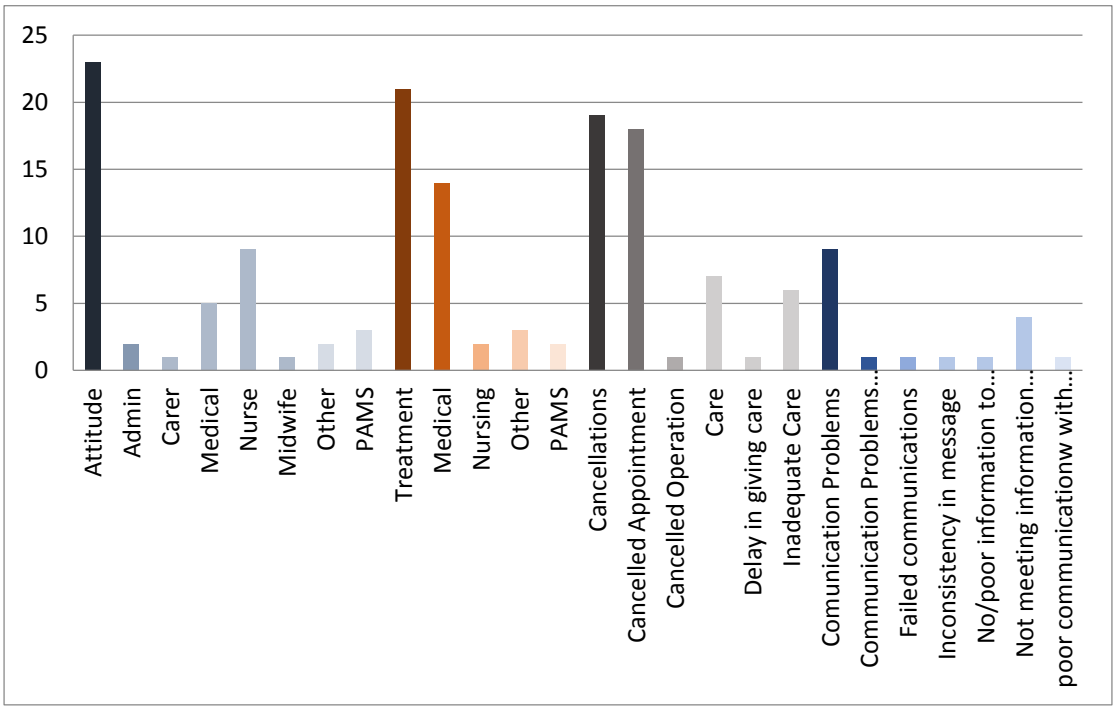
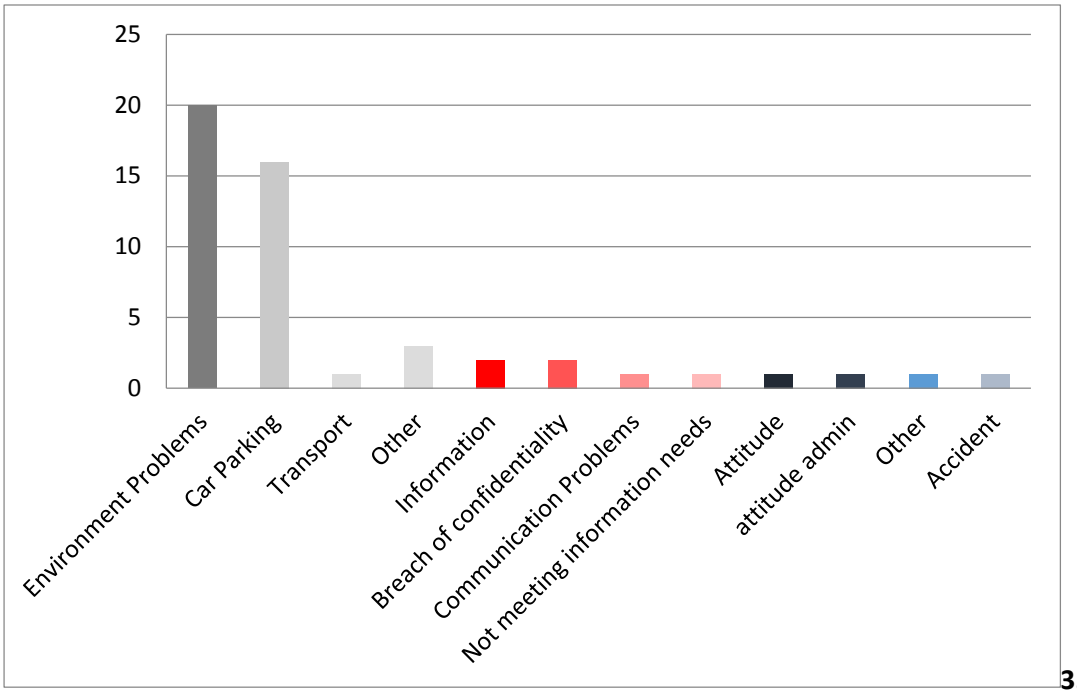


Figure 10 – Top 5 Subjects for Corporate Services for 2014/2015



3.3

3.3 Demographic analysis of complaints

In accordance with guidance from the NHS Information Centre, the Trust is required to undertake a demographic analysis of complaints, which includes analysis by the age and gender of the person referred to in the complaint.

Figure 11 – Complaints by gender

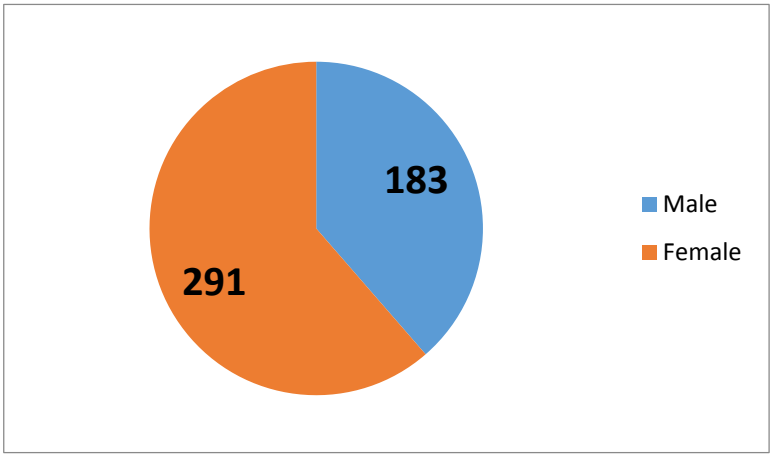
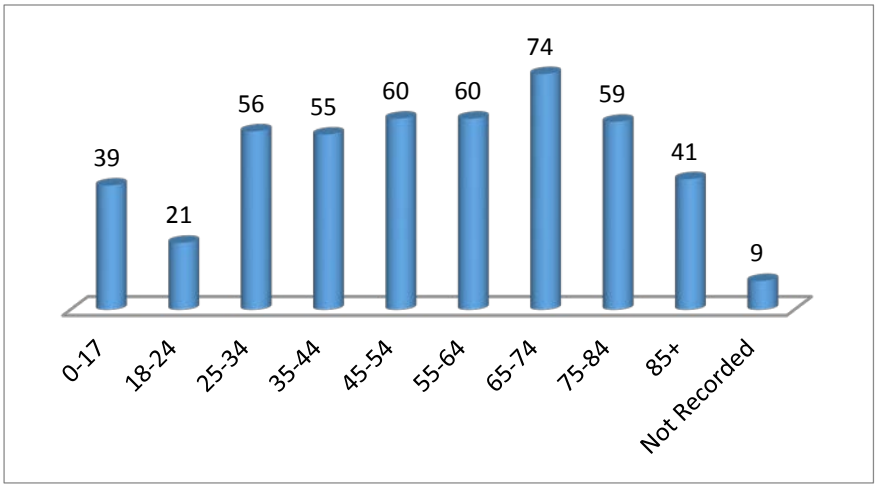


Figure 12 – Complainants by age group



If the complaint is about an individual patient, the Trust records the age of the patient however if the complaint is about a service we cannot record this information. The highest number of complaints are received from people aged 65-74 years.

Figure 13 – Complaint origin

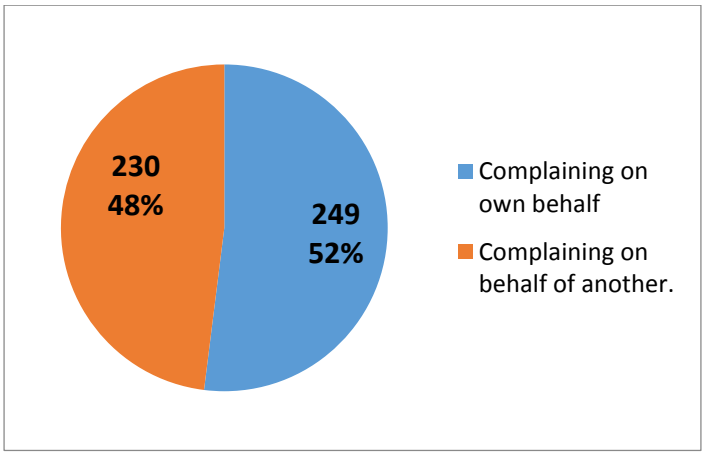
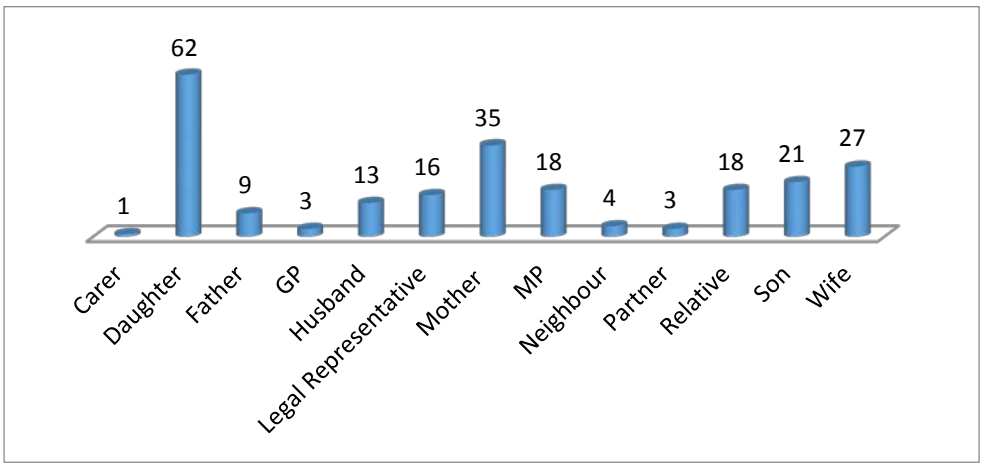


Figure 14 – Breakdown of who complained



The complaints from GP should have been recorded as interface incidents and investigated through a clinical incident report.

3.4 Responding to people who want to tell us about their experience in a timely manner

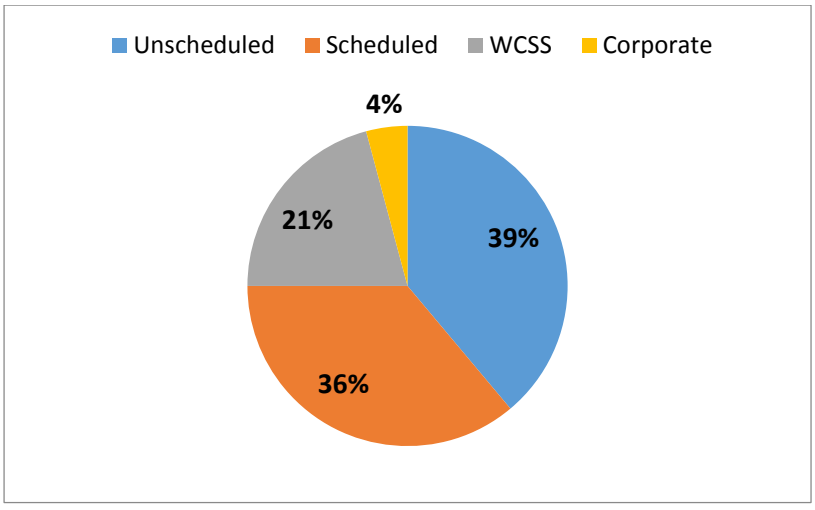
Since March 2014 the Trust has met/exceeded its key performance indicator (KPI) of 94% of complaints closed within agreed timescales, an indicator that both systems and communication with complainants has improved.

Complaints investigations require more time to reach completion when the concerns raised are significantly more complex, and often cross-divisional. For example a patient's journey may cross diagnostic services, support services, theatres and pharmacy. The impact of investigation concerns across services and departments can build delays in completing the investigation. A major factor in this is availability of medical records. Therefore agreement for an extension for the response date needed to be negotiated with the complainant.

3.5 Complaints withdrawn

During 2014/2015 a total of 72 complaints were withdrawn. Complaints can be withdrawn for a variety of reasons, generally it is because the service user had the opportunity to discuss their issues with a member of the service or a member of staff from the divisional team had contacted them to discuss their concerns and they had been resolved, for example this could be an appointment confirmed, or clarity of information provided satisfactorily. Sometimes complainants do not return completed consent forms and the complaint may be withdrawn, after providing the complainant with a final date for sending the consent.

Figure 15 - Split of complaints that are withdrawn



3.6 Returned complaints

Of those who complained, 37 people felt they were unhappy with their initial responses and they wrote to us asking for further information, to meet with us, or to provide clarification. In 2013/2014, there were more than double the number of returns, with 40 more than last year. The disparity between the numbers of returns seems inconsistent with the seemingly high number of PHSO referrals and will be considered as part of the review to be done. Partly, this can be explained by the time lag following a closed complaint to when the

complainant approaches the PHSO. They have a year to do so, but we have seen the PHSO take on cases several years old. Time will tell whether the drop in returns in the past year, shows a corresponding drop in PHSO referrals next year.

Table 9 - Returned complaints, by division

Division	Not Upheld	Partially Upheld	Upheld
Unscheduled	5	7	4
Scheduled	8	7	0
WCSS	1	3	2
Corporate	0	0	0
	14	17	6

3.7 Complaints linked to serious incidents

During 2014/2015, 45 complaints were linked with reported incidents. Of these 4 became level 1 investigations and 1 has been the subject of a serious incident investigation.

New guidance from the CCG has recommended that any complaint that is graded as high risk should be investigated as a serious incident. Since the initial risk grading is done by the Patient Experience Matron and based on the (subjective) complaint letter, any high risk grading will be prioritised when first received by the division, in order that a decision can be made as to whether there has been severe harm caused in a timely manner. If not, the complaint grading can be reduced to reflect the harm.

3.8 Formal meetings organised

There were 43 meetings with complainants and families over the year. We continue to try to encourage meetings in order to resolve complaints, develop rapport and support complainants and families. It is difficult to arrange meetings for multiple people, given work commitments of both complainants and staff.

4. Lessons learned

It is essential that the Trust continues to learn from complaints, and ensures that what is learnt results in service improvements which are embedded in everyday practice. Throughout the year, quarterly reports have included examples of learning and action taken following complaints. Rather than repeat these in this report, we can take an opportunity to identify some priorities for divisional and organisational learning from the themes and trends of the past year.

1. Continue to monitor complaints about attitude and communication. Looking for trends and ensuring that appropriate triggers for formal disciplinary action are in place. Encourage reflection on incidents and use of tools like the care and compassion workbook or, for medical staff, through PDR.

2. Accident and Emergency to continue to monitor complaints about missed fractures or delayed diagnosis of fractures and consider developing patient information to better manage expectations of treatment for bony injuries.

3. More team involvement in reviewing and responding to complaints. Ensure staff know what complaints have been made and what response is given. Also to increase the number of complaint investigators to relieve some of the burden on matrons and other service leads.

4. Ensure that positive feedback is part of the picture so that teams and individuals can see the balance between positive and negative. This will include information from national surveys, friends and family test, local surveys, stories etc.

5. Demonstrating compliance with legislative requirements

The PHSO has identified a vision for what good looks like from the user point of view. In order to echo our long held vision of patient centred care, our complaints must also be patient centred. As we continue to learn from the lessons of Barking and Havering, Morecambe Bay and Mid Staffordshire, the complaints system must evolve to support an open and honest culture and justice for people when things go wrong.

6. Actions for 2015/2016

As the patient experience agenda expands, the relevance of how we listen to and fix complaints becomes more a part of an experience continuum, from poor to excellent. As much as we want to receive excellent ratings through surveys *etcetera*, we want to achieve excellence in handling complaints.

In order to meet the expectations of the Board, the commissioners and, most importantly, the public we must continue to improve the systems in place and ensure that the methods we employ to investigate and learn from complaints provide assurance and demonstrate a transparent and committed process and staff who want to acknowledge failures and learn from them.

Improvements planned for 2013/2014 include:

- Modernisation of the PALS in line with local good practice and national guidance. This will include the actions previously stated.

- A broad range of skills are needed by those handling complaints, those tasked with investigating and those who must make improvements on the back of complaints. Provision of formal teaching, coaching small groups and individuals is ongoing. More protected time is needed to support those staff involved in investigating and responding to complaints.

- Work continues on refining the systems for complaints, both electronic and human. The policy needs to be reviewed in order to update the new CCG guidance regarding high risk complaints and this provides an opportunity to review the pathways and workability of other aspects of the policy.

- Review and investigate the high numbers of PHSO referrals and compare to reduced returns.

- Develop the format of this report to encompass all aspects of Patient Experience. This is behind schedule. As the new experience of care strategy is developed, there is an opportunity to look at how we report the whole of patient experience and where complaints and PALS fit in this.

7. 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.

Appendix 1: A user –led vision for raising concerns and complaints

Source: My expectations for raising complaints and concerns, PHSO 2014